Introduced by _____ Council Bill No. _____R 56-14_____

A RESOLUTION

authorizing a provider agreement with RightCHOICE Managed Care, Inc. to allow for reimbursement of approved clinical services provided to Anthem Blue Cross/Blue Shield participants.

BE IT RESOLVED BY THE COUNCIL OF THE CITY OF COLUMBIA, MISSOURI, AS FOLLOWS:

SECTION 1. The City Manager is hereby authorized to execute a provider agreement with RightCHOICE Managed Care, Inc. to allow for reimbursement of approved clinical services provided to Anthem Blue Cross/Blue Shield participants. The form and content of the agreement shall be substantially as set forth in "Exhibit A" attached hereto and made a part hereof.

ADOPTED this _____ day of _____, 2014.

ATTEST:

_____ _____

City Clerk Mayor and Presiding Officer

APPROVED AS TO FORM:

_____

City Counselor

PROVIDER AGREEMENT

WITH

COLUMBIA-BOONE COUNTY DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

PROVIDER AGREEMENT

This Provider Agreement (hereinafter "Agreement") is made and entered into by and between RightCHOICE Managed Care, Inc. (hereinafter "Company") and Columbia-Boone County Department of Public Health and Human Services (hereinafter "Provider"). Neither HealthLink, Inc. nor HealthLink HMO, Inc. will be considered a party to this Agreement or an Affiliate as defined below. In consideration of the mutual promises and covenants herein contained, the sufficiency of which is acknowledged by the parties, the parties agree as follows:

City of Columbia, Missouri on behalf of its

ARTICLE I
DEFINITIONS

"Affiliate" means any entity owned or controlled, either directly or through a parent or subsidiary entity, by Company, or any entity which is under common control with Company and that accesses the rates, terms or conditions of this Agreement. Company will have a current listing of such Affiliates available through a commonly available web site or upon request.

"Company Rate" means the lesser of Provider's Charges for Covered Services, or the total reimbursement amount that Provider and Company have agreed upon as set forth in the Plan Compensation Schedule ("PCS"). The Company Rate shall represent payment in full to Provider for Covered Services.

"Capitation" means the amount of pre-payment made by Company to a provider or management services organization on a per member per month basis for either specific services or the total cost of care.

"Case Rate" means the all inclusive Company Rate for an entire admission or one outpatient encounter. "Global Case Rate" means the all inclusive Company Rate which includes facility, professional and physician services for specific Coded Service Identifier(s).

"Claim" means either the uniform bill claim form or electronic claim form in the format prescribed by Plan submitted by a provider for payment by a Plan for Health Services rendered to a Covered Individual. "Complete Claim" means, unless state law otherwise requires, an accurate Claim submitted pursuant to this Agreement, for which all information necessary to process such Claim and make a benefit determination is included.

"Coded Service Identifier(s)" means a listing of descriptive terms and identifying codes, updated from time to time by the Centers for Medicare and Medicaid Services ("CMS") or other industry source, for reporting Health Services on the CMS 1500 claim form or its successor. The codes include but are not limited to, American Medical Association Current Procedural Terminology ("CPT®-4"), CMS Healthcare Common Procedure Coding System ("HCPCS"), International Classification of Diseases, 9th Revision, Clinical Modification ("ICD-9-CM"), and National Drug Code ("NDC") or their successors.

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

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

"Covered Services" means Medically Necessary Health Services, as determined by Plan and described in the applicable Health Benefit Plan, for which a Covered Individual is eligible for coverage. Covered Services do not include the preventable adverse events as set forth in the provider manual(s).

"DRG" means Diagnosis Related Group or its successor as established by CMS or other grouper.

"DRG Rate" means the all inclusive dollar amount applied to the appropriate DRG Weight which results in the Company Rate, if the reimbursement methodology as set forth in the PCS is on a DRG basis.

"DRG Weight" means the CMS cost weights for each DRG as published in the Federal Register to be effective on October 1st each year, or other cost weights used by Company.

"Emergency Condition", the sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent lay person, possessing an average knowledge of medicine and health, to believe that immediate medical care is required, which may include, but shall not be limited to: (a) Placing the person's health in significant jeopardy; (b) Serious impairment to a bodily function; (c) Serious dysfunction of any bodily organ or part; (d) Inadequately controlled pain; or (e) With respect to a pregnant woman who is having contractions: (a) that there is inadequate time to effect a safe transfer to another hospital before delivery; or (b) that transfer to another hospital may pose a threat to the health or safety of the woman or unborn child. "Emergency Services" means those Covered Services furnished or required to evaluate and treat an Emergency Condition, which may include, but shall not be limited to, Covered Services that are provided in a licensed hospital's emergency facility by an appropriate provider."

