ANCILLARY PROVIDER AFFILIATION AGREEMENT

This Agreement is made between **Blue Care Network of Michigan, Blue Care of Michigan, Inc. and BCN Service Company** (hereinafter collectively referred to as **Health Plan**) and _____ (hereinafter referred to as **Provider**).

This Agreement is effective _____ (Date to be entered only by Health Plan) for an initial term through the end of the calendar year. The Agreement shall renew automatically for additional one-year terms unless otherwise terminated as provided below.

WHEREAS, Health Plan desires to offer managed care services to persons residing throughout its service areas;

WHEREAS PROVIDER is a qualified provider in the Health Plan service areas and wishes to provide Covered Services to Health Plan Members.

NOW, THEREFORE, the Parties agree as follows:

ARTICLE 1. DEFINITIONS

1.1 **Affiliated Provider** – A qualified provider of Covered Services, including hospitals, facilities, agencies, physicians and other providers, that provides Covered Services to Health Plan Members under the terms and conditions of a signed Health Plan provider affiliation agreement.

1.2 **Agreement**- This Agreement between Health Plan and Provider, including all incorporated exhibits, attachments and amendments hereto, including the Provider Manual, which is incorporated herein by reference.

1.3 **Blue Care Network of Michigan (BCN)**- A nonprofit corporation and health maintenance organization affiliated with Blue Cross and Blue Shield of Michigan and certified by the State of Michigan under applicable Michigan statutory authority. Blue Care Network of Michigan is financed on a prepaid basis. Blue Care Network of Michigan is not an insurance company.

1.4 **Blue Care of Michigan, Inc. or BCMI** - A nonprofit corporation and health carrier affiliated with Blue Cross and Blue Shield of Michigan and certified by the State of Michigan. BCMI is financed on a prepaid basis. BCMI is not an insurance company.

1.5 **BCN Service Company (BCNSC)** - A Michigan licensed Third Party Administrator and wholly owned subsidiary of Blue Care Network of Michigan, that provides administrative services for self-funded health care coverage for employer groups.

1.6 **Blue Cross and Blue Shield of Michigan or BCBSM** - The nonprofit health care corporation which is the parent company of BCN. BCBSM is not an insurance company.

1.7 **Certificate** - The documents issued by Health Plan or by another third party payer under a subcontracting arrangement with Health Plan, specifying the services and benefits to which Members are entitled under a Health Benefits Product.

1.8 **Clean Claim** - A complete and accurate claim for payment of Covered Services pursuant to MCLA 500.2006.

1.9 **Copayment** - Any amount, excluding Deductible, required to be paid by or on behalf of a Member for Covered Services under a Certificate.

1.10 **Covered Services** - Services to which Members are entitled under a Certificate.

1.11 **Deductible** - The amount of expenses for which a Member is responsible before Covered Services will be paid under a Certificate.

1.12 **Member** - Any person entitled to receive Covered Services pursuant to a Certificate; or a Member who is eligible for Medicare and who is enrolled with Health Plan under a contract between Health Plan and the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services.

1.13 **My Blue Medigap Member** - A Medicare eligible Member who is enrolled with Health Plan under a Medicare Supplemental product (as that term is defined in Chapter 38 of the Michigan Insurance Code) which covers Medicare Copayments and Deductibles under benefit packages defined by the State.

1.14 **BCN-65 Member** - A Medicare eligible Member who is enrolled with BCN under a Medicare wrap-around benefits Certificate which covers Medicare Copayments and Deductibles and provides additional benefits, including preventive health services, not covered under Medicare Parts A and B.

1.15 **Primary Care Practitioner or PCP** – A licensed allopathic or osteopathic physician whose practice is general, family, pediatric or internal medicine or other licensed physician or qualified nonphysician provider individually designated by Health Plan who is affiliated with Health Plan for the purposes of providing, arranging and managing medical care and services for Members under the terms and conditions of a Health Plan provider affiliation agreement.

