BLUE CROSS COMPLETE OF MICHIGAN
PRACTITIONER AFFILIATION AGREEMENT

This Agreement is made by and between **Blue Cross Complete of Michigan** (hereinafter referred to as **Health Plan**)
and ______________________________ who is fully licensed or legally authorized to practice in the
(Print or type Provider Name here)
State of Michigan (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, a nonprofit corporation and health maintenance organization licensed by the State of Michigan, 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 Area and wishes to provide Covered Services to Members.

NOW, THEREFORE, the parties agree as follows:

ARTICLE I: 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 provide Covered Services to Members under the terms and conditions of a signed Health Plan provider affiliation agreement.

1.3 **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.

1.4 **Blue Cross Complete of Michigan** (Health Plan) (formerly known as **BlueCaid of Michigan) -** A nonprofit corporation and health maintenance organization certified by the State of Michigan under applicable Michigan statutory authority. Health Plan contracts with the Michigan Department of Community Health (MDCH) to offer a Medicaid managed care HMO. Health Plan is a wholly owned subsidiary of Blue Care Network. Health Plan is not an insurance company.

1.5 **Blue Care Network of Michigan** - 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

1.6 **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 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, free of outstanding subrogation, coordination of benefits, or other secondary payer issues, filed in a correct format electronically or on the appropriate Health Plan -designated claim form, and containing all pertinent information as may be required in accordance with applicable statutory and regulatory guidelines.

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 **Health Plan Service Area** – The area(s) approved by MDCH as being the area(s) to which Health Plan may market and enroll eligible Medicaid beneficiaries in Health Plan.

1.13 **Member** - A Member who is eligible for Medicaid and who is enrolled with Health Plan under a contract (Medicaid Risk Contract) between Health Plan and the Michigan Department of Community Health (MDCH).

1.14 **Payment Exhibit** – Written materials attached hereto which describe the specific payment terms and conditions for Covered Services applicable to this Agreement.

1.15 **Provider** – A licensed allopathic or osteopathic physician or other nonphysician health provider who has agreed to provide medical care and health related services to Members in accordance with the terms and conditions of this Agreement.

1.16 **Primary Care Provider 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.

1.17 **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 II: PROVIDER OBLIGATIONS

2.1 **Qualifications/Standards of Care** – Provider shall maintain all licenses, certifications and accreditations required by law. Provider shall provide proof of applicable licenses, certifications,

accreditations and hospital privileges upon request by Health Plan and shall promptly notify Health Plan of any loss, revocation or suspension of any such licenses, certifications, accreditations or hospital privileges. Provider shall provide 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 supervised by Provider. Provider shall promptly notify Health Plan of any material changes in professional licensure, hospital privileges, or other professional status.

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 provide authorized Covered Services to Members consistent with the scope of his/her license to practice. Provider shall consult with and seek further authorization from Health Plan or Member's Primary Care Provider if he/she believes 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's payment for such services.

2.4 **Health Plan Administrative Programs** – Provider shall cooperate with Health Plan's or its designee's 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 or on behalf of Health Plan to effect the terms and provisions of this Agreement.

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 professional liability coverage with minimum limits of $100,000 per incident and $300,000 annual aggregate and separate general liability coverage in amounts commensurate with applicable industry standards for all sites utilized by Provider for 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 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, 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 professional 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 providers 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 **Identifying Information** – Provider shall provide to Health Plan all identifying information including name, address, central telephone number, tax ID number, NPI numbers and office hours. Reasonable advance notice to Health Plan is required for changes in such information.

2.9 **Nondiscrimination** – Provider shall provide Covered Services to Members in the same manner, quality and promptness as services are provided to Provider's other patients. Provider shall not intentionally segregate Members in any way from other persons receiving health care services.

Provider shall provide Covered Services in a manner consistent with professionally recognized standards of health care. Provider shall provide Covered Services in a culturally competent manner to Members of different cultural and ethnic backgrounds. Provider shall not discriminate against any Member on the basis of membership in Health Plan, source of payment, sex, 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, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability or handicap, or any basis prohibited by federal law in providing Covered Services under the Agreement.

2.10 **Health Improvement Programs** - Provider 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.

2.11 **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.

