Guilford County Health Department
1203 Maple Street
Greensboro, NC 27401

0239

BlueCross BlueShield of North Carolina | Healthy

Healthy Blue
Medicaid Managed Care

March 1, 2019

**Subject: Healthy Blue network participation**

Blue Cross and Blue Shield of North Carolina (Blue Cross NC) is excited to announce that we have been selected as one of the Prepaid Health Plans for the North Carolina Medicaid Managed Care program.

Blue Cross NC has created Healthy Blue, a new plan designed to serve the millions of North Carolinians who participate in the state Medicaid program. Healthy Blue combines the deep expertise of Blue Cross NC in responding to local needs and providing solutions and community support with the best-in-class Medicaid managed care capabilities of Amerigroup Partnership Plan. We believe this combination is important to successfully impacting the evolving health care in North Carolina.

Healthy Blue embraces the mission of Blue Cross NC to improve the health and well-being of members and communities as well as our commitment to enhancing the health of each member served.

## We want you to join us!

Enclosed are the forms and documents needed to ensure participation in our Healthy Blue network:

- *Healthy Blue Provider Agreement* — Complete and sign page 16. **Note: You only need to return the signature page, not the entire agreement.**
- *W-9* — Attach a completed *W-9* form.

Please send completed documents via fax to 855-481-3733 or email to NCProviderDocuments@NCHealthyBlue.com. **We must receive your signed agreement by April 30th, 2019.** Note, this agreement is subject to review and approval by the North Carolina Department of Health and Human Services.

If you have questions, please call our Network Development department at 844-415-2045. Blue Cross NC is excited to expand our relationship with you to serve Medicaid members in North Carolina.

We hope you will join us, and we thank you for your consideration.

Sincerely,

Blue Cross and Blue Shield of North Carolina

Enclosures: [*Healthy Blue Provider Agreement*]
[*W-9*]


NCPEC-0009-18 February 2019

# BLUE CROSS NC
# MEDICAID PROVIDER AGREEMENT

This Medicaid Provider Agreement (hereinafter "Agreement") is made and entered into by and between Blue Cross Blue Shield of North Carolina or an Affiliate (hereinafter "Blue Cross NC") and the undersigned Provider (hereinafter "Provider"), effective as of the date next to Blue Cross NC's signature (the "Effective Date"). In consideration of the mutual promises and covenants herein contained, the sufficiency of which is acknowledged by the parties, the parties agree as follows:

## ARTICLE I
## DEFINITIONS

"Affiliate" means any entity that is: (i) owned or controlled, either directly or through a parent or subsidiary entity, by Blue Cross NC, or any entity which controls or is under common control with Blue Cross NC, and/or (ii) that is identified as an Affiliate on a designated web site as referenced in the provider manual(s). Unless otherwise set forth in the Participation Attachment(s), an Affiliate may access the rates, terms and conditions of this Agreement.

"Agency" means a federal, state or local agency, administration, board or other governing body with jurisdiction over the governance or administration of a Health Benefit Plan.

"Audit" means a review of the Claim(s) and supporting clinical information submitted by Provider to ensure payment accuracy. The review ensures Claim(s) comply with all pertinent aspects of payment including, but not limited to, contractual terms, Regulatory Requirements, Coded Service Identifiers (as defined in the PCS) guidelines and instructions, Blue Cross NC medical policies and clinical utilization management guidelines, reimbursement policies, and generally accepted medical practices. Audit does not include medical record review for quality and risk adjustment initiatives.

"Blue Cross NC Rate" means the lesser of Eligible Charges for Covered Services, or the total reimbursement amount that Provider and Blue Cross NC have agreed upon as set forth in the Plan Compensation Schedule ("PCS"). The Blue Cross NC Rate includes applicable Cost Shares, and shall represent payment in full to Provider for Covered Services.

"Claim" means either the uniform bill claim form or electronic claim form in the format prescribed by Blue Cross NC submitted by a provider for payment by Blue Cross NC for Health Services rendered to a Member.

"CMS" means the Centers for Medicare & Medicaid Services, an administrative agency within the United States Department of Health & Human Services ("HHS").

"Cost Share" means, with respect to Covered Services, an amount which a Member is required to pay under the terms of the applicable Health Benefit Plan. Such payment may be referred to as an allowance, coinsurance, copayment, deductible, penalty or other Member payment responsibility, and may be a fixed amount or a percentage of applicable payment for Covered Services rendered to the Member.

"Covered Services" means Medically Necessary Health Services, as determined by Blue Cross NC and described in the applicable Health Benefit Plan, for which a Member is eligible for coverage.

"Government Contract" means the contract between Blue Cross NC and an applicable party, such as an Agency, which governs the delivery of Health Services by Blue Cross NC to Member(s) pursuant to a Government Program.

"Government Program" means any federal or state funded program under the Social Security Act, and any other federal, state, county or other municipally funded program or product in which Blue Cross NC maintains a contract to furnish services. For purposes of this Agreement, Government Program does not include the Federal Employees Health Benefits Program ("FEHBP"), or any state or local government employer program.

"Health Benefit Plan" means the document(s) that set forth Covered Services, rules, exclusions, terms and conditions of coverage. Such document(s) may include but are not limited to a Member handbook, a health certificate of coverage, or evidence of coverage.

"Health Service" means those services, supplies or items that a health care provider is licensed, equipped and staffed to provide and which he/she/it customarily provides to or arranges for individuals.

"Medically Necessary" or "Medical Necessity" means the definition as set forth in the applicable Participation Attachment(s).

"Member" means any individual who is eligible, as determined by Blue Cross NC, to receive Covered Services under a Health Benefit Plan. For all purposes related to this Agreement, including all schedules, attachments, exhibits, provider manual(s), notices and communications related to this Agreement, the term "Member" may be used interchangeably with the terms Insured, Covered Person, Covered Individual, Enrollee, Subscriber, Dependent Spouse/Domestic Partner, Child, Beneficiary or Contract Holder, and the meaning of each is synonymous with any such other.

"Network" means a group of providers that support, through a direct or indirect contractual relationship, one or more product(s) and/or program(s) in which Members are enrolled.

"Other Payors" means persons or entities, pursuant to an agreement with Blue Cross NC or an Affiliate, that access the rates, terms or conditions of this Agreement with respect to certain Network(s), excluding Government Programs unless otherwise set forth in any Participation Attachment(s) for Government Programs. Other Payors include, without limitation, employers or insurers providing Health Benefit Plans pursuant to partially or wholly insured, self-administered or self-insured programs.

"Participating Provider" means a person, including but not limited to, a physician or other health care professional or entity, including but not limited to a hospital, health care facility, a partnership of such professionals, or a professional corporation, or an employee or subcontractor of such person or entity, that is party to an agreement to provide Covered Services to Members that has met all applicable required Blue Cross NC credentialing requirements, standards of participation and accreditation requirements for the services the Participating Provider provides, and that is designated by Blue Cross NC to participate in one or more Network(s). Unless otherwise specifically delineated, all references herein to "Provider" may also mean and refer to "Participating Provider".

"Participation Attachment(s)" means the document(s) attached hereto and incorporated herein by reference, and which identifies the additional duties and/or obligations related to Network(s), Government Program(s), Health Benefit Plan(s), and/or Blue Cross NC programs such as quality and/or incentive programs.

"Plan Compensation Schedule" ("PCS") means the document(s) attached hereto and incorporated herein by reference, and which sets forth the Blue Cross NC Rate(s) and compensation related terms for the Network(s) in which Provider participates. The PCS may include additional Provider obligations and specific Blue Cross NC compensation related terms and requirements.

"Regulatory Requirements" means any requirements, as amended from time to time, imposed by applicable federal, state or local laws, rules, regulations, guidelines, instructions, Government Contract, or otherwise imposed by an Agency or government regulator in connection with the procurement, development or operation of a Health Benefit Plan, or the performance required by either party under this Agreement. The omission from this Agreement of an express reference to a Regulatory Requirement applicable to either party in connection with their duties and responsibilities shall in no way limit such party's obligation to comply with such Regulatory Requirement.

## ARTICLE II
## SERVICES/OBLIGATIONS

2.1 Member Identification. Blue Cross NC shall provide a means of identifying Member either by issuing a paper, plastic, electronic, or other identification document to Member or by a telephonic, paper or electronic communication to Provider. This identification need not include all information necessary to determine Member's eligibility at the time a Health Service is rendered, but shall include information necessary to contact Blue Cross NC to determine Member's participation in the applicable Health Benefit Plan. Provider acknowledges and agrees that possession of such identification document or ability to access eligibility information telephonically or electronically, in and of itself, does not qualify the holder thereof as a Member, nor does the lack thereof mean that the person is not a Member.

2.2 Provider Non-discrimination. Provider shall provide Health Services to Members in a manner similar to and within the same time availability in which Provider provides Health Services to any other individual. Provider will not differentiate, or discriminate against any Member as a result of his/her enrollment in a Health Benefit Plan, or because of race, color, creed, national origin, ancestry, religion, sex, marital status, age, disability, payment source, state of health, need for Health Services, status as a litigant, status as a Medicare or Medicaid beneficiary, sexual orientation, gender identity, or any other basis prohibited by law. Provider shall

not be required to provide any type, or kind of Health Service to Members that he/she/it does not customarily provide to others. Additional requirements may be set forth in the applicable Participation Attachment(s).

2.3 Publication and Use of Provider Information. Provider agrees that Blue Cross NC or their designees may use, publish, disclose, and display, for commercially reasonable general business purposes, either directly or through a third party, information related to Provider, including but not limited to demographic information, information regarding credentialing, affiliations, performance data, Blue Cross NC Rates, and any other information related to Provider for transparency initiatives.

2.4 Use of Symbols and Marks. Neither party to this Agreement shall publish, copy, reproduce, or use in any way the other party's symbols, service mark(s) or trademark(s) without the prior written consent of such other party. Notwithstanding the foregoing, the parties agree that they may identify Provider as a participant in the Network(s) in which he/she/it participates.

2.5 Submission and Adjudication of Claims. Provider shall submit, and Blue Cross NC shall adjudicate, Claims in accordance with the applicable Participation Attachment(s), the PCS, the provider manual(s) and Regulatory Requirements. If Provider submits Claims prior to receiving notice of Blue Cross NC's approval pursuant to section 2.13, then such Claims must be submitted in accordance with prior authorization requirements, and shall be processed as out of network. Blue Cross NC shall not make retroactive adjustments with respect to such Claims.

2.6 Payment in Full and Hold Harmless.

2.6.1 Provider agrees to accept as payment in full, in all circumstances, the applicable Blue Cross NC Rate whether such payment is in the form of a Cost Share, a payment by Blue Cross NC, or a payment by another source, such as through coordination of benefits or subrogation. Provider shall bill, collect, and accept compensation for Cost Shares. Provider agrees to make reasonable efforts to verify Cost Shares prior to billing for such Cost Shares. In no event shall Blue Cross NC be obligated to pay Provider or any person acting on behalf of Provider for services that are not Covered Services, or any amounts in excess of the Blue Cross NC Rate less Cost Shares or payment by another source, as set forth above. Consistent with the foregoing, Provider agrees to accept the Blue Cross NC Rate as payment in full if the Member has not yet satisfied his/her deductible.

2.6.2 Except as expressly permitted under Regulatory Requirements, Provider agrees that in no event, including but not limited to, nonpayment by Blue Cross NC, insolvency of Blue Cross NC, breach of this Agreement, or Claim payment denials or adjustment requests or recoupments based on miscoding or other billing errors of any type, whether or not fraudulent or abusive, shall Provider, or any person acting on behalf of Provider, bill, charge, collect a deposit from, seek compensation from, or have any other recourse against a Member, or a person legally acting on the Member's behalf, for Covered Services provided pursuant to this Agreement. Notwithstanding the foregoing, Provider may collect reimbursement from the Member for the following:

2.6.2.1 Cost Shares, if applicable;

2.6.2.2 Health Services that are not Covered Services. However, Provider may seek payment for a Health Service that is not Medically Necessary or is experimental/investigational only if Provider obtains a written waiver that meets the following criteria:

a) The waiver notifies the Member that the specifically listed Health Service is likely to be deemed not Medically Necessary, or experimental/investigational;

b) The waiver notifies the Member of the Health Service being provided and the date(s) of service;

c) The waiver notifies the Member of the approximate cost of the Health Service;

d) The waiver is signed by the Member, or a person legally acting on the Member's behalf, prior to receipt of the Health Service.

2.6.2.3 Any reduction in or denial of payment as a result of the Member's failure to comply with his/her utilization management program pursuant to his her/her Health Benefit Plan, except when Provider has been designated by Blue Cross NC to comply with utilization management for the Health Services provided by Provider to the Member.

2.7 Recoupment/Offset/Adjustment for Overpayments. Blue Cross NC shall be entitled to offset and recoup an amount equal to any overpayments or incorrect payments made by Blue Cross NC to Provider against any payments due and payable by Blue Cross NC to Provider with respect to any Health Benefit Plan under this Agreement. Provider shall voluntarily refund all duplicate or erroneous Claim payments regardless of the cause, including, but not limited to, payments for Claims where the Claim was miscoded, non-compliant with industry standards, or otherwise billed in error, whether or not the billing error was fraudulent, abusive or wasteful. Upon determination by Blue Cross NC that any recoupment, improper payment, or overpayment is due from Provider, Provider must refund the amount to Blue Cross NC within thirty (30) days of when Blue Cross NC notifies Provider. If such reimbursement is not received by Blue Cross NC within the thirty (30) days following the date of such notice, Blue Cross NC shall be entitled to offset such overpayment against any Claims payments due and payable by Blue Cross NC to Provider under any Health Benefit Plan in accordance with Regulatory Requirements. In such event, Provider agrees that all future Claim payments applied to satisfy Provider's repayment obligation shall be deemed to have been paid in full for all purposes, including section 2.6.1. Should Provider disagree with any determination by Blue Cross NC that Provider has received an overpayment, Provider shall have the right to appeal such determination under Blue Cross NC's procedures set forth in the provider manual, and such appeal shall not suspend Blue Cross NC's right to recoup the overpayment amount during the appeal process unless prohibited under Regulatory Requirements. Blue Cross NC reserves the right to employ a third party collection agency in the event of non-payment.

2.8 Use of Subcontractors. Provider and Blue Cross NC may fulfill some of their duties under this Agreement through subcontractors. For purposes of this provision, subcontractors shall include, but are not limited to, vendors and non-Participating Providers that provide supplies, equipment, staffing, and other services to Members at the request of, under the supervision of, and/or at the place of business of Provider. Provider shall provide Blue Cross NC with thirty (30) days prior notice of any Health Services subcontractors with which Provider may contract to perform Provider's duties and obligations under this Agreement, and Provider shall remain responsible to Blue Cross NC for the compliance of his/her/its subcontractors with the terms and conditions of this Agreement as applicable, including, but not limited to, the Payment in Full and Hold Harmless provisions herein.

2.9 Compliance with Provider Manual(s) and Policies, Programs and Procedures. Provider agrees to cooperate and comply with, Blue Cross NC's provider manual(s), and all other policies, programs and procedures (collectively "Policies") established and implemented by Blue Cross NC, applicable to the Network(s) in which Provider participates. Blue Cross NC or its designees may modify the provider manual(s) and its Policies by making a good faith effort to provide notice, including electronic notice, to Provider at least thirty (30) days in advance of the effective date of material modifications thereto.

2.10 Referral Incentives/Kickbacks. Provider represents and warrants that Provider does not give, provide, condone or receive any incentives or kickbacks, monetary or otherwise, in exchange for the referral of a Member, and if a Claim for payment is attributable to an instance in which Provider provided or received an incentive or kickback in exchange for the referral, such Claim shall not be payable and, if paid in error, shall be refunded to Blue Cross NC.

2.11 Networks and Provider Panels. Provider shall be eligible to participate only in those Networks designated on the Provider Networks Attachment of this Agreement. Provider shall not be recognized as a Participating Provider in such Networks until the later of: 1) the Effective Date of this Agreement or; 2) as determined by Blue Cross NC in its sole discretion, the date Provider has met Blue Cross NC's applicable credentialing requirements, standards of participation and accreditation requirements. Provider acknowledges that Blue Cross NC may develop, discontinue, or modify new or existing Networks, products and/or programs. In addition to those Networks designated on the Provider Networks Attachment, Blue Cross NC may also identify Provider as a Participating Provider in additional Networks, products and/or programs designated in writing from time to time by Blue Cross NC unless specifically prohibited by Regulatory Requirements. The terms and conditions of Provider's participation as a Participating Provider in such additional Networks, products and/or programs shall be on the terms and conditions as set forth in this Agreement unless otherwise agreed to in writing by Provider and Blue Cross NC.