"Encounter Data" means Claims information submitted by a Provider under capitated or risk-sharing arrangements, for Health Services rendered to Covered Individuals.

"Health Benefit Plan" means the document(s) describing the partially or wholly: insured, underwritten, and/or administered, marketed health care benefits, or services program between the Plan and an employer, governmental entity, or other entity or individual.

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

"Medically Necessary" or "Medical Necessity" means the definition as set forth in the Health Benefit Plan, unless a different definition is required by statute or regulation.

"Network" means a group of providers that support, through a direct or indirect contractual relationship, some or all of the product(s) and/or program(s) in which Covered Individuals are enrolled.

"Network/Participating Provider" means a provider designated by Plan to participate in one or more Network(s).

"Other Payors" means persons or entities, utilizing the Network(s)/Plan Program(s) pursuant to an agreement with Company or an Affiliate, including without limitation, other Blue Cross and/or Blue Shield Plans that are not Affiliates, and employers or insurers providing Health Benefit Plans pursuant to insured, self-administered or self-insured programs.

"Participation Attachment" means the document(s) attached to and made a part of this Agreement which identifies the additional duties and/or obligations related to Network(s) and/or Plan Program(s).

"Percentage Rate" means the Company Rate that is expressed as a percentage of allowed Provider Charges.

"Per Diem Rate" means the Company Rate that is expressed as the all inclusive fixed payment for Covered Services rendered on a single date of service.

"Per Hour Rate" means the Company Rate that is applicable when payment is derived based on an increment of time multiplied by the Company Rate in the applicable fee schedule.

"Per Unit Rate" means the Company Rate that is applicable when payment is derived based on a unit of service multiplied by the Company Rate in the applicable fee schedule(s).

"Per Visit Rate" means the Company Rate that is expressed as the all inclusive fixed payment for one outpatient encounter.

"Plan" means Company, an Affiliate as designated by Company, and/or an Other Payor. For purposes of this Agreement, when the term "Plan" applies to an entity other than Company, "Plan" shall be construed to only mean such entity.

"Plan Compensation Schedule" ("PCS") means the document(s) attached to, or made a part of this

Agreement which sets forth the Company Rate(s) and compensation related terms for the Network(s) in which Provider participates. The PCS may include additional Provider obligations and specific Company compensation related terms and requirements.

"Plan Fee Schedule(s)" means the schedule of the maximum amounts that Plan will pay for Covered Services, less Cost Shares if applicable. The Plan Fee Schedule(s) applicable for the Network(s) in which Provider participates is further described in the PCS.

"Plan Program" means any program now or hereafter established, marketed, administered, sold, or sponsored by Plan, or Blue Cross Blue Shield Association ("BCBSA") (and includes the Health Benefit Plans that access, or are issued, or entered into in connection with such program). Plan Program shall include but is not limited to, a health maintenance organization(s), a preferred provider organization(s), a point of service product(s) or program(s), an exclusive provider organization(s), an indemnity product(s) or program(s) and a quality program(s). The term Plan Program shall not include any program excluded by Plan or BCBSA.

"Provider Charges" means the regular, uniform rate or price Provider determines and submits to Company as charges for Health Services provided to Covered Individuals. Such Provider Charges shall be no greater than the rate or price Provider submits to any person or other health care benefit payor for the same Health Services provided, regardless of whether Provider agrees with such person or other payor to accept a different rate or price as payment in full for such services.

ARTICLE II
SERVICES/OBLIGATIONS

2.1 Covered Individual Identification. When required by applicable law, Company will make available to Provider a method whereby Provider can obtain, in a timely manner, general information about eligibility and coverage, including information regarding Cost Share amounts, and information regarding the Provider's obligations to collect applicable Cost Share amounts and the Provider's obligations, if any, to notify Covered Individuals of their personal financial obligations for non-Covered Services.

2.2 Provider Non-discrimination. Provider shall provide Health Services to Covered Individuals in a manner similar to and within the same time availability in which Provider provides Health Services to any other individual. Provider will not differentiate, or discriminate against any Covered Individual as a result of his/her enrollment in a Plan, or because of race, color, creed, national origin, ancestry, religion, sex, marital status, age, disability, payment source, state of health, need for health services, status as a litigant, status as a Medicare or Medicaid beneficiary, sexual orientation, or any other basis prohibited by law. Provider shall not be required to provide any type, or kind of Health Service to Covered Individuals that he/she/it does not customarily provide to others.

