blue of california

Dear Valued Provider,

Thank you for your interest in becoming part of Blue Shield of California's Provider Network. Enclosed, you will find the *Allied & Ancillary Provider Agreement.*

Along with the rest of the market, our customers are demanding more choices at competitive prices. The evolving needs of employer groups and individual members are shaping the way we plan for future business, and your participation is a valued part of the quality we want to offer them.

The enclosed Allied & Ancillary Provider Agreement represents another important step we have taken to stay current with market needs. The agreement is streamlined and it allows providers more flexibility to participate in new types of future networks and products at Blue Shield currently under development. Information for participation appears in section 2.7, and Exhibit B.

Please complete the agreement, including Exhibit A; Exhibit A, Addresses for Notification; and Exhibit A, Attachment 1. Once you have completed it, return the signed, dated agreement to Blue Shield for processing. Please note that any changes made to the language of the contract will not be accepted.

If you have any questions about the enclosed documents, please contact Provider Information & Enrollment at **(800) 258-3091**.

Sincerely,

Provider Information & Enrollment

blue of california

Dear Behavioral Health Clinician:

In addition to contracting directly with behavioral health clinicians, Blue Shield of California contracts with a mental health service administrator (MHSA) to manage behavioral health service needs for approximately 2 million of Blue Shield of California's and Blue Shield of California Life & Health Insurance Company's (Blue Shield's) members. The MHSA provides customer service, utilization management, claims processing and network management for those members whose plans are designated by Blue Shield for MHSA management.

Blue Shield's current MHSA is Human Affairs International of California (HAI-CA), a subsidiary of Magellan Health Services which, nationally, provides services to over 40 million subscribers. As you may know, many panels across California are not actively recruiting behavioral health providers. We highly recommend that you join HAI-CA's behavioral health provider network so you can easily offer continuing care should any of your Blue Shield member patients switch to one of Blue Shield's plans that are managed by the MHSA.

As a credentialed and contracted HAI-CA provider, you would also have the opportunity to receive new referrals for a wide variety of members matched to your areas of clinical expertise. HAI-CA offers competitive fees based on your license level and geography in addition to accurate and timely reimbursement, and its provider website allows you to conduct your administrative transactions with ease. HAI-CA also offers a number of opportunities throughout the year to earn continuing education units at minimal to no cost to you, and you would be eligible for discounts on telephone and computer services offered exclusively to HAI-CA's network providers.

If you are interested in becoming contracted with HAI-CA, please contact HAICA/Magellan's California Network Team at (800) 430-0535, option 4, or email CaliforniaProvider@MagellanHealth.com. Please note that your participation in the HAICA clinician network will not impact your direct participation in the Blue Shield clinician network or your provision of services to Blue Shield members who are not currently managed by HAI-CA.

Sincerely,

Shari Glago Senior Network Manager Specialty
Networks and Vendor Management

blue of california

ALLIED & ANCILLARY PROVIDER AGREEMENT
[FEE FOR SERVICE]

This ALLIED & ANCILLARY PROVIDER AGREEMENT (this **"Agreement"**) is entered into between California Physicians' Service, dba Blue Shield of California, a California nonprofit corporation, (**"Blue Shield"**) and _____ (**"Provider"**), with reference to the following:

RECITALS

A. Blue Shield is licensed as a prepaid health care service plan under the Knox-Keene Act of 1975 and the regulations promulgated thereunder, each as amended (the **"Knox-Keene Act"**). Blue Shield contracts with individuals, associations, employer groups, and governmental entities to provide or to arrange for the provision of covered health care services to Members (as defined herein) enrolled in health maintenance organization (**"HMO"**), point of service (**"POS"**), exclusive provider organization (**"EPO"**) and preferred provider organization (**"PPO"**) benefit plans.

B. Provider is duly licensed in the State of California, or is an entity comprised of individuals who are duly licensed to practice in the State of California.

C. Blue Shield and Provider desire that Provider be included as a participating provider in its provider networks to provide certain Covered Services (as defined herein) to its Members.

NOW, THEREFORE, the parties hereto agree as follows:

I. DEFINITIONS

The terms set forth in this Agreement shall have the meanings described below, except where the context indicates that such meanings are not intended. In the event of any dispute with regard to the definition of any of the terms, reference to the use of any such disputed term in the Knox-Keene Act shall be controlling:

1.1 **Authorization/Authorized**: is the approval of Blue Shield, or its delegate, for the provision of Covered Services obtained in accordance with, and as further described in, the Provider Manual and Section 2.3 of this Agreement.

1.2 **Benefit Program**: is a group or individual Health Maintenance Organization (HMO), including Point-of-Service (POS), Exclusive Provider Organization (EPO), or Preferred Provider Organization (PPO) health care product offered by Blue Shield pursuant to a Health Services Contract (and riders, if any, thereto).

1.3 **Blue Shield Provider Allowances:** is the term used to describe the compensation schedules, as further described in the Provider Manual.

1.4 **Copayment:** is any copayment, deductible, coinsurance and/or amounts in excess of the maximum benefit for which a Member is financially responsible in connection with the receipt of Covered Services, as specifically described in the Health Services Contract and/or Evidence of Coverage applicable to the Member and in effect as of the date of service. Any other amount which Provider may seek to recover from Members for Covered Services constitutes a surcharge and is prohibited by both this Agreement and the Knox-Keene Act.

1.5 **Covered Services:** are Medically Necessary health care services, supplies and drugs that a Member is entitled to receive pursuant to the Health Services Contract and/or Evidence of Coverage applicable to the Member. Except as otherwise provided in the Member's Health Services Contract and Evidence of Coverage, Covered Services must generally be referred and authorized in conformity with Blue Shield's utilization management programs.

1.6 **Emergency Services:** are Covered Services required to address an unexpected medical condition, including a psychiatric emergency medical condition, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: (a) placing the Member's health in serious jeopardy, or in the case of a pregnant woman, the health of the woman or her unborn child; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. For Blue Shield Medicare Members, Emergency Services also include any other services defined as emergency services in Title 42 of the Code of Federal Regulations, Section 422.113.

1.7 **Evidence of Coverage:** is the document issued to the Member pursuant to California law which describes the benefits, limitations and other features of the Benefit Program in which the Member is enrolled.

1.8 **Health Services Contract:** is the group or individual contract that describes the Benefit Program and the Covered Services to which a Member is entitled, as well as the Member's Copayment obligation.

1.9 **Medically Necessary or Medical Necessity**: means, with respect to the provision of medical services, supplies and drugs: (a) required by a Member; (b) provided in accordance with recognized professional medical and surgical practices and standards; (c) appropriate and necessary for the symptoms, diagnosis, or treatment of the Member's medical condition; (d) provided for the diagnosis and direct care and treatment of such medical condition; (e) not furnished primarily for the convenience of the Member, the Member's family, or the treating provider or other provider; (f) furnished at the most appropriate level that can be provided consistent with generally accepted medical standards of care; and (g) consistent with Blue Shield Medical Policy and Blue Shield Medication Policy.