1.16 **Provider** –An ancillary provider that has been accepted by Health Plan as an Affiliated Provider; has agreed to comply with the terms and conditions of this Agreement; and bills services using Provider Tax Identification Number and/or National Provider Identifier number registered under the Provider's tax ID number.

1.17 **Provider Manual**- A working document developed and maintained by Health Plan, including associated bulletins and provider notices, which defines certain terms of this Agreement and provides specific guidelines and direction for carrying out the responsibilities of Affiliated Providers.

1.18 **Third Party Administrator (TPA)** - An entity, licensed under the Michigan Third Party Administrator Act and contracted by Health Plan to provide certain delegated administrative services under this Agreement.

ARTICLE 2. PROVIDER OBLIGATIONS

2.1 **Qualifications/Standards of Care** – Provider shall maintain all licenses, certifications and accreditations required by law, certification under Titles XVIII and XIX of the Social Security Act and BCBSM participating provider status. Provider shall provide proof of applicable licenses, certifications and accreditations upon request by Health Plan and shall promptly notify Health Plan of any loss, revocation or suspension of any such licenses, certifications or accreditations. Provider shall individually submit all proposed treatment sites for approval and credentialing by Health Plan. Provider shall ensure that Members are treated only at sites approved by Health Plan for affiliation under this Agreement. Provider shall render all Covered Services in a manner consistent with professionally recognized standards of health care.

2.2 **Credentialing Requirements** – Provider shall comply fully with Health Plan credentialing requirements applicable to Provider and health care personnel employed by or contracted with Provider. Provider shall promptly notify Health Plan of any material changes in Provider's certification, licensure, or other qualification status. To the extent Health Plan delegates credentialing of practitioners to Provider, Health Plan shall review and approve the credentialing process and will audit the credentialing process on an ongoing basis.

2.3 **Providing Covered Services** - Provider shall follow the authorization and referral procedures set forth in the Provider Manual for the authorization and payment of Covered Services. Provider shall furnish Covered Services through qualified personnel and, where applicable, appropriately credentialed health care professionals. Provider shall furnish to Members only such Covered Services as Health Plan has contracted with Provider to provide, and as to which Provider is legally qualified to provide and as are consistent with Provider's customary practice and staff credentials. Provider shall consult with and seek further authorization from Health Plan or Member's Primary Care Practitioner if it is believed that additional treatment or tests are needed beyond those initially authorized. Provider understands and agrees that Health Plan's authorization of services does not constitute a guarantee of Health Plan payment for such services.

2.4 **Health Plan Administrative Programs** – Provider shall cooperate with Health Plan's network management, Member education, Member grievance, claims processing and administration, clinical and nonclinical performance measurement and improvement programs, and other policies, procedures and corrective measures reasonably established by Health Plan to effect the terms and provisions of this Agreement. Provider shall also participate in Health Plan's quality improvement, and/or medical management programs.

2.5 **Mandated Provisions** – Provider shall comply with all applicable legislative, regulatory and certification requirements, whether or not explicitly set forth herein.

2.6 **Liability Coverage** – Provider shall maintain medical liability coverage with minimum limits of $500,000 per incident, $1,000,000 annual aggregate and separate general liability coverage in amounts commensurate with applicable industry standards. Such coverage shall include Provider, its employees, officers, trustees and agents at all sites and for all activities related to provision of Covered Services. Provider shall furnish evidence of this insurance coverage upon request by Health Plan and shall promptly notify Health Plan in the event of any loss or impairment of such coverage or when more than half the annual limit has been exhausted. In the event that medical liability coverage required under this Section is secured in the form of a "claims made" policy, Provider shall purchase, upon termination of such coverage, a "tail" policy covering a period of not less than five (5) years following termination of the coverage or termination of this Agreement, whichever is later. From time to time, Health Plan may revise the required limits for medical liability coverage in accordance with applicable industry standards.

2.7 **Health Plan Designation of Panel Providers** - Provider acknowledges Health Plan's authority to designate specific hospitals, facilities, agencies, physicians and other practitioners as preferred or exclusive Affiliated Providers of Covered Services for Members and shall cooperate with Health Plan in the designation and utilization of such Affiliated Providers.

