Highmark Blue Shield Regulations for Participating Providers, PremierBlue Shield Providers and Government Sponsored Program Providers

PART I – SHARED PROVISIONS

Part I of these Highmark Blue Shield Regulations for Participating Providers, PremierBlue Shield Providers, and Government Sponsored Program Providers ("Regulations") applies to you as a Participating Provider and/or a PremierBlue Shield Preferred Provider and/or Government Sponsored Programs Provider, regardless of the version of the Participating Provider Agreement and/or the PremierBlue Shield Preferred Provider Agreement and/or Government Sponsored Programs Agreement (individually, an "Agreement" and, collectively, the "Agreements") you hold and regardless of whether you have entered into any number of said Agreements and apply in full force and effect to each such Agreement, unless expressly limited to a specific network in these shared provisions. Providers enrolled in the Blue Shield Participating Provider network must also comply with the provisions set forth in Part II below. Providers enrolled in the Blue Shield PremierBlue Shield Preferred Provider network must also comply with the provisions set forth in Part III below. Providers enrolled in the Government Sponsored Programs network(s) must also comply with the provisions set forth in Part IV below. The Government Sponsored Programs Agreement is offered only to select providers at Highmark's discretion. ***This set of Regulations is a comprehensive set that contains provisions applicable to more than one network. Highmark, in its discretion, requires underlying network contracts to be executed for each such applicable network, including, without limitation, a Participating Provider Agreement for the Participating Provider Network, a PremierBlue Shield Agreement for the PremierBlue Shield Provider Network, and/or a Government Sponsored Provider Agreement for the Government Sponsored Agreement Network, subject to Highmark's discretion to offer such contracts. Networks may support various Products and Provider's participation in a Product shall be subject to Highmark's discretion as set forth herein. The inclusion of multiple networks in this comprehensive set of Regulations does not act as an offer or an agreement for any network.***

1. DEFINITIONS

Unless otherwise defined, capitalized terms as used in the Agreements and in these Regulations shall have the meanings assigned to them below.

1.1. "Administrative Requirements" shall mean, individually and collectively, Blue Shield's and/or, where applicable, Health Plan's guidelines, policies, procedures, medical policy, manuals, instructions, bulletins, directives, Bylaws, Review Committee Guidelines, publications, newsletters, and/or other documents applicable to Health Plan programs, either in written or electronic format.

1.2. "ASO Account" shall mean a benefit plan of a self-insured employer or group for which Blue Shield or Health Plan, as the case may be, agrees to provide a network of providers and is responsible for all or part of the administration of the applicable Plan Document.

1.3. "Blue Shield" shall mean Highmark Inc. d/b/a Highmark Blue Shield.

1.4. "BSOM" shall mean the Blue Shield Office Manual or its successor.

1.5. "Bylaws" shall mean the bylaws of Blue Shield.

1.6. "Clean Claim" shall mean, as required by applicable Laws, a claim for payment for Covered Services that has no defect or impropriety. A defect or impropriety shall include lack of required substantiating documentation or a particular circumstance requiring special treatment that prevents timely payment from being made on the claim. The term shall not include a claim from Provider on its own behalf or on behalf of any Practitioner who/which is under investigation for fraud and/or abuse regarding that claim.

1.7. "Coinsurance" shall mean the percentage or portion of fees and charges payable by a Member.

1.8. "Copayment" shall mean the fixed, up-front dollar amount payable by a Member.

1.9. "Covered Services" shall mean those Provider Services rendered to Members which qualify for payment or reimbursement pursuant to the terms of the applicable Plan Document and/or Administrative Requirements, subject to applicable Coinsurance, Copayments and/or Deductibles. Any benefit maximums, exclusions and/or limitations for each Member shall be referenced in the applicable Plan Document applicable to that Member.

1.10. "Deductible" shall mean a specified amount of liability for Covered Services that must be incurred before Blue Shield, on its own behalf or on behalf of Health Plan, will assume any liability for all or part of the payment for Covered Services.

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

1.12. "**Government Sponsored Programs**" shall mean those government sponsored programs, as designated by Highmark, for which the Provider has been designated to participate, at Highmark's sole discretion, which includes but is not limited those qualified benefit plans offered by Highmark or Health Plan, in its discretion, to individuals and/or families and/or small groups, as determined by Highmark on or off an American Health Benefit Exchange as defined in the Patient Protection and Affordable Care Act (P.L. 111-148) as amended from time to time.

1.13. "Government Sponsored Programs Agreement" shall mean an agreement between Government Sponsored Programs Provider and Blue Shield, regardless of the title, whereby Government Sponsored Programs Provider participates in the Government Sponsored Programs network(s).

1.14. "Government Sponsored Programs Provider" shall mean those providers of health care services who/which have entered into a Government Sponsored Programs Agreement with Blue Shield or a participant in another network, as designated by Highmark, to cover Government Sponsored Program products.

1.15. "HIPAA" shall mean the Health Insurance Portability and Accountability Act of 1996 and the regulations adopted thereunder by the Department of Health and Human Services, 45 C.F.R.

Parts 160, 162, 164, as amended by the HITECH Act, as well as all subsequent amendments and regulations.

1.16. "HITECH" shall mean the Health Information Technology for Economic and Clinic Health Act, as incorporated into the American Recovery and Reinvestment Act of 2009 and all regulations adopted thereunder, as well as all subsequent amendments and regulations.

1.17. "Health Plan" shall mean individually and collectively, as applicable, (a) Blue Shield; (b) a Highmark Affiliate, except where Members are covered under a separate agreement between Provider and the Highmark Affiliate; (c) an ASO Account; (d) the Blue Card or similar program, which covers persons entitled to benefits as a member of any other Blue Cross and/or Blue Shield plan licensed by the Blue Cross Blue Shield Association and which requires claims to be processed pursuant to the requirements of the Blue Cross Blue Shield Association's Blue Card or similar program or its successor; and/or (e) any entity or entities which are parties to a Network Access Arrangement with Blue Shield which enables such entity or entities to have access to and utilize the Participating Provider network, the Preferred Provider network, and/or the Government Sponsored Programs Provider network(s) in connection with healthcare benefit products offered or administered by such entity or entities.

1.18. "Highmark Affiliate" or "**Highmark Affiliates**" shall mean an entity or entities that directly controls, is controlled by, or is under common control with Highmark. The term "control" (including the terms "controls," "controlling," "controlled," "controlled by" and "under common control with"), as applied to Highmark in the immediately preceding sentence, means (i) the right to directly exercise at least fifty percent (50%) of the voting rights (whether as owner of shares, owner of membership, general partnership or other ownership interests, trustee, executor or otherwise) attributable to the shares or membership, general partnership, or other ownership interests of the controlled entity; and/or (ii) the possession of the power to direct or cause the direction of the management or policies of the controlled entity (whether by contract, credit arrangement or otherwise).

1.19. "Law" or **"Laws"** shall mean any applicable foreign, United States, 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 that is then in effect. 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 or the applicable specific sections or provisions which are adopted, issued, enacted or promulgated after the Agreement's execution.

1.20. "Medical Review Committee" shall mean the Medical Review Committee of Blue Shield.

1.21. "Member" shall mean any person covered under a Product.

1.22. "Network Access Arrangement" shall mean an arrangement or arrangements with one or more unrelated entity or entities whereby Blue Shield agree(s) that some or all of the Providers of Blue Shield's Participating Provider network and/or Preferred Provider network and/or Government Sponsored Programs network(s) shall render Provider Services to persons covered

under a Plan Document of such entity or entities and shall be considered as an in-network provider thereunder.

1.23. "Official Body" shall mean any governmental or political subdivision or any agency, authority, bureau, commission, department or instrumentality of either, or any court, tribunal, grand jury or arbitrator, in each case, whether foreign or domestic that has jurisdiction over Blue Shield or Provider.

1.24. "Overpayments" shall mean a payment or payments greater in amount than actually due Provider under the Agreement or a payment or payments to which Provider was not entitled hereunder regardless of the reason and no matter how Blue Shield, Health Plan, or Provider learns of such error. Payments shall also include any payments to Provider for Provider Services provided during any period in which Provider failed to satisfy any Participation Criteria related to a Product.

1.25. "Participating Provider" shall mean those health service doctors who have registered with Blue Shield and have executed a Participating Provider Agreement evidencing such registration.

1.26. "Participating Provider Agreement" shall mean an agreement between Participating Provider and Blue Shield, regardless of the title, whereby Participating Provider participates in the Participating Provider network.

1.27. "Participation Criteria" shall mean the general participation criteria, specific participation criteria, any applicable credentialing criteria (for credentialed networks), and insurance criteria as described in the Agreements, any and all attachments thereto, and/or Administrative Requirements.

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

1.29. "Plan Document" shall mean any insured or self-insured individual or group benefit contract or other legally binding document or documents that contain(s) the rights and responsibilities of a Member or a group account with respect to a Product.

1.30. "Practitioner" shall mean each individual professional provider who meets the definition of Provider and all individual professional providers covered under an Agreement.

1.31. "Preferred Provider" shall mean those providers of health care services who/which have entered into a Preferred Provider Agreement with Blue Shield.

1.32. "Preferred Provider Agreement" shall mean an agreement between a Provider and Blue Shield, regardless of the title, enabling such Provider to participate in the Preferred Provider network.

1.33. "Product" or "**Products**" shall mean indemnity, managed care and other products and benefit programs offered or administered by Blue Shield or Health Plan which utilizes any one or more of the Participating Provider, Preferred Provider, or Government Sponsored Programs Provider network(s), at Blue Shield's discretion and for which Blue Shield is offered a contract as

executed by Provider. The term "Product" or "Products" shall not include any products or benefit programs that require the execution of a separate provider agreement as determined by Blue Shield, in its sole discretion.

1.34. "Protected Member Information" shall mean all personally identifiable information about Members, which includes Protected Health Information as defined by HIPAA.

1.35. "Provider" shall include individually and/or collectively Participating Providers, Preferred Providers, and Government Sponsored Programs Provider.

1.36. "Provider Services" shall mean those Provider services as customarily furnished to patients by Provider and that are within the scope of the rendering Practitioner and/or Provider's license and upon Provider's physical premises.

1.37. "Regulations" shall mean these Highmark BlueShield Regulations for Participating Providers, PremierBlue Shield Preferred Providers, and Government Sponsored Programs Providers.

1.38. "Review Committee" shall mean the Medical Review Committee of Blue Shield.

1.39. "Review Committee Guidelines" shall mean the requirements of the Review Committee.

1.40. "Term" shall mean, collectively, the initial term and all renewal terms.

2. REGISTRATION OF PROVIDERS

2.1. General Criteria. Provider hereby represents and warrants, on his, her or its own behalf and on behalf of each Practitioner, as follows:

2.1.1. For credentialed networks, each Practitioner may be credentialed under either an individual Agreement as well as under another group's Agreement.

2.1.2. Provider and/or Practitioner are bound by all Administrative Requirements that may be published in written or electronic form and made available to Provider.