1.10 **Member:** is an individual who is eligible for and enrolled in a Benefit Program to which this Agreement applies (as identified in Exhibit A) or a health benefit plan of an Other Payor (as defined in Section 9.11 hereof).

1.11 **Provider Appeal:** is Provider's written notice to Blue Shield challenging, appealing, or requesting reconsideration of a claim, requesting resolution of billing determinations, such as bundling/unbundling of claims/procedure codes or allowances, or disputing administrative policies & procedures, administrative terminations, retro-active contracting, or any other issue related to the parties' respective obligations under this Agreement.

1.12 **Provider Manual:** is the set of written operating rules, procedures and policies developed by Blue Shield and applicable to Provider and the performance of services hereunder, as from time-to-time amended and updated by Blue Shield in accordance with this Agreement, including, without limitation Blue Shield's Medical Policy and Blue Shield Medication Policy. Subject to Section 7.4 of this Agreement, Blue Shield from time to time may modify or amend the Provider Manual, provided that Blue Shield shall notify Provider no fewer than forty-five (45) working days prior to the effective date of any change to the Provider Manual and shall make reasonable efforts to ensure that such notices are appropriately and conspicuously labeled. To the extent of any conflict between this Agreement and the Provider Manual, the terms of this Agreement shall govern.

II. PROVIDER SERVICES

2.1 **Providing Covered Services.** Provider shall provide to Members those Covered Services which Provider is licensed and qualified to provide. ("Provider Services") Consistent with Section 2240.4 of Title 10 of the California Code of Regulations, Provider's primary consideration shall be the quality of the health care services rendered to Members.

2.2 **Non-Discrimination.** Provider shall provide services to Members in a manner similar to that in which Provider furnishes services to all other Provider patients, and with the same availability afforded to such patients. Provider shall not discriminate against Members on the basis of race, sex, gender, gender identity, gender expression, color, religion, national origin, ancestry, age, marital status, physical or mental handicap, health status, disability, need for medical care, utilization of medical or mental health services or supplies, sexual preference or orientation, veteran's status, health insurance coverage, status as a Member, or other unlawful basis including without limitation, the filing by a Member of any complaint, grievance, or legal action against Provider. In providing services to Members, Provider shall comply with all applicable laws including, without limitation, the Americans with Disabilities Act.

2.3 **Service Authorization.** Provider shall comply with the Authorization procedures and requirements set forth in the Provider Manual and this Section 2.3. Provider understands and agrees that, except in the case of Emergency Services, Medically Necessary post-stabilization care services deemed Authorized pursuant to Section 1300.71.4(b)(2) of Title

28 of the California Code of Regulations, or as otherwise provided in the Provider Manual, Provider Services must be Authorized in advance by Blue Shield or its delegate in order for Provider to be eligible for payment hereunder. Blue Shield will not retroactively deny Provider's claims on the basis of Medical Necessity for services reviewed and Authorized pursuant to the Quality Improvement and Utilization Management Program, provided that Provider submitted full and accurate information to Blue Shield for review under its Quality Improvement and Utilization Management Program. If Provider fails to obtain Authorization prior to providing Provider Services to a Member, as required, or if Provider provides services outside of the scope of the Authorization obtained, then Blue Shield, or its delegate, shall have no obligation to compensate Provider for such services; Provider will be deemed to have waived payment for such services and shall not seek payment from Blue Shield, its delegate, or the Member.

2.4 **Provider Referrals.** Except as permitted by the Member's Evidence of Coverage, Provider shall not refer a Blue Shield Member to other health care providers without an advance authorization from Blue Shield or its delegate or otherwise in accordance with the utilization management procedures established by Blue Shield and as described in the Provider Manual. Without limiting the foregoing, if this Agreement applies to Blue Shield commercial HMO, EPO and/or Medicare Advantage Benefit Programs, Provider shall refer commercial HMO, EPO and/or Medicare Advantage Members only to health care providers who/that have entered into agreements with Blue Shield to provide Covered Services to Members for the provision of Covered Services. This provision shall not apply in the event a Member requires Emergency Services.

2.5 **Ancillary Tests and Procedures.** Except as otherwise set forth in the Provider Manual, any ancillary testing and/or procedures (e.g., radiologic, laboratory, etc.) required in the treatment of Blue Shield Members shall be performed by Provider unless (a) Provider does not have the facilities or capacity to perform a particular test or procedure, or (b) it is Medically Necessary to have the test or procedure performed by persons other than Provider. Provider shall, as set forth in the Provider Manual, obtain authorization from Blue Shield prior to performing such ancillary test or procedures.

2.6 **Language Assistance Program.** Provider shall cooperate and comply with Blue Shield's language assistance program, as set forth in the Provider Manual. Nothing in this Section shall be construed as a delegation to Provider of Blue Shield's obligations pursuant to Section 1300.67.04 of Title 28 of the California Code of Regulations or Section 2538.3 of Title 10 of the California Code of Regulation.

2.7 **Tiered Benefit Designs and Narrow Networks.**

(a) Provider acknowledges and agrees that nothing in this Agreement shall limit or otherwise prohibit Blue Shield from:

(i) at any time developing, marketing and implementing: (A) tiered products,

plans, benefit designs or Benefit Programs; (B) provider networks which tier or rank participating providers (including Provider) and where such tier or rank directly affects the Member's and/or employer's premium, copayment or cost share or restricts or limits network access; and/or (C) narrow, restricted or limited provider networks or products that require Members (or those who pay for their coverage) to pay more for the same (or substantially similar) product or benefit design to access all Blue Shield contracted providers compared to a network that does not include Provider (collectively, **"Tiered/Narrow Products"**); and

(ii) except as expressly provided in Exhibit A hereto, including Provider in or excluding Provider from, or tiering or ranking Provider within, any such Tiered/Narrow Product.

(b) Prior to excluding Provider from, or tiering or ranking Provider within, any Tiered/Narrow Product, Blue Shield shall provide written notice to Provider, reasonably prior to implementing or modifying the Tiered/Narrow Product, that explains in detail how the Tiered/Narrow Product will work and Provider's status within the Tiered/Narrow Product.

2.8 **Members' Rights and Responsibilities.** Blue Shield does not delegate or sub-delegate member rights and responsibilities. For additional details and a full listing of these rights and responsibilities, please refer to the Provider Manual.

III. COMPENSATION

3.1 **Compensation.** In exchange for the provision of Covered Services to Members Blue Shield shall pay Provider the lesser of (i) the applicable reimbursement rates set forth in Exhibit B hereto, or (ii) Provider's billed charges, in either case, less the Member's applicable Copayment.