In addition to and separate from Networks that support some or all of Blue Cross NC's products and/or programs (e.g., HMO, PPO and Indemnity products), Provider further acknowledges that certain Health Services, including by way of example only, laboratory services, may be provided exclusively by designated Participating Providers (a "Health Services Designated Network"), as determined by Blue Cross NC. Provider agrees to refer Members to such designated Participating Providers in a Health Services Designated Network for the provision of certain Health Services, even if Provider performs such services. Notwithstanding any other provision in this Agreement, if Provider provides a Health Service to a Member for which Provider is not a designated Participating Provider in a Health Services Designated Network, then Provider agrees that he/she/it shall not be reimbursed for such services by Blue Cross NC, or the Member, unless Provider was authorized to provide such Health Service by Blue Cross NC.

2.12 Change in Provider Information. Provider shall immediately send written notice, in accordance with the Notice section of this Agreement, to Blue Cross NC of:

2.12.1 Any legal, governmental, or other action or investigation involving Provider which could affect Provider's credentialing status with Blue Cross NC, or materially impair the ability of Provider to carry out his/her/its duties and obligations under this Agreement, except for temporary emergency diversion situations; or

2.12.2 Any change in Provider accreditation, affiliation, hospital privileges (if applicable), insurance, licensure, certification or eligibility status, or other relevant information regarding Provider's practice or status in the medical community.

2.13 Provider Credentialing, Standards of Participation and Accreditation. Provider warrants that he/she/it meets all applicable Blue Cross NC credentialing requirements, standards of participation, and accreditation requirements for the Networks in which Provider participates. A description of the applicable credentialing requirements, standards of participation, and accreditation requirements, are set forth in the provider manual(s) and/or in the PCS. Provider acknowledges that until such time as Provider has been determined to have fully met Blue Cross NC's credentialing requirements, standards of participation, and accreditation requirements, as applicable, Provider shall not be entitled to the benefits of participation under this Agreement, including without limitation the Blue Cross NC Rates set forth in the PCS attached hereto.

2.14 Provider Staffing and Staff Privileges. Provider agrees to maintain professional staffing levels to meet community access standards and where applicable, agrees to facilitate and to expeditiously grant admitting privileges to Participating Providers who meet facility's credentialing standards.

2.15 Adjustment Requests. If Provider believes a Claim has been improperly adjudicated for a Covered Service for which Provider timely submitted a Claim to Blue Cross NC, Provider must submit a request for an adjustment to Blue Cross NC in accordance with the provider manual(s).

2.16 Provision and Supervision of Services. In no way shall Blue Cross NC be construed to be providers of Health Services or responsible for, exercise control, or have direction over the provision of such Health Services. Provider shall be solely responsible to the Member for treatment, medical care, and advice with respect to the provision of Health Services. Provider agrees that all Health Services provided to Members under this Agreement shall be provided by Provider or by a qualified person under Provider's direction. Provider warrants that any nurses or other health professionals employed by or providing services for Provider shall be duly licensed or certified under applicable law. In addition, nothing herein shall be construed as authorizing or permitting Provider to abandon any Member.

2.17 Coordination of Benefits/Subrogation. Subject to Regulatory Requirements, Provider agrees to cooperate with Blue Cross NC regarding subrogation and coordination of benefits, as set forth in Policies and the provider manual(s), and to notify Blue Cross NC promptly after receipt of information regarding any Member who may have a Claim involving subrogation or coordination of benefits.

2.18 Cost Effective Care. Provider shall provide Covered Services in the most cost effective, clinically appropriate setting and manner. In addition, in accordance with the provider manual(s) and Policies, Provider shall utilize Participating Providers, and consistent with Medical Necessity, refer and transfer Members to Participating Providers for all Covered Services, including but not limited to specialty, laboratory, ancillary and supplemental services.

2.19 Facility-Based Providers. Provider agrees to require its contracted facility-based providers or those with exclusive privileges with Provider to obtain and maintain Participating Provider status with Blue Cross NC.

Until such time as facility-based providers enter into agreements with Blue Cross NC, Provider agrees to fully cooperate with Blue Cross NC to prevent Members from being billed amounts in excess of the applicable Blue Cross NC non-participating reimbursement for such Covered Services. Facility-based providers may include, but are not limited to, anesthesiologists, radiologists, pathologists, neonatologists, hospitalists and emergency room physicians.

## ARTICLE III
## CONFIDENTIALITY/RECORDS

3.1 Proprietary and Confidential Information. Except as otherwise provided herein, all information and material provided by either party in contemplation of or in connection with this Agreement including, but not limited to, (i) the negotiation of this Agreement or any amendments to the Agreement (including all reimbursement rate negotiations), (ii) this Agreement, or any copies thereof, (iii) any documents, information, or data from the Blue Cross and Blue Shield Association or other Blues Plan, (iv) any of Blue Cross NC's programs, policies, or data, and (v) Blue Cross NC's trade secret information shall be and remain confidential. (Collectively, subsections (i), (ii) and (iii) above are referred to as the "Proprietary or Confidential Information"). Neither party shall disclose any Proprietary or Confidential Information to the other, or use such information or material except: (1) as otherwise set forth in this Agreement; (2) as may be required to perform obligations hereunder; (3) as required to deliver Health Services or administer a Health Benefit Plan; (4) to Blue Cross NC or its designees; (5) upon the express written consent of the parties; or (6) as required by Regulatory Requirements. Notwithstanding the foregoing, either party may disclose such information to its legal advisors, lenders and business advisors, provided that such legal advisors, lenders and business advisors agree to maintain confidentiality of such information. Provider and Blue Cross NC shall each have a system in place that meets all applicable Regulatory Requirements to protect all records and all other documents relating to this Agreement which are deemed confidential by law. Any disclosure or transfer of Proprietary or Confidential Information by Provider or Blue Cross NC will be in accordance with applicable Regulatory Requirements. Provider shall immediately notify Blue Cross NC if Provider is required to disclose any Proprietary or Confidential Information at the request of an Agency or pursuant to any federal or state freedom of information act request.

3.2 Confidentiality of Member Information. Both parties agree to comply with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act ("HITECH Act"), and as both may be amended, as well as any other applicable Regulatory Requirements regarding confidentiality, use, disclosure, security and access of the Member's personally identifiable information ("PII") and protected health information ("PHI"), (collectively "Member Information"). Provider shall review all Member Information received from Blue Cross NC to ensure no misrouted Member Information is included. Misrouted Member Information includes but is not limited to, information about a Member that Provider is not currently treating. Provider shall immediately destroy any misrouted Member Information or safeguard the Member Information for as long as it is retained. In no event shall Provider be permitted to misuse or re-disclose misrouted Member Information. If Provider cannot destroy or safeguard misrouted Member Information, Provider must contact Blue Cross NC to report receipt of misrouted Member Information.

3.3 Network Provider/Patient Discussions. Notwithstanding any other provision in this Agreement and regardless of any benefit or coverage exclusions or limitations associated with a Health Benefit Plan, Provider shall not be prohibited from discussing fully with a Member any issues related to the Member's health including recommended treatments, treatment alternatives, treatment risks and the consequences of any benefit coverage or payment decisions made by Blue Cross NC or any other party. In addition, nothing in this Agreement shall be construed to, create any financial incentive for Provider to withhold Covered Services, or prohibit Provider from disclosing to the Member the general methodology by which Provider is compensated under this Agreement, such as for example, whether Provider is paid on a fee for service, capitation or Percentage Rate basis. Blue Cross NC shall not refuse to allow or to continue the participation of any otherwise eligible provider, or refuse to compensate Provider in connection with services rendered, solely because Provider has in good faith communicated with one or more of his/her/its current, former or prospective patients regarding the provisions, terms or requirements of a Health Benefit Plan as they relate to the health needs of such patient. Nothing in this section shall be construed to permit Provider to disclose Blue Cross NC Rates or specific terms of the compensation arrangement under this Agreement.

3.4 Blue Cross NC Access to and Requests for Provider Records. Provider and its designees shall comply with all applicable state and federal record keeping and retention requirements, and, as set forth in the provider manual(s) and/or Participation Attachment(s), shall permit Blue Cross NC or its designees to have, with appropriate working space and without charge, on-site access to and the right to perform an Audit, examine,

copy, excerpt and transcribe any books, documents, papers, and records related to Member's medical and billing information within the possession of Provider and inspect Provider's operations, which involve transactions relating to Members and as may be reasonably required by Blue Cross NC in carrying out its responsibilities and programs including, but not limited to, assessing quality of care, complying with quality initiatives/measures, Medical Necessity, concurrent review, appropriateness of care, accuracy of payment, risk adjustment assessment as described in the provider manual(s), including but not limited to completion of the Encounter Facilitation Form (also called the "SOAP" note), compliance with this Agreement, and for research. In lieu of on-site access, at Blue Cross NC's request, Provider or its designees shall submit records to Blue Cross NC, or its designees via photocopy or electronic transmittal, within thirty (30) days, at no charge to Blue Cross NC from either Provider or its designee. Provider shall make such records available to the state and federal authorities involved in assessing quality of care or investigating Member grievances or complaints in compliance with Regulatory Requirements. Any examination or Audit of Provider records shall be performed using generally accepted, statistically valid or industry standard methodology. Provider acknowledges that failure to submit records to Blue Cross NC in accordance with this provision and/or the provider manual(s), and/or Participation Attachment(s) may result in a denial of a Claim under review, whether on pre-payment or post-payment review, or a payment retraction on a paid Claim, and Provider is prohibited from balance billing the Member in any of the foregoing circumstances.

3.5 Transfer of Medical Records. Following a request, Provider shall transfer a Member's medical records in a timely manner, or within such other time period required under applicable Regulatory Requirements, to other health care providers treating a Member at no cost to Blue Cross NC, the Member, or other treating health care providers.

3.6 Clinical Data Sharing. Blue Cross NC and Provider desire to collaborate by sharing data, including Member Information, to enhance certain health care operations activities, primarily to help improve quality and efficiency of health care. Each party's access to better clinical and administrative data is critical to the mutual goal of Blue Cross NC and Provider improving health care quality as it relates to their respective Members and patients. Therefore and upon request, Provider agrees to provide data to Blue Cross NC for treatment purposes, for payment purposes, for health care operations purposes consistent with those enumerated in the first two paragraphs of the health care operations definition in HIPAA (45 CFR 164.501), or for purposes of health care fraud and abuse detection or compliance. Provider shall provide data as set forth in Policies or the provider manual(s), as applicable.

## ARTICLE IV
## INSURANCE

4.1 Blue Cross NC Insurance. Blue Cross NC shall self-insure or maintain insurance as required under applicable Regulatory Requirements to insure Blue Cross NC and its employees, acting within the scope of their duties.

4.2 Provider Insurance. Provider shall self-insure or maintain insurance acceptable to Blue Cross NC as set forth in the provider manual(s), Participation Attachment(s), PCS, or as required under applicable Regulatory Requirements.

## ARTICLE V
## RELATIONSHIP OF THE PARTIES

5.1 Relationship of the Parties. For purposes of this Agreement, Blue Cross NC and Provider are and will act at all times as independent contractors. Nothing in this Agreement shall be construed, or be deemed to create, a relationship of employer or employee or principal and agent, partnership, joint venture, or any relationship other than that of independent entities contracting with each other for the purposes of effectuating this Agreement.

5.2 Provider Representations and Warranties. Provider represents and warrants that it has the corporate power and authority to execute and deliver this Agreement on its own behalf, and on behalf of any other individuals or entities that are owned, employed or subcontracted with or by Provider to provide services under this Agreement. Provider further certifies that individuals or entities that are owned, employed or subcontracted with Provider agree to comply with the terms and conditions of this Agreement.

## ARTICLE VI
## INDEMNIFICATION AND LIMITATION OF LIABILITY

6.1 Indemnification. Blue Cross NC and Provider shall each indemnify, defend and hold harmless the other party, and his/her/its directors, officers, employees, agents, Affiliates and subsidiaries ("Representatives"), from and against any and all losses, claims, damages, liabilities, costs and expenses (including without limitation, reasonable attorneys' fees and costs) arising from third party claims resulting from the indemnifying party's or his/her/its Representative's failure to perform the indemnifying party's obligations under this Agreement, and/or the indemnifying party's or his/her/its Representative's violation of any law, statute, ordinance, order, standard of care, rule or regulation. The obligation to provide indemnification under this Agreement shall be contingent upon the party seeking indemnification providing the indemnifying party with prompt written notice of any claim for which indemnification is sought, allowing the indemnifying party to control the defense and settlement of such claim, provided however that the indemnifying party agrees not to enter into any settlement or compromise of any claim or action in a manner that admits fault or imposes any restrictions or obligations on an indemnified party without that indemnified party's prior written consent which will not be unreasonably withheld, and cooperating fully with the indemnifying party in connection with such defense and settlement.

6.2 Limitation of Liability. Regardless of whether there is a total and fundamental breach of this Agreement or whether any remedy provided in this Agreement fails of its essential purpose, in no event shall either of the parties hereto be liable for any amounts representing loss of revenues, loss of profits, loss of business, the multiple portion of any multiplied damage award, or incidental, indirect, consequential, special or punitive damages, whether arising in contract, tort (including negligence), or otherwise regardless of whether the parties have been advised of the possibility of such damages, arising in any way out of or relating to this Agreement. Further, in no event shall Blue Cross NC be liable to Provider for any extracontractual damages relating to any claim or cause of action assigned to Provider by any person or entity.

## ARTICLE VII
## DISPUTE RESOLUTION AND ARBITRATION

7.1 Dispute Resolution. All disputes between Blue Cross NC and Provider arising out of or related in any manner to this Agreement shall be resolved using the dispute resolution and arbitration procedures as set forth below. Provider shall exhaust any other applicable provider appeal/provider dispute resolution procedures under this Agreement and any applicable exhaustion requirements imposed by Regulatory Requirements as a condition precedent to Provider's right to pursue the dispute resolution and arbitration procedures as set forth below.

7.1.1 In order to invoke the dispute resolution procedures in this Agreement, a party first shall send to the other party a written demand letter that contains a detailed description of the dispute and all relevant underlying facts, a detailed description of the amount(s) in dispute and how they have been calculated and any other information that the Blue Cross NC provider manual(s) may require Provider to submit with respect to such dispute. If the total amount in dispute as set forth in the demand letter is less than two hundred thousand dollars ($200,000), exclusive of interest, costs, and attorneys' fees, then within twenty (20) days following the date on which the receiving party receives the demand letter, representatives of each party's choosing shall meet to discuss the dispute in person or telephonically in an effort to resolve the dispute. If the total amount in dispute as set forth in the demand letter is two hundred thousand dollars ($200,000) or more, exclusive of interest, costs, and attorneys' fees, then within ninety (90) days following the date of the demand letter, the parties shall engage in non-binding mediation in an effort to resolve the dispute unless both parties agree in writing to waive the mediation requirement. The parties shall mutually agree upon a mediator, and failing to do so, Judicial Arbitration and Mediation Services ("JAMS") shall be authorized to appoint a mediator.

7.2 Arbitration. Any dispute within the scope of subsection 7.1.1 that remains unresolved at the conclusion of the applicable process outlined in subsection 7.1.1 shall be resolved by binding arbitration in the manner as set forth below. Except to the extent as set forth below, the arbitration shall be conducted pursuant to the JAMS Comprehensive Arbitration Rules and Procedures, provided, however, that the parties may agree in writing to further modify the JAMS Comprehensive Arbitration Rules and Procedures. The parties agree to be bound by the findings of the arbitrator(s) with respect to such dispute, subject to the right of the parties to appeal such findings as set forth herein. No arbitration demand shall be filed until after the parties have completed the dispute resolution efforts described in section 7.1 above. If the dispute resolution efforts described in section 7.1 cannot be completed within the deadlines specified for such efforts despite the parties' good faith efforts to meet such deadlines, such deadlines may be extended as necessary upon mutual agreement of the parties. Enforcement of this arbitration clause, including the waiver of class actions, shall be determined under the Federal Arbitration Act ("FAA"), including the FAA's preemptive effect

on state law. The parties agree that the arbitration shall be conducted on a confidential basis pursuant to Rule 26 of the JAMS Comprehensive Arbitration Rules and Procedures. Subject to any disclosures that may be required or requested under Regulatory Requirements, the parties further agree that they shall maintain the confidential nature of the arbitration, including without limitation, the existence of the arbitration, information exchanged during the arbitration, and the award of the arbitrator(s). Nothing in this provision, however, shall preclude either party from disclosing any such details regarding the arbitration to its accountants, auditors, brokers, insurers, reinsurers or retrocessionaires.

7.2.1 Location of Arbitration. The arbitration hearing shall be held in North Carolina. Notwithstanding the foregoing, both parties can agree in writing to hold the arbitration hearing in some other location.

7.2.2 Selection and Replacement of Arbitrator(s). If the total amount in dispute is less than four million dollars ($4,000,000), exclusive of interest, costs, and attorneys' fees, the dispute shall be decided by a single arbitrator selected, and replaced when required, in the manner described in the JAMS Comprehensive Arbitration Rules and Procedures. If the total amount in dispute is four million dollars ($4,000,000) or more, exclusive of interest, costs, and attorneys' fees, the dispute shall be decided by an arbitration panel consisting of three (3) arbitrators, unless the parties agree in writing that the dispute shall be decided by a single arbitrator.