2.2. Insurance Criteria. Provider shall, at its sole cost and expense, or shall cause each Practitioner at his or her sole cost and expense, to obtain, if applicable, and maintain at all times during the Term such policies of general liability and professional liability (malpractice) insurance to insure Provider and each Practitioner against any claim or claims for damages arising by reason of personal injury or death occasioned, directly or indirectly, in connection with the performance or omission of any Provider Service by Provider or a Practitioner. The amounts and extent of professional liability (malpractice) insurance coverage shall not be less than the amount required by any applicable state Law and/or for credentialed networks, as required by Blue Shield in accordance with credentialing and recredentialing Administrative Requirements. Provider shall provide evidence of such general liability and professional liability (malpractice) insurance coverage to Blue Shield upon request. In addition, Provider shall notify Blue Shield in writing at least ten (10) days in advance of any reduction or termination of such coverage.

2.3. Notification of Status Changes. Each Provider shall promptly advise Blue Shield of: (a) any changes in the Participation Criteria as applicable to Provider and any Practitioner and as described in Section 2 of Part I of these Regulations; (b) for credentialed networks, any changes in the credentialing information as set forth in the credentialing application or required by applicable Administrative Requirements; (c) any changes in Provider's identification information, including, without limitation, any changes in the address of Provider's professional office or other place of practice; (d) any intent to close its practice to additional Members by providing Blue Shield with notice within the time period and under the conditions described in the Administrative Requirements; (3) and any other changes that may affect the delivery of services safely to Members.

2.4. Condition. Provider understands and agrees that meeting all of the above Participation Criteria is a condition precedent to the execution of this Agreement and is an ongoing condition to any Practitioner's provision of Provider Services to Members and Blue Shield's payment for Covered Services. Any change in such criteria can result in termination of this Agreement or termination of participation of the applicable Practitioner by Blue Shield in its sole discretion. Further, any such change may result, in the sole discretion of Blue Shield, in repayment by Provider to Blue Shield or setoff of future amounts due to Provider of any Overpayments made to Provider on or after the date of such change as a result of Provider's or any Practitioner's failure to meet such criteria.

3. PROGRAM PARTICIPATION

3.1. Provision of Services. 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. 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 Provider shall be performed by Provider and/or Practitioners either personally or under his, her, or its supervision as defined in the Administrative Requirements. In rendering Provider Services, 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. 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.

3.2. Product Participation. Participating Providers, Preferred Providers, and Government Sponsored Programs Providers participate in all Blue Shield and Health Plan Products utilizing the Participating Provider network, the Preferred Provider network, and/or the Government Sponsored Programs network(s) respectively, and as designated by Blue Shield and/or Health Plan as applicable and so long as Provider and Practitioners, as applicable, meet all required Participation Criteria applicable to a Product by Blue Shield at Blue Shield's discretion. Provider's and each Practitioner's participation in a Product will be subject to all terms and conditions contained in the Agreement and, as applicable, and any related attachments thereto. Provider and Blue Shield and/or Health Plan, as applicable, agree that such participation is not exclusive and that other Providers and Practitioners may also participate as designated by Network Plan.

Provider and Practitioners agree that Blue Shield and/or Health Plan, as applicable, in its sole discretion: (a) retains the exclusive authority to designate those providers that may participate in any particular Product and that all such providers will be subject to all applicable participation criteria related to such Product; (b) may choose to require execution of different participation agreements for any particular Product in its sole discretion; (c) may assign providers to a specific tier and/or differential cost sharing network, including Products of other health plans to which Blue Shield has granted access to the Participating Provider network, the Preferred Provider network, and/or the Government Sponsored Programs network(s) through a Network Access Arrangement and (d) provider may be designated to participate in a Product which may utilize multiple professional networks in order to achieve Member access to Provider Services as necessary.

3.3. Directories. As determined by Blue Shield, Provider agrees to allow its and any Practitioner's name, office address, telephone number, description of its facilities and services, participation status in any one or more Products and at various benefit levels, quality data and similar information to be listed in Blue Shield's and/or Health Plan's marketing materials and its roster and/or directory of Providers that is given to Members and prospective Members or as available on internet web-sites. Provider shall not reference Blue Shield or any Health Plan in any publicity, advertisements, notices, or promotional material or in any announcement or communication to the Members or the public without prior review and written approval of Blue Shield

3.4. Use of Blue Shield Providers. Except in the event of an emergency, a Member's specific request or the unavailability of a Provider, Provider shall, and shall cause each Practitioner to, direct Members as needed for additional health care services to, and when ordering drugs and medical items or supplies for Members, use only Providers enrolled in the Blue Shield network(s) applicable to such Member's Product. Provider and each Practitioner shall document in the Member's records any and all reasons why a Member was directed to a Provider not enrolled in the Blue Shield network(s) applicable to such Member's Product, and shall inform the Member that there may be additional costs to the Member resulting from the use of a Provider not enrolled in such network(s).

3.5. Equal Access and Non-Discrimination. Provider and each Practitioner shall not deny, limit, discriminate or condition the furnishing of Provider Services to Members on the basis of any factor that is related to race, color, national origin, ancestry, religion, sex, marital status, sexual preference, disability, age, source of payment, cost, anticipated cost, membership in Blue Shield 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). In accordance with the preceding sentence, Provider agrees that under no circumstances will Provider or any Practitioner refuse to render Provider Services based on the assumption that the anticipated cost that will be incurred by Provider will be in excess of Blue Shield's payment for Covered Services. Further, Provider and each Practitioner shall provide Members with equal access at all times to Provider Services. Provider and each Practitioner shall not deny, limit, discriminate or condition the furnishing of Provider Services to Members based on their known or believed relationship or association with an individual or individuals of a particular race, color, national origin, sex, age, or disability.

3.6. Assignment/Delegation. Unless as permitted otherwise in the applicable Agreement, no assignment of this Agreement or delegation of its rights, duties or obligations under this Agreement shall be made by Provider, except for an assignment of payments made in accordance with applicable assignment account guidelines. Blue Shield may, in its sole discretion, assign this Agreement or delegate any or all of its rights, duties or obligations hereunder without the consent of Provider. Further, Blue Shield, in its sole discretion, has the right to designate one or more agents to act on its behalf in performing one or more administrative services under this Agreement to include, but not be limited to, development of fee schedules, administration of payments, development of Administrative Requirements, and utilization management, care management and quality management activities, as well as inspections, reviews and audits.

4. GENERAL OBLIGATIONS

4.1. Administrative Requirements. Blue Shield shall, or shall cause Health Plan to, make available to Provider information concerning the Administrative Requirements with which Provider must comply in the form of a manual, other written format or in another accessible format such as on an internet website. Blue Shield shall, or shall cause Health Plan to, provide notice of any changes thereto. Provider agrees to, and shall ensure that its Practitioners and auxiliary personnel, comply with and abide by any final determination made in accordance with Administrative Requirements and review and service programs, including, but not limited to, utilization and quality assurance programs, procedures and activities; credentialing and recredentialing (for credentialed networks); sanctioning; external audit systems; administrative, appeal, complaint and grievance procedures, as in effect from time to time; and the terms of any and all applicable Plan Documents. If Provider fails to comply with Administrative Requirements, Blue Shield shall have the right in appropriate circumstances to pursue remedial actions as appropriate on its own behalf or on behalf of Health Plan, including, without limitation, rejection of claims, review of claims on a retrospective basis, collection of any Overpayments and/or termination of this Agreement. In such event, Provider will hold Blue Shield, Health Plan and Members harmless with respect to fees and/or charges for Provider Services.

4.2. Member Documents. The Plan Documents applicable to Members may be changed or supplemented from time to time by Blue Shield or the plan sponsor and the terms and conditions of said contracts and documents shall be binding upon Blue Shield and Provider.

4.3. Records. Provider will maintain in a current, detailed, comprehensive, accurate and timely manner an adequate system for the collection, processing, maintenance, storage, retrieval and distribution of administrative, medical, claims and financial records of all Provider Services rendered by its Practitioners and auxiliary personnel to Members. Provider agrees to 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 each Member receiving Provider Services, Provider will maintain a single standard medical record in such form containing such information as required by all applicable Laws that govern its operations and the performance of its obligations under this Agreement.

4.3.1. Provider agrees to (a) abide by all applicable Laws regarding confidentiality and disclosure for medical records, other health information, and patient information; (b) protect and maintain the confidentiality of all information and records relative to

Members; (c) safeguard the privacy of any information that identifies a particular Member in compliance with all applicable Laws, including, without limitation, HIPAA and HITECH, in accordance with the standards described in Section 6 of Part I of these Regulations and the Administrative Requirements governing the use and disclosure of such information and records; and (d) abide by all confidentiality requirements established by Blue Shield or Health Plan, as well as all applicable Product requirements. Except as specifically provided herein or permitted by Law, Provider will not disclose Member information to any third party without the consent of the Member.

4.3.2. Provider will ensure timely access by Members to the records and information that pertain to them. Provider shall also ensure that Blue Shield, Health Plan, accrediting bodies and Official Bodies, and/or each of their designated agent or agents have access at all reasonable times to the books, medical records and other records and papers of Provider relating to this Agreement, Provider Services rendered to Members, the charges made by Provider for Provider Services, and payments received by Provider from Members or other third-party payers for Members so long as the demand for such records is reasonable and complies with applicable Laws.

4.3.3. In all cases of disclosure, information from, or copies of, records may be released only to authorized individuals. Provider must ensure that unauthorized individuals cannot gain access to or alter Member records. Original medical records must be released only in accordance with Laws, court orders or subpoenas.

4.4. Reviews, Inspections and Audits. Blue Shield, Health Plan or each of their respective designated agent or agents may perform any and all reviews (on-site or otherwise), audits, and statistically valid sampling techniques of Provider that are deemed necessary to include, but not be limited to, credentialing (for credentialed networks) and peer review program activities, medical practice audits, medical necessity reviews, data validation reviews, billing and claims payment audits, coding audits and quality improvement audits. In addition, Blue Shield or Health Plan may be required by applicable Laws to provide for on-site inspections, medical record reviews, financial audits and medical review of its Providers by appropriate Official Bodies and/or any approved external quality review organization of such Official Body on a periodic basis, and required to make available to such Official Body various records and reports relating to such Provider. In connection with the foregoing, Provider agrees to reasonably cooperate with Blue Shield, Health Plan, the applicable Official Body and/or any designated agent or agents in arranging or allowing such inspection and making available Provider's premises, physical facilities and equipment, medical and other records relating to Members, and any additional relevant information that may be required with the understanding that the medical records referred to above shall be and remain the property of Provider and shall not be removed or transferred from Provider except in accordance with applicable Laws. Further, Provider agrees to participate in any corrective action plan required by Blue Shield, on its own behalf or on behalf of a Health Plan. Based on such review, Blue Shield may, on its own behalf or on behalf of a Health Plan, deny payment, reject claims and/or review claims on a retrospective basis and collect any Overpayments. In such event, Provider will hold Blue Shield, Health Plan, and the Member harmless with respect to payment for Provider Services.