3.2 **Payment of Claims.** Blue Shield shall pay all valid and complete claims from Provider for Covered Services upon receipt, in accordance with the timeframes set forth in California law and in accordance with the Blue Shield claims adjudication rules and procedures as set forth in the Provider Manual. Provider shall accept electronic payment for Covered Services and receive related explanations of payments (**"EOPs"**) via electronic funds transfer (**"EFT"**) and electronic remittance advice (**"ERA"**), respectively. Blue Shield shall give Provider no fewer than forty-five (45) working days' prior notice of any proposed changes in the Blue Shield Provider Allowances (as described in the Provider Manual) other than those affecting reimbursement for drugs and immunizations and shall make reasonable efforts to ensure that such notices are appropriately and conspicuously labeled. Changes to the Blue Shield Provider Allowances affecting reimbursement for drugs and immunizations shall be made on the first day of each calendar quarter, as described in the Provider Manual

and shall be posted on Blue Shield's website at https://www.blueshieldca.com/provider/. Provider shall bill Blue Shield in accordance with the procedures as set forth in the Provider Manual and as described on Blue Shield's website at https://www.blueshieldca.com/provider/. All claims payments by Blue Shield will be accompanied by a remittance advice which describes the manner in which the claim was adjudicated and payment was issued. In the event a claim or any portion thereof is denied payment by Blue Shield, Provider will receive an appropriate communication from Blue Shield which describes the basis for the denial and contains all appropriate information as may be required by applicable state and federal law.

3.3 **Timely Submission of Claims.** Provider shall submit complete claims to Blue Shield for Covered Services furnished to Members no later than twelve (12) months from the date such Covered Services were furnished by Provider or, if Blue Shield is not the primary payor under the coordination of benefits rules described in Section 3.6 hereof, the date payment or denial is received by Provider from the primary payor. If Provider fails to submit a claim for Covered Services within the time-frames set forth in this Section, Blue Shield may deny payment of the claim. In such event, Provider waives its right to any remedies and to pursue the claim further, and may not initiate a demand for arbitration or other legal action against Blue Shield or pursue the Member for additional payment; provided, however, that Blue Shield shall, upon submission of a Provider Appeal by Provider, consider good cause for late submission of a claim denied as untimely.

3.4 **Claims Submission.** Provider shall submit claims electronically, following the procedures set forth in the Provider Manual. Payment by Blue Shield will be made only upon receipt of a complete claim submitted by Provider in accordance with this Agreement. Failure to submit claims electronically in accordance with the Provider Manual shall be deemed a material breach of the Agreement.

3.5 **Charges to Members.**

(a) In no event, including without limitation nonpayment by Blue Shield, or Blue Shield's insolvency or breach of this Agreement, shall Provider bill, charge, collect a deposit from, impose a surcharge on, seek compensation, remuneration or reimbursement from, or have any recourse against, a Member, or any individual responsible for such Member's care, for Covered Services. Without limiting the foregoing, Provider shall not seek payment from a Member, or any individual responsible for such Member's care, for Covered Services for which payment was denied by Blue Shield because the bill or claim for such Covered Services was not timely or properly submitted. If Blue Shield receives notice of a violation of this Section, it shall have the right to take all appropriate action, including without limitation, the right, following thirty (30) days written notice to Provider, to reimburse the Member for the amount of any payment made and to offset the amount of such payment from any amounts then or thereafter owed by Blue Shield to Provider.

(b) Provider shall not bill or collect from a Member any charges in connection with non-Covered Services, non-authorized services, or services determined not to be Medically Necessary unless Provider has first obtained a written acknowledgment from the Member, or the individual responsible for such Member's care, that such services are either not Covered Services, not authorized, or not Medically Necessary, as the case may be, and that the Member, or the individual responsible for such Member's care, is financially responsible for the cost of such services. Such acknowledgment shall be obtained prior to the time that such services are furnished to the Member and shall satisfy the applicable requirements set forth in the Provider Manual. Notwithstanding the foregoing, if, due to specific circumstances, Provider is not reasonably able to obtain such acknowledgment prior to the time the services are rendered, Provider shall be permitted to seek payment from the Member for such non-Covered Services.

(c) In the event of Blue Shield's insolvency or other cessation of operations, Provider shall continue to provide Covered Services to Members through the period for which such Members' premiums have been paid, or, with respect to Members enrolled in Blue Shield's Medicare Advantage Benefit Program, the duration of the contract period for which the Centers for Medicare and Medicaid Services (**"CMS"**) payments have been made, and, with respect to any Member who is confined in an inpatient facility on the date of insolvency or other cessation of operations, until the Member's discharge.

(d) The provisions of this Section 3.5 shall: (i) survive the expiration or termination for any reason of this Agreement; (ii) be construed to be for the benefit of Members; and, (iii) supersede any oral or written contrary agreement (now existing or hereafter entered into) between Provider and any Member.

3.6 **Coordination of Benefits & Third Party Recoveries.** Provider agrees that coordination of benefits will be conducted in accordance with established California law and the provisions of the Member's Evidence of Coverage. If another payor, including Medicare, is primary, in no event will application of the coordination of benefits rules result in a combined payment to Provider which is lower than the amount that would have been paid to Provider under this Agreement in the absence of the other payor. If Medicare is primary and the Medicare allowance for a Covered Service exceeds the Blue Shield Provider Allowance, payment by Blue Shield will be based on the higher Medicare allowance. In the event a Member seeks and obtains a recovery from a third party or a third party's insurer for injuries caused to that Member, Provider shall have no right to assert or pursue a third party lien for any Covered Services provided to that Member.

3.7 **Provider Contracts with Groups or IPAs.** If Provider is a party to an agreement with a medical group or independent provider organization (**"IPA"**) under which Provider agrees to provide services to enrollees of health maintenance organizations, including Members of Blue Shield, then Provider agrees that such agreement shall apply to Services rendered to Members

of Blue Shield to which such agreement applies. This Agreement shall not apply to Covered Services rendered to any such Members unless a judicial or regulatory interpretation of existing statutes reaches, or enacted legislation results in, a contrary conclusion.

3.8 **Copayments**. Provider shall collect and retain a Member's applicable Copayment for Covered Services provided pursuant to this Agreement. Provider shall not waive a Member's Copayment obligation. Notwithstanding the foregoing, Provider acknowledges that cost sharing for Members eligible for both Medicare and Medicaid/Medi-Cal (**"Dual Eligible Members"**) is limited to the cost sharing limits established by Medicaid/Medi-Cal. With respect to Covered Services provided to Dual Eligible Members, Provider shall accept payment by Blue Shield as payment-in-full for such Covered Services, or will separately bill the appropriate State source for any amounts above the Medicaid/Medi-Cal cost sharing limits.

3.9 **Payments to Subcontractors.** If Provider subcontracts with any individual or entity to provide Covered Services on behalf of Provider, Provider shall process claims from and pay such individual or entity for such Covered Services in compliance with the timeliness requirements set forth in applicable state and federal law.

3.10 **BlueCard Claims**.

(a) If and for so long as Provider is not contracted with another licensee of the Association (as defined in Section 9.13) in the State of California, Provider shall submit to Blue Shield for processing all claims for medical services (including, without limitation, Provider Services) furnished by Provider and reimbursable through the BlueCard Program.

(b) Nothing in Section 3.10(a) shall be construed to require Provider to submit to Blue Shield for processing claims for Provider Services furnished to a Member enrolled in a benefit plan having an exclusive arrangement with another licensee of the Association in the State of California, it being expressly understood that claims for Provider Services furnished to a Member enrolled in a benefit plan having an exclusive arrangement with a particular licensee of the Association in the State of California should be sent to and processed by such licensee.

