PROVIDER GROUP 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**), composed of Michigan licensed health care practitioners (hereinafter referred to as **Practitioners**)**.**

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 provider of health care services in the Health Plan service areas and wishes to arrange for its member practitioners to provide Covered Services to Health Plan Members.

NOW, THEREFORE, the parties agree as follows:

ARTICLE 1. DEFINITIONS

1.1 **Affiliated Hospital** - A state licensed, Medicare-certified acute care facility which has a contract with Health Plan for hospital services and which provides continuous emergency room services; and inpatient medical, surgical, or psychiatric diagnosis, treatment and care for injured or sick persons by or under the supervision of a staff of physicians with twenty-four (24) hour nursing service by registered nurses. Affiliated Hospital is not, other than incidentally, a nursing or rest home, a place for the aged or for the treatment of substance abuse or pulmonary tuberculosis.

1.2 **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.

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

1.4 **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.

1.5 **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 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.

1.7 **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.

1.8 **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.

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

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

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

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

1.13 **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.

1.14 **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.

1.15 **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.

1.16 **Practitioner** - A licensed allopathic or osteopathic physician or other nonphysician health practitioner who is a member of Practitioner Group and has agreed to provide medical care and health related services to Members in accordance with the terms and conditions of this Agreement.

1.17 **Provider** –A group of Practitioners, billing for services using Provider's Tax Identification Number and any National Provider Identifier Number registered under the Provider's Tax Identification Number; who are affiliated with Health Plan under this Agreement for the purpose of providing, arranging and managing medical care and Covered Services to Members.

1.18 **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.

1.19 **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.

1.20 **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. SHARED OBLIGATIONS OF PROVIDER AND PRACTITIONER

2.1 **Provider Contracting Authority** - Provider represents that it is duly authorized and empowered to contract on behalf of Practitioners for the purpose of binding such parties to the terms and conditions of this Agreement and any amendments hereto. Provider shall designate an individual with authority to execute contracts on behalf of Provider and Practitioners.

2.2 **Practitioner Credentialing/Affiliation** - Provider shall submit all Provider members for Health Plan credentialing and affiliation. Provider shall cooperate with Health Plan in credentials review of Provider members. The effective date of affiliation for each Practitioner shall be the date of notification regarding Practitioner's satisfactory completion of credentialing. Health Plan has the right to refuse to accept or to terminate the Health Plan affiliation of any Provider member in accordance with Health Plan's own standards and procedures. To the extent Health Plan delegates the 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 **Identifying Information** - Provider shall provide to Health Plan all identifying information including name, address, central telephone number, tax ID number, NPI numbers (including new NPI numbers or changes to existing NPI numbers), and office hours for all Practitioners. Reasonable advance notice to Health Plan is required for all changes in such information.

2.4 **Providing and Authorizing Covered Services**- Provider and Practitioner shall follow the authorization and referral procedures set forth in the Provider Manual for the authorization and payment of Covered Services. For Practitioners providing services only in the hospital, (e.g., Pathology, Anesthesiology, Radiology, Emergency Room, Hospitalists), authorization for Covered Services typically is effected by the associated Health Plan hospital authorization or referral. Practitioner shall provide authorized Covered Services to Members consistent with the scope of his/her license to practice. Practitioner shall consult with and seek further authorization from Health Plan or Member's PCP if he/she believes that additional treatment or tests are needed beyond those initially authorized.

2.5 **Health Plan Administrative Programs** - Provider and Practitioner 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 and Practitioner shall also participate in Health Plan's quality improvement, performance improvement, and/or medical management programs.

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

2.7 **Liability Coverage**– Practitioner shall maintain and Provider shall ensure that each Practitioner maintains in force throughout the term of this Agreement professional liability coverage with minimum limits of $100,000 per incident, $300,000 annual aggregate and separate general liability coverage in amounts commensurate with applicable industry standards for all sites utilized by Practitioner for provision of Covered Services. Provider and Practitioner 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 the required coverage or when more than half the annual limit has been exhausted. In the event that professional liability coverage required under this Section is secured in the form of a "claims made" policy, Practitioner 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 professional liability coverage in accordance with applicable industry standards.

2.8 **Health Plan Designation of Panel Providers** - Provider and Practitioner acknowledge 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.