4.5. Use of Information and Data. Provider agrees that the proprietary methods and operations of Blue Shield and Health Plan, including, without limitation, the Administrative

Requirements, contract terms, payment rates, levels of costs, utilization and revenues, software, data, functions, and the procedures, forms, and techniques for servicing accounts and Members, are highly confidential trade secrets of Blue Shield or Health Plan, as the case may be, and are entitled to protection as such. Provider agrees not to reveal such methods of operation to any other person or entity during the Term of, and after the termination of, this Agreement without the prior written consent of Blue Shield. For the purposes of the preceding sentence, proprietary 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 Provider. Notwithstanding the foregoing, information and methods of operation of Blue Shield or Health Plan may be disclosed if required by Laws, by an Official Body, in connection with Provider's performance of its responsibilities under this Agreement, and/or where the well-being of the Member requires such disclosure; provided that Provider gives Blue Shield prompt written notice thereof of any such required disclosure.

4.5.1. Provider further agrees, except as required by Laws or to the extent information is otherwise publicly 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) without the prior written consent of Blue Shield. Further, Provider will not disclose or permit the disclosure of any Member or group information derived from, through or provided by Blue Shield or Health Plan.

4.5.2. Upon termination of this Agreement, Provider hereby agrees to immediately return all material related to Administrative Requirements including forms, policies, procedures, manuals and materials of every kind, if any, provided by Blue Shield or a Health Plan. Blue Shield may disclose the terms of this Agreement or provide a third party with a copy of this Agreement and information regarding terms of payment where a disclosure of terms is required for an audit.

5. PAYMENT PROVISIONS

5.1. Member Eligibility and Payment Determinations. Blue Shield shall, and/or shall cause Health Plan to provide each Member with an identification card and provide Provider with Member benefit information. Blue Shield shall, and/or shall cause any applicable Health Plan to, also provide determinations as to eligibility and authorization for, and coverage of, Provider Services in accordance with Administrative Requirements and any time frames and procedures as set forth in applicable Laws. Except in the case of an emergency, Provider shall verify a Member's eligibility, as well as coverage of a Provider Service, in accordance with Administrative Requirements.

5.2. Payment. Blue Shield shall and/or shall cause Health Plan to pay Provider for those Provider Services that are (a) rendered by Provider or its Practitioners to Members, and (b) Covered Services, in accordance with the reimbursement terms contained in the Member's Plan Documents as well as the reimbursement amounts contained in the fee schedule applicable to the Product and Provider. All payments shall be subject to all payment terms and conditions set forth in these Regulations. In addition, all payments shall be subject to and net of applicable Copayments, Coinsurance and Deductibles. Further, all payments shall be subject to the terms of the Member's Plan Documents, applicable Administrative Requirements, medical necessity and appropriateness determinations, and Health Plan medical policies.

5.3. Payment Data/Billing. Provider will submit encounter, claim and/or certain clinical data to Blue Shield and/or, as applicable, Health Plan, or, as appropriate, to other providers, using such forms, media, format and coding structures as may from time to time be acceptable to and required by Blue Shield and/or, as applicable, Health Plan. Billings shall include all patient identification information and itemization of Provider Services in a standardized format acceptable to Blue Shield 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 Blue Shield and/or, as applicable, Health Plan. When requested by Blue Shield and/or, as applicable, Health Plan, or as required by Administrative Requirements, Provider shall also provide a description of a Provider Service, a copy of the Member's records, or other appropriate documentation. During the Term, Provider billing instructions will be issued periodically and made available to Provider to update and clarify the billing requirements of Blue Shield and/or, as applicable, Health Plan. Such instructions shall be binding upon Provider and its Practitioners. Provider may not bill for Provider Services rendered by a Practitioner if such Provider Services are subject to billing independently by Practitioner, by another Provider, and/or another entity subject to another agreement or arrangement with Blue Shield and/or, as applicable, Health Plan. Under no circumstances may Provider engage in duplicative billing.

5.4. Provider Statements. Provider shall be fully and completely responsible for all statements made on any claim form submitted to Blue Shield 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 Blue Shield and/or, as applicable, Health Plan. If Provider misreports services to Blue Shield and/or Health Plan, or engages in duplicative billing, Provider shall immediately notify Blue Shield and/or, as applicable, Health Plan in writing of such misreporting. Provider shall be responsible for reimbursing Blue Shield and/or, as applicable, Health Plan, for all Overpayments caused by such misreporting or duplicative billing.

5.5. Restrictions on Collection of Payment. Provider shall not bill or collect from a Member, Blue Shield or another Health Plan any fees or charges itemized and distinguished from Provider Services provided and submitted to Blue Shield for payment unless such fees or charges are expressly permitted under applicable Plan Documents or Administrative Requirements.

5.6. Restrictions on Billing. Provider may not charge Members or Blue Shield more than Provider charges its other insured and uninsured patients. When requested, Provider must substantiate his, her, or its usual charges to Blue Shield. Provider may enter into agreements with a health maintenance organization, preferred provider organization, insurer, third party administrator or similar entity to accept allowances or reimbursement different than Provider routinely receives from Blue Shield. Additionally, a 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 provider's records and is appropriate under the circumstances.

5.7. Timely Filing. Provider shall submit original claim forms for Provider Services rendered to Members as soon as possible, but in no event no later than three hundred sixty five (365) after the date of service. Provider may submit corrections to those diagnosis and procedure codes listed on an original claim form and/or on any subsequent resubmissions at any time after denial

or payment by Blue Shield and/or, as applicable, Health Plan so long as any such corrections are submitted prior to three hundred sixty five (365) days after the date of service, at which point a claim shall be considered final as to Provider. Blue Shield and/or as applicable Health Plan will deny any original claim forms and/or any subsequent resubmissions not submitted within the applicable original claim or correction submission time limits, and Provider shall be prohibited from collecting fees and/or charges for such denied services from the Member.

5.8. Prompt Payment. Blue Shield agrees to, and/or cause Health Plan to, promptly pay Provider for Clean Claims submitted for Covered Services rendered by Practitioners in accordance with applicable Laws. In the event Blue Shield does not, and/or does not cause Health Plan to, timely pay any such amount, Blue Shield further agrees to, and/or cause Health Plan to, pay any interest due on such amount as required by applicable Laws. If Provider has any questions or concerns regarding a submitted claim, including, without limitation, whether the claim is a Clean Claim or why the claim has not been paid, Provider hereby agrees to contact Blue Shield first regarding such questions and concerns.

5.9. Prohibition of Fees For Directing Members. 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 provider or (b) furnishing services to a Member as directed to Provider or a Practitioner by another provider.

5.10. Overpayments. If Provider receives an Overpayment from Blue Shield and/or Health Plan, Blue Shield shall be entitled to set off any such Overpayment against any future payments due Provider and/or take any other action against Provider authorized under this Agreement or as otherwise permitted by Law. If no future payments are due to Provider, Provider shall reimburse Blue Shield for such Overpayment within thirty (30) days of demand by Blue Shield. Provider shall report the receipt of any Overpayment it receives from Blue Shield as soon as practicable after learning of such Overpayment. Health Plan may take any action against Provider as permitted by Law if Provider receives an Overpayment from Health Plan.

5.10.1. If an Overpayment appealed to the Review Committee has not been returned to Blue Shield within thirty (30) calendar days of notification of a Review Committee determination in favor or Blue Shield, in whole or in part, claim payments otherwise due Provider will be subject to withholding and the assessment of interest on the unpaid balance. The rate of interest shall be determined in the manner provided in the Review Committee Guidelines, which are included in the BSOM or its successor. If a Provider terminates his, her or its Participating Provider Agreement, Preferred Provider Agreement, and/or Government Sponsored Programs Agreement while an Overpayment is being disputed, claim payments otherwise due Provider for services rendered prior to the effective date of such termination will be subject to withholding pending a Review Committee determination as to the dispute. Any such amounts withheld by Blue Shield will not be subject to the assessment of interest until thirty (30) calendar days following a Review Committee determination in favor of Provider, in whole or in part. Should a Review Committee determination result in the reduction or the elimination of an Overpayment amount, any excess claims payments withheld by Blue Shield will be promptly paid to Provider. This provision will survive the expiration or earlier termination of this Agreement regardless of the reason.

5.11. Member Hold Harmless and Continuation of Benefits. Except for Copayments, Coinsurance and Deductibles, Provider shall look only to Blue Shield for the payment of Covered Services rendered to Members. In no event, including, without limitation, nonpayment by Blue Shield and/or Health Plan, insolvency of Blue Shield or Health Plan, or breach of this Agreement by Blue Shield or Provider, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from or have any recourse against Blue Shield, Health Plan and/or Member or any persons acting on Member's behalf for Covered Services provided pursuant to this Agreement. This subsection does not prohibit the collection of Copayments, Coinsurance and Deductibles from Members, as set forth in the applicable Plan Document. Provider agrees that in the event of Blue Shield's or Health Plan's insolvency or other cessation of operations, benefits to Members will continue through the period for which a premium has been paid, and benefits to Members confined in an inpatient facility on the date of insolvency or other cessation of operations will continue until their discharge where the Member's Plan Document so requires. Provider further agrees that:

5.11.1. these provisions shall survive the termination of this Agreement, regardless of the cause giving rise to the termination, including, without limitation, insolvency of Blue Shield or Health Plan, and shall be construed for the benefit of Members; and

5.11.2. these provisions shall supersede any oral or written contrary agreement now in existence or hereafter entered into between Provider and Members or persons acting on their behalf or on whose behalf they are acting hereunder insofar as such contrary agreement relates to liability for payment for, or continuation of, Covered Services provided under the terms and conditions hereof; and

5.11.3. any modification, addition or deletion to the provisions of this Section 5.11 shall become effective only when approved or deemed approved by appropriate Official Bodies in accordance with applicable Laws.

5.12. Non-Covered Services. Except as otherwise stated herein, Provider may, at all times, bill a Member for non-covered services if Provider has given the Member advance written notice that the service(s) 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(s) in advance of receiving such service(s). The signed agreement shall be kept in 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 Blue Shield and/or, as applicable, Health Plan.

5.13. Preauthorization. Preauthorization, the pretreatment review by Blue Shield or Health Plan of a treatment plan and/or treatment site, is a contractual obligation under the terms of the Administrative Requirements and certain Member Plan Documents. Preauthorization must be requested prior to the initiation of certain services in accordance with the Member's Plan Documents. Blue Shield or Health Plan may require certain clinical records and diagnostic aids relating to a Member to be included with requests for preauthorization. Charges for services rejected because Provider failed to initiate or receive preauthorization shall not be collected from the Member.

5.14. Additional Payment Programs. Blue Shield may, in its own discretion, from time to time, offer one or more additional or supplemental payment programs involving Providers. Blue Shield may, in its own discretion, require Provider to participate in any such program(s). An additional or supplemental payment program may apply to one or more Products. If Provider participates in any such program(s), Provider shall ensure that its Practitioners, as applicable, participate in Blue Shield's additional or supplemental payment program(s). Details regarding participation criteria for, and the terms and conditions of, any Blue Shield additional or supplemental payment program shall be communicated to Provider in a manual, newsletter or other appropriate means of communication. Provider agrees that Blue Shield may prohibit participation in any additional payment programs for any Provider and/or Practitioner already participating in such a program under another agreement with Highmark or a Highmark Affiliate.

5.14.1. If applicable, 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 additional or supplemental payment program(s) offered by Blue Shield, or as reasonably requested by Blue Shield in order to carry out the provisions and purposes of this Agreement as it pertains to any additional or supplemental payment program(s).

6. PRIVACY REQUIREMENTS

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

6.1. 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. 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 the Agreement or to comply with judicial process or any applicable Law.