7.2.3 Appeal. If the total amount of the arbitration award is five million dollars ($5,000,000) or more, inclusive of interest, costs, and attorneys' fees, or if the arbitrator(s) issues an injunction against a party, the parties shall have the right to appeal the decision of the arbitrator(s) pursuant to the JAMS Optional Arbitration Appeal Procedure. A decision that has been appealed shall not be enforceable while the appeal is pending. In reviewing a decision of the arbitrator(s), the appeal panel shall apply the same standard of review that a United States Court of Appeals would apply in reviewing a similar decision issued by a United States District Court in the jurisdiction in which the arbitration hearing was held.

7.2.4 Waiver of Certain Claims. The parties, on behalf of themselves and those that they may now or hereafter represent, each agree to and do hereby waive any right to join or consolidate claims in arbitration by or against other individuals or entities or to pursue, on a class basis, any dispute; provided however, if there is a dispute regarding the applicability or enforcement of the waiver provision in this subsection 7.2.4, that dispute shall be decided by a court of competent jurisdiction. If a court of competent jurisdiction determines that such waiver is unenforceable for any reason with respect to a particular dispute, then the parties agree that section 7.2 shall not apply to such dispute and that such dispute shall be decided instead in a court of competent jurisdiction.

7.2.5 Limitations on Injunctive Relief. The parties, on behalf of themselves and those that they may now or hereafter represent, each agree that any injunctive relief sought against the other party shall be limited to the conduct relevant to the parties to the arbitration and shall not be sought for the benefit of individuals or entities who are not parties to the arbitration. The arbitrator(s) are not authorized to issue injunctive relief for the benefit of an individual or entity who is not a party to the arbitration. The arbitrator shall be limited to issuing injunctive relief related to the specific issues in the arbitration.

7.3 Attorney's Fees and Costs. The shared fees and costs of the non-binding mediation and arbitration (e.g. fee of the mediator, fee of the independent arbitrator) will be shared equally between the parties. Each party shall be responsible for the payment of its own specific fees and costs (e.g. the party's own attorney's fees, the fees of the party selected arbitrator, etc.) and any costs associated with conducting the non-binding mediation or arbitration that the party chooses to incur (e.g. expert witness fees, depositions, etc.). Notwithstanding this provision, the arbitrator may issue an order in accordance with Federal Rule of Civil Procedure Rule 11.

7.4 Period of Limitations. Unless otherwise provided for in this Agreement or a Participation Attachment(s), neither party shall commence any action at law or equity, including but not limited to, an arbitration demand, against the other to recover on any legal or equitable claim arising out of this Agreement ("Action") more than two (2) years after the events which gave rise to such Action; provided, however, this two (2) year limitation shall not apply to Actions by Blue Cross NC against Provider related to fraud, waste or abuse which shall be subject to the period of limitations set forth in applicable Regulatory Requirements. In the situation where Provider believes that Blue Cross NC underpaid a Claim, the Action arises on the date when Blue Cross NC first denies the Claim or first pays the Claim in an amount less than expected by Provider. In the situation where Blue Cross NC believes that it overpaid a Claim, the Action arises when Provider first

contests in writing Blue Cross NC's notice to it that the overpayment was made. The deadline for initiating an Action shall not be tolled by the appeal process, provider dispute resolution process or any other administrative process. To the extent an Action is timely commenced, it will be administered in accordance with Article VII of this Agreement.

## ARTICLE VIII
## TERM AND TERMINATION

8.1 Term of Agreement. The initial term of this Agreement shall commence at 12:01 AM on the Effective Date for a term of one (1) year ("Initial Term"), and shall continue automatically in effect thereafter for a consecutive four (4) year term unless otherwise terminated as provided herein. Pursuant to Section 9.1.3, the term may be further extended upon sixty (60) days prior written notice to Provider.

8.2 Termination Without Cause. After the Initial Term, either party may terminate this Agreement without cause at any time by giving at least one hundred eighty (180) days prior written notice of termination to the other party. Notwithstanding the foregoing, should a Participation Attachment(s) contain a longer without cause termination period, the Agreement shall continue in effect only for such applicable Participation Attachment(s) until the termination without cause notice period in the applicable Participation Attachment(s) ends.

8.3 Breach of Agreement. Except for circumstances giving rise to the Immediate Termination section, if either party fails to comply with or perform when due any material term or condition of this Agreement, the other party shall notify the breaching party of its breach in writing stating the specific nature of the material breach, and the breaching party shall have thirty (30) days to cure the breach. If the breach is not cured to the reasonable satisfaction of the non-breaching party within said thirty (30) day period, the non-breaching party may terminate this Agreement by providing written notice of such termination to the other party. The effective date of such termination shall be no sooner than sixty (60) days after such notice of termination.

8.4 Immediate Termination.

8.4.1 This Agreement or any Participation Attachment(s) may be terminated immediately by Blue Cross NC if:

8.4.1.1 Provider commits any act or conduct for which his/her/its license(s), permit(s), or any governmental or board authorization(s) or approval(s) necessary for business operations or to provide Health Services are lost or voluntarily surrendered in whole or in part; or

8.4.1.2 Provider commits fraud or makes any material misstatements or omissions on any documents related to this Agreement which Provider submits to Blue Cross NC or to a third party or upon a confirmed finding of fraud, waste, or abuse by State Agency or the North Carolina Department of Justice Medicaid Investigations Division; or

8.4.1.3 Provider files a petition in bankruptcy for liquidation or reorganization by or against Provider, if Provider becomes insolvent, or makes an assignment for the benefit of its creditors without Blue Cross NC's written consent, or if a receiver is appointed for Provider or its property; or

8.4.1.4 Provider's insurance coverage as required by this Agreement lapses for any reason; or

8.4.1.5 Provider fails to maintain compliance with Blue Cross NC's applicable credentialing requirements, accreditation requirements or standards of participation; or

8.4.1.6 Blue Cross NC reasonably believes based on Provider's conduct or inaction, or allegations of such conduct or inaction, that the well-being of patients may be jeopardized; or

8.4.1.7 Provider has been abusive to a Member, an Blue Cross NC employee or representative; or

8.4.1.8 Provider and/or his/her/its employees, contractors, subcontractors, or agents are ineligible, excluded, suspended, terminated or debarred from participating in a

Government Program, and in the case of an employee, contractor, subcontractor or agent, Provider fails to remove such individual from responsibility for, or involvement with, the Provider's business operations related to this Agreement, or if Provider has voluntarily withdrawn his/her/its participation in any Government Program as the result of a settlement agreement; or

8.4.1.9 Provider is convicted or has been finally adjudicated to have committed a felony or misdemeanor, other than a non-DUI related traffic violation; or

8.4.1.10 A Government Contract between the applicable State Agency and Blue Cross NC terminates or expires or ends for any reason or is modified to eliminate a Medicaid Program.

8.4.2 This Agreement may be terminated immediately by Provider if:

8.4.2.1 Blue Cross NC commits any act or conduct for which its license(s), permit(s), or any governmental or board authorization(s) or approval(s) necessary for business operations are lost or voluntarily surrendered in whole or in part; or

8.4.2.2 Blue Cross NC commits fraud or makes any material misstatements or omissions on any documents related to this Agreement which it submits to Provider or to a third party; or

8.4.2.3 Blue Cross NC files for bankruptcy, or if a receiver is appointed.

8.5 Partial Termination of Participating Providers. Blue Cross NC shall be entitled to terminate this Agreement as it applies to one or a number of Participating Providers under the terms of this Article VIII, without terminating the Agreement in its entirety, and in such case, the Agreement shall continue in full force and effect in connection with Provider and/or any and all Participating Providers as to which the Agreement has not been terminated. Notwithstanding the foregoing, Blue Cross NC reserves the right to terminate Participating Provider(s) from any or all Network(s) under the terms of this Article VIII while continuing the Agreement for the remaining Participating Provider(s).

8.6 Transactions Prior to Termination. Except as otherwise set forth in this Agreement, termination shall have no effect on the rights and obligations of the parties arising out of any transaction under this Agreement occurring prior to the date of such termination.

8.7 Continuation of Care Upon Termination. If this Agreement or any Participation Attachment terminates for any reasons other than one of the grounds set forth in the "Immediate Termination" section, then Provider shall, at Blue Cross NC's discretion, continue to provide Covered Services to all designated Members under this Agreement or any terminating Participation Attachment, as applicable, in accordance with Regulatory Requirements. During such continuation period, Provider agrees to: (i) accept reimbursement from Blue Cross NC for all Covered Services furnished hereunder in accordance with this Agreement and at the rates set forth in the PCS attached hereto; and (ii) adhere to Blue Cross NC's Policies, including but not limited to, Policies regarding quality assurance requirements, referrals, pre-authorization and treatment planning.

8.8 Survival. The provisions of this Agreement set forth below shall survive termination or expiration of this Agreement or any Participation Attachment(s):

8.8.1 Publication and Use of Provider Information;

8.8.2 Payment in Full and Hold Harmless;

8.8.3 Recoupment/Offset/Adjustment for Overpayments;

8.8.4 Confidentiality/Records;

8.8.5 Indemnification and Limitation of Liability;

8.8.6 Dispute Resolution and Arbitration;

8.8.7 Continuation of Care Upon Termination; and

8.8.8 Any other provisions required in order to comply with Regulatory Requirements.

## ARTICLE IX
## GENERAL PROVISIONS

9.1 Amendment. This Agreement may be amended by written mutual agreement of the parties, or as follows:

9.1.1 Changes in Law. In the event that Blue Cross NC determines that Regulatory Requirements or an applicable accrediting organization requires amendments to this Agreement, Blue Cross NC will make good faith efforts to provide sixty (60) days' prior written notice of such amendments. Provider acknowledges and agrees that such amendments may include, but are not limited to, modifications to the Agreement mandated by State Agency (as hereinafter defined) pursuant to its approval and review of the Agreement template. Such modifications may occur at any time during the course of the Agreement. Except as otherwise required by Regulatory Requirements or an applicable accrediting organization, this Agreement will be automatically amended to include the amendments set forth in the written notice from Blue Cross NC no earlier than sixty (60) days following delivery of such amendment.

9.1.2 Changes to Fee Schedules. Pursuant to N.C.G.S. §§ 58-50-270 through 58-50-285 or successor thereto, Blue Cross NC will provide at least sixty (60) days' prior written notice of a proposed change to the terms of the Agreement, including terms incorporated by reference, that modifies Provider's fee schedule(s) and that is not a change required by Regulatory Requirements, administrative hearing, or court order ("Proposed Change" or "Proposed Change to a Fee Schedule"). The Proposed Change shall be dated, labeled "Amendment," signed by Blue Cross NC, and include an effective date for the Proposed Change. The effective date shall be at least sixty (60) days from the date of receipt of the Proposed Change, or greater if otherwise required by the Agreement. If Provider does not notify Blue Cross NC within sixty (60) days from the date of the receipt of a Proposed Change, such Proposed Change shall be effective upon the effective date specified in the Proposed Change unless Blue Cross NC notifies Provider that Blue Cross NC will not implement the Proposed Change. If Provider objects to the Proposed Change, then the Proposed Change is not effective and, notwithstanding any other provisions of the Agreement, Blue Cross NC shall be entitled to terminate this Agreement upon sixty (60) days' prior written notice. Notwithstanding the foregoing, the parties may negotiate terms providing for mutual consent to a Proposed Change, a process for reaching mutual consent, or alternative addresses for providing notice as described in Section 9.11.

9.1.3 All Other Terms. Except as otherwise provided in this Section 9.1 or elsewhere in this Agreement, Blue Cross NC may amend any terms of this Agreement by providing no fewer than sixty (60) days' prior written notice to Provider.

9.2 Assignment. This Agreement may not be assigned by Provider without the prior written consent of Blue Cross NC. Any assignment by Provider without such prior consent shall be voidable at the sole discretion of Blue Cross NC. Blue Cross NC may assign this Agreement in whole or in part; provided, however, that to the extent required under applicable Regulatory Requirements, Blue Cross NC shall notify Provider, in writing, of any duties or obligations that are to be delegated or transferred, before the delegation or transfer. In the event of a partial assignment of this Agreement by Blue Cross NC, the obligations of the Provider shall be performed for Blue Cross NC with respect to the part retained and shall be performed for Blue Cross NC's assignee with respect to the part assigned, and such assignee is solely responsible to perform all obligations of Blue Cross NC with respect to the part assigned. The rights and obligations of the parties hereunder shall inure to the benefit of, and shall be binding upon, any permitted successors and assigns of the parties hereto.

9.3 Scope/Change in Status.

9.3.1 Blue Cross NC and Provider agree that this Agreement applies to Health Services rendered at the Provider's location(s) on file with Blue Cross NC. Blue Cross NC may, in its discretion, limit this Agreement to Provider's locations, operations, business or corporate form, status or structure in existence on the Effective Date of this Agreement and prior to the occurrence of any of the events set forth in subsections 9.3.1.1 – 9.3.1.5. Unless otherwise required by Regulatory Requirements, Provider shall provide at least ninety (90) days prior written notice of any such event.

9.3.1.1 Provider (a) sells, transfers or conveys his/her/its business or any substantial portion of his/her/its business assets to another entity through any manner including but not limited to a stock, real estate or asset transaction or other type of transfer; (b) is otherwise acquired or controlled by any other entity through any manner, including but not limited to purchase, merger, consolidation, alliance, joint venture, partnership, association, or expansion; or

9.3.1.2 Provider transfers control of his/her/its management or operations to any third party, including Provider entering into a management contract with a physician practice management company or with another entity which does not manage Provider as of the Effective Date of this Agreement, or there is a subsequent change in control of Provider's current management company; or

9.3.1.3 Provider acquires or controls any other medical practice, facility, service, beds or entity; or

9.3.1.4 Provider changes his/her/its locations, business or operations, corporate form or status, tax identification number, or similar demographic information; or

9.3.1.5 This provision intentionally left blank.

9.3.2 Notwithstanding the termination provisions of Article VIII, and without limiting any of Blue Cross NC's rights as set forth elsewhere in this Agreement, Blue Cross NC shall have the right to terminate this Agreement by giving at least sixty (60) days written notice to Provider if Blue Cross NC determines, that as a result of any of the transactions listed in subsection 9.3.1, Provider cannot satisfactorily perform the obligations hereunder, or cannot comply with one or more of the terms and conditions of this Agreement, including but not limited to the confidentiality provisions herein; or Blue Cross NC elects in its reasonable business discretion not to do business with Provider, the successor entity or new management company, as a result of one or more of the events as set forth in subsection 9.3.1.

9.3.3 Provider shall provide Blue Cross NC with thirty (30) days prior written notice of:

9.3.3.1 Addition or removal of individual provider(s) who are employed or subcontracted with Provider, if applicable. Any new individual providers must meet Blue Cross NC's credentialing requirements or other applicable standards of participation prior to being designated as a Participating Provider; or

9.3.3.2 A change in mailing address.

9.3.4 If Provider is acquired by, acquires or merges with another entity, and such entity already has an agreement with Blue Cross NC, Blue Cross NC will determine in its sole discretion which Agreement will prevail.

9.4 Definitions. Unless otherwise specifically noted, the definitions as set forth in Article I of this Agreement will have the same meaning when used in any attachment, the provider manual(s) and Policies.

9.5 Entire Agreement. This Agreement, exhibits, attachments, appendices, and amendments hereto, and the provider manual(s), together with any items incorporated herein by reference, constitute the entire understanding between the parties and supersedes all prior oral or written agreements between them with respect to the matters provided for herein. If there is an inconsistency between any of the provisions of this Agreement and Policies, then this Agreement shall govern. In addition, if there is an inconsistency between the terms of this Agreement and the terms provided in any attachment to this Agreement, then the terms provided in that attachment shall govern.

9.6 Force Majeure. Neither party shall be deemed to be in violation of this Agreement if such party is prevented from performing any of his/her/its obligations hereunder for any reason beyond his/her/its reasonable control, including without limitation, acts of God, natural or man-made disasters, acts of any public enemy, statutory or other laws, regulations, rules, orders, or actions of the federal, state, or local government or any agency thereof.

9.7 Compliance with Regulatory Requirements. Blue Cross NC and Provider agree to comply with all applicable Regulatory Requirements, as amended from time to time, relating to their obligations under this Agreement, and maintain in effect all permits, licenses and governmental and board authorizations and approvals as necessary for business operations. Provider warrants that as of the Effective Date, he/she/it is and shall remain licensed and certified for the term of this Agreement in accordance with all Regulatory Requirements (including those applicable to utilization review and Claims payment) relating to the provision of Health Services to Members. Provider shall supply evidence of such licensure, compliance and certifications to Blue Cross NC upon request. If there is a conflict between this section and any other provision in this Agreement, then this section shall control.

