

**Blue Cross and Blue Shield of Louisiana
Allied Health Provider Agreement**

This Agreement is made and entered into by and between Louisiana Health Service & Indemnity Company d/b/a Blue Cross and Blue Shield of Louisiana, a non-profit mutual insurance company organized and existing under the laws of the State of Louisiana, and its subsidiary HMO Louisiana, Inc., a Louisiana corporation, duly licensed by the Insurance Commissioner of the State of Louisiana as a health maintenance organization, (hereinafter referred to collectively as "PLAN," unless otherwise noted) and, the City of Baton Rouge and Parish of East Baton Rouge, Department of Emergency Services who is an Allied Health Provider (hereinafter referred to as "AHP").

WHEREAS, Blue Cross and Blue Shield of Louisiana ("BCBSLA") is a non-profit mutual insurance company organized and existing under the laws of the State of Louisiana that offers health and accident insurance coverage, provides or arranges for the provision of health care services, and/or offers third party administration services for group health plans;

WHEREAS, HMO Louisiana, Inc. ("HMOLA") is a Louisiana corporation, duly licensed by the Insurance Commissioner of the State of Louisiana as a health maintenance organization (HMO), providing HMO, HMO point of service and other managed care Member Contracts/Certificates covering the provision of Medical Services in certain markets of Louisiana; and

WHEREAS, AHP is duly licensed and/or certified by the appropriate state agency where required, and/or approved by the PLAN to provide and arrange basic and supplemental Medical Services; and

WHEREAS, AHP and PLAN desire to enter into a written service agreement to provide and/or arrange for the provision of Medical Services to certain PLAN Members in an effective manner, recognizing the need to contain the cost of health care, to improve health care, and to maintain the viability of the voluntary health care system;

NOW THEREFORE, in consideration of the promises and the mutual covenants herein stated, it is agreed by and between PLAN and AHP as follows:

**ARTICLE I
DEFINITIONS**

For purposes of this Agreement (means Allied Health Provider Agreement) and any attachment, exhibit, addendum or schedule attached hereto, the following terms shall have the meanings set forth below. The technical insurance terms and managed care terms defined below are consistent with definitions included in each applicable Subscriber Contract/Certificate. In the event that any of the following defined terms are inconsistent with any federal and/or Louisiana state law or regulation which requires conformity of such terms, then the term as used herein shall automatically be deemed to conform with the applicable law and/or regulation.

- 1.1 **Affiliate(s) of PLAN** - Those organizations designated from time to time by PLAN that are associated with PLAN or for whom PLAN may administer claims or arrange Benefits on behalf of self-insured employers or other entities.
- 1.2 **Agreement** - This contract, including attachments, appendices, exhibits or addenda hereto, that may be issued or amended by PLAN from time to time.
- 1.3 **AHP(s)** - Any AHP(s) licensed in the State of Louisiana who meets PLAN's criteria to become a Network Provider and who has signed this AHP Agreement either directly or through a Medical Group, Physician Hospital Organization (PHO), Independent Practice Association (IPA) or other

such arrangement as recognized by PLAN.

- 1.4 **Allied Health Provider** - A licensed and/or certified health care provider other than a Physician or Hospital, which may include a clinical laboratory company, managed mental health care company, optometrist, chiropractor, podiatrist, psychologist, therapist, licensed professional counselor (LPC), board certified substance abuse counselor (BCSAC), licensed clinical social worker (LCSW), durable medical equipment supplier, diagnostic center, advanced practice registered nurse, urgent care center, home health agency, retail health clinic, ambulatory surgical center ("ASC"), and any other health care provider, organization, institution or such other arrangement as recognized by PLAN providing allied health services, and through execution of this Agreement, agrees to provide or arrange for the provision of Covered Services to Members.
- 1.5 **Authorization (Authorized)** - A determination by PLAN regarding an admission, continued hospital stay, or other health care service or supply which, based on the information provided, satisfies the clinical review criteria requirement for Medical Necessity, appropriateness of the health care setting or level of care and effectiveness. An Authorization is not a guarantee of payment. Additionally, an Authorization is not a determination about the Member's choice of provider or health care services.
- 1.6 **BCBSLA Traditional/Key Allowable Charge** - The lesser of the billed charge or the amount established by BCBSLA as the maximum amount allowed for provider services covered under the terms of the BCBSLA Traditional/Key Member Contract/Certificate.
- 1.7 **BCBSLA Preferred Provider Organization ("PPO") Allowable Charge** - The lesser of the billed charge or the amount established by BCBSLA as the maximum amount allowed for provider services covered under the terms of the BCBSLA Preferred Care PPO Member Contract/Certificate.
- 1.8 **Benefit(s)** - Medical services, treatment, procedures, equipment, drugs, devices, items or supplies provided under a Benefit Plan. Benefits are based on the Allowable Charge for Covered Services.
- 1.9 **Claim** - A written or electronic proof, in a form acceptable to PLAN, of charges for services that have been incurred by a Member while the Member was insured under a Member Contract/Certificate. The provisions in effect at the time the Benefit is received shall govern the processing of any Claim expense actually incurred as a result of the Benefit rendered.
- 1.10 **Coinsurance** - The sharing of eligible charges for Covered Services between PLAN and Member. The sharing is expressed as a percentage. Once the Member has met any applicable Deductible amount, the Member's percentage will be applied to the Allowable Charges for Covered Services to determine the Member's financial responsibility. PLAN's percentage will be applied to the Allowable Charges for Covered Services to determine the Benefits provided.
- 1.11 **Coordination of Benefits (also referred to as "COB")** - The combining of benefits under a Member Contract/Certificate with duplicate coverage under another health insurance policy such that total Benefits paid for Covered Services rendered to a Member do not exceed the amount PLAN would have paid under the terms of this Agreement had PLAN been the primary payor.
- 1.12 **Copayment (Co-pay)** - The amount of charges for Covered Services which a Member must pay. The Copayment may be collected directly from the Member by AHP each time a specified Covered Service is rendered.
- 1.13 **Covered Services** - Those Medically Necessary health care services or supplies for which Benefits are available under a Member Contract/Certificate.

- 1.14 **Deductible** - A specific amount of charges for Covered Services, usually expressed in dollars, that must be incurred by the Member before an obligation to Member arises under the Member Contract/Certificate to assume financial responsibility for all or part of the remaining Covered Services.
- 1.15 **Emergency Medical Condition** - A medical condition manifesting itself as acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.
- 1.16 **Exhibit(s)** – The exhibits attached to this Agreement, incorporated herein by reference as if set forth in full, including but not limited to developing additional exhibits, and as may be subsequently amended from time to time.
- 1.17 **HMOLA Allowable Charge** - The lesser of the billed charge or the amount established by HMOLA as the maximum amount allowed for provider services covered under the terms of the HMOLA Member Contract/Certificate.
- 1.18 **Home Health Care** - Health services rendered in the Member's place of residence by an organization licensed as a home health care agency by the appropriate state agency and approved by PLAN. These organizations are primarily engaged in providing to individuals, at the written direction of a licensed physician, in the individual's place of residence, home health services rendered by the appropriate health worker, including but not limited to physical therapist, speech therapist, occupational therapist, registered nurse, licensed practical nurse, or home health aide who meets the certification, registration and licensing requirements of the state in which services are rendered.
- 1.19 **Identification Card** - A currently valid identification card issued by PLAN, or Affiliate of PLAN, entitling a Member to receive Covered Services through a Member Contract/Certificate.
- 1.20 **Investigational** – A medical treatment, procedure, drug, device, or biological product is Investigational if the effectiveness has not been clearly tested and it has not been incorporated into standard medical practice. Any determination that PLAN makes that a medical treatment, procedure, drug, device, or biological product is Investigational will be based on a consideration of the following:
- A. whether the medical treatment, procedure, drug, device, or biological product can be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and whether such approval has been granted at the time the medical treatment, procedure, drug, device, or biological product is sought to be furnished; or
 - B. whether the medical treatment, procedure, drug, device, or biological product requires further studies or clinical trials to determine its maximum tolerated dose, toxicity, safety, effectiveness, or effectiveness as compared with the standard means of treatment or diagnosis, must improve health outcomes, according to the consensus of opinion among experts as shown by reliable evidence, including:
 - 1. consultation with the Blue Cross and Blue Shield Association technology assessment program (TEC) or other non-affiliated technology evaluation center(s);
 - 2. credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; or

3. reference to federal regulations.

- 1.21 **Medical Management Program** – A program which may include, without limitation, evaluation of the Medical Necessity, appropriateness, and efficiency of the use of Medical Services, procedures, and facilities on a prospective, concurrent, or retrospective basis. A description of the PLAN’s Medical Management Program is included in the PLAN’s Provider Office Manual.
- 1.22 **Medical Service(s)** - Those services or supplies that a professional provider is licensed to provide and which he/she provides to individuals or those inpatients and outpatient services or supplies that a health care facility is licensed, equipped and staffed to provide, and which is customarily provided to individuals.
- 1.23 **Medically Necessary (or “Medical Necessity”)** - Those health care services, treatment, procedures, equipment, drugs, devices, items or supplies that a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:
- A. in accordance with nationally accepted standards of medical practice;
 - B. clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient's illness, injury or disease; and
 - C. not primarily for the personal comfort or convenience of the patient, or provider, and not more costly than an alternative services treatment, procedures, equipment, drugs, devices, items or supplies or sequence thereof and that are as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, “nationally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, AHP Specialty Society recommendations and the views of AHPs practicing in relevant clinical areas and any other relevant factors.