3.11 **Directory Information Validation.** At least semi-annually, Blue Shield shall send Provider a notice in accordance with Health and Safety Code Section 1367.27(l) to validate Provider information in order to maintain the directory of Blue Shield Providers described in Section 9.8 of this Agreement. If, after following the process described in the Provider Manual, Blue Shield has not received a response from Provider, Blue Shield may delay payment or reimbursement in accordance with 1367.27 of the California Health & Safety Code.

IV. REPRESENTATIONS AND WARRANTIES OF PROVIDER

4.1 **Licenses & Insurance.** At all times during the term of this Agreement, Provider shall, and if Provider is comprised of a group of licensed providers, each such licensed provider shall:

(a) be licensed under the laws of the State of California to provide the services described in Exhibit A, and such license shall be free of any restrictions or limitations;

(b) be in compliance with all applicable local, state and federal laws relating to the provision of services hereunder, and furnish such services in accordance with all applicable licensing requirements and all local standards of professional ethics and practice;

(c) maintain in effect such policies of general and professional liability insurance and other insurance as shall be necessary and appropriate to insure him/her/it and his/her/its employees against any claims or claims for damages arising by reason of or indirectly in connection with the provision of Covered Services pursuant to this Agreement; provided that such insurance shall have limits of not less than One Million Dollars ($1,000,000) per each occurrence and not less than Three Million Dollars ($3,000,000) in the aggregate per calendar year; and

(d) provide evidence to Blue Shield of compliance with the forgoing requirements set forth in this Section 4.1.

4.2 **Authority to Bind Group.** If Provider is comprised of a group of licensed providers, then the signatory hereto warrants that he/she has the authority to bind each of the providers included in the Providers' roster, as from time to time modified in accordance with Section 4.4(a). Moreover, Provider agrees that the provisions of this Agreement bind all officers, members or employees of Provider who are similarly licensed, including all such providers affiliating with Provider subsequent to the date of this Agreement.

4.3 **Qualification of Group Providers.** If Provider is comprised of a group of licensed providers, all such licensed providers shall at all times while providing Covered Services hereunder: (a) satisfy Blue Shield's credentialing requirements, and (b) comply with the requirements of this Agreement, and (c) accept, as payment in full for the provision of Covered Services to Members, the reimbursement rates set forth herein.

4.4 **Disclosures.**

(a) Provider shall promptly notify Blue Shield of any changes in Provider's status, including, without limitation whenever a licensee becomes affiliated with or ceases to be affiliated with Provider or upon any change to the Medical Staff affiliation(s) as included in the Providers' roster, in accordance with and as required by the Provider Manual.

(b) Provider shall notify Blue Shield immediately in writing of the occurrence of any of

the following events: (i) Provider or any licensee affiliated with Provider no longer meets any of the Blue Shield credentialing criteria set forth in the Provider Manual; (ii) Provider or any licensee affiliated with Provider is excluded or suspended from participation in, ceases to be certified by, or is sanctioned by any state or federal healthcare program, including, without limitation, Medicare or Medi-Cal; (iii) Provider's liability insurance (or that of any licensee affiliated with Provider) is canceled, terminated, not renewed, or materially modified; (iv) a petition is filed to declare Provider bankrupt or for reorganization under the bankruptcy laws of the United States or a receiver is appointed over all or any portion of Provider's assets; or (vi) any act of nature or other event or circumstance which has, or reasonably could be expected to have, a material adverse effect on Provider's ability to perform its obligations under this Agreement.

(c) Provider shall notify Blue Shield within five (5) business days of Provider or any licensee affiliated with Provider opening or closing his/her practice to new Members.

4.5 **Compliance with Administrative Requirements.** Provider shall comply with the policies and administrative procedures of Blue Shield set forth in the Provider Manual, the terms of which are incorporated by reference herein, including, without limitation, those relating to the administration of Blue Shield's Medicare program(s), as applicable. Failure to comply with such policies and administrative procedures shall be grounds for termination for cause following notice and failure to cure as set forth in Section 7.2 hereof.

4.6 **Compliance With State and Federal Law.** Provider will comply with applicable state and federal laws and regulations. If this Agreement applies to Medicare Members, provider acknowledges that payments made by Blue Shield are, in whole or in part, derived from federal funds. Provider agrees to comply with all applicable Medicare laws, regulations and CMS instructions including Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and to require his/her/its subcontractors to do the same.

4.7 **Provider Statements.** Provider shall be responsible for all statements made on any claim or supporting documentation submitted to Blue Shield. Provider shall be responsible for reimbursement of all overpayments resulting from such misreporting or duplicate claims submission consistent with the requirements set forth in Section 1300.71(b)(5) of Title 28 of the California Code of Regulations.

V. MAINTENANCE AND INSPECTION OF RECORDS

5.1 **Records.**

(a) Provider shall maintain the usual and customary records for Members in the same manner as for other patients of Provider and in accordance with good professional standards.

(b) Provider shall comply with all applicable state and federal laws regarding privacy and confidentiality of medical information and records, including, without limitation, mental health records. Provider shall develop policies and procedures to ensure that Member medical records are not disclosed in violation of California Civil Code Section 56, et seq. or any other applicable state or federal law. To the extent Provider receives, maintains or transmits medical or personal information of Members electronically, Provider shall comply with all state and federal laws relating to the protection of such information including, without limitation, the Health Insurance Portability and Accountability Act (**"HIPAA"**) provisions on security and confidentiality and any CMS regulations or directives relating to Medicare beneficiaries.

(c) Provider shall ensure that Members have access to their medical records in accordance with the requirements of state and federal law.

(d) Provider shall comply with all provisions of the Omnibus Reconciliation Act of 1980 regarding access to books, documents, and records. Without limiting the foregoing, Provider shall maintain such records and provide such information to Blue Shield and to the California Department of Managed Health Care (DMHC) (or any successor agency), the Department of Health and Human Services (DHHS), CMS, any Quality Improvement Organization ("QIO") with which CMS contracts, the U.S. Comptroller General, their designees and any other governmental officials entitled to such access by law (collectively, **"Governmental Officials"**), as required by law and as may be necessary for compliance by Blue Shield with the provisions of all state and federal laws governing Blue Shield. Provider shall grant to Blue Shield and/or Government Officials, upon request and within a reasonable amount of time, access to and copies of, the medical records, books, charts, papers, and computer or other electronic systems relating to the Provider's provision of health care services to Members, the cost of such services, and payment received by the Provider from the Member (or from others on Member's behalf). Such records described herein shall be maintained at least six (6) years from the date of service, and, if this Agreement is applicable to Blue Shield Medicare Benefit Programs, ten (10) years from the end of the final contract period between Blue Shield and CMS or the completion of any audit of Blue Shield or its contractors by DHHS, the General Accounting Office or their designees (or for a particular record or group of records, a longer time period when CMS or DMHC requests such longer record retention and Provider is notified of such request by Blue Shield), and in no event for a shorter period than as may be required by the Knox-Keene Act. All books, documents, and records of Provider shall be maintained in accordance with the general standards applicable to such book, document or record keeping and shall be maintained during any audit or investigation by Government Officials.