9.7.1 In addition to the foregoing, Provider warrants and represents that at the time of entering into this Agreement, neither he/she/it nor any of his/her/its employees, contractors, subcontractors, principals or agents are ineligible, excluded, suspended, terminated or debarred from participating in a Government Program ("Ineligible Person"). Provider shall remain continuously responsible for ensuring that his/her/its employees, contractors, subcontractors, principals or agents are not Ineligible Persons. If Provider or any employees, subcontractors, principals or agents thereof becomes an Ineligible Person after entering into this Agreement or otherwise fails to disclose his/her/its Ineligible Person status, Provider shall have an obligation to (1) immediately notify Blue Cross NC of such Ineligible Person status and (2) within ten (10) days of such notice, remove such individual from responsibility for, or involvement with, Provider's business operations related to this Agreement.

9.8 Governing Law. This Agreement shall be governed by and construed in accordance with the laws of North Carolina, unless such state laws are otherwise preempted by federal law. However, coverage issues specific to a Health Benefit Plan are governed by the state laws where the Health Benefit Plan is issued, unless such state laws are otherwise preempted by federal law.

9.9 Intent of the Parties. It is the intent of the parties that this Agreement is to be effective only in regards to their rights and obligations with respect to each other; it is expressly not the intent of the parties to create any independent rights in any third party or to make any third party a third party beneficiary of this Agreement, except to the extent specified in the Payment in Full and Hold Harmless section of this Agreement, or in a Participation Attachment(s).

9.10 Non-Exclusive Participation. None of the provisions of this Agreement shall prevent Provider or Blue Cross NC from participating in or contracting with any provider, preferred provider organization, health maintenance organization/health insuring corporation, or any other health delivery or insurance program. Provider acknowledges that Blue Cross NC does not warrant or guarantee that Provider will be utilized by any particular number of Members.

9.11 Notice. Any notice required to be given pursuant to the terms and provisions of this Agreement shall be in writing and shall be delivered by hand, facsimile, electronic mail (except for the notice required under Section 9.1.2), or mail. Notice shall be deemed to be effective: (a) when delivered by hand, (b) upon transmittal when transmitted by facsimile transmission or by electronic mail, (c) by registered or certified mail, postage prepaid, on the date on the return receipt (d) on the next business day if transmitted by national overnight courier, or (e) if sent by regular mail, first class postage prepaid, five (5) days from the date the notice is placed. Unless specified otherwise in writing by a party, Blue Cross NC shall send Provider notice to the contact set forth on the signature page to this Agreement; provided, however, that should Provider provide alternative or additional contact information to Blue Cross NC as part of the credentialing process, notice provided to such address(es) shall be considered valid under this Agreement until such time that Provider notifies Blue Cross NC in writing that such address(es) are no longer valid and provides replacement contact information. Provider shall send Blue Cross NC notice to Blue Cross NC's address as set forth in the provider manual(s). Notwithstanding the foregoing, and unless otherwise prohibited by Regulatory Requirements, Blue Cross NC may post updates to its provider manual and Policies on its web site and unilateral amendments extending the term of the Agreement pursuant to Section 8.1.

9.12 Severability. In case any one or more of the provisions of this Agreement shall be invalid, illegal, or unenforceable in any respect, the remaining provisions shall be construed liberally in order to effectuate the purposes hereof, and the validity, legality and enforceability of the remaining provisions shall not in any way be affected or impaired thereby. If one or more provisions of the Agreement are invalid, illegal or unenforceable and an amendment to the Agreement is necessary to maintain its integrity, the parties shall make commercially reasonable efforts to negotiate an amendment to this Agreement and any attachments

or addenda to this Agreement which could reasonably be construed not to contravene such statute, regulation, or interpretation. In addition, if such invalid, unenforceable or materially affected provision(s) may be severed from this Agreement and/or attachments or addenda to this Agreement without materially affecting the parties' intent when this Agreement was executed, then such provision(s) shall be severed rather than terminating the Agreement or any attachments or addenda to this Agreement.

9.13 Waiver. Neither the waiver by either of the parties of a breach of any of the provisions of this Agreement, nor the failure of either of the parties, on one or more occasion, to enforce any of the provisions of this Agreement, shall thereafter be construed as a waiver of any subsequent breach of any of the provisions of this Agreement.

9.14 Construction. This Agreement shall be construed without regard to any presumption or other rule requiring construction against the party causing this Agreement to be drafted.

9.15 Counterparts and Electronic Signatures.

9.15.1 This Agreement and any amendment hereto may be executed in two (2) or more counterparts, each of which shall be deemed to be an original and all of which taken together shall constitute one and the same agreement.

9.15.2 Either party may execute this Agreement or any amendments by valid electronic signature, and such signature shall have the same legal effect of a signed original.

Each party warrants that it has full power and authority to enter into this Agreement and the person signing this Agreement on behalf of either party warrants that he/she has been duly authorized and empowered to enter into this Agreement.

***THIS AGREEMENT CONTAINS A BINDING ARBITRATION PROVISION WHICH MAY BE ENFORCED BY THE PARTIES***

**Provider shall be designated as a Participating Provider in the Networks set forth on the Provider Network Attachment on the later of: (1) the Effective Date of this Agreement or; (2) as determined by Blue Cross NC in its sole discretion, the date Provider has met applicable credentialing requirements, standards of participation and accreditation requirements.**

**PROVIDER LEGAL NAME ACCORDING TO W-9 FORM WITH D/B/A:**

By: _____ _____
Signature, Authorized Representative of Provider(s) Date

Printed: _____ _____
Name Title

Address _____ _____
Street City State Zip

Tax Identification Number (TIN): _____

(Note: if any of the following is not applicable, please leave blank)

Group NPI Number: _____

**Blue Cross Blue Shield of North Carolina**

**BLUE CROSS NC INTERNAL USE ONLY**

By: _____ _____
Signature, Authorized Representative of Blue Cross NC Date

Printed: Mark Werner Vice President, Provider Network and Transformation
Name Title

## PROVIDER NETWORKS ATTACHMENT

**Provider shall be designated as a Participating Provider in the following Networks on the later of: 1) the Effective Date of this Agreement or; 2) as determined by Blue Cross NC in its sole discretion, the date Provider has met applicable credentialing requirements, standards of participation and accreditation requirements:**

**Health Benefit Plans**:

**Health Benefit Plans issued pursuant to an agreement between Blue Cross NC and Agency in which Members have access to a network of providers and receive an enhanced level of benefits when they obtain Covered Services from Participating Providers regardless of product licensure status. Provider participates in one or more of the following Networks which support such Health Benefit Plans:**

- Medicaid

## MEDICAID
## PARTICIPATION ATTACHMENT TO THE
## BLUE CROSS NC
## MEDICAID PROVIDER AGREEMENT

This is a Medicaid Participation Attachment ("Attachment") to the Blue Cross NC Medicaid Provider Agreement ("Agreement"), entered into by and between Blue Cross NC and Provider and is incorporated into the Agreement.

### ARTICLE I
### DEFINITIONS

The following definitions shall apply to this Attachment. Terms not otherwise defined in this Attachment shall carry the meaning set forth in the Agreement.

"Clean Claim" means, unless otherwise prohibited by applicable state Regulatory Requirements, an accurate and timely filed Claim submitted pursuant to this Attachment, that has no defect or impropriety, for which all information necessary to process such Claim and make a benefit determination is included. This includes but is not limited to, the claim being submitted in a nationally accepted format in compliance with standard coding guidelines, and which does not require adjustment, or alteration by Provider of the services in order to be processed and paid.

"Medicaid Program(s)" means, for purposes of this Attachment, a medical assistance program provided under a Health Benefit Plan approved under Title XVI, Title XIX and/or Title XXI of the Social Security Act or any other federal or state funded program or product as designated by Blue Cross NC.

"Medicaid Covered Services" means, for purposes of this Attachment, only those Covered Services provided under Blue Cross NC's Medicaid Program(s).

"Medicaid Member" means, for purposes of this Attachment, a Member who is enrolled in Blue Cross NC's Medicaid Program(s).

"Medically Necessary/Medical Necessity" Medical necessity is determined by generally accepted North Carolina community practice standards as verified by independent Medicaid consultants. As required by 10A NCAC 25A.0201, a medically necessary service may not be experimental in nature.

"State Agency" means the North Carolina Department of Health and Human Services.

### ARTICLE II
### SERVICES/OBLIGATIONS

2.1 Participation-Medicaid Network. As a participant in Blue Cross NC's Medicaid Network, Provider will render Medicaid Covered Services to Medicaid Members in accordance with the terms and conditions of the Agreement and this Attachment. Such Medicaid Covered Services provided shall be within the scope of Provider's licensure, expertise, and usual and customary range of services pursuant to the terms and conditions of the Agreement and this Attachment, and Provider shall be responsible to Blue Cross NC for his/her/its performance hereunder. Except as set forth in this Attachment or the Plan Compensation Schedule ("PCS"), all terms and conditions of the Agreement will apply to Provider's participation in Blue Cross NC's Medicaid Network. The terms and conditions set forth in this Attachment are limited to the provision of and payment for Health Services provided to Medicaid Members.

2.2 Provider's Duties and Obligations to Medicaid Members. All of Provider's duties and obligations to Members set forth in the Agreement shall also apply to Medicaid Members unless otherwise specifically set forth in this Attachment. Provider shall not discriminate in the acceptance of Medicaid Members for treatment, and shall provide to Medicaid Members the same access to services, including but not limited to, hours of operation, as Provider gives to all other patients. Provider shall furnish Blue Cross NC with at least ninety (90) days prior written notice if Provider plans to close its practice to new patients or ceases to continue in Provider's current practice.

2.2.1 To the extent mandated by Regulatory Requirements, Provider shall ensure that Medicaid Members have access to twenty-four (24) hour-per-day, seven (7) day-per-week urgent and Emergency Services, as defined in the PCS.

2.2.2 Unless otherwise prohibited under Regulatory Requirements, a PCP, as defined in the PCS, shall provide Covered Services or make arrangements for the provision of Covered Services to Medicaid Members on a twenty-four (24) hour-per-day, seven (7) day-per-week basis to assure availability, adequacy, and continuity of care to Medicaid Members. If Provider is unable to provide Covered Services, Provider shall arrange for another Participating Provider to cover Provider's patients in accordance with Blue Cross NC's Policies, which may include, but is not limited to, arranging for call coverage or other backup. Provider and any PCPs employed by or under contract with Provider may arrange for Covered Services to Medicaid Members to be performed by a Specialist Physician only in accordance with Blue Cross NC's Policies.

2.2.3 If Provider is furnishing Specialist Physician services under this Attachment, Provider and the Specialist Physician(s) employed by or under contract with Provider, shall accept as patients all Medicaid Members and may arrange for Covered Services to Medicaid Members to be performed by Specialist Physician only in accordance with Blue Cross NC's Policies.

2.2.4 Provider must cooperate with Medicaid Member appeals and grievance procedures.

2.2.5 If Provider is a PCP, Provider shall perform EPSDT screenings for Medicaid Members less than twenty-one (21) years of age in accordance with the Government Contract.

2.3 Provider Responsibility. Blue Cross NC shall not be liable for, nor will it exercise control or direction over, the manner or method by which Provider provides Health Services to Medicaid Members. Provider shall be solely responsible for all medical advice and services provided by Provider to Medicaid Members. Provider acknowledges and agrees that Blue Cross NC may deny payment for services rendered to a Medicaid Member which it determines are not Medically Necessary, are not Medicaid Covered Services under the applicable Medicaid Program(s), or are not otherwise provided or billed in accordance with the Agreement and/or this Attachment. A denial of payment or any action taken by Blue Cross NC pursuant to a utilization review, referral, discharge planning program or claims adjudication shall not be construed as a waiver of Provider's obligation to provide appropriate Health Services to a Medicaid Member under applicable Regulatory Requirements and any code of professional responsibility. However, this provision does not require Provider to provide Health Services if Provider objects to such service on moral or religious grounds.

2.4 Reporting Fraud and Abuse. Provider shall cooperate with Blue Cross NC's anti-fraud compliance program. If Provider identifies any actual or suspected fraud, abuse or misconduct in connection with the services rendered hereunder in violation of Regulatory Requirements, Provider shall promptly report such activity directly to the compliance officer of Blue Cross NC or through the compliance hotline in accordance with the provider manual(s). In addition, Provider is not limited in any respect in reporting other actual or suspected fraud, abuse, or misconduct to Blue Cross NC.

2.5 Blue Cross NC Marketing/Information Requirements. Provider agrees to abide by Blue Cross NC's marketing/information requirements. Provider shall forward to Blue Cross NC for prior approval all flyers, brochures, letters and pamphlets Provider intends to distribute to Medicaid Members concerning its payor affiliations, or changes in affiliation or relating directly to the Medicaid population. Provider will not distribute any marketing or recipient informing materials without the consent of Blue Cross NC or the applicable State Agency.

2.6 Schedule of Benefits and Determination of Medicaid Covered Services. Blue Cross NC shall make available upon Provider's request the applicable Health Benefit Plan for applicable Medicaid Program(s), and will notify Provider in a timely manner of any material amendments or modifications.

2.7 Medicaid Member Verification. Provider shall verify a Medicaid Member's eligibility for Medicaid Covered Services prior to rendering services, except in the case of an Emergency Medical Condition, as defined in the PCS, where such verification may not be possible. In the case of an Emergency Medical Condition, Provider shall verify a Medicaid Member's eligibility as soon as reasonably practical. Blue Cross NC shall provide a system for Providers to contact Blue Cross NC to verify a Medicaid Member's eligibility twenty-four (24) hours a day, seven (7) days per week. Nothing contained in this Attachment or the Agreement shall, or shall be construed to, require advance notice, coverage verification, or pre-authorization for Emergency Services, as defined in the PCS, provided in accordance with the federal Emergency Medical Treatment and Active Labor Act ("EMTALA") prior to Provider's rendering such Emergency Services.

2.8 Hospital Affiliation and Privileges. To the extent required under Blue Cross NC's credentialing requirements, Provider or any Participating Providers employed by or under contract or subcontract with Provider shall

maintain privileges to practice at one (1) or more of Blue Cross NC's Participating Provider hospitals. In addition, in accordance with the Change in Provider Information Section of the Agreement, Provider shall immediately notify Blue Cross NC in the event any such hospital privileges are revoked, limited, surrendered, or suspended at any hospital or health care facility.

2.9 Participating Provider Requirements. If Provider is a group provider, Provider shall require that all Participating Providers employed by or under contract or subcontract with Provider comply with all terms and conditions of the Agreement and this Attachment. Notwithstanding the foregoing, and unless prohibited under Regulatory Requirements, Provider acknowledges and agrees that Blue Cross NC is not obligated to accept as Participating Providers all providers employed by or under contract or subcontract with Provider.

2.10 Coordinated and Managed Care. Provider shall participate in utilization management, care management, and provider sanctions programs designed to facilitate the coordination of services as referenced in the applicable provider manual(s). None of the foregoing programs shall be construed to override the professional or ethical responsibility of Provider or interfere with Provider's ability to provide information or assistance to Medicaid Members. In accordance with N.C.G.S. § 58-3-200(c), if Blue Cross NC or its authorized representative determines that services, supplies, or other items are covered under a Health Benefit Plan, including any determination under N.C.G.S §. 58-50-61, Blue Cross NC shall not subsequently retract its determination after such services, supplies, or other items have been provided, or reduce payments for a service, supply, or other item furnished in reliance on such a determination, unless the determination was based on a material misrepresentation about the Medicaid Member's health condition that was knowingly made by the insured or the provider of the service, supply, or other item.

2.10.1 Notice of Discharge from High Level Clinical Setting. Provider shall notify Blue Cross NC when a Medicaid Member in a high level clinical setting is discharged.

2.11 Representations and Warranties. Provider represents and warrants that all information provided to Blue Cross NC is true and correct as of the date such information is furnished, and that Provider is unaware of any undisclosed facts or circumstances that would make such information inaccurate or misleading. Provider further represents and warrants that Provider: (i) is legally authorized to provide the services contemplated hereunder; (ii) is qualified to participate in all applicable Medicaid Program(s); (iii) is not in violation of any licensure or accreditation requirement applicable to Provider under Regulatory Requirements; (iv) has not been convicted of bribery or attempted bribery of any official or employee of the jurisdiction in which Provider operates, nor made an admission of guilt of such conduct which is a matter of record; (v) is capable of providing all data related to the services provided hereunder in a timely manner as reasonably required by Blue Cross NC to satisfy its internal requirements and Regulatory Requirements, including, without limitation, data required under the Health Employer Data and Information Set ("HEDIS") and National Committee for Quality Assurance ("NCQA") requirements; and (vi) is not, to Provider's best knowledge, the subject of an inquiry or investigation that could foreseeably result in Provider failing to comply with the representations set forth herein. In accordance with the Change in Provider Information Section of the Agreement, Provider shall immediately provide Blue Cross NC with written notice of any material changes to such information.