- 1.24 **Member(s)** - A subscriber or an enrolled dependent covered under a Member Contract/Certificate who are entitled to receive health care Benefits as defined in and pursuant to a Member Contract/Certificate.
- 1.25 **Member Contract/Certificate** - A contract/certificate or health benefit plan which provides for payment in accordance with this Agreement to AHP and which is issued or administered by or through PLAN, its subsidiaries and affiliates and includes any national and regional group accounts of PLAN or any other Blue Cross Plan, Blue Shield Plan or the Blue Cross and Blue Shield Association having a Benefit provision for which PLAN acts as the control plan, a participating plan or service plan in providing those Benefits. It also includes any health plans or programs sponsored, provided, indemnified, or administered by other entities or persons who have made arrangements with PLAN, such as network access-only agreements, to access and utilize the AHP in connection with their managed care health plans or programs. Such entities or persons may avail themselves of the same access to service and related rights as PLAN, and such entities or persons shall be bound to the same payment responsibilities in regards to their Members as PLAN is for their respective Members under this Agreement. AHP will provide these services and look only to each joined entity or person for the applicable Allowable Charge in the manner it would look to PLAN. The Member Contract/Certificate or health benefit plan entitles Member to receive health care Benefits as defined in and pursuant to a Member Contract/Certificate or health benefit plan.
- 1.26 **Network Provider(s)** - Any AHP or group of AHPs, or any facility, including but not limited to, a hospital, clinical laboratory, free-standing ambulatory surgery facility, skilled nursing facility, hospice, home health agency, or any other health care practitioner or provider of Medical Services who has entered into a contractual agreement with PLAN to provide Covered Services to Members.

- 1.27 **Non-Covered Service** - A service and/or supply (not a Covered Service) for which there is no provision for either partial or total Benefit/payment under the Member Contract/Certificate.
- 1.28 **Private Duty Nursing Services** - Services of an actively practicing Registered Nurse (RN) or Licensed Practical Nurse (LPN) who is unrelated to the patient by blood, marriage or adoption. These services must be ordered by the attending physician and require the technical skills of an RN or LPN in shifts of at least eight (8) continuous hours.
- 1.29 **Professional Provider Office Manual** - That document or set of documents which set forth in detail PLAN rules. For purposes of this Agreement and any attachments or Exhibits hereto, Provider Office Manual may include, without limitation, any applicable Network Provider manual or provider communications. PLAN retains the right to add to, delete from and otherwise modify the Provider Office Manual. The Provider Office Manual and other information and materials provided by PLAN are proprietary and confidential and constitute trade secrets of PLAN. The Provider Office Manual is incorporated into and made a part of this Agreement.
- 1.30 **Parties** - PLAN and the AHP whose name appears on page one (1) of this Agreement when AHP directly signs this Agreement, or PLAN and the AHPs identified by attachment to this Agreement when AHP is bound to this Agreement through a Medical Group, Physician Hospital Organization (PHO), Independent Practice Association (IPA), or other such arrangement as recognized by PLAN.
- 1.31 **Quality Management Program (also referred to as "QM Program")** - The program developed or used by PLAN for the collection and analysis of quantitative and qualitative data which identifies patterns of health care delivery in order to provide the most beneficial outcome for a Member, given a Member's medical condition before, during and after medical intervention.
- 1.32 **Service Area(s)** - The geographic area in which PLAN does business as determined by PLAN and approved by the Commissioner of Insurance of the State of Louisiana.
- 1.33 **Visit Charge** - is a consecutive period of time up to two (2) hours during which Home Health Care is rendered. Charges exceeding two (2) hours require additional pre-service/preauthorization from PLAN.

ARTICLE II AHP SERVICES AND RESPONSIBILITIES

- 2.1 **PLAN Participation.** AHP is authorized pursuant to this Agreement to participate in PLAN's traditional/key, preferred provider organization (PPO), and health maintenance organization (HMO) programs if indicated on Reimbursement Exhibit A. AHP agrees to provide Covered Services to Members in accordance with the terms of this Agreement and all attachments and appendices hereto.
- 2.2 **Non-discrimination.** AHP shall provide Covered Services to Members in the same manner and quality as those services are provided to all non-Member patients of AHP. AHP shall not discriminate against any Member based upon the source of payment for services, race, color, sex, age, religion, national origin, disability, or health status.
- 2.3 **Accessibility.** AHP shall assure that services provided are made available and accessible to Members promptly and in a manner that assures continuity of care (including coordinating overall health care and exchanging health records) and agrees to forward all clinical information in a timely manner to other Network Providers engaged in treatment of Members.
- 2.4 **Availability of Services.** If applicable to AHP standard business practices, AHP shall make

all Covered Services available and accessible to Subscribers twenty-four (24) hours per day, seven (7) days per week, three hundred sixty-five (365) days per year and in a manner that assures continuity of care.

- 2.5 **Network Referrals.** In order to maximize the Member's contract benefits, AHP agrees to refer Members to other Network Providers, when required, except when the Member has an Emergency Medical Condition or when no such Network Provider is available. Upon referral, AHP shall a) furnish such providers with complete medical information on treatment, procedures and diagnostic tests performed on Member prior to such referral; b) inform the Member that there may be additional cost to the Member resulting from such direction. Nothing herein is intended to interfere with the ability of AHP to communicate with a patient regarding his/her health care, including but not limited to communications regarding treatment options and medical alternatives, or other coverage arrangements.
- 2.6 **Hospital Staff Privileges.** The following paragraph applies when AHP's license provides for AHP to have staff privileges: AHP agrees that he/she will have and maintain active staff privileges with at least one hospital within PLAN's hospital network during the term of this Agreement unless otherwise approved by PLAN. AHP agrees to admit Members or arrange for their admission within the hospital network, unless Covered Services cannot be provided within the hospital network or unless the Member has an Emergency Medical Condition.
- 2.7 **Notification Requirements.** AHP shall notify PLAN immediately, in writing, if applicable of:
- a) Any change or notification of potential change in AHP's professional licensure, certification or accreditation status;
 - b) Any change to the information submitted on the initial credentialing or recredentialing AHP application;
 - c) Any change in AHP's business address, ownership, legal status and/or tax identification number and banking information for purposes of PLAN electronic fund transfer payments;
 - d) Any legal or governmental action or any other problem or situation which might impair the ability of AHP to carry out his/her duties and obligations under this Agreement, including, but not limited to, employee strikes or walkouts, financial insolvency, or damages to the physical plant resulting in any interruption of the provision of Medical Services;
 - e) Any written complaint, claim, suit or threat of legal action by a Member against AHP;
 - f) Cancellation of or material modification in malpractice or liability insurance coverage;
 - g) Any change or notification of possible change in professional licensure of staff member or an AHP; and
 - h) Any disciplinary action (suspension, revocation, other forms of reduction of privileges, resignation in lieu of disciplinary action, sanctions or corrective action) taken by a hospital's medical staff, board of directors, hospital authority or administration or any agencies of the state or federal government against AHP. Temporary suspension of AHP's admitting privileges due to untimely completion of medical records is not required to be reported.
 - i) AHP shall notify PLAN in writing thirty (30) days prior to any action or plan of action wherein AHP acquires another Allied Health Provider or AHP itself is acquired by any other entity; or AHP becomes a party to a management agreement whereunder it manages

or is managed by another party; or AHP becomes a party to a lease agreement whereunder it leases another Allied health Provider or itself is leased by any other entity or AHP in any way changes its present form of ownership, governance or management.

Should any of these events occur affecting AHP's contracted providers, PLAN may require that AHP immediately terminate or suspend an AHP contracted provider's contract to participate in PLAN's Allied Health Provider network. Failure on the part of AHP to take appropriate action as determined by PLAN may result in PLAN suspending or terminating AHP's contracted provider's network participation status.

- 2.8 **Staff Licenses and Credentials.** AHP agrees to take reasonable steps to ensure that health professionals working within AHP's practice and/or facility and AHP's employees are at all times appropriately licensed, credentialed, accredited and/or certified by the State of Louisiana and/or all appropriate professional or other organizations. All employees must continue to meet all applicable state laws and regulations and all applicable legal standards of care.
- 2.9 **Facilities and Equipment Licensure.** AHP agrees to ensure that all facilities and equipment used for and in the delivery of health care services which are required to be licensed and/or certified by law, shall be so licensed and/or certified. AHP agrees to provide a functional, sanitary, and comfortable environment for Members, personnel and the public. There shall be an adequate amount of space for services provided and disabilities treated, including waiting and reception areas, staff space, examining rooms, treatment areas, and storage.
- 2.10 **Monitoring and Audits.** AHP agrees to permit PLAN and its authorized agents to conduct any audits of AHP, his/her facilities, policies and procedures, including, but not limited to, Medical Management Program audits, at any time during AHP's regular business hours upon twenty-four (24) hours prior notice. AHP agrees to permit such other monitoring activities as are deemed necessary by PLAN to ensure correct payment to AHP for Covered Services rendered to Members.
- 2.11 **Credentialing Requirements.** In order to become a Network Provider, each such provider must submit a credentialing application as required by PLAN. A contracted credentialing vendor may provide this application. PLAN's approval of a provider credentialing application and its determination of his/her compliance with PLAN's applicable certification standards, if any, as they may be amended by PLAN from time-to-time, are conditions to this Agreement. AHP shall be subject to, and AHP shall cooperate with, re-credentialing on a periodic basis. Such processes may include, but are not limited to, medical record audits, office site surveys, patient satisfaction surveys and provider practice profiling. PLAN shall determine in its sole discretion whether any provider meets its credentialing standards, whether a provider is accepted as a Network Provider and whether to approve AHP's continued participation upon re-credentialing. Such approval may be conditioned upon a Network Provider's compliance with specific limitations or corrective actions.