2.12 **Non-Covered Services** - It is recognized 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 **Non-interference** – Nothing in this Agreement shall be construed to prohibit or otherwise restrict Provider from advising or advocating on behalf of Member about Member’s health status, medical care, or treatment options, including any alternative treatment that may be self-administered; the risks, benefits, and consequences of treatment or non-treatment; the opportunity for Member to participate in decisions regarding his or her health care, including the right to refuse treatment or to express preferences about future treatment decisions, regardless of cost or Health Plan benefit coverage limitations; or any information the Member needs in order to decide among all relevant treatment options. Nothing in this Agreement shall be construed to prohibit or otherwise restrict Provider from advocating on behalf of a Member in any grievance or utilization review process or individual authorization process to obtain health care services deemed necessary by Provider or to refuse treatment or express preferences about future treatment decisions.

2.14 **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.

2.15 **Obligations of Recipients of Federal Funds** – Provider acknowledges that payments to Provider pursuant to this Agreement are made, in whole or in part, from federal funds and that this Agreement is subject to all laws applicable to entities and individuals receiving federal funds. Provider shall comply with all requirements of laws applicable to recipients of federal funds, including Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Rehabilitation Act of 1973, the Americans with Disabilities Act, and applicable state and federal laws requiring the adoption of Health Plan’s Fraud Waste and Abuse Policy.

2.16 **Delegated Responsibilities** – Provider and his/her delegates, including subcontractors or other downstream entities to which Provider delegates responsibilities under the Agreement shall perform such responsibilities in accordance with applicable federal laws and regulations and in accordance with instructions and requirements promulgated by HHS and the State of Michigan. Health Plan shall be responsible for overseeing and is ultimately accountable for the performance

of Provider and delegates with regard to delegated responsibilities referenced in this Agreement. If Provider or delegate fails to perform delegated services, reporting or disclosure responsibilities in a satisfactory manner, Health Plan shall retain the right to terminate this Agreement in accordance with Termination for Cause provisions set forth herein. Health Plan shall retain the right to approve, suspend or terminate all such delegated arrangements.

2.17 **Adverse Actions**

A. **No Adverse Actions or Investigations –** Provider asserts that, to the best of his/her knowledge, information and belief, there are no pending investigations, legal actions, or matters subject to arbitration involving Provider on matters relating to payments from governmental entities, both federal and state, for healthcare and/or prescription drug services.

B. **No Criminal Convictions or Civil Judgments** – Provider asserts that, to the best of his/her knowledge, information and belief, Provider has not been criminally convicted or had a civil judgment entered against him/her for fraudulent activities, nor has Provider been sanctioned under any Federal program involving the provision of heath care or prescription drug services.

C. **No Excluded Or Debarred Individuals** – Provider asserts that, to the best of its knowledge, information and belief, Provider, or its employees, including directors, officers, partners, agents, and persons with more than 5% ownership do not appear in the List of Excluded Individuals/Entities (LEIE) as published by the Department of Health and Human Services Office of the Inspector General; the List of Debarred Contractors (EPLS) as published by the General Services Administration; the Social Security Administration's Death Master File; the National Plan and Provider Enumeration System (NPPES); the Medicare Exclusion Database (MED); the Michigan Department of Community Health (MDCH)/Medical Services Administration (MSA) Sanctioned Provider List; the Licensing and Regulatory Affairs (LARA) Disciplinary Action Report (DAR); and any other database as the Secretary of HHS may prescribe.

All databases shall be checked before the execution of this Agreement and at least annually thereafter, with the exception of the LEIE and the EPLS, which shall be checked before execution of the Agreement and at least monthly thereafter.

D. **Notice of Change of Circumstances** – Provider is obligated to notify Health Plan immediately of any change in circumstances occurring after the effective date of this Agreement which would require a modified response to paragraphs A – C above.

2.18 **Utilization Management** – Provider agrees to participate in applicable quality and utilization management programs as necessary for Health Plan to administer its health benefits program in accordance with MDCH requirements.

2.19 **Enrollee Health and Safety** – Health Plan and Provider agree to cooperate with Health Plan when it is determined that an immediate transfer of an enrollee to another Primary Care Physician is required to ensure enrollee health and safety.

2.20 **Disclosure of Information Related to Business Transactions** - Provider must submit, within thirty-five (35) days of the date on a request by the Secretary of the Department of Health and Human Services or the Michigan Department of Community Health, full and complete information about:

a) The ownership of any subcontractor with whom Provider has had business transactions totaling more than $25,000 during the twelve (12)-month period ending on the date of the request; and

b) Any significant business transactions between Provider and any wholly owned supplier, or between Provider and any subcontractor, during the five (5)-year period ending on the date of the request.

ARTICLE III: HEALTH PLAN OBLIGATIONS

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

3.2 **Program Changes** – Subject to the Mandated Amendments Section, Health Plan shall give Provider prior notice of substantive changes in Covered Services benefits, authorization requirements and procedures, and Health Plan payment policies 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 Provider or any Affiliated Provider.