6.2. General HIPAA and HITECH Compliance. Provider agrees that 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 Provider's activities under the 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 the Agreement or any attachments or Provider's obligations under such documents, Provider agrees to adopt such policies and procedures, execute such written agreements and provide such further assurances as may be required to make Provider's activities under the

Agreement and the attachments compliant on or before the final compliance date of any such modifications.

6.3. Electronic Transactions. The parties agree that all communications between Provider and Blue Shield 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 Provider and Blue Shield, Provider shall use such forms, tape formats or electronic formats as Blue Shield may approve.

6.4. Provision of Protected Member Information for Treatment, Payment and Health Care Operations. The parties acknowledge and agree that HIPAA permits Provider to provide Protected Member Information to Blue Shield 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 providers, and evaluating provider performance. Upon request by Blue Shield or Health Plan, as applicable, 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, Provider will use its best efforts to obtain such consent.

7. BLUE CROSS AND BLUE SHIELD ASSOCIATION LIABILITY DISCLAIMER

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

8. NOTICE

Except as otherwise provided herein, in an Agreement, or an attachment or exhibit hereto or thereto, any notice required to be given by either party pursuant to the terms and provisions of the Agreement(s) or hereof shall be given to a party in writing and shall be sent either by first class mail, postage prepaid, or by overnight mail via a national delivery service. Notwithstanding the foregoing, Blue Shield may give any notice concerning the delivery of amendments resulting from any change in Laws or Administrative Requirements by written publication and/or electronic means including, without limitation, fax or email. Further, notwithstanding the foregoing, any notice of termination required to be given pursuant to the

Agreement and Regulations by Provider shall be given in writing to Blue Shield and shall be sent by certified mail, return receipt requested, or by FedEx or another national delivery service and given by Blue Shield to Provider in writing by first class mail or by FedEx or another national delivery service. A notice period shall begin and/or a notice shall be deemed effective the date that notice is sent.

9. RELATIONSHIP OF THE PARTIES AND LIABILITY

Each party to the Agreement(s) expressly understands and agrees that none of the provisions of this (these) Agreement(s) or Regulations are intended to create, nor shall be deemed or construed to create, the relationship of agent, servant, employee, partnership, joint venture, association or any other relationship between the parties other than that of independent contractors contracting with each other hereunder solely for the purpose of effecting the provisions of the Regulations, any Agreement or an attachment thereto. 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 Provider nor Blue Shield 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, Provider and its Practitioners are not employees of Blue Shield, and Blue Shield shall do nothing to interfere with the customary provider-patient relationship in such cases. Blue Shield shall not be liable or responsible to anyone or any person whatsoever as a result of any negligence, misfeasance, malfeasance or malpractice on the part of Provider or any Practitioner, as applicable, performing services for Members.

10. SURVIVAL

The provisions in Sections 2.3 of the Participating Provider Agreement, the Preferred Provider Agreement, and/or the Government Sponsored Programs Provider Agreement as applicable; Sections ~~4.3, 4.4, 4.5,~~ 5, 6, 9, and 12 of Part I of these Regulations; and Section 2 of Part II of these Regulations; and Section 6 of Part III of these Regulations; and Section 2 of Part IV of these Regulations shall survive the termination of this Agreement, regardless of the cause giving rise to such termination. In addition, any of the other terms and covenants contained in this Agreement or the attachments hereto which require the performance or inaction of either party after the termination shall survive said termination.

11. AMENDMENTS TO THE AGREEMENTS OR REGULATIONS

11.1. Amendments to the Agreement(s). Except as provided herein, either or both of the Agreements may be amended as follows:

11.1.1. By the mutual written consent of the parties to be effective as indicated in such consent; or

11.1.2. By Blue Shield immediately upon written notice to Provider in order to comply with applicable Laws or the directives of Official Bodies or applicable accrediting bodies.

11.2. Amendment to the Regulations. Except as provided herein, these Regulations may be amended by Blue Shield, upon the approval of the DOH, and Provider shall be notified of such amendment in an electronic and/or written professional publication of Blue Shield within six (6) months immediately following their approval or in any other manner or time period approved by

the DOH. Any amendment to these Regulations will become effective and binding upon Blue Shield and Provider thirty (30) days after their publication.

12. OBLIGATIONS UPON TERMINATION

Upon termination of an Agreement, both parties hereby agree as follows, subject, however, to any applicable continuation of benefits provisions:

12.1. Provider will immediately return all forms, policies, procedures, manuals and materials of every kind, if any, provided by Blue Shield or Health Plan upon termination of an Agreement. Blue Shield and Provider acknowledge that any procedures, forms, policies, manuals and materials developed by Provider are the property of Provider and are not subject to this Section 12;

12.2. Provider shall cooperate with Blue Shield and/or Health Plan in obtaining information regarding Members that may be affected by such termination because they are undergoing an ongoing course of treatment or are otherwise active patients of Provider, including providing the name, address and identification number of affected Members;

12.3. The orderly transfer of Members and Members' records to other Providers or other providers designated by Blue Shield or Health Plan, as applicable;

12.4. The continued care of a Member until discharge from an inpatient facility or, for a Member undergoing an ongoing course of treatment, until clinically appropriate as designated by Blue Shield or Health Plan, to be provided and paid in accordance with the terms and conditions of this Agreement; and

12.5. The resolution of any administrative and/or financial matter related to Provider's provision of Provider Services and Blue Shield's payment for Covered Services hereunder.

13. QUALIFIED HEALTH PLAN OBLIGATIONS

The following provisions apply to any benefit plans offered by Health Plan through an Exchange under a Qualified Health Plan Issuer Agreement:

13.1 Definitions.

13.1.1 "Exchange". A governmental agency or non-profit entity that meets the applicable standards of 45 C.F.R. §155 subpart D and makes QHPs available to individuals and employers. This term includes both state and Federally-facilitated Exchanges.

13.1.2 "Downstream Entity." Any individual or entity that enters into an agreement below the level of the Agreement between Government Sponsored Programs Providers and Health Plan for the provision of administrative or health care services offer under a QHP Issuer Agreement.

13.1.3 "Qualified Health Plan or QHP." A health plan that has been certified that it meets the standards described in 45 C.F.R. § 156 subpart C or that has been approved by the Exchange through which such plan is offered.

13.1.4 "QHP Issuer Agreement." An agreement between the Centers for Medicare & Medicaid Services ("CMS") and Health Plan to offer QHPs.

13.2 Compliance with Law and Standards. In providing services and performing its responsibilities under this Agreement, Government Sponsored Programs Providers shall comply with the laws and regulations relating to the standards specified under 45 CFR §156.340 including, as applicable, (i) the standards of subpart C of 45 CFR Part 156; (ii) the exchange processes, procedures, and standards in accordance with subparts H and K of 45 CFR Part 155 and, in the small group market, 45 CFR §155.705; (iii) the standards of 45 CFR §155.220 with respect to assisting with enrollment in QHPs; (iv) the standards of 45 CFR §§156.705 and 156.715 for maintenance of records and compliance reviews for QHP issuers operating in a Federally-facilitated Exchange; and (v) the standards of 45 CFR §156.340 with respect to downstream and delegated entities. In addition, to the extent applicable to the activities under this Agreement, Government Sponsored Programs Providers shall comply with the standard rules of conduct set forth in Section II of Highmark or a Health Plan's Qualified Health Plan Issuer Agreement, to be furnished by Highmark to Government Sponsored Programs Providers in the Administrative Requirements.

13.3 Record Maintenance. Government Sponsored Programs Providers shall maintain timely and accurate medical, financial and administrative records related to services rendered by Government Sponsored Programs Providers. Unless a longer time period is required by applicable statutes or regulations, Government Sponsored Programs Provider shall maintain such records and any related contracts for ten (10) years.

13.4 Audits by HHS. Government Sponsored Programs Providers acknowledges and agrees that the Department of Health and Human Services (HHS) Secretary and Office of Inspector General (OIG) and their designees have the right to evaluate, through audit, inspection, or other means, the performance of Government Sponsored Programs Providers, its related entities and its downstream entities. In furtherance of that right, Government Sponsored Programs Providers shall permit access by the HHS Secretary, OIG and their designees to any books, contracts, computer or other electronic systems, including medical records and documentation related to any services provided under benefit plans offered by Health Plan through an Exchange under a Qualified Health Plan Issuer Agreement. Government Sponsored Programs Providers shall permit access to such records, books, contracts, computer or other electronic systems until ten (10) years from the final date of the Agreement period.

13.5 Downstream Agreements. If Government Sponsored Programs Providers has any arrangements, in accordance with the terms of the Agreement, with affiliates, subsidiaries, or Downstream Entities, directly or through another person or entity, to perform any health care or administrative services under a QHP, Government Sponsored Programs Providers shall ensure that all such arrangements are in writing, duly executed, and include all the terms contained in this Section 1.5.

13.6 Revocation of Agreement as it Applies to Benefit Plans Offered by Health Plan Under or Through an Exchange. Government Sponsored Programs Provider acknowledges and agrees that Health Plan may terminate this Agreement to furnish services under a QHP in instances where CMS or Health Plan determines that Government Sponsored Programs Provider has not performed satisfactorily. Government Sponsored Programs Provider acknowledges and agrees that to the extent CMS directs such revocation, Highmark shall provide immediate written notice of such to Government Sponsored Programs Provider, and such revocation shall become effective as directed by CMS. Any terminations initiated solely by Health Plan shall be in compliance with Section 5 of the Agreement.

14. Indemnification. The indemnification provisions contained in Section 2.3 of the Agreements are made in accordance with 40 Pa. C.S.A. §6322 (as currently stated), which allows companies, such as Blue Shield, to secure indemnity from liability for injuries resulting from the acts of physicians who render services to the company's members, which acts may include negligence and malpractice. The indemnification provisions are not intended to make physicians responsible for any negligence or wrongful acts of Blue Shield.

15. Provider Information. Provider agrees that now and hereafter Blue Shield may utilize, publish, disclose and display information relating to Provider and/or to the Agreement to entities, 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 plans, participating providers, 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, Provider's name, address and telephone number; description of Provider's services; descriptive and educational information, including the results of customer satisfaction surveys concerning Provider and its services, facilities and staff; information relating to Provider's costs, charges, payment rates and/or amounts for services hereunder, patient pay amounts (including coinsurance amounts), quality, utilization, and data relating to Provider's delivery of health care; and any data, information and conclusions generated in connection with a Blue Shield designed program, report and/or study regarding Provider and/or other participating providers.

16. Solo Practitioner. Unless Blue Shield permits otherwise, Blue Shield will recognize a solo Practitioner who contracts individually as a Provider to be at the solo practice level only. Unless otherwise permitted by Blue Shield, any solo Practitioner affiliated with, associated with or otherwise related to a group practice that is non-participating with Blue Shield network(s) shall be considered non-participating with Blue Shield network(s) when rendering Provider Services to Blue Shield Members at such non-participating affiliated, associated, or otherwise related group practice.

PART II

PARTICIPATING PROVIDER PROVISIONS

Part II of these Regulations applies to you as a Participating Provider ONLY, regardless of the version of the Participating Provider Agreement you hold. The provisions contained in Part II of these Regulations are applicable to all current and former active versions of the Participating Provider Agreement, regardless of their title.