Within thirty (30) business days of the acceptance of an offer to employ, contract or associate with a provider, AHP shall submit a credentialing application to PLAN consistent with this Section and this Agreement. In no event shall AHP provide any Covered Services to Members until AHP is credentialed and certified by PLAN.

- 2.12 **Compliance with Law.** AHP warrants that it does now and shall at all times during the term of this Agreement, comply with all applicable ordinances, statutes, regulations, and other requirements of municipal, state and federal authorities relating to the ownership and operation of AHP's practice and related services and entities.
- 2.13 **AHP Cooperation.** AHP shall cooperate with PLAN in developing and implementing innovative methods for delivering services that promote cost effectiveness, quality care and superior customer service, as set forth in PLAN's Provider Office Manual, which may be amended by PLAN at any time.

- 2.14 **Anti-Gag Clause.** AHP is not required to recommend any procedure or treatment which AHP deems professionally unacceptable. AHP also shall discuss all treatment options with Members regardless of whether such services are covered under the Member's benefit plan. AHP shall not be prohibited from protesting or expressing disagreement with a medical decision, medical policy or medical practice of PLAN or an entity represented or working for PLAN.
- 2.15 **Medical Decisions.** AHP hereby expressly acknowledges that PLAN does not practice medicine, and that AHP shall be solely responsible for all clinical decisions regarding the admission, treatment and discharge of eligible persons under AHP's care, notwithstanding the receipt by AHP of any denial, authorization, or recommendation issued by PLAN pursuant to the Medical Management and Quality Management Programs.
- 2.16 **AHP Involvement.** AHP, in cooperation with PLAN and various committees that may be established by PLAN, shall establish, maintain, and, from time to time, review methods, procedures, and details of coverage and systems to ensure adequate Member coverage and quality of care at all times.
- 2.17 **Member Contract Changes.** AHP agrees that PLAN retains the right to change, revise, modify or alter the form and content of any Member Contract/Certificate without prior notice to or approval by AHP.
- 2.18 **Member Cost-Sharing.** AHP agrees not to waive or discount any patient liability amounts including Deductibles, Coinsurance and/or Copayments for Covered Services. In the event of such waiver or discount, PLAN will base the PLAN Allowable Charge on an Allowable Charge amount which is reduced by the amount waived or percentage discounted by AHP.
- 2.19 **HIPAA Consent.** AHP agrees that if it chooses to obtain consent from a PLAN Member, that any consent form it may provide to such a PLAN Member pursuant to the Standards for Privacy of Individually Identifiable Health Information (the "Standards") as permitted by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") will comply fully with the requirements of the Standards and will obtain the PLAN Member's consent for the full range of functions, activities and services permitted under the Standards in connection with treatment, payment and health care operations (as those terms are defined in the Standards). In addition, AHP agrees that, as permitted by the PLAN Member's consent, for all uses or disclosures of protected health information for a function, activity or service within the definition of treatment, payment or health care operations, AHP agrees to disclose such protected health information to PLAN upon PLAN's request, unless prohibited by law.
- 2.20 **HIPAA TPO Activities.** In the event AHP and PLAN fail to agree on whether a particular function, activity or service falls within the definition of treatment, payment or health care operations ("TPO"), AHP agrees that, at the election of the PLAN, this issue shall be resolved either by: (i) PLAN's submission of an authorization from Member that complies with the Standards (pursuant to which AHP agrees to release the requested protected health information); or (ii) the submission of the issue to the Executive Management of PLAN.
- 2.21 **Electronic Health Information – HIPAA Compliance.** Upon the compliance date of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its implementing regulations issued by the U.S. Department of Health and Human Services (45 C.F.R. Parts 160-164), PLAN and AHP agree that when transmitting health information electronically between the parties, both PLAN and AHP will use standard data elements, code sets and formats in every standard transaction as mandated by and in conformity with HIPAA. Alternatively, if AHP contracts with a health care clearinghouse (as defined under HIPAA), AHP shall require the health care clearinghouse, when transmitting health information electronically with PLAN, to use standard

data elements, code sets and formats in every standard transaction as mandated and defined by HIPAA.

- 2.22 **Other Affiliates and Arrangements.** AHP understands and agrees that, as designated from time to time by PLAN, this Agreement may apply to certain enrollees in PLAN and enrollees of other Traditional/Key, PPO, HMO or point of service arrangements with whom PLAN may be affiliated or for whom PLAN may administer Claims or arrange Benefits on behalf of self-insured employers or other entities.
- 2.23 **iLinkBlue.** AHP agrees to utilize, to that to the extent he/she is able to, the electronic services provided by PLAN, such as but not limited to member eligibility, coverage verification and authorizations, claims filing and review, and payment queries and transactions.
- 2.24 **AHP Contracted Provider List/Updates** AHP shall provide PLAN with a list of the names, tax identification number(s), national provider identification number(s), and addresses of all AHP contracted providers, and shall provide PLAN with updates of any deletions to the list no less frequently than monthly.
- 2.25 **Sharing Provisions of Agreement.** AHP shall share provisions of this Agreement with all of its contracted providers prior to the effective date of this Agreement.
- 2.26 **Subcontracts.** AHP shall have the right to subcontract with other providers for services. PLAN will review and may approve all subcontracts prior to AHP's referral of PLAN's Members to subcontractor for services. Such subcontracts shall adhere to all billing and hold harmless provisions in Articles 4.6 and 4.7, all medical management and quality management program provisions in Article V, maintenance of medical records, and access to PLAN and authorized regulatory bodies as may be required by applicable law. PLAN's approval shall be timely and not arbitrarily withheld. Copies of all subcontracts for services provided to PLAN Members under this Agreement must be provided to PLAN no less than thirty (30) days prior to subcontracts becoming effective.
- 2.27 **Third Party Liability:** AHP shall establish procedures for identification and notification to PLAN of Members with work-related injuries or illnesses, with other coverage(s) which may be coordinated with coverage under a Member Contract/Certificate, and Members with injuries caused by a third party who would be primarily responsible for Allied Health Provider Services provided to such Members and for which PLAN could be subrogated. All claims filed by AHP with PLAN shall indicate thereon whether work-related injuries or illnesses are involved, whether the Member has other coverage and, if so, the identity of such other carrier or Plan, and, if known to AHP, the identity of a third party who may be primarily responsible for injuries to Member. The parties agree that AHP is obligated to provide to PLAN only such information as is available to AHP at the time of submission of claims.
- 2.28 **Data.** AHP shall cooperate with PLAN in PLAN's efforts to calculate and report to Health and Human Services (HHS) all statistics and other information related to its business, as may be required or requested by HHS, including but not limited to risk adjustment data as defined in 45 C.F.R. Part 153. AHP shall send to PLAN, as applicable, all information related to risk adjustment as may be necessary for PLAN to calculate and audit its risk adjustment score as determined by PLAN, within the timeframes specified and in a form that meets HHS requirements. By submitting data to PLAN, AHP represents to PLAN, and upon PLAN's request AHP shall certify in writing, that the data is accurate, complete, and truthful, based on AHP's best knowledge, information and belief.