2.8 **Changes in Provider Status**- Provider shall promptly notify Health Plan in the event of any of the following occurrences:

A. Any action which jeopardizes Provider's applicable license, certification, accreditation or Titles XVIII and XIX certification;

B. Any change in Provider's name, ownership status, business or treatment location(s) or range of services or treatments offered;

C. Any termination or substantial reduction in the amount of Provider's liability insurance coverages;

D. Any material reduction in services or any other situation which may substantially interfere with Provider's performance of its duties and obligations under this Agreement.

Provider shall provide Health Plan with copies of any written material relating to any of the foregoing when requested by Health Plan.

2.9 **Nondiscrimination** - Practitioner shall provide Covered Services to Members in the same manner, quality and promptness as services are provided to Practitioner's other patients. Practitioner shall not intentionally segregate Members in any way from other persons receiving health care services. Practitioner shall provide Covered Services in a manner consistent with professionally recognized standards of health care. Practitioner shall provide Covered Services in a culturally competent manner to Members of different cultural and ethnic backgrounds. Practitioner shall not discriminate against any Member on the basis of membership in Health Plan, source of payment, sex, ethnicity, age, race, color, religion, creed, national origin, ancestry, marital status, sexual preference, or any factor related to health status, including but not limited to medical condition, claim experience (including conditions arising out of domestic violence), source of payment, receipt of health care, medical history, genetic information, evidence of insurability, disability or handicap, or any basis prohibited by federal law in providing health care services under this Agreement.

2.10 **Access to Covered Services** - Provider shall make necessary and appropriate arrangements to ensure the availability of Covered Services to Members twenty-four (24) hours per day and seven (7) days per week.

2.11 **Conflicts of Interest** - Provider shall ensure against the creation or continuation of any relationship between Provider and any Primary Care Practitioner which might adversely affect Members' health, safety or reasonable access to medical services or the financial interests of Health Plan or its Members. Such relationships may include, but are not necessarily limited to relationships of ownership, management or control, or the provision of payments or other benefits by Provider to Primary Care Practitioners. Provider shall promptly disclose to Health Plan any such relationship. Provider shall comply with all applicable state and federal conflict of interest statutes. Any violation of this provision shall be deemed a material breach of this Agreement and shall be cause for termination.

2.12 **Non-Covered Services** - Nothing in this Agreement shall be construed to prohibit or otherwise restrict Provider, its employees and agents from advising or advocating on behalf of Member about Member's health status, medical care, or treatment options; the risks, benefits, and consequences of treatment or non-treatment; or the opportunity for Member to refuse treatment or to express preferences about future treatment decisions, regardless of Health Plan benefit coverage limitations. The parties recognize that Members may consent to receive services that are not Covered Services or are not authorized by Health Plan and therefore, may be payable by Member. Provider is responsible for confirming all proposed services as Covered Services and for verifying proper authorization of such services prior to treating Member. When proposed services are not payable by Health Plan, Provider must inform Member in advance and should document in writing Member's consent to be billed for the services.

2.13 **Treatment Sites** – Provider shall ensure that facilities in which Members will be received, screened and treated meet applicable state and local fire, safety and sanitation codes.

ARTICLE 3. HEALTH PLAN OBLIGATIONS

3.1 **Plan Administration** - Health Plan shall develop, coordinate and implement quality management, medical management, network management, claims administration, Member education and Member grievance Programs for the purpose of effecting and administering this Agreement.

3.2 **Program Changes** - Health Plan shall give Provider prior notice of substantive changes in Covered Services benefits, and authorization requirements and procedures.

3.3 **Credentialing/Professional Review** - Health Plan shall review the applications and credentials of health care providers applying for affiliation with Health Plan. Health Plan shall develop and coordinate review activities related to credentialing, quality management, and medical management, as described in the Provider Manual. Health Plan reserves the right to refuse or terminate affiliation status of any provider or Affiliated Provider.