2.12 Credentialing: Compliance with Government Contract Requirements. In addition to the Provider Credentialing, Standards of Participation and Accreditation of this Agreement, and in accordance with 45 C.F.R. § 455.410, Provider must be enrolled in Medicaid Program(s) in which it offers Medicaid Covered Services. Failure to maintain enrollment in such Medicaid Program(s) may result in immediate termination of this Attachment as applied to such Medicaid Program(s). Provider shall complete re-enrollment/re-credentialing before contract renewal and in accordance with the following: (1) during the Provider Credentialing Transition Period, no less frequently than every five (5) years (as described in the Government Contract); (2) during Provider Credentialing under Full Implementation, no less frequently than every three (3) years (as described in the Government Contract), except as otherwise permitted by State Agency.

2.13 Obligation to Provide Data. Blue Cross NC shall provide data and information to Provider, such as: (1) performance feedback reports or information to Provider, if compensation is related to efficiency criteria, (2) information on benefit exclusions; administrative and utilization management requirements; credential verification programs; quality assessment programs; and provider sanction policies, and (3) notification of changes in these requirements, allowing Provider time to comply with such changes.

2.14 Provider Directory. Provider authorizes Blue Cross NC to include, and Blue Cross NC shall include, Provider's name in the provider directory distributed to Medicaid Members.

2.15 Interpreting and Translation Services. Provider must (1) provide qualified sign language interpreters if closed captioning is not the appropriate auxiliary aid for a Medicaid Member, (2) ensure that Provider's staff are trained to appropriately communicate with patients with various types of hearing loss, and (3) report to Blue Cross NC, in a format and frequency to be determined by Blue Cross NC, whether hearing loss accommodations are needed and provided and the type of accommodation provided.

2.16 Perinatal Care. If Provider provides perinatal Medicaid Covered Services, Provider will arrange for perinatal Medicaid Covered Services in a manner consistent with State Agency's Pregnancy Management Program (as defined and described in the Government Contract). Provider shall comply with State Agency's Pregnancy Management Program.

2.17 Advanced Medical Homes. If Provider is an Advanced Medical Home (as defined in the Government Contract), Provider will follow a care management model and requirements consistent with State Agency's Advanced Medical Home Program (as defined and described in the Government Contract). Provider agrees to comply with State Agency's Advanced Medical Home Program.

2.18 Local Health Departments. If Provider is a Local Health Department (as defined in the Government Contract) carrying out care management for high-risk pregnancy and for at-risk children, Provider will follow requirements consistent with State Agency's Care Management for High-Risk Pregnancy Policy and Care Management for At-Risk Children Policy (each policy as defined and described in the Government Contract). Provider agrees to comply with the Department's Care Management for High-Risk Pregnancy Policy and Care Management for At-Risk Children Policy.

## ARTICLE III
## COMPENSATION AND AUDIT

3.1 Submission and Adjudication of Medicaid Claims. Unless otherwise instructed, or prohibited by Regulatory Requirements, Provider shall submit Claims to Blue Cross NC, using appropriate and current Coded Service Identifier(s), within one hundred eighty (180) days from the date the Health Services are rendered, or, from the date the Medicaid Member is discharged, or Blue Cross NC may refuse payment. If Blue Cross NC is the secondary payor, the one hundred eighty (180) day period will not begin until Provider receives notification of primary payor's responsibility. Provider shall not submit Claims or Encounter Data (as defined in the PCS) for Medicaid Covered Services directly to State Agency to the extent Blue Cross NC covers such Medicaid Covered Services.

3.1.1 Provider agrees to submit Claims in a format consistent with industry standards and acceptable to Blue Cross NC either (a) electronically through electronic data interchange ("EDI"), or (b) if electronic submission is not available, utilizing paper forms as defined by the National Uniform Claim Committee ("NUCC").

3.1.2 Provider agrees to provide to Blue Cross NC, unless otherwise instructed, at no cost to Blue Cross NC, or the Medicaid Member, all information necessary for Blue Cross NC to determine its payment liability. Such information includes, without limitation, accurate and Clean Claims for Covered Services. If Blue Cross NC asks for additional information so that Blue Cross NC may process the Claim, Provider must provide that information within sixty (60) days, or before the expiration of the one hundred eighty (180) day period referenced in Section 3.1 above, whichever is longer.

3.1.3 Once Blue Cross NC determines Blue Cross NC has any payment liability, all Clean Claims will be adjudicated in accordance with the terms and conditions of a Medicaid Member's Health Benefit Plan, the PCS, the provider manual(s), and the Regulatory Requirements applicable to Blue Cross NC's Medicaid Program(s).

3.2 This provision intentionally left blank.

3.3 Audit for Compliance with CMS Guidelines. Notwithstanding any other terms and conditions of the Agreement, this Attachment, or the PCS, Blue Cross NC has the same rights as CMS, to review and/or Audit and, to the extent necessary recover payments on any claim for Medicaid Covered Services rendered pursuant to this Attachment and the Agreement to ensure compliance with CMS Regulatory Requirements.

3.4 Medicaid Member Records. In accordance with 42 C.F.R. § 438.208(b)(5), Provider must (1) maintain confidentiality of Medicaid Member medical records and personal information and other health records as required by law; (2) maintain adequate medical and other health records according to industry and Blue

Cross NC standards; and (3) make copies of such records available to Blue Cross NC and State Agency in conjunction with its regulation of Blue Cross NC. The records shall be made available and furnished immediately upon request in either paper or electronic form, at no cost to the requesting party.

3.5 Access to Fee Schedules. Blue Cross NC shall make available its schedule of fees associated with the top thirty (30) services or procedures most commonly billed by Provider's class of provider. Upon the request of Provider, Blue Cross NC shall also make available the full schedule of fees for services or procedures billed by Provider's class of provider or for each class of provider in the case of a contract incorporating multiple classes of providers. If Provider requests fees for more than thirty (30) services and procedures, Blue Cross NC may require Provider to specify the additional requested services and procedures and may limit Provider's access to the additional schedule of fees to those associated with services and procedures performed by or reasonably expected to be performed by Provider.

## ARTICLE IV
## COMPLIANCE WITH FEDERAL REGULATORY REQUIREMENTS

4.1 Federal Funds. Provider acknowledges that payments Provider receives from Blue Cross NC to provide Medicaid Covered Services to Medicaid Members are, in whole or part, from federal funds. Therefore, Provider and any of his/her/its subcontractors are subject to certain laws that are applicable to individuals and entities receiving federal funds, which may include but are not limited to, Title VI of the Civil Rights Act of 1964 as implemented by 45 CFR Part 84; the Age Discrimination Act of 1975 as implemented by 45 CFR Part 91; the Americans with Disabilities Act; the Rehabilitation Act of 1973, lobbying restrictions as implemented by 45 CFR Part 93 and 31 USC 1352, Title IX of the Educational Amendments of 1972, as amended (30 U.S.C. sections 1681, 1783, and 1685-1686) and any other regulations applicable to recipients of federal funds.

4.2 Surety Bond Requirement. If Provider provides home health services or durable medical equipment, Provider shall comply with all applicable provisions of Section 4724(b) of the Balanced Budget Act of 1997, including, without limitation, any applicable requirements related to the posting of a surety bond.

4.3 Laboratory Compliance. If Provider renders lab services in the office, it must maintain a valid Clinical Laboratory Improvement Amendments ("CLIA") certificate for all laboratory testing sites and comply with CLIA regulations at 42 CFR Part 493 for all laboratory testing sites performing Health Services pursuant to this Attachment.

## ARTICLE V
## COMPLIANCE WITH STATE REGULATORY REQUIREMENTS

5.1 Indemnification of State. In addition to the Indemnification provision of the Agreement, Provider shall indemnify and hold harmless the State, its agencies, officers, and employees from all claims and suits, including court costs, attorney's fees, and other expenses, brought because of injuries or damages received or sustained by any person, persons, or property that is caused by any act or omission of Provider.

5.2 Medicaid Hold Harmless. Provider agrees that Blue Cross NC's payment constitutes payment in full for any Medicaid Covered Services rendered to Medicaid Members. Provider agrees it shall not seek payment from the Medicaid Member, his/her representative or the State for any Health Services rendered pursuant to this Attachment, with the exception of Cost Shares, if any, or payment for non-Medicaid Covered Services otherwise requested by, and provided to, the Medicaid Member if the Medicaid Member agrees in writing to pay for the service prior to the service being rendered. The form of agreement must specifically state the admissions, services or procedures that are non-Medicaid Covered Services and the approximate amount of out of pocket expense to be incurred by the Medicaid Member. Provider agrees not to bill Medicaid Members for missed appointments while enrolled in the Medicaid Programs. This provision shall remain in effect even in the event Blue Cross NC becomes insolvent.

5.3 State Agency Government Contract. Provider shall comply with the terms applicable to providers set forth in the Government Contract, including incorporated documents, between Blue Cross NC and the applicable State Agency, which applicable terms are incorporated herein by reference. Blue Cross NC agrees to provide Provider with a description of the applicable terms upon request.

5.4 Performance Within the U.S. Provider agrees that all services to be performed herein shall be performed in the United States of America. Breach, or anticipated breach, of the foregoing shall be a material breach of

this Attachment and, without limitation of remedies, shall be cause for immediate termination of the Agreement and this Attachment.

5.5 No Payment Outside the United States. Provider agrees that Blue Cross NC shall not provide any payments for items or services provided under the Agreement to any financial institution or entity located outside the United States of America.

5.6 Dispute Resolution. Any disputes arising out of this Attachment or the Agreement shall be handled consistent with the provider grievances and appeals guidelines set forth in the Government Contract and the provider manual. To the extent there is a conflict between the provider grievances and appeals guidelines set forth in the Government Contract and the dispute resolution procedures set forth in the provider manual, this Attachment or the Agreement, the provider grievances and appeals guidelines set forth in the Government Contract shall govern. Except as otherwise set forth in this section, all other terms and conditions related to dispute resolution provided in the Agreement remain in full force and effect.

5.7 Government Funds. Provider acknowledges that the funds used for payments under this Attachment are government funds.

5.8 Provider Preventable Conditions. Provider shall comply with 42 C.F.R. § 438.3. Provider agrees to comply with the reporting requirements set forth under federal law and the Government Contract as a condition of payment from Blue Cross NC. Provider shall not be entitled to payment for provider preventable conditions.

5.9 Required Government Contract Language: All Provider Types. In the event of a conflict between this section and other terms and conditions in this Agreement, this section shall prevail. Except as otherwise provided in this section, all other terms and conditions provided in this Agreement remain in full force and effect.

5.9.1 Compliance with State and Federal Laws. Provider understands and agrees that it is subject to all state and federal laws, rules, regulations, waivers, policies and guidelines, and court-ordered consent decrees, settlement agreements, or other court orders that apply to the Agreement and the Government Contract, and all persons or entities receiving state and federal funds. Provider understands and agrees that any violation by a provider of a state or federal law relating to the delivery of services pursuant to this Agreement, or any violation of the Government Contract could result in liability for money damages, and/or civil or criminal penalties and sanctions under state and/or federal law.

5.9.2 Hold Medicaid Member Harmless. Provider agrees to hold the Medicaid Member harmless for charges for any Medicaid Covered Service. Provider agrees not to bill a Medicaid Member for Medically Necessary Covered Services covered by Blue Cross NC so long as the Medicaid Member is eligible for coverage.

5.9.3 Liability. Provider understands and agrees that State Agency does not assume liability for the actions of, or judgments rendered against, Blue Cross NC, its employees, agents or subcontractors. Further, Provider understands and agrees that there is no right of subrogation, contribution, or indemnification against State Agency for any duty owed to Provider by Blue Cross NC or any judgment rendered against Blue Cross NC.

5.9.4 Non-Discrimination: Equitable Treatment of Medicaid Members. Provider agrees to render Covered Services to Medicaid Members with the same degree of care and skills as customarily provided to Provider's patients who are not Medicaid Members, according to generally accepted standards of medical practice. Provider and Blue Cross NC agree that Medicaid Members and non-Medicaid Members should be treated equitably. Provider agrees not to discriminate against Medicaid Members on the basis of race, color, national origin, age, sex, gender, or disability.

5.9.5 Department Authority Related to the Medicaid Program. Provider agrees and understands that in the State of North Carolina, State Agency is the single state Medicaid agency designated under 42 C.F.R. § 431.10 to administer or supervise the administration of the state plan for medical assistance. The Division of Health Benefits is designated with administration, provision, and payment for medical assistance under the Federal Medicaid (Title XIX) and the State Children's Health Insurance (Title XXI) (CHIP) programs. The Division of Social Services (DSS) is designated with the administration and determination of eligibility for the two programs.

5.9.6 Access to Provider Records. Provider agrees to provide at no cost to the following entities or their designees, prompt, reasonable, and adequate access to Blue Cross NC and the Agreement and any records, books, documents, and papers that relate to the Blue Cross NC and the Agreement and/or Provider's performance of its responsibilities under this contract for purposes of examination, audit, investigation, contract administration, the making of copies, excerpts or transcripts, or any other purpose State Agency deems necessary for contract enforcement or to perform its regulatory functions: i. The United States Department of Health and Human Services or its designee; ii. The Comptroller General of the United States or its designee; iii. State Agency, its Medicaid managed care program personnel, or its designee iv. The Office of Inspector General v. North Carolina Department of Justice Medicaid Investigations Division vi. Any independent verification and validation contractor, audit firm, or quality assurance contractor acting on behalf of State Agency; vii. The North Carolina Office of State Auditor, or its designee viii. A state or federal law enforcement agency. ix. And any other state or federal entity identified by State Agency, or any other entity engaged by State Agency. Provider shall cooperate with all announced and unannounced site visits, audits, investigations, post-payment reviews, or other program integrity activities conducted by the NC Department of Health and Human Services. Nothing in this section shall be construed to limit the ability of the federal government, the Centers for Medicare and Medicaid Services, the U.S. Department of Health and Human Services Office of Inspector General, the U.S. Department of Justice, or any of the foregoing entities' contractors or agents, to enforce federal requirements for the submission of documentation in response to an audit or investigation.

5.9.7 Provider Ownership Disclosure. Provider agrees to disclose the required information, at the time of application, and/or upon request, in accordance with 42 C.F.R.§ 455 Subpart B, related to ownership and control, business transactions, and criminal conviction for offenses against Medicare, Medicaid, CHIP and/or other federal health care programs. See 42 C.F.R. § 455, Parts 101 through 106 for definitions, percentage calculations, and requirements for disclosure of ownership, business transactions, and information on persons convicted of crimes related to any federal health care programs. Provider agrees to notify, in writing, Blue Cross NC and State Agency of any criminal conviction within twenty (20) days of the date of the conviction.

5.9.8 N.C.G.S. § 58-3-225 Prompt Claim payments under Health Benefit Plans. Per Section 5.(6).g. of Session Law 2015-245, as amended by Section 6.(b) of Session Law 2018-49 pertaining to Chapter 58 protections, Provider shall submit all Claims to Blue Cross NC for processing and payments within one hundred-eighty (180) calendar days from the date of covered service or discharge (whichever is later). However, Provider's failure to submit a Claim within this time will not invalidate or reduce any Claim if it was not reasonably possible for Provider to submit the Claim within that time. In such case, the Claim should be submitted as soon as reasonably possible, and in no event, later than one (1) year from the time submittal of the Claim is otherwise required. i. For Medical Claims (including behavioral health): 1. Blue Cross NC shall within eighteen (18) calendar days of receiving a Medical Claim notify Provider whether the Claim is a Clean Claim, or pend the Claim and request from Provider all additional information needed to process the Claim. 2. Blue Cross NC shall pay or deny a medical Clean Claim at lesser of thirty (30) calendar days of receipt of the Claim or the first scheduled provider reimbursement cycle following adjudication. 3. A medical pended Claim shall be paid or denied within thirty (30) calendar days of receipt of the requested additional information. ii. For Pharmacy Claims: 1. Blue Cross NC shall within fourteen (14) calendar days of receiving a pharmacy Claim pay or deny a pharmacy Clean Claim or notify Provider that more information is needed to process the Claim. 2. A pharmacy pended Claim shall be paid or denied within fourteen (14) calendar days of receipt of the requested additional information. iii. If the requested additional information on a medical or pharmacy pended Claim is not submitted within ninety (90) days of the notice requesting the required additional information, Blue Cross NC shall deny the Claim per § 58-3-225 (d). 1. Blue Cross NC shall reprocess medical and pharmacy Claims in a timely and accurate manner as described in this provision (including interest and penalties if applicable). iv. If Blue Cross NC fails to pay a Clean Claim in full pursuant to this provision, Blue Cross NC shall pay Provider interest and penalty. Late Payments will bear interest at the annual rate of eighteen percent (18%) beginning on the date following the day on which the Claim should have been paid or was underpaid. v. Failure to pay a Clean Claim within thirty (30) days of receipt will result in Blue Cross NC paying Provider a penalty equal to one percent (1%) of the total amount of the Claim per day beginning on the date following the day on which the Claim should have been paid or was underpaid. vi. Blue Cross NC shall pay the interest and penalty from subsections 58-3-225(e) and (f) as provided in that subsection, and shall not require Provider to request the interest or the penalty.