ARTICLE III PLAN RESPONSIBILITIES

- 3.1 **Member Materials.** PLAN shall distribute and/or make available information to Members detailing Members' responsibilities and procedures, Benefit levels, Deductible, Copayment and Coinsurance requirements, and Network Providers. PLAN shall provide each Member with an Identification Card. AHP acknowledges and agrees that possession of an Identification Card, in and of itself, does not qualify holder thereof as a Member, nor does the lack thereof mean that the person is not a Member.
- 3.2 **Administration.** PLAN agrees to perform, or cause to be performed, administrative, accounting, marketing, enrollment, database management, reporting and other functions as it deems necessary to the administration of PLAN and the performance of this Agreement.
- 3.3 **Provider Manual/Policies and Procedures.** PLAN agrees to provide and/or make available to AHP, BCBSLA Provider Office Manual, PLAN policies and procedures, required billing formats or procedures, Deductibles, Copayments or Coinsurance, if any, to be paid by Members, and such other information as may be reasonably necessary in order to facilitate the provision of Covered Services to Members and payment thereof under this Agreement.
- 3.4 **Eligibility Determinations.** PLAN agrees to furnish to AHP PLAN's best available information regarding Network Providers, Member eligibility for Covered Services and basic coverage. Such information will normally be available only for locally enrolled Members and will be obtained from existing PLAN records which are available in the ordinary course of business through PLAN computer terminals. It is understood and agreed by AHP and PLAN that circumstances inherent in the record keeping system or circumstances beyond the control of PLAN may occasionally cause retroactive changes in reported Member eligibility status and coverage. It is understood and agreed by AHP and PLAN that final Benefit adjudication is subject to and conditioned on the terms and conditions of a Member Contract/Certificate including, without limitation, eligibility, waiting periods, exclusions, medical waivers or riders, Deductibles, Coinsurance, Copayments or other contract limitations, the application of all of which cannot always be conclusively determined prior to Claims submission. AHP understands and agrees that the verification of eligibility status and coverage shall not constitute an assurance or guarantee of coverage or payment.
- 3.5 **AHP'S Independence.** PLAN shall not terminate this contract because AHP expresses disagreement with a decision by PLAN or an entity representing PLAN to deny or limit benefits to a Member or because the AHP assists the Member to seek reconsideration of PLAN's decision, or because the AHP discusses with a current, former or prospective member any aspect of the Member's medical condition, any proposed treatments or treatment alternatives, whether covered by PLAN or not, policy provisions of the health plan, or a AHP's recommendation regarding selection of a health plan based on the AHP's personal knowledge of the health needs of such Members.
- 3.6 **Network Providers.** PLAN agrees to provide to AHP a list of all Network Providers, upon request.
- 3.7 **Member Benefits.** Benefits to which a Member is entitled are limited to those set out in the applicable Member Contract/Certificate in effect at the time services are performed, and as interpreted by PLAN. PLAN shall not be responsible for any misrepresentation of the Member Contract/Certificate made to AHP by Member.
- 3.8 **Other Vendors.** PLAN may contract directly or indirectly with entities such as third party administrators, other Blue Cross and/or Blue Shield Plans, or other entities to perform the requirements of PLAN under this Agreement and PLAN will inform AHP of the identity of those entities, upon request.

- 3.9 **Licensure.** PLAN has, and shall maintain in good standing, all licenses required by law and agrees to comply with the necessary state or federal requirements to the extent that they directly or indirectly bear upon the subject matters of this Agreement.

ARTICLE IV COMPENSATION AND BILLING

- 4.1 **Timely Claims Filing.** AHP shall use his/her best efforts to submit all Claims for Covered Services provided to Members within thirty (30) days after the services are rendered. However, if a Claim is received by PLAN more than fifteen (15) months, or the applicable maximum time period allowed for submission under the Member Contract/Certificate, after the date services were rendered to a Member by AHP, the PLAN and Member shall both be held harmless from any payment obligation of such Claim.
- 4.2 **Claims Submission.** AHP shall bill PLAN for Covered Services, even in cases of third party liability, rendered to Members in a manner and on forms prescribed by PLAN. AHP shall furnish, on request, all information reasonably required by PLAN to verify and substantiate the provision of and the charges for Covered Services. PLAN reserves the right to review any and all statements, bills, Claims or invoices submitted by AHP to PLAN for reimbursement.
- 4.3 **Claims Payment.** PLAN shall pay AHP directly, notwithstanding PLAN's subrogation rights of reimbursement under the Member Contract/Certificate, for the provision of Covered Services rendered to Members based on the PLAN Allowable Charge as outlined in Reimbursement Exhibit A. The payment from PLAN shall be limited to the PLAN Allowable Charge, less Deductible, Copayment and Coinsurance amounts, as applicable, and amounts received from sources other than PLAN pursuant to the COB provisions of a particular Member Contract/Certificate. PLAN may review and adjust as appropriate, the PLAN Allowable Charge for each procedure at least annually.
- 4.4 **PLAN Compensation.** PLAN shall provide compensation only for Benefits provided in accordance with the terms and conditions of the applicable Member Contract/Certificate and PLAN administrative policies, whether the applicable Member Contract/Certificate is underwritten, administered or serviced by PLAN, or whether the Member Contract/Certificate is a Federal Employee Program, national account, or administrative services only type contract.
- 4.5 **Acceptance of Compensation.** AHP shall accept compensation as specified in this Agreement and Reimbursement Exhibit A as payment in full. AHP further agrees that the only charges for which a Member may be liable to AHP are those specified in Articles 4.6 and 4.7 below. The difference between AHP's billed charge and the PLAN Allowable Charge for Covered Services shall be a contractual adjustment which is not collectible from the Member. AHP agrees to refund the Member within thirty (30) days of notification, any payments above the Allowable Charge made by the Member to AHP. AHP shall not charge a Member for Covered Services up-front, beyond collecting Deductibles, Copayments or Coinsurance as specifically provided under the Member's Benefits. If the Member does not have benefits for the service, the AHP may bill the Member at his/her customary rate for such service.
- 4.6 **Hold Harmless.** AHP agrees that in no event, including but not limited to, nonpayment by PLAN, insolvency of PLAN, or breach of this Agreement, shall AHP, his agent, trustee or assignee thereof bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from or have any recourse against a Member or person acting on a Member's behalf for Covered Services provided pursuant to this Agreement. This provision does not prohibit AHP from collecting Deductibles, Copayments, or Coinsurance, as specifically provided under the Member's Benefits or fees for non-Covered Services delivered on a fee-for-service basis to Members, except as provided for below. AHP further agrees that: (1) this hold harmless provision shall survive the

termination of this Agreement regardless of the events giving rise to the termination; (2) this provision shall be construed for the benefit of Members; and (3) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between AHP and Members or persons acting on their behalf.

This Article 4.6 is not intended to apply to services provided after this Agreement has been terminated, except as otherwise provided in Article 10.7 - Effect of Termination.

4.7 **Limitation on Billing Members.** Except as provided for below, AHP is prohibited from billing a Member for services determined to be not Medically Necessary, experimental or Investigational and AHP failing to comply with the Medical Management Program requirements and the Provider Office Manual. PLAN agrees that AHP may bill a Member for services determined to be not Medically Necessary or experimental or Investigational when AHP provides the Member with advance written notice that (a) identifies the proposed services, (b) informs that Member that such services may be deemed by PLAN to be not Medically Necessary or experimental or Investigational, and (c) provides an estimate of the cost to that Member for such services and that Member agrees in writing in advance of receiving such services to assume financial responsibility for such services. General agreements to pay, such as those signed by a Member at the time of admission, are not evidenced that the Member knew specific services were excluded or that the Member agreed to pay. AHP may bill the Member at its customary rate for such services. AHP may bill an individual directly for any services provided following the date the individual ceases to be a Member. PLAN has no obligation under this Agreement to pay for services rendered to individuals who are no longer Members.

4.8 **Claims Information and Records.** For all Covered Services provided by AHP to Members, AHP agrees to furnish to PLAN, without charge, in a format acceptable to PLAN all medical records and information reasonably required to process claims, including, but not limited to, complete and accurate descriptions of health care services performed and charges made, with diagnoses and procedure codes approved by PLAN (only 'CPT IV', 'HCPCS', and 'ICD-9', and any successor codes, are acceptable diagnoses and procedure codes). If submitting electronic claims, AHP will submit claims in a format that complies, or will comply with, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") or engage a health care clearinghouse to do so on AHP's behalf.

4.9 **Payment Recovery and Recoupment.** PLAN shall be permitted to recover from AHP amounts due PLAN because of: 1) payments made in error and/or inaccurate payments, including payments based on erroneous or incomplete information provided by AHP; 2) medical management program determinations; 3) services not rendered; 4) recovery required as a result of a provider audit (according to the PLAN's audit policies); 5) payment for services later determined by PLAN to be Non-Covered Services, experimental or Investigational or not Medically Necessary; 6) payments incorrectly made under a coordination of benefits provision of a Member Contract/Certificate; and 7) payments that have been or should have been made by another source including but not limited to benefits that are available to a Member under the Worker's Compensation laws of any state or federal jurisdiction and medical payments under the Federal Employee Program.

Notice of suspected errors or overpayments shall be initiated by PLAN within fifteen (15) months of the date of payment of the claim. After such time, AHP and PLAN agree to hold each other and the Member harmless for underpayments or overpayments.

PLAN shall have the right to recoupment, in accordance with the procedures as outlined in Louisiana Revised Statute 22:1838 as applicable, deducting from future payments to be made to AHP, amounts due PLAN upon notice to AHP of the amounts offset, the name of the Member, and relevant service dates. AHP has thirty (30) days following the receipt of written notice from

PLAN of its decision to recoup to request an appeal in writing. The written request for appeal must contain the name of the Member/patient, the date or dates of services rendered, and an explanation of the reason for the appeal. Requests submitted to PLAN after thirty (30) days of the notice of recoupment will not be considered. If AHP does not respond timely to PLAN, then PLAN will consider the recoupment accepted. If AHP timely appeals PLAN's decision to recoup, the appeal shall be resolved in accordance with the general dispute resolution provision in Article 9.1.