ARTICLE 3. PRACTITIONER OBLIGATIONS (APPLICABLE TO ALL PRACTITIONERS)

3.1 **Qualifications/Standards of Care** - Practitioner shall maintain all licenses, certifications and accreditations required by law. Practitioner shall provide proof of applicable licenses, certifications, accreditations and hospital privileges upon request by Provider or Health Plan and shall promptly notify Provider and Health Plan of any loss, revocation or suspension of any such licenses, certifications, accreditations or hospital privileges. Practitioner shall provide all Covered Services in a manner consistent with professionally recognized standards of health care.

3.2 **Credentialing Requirements** – Practitioner shall comply fully with Health Plan credentialing requirements applicable to Practitioner and health care personnel supervised by Practitioner. Practitioner shall promptly notify Health Plan and Provider of any material changes in professional licensure, hospital privileges or other professional status. To the extent Health Plan delegates credentialing to Practitioner, Health Plan shall review and approve the credentialing process and will audit the credentialing process on an ongoing basis.

3.3 **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.

3.4 **Health Improvement Programs** - Practitioner shall encourage Member participation in various health education, health maintenance and disease management programs offered by and through Health Plan and shall promote Members' adoption of healthy behaviors.

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

3.6 **Non-Covered Services** - Nothing in this Agreement shall be construed to prohibit or otherwise restrict Practitioner 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. Practitioner 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, Practitioner must inform Member in advance and should document in writing Member's consent to be billed for the services.

ARTICLE 4. PRACTITIONER OBLIGATIONS (APPLICABLE TO PRIMARY CARE PRACTITIONERS)

4.1 **Primary Care Services** - Practitioner shall directly provide primary care services for Members as medically indicated, shall provide or authorize the provision of ancillary and specialty referral services, and shall coordinate the authorization of hospital inpatient and outpatient services, nursing home care and other Covered Services. Practitioner agrees not to subcontract his or her duties under this Agreement without Health Plan approval.

4.2 **Assignment of Members** – Practitioner agrees to accept new Members, including existing patients who wish to join Health Plan, so long as his/her practice is open to other patients. Notwithstanding the foregoing, Practitioner may close his/her practice to new Members at any time after assigned Health Plan Membership reaches 300 Members. Practitioner shall provide sixty (60) days notice to Health plan prior to closing his or her practice to new Members. Such notice shall be provided (a) by certified mail, return receipt requested or (b) by overnight courier and shall be deemed given upon documented receipt. Practitioner shall ensure that his/her total patient population conforms to reasonable quality-of-care capacity limitations.

4.3 **Transfer of Members** - Practitioner shall cooperate with Health Plan in the transfer of Practitioner's Members to the care of another PCP when Practitioner disaffiliates from Health Plan or when the Member requests transfer. Health Plan policies and procedures governing such transfer shall be outlined in the Provider Manual. In order to facilitate continuity of care, Practitioner shall provide copies of Member's medical records without charge when the Member transfers to another PCP.

4.4 **Encounter/Referral/Claim Data** – Provider and Practitioner shall provide to Health Plan in a timely manner pertinent data and financial information concerning services provided to Members and referrals to other providers in accordance with reporting requirements and specifications set forth in the Provider Manual. Sanctions for failure to comply with this provision, including possible withhold of payments or other financial sanctions, shall be outlined in the Provider Manual.

4.5 **Access to Covered Services** – Practitioner 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.

ARTICLE 5. HEALTH PLAN OBLIGATIONS

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

5.2 **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.

5.3 **Enrollment/Eligibility** - Health Plan shall furnish to Provider a monthly eligibility listing showing the names and benefit levels of Members currently assigned to Practitioners. Procedures for retroactive additions to and deletions from eligibility listings are detailed in the Provider Manual.

5.4 **Claims Adjudication** - Health Plan or its designee shall receive, process and pay in a timely manner claims for Covered Services rendered or authorized by Practitioners 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 and Practitioner to resolve any perceived lack of timeliness with regard to claims payment under this Agreement.

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

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

5.7 **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 6. BILLING AND PAYMENT

6.1 **Claims** - Provider shall submit claims on behalf of Practitioner for all 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. Provider shall ensure that Practitioner does not separately submit claims for Covered Services provided under this Agreement.

6.2 **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, Practitioner 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.

6.3 **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 one of the following, less applicable Copayments:

a. Health Plan's applicable Hearing and Audiology Professional Fee Schedule. Covered Services not listed in accordance with rates referenced in the designated Fee Schedule will be paid at 65% of billed charges; or,

b. For individual Practitioners who are affiliated with a Health Plan Medical Care Group (MCG) documented by a properly signed agreement, Health Plan shall pay Practitioner based upon the terms of Health Plan's agreement with MCG as it relates to the payment of services provide to Members assigned to MCG.