5.2 **Site Evaluations.** Provider shall permit Government Officials and Blue Shield to conduct periodic site evaluations, inspections, and onsite audits of their facilities. Blue Shield shall

provide Provider five (5) business days' advance notice (or fewer if mutually agreed upon by the parties) of any proposed site evaluation or inspection by Blue Shield. If Government Officials or Blue Shield finds any deficiencies in such facilities, Provider shall have thirty (30) days to correct such deficiencies which are identified by such Government Official or Blue Shield, unless the Government Official requires that such deficiency be corrected within a shorter timeframe.

5.3 **Accreditation Surveys.** Provider shall cooperate in the manner described in Sections 5.1 and 5.2 hereof with respect to surveys and site evaluations relating to accreditation of Blue Shield by NCQA or any other accrediting organization. Further, Provider agrees to implement any changes reasonably required as a result of all such surveys. Provider shall fully cooperate with Blue Shield with regard to the Healthcare Effectiveness Data and Information Set (HEDIS) measurements and HEDIS audits, guideline development, preventive services utilization, disease/risk management, clinical service monitoring and quality improvement studies and initiatives.

5.4 **Performance/Compliance Monitoring.** Provider shall cooperate with Blue Shield in the performance of any monitoring, studies, evaluations, analyses or surveys required by Government Officials, accrediting organizations, or the Association (as defined in 9.13) of Provider's performance of services hereunder. Provider shall receive reasonable advance notice of any proposed monitoring, studies, evaluations, analyses or surveys by Blue Shield. Nothing in this Agreement shall prohibit Blue Shield from using, releasing, and/or publishing Provider performance data.

5.5 **Quality Assurance Programs.** Provider agrees to participate in any and all quality improvement and utilization management programs implemented by Blue Shield as more fully described in the Provider Manual. Moreover, Provider agrees to participate in Blue Shield's provider credentialing and recredentialing programs. If Provider concludes that care recommended or authorized through the utilization management program is medically inappropriate for the Member, Provider may access the expedited appeal process as described in the Provider Manual. Provider may also furnish that care which Provider, in the exercise of good medical judgment, believes is medically appropriate and may appeal any coverage denial by Blue Shield in accordance with the provisions of Article VIII hereof.

5.6 **Onsite Audits.** Provider shall permit Government Officials and Blue Shield to conduct periodic onsite audits of their records. Blue Shield shall provide Provider five (5) business days' advance notice (or fewer if mutually agreed upon by the parties) of any proposed onsite audit by Blue Shield. Audits will be performed on-site or otherwise and may involve statistically valid sampling techniques of Provider that are deemed necessary to include, but not limited to, medical practice audits, medical necessity reviews, data validation reviews, billing and claims payment audits, coding audits and quality improvement audits. Further, provider agrees to participate in any corrective action plan required by Blue Shield. Based on such review, Blue Shield may deny payment, reject claims, and/or review claims on a retrospective basis and recover any overpayments, consistent with the requirements set forth

in Section 1300.71(b)(5) of Title 28 of the California Code of Regulations. Provider may not bill for services rendered by a practitioner if such services are subject to billing independently by practitioner, another provider, and/or another entity subject to another agreement or arrangement with Blue Shield.

VI. INDEPENDENT RELATIONSHIP

6.1 **Independent Parties**. None of the provisions of this Agreement are intended to create, nor shall they be deemed or construed to create, any relationship between Blue Shield and Provider other than that of independent entities contracting with each other hereunder solely for the purpose of effecting the provisions of this Agreement. Neither of the parties hereto, nor any of their respective employees, shall be construed to be the agent, employer, employee or representative of the other. Each party is solely responsible for its own acts or omissions to act.

VII. TERM & TERMINATION

7.1 **Term.** This Agreement shall be effective as of the date of execution by Blue Shield and shall remain in effect for one (1) year. Thereafter, this Agreement will automatically renew for successive one (1) year terms, unless and until terminated or modified in accordance with the terms set forth herein. Subject to Section 7.7 hereof, either party may terminate this Agreement without cause by giving the other party at least one hundred twenty (120) days' prior written notice of termination. Any termination pursuant to this Section 7.1 shall become effective the first day of the calendar month following the expiration of the notice period. Termination shall have no effect upon the rights and obligations of the parties arising out of any transactions occurring prior to the effective date of such termination.

7.2 **Termination for Cause.** Subject to Section 7.7 hereof, Blue Shield may terminate this Agreement for cause if Provider fails to continuously satisfy Blue Shield's provider credentialing criteria as set forth in the Provider Manual, following notice of deficiency and failure to cure as set forth herein. Provider will be given written notice of any such termination, which shall occur in accordance with the requirements of California law. Either party may terminate this Agreement for cause due to breach by the other party of any material provision of this Agreement, provided that: (a) the non-breaching party has given the breaching party thirty (30) days' prior written notice which specifies the nature of the breach, and (b) the breaching party has failed to cure the breach within such thirty (30)-day period. Blue Shield may also terminate this Agreement if Provider engages in any of the following activities, and following notice of breach as set forth in this Section, fails to correct such conduct:

(a) Fraudulent billing, or, following written notice to and education of Provider, repeated billing in violation of Blue Shield's claims billing policies or procedures, as described in the Provider Manual.

(b) Failure or refusal to comply with Blue Shield's administrative compliance program, as described in the Provider Manual.

(c) Failure or refusal to comply with Blue Shield Quality Assurance programs, as outlined in the Provider Manual, including, without limitation, repeated failure to provide Medically Necessary services (including significant over- and under-utilization) following peer review and notification of such deficiencies.

(d) A pattern or repeated failure to alert Blue Shield to a change in the information required to be in the directory of Blue Shield Providers pursuant to Health & Safety Code Section 1367.27.

7.3 **Immediate Termination.** Subject to Section 7.7 hereof, Blue Shield may immediately terminate this Agreement if (a) Provider is suspended, excluded or barred from participation in Medicare, (b) Provider fails to maintain all insurance required herein, (c) Blue Shield, after consultation with Provider, determines in good faith that continuation of this Agreement may reasonably be expected to jeopardize the health, safety, or welfare of Members, or (d) Blue Shield reasonably determines, after consulting with Provider, that Provider is likely to be financially unable to provide, in a competent and timely manner, Covered Services. If Provider voluntarily ceases participating in the Medicare program and this Agreement applies to any Medicare Benefit Programs, then Provider's participation in the Medicare Benefit Program(s) may be immediately terminated by Blue Shield. The termination of Provider's participation in any Medicare Benefit Program pursuant to this Section shall not be effective as to, and shall have no force or effect upon, the rights, duties and obligations of the parties under the Agreement relating to any other Benefit Programs to which the Agreement applies. Provider may immediately terminate this Agreement if Blue Shield ceases to be licensed as a health care service plan, or is suspended, excluded or barred from participation in Medicare.

7.4 **Termination by Provider Upon Certain Events.** If Provider objects to any changes in the Provider Manual and/or to the Blue Shield Provider Allowances (as described in the Provider Manual), about which Provider receives notice pursuant to Sections 1.12 and/or 3.2 hereof, Provider may, within sixty (60) days of receipt of such notice, terminate this Agreement upon sixty (60) days' prior written notice to Blue Shield, in which case the proposed changes shall not apply during the termination notice period.