- 4.10 **PLAN Payment Errors.** PLAN shall make payments to AHP for Benefit amounts due to AHP because of omissions or underpayments made in error. Payment for such errors shall be made as soon as discovered by PLAN or within thirty (30) days of written notice given by AHP of PLAN's error. Notice of suspected errors or underpayments shall be initiated by AHP within fifteen (15) months of the date of payment of the claim. After such time, AHP and PLAN agree to hold each other and the Member harmless for underpayments or overpayments.
- 4.11 **Code Reassignment.** AHP shall allow PLAN to reassign CPT/HCPCS codes if services have been inappropriately unbundled or incorrectly coded.
- 4.12 **AHP ID/NPI Number.** AHP agrees to submit Claims for Covered Services under the PLAN individual provider number assigned to AHP and/or the national provider identifier (NPI) assigned by the Centers for Medicare and Medicaid Services upon the compliance date of HIPAA and its implementing regulations.
- 4.13 **Coordination of Benefits.** AHP agrees to cooperate with PLAN in programs relating to the Coordination of Benefits and other third party claims for Covered Services provided to Members and to execute any further documents that may reasonably be required or appropriate for this purpose.
- 4.14 **Professional/Technical Component Billing.** AHP agrees to bill PLAN only for the professional component of inpatient and outpatient facility services. AHP shall not bill PLAN or the Member for the technical component of services during a Member's inpatient hospital admission or outpatient facility service nor shall AHP bill PLAN or the Member for charges generated by technicians administering such tests. These services include but are not limited to laboratory services, including pathology and anatomical laboratory services and diagnostic tests. AHP will look only to inpatient/outpatient facility for said payment.
- This provision shall not apply to AHP's who are ambulatory surgery centers who employ and bill on behalf of AHP based physicians for services performed at ambulatory surgery centers.
- 4.15 **Billing for Diagnostic Imaging Services.** If applicable to AHP type, the technical and/or professional components for all radiology and other diagnostic imaging services may be billed by the AHP only if he/she actually renders the service. AHP may not bill PLAN for the technical and/or professional component of any diagnostic test or procedure, including but not limited to, X-rays, ultrasounds, or other imaging services, computerized axial tomography, or magnetic resonance imaging by utilizing another entity's provider number. The referring provider may not receive direct or indirect compensation for a referral from the provider who rendered the service. Compensation received by a provider that is a return on investment is not considered compensation for referral, but must be disclosed to the patient prior to referral in accordance with Louisiana R.S. LSA 37:1744(B).
- 4.16 **Compliance with Agreement.** AHP agrees to honor, perform, and abide by the provisions of this Agreement for those entities identified by PLAN as entitled, in the manner in which AHP honors, performs, and abides by the provisions of this Agreement for PLAN including, but not limited to the application of the indemnification and hold harmless provisions for the benefit of those entities

and Members, and billing of those entities for billed charges and acceptance of the payment from those entities and/or Member as payment in full for Covered Services in accordance with the Reimbursement Exhibit.

- 4.17 **Disputed Claim(s)**. In the event of a disputed health insurance claim that results in litigation, judgment, compromise, and/or settlement, AHP agrees to accept the reimbursement amount in Exhibit A as payment in full and in satisfaction of the disputed claim. If the Member has paid an amount to AHP in excess of the reimbursement amount in Exhibit A on the disputed claim, AHP agrees to refund such excess to the Member.
- 4.18 **Non-Covered Services**. It is recognized that Member or Member's AHP may request services of AHP that are not covered by the Member Contract/Certificate. Member shall have financial responsibility for Non-Covered Services. AHP shall notify Member in writing, in advance, that payment for Non-Covered Services, shall, if provided, be Member's financial responsibility. PLAN shall have no financial responsibility to AHP or Member for Non-Covered Services.
- 4.19 **Advance Deposits/Up-Front Payment**. AHP shall not charge a Member for Covered Services up front, or request an advance deposit from, but shall look only to PLAN for payment, except that AHP may request an advance deposit from Member for Deductibles, Coinsurance, Copayment amounts, or for those Non-Covered Services which are Member's financial responsibility or unless Member has agreed in writing to pay for non-Medically Necessary services after notification of denial by PLAN.

ARTICLE V MEDICAL MANAGEMENT and QUALITY MANAGEMENT PROGRAMS

- 5.1 **Compliance with Program Rules**. AHP agrees to cooperate in the administration and implementation and to be bound by the procedures and determinations of the Medical Management and Quality Management Programs in the PLAN's Provider Office Manual and as described in this Article V. Further, AHP agrees to participate in and comply with PLAN's policies and procedures which shall be communicated to AHP from time to time. PLAN may revise, modify or otherwise change its Medical Management Program from time to time without AHP's consent. PLAN will notify AHP of significant changes to the Medical Management Program prior to implementation of changes.

AHP expressly understands and agrees that failure to follow any procedures specified in the Medical Management Program as described in this Agreement and the PLAN's Provider Office Manual can result in no payment or limitation of payments, and AHP expressly agrees not to bill any Member for any unpaid charges or penalties that result from failure of AHP to comply with the procedures of the Medical Management Program.

The scope of the Medical Management Program includes but is not limited to the following:

- a) **Authorization** – To determine whether an admission, continued hospital stay, or other health care service or supply is Medically Necessary, the appropriate setting, or level of care. An Authorization is not a guarantee of payment. The determination of whether a service or supply is Medically Necessary shall be made according to the protocols and procedures used in the Medical Management Program and is not determined by the fact that AHP has ordered a service or supply.

AHP agrees to indemnify and hold harmless PLAN, its designee and Member for non-covered admission or continued stay determinations made after the admission resulting from AHP's failure to request review in the manner prescribed.

- b) **Inpatient Authorization** - To determine whether an inpatient admission which is not subject to prior Authorization is Medically Necessary. AHP shall notify PLAN of emergency admissions within 48 hours of admission. PLAN or its designee will, where Medical Necessity of an admission has been determined, certify on a case-by-case basis the hospital stay for reimbursement. Failure to obtain Inpatient Authorization from the PLAN will result in a financial sanction in an amount as described in the Professional Provider Office Manual. AHP agrees to indemnify and hold harmless PLAN, its designee and Member resulting from AHP's failure to obtain pre-service review for inpatient facility services.
- c) **Concurrent Review** - To determine whether a continued inpatient hospital stay is Medically Necessary. PLAN, or its designee, will conduct concurrent care review where deemed appropriate by the PLAN and notify AHP of denial or approval to continue hospitalization. Concurrent care review may include on-site inpatient review with the Member. PLAN, its designee, and AHP agree that continuing hospitalization, where appropriate, will be reviewed in accordance with this review schedule until the Member is discharged, or notification of termination of coverage is issued by PLAN or its designee.
- d) **Transition of Care Planning** - To identify and refer inpatient Members for appropriate outpatient services subsequent to discharge from a hospital. AHP shall perform effective transition of care planning in collaboration with the Care Management staff.
- e) **Case Management** - To systematically identify high-risk patients and assess opportunities to coordinate and manage patients' total care to ensure the optimal health outcomes with efficient and cost-effective care. Case Management is a service offered at the PLAN's option administered by medical professionals, which focuses on unusually complex, difficult or catastrophic illnesses. Working with the Member's AHP(s) and subject to consent by the Member and/or the Member's family/caregiver, PLAN's Case Management staff will manage care to achieve the most efficient and effective use of resources.
- f) **Medical Policy** – PLAN's scientific statement on the quality of clinical evidence available in, among other sources, peer-reviewed literature, the conclusions that can be drawn from that evidence, and whether the technology or non-technology based service(s) improves health outcomes as applicable based on individual clinical circumstances. Medical Policy includes, but is not limited to, evidence-based findings.
- g) **Disease Management** – A system of coordinated care interventions and Member communications for populations with health conditions in which Member self-care efforts are significant.

5.2 **Notification of PLAN Determination.** PLAN shall notify AHP promptly, by telephone or other electronic communication and/or followed by written notice, when PLAN determines through the Medical Management Program: (1) that a service is not Medically Necessary or Investigational; (2) that it will not accept financial responsibility for initial or continued inpatient hospitalization, outpatient diagnostic or treatment procedures; or (3) when PLAN determines that a less restrictive or more appropriate setting is available for treatment of the Member in question.

5.2.1 No Authorization or approval by PLAN is a guarantee of payment. However, Authorizations will not be retracted upon retrospective review unless PLAN's Authorization was based upon a material omission or misrepresentation about the Member's health condition made by the AHP or unless the coverage was duly cancelled for fraud or nonpayment of premiums. Final benefit adjudication is subject to and conditioned on the terms and conditions of a Member's Contract/Certificate including,

without limitation, eligibility, waiting periods, exclusions, medical waivers or riders, deductibles, coinsurance, copayments, or other contract limitations, which cannot always be determined conclusively prior to claims submission.