3.4 **Claims Adjudication** - Health Plan or its designee shall receive, process and pay in a timely manner claims for Covered Services rendered by Provider in accordance with the authorization procedures as set forth in the Provider Manual. Health Plan shall ensure that Clean Claims are adjudicated promptly in accordance with applicable statutory and regulatory requirements. Health Plan shall work diligently with Provider to resolve any perceived lack of timeliness with regard to claims payment under this Agreement.

3.5 **Information Services**- Health Plan shall provide inquiry services for Members, Providers and the general public.

3.6 **Legal/Regulatory Functions** - Health Plan shall perform the legal and regulatory functions required under applicable State and Federal laws.

3.7 **Designation of Panel Providers** - Health Plan shall establish contractual arrangements with hospitals, facilities, agencies, physicians and other providers and may designate certain providers as preferred or exclusive Affiliated Providers of Covered Services. Health Plan will publish listings of Affiliated Providers and will update such listings from time to time. Health Plan reserves the right to refuse or terminate the affiliation status of any provider or Affiliated Provider.

ARTICLE 4. BILLING AND PAYMENT

4.1 **Claims** – Provider shall submit claims for billable Covered Services using the appropriate designated NPI number either electronically using Health Plan-specified formats or in written form on Health Plan-designated claim forms; all claims shall include appropriate coding based on established clinical edit rules, including the proper use and combination of billing codes. Electronic claims submission will be preferred over hard copy formats. Claims shall be submitted not later than three hundred sixty-five (365) days after the date of service. Provider recognizes that failure to file claims within the prescribed time limits will at Health Plan's discretion, render the claim unpayable. Billing of Members for claims denied or recovered under this section is prohibited by Member Hold Harmless provisions set forth herein.

4.2 **Medicare Wrap-around Benefits** – In the case of Members who participate in a Medicare supplemental, complementary or other similar products, different rules of billing and payment shall apply. For such Members, Provider shall first bill to and accept payment from the Centers for Medicare and Medicaid Services (CMS) for Covered Services on an accept-assignment basis prior to billing Health Plan for wrap-around or Medicare Supplemental benefits.

4.3 **Payment for Covered Services** – Covered Services shall be paid in accordance with the rates described below or in a separate relevant amendment to the Agreement.

A. **Commercial Members** - For Members enrolled in Health Plan's Commercial HMO Product (Commercial Members), Provider will be paid at the lesser of billed charges or (1) Health Plan's applicable Professional Fee Schedule or (2) any applicable separate payment agreement between Provider and Member's referring PCP, less applicable Copayments. Covered Services not listed on the designated Fee Schedule or applicable separate payment agreement will be paid at 65% of billed charges, less applicable Copayments.

B. **BCN-65 Members** – After adjudication of primary payment by Medicare, claims for supplemental benefits provided to BCN-65 Members will be paid in accordance with Medicare rules and guidelines for payment of such Covered Services.

C. **Audit of Claims** – Health Plan conducts an unbundling audit of all submitted claims to ensure appropriate coding, based on established clinical edit rules. In the event the audit identifies an improper use or combination of billing codes, certain billed service(s) may

be denied. All services denied in accordance with this provision are subject to Member Hold Harmless provisions set forth in the Agreement.

4.4 **Coordination of Benefits** – Provider shall request information from Members regarding other payers which may be primarily responsible for Member's Covered Services. Provider shall pursue payment from such other responsible payers and shall bill Health Plan only for Covered Services not payable by the primary payer. All payment amounts received from other primary payers for Covered Services shall be promptly credited against or deducted from billable amounts otherwise payable under this Agreement. Except with regard to Members who participate in a Medicare supplemental, complementary or other similar products and/or fee-for-service payments by Health Plan as a secondary payer, when combined with payments received by Provider from all other payers shall not exceed the amount which would otherwise be payable by Health Plan as primary payer under this Agreement.

4.5 **Statutory Health Benefits** - Provider shall provide Covered Services to Members even though there might be liability to another party under Worker's Compensation, Occupational Disease, or other statutory coverage. Provider shall bill the appropriate responsible party for Covered Services and shall provide information to Health Plan regarding the applicability of such statutory coverage.