2.3 Publication and Use of Provider Information. For the term of this Agreement, Provider agrees that Company and Plans may use, publish, disclose, and display information and disclaimers, as applicable, relating to Provider. Company will make reasonable efforts to share data with Provider prior to initial disclosure or publication of any information related to a procedure or service for its transparency initiative(s) impacting Provider.

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

2.5 Submission and Payment of Claims. Unless otherwise instructed, or required by state or federal law, Provider shall submit Claims to Plan, using appropriate and current Coded Service Identifier(s), within one hundred eighty (180) days from the date the Health Services are rendered or Plan will refuse payment.

2.5.1 Provider agrees to provide to Company, unless otherwise instructed, at no cost to Company, Plan or the Covered Individual, all information necessary for Plan to determine its payment liability. Such information includes, without limitation, accurate and Complete Claims for Covered Services. Once Company determines Plan has any payment liability, all Complete Claims will be paid in accordance with the terms and conditions of a Covered Individual's Health Benefit Plan and the PCS.

2.5.2 Provider agrees to submit Claims in a format consistent with industry standards and acceptable to Plan either (a) electronically or (b) if electronic submission is not available, utilizing paper forms. If

Plan is the secondary payor, the one hundred eighty (180) day period will not begin until Provider receives notification of primary payor's responsibility.

2.5.3 If Company or Plan asks for additional information so that Plan may process the Claim, Provider must provide that information within sixty (60) days, or before the expiration of the one hundred eighty (180) day period referenced above, whichever is longer.

2.5.4 In no event, shall Provider bill, collect, or attempt to collect payment from the Covered Individual for Claims Plan receives after the applicable period(s) as set forth above, regardless of whether Plan pays such Claims.

2.5.5 In all events, however, Provider shall only look for payment (except for applicable Cost Share or other obligations of Covered Individuals) from the Plan that provides the Health Benefit Plan for the Covered Individual for Covered Services rendered.

2.6 Plan Payment Time Frames. Company shall require Plans or their designees to use commercially reasonable efforts to adjudicate or arrange for adjudication and where appropriate make payment for all Complete Claims for Covered Services submitted by Provider within ninety (90) days, exclusive of Claims that have been suspended due to the need to determine Medical Necessity, or the extent of Plan's payment liability, if any, because of issues such as coordination of benefits, subrogation or verification of coverage.

2.7 Payment in Full and Hold Harmless.

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

2.7.2 Provider agrees that in no event, including but not limited to, nonpayment by applicable Plan, insolvency of applicable Plan, or breach of this Agreement, shall Provider, or any person acting on behalf of Provider, bill, charge, collect a deposit from, seek compensation from, or have any other recourse against a Covered Individual, or a person legally acting on the Covered Individual's behalf, for Covered Services provided pursuant to this Agreement. This section does not prohibit Provider from collecting reimbursement for the following from the Covered Individual:

2.7.2.1 Cost Shares, if applicable;

2.7.2.2 Health Services that are not Covered Services (other than preventable adverse events). However, Provider may seek payment for a Health Service that is not Medically Necessary or is experimental/investigational only if Provider obtains a written waiver that meets the following criteria:

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

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

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

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

2.7.2.3 Any reduction in or denial of payment as a result of the Covered Individual's failure to comply with his/her utilization management program, in those circumstances where Provider has no obligation to obtain Utilization Management.

2.7.3 Except as provided in this section 2.7, this Agreement does not prohibit Provider from pursuing any available legal remedy, including but not limited to, collecting from any insurance carrier providing coverage to a Covered Individual.

2.8 Adjustments for Incorrect Payments. Provider shall refund all duplicate or erroneous Claim payments regardless of the cause. In lieu of a refund, Plan may offset future Claim payments. Except as provided below, Provider and Company agree that any payment or payment determination made by or on behalf of a Plan that is a "health carrier" ("Health Carrier Plan") constitutes full and final satisfaction of any Claim for payment submitted by Provider to or for that Health Carrier Plan. If Company fails to challenge, through a written refund request or an offset, any payment or payment determination made by or on behalf of a Health Carrier Plan within twelve (12) months after such payment or payment determination is made, such payment and/or payment determination shall be deemed a full and final settlement of the Claim and shall constitute an accord and satisfaction between and among Provider, Company and the Health Carrier Plan with respect to the Claim. Nothing in this provision 2.8 prevents or precludes such a Plan (or anyone acting on its behalf) from pursuing recovery, recovering or making an adjustment for any overpayment (i) that a Plan is obligated by law to recover (through the imposition of a duty or otherwise), (ii) that a Plan is obligated by duty or contract to recover and for which the Plan is not prohibited by law from recovering, (iii) that is made due to any fraud or misrepresentation, or (iv) that is made with respect to a Covered Individual with a "Health Benefit Plan" that is not subject to Mo. Rev. Stat. §376.384.1(3) (or any successor thereto) for whatever reason (e.g., by inapplicability, exclusion, preemption, etc.). For purposes of this Section 2.8, the terms "health carrier" and "Health Benefit Plan" have the meanings ascribed to such terms in Mo. Rev. Stat. §376.383 (or any successor thereto).