- 5.3 **Authorization.** AHP expressly understands and agrees that failure to follow any procedures specified in the Medical Management Program as described in this Agreement and the PLAN's Provider Office Manual can result in no payment or limitation of payments, and AHP expressly agrees not to bill any Member for any unpaid charges or penalties that result from failure of AHP to comply with the procedures of the Medical Management Program. PLAN will notify AHP of significant changes to the Medical Management Program in writing prior to implementation of changes. Notwithstanding the provisions of this Section, PLAN agrees to exercise reasonable efforts to avoid retrospective denial of Claims for services to the extent possible within the confines of the Medical Management Program procedures.
- 5.4 **Program Compliance.** AHP also agrees to cooperate and participate with PLAN and other Network Providers in the development, implementation and ongoing operation of PLAN's Quality Management Program (hereinafter referred to as "QM Program") as described in PLAN's Provider Office Manual, and to satisfy any related requirements. Related requirements include, but are not limited to, the supply and collection of data necessary to conduct profiling of Network Providers in a manner and format prescribed by PLAN. The scope of the PLAN's Quality Management Program includes but is not limited to the following:
- a) Quality of Care Issues
 - b) Grievance and Appeal Resolution
 - c) Health Management and Wellness Activities
 - d) Performance Measures

ARTICLE VI RECORDS MAINTENANCE, AVAILABILITY, INSPECTION AND AUDIT

- 6.1 **Record Keeping.** AHP shall prepare and maintain all appropriate medical, financial and administrative records on Members receiving Medical Services from AHP. The records shall be prepared and maintained in accordance with prudent record-keeping procedures and as required by law. All Medical Services from AHP must be thoroughly and completely documented in the medical record for consideration of payment.
- 6.2 **Access and Confidentiality of Records.** Ownership and access to AHP's records of Members shall be controlled by applicable federal, state and local laws and this Agreement. AHP shall maintain the confidentiality of information contained in a Member's medical records and will only release such information as is permitted by applicable laws and that is: (1) necessary to other providers treating a Member; or (2) consented to by a Member. This Section will not be construed to prevent AHP from releasing information which he/she has taken from such medical records to organizations or individuals taking part in research, experimental, educational or similar programs, if no identification of a Member is made in the released information.
- 6.3 **Retention of Records.** Notwithstanding any other provision of this Agreement, including termination for any reason under Article X, AHP shall retain, and PLAN shall have access to, a Member's records for a period of at least six (6) years after the Member's last claim. This information may be retained as originals, on microfilms, or in other usable forms and shall afford a basis for a complete audit of professional information about services rendered to Members.
- 6.4 **Access to Records.** Notwithstanding any other provision of this Agreement, AHP agrees to allow PLAN or its designee, to inspect, audit and duplicate any and all information, including, but

not limited to, billing, payment, Medical Management, and medical records maintained by AHP on Members pursuant to this Agreement. The medical records of Members also shall be made available to other Network Providers participating in a Member's medical care as well as to PLAN to make determinations regarding quality of care, Medical Management Programs, peer review, grievance review or for other purposes. Such inspection, audit and duplication shall be allowed upon reasonable notice to AHP by PLAN during AHP's normal business hours, and duplication of such data and records shall be provided, without cost, to PLAN, its designee or Members. Failure to timely provide medical records upon request to substantiate services provided and/or complete and accurate diagnosis coding may result in limitation of payment or no payment.

- 6.5 **Requests for Records.** AHP shall provide PLAN, upon request and without charge to PLAN or Member, information including medical records of a Member reasonably required by PLAN to determine Benefits and verify services related to AHP's attendance, examination, and/or treatment and allow PLAN on-site audit of such records. Payment shall not be rendered for a particular claim unless AHP provides PLAN with necessary medical records reasonably required by PLAN to determine benefits. AHP expressly agrees not to bill any Member for any unpaid charges that result from failure of AHP to comply with PLAN's medical records request.

ARTICLE VII LIABILITY, INDEMNITY, AND INSURANCE

- 7.1 **No Third Party Beneficiary.** Neither Party to this Agreement nor any agent, employee or other representative of a Party shall be liable to third parties for any act by commission or omission of the other Party in performance of this Agreement and the terms and provisions hereunder.
- 7.2 **Indemnification.** **To the maximum extent allowed by law,** AHP agrees to indemnify and hold PLAN harmless from any and all liability, loss, damage, fines, demands, suits, actions, claims or expenses of any kind, including costs and attorney's fees, which result from any action involving alleged medical liability by AHP, his/her agents or employees, or which result from negligent or willful acts or omissions by AHP, his/her agents or employees regarding the performance of the duties and obligations of AHP under the terms of this Agreement, including, but not limited to, the duty to maintain the legal standard of care applicable to AHP. PLAN agrees to indemnify and hold AHP harmless from any and all liability, loss, damage, fines, demands, suits, actions, claims or expenses of any kind, including costs and attorney's fees, which result from negligent or willful acts or omissions by PLAN, its agents or employees, regarding the performance of the duties and obligations of PLAN under the terms of this Agreement.
- 7.3 **Notification of Legal Action.** AHP shall promptly notify PLAN of the initiation of legal action against him/her by a Member. PLAN shall promptly notify AHP of the initiation of legal action against PLAN by a Member, concerning or relating to the services rendered by AHP.
- 7.4 **Limitation of PLAN's Obligation.** Should an employer, group, individual or entity for whom PLAN or an Affiliate of PLAN provides, indemnifies or administers health care benefits, enter bankruptcy proceedings and be unable to reimburse PLAN-established premiums, claims expenses, administrative or other fees, PLAN's obligations under any Member Contract/Certificate relating to such person shall cease immediately, and PLAN shall have no obligation to AHP under this Agreement.
- 7.5 **Liability Insurance.** AHP shall procure and maintain, at his/her sole cost and expense, such policies of professional liability insurance as are necessary to insure AHP and his/her employees against any and all claims for damages arising from the performance of the duties and obligations of AHP under the terms of this Agreement. AHP also agrees to maintain comprehensive general

liability insurance in amounts consistent with AHP practice standards and participate in the Louisiana Patients' Compensation Fund. PLAN acknowledges that AHP is self-insured

- 7.6 **Proof of Insurance.** AHP agrees to provide to PLAN, upon request, copies of all certificates of insurance required by this Agreement and shall provide evidence of AHP's ability to meet any other requirement of this Article. In the event that AHP reserves funds to meet the insurance requirements of this Agreement, either in whole or in part, AHP agrees to provide to PLAN a statement from its independent auditor, consultant or other independent qualified expert attesting to the adequacy of such reserves.

ARTICLE VIII MARKETING, ADVERTISING, AND PUBLICITY

- 8.1 **Use of AHP'S name.** AHP agrees that PLAN may use his/her name, specialty, practice address and practice phone number in its advertising, publicity and promotional material with current and potential Members and Network Providers, informing Members of the identity of the provider as a AHP, and otherwise to carry out the terms of this Agreement. PLAN agrees that any use of AHP's name, specialty, etc., will be in a conservative and ethical manner so as to preserve the dignity of AHP.
- 8.2 **Marketing PLAN Products.** PLAN shall market, in its discretion, PLAN products to eligible groups and individuals, and shall encourage Members to use the services of all Network Providers.
- 8.3 **Ownership of Trademarks.** Except as provided in other provisions of this Agreement, PLAN and AHP each reserves the right and control of the use of its name, symbols, trademarks and service marks, owned by or licensed to them, presently existing or later established. In addition, except as provided in other provisions of this Agreement, neither PLAN nor AHP shall use the other's name, symbols, trademarks or service marks in advertising or promotional material or otherwise without the prior written consent of the other Party and shall cease any such use immediately upon written notice directing that such use be stopped or upon termination of this Agreement, whichever occurs first.

ARTICLE IX GENERAL DISPUTE RESOLUTION and ARBITRATION

- 9.1 **General Dispute Resolution.** PLAN shall make available to AHP a mechanism for resolution of disputes between the parties to this Agreement.

AHP may submit a notice to PLAN to invoke the dispute resolution process by writing to:

Blue Cross and Blue Shield of Louisiana
Appeals and Grievance Department
P.O. Box 98021
Baton Rouge, LA 70898-9021

Within sixty (60) days of receipt of such notice from AHP, the parties will assign the appropriate staff members who will arrange to discuss and seek resolution of the dispute, consistent with the terms of this Agreement. Any and all dispute resolution procedures shall be conducted only between the parties and shall not include any Member of PLAN unless such involvement of a Member is necessary to the resolution of the dispute. PLAN, in its sole discretion, will determine if Member's involvement is necessary to the resolution of the dispute.

If the parties are unable to reach resolution within the initial sixty (60) day period, then management from each party not involved in the initial discussion will have an additional thirty (30) days to resolve

the dispute. This time period may be extended by mutual agreement of the parties. The parties, as mutually agreed, may include a mediator in such discussions. The parties shall share equally the costs of the mediation. In any event, if additional meetings are held and no resolution of the dispute is reached within sixty (60) calendar days from the initial meeting, the parties shall elect binding arbitration as set forth herein in Article 9.2 to resolve the dispute. A party's failure to participate in the arbitration proceedings means that that party has acquiesced in the other party's demands. If resolution of the dispute occurs, the parties shall reduce such resolution to writing or amend the Agreement to include the resolution, if appropriate.

Notwithstanding the foregoing, benefits and utilization management determination issues (e.g., Medical Necessity or Investigational determinations) shall be handled in accordance with the Member Contract/Certificate and as outlined in the Provider Office Manual.

9.2 **Arbitration.** Subject to Article XII, Section 10 of the Constitution of the State of Louisiana of 1974, the parties shall abide by the following procedures for the arbitration process:

- (i) The party initiating the arbitration process shall send written notice to the other party setting forth the basis of the dispute and the party's desire to arbitrate. Each party shall share equally the costs of the arbitration. Arbitration shall be in accordance with the rules and procedures of either the American Arbitration Association or the American Health Lawyers' Association or another nationally recognized arbitration association acceptable to the parties.
- (ii) Arbitration shall be conducted in Baton Rouge, Louisiana before a single arbitrator mutually agreed upon by the parties.
- (iii) The arbitrator shall be bound by the terms and conditions set forth in the Agreement and the Member Contract/Certificate.
- (iv) The arbitrator may not award consequential, special, punitive or exemplary damages. The arbitrator may award costs, including reasonable attorney's fees, against a party. If the decision of the arbitrator does not include such award, the parties shall share equally the costs of the arbitration.
- (iv) The decision of the arbitrator shall be final in writing and shall be binding on the parties and enforceable under the laws of the state of Louisiana.
- (v) This provision shall survive the termination of this Agreement.