## ARTICLE VI

6.1 This Article intentionally left blank.

## ARTICLE VII
## GENERAL PROVISIONS

7.1 Regulatory Amendment. Notwithstanding the Amendment provision in the Agreement, this Attachment shall be automatically modified to conform to required changes to Regulatory Requirements related to Medicaid Programs without the necessity of executing written amendments.

7.2 Inconsistencies. In the event of an inconsistency between terms and conditions of this Attachment and the terms and conditions as set forth in the Agreement, the terms and conditions of this Attachment shall govern. Except as set otherwise forth herein, all other terms and conditions of the Agreement remain in full force and effect.

7.3 Disclosure Requirements. In accordance with Regulatory Requirements, Provider agrees to disclose to Blue Cross NC complete ownership, control and relationship information ("Disclosures") in accordance with 42 CFR 455.100 through 455.106. Provider shall provide required Disclosures to Blue Cross NC at the time of initial contract, upon contract renewal, and/or upon request by Blue Cross NC. Provider further agrees to notify Blue Cross NC within fourteen (14) days of any changes to the Disclosures. Failure to provide Disclosures as required under Regulatory Requirements shall be deemed a material breach of this Attachment and the Agreement.

7.4 Survival of Attachment. Provider further agrees that: (1) the hold harmless and continuation of care sections shall survive the termination of this Attachment or disenrollment of the Medicaid Member; and (2) these provisions supersede any oral or written contrary agreement now existing or hereafter entered into between Provider and a Medicaid Member or persons acting on their behalf that relates to liability for payment for, or continuation of, Medicaid Covered Services provided under the terms and conditions of these provisions.

## ADVANCED MEDICAL HOME PROVIDER ADDENDUM TO THE MEDICAID PARTICIPATION ATTACHMENT OF THE BLUE CROSS MEDICAID PROVIDER AGREEMENT

The following are required provisions for Advanced Medical Home ("AMH") Providers. These provisions are independent of practices' agreements with the North Carolina Department of Health and Human Services and CCNC around Carolina ACCESS, and will not affect those agreements. The Department will review all PHP (prepaid health plans) and AMH practice contract templates prior to use to ensure that standard contract terms are incorporated.

Any capitalized terms not otherwise defined herein shall have the meaning set forth in the Agreement or the Government Contract, as applicable.

### ARTICLE I
### SERVICES/OBLIGATIONS FOR AMH PRACTICES

1. Provider shall accept Medicaid Members and be listed as a PCP in Blue Cross NC's member-facing materials for the purpose of providing care to members and managing their health care needs.

2. Provider shall provide primary care and member care coordination services to each member.

3. Provider shall provide or arrange for primary care coverage for services, consultation or referral, and treatment for emergency medical conditions, twenty-four (24) hours per day, seven (7) days per week. Automatic referral to the hospital emergency department for services does not satisfy this requirement.

4. Provider shall provide direct patient care a minimum of thirty (30) office hours per week.

5. Provider shall provide preventive services in accordance with the Preventive Health Requirements set forth in the Provider Manual and Government Contract.

6. Provider shall establish and maintain hospital admitting privileges or a formal arrangement for management of inpatient hospital admissions of Medicaid Members.

7. Provider shall maintain a unified medical record for each Medicaid Member following Blue Cross NC's medical record documentation guidelines.

8. Provider shall promptly arrange referrals for Medically Necessary Health Services that are not provided directly and document referrals for specialty care in the medical record.

9. Provider shall transfer the Medicaid Member's medical record to the receiving practice upon the change of PCP at the request of the new PCP or Blue Cross NC (if applicable) and as authorized by the Medicaid Member within thirty (30) days of the date of the request.

10. Provider shall authorize care for Medicaid Members or provide care for Medicaid Members based on the standards of appointment availability as defined by Blue Cross NC's network adequacy standards.

11. Provider shall refer for a second opinion as requested by the Medicaid Member, based on State Agency guidelines and Blue Cross NC's standards.

12. Provider shall review and use Medicaid Member utilization and cost reports provided by Blue Cross NC for the purpose of AMH level utilization management and advise Blue Cross NC of errors, omissions, or discrepancies if they are discovered.

13. Provider shall review and use the monthly enrollment report provided by Blue Cross NC for the purpose of participating in Blue Cross NC or practice-based population health or care management activities.

### ARTICLE II
### Standard Terms and Conditions for Tier 3 AMH Practices

The terms and conditions set forth in this Article II shall apply to the extent Provider is a Tier 3 AMH practice (as defined in the Government Contract). Unless otherwise specified, any required element may be performed either by

the Tier 3 AMH practice itself or by a clinically-integrated network ("CIN") with which the practice has a contractual agreement that contains equivalent contract requirements.

2.1 Provider must be able to risk stratify all empaneled Medicaid Members.

2.1.1 Provider must ensure that assignment lists transmitted to the practice by Blue Cross NC are reconciled with the practice's panel list and up to date in the clinical system of record.

2.1.2 Provider must use a consistent method to assign and adjust risk status for each assigned Medicaid Member.

2.1.3 Provider must use a consistent method to combine risk scoring information received from Blue Cross NC with clinical information to score and stratify the Medicaid Member panel.

2.1.4 Provider must, to the greatest extent possible, ensure that the method is consistent with the State Agency's program Policy of identifying "priority populations" for care management.

2.1.5 Provider must ensure that the whole care team understands the basis of the practice's risk scoring methodology (even if this involves only clinician judgment at the practice-level) and that the methodology is applied consistently.

2.1.6 Provider must define the process and frequency of risk score review and validation.

2.2 Provider must be able to define the process and frequency of risk score review and validation.

2.2.1 Provider must use its risk stratification method to identify Medicaid Members who may benefit from care management.

2.2.2 Provider must perform a Comprehensive Assessment (as described below and in Policies) on each Medicaid Member identified as a priority for care management to determine care needs. The Comprehensive Assessment can be performed as part of a clinician visit, or separately by a team led by a clinician with a minimum credential of RN or LCSW. The Comprehensive Assessment must include at a minimum:

1. Medicaid Member' immediate care needs and current services;

2. Other State or local services currently used;

3. Physical health conditions;

4. Current and past behavioral and mental health and substance use status and/or disorders;

5. Physical, intellectual developmental disabilities;

6. Medications;

7. Priority domains of social determinants of health (housing, food, transportation, and interpersonal safety);

8. Available informal, caregiver, or social supports, including peer supports.

2.2.3 Provider must have North Carolina licensed, trained staff organized at the practice level (or at the CIN level but assigned to specific practices) whose job responsibilities encompass care management and who work closely with clinicians in a team-based approach to care for high-need Medicaid Members.

2.2.4 For each high-need Medicaid Member, Provider must assign a care manager who is accountable for active, ongoing care management that goes beyond office-based clinical diagnosis and treatment and who has the minimum credentials of RN or LCSW.

2.2.5 Provider must use a documented Care Plan for each high-need Medicaid Member receiving care management.

2.2.6 Provider must develop the Care Plan within 30 days of Comprehensive Assessment, or sooner if feasible, while ensuring that needed treatment is not delayed by the development of the Care Plan.

2.2.7 Provider must develop the Care Plan so that it is individualized and person-centered, using a collaborative approach including Medicaid Member and family participation where possible.

2.2.8 Provider must incorporate findings from the PHP Care Needs Screening/risk scoring, practice-based risk stratification and Comprehensive Assessment with clinical knowledge of the Medicaid Member into the Care Plan.

2.2.9 Medicaid Member must include, at a minimum, the following elements in the Care Plan:

1. Measurable Medicaid Member (or Medicaid Member and caregiver) goals
2. Medical needs including any behavioral health needs;
3. Interventions;
4. Intended outcomes; and
5. Social, educational, and other services needed by the Medicaid Member.

2.2.10 Provider must have a process to update each Care Plan as Medicaid Member needs change and/or to address gaps in care; including, at a minimum, review and revision upon re-assessment.

2.2.11 Provider must have a process to document and store each Care Plan in the clinical system of record.

2.2.12 Provider must periodically evaluate the care management services provided to high-risk, high-need Medicaid Members by the practice to ensure that services are meeting the needs of empaneled Medicaid Members, and refine the care management services as necessary.

2.2.13 Provider must track empaneled Medicaid Members' utilization in other venues covering all or nearly all hospitals and related facilities in their catchment area, including local emergency departments (EDs) and hospitals, through active access to an admissions, discharge, and transfer (ADT) data feed that correctly identifies when empaneled Medicaid Members are admitted, discharged, or transferred to/from an emergency department or hospital in real time or near real time.

2.2.14 Provider or CIN must implement a systematic, clinically appropriate care management process for responding to certain high-risk ADT alerts (indicated below):

1. Real time (minutes/hours) response to outreach from EDs relating to Medicaid Member care or admission/discharge decisions, for example arranging rapid follow up after an ED visit to avoid an admission;
2. Same-day or next-day outreach for designated high-risk subsets of the population to inform clinical care, such as beneficiaries with special health care needs admitted to the hospital;
3. Within a several-day period to address outpatient needs or prevent future problems for high risk Medicaid Members who have been discharged from a hospital or ED (e.g., to assist with scheduling appropriate follow-up visits or medication reconciliations post discharge).

2.3 Providers must be able to provide short-term, transitional care management along with medication reconciliation to all empaneled Medicaid Members who have an ED visit or hospital admission / discharge / transfer and who are at risk of readmissions and other poor outcomes.

2.3.1 Provider must have a methodology or system for identifying Medicaid Members in transition who are at risk of readmissions and other poor outcomes that considers all of the following:

1. Frequency, duration and acuity of inpatient, SNF and LTSS admissions or ED visits;

2. Discharges from inpatient behavioral health services, facility-based crisis services, non-hospital medical detoxification, medically supervised or alcohol drug abuse treatment center;

3. NICU discharges;

4. Clinical complexity, severity of condition, medications, risk score.

2.3.2 For each Medicaid Member in transition identified as high risk for admission or other poor outcome with transitional care needs, Provider must assign a care manager who is accountable for transitional care management that goes beyond office-based clinical diagnosis and treatment and who has the minimum credentials of RN or LCSW.

2.3.3 Provider must include the following elements in transitional care management:

1. Ensuring that a care manager is assigned to manage the transition;

2. Facilitating clinical handoffs;

3. Obtaining a copy of the discharge plan/summary;

4. Conducting medication reconciliation;

5. Following-up by the assigned care manager rapidly following discharge;

6. Ensuring that a follow-up outpatient, home visit or face to face encounter occurs;

7. Developing a protocol for determining the appropriate timing and format of such outreach.

2.3.4 Provider must use electronic data to promote care management.

1. Provider must receive claims data feeds (directly or via a CIN) and meet Department-designated security standards for their storage and use.

## PLAN COMPENSATION SCHEDULE ("PCS")

### ARTICLE I
### DEFINITIONS

The definitions set forth below shall apply with respect to all of the terms outlined in this PCS. Terms not otherwise defined in this PCS and defined elsewhere in the Agreement shall carry the meanings set forth in the Agreement.

"Capitation" means the amount paid by Blue Cross NC to a provider or management services organization on a per member per month basis for either specific services or the total cost of care for Covered Services.

"Case Rate" means the all-inclusive Blue Cross NC Rate for an entire admission or one outpatient encounter for Covered Services.

"Chargemaster" or "Charge Master" means facility's listing of facility charges for products, services and supplies.

"Coded Service Identifier(s)" means a listing of descriptive terms and identifying codes, updated from time to time by CMS or other industry source, for reporting Health Services on the CMS 1500 or CMS 1450/UB-04 claim form or its successor as applicable based on the services provided. The codes include but are not limited to, American Medical Association Current Procedural Terminology ("CPT®-4"), CMS Healthcare Common Procedure Coding System ("HCPCS"), International Classification of Diseases, 10th Revision ("ICD-10"), National Uniform Billing Committee ("Revenue Code") and National Drug Code ("NDC") or their successors.

"Cost to Charge Ratio" ("CCR") means the quotient of cost (total operating expenses minus other operating revenue) divided by charges (gross patient revenue) expressed as a decimal, as defined by Regulatory Requirements.

"Diagnosis-Related Group" ("DRG") means Diagnosis Related Group or its successor as established by CMS or other grouper, including but not limited to, a state mandated grouper or other industry standard grouper.

"DRG Rate" means the all-inclusive dollar amount which is multiplied by the appropriate DRG Weight to determine the Blue Cross NC Rate for Covered Services.

"DRG Weight" means the weight applicable to the specific DRG methodology set forth in this PCS, including but not limited to, CMS DRG weights as published in the Federal Register, state agency weights, or other industry standard weights.

"Eligible Charges" means those Provider Charges that meet Blue Cross NC's conditions and requirements for a Health Service to be eligible for reimbursement. These conditions and requirements include: Member program eligibility, Provider program eligibility, benefit coverage, authorization requirements, provider manual guidelines, Blue Cross NC administrative, clinical and reimbursement policies, code editing logic, and coordination of benefits. Eligible Charges do not include Provider Charges for any items or services that Provider receives and/or provides free of charge.

"Emergency Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the health of the individual, or in the case of a pregnant woman, the health of the woman or her unborn child; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

"Emergency Services" means those Covered Services furnished by a provider qualified to furnish emergency services, and which are services furnished or required to screen for or treat an Emergency Condition until the Emergency Condition is stabilized.

"Encounter Data" means Claim information and any additional information submitted by a provider under capitated or risk-sharing arrangements for Health Services rendered to Members.

"Encounter Rate" means the Blue Cross NC Rate that is all-inclusive of professional, technical and facility charges including evaluation and management, pharmaceuticals, routine surgical and therapeutic procedures, and diagnostic testing (including laboratory and radiology) capable of being performed on site.

"Fee Schedule(s)" means a list of the maximum per unit allowed amounts established for Covered Services based on applicable Coded Service Identifier(s).

"Global Case Rate" means the all-inclusive Blue Cross NC Rate which includes facility, professional and physician services for specific Coded Service Identifier(s) for Covered Services.

"Inpatient Services" means Covered Services provided by a facility to a Member who is admitted and treated as a registered inpatient, is assigned a licensed bed within the facility, remains assigned to such bed and for whom a room and board charge is made.

"Observation" means the services furnished on the facility's premises, including use of a bed and periodic monitoring by nursing or other staff, which are Medically Necessary to evaluate a Member's condition and determine if the Member requires an inpatient admission to the facility. Such determination shall be in compliance with Policies or Regulatory Requirements.

"Outlier Rate" means the payment applied to an admission which exceeds the outlier threshold as set forth in the PCS or in compliance with Policies or Regulatory Requirements.

"Outpatient Services" means Covered Services provided by a facility to a Member who is admitted and treated as a registered outpatient within the facility.

"Patient Day" means each approved calendar day of care that a Member receives in the facility, to the extent such day of care is a Covered Service under the terms of the Member's Health Benefit Plan, but excluding the day of discharge.

"Percentage Rate" means the Blue Cross NC Rate that is a percentage of Eligible Charges billed by a provider for Covered Services.

"Per Diem Rate" means the Blue Cross NC Rate that is the all-inclusive fixed payment for Covered Services rendered on a single date of service.

"Per Hour Rate" means the Blue Cross NC Rate that is payment based on an increment of time for Covered Services.

"Per Relative Value Unit" ("RVU") means the Blue Cross NC Rate for each unit of service based on the CMS, State Agency or other (e.g., Anesthesia Society of America (ASA)) defined Relative Value Unit (RVU).

"Per Service Rate" means the Blue Cross NC Rate that is payment for each service allowed based on applicable Coded Service Identifier(s) for Covered Services.

"Per Unit Rate" means the Blue Cross NC Rate that is payment for each unit of service allowed based on applicable Coded Service Identifier(s) for Covered Services.

"Per Visit Rate" means the Blue Cross NC Rate that is the all-inclusive fixed payment for one encounter for Covered Services.

"Provider Charges" means the regular, uniform rate or price Provider determines and submits to Blue Cross NC as charges for Health Services provided to Members. Such Provider Charges shall be no greater than the rate or price Provider submits to any person or other health care benefit payor for the same Health Services provided, regardless of whether Provider agrees with such person or other payor to accept a different rate or price as payment in full for such services. Notwithstanding the foregoing, consistent with N.C.G.S. § 58-50-295, nothing contained in this Provider Charges definition shall be construed to require Provider to agree to reimbursement for any Health Service with a health care benefit payor that is greater than or equal to that applicable to Blue Cross NC.

"Short Stay" means an inpatient hospital stay that is less than a specified number of calendar days in compliance with Policies and/or Regulatory Requirements.

## ARTICLE II
## GENERAL PROVISIONS

Billing Form and Claims Reporting Requirements. Provider shall submit all Claims on a CMS 1500 or CMS 1450/UB-04 claim form or its successor form(s) as applicable based on the services provided in accordance with Policies or applicable Regulatory Requirements. Provider shall report all Health Services in accordance with the Coded Service Identifier(s) reporting guidelines and instructions using HIPAA compliant billing codes. In addition, Blue Cross NC

shall not pay any Claim(s) nor accept any Encounter Data submitted using non-compliant codes. Blue Cross NC audits that result in identification of Health Services that are not reported in accordance with the Coded Service Identifier(s) guidelines and instructions, will be subject to recovery through remittance adjustment or other recovery action as may be set forth in the provider manual(s).