1. REGISTRATION FOR PARTICIPATING PROVIDERS

1.1 **Licensure.** Any health service doctor or ancillary health service provider duly authorized to practice as such under the applicable laws of the Commonwealth of Pennsylvania is entitled to register with Blue Shield as a Participating Provider pursuant to 40 Pa. C.S.A. §6324 (c) and to continue such registration, upon maintaining a current license and complying with these Regulations, as amended from time to time with approval of the DOH and in accordance with the provisions of Section 11.2 of Part I of these Regulations.

1.2 **Effective Date of Registration.** Registration as a Participating Provider shall be effective immediately upon acceptance by Blue Shield of the application and the execution by Blue Shield of the Participating Provider Agreement.

1.3 **Termination.** Blue Shield may remove, suspend or terminate registration as a Participating Provider with the approval of the DOH. Action may not be taken by Blue Shield to remove, terminate or suspend the registration of any Participating Provider until he, she or it has been afforded due notice and an opportunity to be heard and be represented by counsel at a hearing held by the Review Committee in the manner provided by the provisions in the Bylaws pertaining to the Review Committee, as well as the Review Committee Guidelines reproduced in the BSOM or its successor. Such Bylaw provisions and Review Committee Guidelines are also available upon the written request of any Participating Provider at any time.

2. DISPUTES

All matters, disputes or controversies relating to the services performed by Participating Providers or any questions involving professional ethics shall be considered and determined only by the Review Committee in the manner provided by the applicable provisions in the Bylaws pertaining to the Review Committee, and the Review Committee Guidelines, which are included in the BSOM or its successor. Such Bylaws and Review Committee Guidelines are also available from Blue Shield upon the written request of Participating Provider. **Except as otherwise provided in Section 1.3 of Part II of these Regulations, all Review Committee determinations are final and binding upon Blue Shield and the applicable Participating Provider.**

3. CONFLICTS

To the extent any terms or conditions of the provisions in this Part II conflicts with any terms or conditions set forth in the provisions of Part I with respect to Participating Providers, the provisions in this Part II shall apply and govern.

PART III

PREMIERBLUE SHIELD PREFERRED PROVIDER PROVISIONS

Part III of these Regulations applies to you as a PremierBlue Shield Preferred Provider ONLY, regardless of the version of the PremierBlue Shield Preferred Provider Agreement you hold. The provisions contained in Part III of these Regulations are applicable to all current and former active versions of the PremierBlue Shield Preferred Provider Agreement, regardless of their title.

1. DEFINITIONS

Unless otherwise defined, capitalized terms as used in one or both of the Agreements and in these Regulations shall have the meanings assigned to them below.

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.

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.

1.3 **"Act 146 Products**" 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.

1.4 **"PCP"** shall mean a health care provider who, within the scope of the 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.

1.5 **"PID"** shall mean the Pennsylvania Insurance Department of the Commonwealth of Pennsylvania.

2. REGISTRATION FOR PREMIERBLUE SHIELD PREFERRED PROVIDERS

2.1 **Licensure.** Any health service doctor or ancillary health service provider duly authorized to practice as such under the applicable laws of the Commonwealth of Pennsylvania may apply to participate as a Preferred Provider with Blue Shield. Each Practitioner must maintain a current license and comply with these Regulations, as amended from time to time hereafter with the approval of the DOH and in accordance with the provisions of Section 11.2 of Part I of these Regulations.

2.2 **Refusal.** Blue Shield may, on consideration of applicable credentialing criteria or other reasons, pertaining to cost effectiveness, quality of care or other factors, refuse to permit the participation of Provider as a Preferred Provider in its sole discretion.

2.3 **Effective Date of Participation.** The participation of any Provider as a Preferred Provider shall be effective upon acceptance by Blue Shield of Provider's application, Provider's satisfaction of all applicable credentialing criteria, and execution of the Preferred Provider Agreement by Blue Shield.

2.4 **Termination.** A Provider's participation with Blue Shield as a Preferred Provider shall continue until such time as the Preferred Provider Agreement is terminated by either party in accordance with the terms of the Preferred Provider Agreement.

2.5 **Rejection.** Blue Shield may reject an application to be a Preferred Provider, or may terminate the participation as a Preferred Provider, in accordance with the terms of the Preferred Provider Agreement, these Regulations and/or Administrative Requirements. Applicant shall have the right to appeal a rejection based upon cause. Preferred Provider shall have the right to appeal a suspension or termination initiated by Blue Shield based upon cause. Such appeals shall be in writing and shall be addressed to the Blue Shield credentialing committee if the suspension or termination arose in connection with the recredentialing of Preferred Provider or any of its Practitioners. Reinstatement as a Preferred Provider, which has been suspended or terminated with cause, if the suspension or termination arose in correction with the recredentialing of a Provider or any of its Practitioners, may be approved if it is established to the satisfaction of the Blue Shield credentialing committee. Any determination of said credentialing committee or other rejection, suspension, or termination shall be appealable to the Review Committee.

2.6 **Credentialing.** Each Practitioner meets and will continue throughout the Term to meet all credentialing and recredentialing requirements as established by Blue Shield for participation as a Preferred Provider in the Preferred Provider network and as set forth in the Administrative Requirements.

3. PROGRAM PARTICIPATION

Except in emergency situations or upon prior approval of Blue Shield, Preferred Provider must make any necessary referrals to another Preferred Provider and/or contracted hospital participating in the Member's benefit plan. Preferred Provider shall notify Blue Shield of any referral to a non-Preferred Provider or to a non-participating hospital and shall document the reason for such referral in the Member's records.

4. ACT 146 PRODUCT PROVISIONS

The following provisions will apply in all instances where Preferred Provider is providing services to a Member enrolled in an Act 146 Product:

4.1 **Hold Harmless.** Preferred Provider acknowledges and reaffirms the hold harmless provision in Section 5.11 of Part I of these Regulations and agrees that such provision shall survive the termination of the Preferred Provider Agreement and is to be construed for the benefit of the Members.

4.2 **Act 68 and Act 146 Member Records.** All Member records shall be kept confidential by Blue Shield and Preferred 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.

4.3 **Primary Care 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, Preferred Providers who are PCPs shall meet the following minimum responsibilities:

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

4.3.2 Maintaining continuity of each Member's health care;

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

4.3.4 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);

4.3.5 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 Preferred Providers who are PCPs twenty-four (24) hours per day, seven (7) days per week for urgent and emergency care; and

4.3.6 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).

4.4 **Act 68 and Act 146 Member Records and Access to Records.** Preferred Provider will maintain medical records in accordance with all requirements set by Blue Shield, and shall permit Blue Shield 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 Blue Shield and Official Bodies' employees or agents with direct responsibilities for the functions enumerated above.

4.5 **Quality Programs.** Preferred 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).

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

4.7 **Prompt Payment.** Blue Shield will pay all Clean Claims as required by Section 2166 of Act 68 and Act 146 and 31 Pa. Code §154.18.

4.8 **Notice.** Where required by Act 68 and Act 146, Blue Shield will notify Preferred Provider in writing at least thirty (30) days before it implements any changes to its contracts, policies or procedures affecting Preferred 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 Preferred Provider upon the effective date thereof.

4.9 **No-Gag Clause.** Nothing in these Regulations shall be construed to limit or prohibit Preferred Provider's right to discuss, and Preferred Provider may freely discuss, with any Member, or, where applicable, on behalf of such Member with such Member's representative: (a) the process that Blue Shield 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 Preferred 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 Blue Shield to deny payment for a health care service.

4.10 **Termination.** As required by Act 68 and Act 146, Blue Shield will not sanction, fail to renew or terminate Preferred Provider's participation in the Preferred Provider network for any of the following reasons:

4.10.1 Preferred Provider's 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 provider practicing according to the applicable legal standard of care;

4.10.2 Preferred Provider's 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;

4.10.3 Preferred Provider's protesting a decision, policy or practice that Preferred Provider, consistent with the degree of learning and skill ordinarily possessed by a reputable health care provider practicing according to the applicable legal standard of care, reasonably believes interferes with Preferred Provider's ability to provide (based on Preferred Provider's clinical judgment) medically necessary and appropriate health care;

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

4.10.5 Preferred 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 Preferred Provider is based on moral or religious grounds and Preferred Provider makes adequate information available to Members or, if applicable, prospective Members;

4.10.6 Preferred Provider's communicating with a Member or a Member's representative in accordance with the terms of Section 4.9 of Part III of these Regulations; or

4.10.7 Preferred 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*).

4.11 **Obligation Upon Termination.** In the event of the termination of the Preferred Provider Agreement by Blue Shield or Preferred Provider, Preferred Provider agrees upon request to cooperate with Blue Shield in Blue Shield obtaining information from Preferred Provider regarding those Members enrolled in an Act 146 Product that may be affected by such termination because they are undergoing an ongoing course of treatment or are otherwise active patients of Preferred Provider. Such information includes the name, address and identification number of affected Members of an Act 146 Product.

5. PENNSYLVANIA CHIP COMPLIANCE REQUIREMENTS

5.1 **Definitions.** The following terms shall have the meaning assigned to them below or if not defined shall be interpreted to be in compliance with applicable Laws and any Requirements (as defined below). In the event of a conflict, the definitions contained in the Plan Document or Laws or CHIP Requirements shall control.

5.1.1 **"CHIP"** shall mean the Children's Health Insurance Program as offered from time-to-time by Highmark or Health Plan (referred to herein for simplicity as "Highmark"), pursuant to a contract with an Official Body of the Commonwealth of Pennsylvania.

5.1.2 **"Medically Necessary"** with respect to CHIP shall mean a service, item, or medicine that does one of the following:

5.1.2.1 It will, or is reasonably expected to, prevent the onset of an illness, condition, injury, or disability;

5.1.2.2 It will, or is reasonably expected to, reduce or improve the physical, mental, or developmental effects of an illness, condition, injury, or disability; or

5.1.2.3 It will help a child get or keep the ability to perform daily tasks, taking into consideration both the child's abilities and the abilities or someone of the same age.

5.1.3 **"CHIP Requirements"** shall mean the applicable requirements, policies, procedures and guidance issued under the Health Investment Insurance Act (Chapter 13 of Act 77 of 2001) (35 P.S. § 5701.1301 et seq.); Title XXI of the Social Security Act, as amended to include the State Children's Health Insurance Act (42 U.S.C. § 1397aa et seq.); and the Children's Health Care Act, Article XXIII of the Insurance Company law of 1921, as amended via the Act of 1996-68 and the Act of 2022-146 (40 P.S. § 991.2301 et seq., as amended and the regulations promulgated thereunder) as well as all Policy and Procedure Handbooks, Data

Books and other guidance and materials issued by an Official Body responsible with the administration of CHIP.

5.1.4 **"DHS"** shall mean the Department of Human Services of the Commonwealth of Pennsylvania or such successor Official Body with authority to administer CHIP. Currently CHIP is administered by DHS and Highmark, and/or a Highmark Affiliate, has entered into an agreement with DHS allowing Highmark or a Health Plan to offer CHIP Products which must comply with all CHIP Requirements issued by DHS.