ARTICLE X
TERM AND TERMINATION

10.1 **Term.** When executed by both Parties, this Agreement shall become effective on the Date Accepted by PLAN and apply to Claims with dates of service on and after the Date Accepted by PLAN and shall have an initial term of one (1) year. This Agreement shall thereafter automatically be renewed for successive one (1) year periods unless terminated by either AHP or PLAN as provided in this Agreement.

10.2 **Termination.** This Agreement may be terminated:

- i) with or without cause by either party upon sixty (60) days prior written notice to the other party. The effective date of such termination shall be the first day of the month occurring at least sixty (60) days after the date of the notice of termination.
- ii) in the event AHP commits a material breach of this Agreement, which is not corrected within thirty (30) days of receipt by AHP of PLAN's written notice of such breach to AHP. PLAN may, at its sole option, extend the period for cure upon submission of a written plan by AHP to effectuate a cure, which plan is expeditiously carried out by the AHP. Any extension by the PLAN subject to submission of a plan of cure is immediately terminable by PLAN at its sole option.
- iii) automatically and immediately upon notice from PLAN upon the cancellation of the AHP's insurance coverage required to be maintained in accordance with this Agreement.
- iv) automatically and immediately upon notice in the event either party fails to obtain or maintain any licenses or certifications required by applicable law or regulation.
- v) automatically and immediately upon notice from PLAN in the event AHP's ability to participate in Medicare, Medicaid, TRICARE or the FEHBP programs is terminated, suspended, or restricted in any material way.
- vi) automatically and immediately upon notice from PLAN if PLAN determines in its reasonable judgment that AHP's continued participation may jeopardize the health, safety or welfare of Members.
- vii) automatically and immediately upon notice from PLAN in the event that PLAN determines in its reasonable judgment that AHP has committed fraud or misrepresentation.
- viii) automatically and immediately upon notice from PLAN in the event AHP is convicted of a felony or commits acts of moral turpitude.
- ix) automatically and immediately upon notice from PLAN in the event that AHP fails to meet PLAN's credentialing criteria.
- x) upon sixty (60) days prior written notice from PLAN to AHP if the AHP changes affiliations, admitting privileges or specialty status in such a way as to substantially limit the AHP's range of services or access to network facilities.

10.3 **Termination of Affiliated AHPs.** If AHP is contracting on behalf of multiple AHPs through a medical group, independent physician association, physician hospital organization or similar such entity and/or arrangement, then PLAN may require AHP to terminate or suspend a member AHP pursuant to this provision. In that case, AHP shall provide affected AHP written notice of the reasons for the action.

10.4 **Assignment.** No assignment of the rights, duties or obligations of this Agreement shall be made by either party without the written consent of the other party. In the event a party does not obtain the written consent of the other party to an assignment, the other party may terminate this Agreement without advance notice.

10.5 **Continuation of Services.** If this Agreement is terminated pursuant to any provision other than Section 11.2 (iii), (iv), (v), (vi), (vii), (viii) or (ix), AHP shall continue to provide Covered Services under the terms of this Agreement to Members who are hospital inpatients or who are

receiving care in a free-standing ambulatory facility on the date of termination until those Members are discharged or are transferred by PLAN to another Network Provider or at the end of the Member's Contract/Certificate Benefit period, or upon reaching the Member's Contract/Certificate lifetime maximum, whichever occurs first. In such circumstances, PLAN shall compensate AHP for such Covered Services provided in accordance with the terms of this Agreement.

- 10.6 **Continuity of Care.** If this Agreement is terminated pursuant to any provision other than termination due to suspension or revocation of the AHP's license to practice in Louisiana or for another documented reason related to quality of care, AHP has the option to provide Covered Services under the terms of this Agreement to a Member who has begun a course of treatment by AHP before the effective date of the termination and who has been diagnosed as either: 1) being in a high-risk pregnancy or is past the 24th week of pregnancy; or 2) diagnosed with a life-threatening illness. "Life-threatening illness" means a severe, serious, or acute condition for which death is probable. In the case of a Member who has been diagnosed as being in a high-risk pregnancy or is past the 24th week of pregnancy, the Member shall be allowed to continue receiving Covered Services from AHP through delivery and postpartum care related to the pregnancy and delivery. If a Member has been diagnosed with a life-threatening illness, the Member shall be allowed to continue receiving Covered Services from AHP until the course of treatment is completed, not to exceed 3-months from the effective date of the termination. If AHP notifies PLAN of a Member who meets the above criteria, PLAN shall compensate AHP for such Covered Services provided in accordance with the terms of this Agreement. However, AHP must still follow PLAN's utilization management and quality management policies and procedures and not balance or discount bill the Member for Covered Services rendered during the applicable period specified above. This provision shall not apply if the Member chooses to change providers, the Member moves out of the geographic service area of PLAN, or the Member requires only routine monitoring for a chronic condition but is not in an acute phase of the condition.
- 10.7 **Effect of Termination.** Termination of this Agreement shall have no effect upon the rights and obligations of the Parties arising out of any transactions occurring prior to the effective date of termination. In the event of termination, AHP will cooperate with PLAN in the orderly transfer of a Member's care, including a Member's medical records, to other Network Providers. AHP and PLAN will cooperate to promptly resolve any outstanding financial, administrative or patient care issues upon the termination or expiration of this Agreement.
- 10.8 **AHP Non-Interference.** During the term of this Agreement, and following the termination or expiration of this Agreement, AHP agrees to refrain from any action that interferes with the relationship between PLAN and its existing or prospective Members or Network Providers.
- 10.9 **Notification of Termination.** It is the responsibility of PLAN to notify Members of the termination of this Agreement. Upon termination of this Agreement, AHP hereby authorizes PLAN to publish AHP's name via newspaper or otherwise to convey to Members that AHP no longer participates in PLAN's provider networks.

ARTICLE XI RELATIONSHIP OF PARTIES

- 11.1 **Independent Parties.** In the performance of this Agreement and in rendering Covered Services as required herein, AHP shall at all times act as an independent contractor who practices the profession of medicine. Nothing in this Agreement shall be construed or be deemed to create a relationship of employer and employee or principal and agent, or any relationship other than that of independent parties contracting with each other solely for the purpose of carrying out the provisions of this Agreement. PLAN shall not have nor exercise any control or direction over the methods by which AHP shall perform his/her professional duties or over the doctor/patient relationship.

- 11.2 **Blue Cross and Blue Shield Association.** AHP hereby expressly acknowledges his/her understanding that this Agreement constitutes a contract between AHP and PLAN, that PLAN 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 PLAN to use the Blue Cross and Blue Shield Service Mark(s) in the State of Louisiana, and that PLAN is not contracting as an agent of the Association. AHP further acknowledges and agrees that he/she has not entered into this Agreement based upon representations by any person other than PLAN and that no person, entity, or organization other than PLAN shall be held accountable or liable to AHP for any of PLAN's obligations to AHP created under this Agreement. This paragraph shall not create any additional obligations whatsoever on the part of PLAN other than those obligations created under other provisions of this Agreement.
- 11.3 **AHP Entity.** If the party contracting hereunder for AHP is a partnership, corporation, or any other entity other than an individual professional provider, all references herein to "AHP" shall also mean and refer to each AHP of such entity individually who has applied for and been accepted by PLAN as a Network Provider.
- 11.4 **Applicability of Agreement.** Unless clearly inapplicable, all of the terms of this Agreement shall apply to AHP and other health care providers affiliated with, employed by or associated with AHP (as indicated on the signature page and as updated regularly) and it shall be AHP's obligation to ensure such compliance. If applicable, AHP shall enter into a written agreement with each and every AHP contracted provider, obligating said provider to the terms and conditions of this Agreement and shall provide a listing of such executed contracts to PLAN upon AHP's receipt thereof.

ARTICLE XII CONFIDENTIALITY

- 12.1 **Confidentiality and Non-Disclosure.** Due to the competitive nature of the health care market, PLAN and AHP agree that the terms of this Agreement and all records, documents, data, figures and other information required to be prepared or maintained by this Agreement shall be kept strictly confidential. Such information includes, but is not limited to, the terms of this Agreement, particular Reimbursement Amounts/Allowable Charges, PLAN enrollment data, and medical and utilization management program and figures. Disclosure of such information by AHP, or AHP's agents, employees or representatives may result in automatic termination of this Agreement. Nothing in this section shall restrict AHP from communicating with his/her patient regarding health care, treatment options, and medical alternatives, or other coverage arrangements. PLAN and AHP may disclose the terms of this Agreement to affiliated companies which are owned, in whole or in part, by PLAN or AHP directly or indirectly through one of its intermediaries or subsidiaries. PLAN and AHP may also disclose the terms of this Agreement to non-parties for the purpose of (1) soliciting new business to be served by network providers including, but not limited to responding to request for proposals or request for information; (2) administering claims incurred by accounts which are served by network providers; (3) facilitating a claims audit; (4) responding to a survey for statistical information that does not identify AHP; (5) responding to a reinsurer's request for information; or (6) compliance with federal, state and/or local laws. PLAN and AHP, their agents and employees, may disclose to non-parties that AHP is a network provider. Except as otherwise stated, PLAN and AHP may disclose the terms of this Agreement to non-parties with the prior written approval of both AHP and PLAN.
- 12.2 **Release of Certain Provider Data.** Notwithstanding Article 12.1, PLAN is permitted to release provider-specific health care data for the purpose of allowing Members, employer groups and others to relatively compare the cost and level of quality of care.