3.8 **Member Grievance, Appeal, and Fair Hearing Procedures** – Upon execution of this Agreement, Health Plan shall provide Provider with the following Member grievance, appeal, and fair hearing procedures and timeframes:

a) the Member’s right to a state fair hearing, how to obtain a hearing, and representation rules at a hearing;

b) the Member's right to file grievances and appeals and their requirements and timeframes for filing;

c) the availability of assistance in filing;

d) the toll-free numbers to file oral grievances and appeals; and

e) the Member's right to request continuation of benefits during an appeal or state fair hearing filing and, if Health Plan's action is upheld in a hearing, the Member's possible liability for the cost of any continued benefits.

ARTICLE IV: BILLING AND PAYMENT

4.1 **Claims** – Provider shall submit claims to Health Plan or its designee for billable Covered Services in accordance with the procedures identified in the Provider Manual. Any change to the claim submission process will be communicated to Provider through: Web-DENIS (Direct Eligibility Network Information System), updates to the Health Plan chapter of the BCN Provider News, and/or *BCN Network News.* Provider shall submit claims 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 **Payment for Covered Services** – Covered Services provided by Provider to Members shall be paid at the lesser of billed charges or (1) applicable Health Plan 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 in accordance with Medicaid policy, or if none, at 40% of billed charges, less applicable Copayments.

4.3 **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 this 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. 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 Workers' 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** – 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 which are the Member's responsibility. All Copayments assessed by Health Plan must be approved in advance by MDCH. Provider shall not deny services to a Member who is otherwise eligible to receive such services but for the Member's inability to pay the Copayment.

4.7 **Member Hold-Harmless** - Provider agrees to look solely to Health Plan for payment for Covered Services rendered to Members and to accept payment made in accordance with the Agreement as payment in full, except to the extent that copayments and deductibles are specified in Member's Certificate or as permitted under the Coordination of Benefits Section of this Agreement. Provider will in no event, including but not limited to nonpayment, insolvency or breach of the 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) acting on behalf of Member for Covered Services provided pursuant to the Agreement. This provision does not prohibit Provider from collecting for non-Covered Services delivered on a fee-for-service basis to Members who are informed in advance of their payment responsibility and the estimated charges. 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.

ARTICLE V: RECORDS AND ACCESS

5.1 **Medical Records –** Provider shall maintain accurate and timely medical records for Members treated by Provider 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. Medical records for Members shall be maintained for at least ten (10) years after the final date of this Agreement or completion of audit, whichever is later.

5.2 **Records and Inspection –** 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.

a) **Access to Records** - Provider shall permit at all reasonable times during usual business hours Health Plan, the U.S. Department of Health and Human Services (HHS), the Comptroller General, the State of Michigan or their designees to audit, evaluate, inspect, or copy or obtain extracts of any books, contracts, medical records, patient care documentation, and other records that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable for Members. Such records shall be maintained and access shall be permitted for up to ten (10) years after the final date of this Agreement or completion of audit, whichever is later.

b) **Inspection of Records by Health Plan** - 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.

c) **Inspection of Records by the State of Michigan** - The State must notify Provider twenty (20) days before examining Provider's books and records. The State does not have the right to review any information deemed confidential by the Provider to the extent access would require the confidential information to become publicly available.

d) **Inspection of Premises by State of Michigan** – Provider agrees to allow the State of Michigan and/or its authorized representative to access, at all reasonable times and with ten (10) days prior written request, Provider's premises, or any other places, where the services required under this Agreement are being performed. Upon ten (10) days prior written notice and at all reasonable times, the State's representatives must be allowed to inspect, monitor, or otherwise evaluate the work being performed and to the extent that the access will not reasonably interfere or jeopardize the safety or operation of the systems or facilities. Provider must provide all reasonable facilities and assistance for the State's representatives.

5.3 **Reporting Covered Services** - Provider shall submit to Member's PCP a prompt written report of all Covered Services provided to the Member.

5.4 **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.

5.5 **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.

5.6 **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** – In accordance with applicable state and Federal statutes and regulations, 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 as required or permitted by law or pursuant to the separate written consent of Member.

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 **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. This Section shall not be construed to restrict Health Plan from sharing all such information with BCBSM and its subsidiaries.