4.6 **Copayments and Deductibles** – Except in cases of extreme financial hardship that are documented in the Member's medical record or where reasonable collection efforts have failed, Provider shall collect all applicable Copayments and Deductibles, including Medicare Copayments and Deductibles, which are the Member's responsibility.

4.7 **Member Hold-Harmless** - Except in the event that Member has primary coverage with another carrier or third party payer and except for applicable Copayments or Deductibles, Provider agrees to look solely to Health Plan or TPA for payment for Covered Services rendered under this Agreement and to accept payment made in accordance with the Agreement as payment in full. Provider will in no event, including but not limited to nonpayment, insolvency or breach of this Agreement, bill, charge, collect a deposit from, seek payment from, maintain any action at law or in equity or have any other recourse against a Member or person (other than Health Plan or TPA) acting on behalf of Member for Covered Services provided pursuant to this Agreement. This provision does not prohibit Provider from collecting charges for supplemental benefits or Copayments or Deductibles where appropriate, or for non-Covered Services provided to Members on a fee-for-service basis. This provision shall survive termination of the Agreement for Covered Services rendered prior to termination regardless of the cause giving rise to such termination and shall be construed to be for the benefit of the Member. This provision supersedes any oral or written agreement to the contrary now existing or hereafter entered into between Provider and Member or person acting on Member's behalf, insofar as such contrary agreement relates to liability for payment of Covered Services provided under this Agreement.

4.8 **Transitional Care for Federal Employee Health Benefits (FEHB) Members** – For Members enrolled with Health Plan under FEHB group coverage, special transitional care provisions apply. In the event that a FEHB Member who is receiving treatment by Provider for a chronic or disabling condition or in the second or third trimester of pregnancy undergoes an involuntarily disaffiliation from Health Plan or Provider undergoes disaffiliation from Health Plan for reasons other than cause, Provider shall continue to provide Covered Services in accordance with this Agreement for up to 90 days or in the case of pregnant members, through the end of postpartum care, whichever is later. Patients receiving transitional care after a disaffiliation event will not be required by Provider to pay any more for such care than they had paid before disaffiliation. Until such time as replacement coverage takes effect or the patient is transferred to a new designated provider, Health Plan shall continue to pay according to the terms of this Agreement for all Covered Services provided. Provider shall accept such payment as payment in full in accordance with Member Hold-harmless provisions set forth herein.

ARTICLE 5. RECORDS AND ACCESS

5.1 **Medical Records** - Provider shall maintain accurate and timely medical records for Members treated by Provider for at least six (6) years in accordance with all federal and state laws and regulations regarding confidentiality and disclosure of Member health information and in a manner which safeguards the privacy of any information which may identify a particular Member.

5.2 **Reporting Covered Services** – Upon request by Member's PCP, Provider shall furnish a written report of services and treatments for inclusion in Members medical record and to facilitate management of Covered Services.

5.3 **Administrative Access to Records** - In accordance with applicable law and in particular, applicable HIPAA records access standards, Provider shall provide access by Health Plan to Member medical records upon reasonable request in order to facilitate its role in adjudicating claims, conducting quality management and utilization management and handling Member complaints. Upon reasonable request by Health Plan, Provider shall provide copies of Members' medical records for such purposes without additional charge.

5.4 **Access Pursuant to Member Appeals** – Provider shall, within ten (10) days of Health Plan request, provide copies of specified Members' medical records to enable Health Plan to meet statutorily-imposed time frames for resolving Member appeals. The parties acknowledge that, because of substantial fines and penalties imposed under applicable legislation, timely provision of records under this section is extremely important. Both parties agree to fully cooperate with one another to minimize delays in the production of such records.

5.5 **Regulatory Access to Records** - Upon reasonable request and as permitted and/or required by law, Provider shall provide access by Health Plan and legally authorized peer review and government representatives to Provider's facilities for the purpose of inspecting the facilities and/or Members' medical records.