Claim Submissions for Pharmaceuticals. Each Claim submitted for a pharmaceutical product must include standard Coded Service Identifier(s), a National Drug Code ("NDC") number of the covered medication, a description of the product, and dosage and units administered. Unless otherwise required under Regulatory Requirements, Blue Cross NC shall not reimburse for any pharmaceuticals that are not administered to the Member and/or deemed contaminated and/or considered waste.

Coding Updates. Coded Service Identifier(s) used to define specific rates are updated from time to time to reflect new, deleted or replacement codes. Blue Cross NC shall use commercially reasonable efforts to update all applicable Coded Service Identifiers within sixty (60) days of release by CMS or other applicable authority. When billing codes are updated, Provider is required to use appropriate replacement codes for Claims for Covered Services, regardless of whether this Agreement has been amended to reflect changes to standard billing codes. If Provider bills a revised code prior to the effective date of the revised code, the Claim will be rejected and Provider shall resubmit Claim with correct code. In addition, Claims with codes which have been deleted will be rejected.

Coding Software. Updates to Blue Cross NC's Claims processing filters, code editing software, pricers, and any edits related thereto, as a result of changes in Coded Service Identifier(s) reporting guidelines and instructions, shall take place automatically and do not require any notice, disclosure or amendment to Provider. Blue Cross NC reserves the right to use a code editing software as reasonably required by Blue Cross NC to ensure Claims adjudication in accordance with industry standards, including, but not limited to, determining which services are considered part of, incidental to, or inclusive of the primary procedure and ensuring medically appropriate age, gender, diagnosis, frequency, and units billed.

Modifiers. All appropriate modifiers must be submitted in accordance with industry standard billing guidelines, if applicable.

New/Expanded Service or New/Expanded Technology. In accordance with the Scope/Change in Status section of the Agreement, as of the Effective Date of this Agreement, any New/Expanded Service or New/Expanded Technology (defined below) is not reimbursable under this Agreement. Notwithstanding the foregoing, Provider may submit the following documentation to Blue Cross NC at least sixty (60) days prior to the implementation of any New/Expanded Service or New/Expanded Technology for consideration as a reimbursable service: (1) a description of the New/Expanded Service or New/Expanded Technology; (2) Provider's proposed charge for the New/ Expanded Service or New/ Expanded Technology; (3) such other reasonable data and information required by Blue Cross NC to evaluate the New/Expanded Service or New/Expanded Technology. In addition, Blue Cross NC may also need to obtain approval from applicable Agency prior to Blue Cross NC making determination that New/Expanded Service or New/Expanded Technology can be considered a reimbursable service. If Blue Cross NC agrees that the New/Expanded Service or New/ Expanded Technology may be reimbursable under this Agreement, then Blue Cross NC shall notify Provider, and both parties agree to negotiate in good faith, a new Blue Cross NC Rate for the New/Expanded Service or New/Expanded Technology within sixty (60) days of Blue Cross NC's notice to Provider. If the parties are unable to reach an agreement on a new Blue Cross NC Rate for the New/Expanded Service or New/Expanded Technology before the end of the sixty (60) day period, then such New/Expanded Service or New/Expanded Technology shall not be reimbursed by Blue Cross NC, and the Payment in Full and Hold Harmless provision of this Agreement shall apply.

a. "New/Expanded Service" shall be defined as a Health Service: (a) that Provider was not providing to Members as of the Effective Date of this Agreement and; (b) for which there is not a specific Blue Cross NC Rate as set forth in this PCS.

b. "New/Expanded Technology" shall be defined as a technological advancement in the delivery of a Covered Service which results in a material increase to the cost of such service. New/ Expanded Technology shall not include a new device, or implant that merely represents a new model or an improved model of a device or implant used in connection with a service provided by Provider as of the Effective Date of this Agreement.

Non-Priced Codes for Covered Services. Blue Cross NC reserves the right to establish a rate for codes that are not priced in this PCS or in the Fee Schedule(s), including but not limited to, Not Otherwise Classified Codes ("NOC"), Not Otherwise Specified ("NOS"), Miscellaneous, Individual Consideration Codes ("IC"), and By Report ("BR") (collectively "Non-Priced Codes"). Blue Cross NC shall only reimburse Non-Priced Codes for Covered Services in the following situations: (i) the Non-Priced Code does not have a published dollar amount on the then current

applicable Blue Cross NC, State or CMS Fee Schedule, (ii) the Non-Priced Code has a zero dollar amount listed, or (iii) the Non-Priced Code requires manual pricing. In such situations, such Non-Priced Code shall be reimbursed at a rate established by Blue Cross NC for such Covered Service. Notwithstanding the foregoing, Blue Cross NC shall not price Non-Priced Codes that are not Covered Services under the Members Health Benefit Plan. Blue Cross NC may require the submission of medical records, invoices, or other documentation prior to the adjudication of Claims for Non-Priced Codes.

Reimbursement for Blue Cross NC Rate Based on Eligible Charges. Notwithstanding any reimbursement amount set forth herein, Provider shall only be allowed to receive such reimbursement if such reimbursement is for an Eligible Charge. In addition, if Provider reimbursement is under one or more of the following methodologies: Capitation, Case Rate, DRG Rate, Encounter Rate, Global Case Rate, Per Diem Rate, Per Relative Value Unit (RVU), and Per Visit Rate, then individual services billed shall not be reimbursed separately, unless otherwise specified in Article IV of this PCS.

Reimbursement for Subcontractors. Blue Cross NC shall not be liable for any reimbursement in addition to the applicable Blue Cross NC Rate as a result of Provider's use of a subcontractor. Provider shall be solely responsible to pay subcontractors for any Health Services, and shall via written contract, contractually prohibit such subcontractors from billing, collecting or attempting to collect from Blue Cross NC, or Members. Notwithstanding the foregoing, if Blue Cross NC has a direct contract with the subcontractor, the direct contract shall prevail over this Agreement and the subcontractor shall bill Blue Cross NC under the direct contract for any subcontracted services, with the exception of nursing services provided for Home Infusion Therapy, or unless otherwise agreed to by the parties.

Tax Assessment and Penalties. The Blue Cross NC Rates in this Agreement include all sales and use taxes and other taxes on Provider revenue, gross earnings, profits, income and other taxes, charges or assessments of any nature whatsoever (together with any related interest or penalties) now or hereafter imposed against or collectible by Provider with respect to Covered Services, unless otherwise required by Agency pursuant to Regulatory Requirements. Neither Provider nor Blue Cross NC shall add any amount to or deduct any amount from the Blue Cross NC Rates, whether on account of taxes, assessments, tax penalties or tax exemptions.

Updates to Blue Cross NC Rate(s) Based on External Sources. Unless otherwise required by Regulatory Requirements, and notwithstanding any proprietary fee schedule(s)/rate(s)/methodologies, Blue Cross NC shall use commercially reasonable efforts to update the Blue Cross NC Rate(s) based on External Sources, which include but are not limited to, i) CMS Medicare fee schedule(s)/rate(s)/methodologies; ii) Medicaid or State Agency fee schedule(s)/rate(s)/methodologies; iii) vendor fee schedule(s)/rate(s)/methodologies; or iv) any other entity's published fee schedule(s)/rate(s)/methodologies (collectively "External Sources") no later than sixty (60) days after Blue Cross NC's receipt of the final fee schedule(s)/rate(s)/methodologies change from such External Sources, or on the effective date of such final fee schedule(s)/rate(s)/methodologies change, whichever is later. The effective date of such final fee schedule(s)/rate(s)/methodologies change shall be the effective date of the change as published by External Sources. Fee schedule(s)/rate(s)/methodologies will be applied on a prospective basis. Claims processed prior to the implementation of the new Blue Cross NC Rate(s) in Blue Cross NC's payment system shall not be reprocessed, however, if reprocessing is required by Regulatory Requirements, and such reprocessing could result in a potential under and/or over payment to a Provider, then Blue Cross NC may reconcile the Claim adjustments to determine the remaining amount Provider owes Blue Cross NC, or that Blue Cross NC owes to Provider. Any resultant overpayment recoveries (i.e. Provider owes Blue Cross NC) shall occur automatically without advance notification to Provider to the extent permitted under Regulatory Requirements. Unless otherwise required by Regulatory Requirements, Blue Cross NC shall not be responsible for interest payments that may be the result of a late notification by External Sources to Blue Cross NC of fee schedule(s)/rate(s)/methodologies change.

## ARTICLE III
## PROVIDER TYPE

Participating Provider(s) shall be limited to performing those Covered Services for which Participating Provider(s) is credentialed and licensed to perform.

"Acute Care General Hospital" means an institution providing medical, nursing and surgical treatment for sick or injured Members, usually for a short term illness or condition.

"Ambulance Provider (Air AMB)" means air transportation by fixed wing or rotary wing equipped aircraft and used only to transport the sick and injured for the purpose of, or related to, medical treatment. Air AMB shall be licensed and operated according to Regulatory Requirements.

"Ambulance Provider (Ground AMB)" means local ground transportation by a vehicle designed, equipped, and used only to transport the sick and injured for the purpose of, or related to, medical treatment. Ground AMB shall be licensed and operated according to Regulatory Requirements.

"Ambulatory Event Monitoring (AEM)" means services related to event recording with a pre or post memory loop, twenty-four (24) hour attended monitoring, receipt of recorded data and analysis of data. It shall not include holter monitoring, pacemaker checks, medical equipment and/or supplies, ambulatory blood pressure monitoring, or mobile cardiac telemetry or "real time" monitoring.

"Ambulatory Infusion Suite Provider (AIS)" means a health care provider that is a licensed pharmacy which offers intravenous administration of drugs or other substances that require infusion to be administered, subcutaneous treatments or administered injections on an outpatient basis in a licensed ambulatory infusion suite when ordered by a physician or other authorized health care professional.

"Ambulatory Surgical/Surgery Center (ASC)" means a free-standing facility with an organized staff of providers, which has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis and provides treatment by or under the supervision of physicians and nursing services whenever the patient is in the facility.

"Audiologist Provider" means an individual who (a) is licensed as an audiologist and (b) who practices audiology and presents himself/herself to the public by any title or description of services incorporating the words audiologist, hearing clinician, hearing therapist, or any similar title or description of services. For purposes of this PCS, audiology means the application of non-medical and non-surgical principles, methods and procedures of measurement, testing, evaluation, prediction, consultation, counseling, instruction, habilitation, or rehabilitation related to hearing and disorders of hearing for the purpose of evaluating, identifying, preventing, ameliorating, or modifying such disorders and conditions in individuals or groups of individuals.

"Behavioral Health Facility" means a facility that provides psychiatric and/or substance abuse services usually for multiple levels of care with appropriate state licensure and quality accreditation certification. Behavioral health levels of care may include all of the following or a combination thereof – inpatient acute mental health, inpatient acute detoxification, inpatient acute substance abuse rehabilitation, substance abuse residential treatment, psychiatric residential treatment, partial hospital programs (sometimes called day treatment), and intensive outpatient programs.

"Behavioral Health Practitioner" means a licensed or certified mental health and/or substance abuse practitioner, or a group of licensed or supervised practitioners with varying specialties, who work either in an independent private practice, a group setting in one or more locations, or at an appropriately licensed clinic/facility or agency providing behavioral health and/or substance abuse Health Services.

"Cardiology Event Monitoring (CEM)" means the provision and hook-up of equipment to monitor the electrical and mechanical activity of the heart muscle, the monitoring and recording of such activity.

"Chiropractor Provider" means an individual who is licensed as a doctor of chiropractic (DC). For the purposes of this PCS, the practice of chiropractic means the adjustment of the twenty-four (24) movable vertebrae of the spinal column, and assisting nature for the purpose of normalizing the transmission of nerve energy, but does not include the use of surgery, obstetrics, osteopathy or the administration or prescribing of any drugs, medicines, serums or vaccines.

"Community Mental Health Center (CHMC)" means an entity which provides medical and behavioral care staffed by licensed practitioners including but not limited to licensed practitioners and/or licensed or certified mental health and/or substance abuse practitioner, or a group of licensed or supervised practitioners with varying specialties, who work either in an independent private practice, a group setting in one or more locations, or at an appropriately licensed clinic/facility or agency.

"Critical Access Hospital (CAH)" means a hospital certified under a set of CMS Conditions of Participation ("CoP"), which are structured differently than an Acute Care General Hospital by providing essential service in rural communities.

"Custodial Care/Nursing Home" means a nursing home, convalescent home, skilled nursing facility ("SNF"), care home, rest home or intermediate care facility that provides a type of residential care. It is a place of residence for people who require continual nursing care and have significant difficulty performing activities of daily living.

"Developmental Disability Service" means services to treat a severe, lifelong disability that substantially limits the functioning ability in three or more life activities, such as self-care, receptive and expressive language, learning, mobility, self-direction, independent living, and employability.

"Diagnostic Treatment Center" means a medical facility with one or more organized Health Services not part of an inpatient hospital facility or vocational rehabilitation center primarily engaged in providing services and facilities to out-of-hospital or ambulatory patients by or under the supervision of a physician for the prevention, diagnosis and, treatment of human disease, pain, injury, deformity or physical condition.

"Dialysis Facility" means a facility, either freestanding or within a facility, providing outpatient dialysis and other similar therapeutics.

"Federally Qualified Health Center (FQHC)" means an outpatient clinic that qualifies for a reimbursement designation from the Bureau of Primary Health Care and CMS of the United States Department of Health and Human Services.

"Flu Clinics/Immunization Provider" means a provider licensed to administer immunizations at employer group work-sites, promotional health events, local health departments and/or other designated sites.

"Free Standing Birthing Center" means a facility as designated by the applicable Agency, other than a hospital's maternity facilities or a physician's office, which provides a setting for prenatal, labor, delivery, and immediate post-partum care as well as immediate care of new born infants.

"Health Professional Practitioner (Employed)" means any state or nationally licensed or certified health professional such as Nurse Practitioners, Midwives, Registered Nurse Anesthetists, Clinical Nurse Specialists, Physician Assistants, Registered Nurse First Assistant.

"Health Professional Practitioner (Independent)" means any state or nationally licensed or certified health professional such as Nurse Practitioners, Midwives, Registered Nurse Anesthetists, Clinical Nurse Specialists, Physician Assistants, Registered Nurse First Assistant.

"Hearing Aid Supplier (HAS)" means a provider that sells hearing aids to improve hearing acuity in compliance with the Regulatory Requirements governing such sales, if any, of the state in which the hearing aids are sold.

"Home and Community Based Services (HCBS)" means a provider managing long-term care services. Long-term care services include, but are not limited to, assistance doing everyday tasks for older, infirmed or disabled Members who may no longer be able to do these tasks for themselves. These services provide opportunities for Members to receive services in their own home or community rather than institutions or other isolated settings.

"Home Health Agency (HHA)" means a health care provider which provides skilled nursing and other skilled services on a part time, episodic, or intermittent basis in the Member's current residence; and is responsible for supervising the delivery of such services under a Plan of Care. "Plan of Care" means the program written by the Member's attending physician, setting forth the diagnosis and the prescribed Covered Services for the Member, prescribed and approved in writing by the attending physician.

"Home Infusion Therapy Provider (HIT)" means a health care provider that is a licensed pharmacy which offers intravenous administration of drugs or other substances that require infusion to be administered, subcutaneous treatments or administered injections in a home setting when ordered by a physician or other authorized health care professional.

HIT Provider provides a wide range of services required to safely and effectively administer home infusion, nutritional therapies, specialty drugs, and disease state and care management services in a home setting. Typical therapies include but are not limited to, antibiotic therapy, total parenteral nutrition, chemotherapy and pain management. Provider offers supplies and clinical services to a Member who is under the care of a physician, or other healthcare provider. Such supplies and clinical services are provided in an integrated manner under a plan established and periodically reviewed by the ordering physician or other healthcare provider. Routine supplies, as defined by CMS, are included in these services.

"Hospice Services" means Covered Services designed to give supportive care to Members in the final phase of a terminal illness. Services include, but are not limited to, Routine Home Care Day, Continuous Home Care Day, Inpatient Respite Care Day and General Inpatient Care Day.

1. Routine Home Care Day – means Covered Services for a day on which a Member who has elected to receive hospice care at current residence and is not receiving continuous care.

2. Continuous Home Care Day – means Covered Services for a day on which a Member who has elected hospice care is at home and receives hospice care consisting predominately of nursing care on a continuous basis at home. A continuous home care day is only furnished during brief periods of crisis, and only as necessary to maintain the terminally ill patient at home with a minimum of eight (8) hours of care being furnished on a particular day to qualify as a continuous home care day.

3. Inpatient Respite Care Day – means Covered Services for a day on which a Member who has elected Hospice care receives services in an inpatient facility (skilled nursing facility, hospital or inpatient hospice house) on a short-term basis when necessary to relieve family members or others caring for the Member, for respite.