5.1.5 **"Managed Care Organization (MCO)"** shall mean a risk bearing entity which manages the purchase and provision of physical and behavioral health services under CHIP. This includes Highmark or Health Plan who holds a CHIP contract with the Commonwealth.

5.1.6 **"Physician Incentive Plan"** Any compensation arrangement between an MCO and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services furnished to a CHIP enrollee who is enrolled in the MCO that complies with 42 C.F.R. § 438.3(i), as incorporating 42 CFR §§ 422.208 and 422.210.

5.2 **Compliance with CHIP Requirements.** Preferred Provider agrees to comply with all applicable CHIP requirements as issued by the appropriate Official Body. In accordance with terms of this Agreement, Highmark may update, its Administrative Requirements, this Attachment or the Agreement from time to time in order to comply with CHIP Requirements.

5.3 **CHIP Requirements for Provider Agreements.** Preferred Provider acknowledges and agrees that CHIP Requirements dictate that certain provisions are to be included in agreements between Highmark and Participating Providers who are designated to participate in Highmark CHIP Products covered under this Agreement. Those CHIP required provisions are contained herein as follows:

5.3.1 Notwithstanding any provision of the Provider Agreement to the contrary, Providers who render Provider Services to CHIP Members must submit all claims to Highmark within one hundred and eighty (180) days from the date of service or discharge. This is a requirement of CHIP on all participating managed care organizations including Highmark.

5.3.2 Preferred Providers must enroll each of their NPIs and service locations out of which they operate in the CHIP Program using the DHS PROMISe ID system. Claims will deny if the service location is not enrolled with a valid PROMISe ID before the enrollment deadline. Preferred Provider shall not bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against Highmark, Health Plan, and/or Member or any persons acting on Member's behalf for claims denied for lack of valid PROMISe ID. Provider agrees that this hold harmless provision shall survive the termination of this Agreement, regardless of the cause giving rise to the termination. In the event Highmark receives notice that Preferred Provider has received or collected money from a Member for any services rendered in

violation of the terms of this section, Highmark may (1) require Preferred Provider to refund the amount to the Member; (2) treat the amount as an Overpayment; and/or (3) take any other action against Preferred Provider authorized under this Agreement or as otherwise permitted by Law. Preferred Provider will provide Highmark with documentation of any such Member reimbursement upon request. All providers must revalidate enrollment of each service location every 5 years. Preferred Providers should log into PROMISe to check the revalidation dates of each service location and submit revalidation applications at least 60 days prior to the revalidation dates.;

5.3.3 Highmark and Preferred Provider shall communicate, exchange enrollment and individual health information, service needs of Highmark, the Member's PCP and community providers, and participate in Quality Management and Utilization Management programs as required by Highmark, in accordance with the terms of this Agreement and the Administrative Requirements. Highmark shall have a process to monitor the collaborative activities contemplated in this section.

5.3.4 Highmark shall develop Administrative Requirements, programs, or processes that govern referrals and promote collaboration and coordination of diagnostic assessment and treatment, prescribing practices and other treatment issues necessary for optimal health and disease prevention, including coordination of specialized service plans for enrollees with special health needs;

5.3.5 **Prohibitions against Terminations.** Highmark will not terminate this Agreement with respect to Preferred Provider's CHIP participation or discontinue a Provider's participation in any one or more CHIP Products for any of the following reasons:

5.3.5.1 Preferred Provider provides services that include a substantial number of CHIP Members and/or patients with expensive medical conditions; and

5.3.5.2 Preferred Provider advocates on behalf of CHIP Members for medically necessary and appropriate health care consistent with the degree of learning and skill ordinarily possessed by a reputable provider practicing according to the applicable legal standard of care; and

5.3.5.3 Preferred Provider files a grievance on a Member's behalf, and/or assists a Member with filing a grievance.

5.3.6 **False Claims.** Preferred Provider is prohibited from submitting any false claims and/or statements. Any false claims and/or statements submitted by Preferred Provider may result in sanctions against Preferred Provider.

5.3.7 **No-Gag.** Notwithstanding anything to the contrary in this Agreement, nothing herein shall be construed to prohibit any Preferred Provider acting within the lawful scope of practice from:

5.3.7.1 Discussing care and advising or advocating appropriate medical care with or on behalf of a CHIP Member including, but not limited to: information regarding the nature of treatment options; risks of

treatment; alternative treatments; or the availability of alternative therapies, consultation, or tests that may be self-administered.

5.3.7.2 Providing information that the CHIP Member needs in order to decide among all relevant treatment options and the risks, benefits, and consequences of treatment or non-treatment.

5.3.8 **Moral or Religious Grounds.** Nothing in this Agreement shall be construed as requiring Highmark to provide, reimburse for, or provide coverage of a counseling or referral service if Preferred Provider objects to the provision of such services on moral or religious grounds.

5.3.9 **Quality and Utilization Management and Monitoring.** Preferred Provider will comply with the Quality Management ("QM") and Utilization Management ("UM") programs contained in accordance with this Agreement and Administrative Requirements and, as applicable, cooperate with Highmark's CHIP QM and UM programs' standards which align with those outlined in the CHIP Procedure Handbook found at www.CHIPCoversPAKids.com.

5.3.10 **Encounter Data.** Preferred Provider must submit within 180 days after date of service for all required encounter data for all services provided within the time frames as required by CHIP, no matter whether reimbursement for these services is made by Highmark directly or indirectly through capitation. DHS owns all encounter data recorded to document services rendered to CHIP Members and Preferred Provider has no rights to this data.

5.3.11 **Continuation of Benefits.** In the event of Highmark and/or Health Plan's insolvency or other cessation of operations, Preferred Provider must continue to provide benefits to CHIP Members, including CHIP Members in an inpatient setting, through the period for which a capitation or other payment has been made.

5.3.12 **PCP and Bright Futures CHIP Requirements.**

5.3.12.1 If a primary care physician ("PCP") is not designated by the Enrollee's family, Highmark will send a notification letter to inform the Enrollee of the necessity to select a PCP within ten (10) days or a PCP will be assigned based on the age of the Enrollee, any special health condition (if known), travel time, and distance. In making an assignment, Highmark considers such factors as the age of the Enrollee, any special health condition (if known), travel time and distance.

5.3.12.2 Providers who are PCPs for CHIP Members under the age of nineteen (19) are responsible for conducting all Bright Futures screens. Should a PCP be unable to conduct the necessary Bright Futures screens, the PCP is responsible for arranging to have the necessary screens conducted by another CHIP Product participating provider and ensure that all relevant medical information, including the results of the screens, are incorporated into the CHIP Member's medical record and submitted as an encounter.

5.3.12.3 PCPs who conduct Bright Futures screens must report encounter data associated with the screen to Highmark and in a format approved by DHS within ninety (90) days from the date of service.

5.3.12.4 PCPs must contact new CHIP Members identified in the quarterly encounter lists who have not had an encounter during the first six (6) months of enrollment, or who have not complied with Bright Futures periodicity and immunization schedules for children. Where possible, the PCP must also document the reasons for noncompliance and document the Provider's efforts to bring the CHIP Member's care into compliance with the standards.

5.3.13 Each physician providing Services to CHIP Members shall have a unique identifier in accordance with the system established under Section 1173(b) of the Social Security Act. (42 U.S.C. § 1320d–2).

5.3.14 If required by DHS, Preferred Provider shall disclose annually any Physician Incentive Plan or risk arrangements it may have with physicians either within the group practice or other physicians not associated with the group practice even if there is not substantial financial risk between the MCO and the physician or physician group.

5.3.15 Preferred Providers shall develop and implement, as applicable to Preferred Provider's services and in accordance with the Medical Care Availability and Reduction of Error (MCARE) Act, an internal infection control plan that is established for the purpose of improving the health and safety of patients and health care workers and includes effective measures for the detection, control, and prevention of health care-associated infections.

5.3.16 Highmark's Utilization Management ("UM") Departments are mandated to monitor the progress of a CHIP Member's inpatient hospital stay, if applicable. Highmark must receive appropriate clinical information from the admitting hospital that details the CHIP Member's admission information, progress to date, and any pertinent data within two (2) business days from the time of admission. Preferred Providers must agree to Highmark's UM Department's monitoring of the appropriateness of a continued inpatient stay beyond the approved days according to established criteria, under the direction of Highmark's Medical Director. As part of the concurrent review process and in order for the UM Department to coordinate the discharge plan and assist in arranging additional services, special diagnostics, home care and durable medical equipment, Preferred Provider must provide Highmark with all clinical information on the inpatient stay in a timely manner which allows for decisions and appropriate management of care.

5.3.17 Behavioral Health Coordination Requirements. If applicable to Preferred Provider:

5.3.17.1 Preferred Provider shall comply with all applicable laws and regulations pertaining to the confidentiality of CHIP Member's medical records,

including obtaining any required written enrollee consent to disclose confidential medical records;

5.3.17.2 Preferred Provider shall make referrals for social, vocational, education, or human services when a need for such service is identified through assessment.

5.3.17.3 Preferred Provider shall provide health records if requested by the behavioral health provider.

5.3.17.4 Preferred Provider shall notify the behavioral health provider of all prescriptions, and when advisable, check with the behavioral health provider before prescribing medication. Provider shall ensure that the behavioral health provider has a complete up-to-date record of Member's medications.

5.3.17.5 Preferred Provider shall be available to the behavioral health provider on a timely basis for consultations.

5.3.17.6 Preferred Provider shall assist, when appropriate, in the coordination of services with the behavioral health provider, including pharmacy coordination, to the extent permitted by Law.

5.3.18 **Mandatory Reporting.** As required by Laws, if Preferred Provider is a Facility it must ensure that its Emergency Department staff and all physicians know procedures for reporting suspected abuse and neglect to an Official Body in addition to performing required exams for the county.

5.3.19 **Coordination and Continuity of Care.**

5.3.19.1 Each provider furnishing services to CHIP Members must maintain and share, as appropriate, the CHIP Member's health record in accordance with professional standards.

5.3.19.2 Preferred Provider must, when appropriate, interact with a CHIP Member's PCP for prompt treatment, coordination of care or referral for other identified services that are not the responsibility of the Preferred Provider.

5.3.19.3 Highmark and Preferred Provider will jointly identify the services to be delivered and Highmark and Preferred Provider will monitor the quality of the services delivered.

5.3.19.4 Highmark and Preferred Provider shall work cooperatively to establish programmatic responsibility for each CHIP Member.

5.3.19.5 Preferred Provider may be called upon to serve on interagency teams when requested by DHS.

5.3.19.6 PCPs shall interact for prompt treatment, coordination of care, or referral of CHIP Members for other identified services that are not the responsibility of Preferred Provider.

5.3.19.7 Highmark will provide training and consultations to facilitate continuity of care and the cost-effective use of resources.

5.3.19.8 Preferred Provider and Highmark agree to make mutual intensive outreach efforts to CHIP Members identified as needing service.

5.3.19.9 Preferred Provider, Highmark, and PCPs agree to communicate on an ongoing basis; exchange relevant enrollment and individual health related information; and coordinate service needs. Highmark will monitor such activity pursuant to this Agreement.

5.3.20 **Timely Dispute Resolution.** Disputes will be timely resolved in accordance with this Agreement or the Administrative Requirements.