5.6 **Member Access to Records** – Upon reasonable advance notice and in accordance with applicable state and federal law and regulation, Provider shall provide access by Member or in the case of minor children, Member's parent or legal guardian to Member's medical records. Provider may limit such access by parents or legal guardians of minor children as permitted or required by law.

5.7 **Confidentiality of Member Records** - Except as otherwise provided below, Health Plan and Provider shall not disclose Members' medical, personal, or financial records or information except to an authorized representative of Health Plan, or to a properly identified and authorized government agent and as otherwise specifically provided in this Agreement, or pursuant to the separate written consent of Member. Provider agrees to:

A. Abide by all federal and state laws regarding confidentiality and disclosure of medical records, or other health enrollment information. Provider must safeguard the privacy of any information that identifies a particular Member and have procedures that specify:
    a. For what purpose the information will be used within Provider's organization; and
    b. To whom and for what purposes Provider will disclose the information.

B. Ensure that medical information is released only in accordance with applicable federal or state law, or pursuant to court orders or subpoenas.

C. Maintain the records and information in a timely and accurate manner.

D. Ensure timely access by Members to the records and information that pertain to them.

5.8 **Business Records** – Provider shall maintain accurate records of all matters pertaining to this Agreement. Such records must be kept in accordance with generally accepted business practices.

5.9 **Health Plan Audit of Records** – Health Plan shall have the right at all reasonable times during usual business hours to audit, examine and make copies of or obtain extracts from Provider's books of account for business pertaining directly to this Agreement during the term of the Agreement and for a period of three (3) years from the date of final payment under the Agreement. Health Plan's access shall be limited to records reasonably necessary to fulfill network management and oversight responsibilities imposed by applicable regulatory and certification agencies. At Health Plan's option, any audit or inspection may be performed by Health Plan's own internal auditors and/or independent auditors selected by Health Plan. Provider shall include in all subcontractor agreements a similar right of inspection and audit of subcontractor records by Health Plan.

5.10 **Confidentiality of Business Information** - Health Plan and Provider agree to hold all confidential or proprietary information or trade secrets of each other in trust and confidence and agree that such information shall be used only for the purposes contemplated by this Agreement. The parties shall keep strictly confidential all compensation arrangements set forth in this Agreement, except as otherwise required by law. However, Health Plan may disclose Confidential Information as defined in this subsection to a customer for purpose of audit and health plan administration so long as the customer agrees to restrict its use of information to these purposes and agrees not to further disclose the information. Furthermore, this section shall not be construed to restrict Health Plan from sharing all such information with BCBSM and its subsidiaries.

ARTICLE 6. TERM AND TERMINATION

6.1 **Termination Without Cause** - This Agreement may be terminated by either party at any time and for any or no reason upon sixty (60) days prior notice to the other party.

6.2 **Termination for Cause** - This Agreement may be terminated by either party for cause due to a material breach upon thirty (30) days advance notice. During the notice period, the breaching party may attempt to cure the noticed breach. The termination will not take effect if, prior to the expiration of this period, the aggrieved party gives notice that the breach has been cured to its satisfaction.

6.3 **Automatic Termination** – This Agreement shall automatically terminate in the event of any of the following occurrences:

A. Provider's applicable license, certification or accreditation is revoked or suspended;

B. Provider loses certification under Titles XVIII and XIX of the Social Security Act;

C. Provider's liability coverage terminates or is substantially impaired for any reason;

D. Provider declares bankruptcy or becomes insolvent;

E. Provider submits false or misleading information to Health Plan or a Health Plan-related entity;

F. Health Plan believes that termination is necessary to protect the safety or medical interests of Members;

Termination of this Agreement does not relieve Provider of any outstanding obligations to Health Plan or Members receiving care or treatment prior to or at the time of termination.

6.4 **Continuity of Care** - Termination of this Agreement shall have no effect on the rights and obligations of the parties arising out of any transaction occurring prior to the effective date of termination. If, as permitted by Michigan law, Provider continues to provide Covered Services to Members after this Agreement terminates or expires, Provider agrees as follows:

A. Health Plan shall continue to pay for such Covered Services under the terms of this Agreement and Provider shall accept such payment as payment in full in accordance with Member Hold-harmless provisions set forth herein.