4. General Inpatient Care Day – means Covered Services for a day on which the Member who has elected Hospice care receives inpatient services for pain control or acute or chronic symptom management which cannot be managed in other settings.

"Independent Laboratory (LAB)" means an entity that provides Health Services involving the procurement, transportation, testing (which includes clinical and anatomic/surgical pathology), reporting of specimens and consulting services provided by the LAB. LAB does not include providers of laboratory services rendered in connection with an inpatient service, outpatient surgery, observation room stay and pre-surgery testing.

"Independent Practice Association (IPA)" means a legal entity organized and operated on behalf of individual participating medical professionals for the primary purpose of collectively entering into contracts to provide Health Services to Members.

"Indian Health Services Unit" means a provider who provides comprehensive health services for American Indians and Alaska Natives who are members of federally recognized Tribes across the United States.

"Intellectual Disability Services" means services to treat a disability characterized by significant limitations in both intellectual functioning and in adaptive behavior, which covers many everyday social and practical skills.

"Intermediate Care Facility (ICF)" means a facility for Members with Intellectual Disability which is an optional Medicaid benefit that enables states to provide comprehensive and individualized health care and rehabilitation services to Member to promote their functional status and independence.

"Invitro Fertilization Clinic" shall mean an entity which provides infertility treatment and reproductive services.

"Long Term Services and Support (LTSS)" means a spectrum of health and social services that support Members with disabilities who need help with daily living tasks.

"Medical Equipment" shall mean Durable Medical Equipment, Orthotics, Prosthetics, Respiratory Therapy Equipment and Supplies.

"Durable Medical Equipment (DME)" shall mean items prescribed by a provider which can withstand repeated use; are primarily used to serve a medical purpose; are generally not useful to a person in the absence of illness, injury, or disease; and are appropriate for use for activities of daily living.

"Orthotics" shall mean devices prescribed by a provider that are rigid or semi-rigid which support, restore or protect body function and restrict or eliminate motion of a weak or diseased body part.

"Prosthetics" means appliances prescribed by a provider that replace all or part of a body organ (including contiguous tissue), or replace all or part of the function of a permanently inoperative, absent or malfunctioning body part.

"Respiratory Therapy Equipment" shall mean equipment prescribed by a physician used to introduce dry or moist gases into the lungs to treat illness or injury.

"Supplies" shall mean medical items prescribed by a physician that need replacement on a frequent basis.

"Methadone Treatment Provider" means a provider who offers a comprehensive treatment program which involves the long-term prescribing of methadone as an alternative to the opioid on which the Member was dependent.

Central to methadone treatment is the provision of counseling, case management and other medical and psychosocial services. Provider must have a dispensing unit, counseling offices, examining rooms and an administrative area. In addition to dispensing medication, Provider must also provide counseling and other medical services. At all times during the term of this Agreement, Provider agrees to maintain certification by the Substance Abuse and Mental Health Services Administration (SAMHSA).

"Multispecialty Group Practice" means a group of licensed practitioners with varying specialties who provide Health Services to Members.

To the extent required by Regulatory Requirements or an accrediting body, upon termination without cause, Provider will provide timely, sixty (60) day, notice to affected Member(s) of termination of this Agreement or termination of individual Network participation.

"Multispecialty Physician" means a licensed medical practitioner who: (1) agrees to be primarily responsible for managing and coordinating the overall health care needs of Members (a "PCP") and; (2) has specialized education, training or experience in accordance with the Regulatory Requirements of the state in which Health Services are rendered (a "Specialty Physician/Provider").

To the extent required by Regulatory Requirements or an accrediting body, upon termination without cause, Provider will provide timely, sixty (60) day, notice to affected Member(s) of termination of this Agreement or termination of individual Network participation.

"Nurse Midwives" means an individual who is certified/licensed as a certified nurse midwife to assist women in childbirth or obstetrics.

"Optometrist" means a provider who is licensed in the professional practice of primary eye and vision care that includes the measurement of visual refractive power and the correction of visual defects.

"Oral Surgeon" means a physician specialist expert in the surgical treatment of the jaw, face, teeth and associated structures.

"PCP Group" means one or more licensed medical practitioners who agree to be primarily responsible for managing and coordinating the overall health care needs of Members.

"PCP Group (Non-MD or DO)" means one or more licensed medical practitioners who agree to be primarily responsible for managing and coordinating the overall health care needs of Members.

"PCP Individual" means a licensed medical practitioner who agrees to be primarily responsible for managing and coordinating the overall health care needs of Members.

"PCP Individual (Non-MD or DO)" means a licensed medical practitioner who agrees to be primarily responsible for managing and coordinating the overall health care needs of Members.

"Pharmacist" means a provider licensed as a pharmacist and meeting the requirements to perform immunizations and diabetic education in the state in which they render services.

"Physical Therapy (PT)" means corrective rehabilitation provided by licensed practitioners through the use of physical, chemical and other properties of heat, light, water, electricity, sound, massage and active, passive and resistive exercise.

"Occupational Therapy (OT)" means the development of adaptive skills, increased performance capacity, and those factors that may impede or restrict ability to function provided by licensed practitioners.

"Speech Therapy (ST)" means the evaluation and treatment of disorders that result in impaired or ineffective communication provided by licensed practitioners.

"Physician Hospital Organization (PHO)" means a separate legal entity formed by one or more physicians and one or more hospitals whose objective it is to provide and arrange for Health Services to Members.

"Primary Care Physician" or "Primary Care Provider" ("PCP") means a Participating Provider who (a) is primarily responsible for supervising, managing and coordinating the overall health care needs of Members; (b) is credentialed in accordance with this Agreement; (c) provides Primary Care Services; and (d) practices in the medical specialty

areas of general practice, internal medicine, pediatrics, family medicine, or such other medical specialty areas as are specified to provide Primary Care Services in an applicable Government Contract.

To the extent mandated by Regulatory Requirements, Provider shall ensure that Members have access to twenty-four (24) hour-per-day, seven (7) day-per-week urgent and Emergency Services, as defined in the PCS.

Unless otherwise required under Regulatory Requirements, PCP shall provide Covered Services or make arrangements for the provision of Covered Services to Members on a twenty-four (24) hour per day, seven (7) day a week basis to assure availability, adequacy, and continuity of care to Members. If Provider is unable to provide Covered Services, Provider will arrange for another Participating Provider to cover Provider's patients in accordance with Policies. Provider and any Primary Care Providers employed by or under contract with Provider may arrange for Covered Services to Members to be performed by a Specialty Physician only in accordance with Policies.

Primary Care Services means (a) those Covered Services provided to a Member involving primary medical care, including, but not limited to, the Covered Services specifically identified as primary care services in an applicable Government Contract, and (b) the supervision and coordination of the delivery of these Covered Services to a Member.

"Private Duty Nursing (PDN)" means the provision of medically necessary, complex skilled nursing care in the home by a Registered Nurse (RN) or a Licensed Practical Nurse (LPN).

The purpose of private duty nursing is to assess, monitor and provide skilled nursing care in the home on an hourly basis; to assist in the transition of care from a more acute setting to home; and to teach competent caregivers the assumption of this care when the condition of the Member is stabilized. The length and duration of private duty nursing services is intermittent and temporary in nature and not intended to be provided on a permanent ongoing basis. The private duty nurse cannot be a member of the Member's immediate family or anyone living in the home.

"Psychiatric Medical Institute for Children (PMIC)" means a facility licensed to provide in-patient psychiatric treatment to Members under the age of twenty-one (21).

"Radiology Imaging Center" means a free standing facility which has equipment for diagnostic imaging services such as X-rays, computerized axial tomography ("CAT") scans, and magnetic resonance imaging ("MRI").

"Registered Dietician, Nutritionist" means an individual certified to specialize in the study and regulation of diets.

"Rehabilitation Facility" means a facility which is licensed to provide comprehensive rehabilitation services, including but not limited to, therapy and training for rehabilitation, occupational therapy, physical therapy and speech therapy to Members for the alleviation of disabling effects of illness or intended to achieve the goal of maximizing the self-sufficiency of the Member.

"Residential Treatment Facility (RTF)" means an inpatient psychiatric or substance abuse facility that provides psychiatric, substance abuse and other therapeutic and clinically informed services to Members whose immediate treatment needs require a structured twenty four (24) hour residential setting that provides all required services (including schooling) on site. Services provided include, but are not limited to, multi-disciplinary evaluation, medication management, individual, family and group therapy, parent guidance, substance abuse education/counseling (when indicated) and other support services including on site education (where appropriate), designed to assist the person to achieve success in a less restrictive setting.

"Respite Care" means the temporary care of a dependent elderly, ill, or handicapped person, providing relief for their usual caregivers.

"Rural Health Clinic (RHC)" means a clinic that is located in an area that is designated both by the U.S. Census Bureau as rural and by the Secretary of Health and Human Services as medically underserved. RHCs provide primarily outpatient services that are typically furnished in a physician's office.

"School Based Health Centers" means a model of health care services provided to youth in a convenient and accessible environment consisting of onsite school-based health care delivery by an interdisciplinary team of health professionals, which can include primary care and mental health clinicians.

"Shockwave Therapy Provider (Shockwave Therapy - Lithotripsy)" means a provider which provides extracorporeal shockwave therapy services in a facility setting.

"Skilled Nursing Facility" means a facility which mainly provides inpatient skilled nursing and related services to Members requiring convalescent and rehabilitation care given by or under the supervision of a qualified/certified practitioner as licensed in the state, following a hospitalization, for a limited period.

"Sleep Clinics" means an entity certified for the diagnosis and treatment of sleep disorders.

"Specialty Physician Group" means one or more licensed or certified medical practitioners who have specialized education, training or experience in accordance with the Regulatory Requirements of the state in which Health Services are rendered.

If Provider is furnishing Specialty Physician services under this Agreement, Provider, and the Specialty Physician(s) employed by or under contract with Provider, shall accept as patients all Members and may arrange for Covered Services to Members to be performed by a Specialty Physician only in accordance with Policies.

"Specialty Physician Individual" means a licensed or certified medical practitioner who has specialized education, training or experience in accordance with the Regulatory Requirements of the state in which Health Services are rendered.

If Provider is furnishing Specialty Physician services under this Agreement, Provider, and the Specialty Physician(s) employed by or under contract with Provider, shall accept as patients all Members and may arrange for Covered Services to Members to be performed by a Specialty Physician only in accordance with Policies.

"Specialty Provider Group (Non-MD or DO)" means one or more licensed or certified medical practitioner(s) who has specialized education, training or experience in accordance with the Regulatory Requirements of the state in which Covered Services are rendered.

"Specialty Provider Individual (Non-MD or DO)" means a licensed or certified medical practitioner who has specialized education, training or experience in accordance with the Regulatory Requirements of the state in which Health Services are rendered.

"Flu Clinics/Immunization Services" means a provider licensed to administer immunizations at local health departments in accordance with applicable Regulatory Requirements.

"Subacute Care" means a level of care needed by a Member who does not require hospital acute care, but who requires more intensive skilled nursing care than is provided to the majority of Members in a Skilled Nursing Facility.

"Surgical/Surgery Suite" means a group of rooms, typically attached to a physician's office, which has permanent equipment for the primary purpose of performing surgical procedures on an outpatient basis.

"Urgent Care Center (UCC)" means an entity which provides treatment and diagnosis of conditions that require prompt attention in order to prevent serious deterioration to the Member's health, but would not generally be considered to require treatment in an emergency room.

"Walk-In Doctor's Office" means a physician practice that treats patients without requiring that they be an existing patient or that they have an appointment and that can provide routine care and treatment of common family illnesses for adults and/or children.

"Walk-In Medical Center" means an entity which typically provides both routine medical care and urgent care (non-emergent) services.

## ARTICLE IV
## SPECIFIC REIMBURSEMENT TERMS

### MEDICAID

For purposes of determining the Blue Cross NC Rate, the total reimbursement amount that Provider and Blue Cross NC have agreed upon for the applicable provider type(s) for Covered Services provided under this Agreement shall be one hundred percent (100%) of the Blue Cross NC Medicaid Fee Schedule(s) in effect on the date of service.

The parties acknowledge and agree that the Blue Cross NC Medicaid Fee Schedule(s) are subject to modification by Blue Cross NC at any time during the term of this Agreement and will be applied on a prospective basis.

**Reimbursement Specific to Provider Type**

The following will be reimbursed for facility services only: Acute Care Hospital, ASC, Behavioral Health Facility, Free Standing Birthing Center, Rehabilitation Facility and SNF.

Ambulance Provider Air and/or Ground shall be reimbursed in accordance with Regulatory Requirements for the applicable methodology based on the referenced fee schedule. If such reimbursement is based on an Blue Cross NC Rate, the applicable state methodology on which such fee schedule is based, shall be used to determine the appropriate level of reimbursement.

Hospice reimbursement is inclusive of skilled nursing, home health aide, medical social worker services, dietary, pastoral, bereavement counseling, DME, medical supplies and administration of medication.

Specialty Provider Individual and/or group (Non-MD or DO) shall be reimbursed in accordance with Regulatory Requirements for the applicable methodology based on the referenced fee schedule. If such reimbursement is based on an Blue Cross NC proprietary fee schedule, the applicable state methodology on which such fee schedule is based, shall be used to determine the appropriate level of reimbursement.

"Ambulatory Patient Group" ("APG") means the Blue Cross NC Rate that is a fixed reimbursement to a facility for Outpatient Services and which incorporates data regarding the reason for the visit and patient data.

"Ambulatory Payment Classification" ("APC") or its successor shall have the meaning set forth in the Medicare law and CMS regulations and guidance.

"Blue Cross NC DMEPOS and PEN Fee Schedule" means the applicable Blue Cross NC DMEPOS and PEN Fee Schedule for the market(s) and program(s) covered by the Agreement. The parties acknowledge and agree that the Blue Cross NC DMEPOS and PEN Fee Schedule is subject to modification by Blue Cross NC at any time during the term of the Agreement. Blue Cross NC DMEPOS and PEN Fee Schedule and/or rate changes will be applied on a prospective basis.

"Blue Cross NC Reference Laboratory Fee Schedule" means the Blue Cross NC Rate that is the Blue Cross NC Reference Laboratory Fee Schedule that is based on the Medicare Fee Schedule and may contain additional CPT/HCPCS codes. Blue Cross NC Reference Laboratory Fee Schedule and/or rate changes will be applied on a prospective basis.

"Blue Cross NC Medicaid Fee Schedule(s)/ Rate(s)/ Methodologies" means the proprietary rate that may be based on, but is not limited to, the applicable North Carolina Medicaid Fee Schedule(s)/ Rate(s)/ Methodologies, CMS and/or Medicare Fee Schedule(s)/ Rate(s)/ Methodologies, or the Fee Schedule(s)/ Rate(s)/ Methodologies developed by Blue Cross NC in accordance with industry standards.

"CMS Outpatient Prospective Payment System" ("OPPS") shall have the meaning set forth in Medicare law and CMS regulations and guidance.

"Medical Care Management Rate" means the amount paid by Blue Cross NC to Provider on a per member per month basis for facilitation of collaborative programs meant to manage medical/social/mental health conditions more effectively.

"Medicare Fee Schedule" means the applicable Medicare Fee Schedule for the provider type(s) identified herein, including payment conversion factor, where applicable, and in effect on the date of the service is initiated to Members. Medicare Fee Schedule and/or rate changes will be applied on a prospective basis.

"Medicare LUPA National Base Rate" means the Medicare LUPA ("Low Utilization Payment Adjustment") National Base rate in effect as of the date of service for the market(s) and program(s) covered by the Agreement at the time the Covered Services are initiated to the Member. Medicare LUPA National Base Rate changes will be applied on a prospective basis.

"Medicare Part B Drug Average Sales Price ("ASP") Fee Schedule" means the Medicare Part B Drug Average Sales Price ("ASP") Fee Schedule (or successor) in effect as of the date of service for the market(s) and programs covered

by the Agreement at the time the Covered Services is initiated to the Member. Medicare Part B Drug Average Sales Price ("ASP") Fee Schedule and/or rate changes will be applied on a prospective basis.

"North Carolina Medicaid Rate(s)/Fee Schedule(s)/Methodologies" means the North Carolina Medicaid Rate(s)/Fee Schedule(s)/Methodologies in effect on the date of service for the provider type(s)/service(s) identified herein for the applicable Medicaid Program(s).

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

# Request for Taxpayer Identification Number and Certification

▶ **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

**Give Form to the requester. Do not send to the IRS.**

Print or type. See Specific Instructions on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ _____

**Note:** Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

*(Applies to accounts maintained outside the U.S.)*

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

## Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

**Note:** If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

**Social security number**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | – | | | – | | | | |

**or**

**Employer identification number**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | – | | | | | | | |

## Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

**Certification instructions.** You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

**Sign Here** **Signature of U.S. person** ▶ **Date** ▶

# General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

**Future developments.** For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9*.

## Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

*If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See* What is backup withholding, *later.*