5.3.21 Highmark will assist Preferred Provider, when appropriate, in the development of its CHIP provider network(s) to serve CHIP Members with chronic and complex medical conditions.

5.3.22 **Fraud, Waste, and Abuse.** Providers must comply with CHIP Requirements and enforcement actions directly initiated by DHS under its regulations, including termination and restitution actions. Preferred Provider and Highmark agree to collaborate on identifying and reducing the frequency of fraud, abuse, overuse, under use, and inappropriate or unnecessary medical care.

5.3.23 **Record Maintenance.** Preferred Provider shall maintain timely and accurate medical, financial, and administrative records related to services rendered by Preferred Provider. Unless a longer time period is required by applicable Laws, Preferred Provider shall maintain such records and any related contracts for ten (10) years.

5.3.24 **Audit, Reviews and Evaluations.** Preferred Provider will, at its expense, make all books, records, documents, and other evidence relating to CHIP, as the case may be, and the Provider Services rendered to CHIP Members under this Compliance Attachment and this Agreement, available for audit, review, or evaluation by Highmark, applicable Official Bodies or any of the preceding entities' designated representatives. Preferred Provider will make such books and records available onsite, during normal business hours, or, as requested by Highmark or the Official Bodies of the Commonwealth of Pennsylvania, through the mail within fifteen (15) calendar days of any such request (in accurate, legible paper copies, unless otherwise indicated). Preferred Provider will cooperate with any such review or audit by assisting in the identification and collection of any books, records, data, or clinical records, and by making appropriate practitioners, other employees and involved parties available for interviews upon request. The following additional requirements consistent with 42 C.F.R. § 438.230(c)(3) shall apply to Preferred Provider:

5.3.24.1 The Commonwealth of Pennsylvania "Commonwealth", CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of Preferred Provider, or of

Preferred Provider's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Highmark's CHIP contract with the Commonwealth.

5.3.24.2 Preferred Provider will, at no cost, make available, for purposes of an audit, evaluation, or inspection under subsection (i) of this section, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to CHIP enrollees.

5.3.24.3 The right to audit under subsection (i) of this section will exist through ten (10) years from the final date of the CHIP contract between Highmark and the Commonwealth or from the date of completion of any audit, whichever is later.

5.3.24.4 If the Commonwealth, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the Commonwealth, CMS, or the HHS Inspector General may inspect, evaluate, and audit the Preferred Provider at any time.

5.3.25 Information and Confidentiality Requirements.

5.3.25.1 Preferred Provider must comply with all applicable Laws pertaining to the confidentiality of all CHIP Members' medical records, including those applicable to behavioral health medical records and obtain any required written CHIP Member consents to disclose confidential medical records.

5.3.25.2 When necessary, Preferred Provider must obtain the appropriate releases to share clinical information and Provider health records to Highmark as requested consistent with applicable Laws.

5.3.25.3 Preferred Provider must maintain and keep confidential medical records and other confidential information and a process for addressing confidentiality problems.

5.3.25.4 Upon request, Highmark may collect information from Preferred Provider on the services delivered which are to be shared with the required Official Body.

5.3.25.5 If necessary, Highmark and Preferred Provider agree to report health-related information to the appropriate Official Body.

5.3.26 Non-Compliance and Corrective Action Plans. In the event that Preferred Provider fails to comply with the terms of this Agreement, Preferred Provider must participate in any reasonable corrective action plan required by Highmark.

5.3.27 Americans with Disabilities Act Compliance. Preferred Provider shall comply with the Americans with Disabilities Act (ADA) (42 U.S.C. §§ 12101 et seq.) and the Rehabilitation Act of 1973 (29 U.S.C. §§ 701 et seq.). If Preferred Provider is a PCP or dentist, Highmark or its agents may inspect Preferred Provider's office (excluding offices located in hospitals) to determine if the office is architecturally accessible to persons with mobility impairments in accordance with ADA

accessibility guidelines. If Preferred Provider's office or facility is not accessible, the PCP or dentist may only participate in CHIP provided that the PCP or dentist: (1) requests and is determined in Highmark's sole judgment to qualify for an exemption from this requirement, consistent with the requirements of the ADA; or (2) agrees in writing to remove the barrier to make the office or facility accessible to persons with mobility impairments within six (6) months after the Highmark identified the barrier. Highmark will document its efforts to determine architectural accessibility. Highmark must submit this documentation to DHS upon request.

5.3.28 **Freedom to Contract.** Preferred Provider is not prohibited from contracting with another managed care organization providing services for CHIP and Highmark will not penalize Preferred Provider for contracting with other managed care organizations for participation in any CHIP plans or products offered by such entity.

5.4 **Cultural Competency.** Both Highmark and Preferred Provider must demonstrate cultural competency and must understand that racial, ethnic, and cultural differences between Preferred Provider and a CHIP Member cannot be permitted to present barriers to accessing and receiving quality health care; must demonstrate the willingness and ability to make the necessary distinctions between traditional treatment methods and/or non-traditional treatment methods that are consistent with the enrollee's racial, ethnic or cultural background and which may be equally or more effective and appropriate for the particular enrollee; and demonstrate consistency in providing quality care across a variety of races, ethnicities and cultures. For example, language, religious beliefs, cultural norms, social-economic conditions, diet, etc., may make one treatment method more palatable to an enrollee of a particular culture than to another of a differing culture.

5.5 **PCPs.** The PCP must serve as the CHIP Member's initial and most important point of contact regarding health care needs. At a minimum, CHIP participating PCPs are responsible for:

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

5.5.2 Documenting all care rendered in a complete and accurate encounter record that meets or exceeds DHS's data specifications;

5.5.3 Maintaining continuity of each CHIP Member's health care, participating in or coordinating with an overall chronic care management team, where appropriate;

5.5.4 Communicating effectively with CHIP Members by using sign language interpreters for those who are deaf or hard of hearing and oral interpreters for a CHIP Member with LEP when needed by a CHIP Member. Services must be free of charge to the CHIP Member;

5.5.5 Making referrals for specialty care and other medically necessary services, both in and out-of-plan;

5.5.6 Maintaining a current medical record for each CHIP Member including documentation of all services provided to the CHIP Member by the PCP, as well as any specialty or referral services;

5.5.7 Arranging for behavioral health services in accordance with CHIP Requirements;

5.5.8 Providing office hours accessible to an enrollee for a minimum of twenty (20) hours per week and directly or through on-call arrangements with other qualified, plan-participating PCPs twenty-four (24) hours per day, seven (7) days a week for urgent and emergency care; and

5.5.9 Complying with all conditions and standards applicable to managed care plans set forth in 40 P.S. §§ 991.2101 – 991.2194 unless otherwise specified. Highmark retains responsibility for monitoring PCP actions to ensure they comply with CHIP Requirements.

5.6 **Mainstreaming CHIP Members.** Preferred Providers must not intentionally segregate CHIP Members in any way from other patients receiving Provider Services. Such segregation will be treated as Member discrimination under this Agreement and may result in termination of this Agreement or discontinuance of participation in CHIP Products.

5.7 **CHIP Enrollees Eligible For Medical Assistance Due to a Special Need.** DHS has a program for children under the age of 18 with special needs who meet the Social Security Administration "SSA" definition of disability for a child. The SSA's definition of disability for a child is:

5.7.1 A physical or mental condition or a combination of conditions that result in "marked and severe functions limitations." This means that the condition(s) must very seriously limit the child's activities; and

5.7.2 The child's condition must be permanent or have lasted or expected to last at least 12 months, or must be expected to result in death.

Highmark will contact Preferred Provider and fax or mail the partially completed Physician Certification Form with a copy of a letter form DHS. The letter from DHS will explain Highmark's need to collect the information for the CHIP PH-95 Referral and the importance of the need to verify the child's level of disability. Preferred Provider must complete, sign, and return the Physician Certification Form within 20 days of receipt. In the event that the Physician Certification Form is not returned, Highmark will submit credible claims information, case management information, or other information indicating that the child meets the SSA definition of disability to DHS in accordance with the CHIP Handbook after which DHS will determine the child's CHIP eligibility.

5.8 **Drug Coverage Exclusions.** Highmark will not reimburse Preferred Provider for Drug Efficacy Study Implementation (DESI) drugs. Highmark will not reimburse Provider for non-compensable drugs in accordance with 55 P.S. § 1121.54.

5.9 **CHIP Gap Report Requirements.** Highmark will provide the CHIP Gap report. On a monthly basis, Preferred Provider shall review the CHIP Gap report to identify, schedule,

and provide services to CHIP Members prior to the compliance due date on the CHIP Gap Report.

5.10 **Term and Termination.** Preferred Provider's participation in CHIP will have the same term as this Agreement and shall immediately terminate if this Agreement terminates; provided that in the event of a successful prosecution of Preferred Provider related to CHIP Highmark may, at its discretion, suspend or terminate Preferred Provider's participation in CHIP.

6. DISPUTES

All matters, disputes or controversies relating to the services performed by Preferred Providers or any questions involving professional ethics (including determinations of any Blue Shield committee that a Preferred Provider disputes) shall be considered and determined only by the Review Committee in the manner provided by the applicable provisions in the Bylaws and the Review Committee Guidelines, which are included in the BSOM or its successor. Such Bylaws and Review Committee Guidelines are also available from Blue Shield upon the written request of any Preferred Provider. **All Review Committee determinations are final and binding upon Blue Shield and the applicable Preferred Provider.**

7. CONFLICTS

To the extent any terms or conditions of the provisions in this Part III conflicts with any terms or conditions set forth in the provisions of Part I with respect to Preferred Providers, the provisions in this Part III shall apply and govern.

PART IV

GOVERNMENT SPONSORED PROGRAMS PROVISIONS

Part IV of these Regulations applies to you as a Government Sponsored Programs Provider ONLY, regardless of the version of the Government Sponsored Programs Agreement you hold. The provisions contained in Part IV of these Regulations are applicable to all current and former active versions of the Government Sponsored Programs Agreement, regardless of their title.

1. QUALIFIED HEALTH PLAN OBLIGATIONS

The following provisions apply to any benefit plans offered by Health Plan through an Exchange under a Qualified Health Plan Issuer Agreement:

1.1 Definitions.

1.1.1 "Exchange". A governmental agency or non-profit entity that meets the applicable standards of 45 C.F.R. §155 subpart D and makes QHPs available to individuals and employers. This term includes both state and Federally-facilitated Exchanges.

1.1.2 "Downstream Entity." Any individual or entity that enters into an agreement below the level of the Agreement between Government Sponsored Programs Providers and Health Plan for the provision of administrative or health care services offer under a QHP Issuer Agreement.

1.1.3 "Qualified Health Plan or QHP." A health plan that has been certified that it meets the standards described in 45 C.F.R. § 156 subpart C or that has been approved by the Exchange through which such plan is offered.

1.1.4 "QHP Issuer Agreement." An agreement between the Centers for Medicare & Medicaid Services ("CMS") and Health Plan to offer QHPs.