B. Provider shall continue to comply with Health Plan administrative programs including but not limited to quality management, medical management, network management, Member education, Member grievance, claims processing and administration, clinical and nonclinical performance measurement and improvement programs, and other policies, procedures and corrective measures reasonably established by Health Plan to effect the terms and provisions of this Agreement.

6.5 **Form and Means of Notice: Termination** - All notices provided pursuant to this Article shall be sent to the designated recipient set forth herein (a) by certified mail, return receipt requested or (b) by overnight courier, return receipt requested. Notices given hereunder shall be deemed given upon documented receipt.

ARTICLE 7. REMEDIES OF THE PARTIES

7.1 **Good Faith Resolution of Disputes** - In the event that disputes or problems may arise hereunder, the parties agree to meet in good faith to attempt to settle such disputes or problems.

7.2 **Notice of Dispute** - The parties agree that before any legal action is brought based on any dispute or problem arising out of or relating to this Agreement, thirty (30) days notice of the facts and circumstances supporting the claim shall be provided to the other party.

7.3 **Negotiation of Dispute not a Waiver** - The pursuit of any remedy under this Article shall not constitute a waiver of any other rights or provisions of this Agreement, including the right to terminate the Agreement.

7.4 **Actions Pending Resolution of Dispute** - Notwithstanding any provisions of this Agreement to the contrary, and even during pending litigation, Health Plan may take all necessary actions, including transfer of Members to another qualified Affiliated Provider if Health Plan, in good faith, believes that Provider's actions endanger Members' health, safety or reasonable access to medical services or expose Health Plan or its Members to unreasonable financial liability.

7.5 **Disputed Claims/Medical Necessity** - Disagreements between Health Plan and Provider pertaining to disputed claims or the issue of medical necessity will be resolved according to the appeal procedures set forth in the Provider Manual for such disputes.

ARTICLE 8. AMENDMENT

8.1 **Mutual Agreement** - This Agreement may be amended from time to time as mutually agreed by the parties. Subject to the Mandated Amendments section, such amendment shall be effective when agreed to in writing by the authorized representative of Provider and the authorized officer of Health Plan.

8.2 **Generally Applicable Amendments** - When an amendment to this Agreement is intended to be of general application to existing agreements between Health Plan and similar Affiliated Providers, Health Plan may in its discretion give Provider sixty (60) days notice of the proposed amendment, in which case the amendment shall become a binding part of the Agreement.

8.3 **Financial Terms** – Payment terms described in this Agreement may be revised by Health Plan at any time upon ninety (90) days notice to Provider.

8.4 **Mandated Amendments** – Amendments to this Agreement which are required because of applicable legislative, regulatory or certification requirements do not require the prior approval of Provider and shall become effective upon prior notification of Provider by Health Plan.

8.5 **Amendments Subject to Regulatory Approval** – Amendments to this Agreement which are subject to prior approval of or notice to any federal or state regulatory agency shall not become effective until all necessary approvals have been granted or required notice periods have expired.

8.6 **Provider Manual Revisions** - Updates and modifications of the Provider Manual do not require the prior approval of Provider. Upon prior notification, Health Plan may modify the Provider Manual from time to time within the scope of this Agreement as the needs of business require.

ARTICLE 9. GENERAL PROVISIONS

9.1 **Headings** - The headings of articles and sections contained in this Agreement are for reference purposes only and shall not affect in any way the meaning or interpretation of this Agreement.

9.2 **Relationship of the Parties/Assignment** - Each party to this Agreement is acting in the capacity of an independent contractor and shall not be regarded as the servant, agent, or principal of the other party. This Agreement is a contract for the provision of health care services and may not be assigned, sold or otherwise transferred by Provider without Health Plan's prior written consent. Any attempt to so alienate this Agreement or any of its rights or responsibilities in violation of this provision shall constitute a material breach subject to "Termination for Cause" provisions set forth herein. Subject only to applicable regulatory oversight and upon prior notification of Provider, Health Plan may assign the Agreement or delegate administrative rights and/or responsibilities hereunder.