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.

6.4 **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.

6.5 **Statutory Health Benefits** - Practitioner 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.

6.6 **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.

6.7 **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.

6.8 **Nonaffiliated Practitioners** - Provider shall ensure that Covered Services are provided only by Practitioners that have been accepted by Health Plan as Affiliated Providers. In the event that Covered Services are inadvertently provided by a nonaffiliated Practitioner, Provider shall bill Health Plan directly and accept applicable Health Plan payment rates as payment in full. Notwithstanding the above, medical services provided by any nonaffiliated Practitioner that has failed Health Plan credentials or quality review or has been excluded or debarred from Medicare shall not be payable. All Covered Services provided by nonaffiliated Practitioners are subject to Member Hold Harmless provisions herein.

6.9 **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 Practitioner for a chronic or disabling condition or in the second or third trimester of pregnancy undergoes an involuntary disaffiliation from Health Plan or Practitioner undergoes disaffiliation from Health Plan for reasons other than cause, Practitioner shall continue to provide Covered Services in accordance with this Agreement for up to ninety (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 or Practitioner 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 Affiliated Provider, Health Plan shall continue to pay according to the terms of this Agreement for all Covered Services provided. Provider and Practitioner shall accept such payment as payment in full in accordance with Member Hold-harmless provisions set forth herein.

ARTICLE 7. RECORDS AND ACCESS

7.1 **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.

7.2 **Reporting Covered Services** – Practitioners providing Covered Services on referral from another Primary Care Practitioner shall submit to Member's PCP a prompt written report of all Covered Services provided to the Member.

7.3 **Administrative Access to Records** - In accordance with applicable law and in particular, applicable HIPAA records access standards, Practitioner 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, Practitioner shall provide copies of Members' medical records for such purposes without additional charge.

7.4 **Access Pursuant to Member Appeals** – Provider and Practitioner 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. All parties agree to fully cooperate with one another to minimize delays in the production of such records.

7.5 **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.

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

7.7 **Confidentiality of Member Records** - Except as otherwise provided below, Health Plan, Provider and Practitioners 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 and Practitioners agree to:

A. Abide by all federal and state laws regarding confidentiality and disclosure of medical records, or other health enrollment information. Provider and Practitioners 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 or Practitioner's organization; and

b. To whom and for what purposes Provider or Practitioners 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.

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

7.9 **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 the books of account of Practitioner and Provider 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.

7.10 **Confidentiality of Business Information** - Health Plan, Provider and Practitioner 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 8. TERM AND TERMINATION

8.1 **Termination as to all Parties**

A. **Voluntary** – Health Plan or Provider may terminate this Agreement with respect to all parties at any time and for any or no reason by providing ninety (90) days prior notice to the other party.

B. **For Cause** - This Agreement may be terminated with respect to all parties for cause due to a material breach if Health Plan or Provider gives the other party 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.

C. **Automatic** - This Agreement will automatically terminate with respect to all parties if Health Plan determines that the immediate termination of this Agreement is necessary to protect the safety or medical interest of Members.

8.2 **Termination of Individual Practitioners** – This Agreement, as it pertains to an individual Practitioner may be terminated without otherwise affecting the continuation of this Agreement. Such termination may be effected by Health Plan, Provider or Practitioner for any or no reason by providing sixty (60) days notice to all parties. This Agreement as it pertains to an individual Practitioner shall automatically terminate in the event of any of the following occurrences:

A. Practitioner fails to maintain a required license, hospital privileges, certifications, accreditations or professional liability insurance in an amount satisfactory to Health Plan;

B. Practitioner is unable to meet Health Plan's credentialing or recredentialing requirements;

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

D. Practitioner is convicted of or pleads guilty or nolo contendere to any felony crime;

E. Practitioner's practice declares bankruptcy or insolvency;

F. Practitioner submits false or misleading information to Provider, Health Plan or a Health Plan-related entity;

G. This Agreement, as it pertains to Health Plan and Provider terminates for any reason;

H. Practitioner leaves Provider or relocates his/her practice outside the Health Plan service areas.

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

8.3 **Affiliation with Individual Practitioners** - In the event that this Agreement terminates for any reason or an individual Practitioner's affiliation with Provider terminates for any reason, Health Plan shall be permitted to pursue separate affiliation with Practitioner(s) affected by such termination. Policies and Procedures for the possible reassignment of Members previously assigned to Primary Care Practitioners affected by such terminations will be set forth in the Provider Manual.