1.2 Compliance with Law and Standards. In providing services and performing its responsibilities under this Agreement, Government Sponsored Programs Providers shall comply with the laws and regulations relating to the standards specified under 45 CFR §156.340 including, as applicable, (i) the standards of subpart C of 45 CFR Part 156; (ii) the exchange processes, procedures, and standards in accordance with subparts H and K of 45 CFR Part 155 and, in the small group market, 45 CFR §155.705; (iii) the standards of 45 CFR §155.220 with respect to assisting with enrollment in QHPs; (iv) the standards of 45 CFR §§156.705 and 156.715 for maintenance of records and compliance reviews for QHP issuers operating in a Federally-facilitated Exchange; and (v) the standards of 45 CFR §156.340 with respect to downstream and delegated entities. In addition, to the extent applicable to the activities under this Agreement, Government Sponsored Programs Providers shall comply with the standard rules of conduct set forth in Section II of Highmark or a Health Plan's Qualified Health Plan Issuer Agreement, to be furnished by Highmark to Government Sponsored Programs Providers in the Administrative Requirements.

1.3 Record Maintenance. Government Sponsored Programs Providers shall maintain timely and accurate medical, financial and administrative records related to services rendered by Government Sponsored Programs Providers. Unless a longer time period is required by applicable statutes or regulations, Government Sponsored Programs Provider shall maintain such records and any related contracts for ten (10) years.

1.4 Audits by HHS. Government Sponsored Programs Providers acknowledges and agrees that the Department of Health and Human Services (HHS) Secretary and Office of Inspector General (OIG) and their designees have the right to evaluate, through audit, inspection, or other means, the performance of Government Sponsored Programs Providers, its related entities and its downstream entities. In furtherance of that right, Government Sponsored Programs Providers shall permit access by the HHS Secretary, OIG and their designees to any books, contracts, computer or other electronic systems, including medical records and documentation related to any services provided under benefit plans offered by Health Plan through an Exchange under a Qualified Health Plan Issuer Agreement. Government Sponsored Programs Providers shall permit access to such records, books, contracts, computer or other electronic systems until ten (10) years from the final date of the Agreement period.

1.5 Downstream Agreements. If Government Sponsored Programs Providers has any arrangements, in accordance with the terms of the Agreement, with affiliates, subsidiaries, or Downstream Entities, directly or through another person or entity, to perform any health care or administrative services under a QHP, Government Sponsored Programs Providers shall ensure that all such arrangements are in writing, duly executed, and include all the terms contained in this Section 1.5.

1.6 Revocation of Agreement as it Applies to Benefit Plans Offered by Health Plan Under or Through an Exchange. Government Sponsored Programs Provider acknowledges and agrees that Health Plan may terminate this Agreement to furnish services under a QHP in instances where CMS or Health Plan determines that Government Sponsored Programs Provider has not performed satisfactorily. Government Sponsored Programs Provider acknowledges and agrees that to the extent CMS directs such revocation, Highmark shall provide immediate written notice of such to Government Sponsored Programs Provider, and such revocation shall become effective as directed by CMS. Any terminations initiated solely by Health Plan shall be in compliance with Section 5 of the Agreement.

2. FEDERAL FUNDING

Payment for Covered Services provided to Members under the Government Sponsored Programs Provider Agreement may be derived in whole or in part from federal funds. Blue Shield and/or Health Plan may modify payment rates or reimbursement under the Agreement based upon any changes in the amount of the funding received by Blue Shield and/or Health Plan. To the extent that Laws or an Official Body makes a change that reduces any funding or reimbursement to Blue Shield and/or Health Plan, Blue Shield may implement a corresponding modification to payment rates or reimbursement effective as of the date of such change.

3. REGISTRATION FOR GOVERNMENT SPONSORED PROGRAMS PROVIDERS

3.1 Licensure. Any health service doctor or ancillary health service provider duly authorized to practice as such under the applicable laws of the Commonwealth of Pennsylvania may apply to participate as a Government Sponsored Programs Provider with Blue Shield. Each Practitioner must maintain a current license and comply with these Regulations, as amended from time to time hereafter with the approval of the DOH and in accordance with the provisions of Section 11.2 of Part I of these Regulations.

3.2 Refusal. Blue Shield may, on consideration of applicable credentialing criteria or other reasons, pertaining to cost effectiveness, quality of care or other factors, refuse to permit the participation of Provider as a Government Sponsored Programs Provider in its sole discretion.

3.3 Effective Date of Participation. The participation of any Provider as a Government Sponsored Programs Provider shall be effective upon acceptance by Blue Shield of Provider's application, Provider's satisfaction of all applicable credentialing criteria, and execution of the Government Sponsored Programs Provider Agreement by Blue Shield.

3.4 Termination. A Provider's participation with Blue Shield as a Government Sponsored Programs Provider shall continue until such time as the Government Sponsored Programs Provider Agreement is terminated by either party in accordance with the terms of the Government Sponsored Programs Provider Agreement.

3.5 Rejection. Blue Shield may reject an application to be a Government Sponsored Programs Provider, or may terminate the participation as a Government Sponsored Programs Provider, in accordance with the terms of the Government Sponsored Programs Provider Agreement, these Regulations and/or Administrative Requirements. Applicant shall have the right to appeal a rejection based upon cause. Government Sponsored Programs Provider shall have the right to appeal a suspension or termination initiated by Blue Shield based upon cause. Such appeals shall be in writing and shall be addressed to the Blue Shield credentialing committee if the suspension or termination arose in connection with the recredentialing of Government Sponsored Programs Provider or any of its Practitioners. Reinstatement as a Government Sponsored Programs Provider, which has been suspended or terminated with cause, if the suspension or termination arose in correction with the recredentialing of a Provider or any of its Practitioners, may be approved if it is established to the satisfaction of the Blue Shield credentialing committee. Any determination of said credentialing committee or other rejection, suspension, or termination shall be appealable to the Review Committee.

3.6 Credentialing. Each Practitioner meets and will continue throughout the Term to meet all credentialing and recredentialing requirements as established by Blue Shield for participation as a Government Sponsored Programs Provider in the Government Sponsored Programs Provider network and as set forth in the Administrative Requirements.

4. PROGRAM PARTICIPATION

Except in emergency situations or upon prior approval of Blue Shield, Government Sponsored Programs Provider must make any necessary referrals to another Government Sponsored Programs Provider

and/or contracted hospital participating in the Member's benefit plan. Government Sponsored Programs Provider shall notify Blue Shield of any referral to a non-Government Sponsored Programs Provider or to a non-participating hospital and shall document the reason for such referral in the Member's records.

5. ACT 146 PRODUCT PROVISIONS

The following provisions will apply in all instances where Government Sponsored Programs Provider is providing services to a Member enrolled in an Act 146 Product:

5.1 **Hold Harmless.** Preferred Provider acknowledges and reaffirms the hold harmless provision in Section 5.11 of Part I of these Regulations and agrees that such provision shall survive the termination of the Government Sponsored Programs Provider Agreement and is to be construed for the benefit of the Members.

5.2 **Act 68 and Act 146 Member Records.** All Member records shall be kept confidential by Blue Shield and Government Sponsored Programs 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.

5.3 **Primary Care 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, Government Sponsored Programs Providers who are PCPs shall meet the following minimum responsibilities:

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

5.3.2 Maintaining continuity of each Member's health care;

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

5.3.4 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);

5.3.5 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 Government Sponsored Programs Providers who are PCPs twenty-four (24) hours per day, seven (7) days per week for urgent and emergency care; and

5.3.6 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).

5.4 **Act 68 and Act 146 Member Records and Access to Records.** Government Sponsored Programs Provider will maintain medical records in accordance with all requirements set by Blue Shield, and shall permit Blue Shield 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 Blue Shield and Official Bodies' employees or agents with direct responsibilities for the functions enumerated above.

5.5 **Quality Programs.** Government Sponsored Programs 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).

5.6 **Compliance with Laws.** Government Sponsored Programs Provider will adhere to all Laws applicable to the provision of professional health care services under this Agreement.

5.7 **Prompt Payment.** Blue Shield will pay all Clean Claims as required by Section 2166 of Act 68 and Act 146 and 31 Pa. Code §154.18.

5.8 **Notice.** Where required by Act 68 and Act 146, Blue Shield will notify Government Sponsored Programs Provider in writing at least thirty (30) days before it implements any changes to its contracts, policies or procedures affecting Government Sponsored Programs 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 Government Sponsored Programs Provider upon the effective date thereof.

5.9 **No-Gag Clause.** Nothing in these Regulations shall be construed to limit or prohibit Government Sponsored Programs Provider's right to discuss, and Government Sponsored Programs Provider may freely discuss, with any Member, or, where applicable, on behalf of such Member with such Member's representative: (a) the process that Blue Shield 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 Government Sponsored Programs 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 Blue Shield to deny payment for a health care service.

5.10 **Termination.** As required by Act 68 and Act 146, Blue Shield will not sanction, fail to renew or terminate Government Sponsored Programs Provider's participation in the Government Sponsored Programs Provider network for any of the following reasons:

5.10.1 Government Sponsored Programs Provider's 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 provider practicing according to the applicable legal standard of care;

5.10.2 Government Sponsored Programs Provider's 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;

5.10.3 Government Sponsored Programs Provider's protesting a decision, policy or practice that Government Sponsored Programs Provider, consistent with the degree of learning and skill ordinarily possessed by a reputable health care provider practicing according to the applicable legal standard of care, reasonably believes interferes with Government Sponsored Programs Provider's ability to provide (based on Government Sponsored Programs Provider's clinical judgment) medically necessary and appropriate health care;

5.10.4 Government Sponsored Programs Provider's having a practice that includes a substantial number of patients with expensive medical conditions;

5.10.5 Government Sponsored Programs 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 Government Sponsored Programs Provider is based on moral or religious grounds and Government Sponsored Programs Provider makes adequate information available to Members or, if applicable, prospective Members;

5.10.6 Government Sponsored Programs Provider's communicating with a Member or a Member's representative in accordance with the terms of Section 5.9 of Part IV of these Regulations; or

5.10.7 Government Sponsored Programs 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*).

5.11 **Obligation Upon Termination.** In the event of the termination of the Government Sponsored Programs Provider Agreement by Blue Shield or Government Sponsored Programs Provider, Government Sponsored Programs Provider agrees upon request to cooperate with Blue Shield in Blue Shield obtaining information from Government Sponsored Programs Provider regarding those Members enrolled in an Act 146 Product that may be affected by such termination because they are undergoing an ongoing course of treatment or are otherwise active patients of Government Sponsored Programs Provider. Such information includes the name, address and identification number of affected Members of an Act 146 Product.

6. DISPUTES

All matters, disputes or controversies relating to the services performed by Government Sponsored Programs Providers or any questions involving professional ethics (including determinations of any Blue Shield committee that a Government Sponsored Programs Provider disputes) shall be considered and determined only by the Review Committee in the manner provided by the applicable provisions in the Bylaws and the Review Committee Guidelines, which are included in the BSOM or its successor. Such

Bylaws and Review Committee Guidelines are also available from Blue Shield upon the written request of any Government Sponsored Programs Provider. **All Review Committee determinations are final and binding upon Blue Shield and the applicable Government Sponsored Programs Provider.**

7. CONFLICTS

To the extent any terms or conditions of the provisions in this Part IV conflicts with any terms or conditions set forth in the provisions of Part I with respect to Government Sponsored Programs Providers, the provisions in this Part IV shall apply and govern.