- 12.2.1 Data may include, but shall not be limited to, provider demographic information, utilization information, quality of care measures and initiatives, service volumes, small area analysis, credentialing information, outcome measures, patient satisfaction results, costs and similar health care data.
- 12.2.2 AHP agrees to provide or assist in the provision of such provider-specific health care data.
- 12.2.3 PLAN shall make available a description of how PLAN intends to use a particular category of provider-specific health care data, the methodology used in collecting and analyzing the data and a copy of the AHP's data which PLAN intends to disclose.
- 12.2.4 To the extent AHP can reasonably demonstrate, in writing, that any data which PLAN intends to disclose is inherently inaccurate, AHP shall notify PLAN of its specific concerns

ARTICLE XIII GENERAL PROVISIONS

- 13.1 **Waiver of Breach.** Waiver of a breach of any provision of this Agreement shall not be deemed a waiver of any other breach of the same or a different provision.
- 13.2 **Severability.** In the event any provision of this Agreement is rendered invalid or unenforceable by any federal, state or local law, or by any regulation duly promulgated by officers of the United States or of the State of Louisiana acting in accordance with the law, or declared null and void by any court of competent jurisdiction, the remainder of the provisions of this Agreement shall remain in full force and effect. In the event that any provision of this Agreement is rendered invalid or unenforceable or is declared null and void as provided in this Article, and its removal has the effect of materially altering the obligations of either AHP or PLAN in such manner as, in the judgment of the entity affected: (1) will preclude the provision of Covered Services pursuant to the terms of this Agreement; (2) will cause serious financial hardship to the entity affected; or (3) will cause such entity to act in violation of its corporate articles and bylaws, the entity so affected shall have the right to terminate this Agreement upon thirty (30) days prior written notice to the other entity.
- 13.3 **Amendment to Agreement.** PLAN retains the right to amend this Agreement, the Provider Office Manual, any Exhibits, attachments or addenda, and the Medical Management and Quality Management Programs, by making a good faith effort to provide notice to AHP at least sixty (60) days in advance of the effective date of the amendment. If AHP decides not to accept the amendment, AHP has the right to terminate this Agreement by providing written notice to PLAN at least thirty (30) days from receipt of such notice from PLAN. AHP's termination shall take effect thirty (30) days from the date AHP has provided notice of its intention to terminate pursuant to this provision. Failure of AHP to provide such notice to PLAN within the timeframes described herein will constitute acceptance of the amendment by AHP. If however, any amendment is required as a result of federal and/or state laws, regulations or procedures, this Agreement shall be deemed to conform to such laws, regulations or procedures and such amendment will be effective in accordance with such laws, regulations or procedures, as determined by PLAN.
- 13.4 **Examinations under Law.** AHP agrees that when examinations are conducted pursuant to Louisiana state law, AHP and PLAN will produce and make freely accessible to the Louisiana Insurance Commissioner all accounts, records, documents and files in their possession or control relating to the subject of the examination. AHP and PLAN's officers, employees and representatives also will produce and make freely accessible such material and will facilitate the examination and aid the examiners as far as is within their powers.
- 13.5 **Headings.** The headings of the Articles contained in this Agreement are for reference

- 13.14 **Survival of Articles.** The provisions of Articles 7.2, 7.5, 9 and 12 will survive the expiration of this Agreement for any reason.
- 13.15 **Electronic Signatures.** This Agreement may be validly executed via facsimile transmission showing the signatures of the parties. Further, any reproduced or electronic copy of this Agreement shall constitute an original Agreement for all purposes.
- 13.16 **Legal Action.** In the event that either PLAN or AHP initiate any action, suit, or proceedings to enforce the provisions of this Agreement, each party shall bear its own costs and attorney fees.
- 13.17 **Premium Payment.** Premiums are owed by Members. Premiums may not be paid by third parties, including but not limited to AHP. The PLAN will not accept premium payments by third parties or AHP unless required by law to do so. The fact that the PLAN may have previously accepted a premium from an unrelated third party does not mean that the PLAN will accept premiums from these parties in the future.

IN WITNESS WHEREOF, this Agreement has been duly executed by the authorized officials of PLAN and AHP on the date(s) written below:

AHP

BLUE CROSS AND BLUE SHIELD OF LOUISIANA

Signature

Duly Authorized Official

Mayor-President
Title

Senior Vice President
Title

PRINTED
NAME: Sharon Weston Broome
Duly Authorized Official

PRINTED
NAME: Sabrina B. Heltz
Duly Authorized Official

P.O. Box 1471
Address

Date Accepted (Effective Date)

Baton Rouge, LA 70821-1471
City Zip Code

HMO LOUISIANA, INC.

Phone No. Specialty

Duly Authorized Officer

Date

Date

TAX ID: _____

CHECK APPROPRIATE BOX:

- Allied Health Provider (Professional)
- Allied Health Provider Group (Professional)
- Allied Health Provider (Facility)

**REIMBURSEMENT EXHIBIT A
TO THE AHP AGREEMENT**

ARTICLE 1. EFFECTIVE PERIOD

The compensation arrangement contained in this Exhibit shall be effective from the Effective Date (Date Accepted by PLAN) of this Agreement.

ARTICLE 2. NETWORK PARTICIPATION

PLAN and City of Baton Rouge Parish of East Baton Rouge do hereby agree that AHP will render services as a participant in the following network programs (please indicate by placing an X below):

<u> X </u>	Traditional/Key Program (effective through 8/31/13, at which time Program will terminate)
<u> X </u>	Preferred Provider Organization Program (PPO)
<u> X </u>	Health Maintenance Organization Program (HMO)

By signing this Agreement, AHP agrees to tender services as a Traditional/Key Provider, Preferred Provider Organization (PPO) Provider or Health Maintenance Organization (HMO) Provider when the respective programs are indicated above and to accept the appropriate PLAN Allowable Charge(s) accordingly. If AHP is a Traditional/Key or PPO Provider but is not an HMO Provider, AHP agrees to accept the BCBSLA PPO Allowable Charge as described in the Reimbursement Exhibit when treating members with HMO Contracts/Certificates subject to applicable Deductible, Non-Covered Services, Copayment, and/or Coinsurance as defined by the Member Contract/Certificate.

ARTICLE 3. SERVICES AND COMPENSATION

3.1 Services

AHP agrees to provide or arrange for the provision of Covered Services to Members within the scope of his/her medical practice in accordance with terms and conditions of this agreement and Exhibits attached hereto.

3.2 Compensation

AHP understands and agrees that PLAN shall pay AHP for the provision of Covered Services based upon either the applicable BCBSLA Allowable Charge or HMOLA Allowable Charge, depending upon the applicable Member Contract/Certificate.

3.3 Ambulance

Procedure Codes	Description	BCBSLA Allowable Charge	HMOLA Allowable Charge
A0425	Ground Mileage	\$13.46	\$12.31
A0426	Ambulance service, advanced life support, non-emergency transport, level 1 (ALS1)	\$641.52 *	\$583.93 *

Procedure Codes	Description	BCBSLA Allowable Charge	HMOLA Allowable Charge
A0427	Ambulance service, advanced life support, emergency transport, level 1 (ALS1-emergency)	\$914.76 *	\$836.70 *
A0428	Ambulance service, basic life support, non-emergency transport (BLS)	\$413.21 *	\$377.95 *
A0429	Ambulance service, basic life support, emergency transport (BLS-emergency)	\$729.78 *	\$667.50 *
A0430	Ambulance service, conventional air services, transport, one way (fixed wing)	\$5,215.01 *	\$4,770.03 *
A0431	Ambulance service, conventional air services, transport, one way (rotary wing)	\$6,075.14 *	\$5,545.85 *
A0433	Advanced life support, level 2 (ALS2)	\$1,121.19	\$972.35 *
A0434	Specialty care transport	\$1,325.80*	\$1,173.55*
A0435	Fixed wing air mileage	\$15.21	\$13.91
A0436	Rotary wing air mileage	\$62.16	\$54.45

* Supplies included in the fee.

AHP will indemnify and hold PLAN and Member harmless from any and all Billed Charges and for any and all HCPCS procedure codes not listed in Exhibit A.

All transports by fixed wing aircraft shall be approved by PLAN prior to the time of such transports.

The Medical Necessity of air versus land transportation will be evaluated in every case. If it is determined that air transportation was not Medically Necessary, than the applicable land rate will apply.

PLAN may expand and/or modify the Reimbursement Exhibit A based on new, deleted, or modified codes developed subsequent to the effective date of the Agreement. PLAN shall provide notice of the Schedule change.