7.5 **Termination of Individual Physician in Group.** If Provider is a group of licensed providers and grounds for termination of any individual provider arise pursuant to Sections 7.2 or 7.3 hereof, then Blue Shield may, at its sole election, elect to terminate only the participation of such individual provider under this Agreement rather than the entire Agreement.

7.6 **Effect of Termination.** As of the date of termination, this Agreement shall be considered of no further force or effect whatsoever, and each of the parties shall be relieved and discharged herefrom, except that:

(a) Termination shall not affect any rights or obligations hereunder which have previously accrued, or shall hereafter arise with respect to any occurrence prior to termination, and such rights and obligations shall continue to be governed by the terms of this Agreement.

(b) In the event of termination of this Agreement, Provider shall comply with all applicable requirements of the Knox-Keene Act, including without limitation those set forth in Cal. Health & Safety Code Section 1373.65.

(c) Following termination, Provider agrees to continue rendering Covered Services to Members who qualify for completion of Covered Services under Health & Safety Code Section 1373.96(c), as determined by Blue Shield in accordance with the provisions therein, at the rates set forth herein.

(d) For Members who retain eligibility under the plan contract through which they are enrolled and who are receiving Covered Services from Provider at the time of termination, Provider shall continue to provide Covered Services until such Covered Services are completed or until Blue Shield makes reasonable and medically appropriate provision for the assumption of such Covered Services by another provider. Provider shall be compensated for such Covered Services in accordance with the provisions of this Agreement. Blue Shield shall make reasonable efforts to timely notify such Members that Provider is no longer a contracting provider and, for Members in HMO plans, shall make reasonable and timely efforts to effectuate the assumption of Covered Services by another provider.

(e) Notwithstanding the above, if the Agreement is terminated by Provider due to nonpayment by Blue Shield of amounts due under this Agreement, Provider shall not be limited to compensation under the terms of this Agreement, except to the extent that Health & Safety Code Section 1373.96(c) requires that Blue Shield permit the Member to continue to receive services from Provider.

(f) The following Sections of this Agreement shall survive the termination of this Agreement, whether such termination is the result of rescission or otherwise: Sections 3.1, 3.2, 3.3, 3.4, 3.5, 5.1, 7.6, 8.1, 8.2, and 9.11.

(g) All written, printed, or electronic communications to Members concerning the termination of this Agreement shall comply with Health & Safety Code Section 1373.65(f).

7.7 **Provider Rights on Termination.** In the event of termination of this Agreement by Blue Shield pursuant to Sections 7.1, 7.2 or 7.3 hereof, Provider shall be entitled to those due process procedures which are required of Blue Shield by State or Federal law.

VIII. RESOLUTION OF DISPUTES

8.1 **Provider Appeal Resolution Process.**

(a) Blue Shield's Provider Appeal resolution process (**"Appeal Process"**) shall comply with Sections 1367(h), 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4, and 1371.8 of the Health & Safety Code and Sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of Title 28 of the Cal. Code of Regulations. It shall be described in the Provider Manual and on the provider portal of Blue Shield's website at www.blueshieldca.com.

(b) The Appeal Process shall apply to any and all disputes arising under the Agreement. This provision does not in any way modify the provisions of Section 8.2 hereof relating to arbitration of disputes which cannot be resolved through the Appeal Process. However, if Provider fails to submit a Provider Appeal to either level of the Appeal Process within the timeframes set forth below, Provider shall be deemed to have waived his/her/its right to any remedies and to pursue the matter further. Without limiting the foregoing, in such instance, Provider may neither initiate a demand for arbitration pursuant to Section 8.2 of this Agreement nor pursue additional payment from the Member.

(c) Blue Shield's Provider Appeal Resolution Process consists of two levels:

(i) *Initial Appeals Process.* Provider Appeals initially must be submitted by Provider, in writing, within three hundred sixty-five (365) days of Blue Shield's determination, lack of action or alleged breach, to the address for Initial Provider Appeals provided on the provider portal of Blue Shield's website at www.blueshieldca.com.

(ii) *Final Appeal Process.* Any Provider Appeal that is not resolved to Provider's satisfaction during the Initial Appeal Process must be submitted to the Final Appeal Process. All Provider Appeals must be submitted to the Final Appeal Process by Provider, in writing, within ninety (90) days of Blue Shield's Initial Provider Appeal determination, to the address for such Provider Appeals provided on the provider portal of Blue Shield's website at www.blueshieldca.com.

(d) Each Provider Appeal must contain the following information:

- The provider's name
- The provider's identification number – The Blue Shield provider identification number (PIN), Provider's tax or social security number, or National Provider Identifier (NPI)
- Provider's mailing address and phone number

- Blue Shield's Internal Control Number (ICN), when applicable
- The patient's name, when applicable
- The patient's Blue Shield subscriber number, when applicable
- The date of service, when applicable
- A clear explanation of the issue the provider believes to be incorrect, including supporting medical records when applicable.

As applicable, Bundled Appeals must identify individually each item by using either the ICN or the section of the contract and sequential numbers that are cross-referenced to a document or spreadsheet.

8.2 **Arbitration of Disputes.** If any dispute, controversy, or misunderstanding (other than a claim of medical malpractice or any other dispute with a Member) arises between the parties to this Agreement which exceeds the jurisdiction of Small Claims Court, which was not resolved in the Provider Appeal Resolution Process set forth in Section 8.1, and which may directly or indirectly concern or involve any term, covenant, or condition hereof, the parties shall settle the dispute by final and binding arbitration in San Francisco, Los Angeles, San Diego or Sacramento, California, whichever city is closest to Provider. Arbitration shall be conducted under the Commercial Rules of the American Arbitration Association. The arbitrator shall be a retired judge of the State of California, unless otherwise agreed to by the parties. The arbitration decision shall be binding on both parties. It is agreed that the arbitrator shall be bound by applicable state and federal law and that the arbitrator shall issue written findings of fact and conclusions of law. The arbitrator shall have no authority to conduct or issue a decision with respect to any class arbitration or other claim brought by Provider on behalf of the general public under a statute or regulation that allows an individual to sue on behalf of the Attorney General or other federal, state or municipal actor, or in any other representative capacity. The arbitrator shall have no authority to award damages or provide a remedy which would not be available to such prevailing party in a court of law, nor shall the arbitrator have the authority to award punitive damages. The cost of the arbitration shall be shared equally by Provider and Plan. Each party shall be responsible for its own attorneys' fees.

8.3 **Cooperation With Member Disputes.** Provider shall cooperate in the Member grievance and appeals process as described in the Provider Manual.