9.3 **Use of Information** - Health Plan may share with BCBSM and may generally publish identifying information for Provider including, but not necessarily limited to name, location(s) and Covered Services available. Provider shall not use Health Plan's name, symbols, trademarks or service marks in marketing, advertising, educational or solicitation activities or materials without Health Plan's prior written consent.

9.4 **Entire Agreement** - The Provider Manual and all exhibits, attachments and amendments to this Agreement are incorporated into and made a part of this Agreement. This Agreement constitutes the entire agreement and understanding between Health Plan and Provider with regard to matters herein. There are no other agreements, conditions or representations, oral or written, expressed or implied, and any prior agreements are hereby superseded. This Agreement is binding upon the parties and their respective successors.

9.5 **Third Party Rights** - Except as otherwise specifically stated herein, this Agreement is not intended to confer benefits or rights upon any person or entity not a party to it, and it shall not be interpreted or construed to give rise to any right or benefit on behalf of any third party. A Member's rights under a Certificate do not give rise to any rights on behalf of Provider or other persons, facilities or agencies unless otherwise specifically set forth in this Agreement.

9.6 **Conflicts in Language** - In the event of a conflict between language contained this Agreement and language contained in the Provider Manual, the provisions of this Agreement shall take precedence and supersede.

9.7 **Governing Law** - This Agreement shall be construed and enforced in accordance with the laws of the State of Michigan.

9.8 **Waiver of Breach** - The waiver by any party of a breach or violation of any provision of this Agreement shall not be deemed a waiver of any other breach of the same or different provision.

9.9 **Severability**- In the event any provision of this Agreement is held by a court of competent jurisdiction to be invalid or unenforceable, the remainder of the Agreement shall continue in full force and effect and shall in no way be impaired or invalidated.

9.10 **Incorrect Payments** – Each party shall promptly inform the other upon discovery of any incorrect payment(s) made under this Agreement and shall take prompt and effective measures to remedy such incorrect payment. Upon audit or exchange of information as provided herein, Health Plan shall have the right of denial or recovery of payments incorrectly made for whatever reason. Recoveries made pursuant to this Section may be made from any future payments owed to Provider. Health Plan will limit the time frames for such recoveries in accordance with applicable Health Plan recovery policies. Termination of this Agreement shall not terminate or otherwise limit Health Plan's right of recovery under this Section.

9.11 **Parties to the Agreement** - The Parties expressly acknowledge that this Agreement constitutes a contract between Health Plan and Provider and that Health Plan is an independent corporation operating under a license from Blue Cross and Blue Shield Association (BCBSA), an association of independent Blue Cross and Blue Shield Plans, permitting Health Plan to use the Blue Cross and Blue Shield Service Marks in the State of Michigan. Health Plan is not contracting as an agent of BCBSA. Provider further acknowledges and agrees that it has not entered into this Agreement based on representations by any person other than Health Plan and that no person, entity, or organization other than Health Plan shall be held accountable or liable to Provider for any of Health Plan's obligations created under this Agreement. This Section shall not create any additional obligations whatsoever on the part of Health Plan other than those obligations created under other provisions of this Agreement.

9.12 **Form and Means of Notice: General** - All notices to parties pursuant to this Agreement shall be in writing and shall be sent to the designated recipient set forth below. The addresses to which notices are to be sent may be changed by written notice to the other party. Except as otherwise specified in this Agreement or in the Provider Manual, either party may communicate required notices by first class mail. Health Plan may communicate general notices to Affiliated Providers via the Health Plan provider newsletter or web site postings or in other appropriate written or electronic provider bulletins periodically issued by Health Plan.

To Provider: At the name and address in Provider's Health Plan application/enrollment materials or to such other address as Provider may have designated in writing to Health Plan from time to time.

To Health Plan: Regional Director, Provider Contracting
BCN of Michigan Regional Office
20500 Civic Center Drive
Southfield , MI 48076