8.4 **Transfer of Members upon Termination** - Procedures for orderly termination of the Agreement and to minimize patient disruption shall be established by Health Plan and set forth in the Provider Manual. In the event any party gives notice of intent to terminate or not to renew this Agreement, Health Plan may limit or suspend the assignment of new Members to Practitioners and may proceed as medically feasible and appropriate to transfer Practitioners' currently assigned Members to other PCPs. If Health Plan is not able to transfer all Members by the effective termination date, Practitioners shall continue to provide services in accordance with this Agreement to remaining Members until they are all transferred to another PCP or until the Member's annual enrollment date, whichever comes first. During this time, Health Plan will pay Provider for all Covered Services on a fee-for-service basis at Health Plan's applicable fee schedule rates. Provider shall accept such payment as payment in full in accordance with Member Hold Harmless provisions contained herein.

8.5 **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, Practitioner continues to provide Covered Services to Members after this Agreement terminates or expires, Practitioner agrees as follows:

A. Health Plan shall continue to pay for such Covered Services at Health Plan's applicable fee schedule rates and Provider shall accept such payment as payment in full in accordance with Member Hold-harmless provisions set forth herein.

B. Provider and Practitioner 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.

8.6 **Notification of Members** - Within thirty (30) days after learning of the effective date of termination of this Agreement or disaffiliation of Practitioner, Health Plan shall attempt to notify impacted Members regarding such termination and its effective date. Health Plan shall establish procedures to assist Members in the transfer of care to another Affiliated Provider. Health Plan shall inform Members regarding the personal financial consequences of continuing care with a disaffiliated provider. Provider or Practitioner shall notify any Member seeking services after termination that Practitioner is no longer affiliated with Health Plan for the provision of Covered Services.

8.7 **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 9. REMEDIES OF THE PARTIES

9.1 **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.

9.2 **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.

9.3 **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.

9.4 **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.

9.5 **Disputed Claims/Medical Necessity** - Disagreements between Health Plan and Provider or Practitioner 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 10. AMENDMENT

10.1 **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.

10.2 **Generally Applicable Amendments** - When an amendment to this Agreement is intended to be of general application to existing agreements between Health Plan and Affiliated Providers, Health Plan may in its discretion give Provider ninety (90) days notice of the proposed amendment, in which case the amendment shall become a binding part of the Agreement.

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

10.4 **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.

10.5 **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.

10.6 **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 11. GENERAL PROVISIONS

11.1 **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.

11.2 **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 Practitioner or 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.

11.3 **Use of Information** - Health Plan may share with BCBSM and may generally publish identifying information for Provider and Practitioner including, but not necessarily limited to name, office locations, specialties of practice, board certification status, performance data and Affiliated Hospitals in which Practitioner maintains staff privileges. Health Plan shall treat peer review and malpractice-related information concerning Practitioner as confidential information. Neither Practitioner nor Provider shall 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.

11.4 **Practitioner/Patient Relationship** – Health Plan, Provider and Practitioner recognize that a practitioner-patient relationship is a personal relationship and that circumstances may arise under which relationships between particular Members and their PCP may become unsatisfactory to one or the other. Provider or Practitioner shall give Health Plan prior notice of any desire to terminate an existing practitioner-patient relationship and shall follow procedures set forth in the Provider Manual for such termination and reassignment to another PCP. Nondiscrimination provisions contained herein prohibit Provider or Practitioner from seeking to terminate an existing practitioner-patient relationship for unlawful or discriminatory reasons, including financial considerations.

11.5 **Exercise of Professional Judgment** - Health Plan shall neither dictate nor direct Practitioner in his/her health care practice or the exercise of professional judgment, nor shall Practitioner or Provider hinder Health Plan in the conduct of its business. Health Plan's quality management and medical management activities and designation of exclusive or preferred Affiliated Providers shall not be construed as a violation of this provision.

11.6 **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 by and among Health Plan, Provider and Practitioners 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.

11.7 **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, Practitioner or other persons, facilities or agencies unless otherwise specifically set forth in this Agreement.

11.8 **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.

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

11.10 **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.

11.11 **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.

11.12 **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.

11.13 **Parties to the Agreement** - The parties expressly acknowledge that this Agreement constitutes a contract between Health Plan, Provider and Practitioner 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 and Practitioner further acknowledge and agree that they have 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 or Practitioner 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.

11.14 **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 applicable Health Plan group enrollment materials or to such other address as Provider may have designated in writing to Health Plan from time to time.

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

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