IX. GENERAL PROVISIONS

9.1 **Consistency with State & Federal Law.** This Agreement is subject to the requirements of the Knox Keene Act and Title 28 of the California Code of Regulations. Any provision required to be in this Agreement by either of the above Codes shall bind Blue Shield and Provider, whether or not provided in this Agreement. With respect to Covered Services provided to Members enrolled in a Blue Shield Medicare Benefit Program, Provider shall comply with the applicable statutes, regulations, and CMS instructions. In addition, all such Covered Services shall be performed in a manner consistent and otherwise in compliance with

Blue Shield's Agreement with CMS. Provider shall also comply with all applicable provisions of the Patient Protection and Affordable Care Act and regulations promulgated thereunder and all such Covered Services shall be performed in a manner consistent and otherwise in compliance with Blue Shield's agreement with Covered California.

9.2 **Preemption by Federal Law.** To the extent any of the requirements of the Knox-Keene Act as stated herein is preempted by federal law applicable to the Medicare program, no such requirements shall apply with respect to Blue Shield's Medicare Benefit Programs.

9.3 **Precedence.** In the event of any conflict or inconsistency between this Agreement, the Provider Manual and/or any of the cited state or federal laws and regulations, the provision which governs shall be determined by applying the following order of precedence: the Balance Budget Act (BBA), CMS regulations and instructions, the Knox-Keene Act and regulations, the Agreement and the Provider Manual.

9.4 **Disclosure of Information.** Blue Shield shall make available to Provider, upon contracting and upon written request as well as on-line, such information as is required by the regulations of Title 28 Cal. Code of Regulations Sections 1300.71(l) and (o), Blue Shield shall make the information available in the Provider Manual and on the provider portal of Blue Shield's website at www.blueshieldca.com.

9.5 **Amendments.** Except as provided in Section 1.12, Section 3.2, Section 4.4(a), and this Section 9.5, this Agreement may be amended only by mutual, written consent of Blue Shield and Provider. Notwithstanding the foregoing, or if Blue Shield's legal counsel determines in good faith that this Agreement must be modified to be in compliance with applicable federal or state law or to meet the requirements of accreditation organizations which accredit Blue Shield and its providers, Blue Shield may amend this Agreement by delivering to Provider a written amendment to this Agreement incorporating the required modifications (the **"Legally Required Amendment"**), along with an explanation of why such Legally Required Amendment is necessary. If Provider does not object to the Legally Required Amendment, in writing, within sixty (60) days following receipt thereof, such Legally Required Amendment shall be deemed accepted by Provider and an amendment to this Agreement. If Provider timely objects to the Legally Required Amendment, then Provider and Blue Shield shall confer in good faith regarding Provider's objection(s). If Provider and Blue Shield are unable to resolve Provider's objection(s) to the parties' mutual satisfaction within thirty (30) days of Provider's notice, then, within sixty (60) days of Provider's notice, Provider may elect to terminate this Agreement upon ninety (90) days' prior written notice to Blue Shield. Unless Provider so terminates this Agreement, such Legally Required Amendment shall be deemed accepted by Provider and an amendment to this Agreement.

9.6 **Entire Agreement.** This Agreement, all attachments and Exhibits referenced in this Agreement and attached hereto, and the Provider Manual, as amended from time to time, are incorporated herein by reference, and constitute the entire understanding between the parties

relating to the subject matter hereof. This Agreement constitutes the entire understanding and agreement of the parties regarding its subject matter, and supersedes any prior oral or written agreements, representations, understandings or discussions among the parties with respect to such subject matter. Notwithstanding the foregoing, this Agreement does not supersede or modify any agreement between Provider and a medical group or independent practice association as more fully described in Section 3.7 hereof.

9.7 **Assignment and Subcontracting.** Neither party shall assign, transfer, or subcontract any of its rights, interests, duties, or obligations under this Agreement, whether by sale, assignment, negotiation, pledge or otherwise, without the prior written consent of the other party. Without limiting the foregoing, the following events shall constitute an assignment of this Agreement for purposes of this Section 9.7: (a) the sale, transfer or other disposition of all or substantially all of the issued and outstanding voting securities or interests of Provider or Provider's direct or indirect corporate parent; (b) the merger, consolidation or other reorganization of Provider if, immediately following such transaction, either Provider or its member(s) shareholders or other equity holders (as existing immediately preceding such transaction) do not own a majority of all classes of the issued and outstanding membership interests or voting securities of the surviving, consolidated or reorganized entity; and (c) the issuance of any class of voting securities or interests by Provider (or its successor) if, immediately following such transaction, Provider's shareholders or other equity holders existing immediately preceding such issuance do not own a majority of all classes of the issued and outstanding voting securities or interests of Provider. Subject to the foregoing, this Agreement shall be binding on and shall inure to the benefit of the parties and their respective heirs, successors, assigns and representatives.

9.8 **Directory and Use of Names.** Blue Shield maintains a directory of healthcare providers participating in Blue Shield which may be distributed and/or made available to Members. Provider agrees that the following information may be included in Blue Shield's marketing materials, Blue Shield publications provided to current or potential Members and subscriber groups, and in other written or electronic information sources: (a) Provider's name, practice location or locations, and contact information, including open and closed panel status for PCPs; (b) type of practitioner; (c) National Provider Identifier number; (d) California license number and type of license; (e) area of specialty, including board certification, if any; (f) Provider's office email address, if available; (g) For physicians, surgeons, and podiatrists, the admitting privileges, if any, at hospitals contracted with the insurer; and (h) such other types of information regarding Provider that are reasonable to include in directories, marketing materials, or publications. Blue Shield shall maintain said directory pursuant to state and federal law, including, but not limited to, Health & Safety Code 1367.27. Provider may identify himself/herself/itself as a participating/contracting provider with Blue Shield in all Benefit Programs and Tiered/Narrow Products in which he/she/it participates.

9.9 **Interpretation of Agreement.** This Agreement shall be governed in all respects, whether as to validity, construction, capacity, performance, or otherwise, by the laws of the State of California and such federal laws as are applicable to Blue Shield. The captions herein

are for convenience only and shall not affect the meaning or interpretation of this Agreement. If any provision of this Agreement, in whole or in part, or the application of any provision, in whole or in part, is determined to be illegal, invalid or unenforceable by a court of competent jurisdiction, such provision, or part of such provision, shall be severed from this Agreement. The illegality, invalidity or unenforceability of any provision, or part of any provision, of this Agreement shall have no affect on the remainder of this Agreement, which shall continue in full force and effect.

9.10 **Notices.** All notices or communications required or permitted under this Agreement shall be given in writing and shall be delivered to the party to whom notice is to be given either: (a) by personal delivery, in which cases such notice shall be deemed given on the date of delivery; (b) by next business day courier service (e.g., Federal Express, UPS or other similar service), in which case such notice shall be deemed given on the business day following date of deposit with the courier service; (c) by United States mail, first class, postage prepaid, in which case such notice shall be deemed given on the third (3rd) day following the date of deposit with the United States Postal Service; (d) by United States mail, registered, in which case such notice shall be deemed given on the third (3rd) day following the date of deposit with the United States Postal Service; (e) by United States mail, certified, return receipt requested, in which case such notice shall be deemed given on the third (3rd) day following the date of deposit with the United States Postal Service; or (f) by facsimile transmission, in which case such notice shall be deemed given upon receipt of facsimile transmission confirmation. Notice shall be delivered or sent to the party's address or facsimile number set forth in Exhibit A, or such other address or facsimile number as may be provided by a party, from time to time, pursuant to this Section.