ARTICLE VI: TERM AND TERMINATION

6.1 **Termination** – 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. The Agreement shall automatically terminate in the event of any of the following occurrences:

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

B. Provider 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. Provider is convicted of or pleads guilty or nolo contendere to any felony crime;

E. Provider's practice declares bankruptcy or insolvency;

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

G. Provider relocates his/her practice outside the State of Michigan; or

H. Health Plan's Medicaid Risk Contract with MDCH to offer a Medicaid HMO is terminated or expires.

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.

6.2 **Termination with Cause –** The Agreement may be terminated by either party in the event of a material breach by the other party. Such termination may be effected upon thirty (30) days prior notice, provided the breaching party has been given a reasonable opportunity to cure the breach within thirty (30) days of receipt of notice of such breach.

6.3 **Continuation of Benefits** – Provider agrees that, even in the event of insolvency or other cessation of operations by Health Plan will continue to provide Covered Services to Members through the period for which Member's applicable premium has been paid and, for Members confined to an inpatient facility, the end of the period for which Member's applicable premium has been paid or the date of Member's discharge, whichever is later. Upon termination of this Agreement for reasons other than quality of care, Provider shall continue to furnish Covered Services to Members and Health Plan shall continue to pay for such services according to the terms of the Agreement as amended herein, until mutually equitable and medically appropriate provisions are made for the assumption of such services by another Affiliated Provider. 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 continuation of benefits provision.

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 **Notification of Members -** Within thirty (30) days after learning of the effective date of termination of this Agreement, 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 shall notify any Member seeking services after termination that Provider is no longer affiliated with Health Plan for the provision of Covered Services.

6.6 **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 VII: 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 VIII: AMENDMENT

8.1 **Mutual Agreement** – This Agreement may be amended from time to time as mutually agreed by the parties. Subject to Section 8.4, such amendment shall be effective when agreed to in writing by 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 Provider or 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** – Subject to Section 8.4, 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 IX: 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 BCN and may generally publish identifying information for Provider including, but not necessarily limited to name, office locations, specialties of practice, board certification status, performance data and Affiliated Hospitals in which Provider maintains staff privileges. Health Plan shall treat peer review and malpractice-related information concerning Provider as confidential information. 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 **Exercise of Professional Judgment** - Health Plan shall neither dictate nor direct Provider in his/her health care practice or the exercise of professional judgment, nor shall 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.

9.5 **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.

9.6 **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.

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

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

9.9 **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.

9.10 **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 he/she 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 **Severability** - In the event any provision of this Agreement is rendered invalid or unenforceable by legislative or regulatory act, or declared null and void by any court of competent jurisdiction, the remainder of the provisions of this Agreement shall remain in full force and effect. In the event that such an occurrence has the effect of (a) causing serious financial hardship to any party or (b) substantially disrupting or hampering the mutual efforts of the parties to maintain a cost-efficient means of delivering health care services, or (c) causing a party to act in violation of its Articles of Incorporation or Bylaws, the party so affected shall have the right to terminate this Agreement in accordance with procedures set forth herein for Termination for Cause.

9.13 **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 in the Network News or Health Plan 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/credentialing 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
Blue Cross Complete Regional Office
2311 Green Road
Ann Arbor, Michigan 48105

9.14 **Electronic Images and Photocopies** - A scanned, imaged, electronic, photocopy, or stamp of this Agreement shall have the same force and effect as an originally executed document.

9.15 **Effective Date** - Provider acknowledges that submission of this Agreement does not mean the Provider is automatically accepted into the Health Plan network. Participation in the Health Plan network is contingent upon regulatory approval, network need, determination, and successful completion of Health Plan credentialing. Provider acknowledges that affiliation in the Health Plan network is not retroactive. The Effective Date will be established by Health Plan and documented on the first page of the Agreement, and the Agreement shall remain in effect for a period of one (1) year. The Agreement shall thereafter renew automatically for additional one-year terms unless otherwise terminated as provided above. A copy of the countersigned Agreement with the effective date will be returned to the provider upon completion of the affiliation process.

IN WITNESS WHEREOF, the parties, wishing to be bound by the terms and conditions of this Agreement, have affixed their signatures below. Provider acknowledges he/she has submitted license number and NPI number below and these numbers are accurate and appropriate for all billing with respect to this Agreement.

A scanned, imaged, electronic, photocopy, or stamp of the signatures shall have the same force and effect as an originally executed signature.

PROVIDER	**HEALTH PLAN**
______________________	______________________
Signature	Signature
______________________	**Alison Pollard**
Name (Print or Type)	Name (Print or Type)
______________________	**Vice President, Provider Affairs**
Date	Title
______________________	______________________
NPI Number	Date
______________________	______________________

Tax ID Number	Contract Instance No.

Telephone Number