9.11 **Other Payors.** Blue Shield may contract with employers, insurance companies, associations, health and welfare trusts or other organizations to provide administrative services for plans provided by those entities which are not underwritten by Blue Shield. In addition, Blue Shield may extend this Agreement to managed care arrangements established by Blue Shield subsidiaries, or by persons or entities utilizing the Managed Care Network which Blue Shield has established pursuant to agreements with CareTrust Networks and Blue Shield of California Life & Health Insurance Company. All such entities shall be referred to as **"Other Payors"**. Blue Shield shall require that: (a) the health programs of Other Payors include provisions to encourage the use of Blue Shield contracting providers, and (b) Other Payors comply with performance standards relating to timely processing of claims which meet or exceed the time requirements set forth in California law. Provider agrees that, if Blue Shield is not the underwriter of the health plan for the Other Payor, Provider shall look solely to Other Payor for payment for services. The identity of Other Payors shall be disclosed in the Provider Manual. If, despite reasonable efforts, Provider is unable to obtain appropriate payment from an Other Payor, Provider may notify Blue Shield and Blue Shield shall undertake reasonable efforts to assist Provider in obtaining proper payment. If, within fifteen (15) days following notification to Blue Shield, Provider still has not obtained payment from the Other Payor, then Provider may immediately terminate this Agreement.

9.12 **Waiver of Breach.** No delay or failure to require performance of any provision of this Agreement shall constitute a waiver of the performance of such provision or any other instance. Any waiver granted by a party must be in writing and shall apply solely to the specific instance expressly stated. A waiver of any term or condition of this Agreement shall not be construed as a waiver of any other terms and conditions of this Agreement, nor shall any waiver constitute a continuing waiver.

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

9.14 **Free Exchange of Information.** No provision of this Agreement shall be construed to prohibit, nor shall any provision in any contract between Provider and its employees or subcontractors prohibit, the free, open and unrestricted exchange of any and all information of any kind between health care providers and Members regarding the nature of the Member's medical condition, the health care treatment options and alternatives available and their relative risks and benefits, whether or not covered or excluded under the Member's health plan, and the Member's right to appeal any adverse decision made by Provider or Blue Shield regarding coverage of treatment which has been recommended or rendered. Moreover, Provider shall not be penalized nor sanctioned in any way for engaging in such free, open and unrestricted communication with a Member nor for advocating for a particular service on a Member's behalf.

9.15 **Payment of Premiums.** Payment of Member premiums by Provider shall be deemed a material breach of the Agreement.

9.16 **Counterparts**. This Agreement may be executed in one or more counterparts, each of which shall be deemed to be an original, but all of which together shall constitute one and the same instrument.

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed by their authorized representatives:

BLUE SHIELD OF CALIFORNIA **[NAME OF PROVIDER]**

Signature:		Signature:	
Print Name:	Hugo Florez	Print Name:	
Title:	Vice President, Provider Network Management, Care1st and Specialty Networks	Title:	
Date:		Date:	

EXHIBIT A
Allied & Ancillary Provider Agreement

PROVIDER INFORMATION

Provider Name (or if group practice, group practice name)	License Number	License Type

Type of Service Provided	IRS (TIN/EIN) or Social Security Number

National Provider Identification Number: _____

Check One: ☐ Individual ☐ Group

For this Section, complete either 1 or 2 but not both.

1.

☐ All Products. Provider agrees to participate in, and this Agreement shall apply to, all Benefit Programs under which Blue Shield compensates Provider for Covered Services pursuant to the compensation described in Section 3.1 of this Agreement, subject to Section 2.7 of this Agreement.

OR

2.

Opt Out. Provider agrees to participate in, and this Agreement shall apply to, Blue Shield's Commercial PPO/EPO (Blue Shield Standard Network) Benefit Programs and all other Benefit Programs under which Blue Shield compensates Provider for Covered Services pursuant to the compensation described in Section 3.1 of this Agreement, except as follows:

Provider does not agree to participate in, and this Agreement shall not apply to, the following Benefit Programs (Check the box for each product):

☐ Commercial PPO/EPO (Blue Shield Network A)
☐ Commercial PPO/EPO (Blue Shield Network B)
☐ Commercial PPO/EPO (Blue Shield Network C)
☐ Medicare Advantage PPO
☐ Commercial HMO
☐ Medicare Advantage HMO

Addresses for Notice:

If to Provider:

PROVIDER			
Name of Provider			
Address Line 1			
Address Line 2			
City, State, Zip			
Title			
Phone Number		*Fax Number*	
Practice E-mail Address			

If to Blue Shield:

NOTICE OF BREACH OR TERMINATION PURSUANT TO ARTICLE VII	**ALL OTHER NOTICES**
Blue Shield of California	Blue Shield of California
6300 Canoga Avenue, 7th Floor	P.O. Box 629017
Woodland Hills, CA 91367	El Dorado Hills, CA 95762-9017
Attn.: Vice President, Provider Network Management, Care1st and Specialty Networks	Attn.: Provider Services
Fax No.: 818-228-5101	Fax No.: 916-350-8860

Attachment 1
To EXHIBIT A
Allied & Ancillary Provider Agreement

PRACTICE SITES

As of the effective date, Provider provides Covered Services at the site(s) listed in the table below. Provider shall notify Blue Shield of changes to the information below pursuant to Section 4.4 of this Agreement.

Site Name	Site Address	Site Suite	Site City	Site State	Site Zip	Blue Shield ID	Tax ID/SSN	NPI

EXHIBIT B
Allied & Ancillary Provider Agreement

COMPENSATION RATES

1. **Compensation.** Blue Shield shall reimburse Provider for Covered Services provided to Members enrolled in Benefit Programs in which Provider has agreed to participate and to which this Agreement applies, as follows:

(a) Commercial PPO/EPO (Blue Shield Standard Network):

One hundred percent (100%) of the rates set forth in the Blue Shield Provider Allowances.

(b) Commercial PPO/EPO (Blue Shield Network A):

For services other than drugs and immunizations, ninety percent (90%) of the rates set forth in the Blue Shield Provider Allowances. For drugs and immunizations, one hundred percent (100%) of the rates set forth in the Blue Shield Provider Allowances.

(c) Commercial PPO/EPO (Blue Shield Network B):

For services other than drugs and immunizations, eighty percent (80%) of the rates set forth in the Blue Shield Provider Allowances. For drugs and immunizations, one hundred percent (100%) of the rates set forth in the Blue Shield Provider Allowances.

(d) Commercial PPO/EPO (Blue Shield Network C):

For services other than drugs and immunizations, seventy percent (70%) of the rates set forth in the Blue Shield Provider Allowances. For drugs and immunizations, one hundred percent (100%) of the rates set forth in the Blue Shield Provider Allowances.

(e) Commercial HMO:

One hundred percent (100%) of the rates set forth in the Blue Shield Provider Allowances.

(f) Medicare Advantage:

Ninety-five percent (95%) of the reimbursement established by the Medicare program for such services.