2.9 Provider Subcontractors. Provider may fulfill some of his/her/its duties under this Agreement through subcontractors or delegates. Hereinafter, subcontractors and delegates are referred to as "subcontractors". Provider shall assure the compliance of his/her/its subcontractors with the terms and conditions of this Agreement as applicable. Provider shall be solely responsible to pay subcontractor for any Health Services. Provider shall indemnify Company, Plan and Covered Individuals for any failure of any subcontractor to so comply. If Company has a direct contract with the subcontractor ("direct contract"), the direct contract shall prevail over this Agreement.

2.10 Compliance with Provider Manual(s) and Policies, Programs and Procedures. Provider agrees to abide by, and comply with, Company's provider manual(s), and all other policies, programs and procedures (collectively "Policies") established and implemented by Plan. Company or its designees may modify the provider manual(s) and Policies by making a good faith effort to provide notice to Provider at least forty-five (45) days in advance of the effective date of material modifications thereto.

2.11 In Network Referrals and Transfers. Provider shall refer and transfer Covered Individuals to Network/Participating Providers unless Provider has obtained a written acknowledgement (e.g. written waiver form) from the Covered Individual, prior to the provision of the service, indicating that (1) the Covered Individual was advised that no coverage, or only out-of-network coverage would be available from Plan and (2) the Covered Individual agreed to be financially responsible for additional costs related to such service. Additionally, Provider represents and warrants that Provider does not give, provide, condone or receive any incentives or kickbacks, monetary or otherwise, in exchange for the referral of a Covered Individual, and if a Claim for payment is attributable to an instance in which Provider provided or received an incentive or kickback in exchange for the referral, such Claim shall not be payable and, if paid in error, shall be refunded to Company.

2.12 Programs and Provider Panels. Provider acknowledges that Plan may have, develop, or contract to develop, various networks or programs that have a variety of provider panels, program components and other requirements, and that Plan may discontinue, or modify such networks or programs. In addition to those Networks designated on the signature page of the Agreement, Company may also identify Provider as a Network/Participating Provider in additional Networks and/or products designated in writing from time to time by Company. The terms and conditions of Provider's participation as a Network/Participating Provider in such Networks and/or products shall be on the terms and conditions set forth in this Agreement unless otherwise agreed to in writing by Provider and Company.

2.12.1 Provider further acknowledges and understands that Company participates in the Federal Employees Health Benefit Program (FEHBP) the health insurance plan for federal employees. Provider further understands and acknowledges that the FEHBP is a federal government program and the requirements of the program are subject to change at the sole direction and discretion of

the United States Office of Personnel Management. Provider agrees to abide by the rules, regulations and other requirements of the FEHBP as they exist and as they may be amended or changed from time to time. Provider further agrees that in the event of a conflict between this Agreement and/or the provider manual, and the rules/regulations/other requirements of the FEHBP, the terms of the rules/regulations/other requirements of the FEHBP shall control.

2.12.2 Provider agrees to participate in Company's Pathway X/Pathway Network, which may support both products or Plan Programs offered by Company through state-based, regional or federal health insurance exchanges ("Exchanges") established by the Patient Protection and Affordable Care Act that will become effective on January 1, 2014 and products or Plan Programs offered by Company outside of Exchanges. Provider acknowledges and understands that products or Plan Programs offered through or outside of the Exchanges may differ, and that such products or Plan Programs are subject to federal and state regulatory requirements. Provider agrees to abide by all applicable rules, regulations and other requirements of the Exchanges as they exist and as they may be amended or changed from time to time. Should Company change the name of the Network set forth in this subsection 2.12.2, and on the Provider Locations/Networks Attachment, it shall notify Provider.

2.13 Provider's Inability to Carry Out Duties. Provider shall immediately send written notice, in accordance with the Notice section of this Agreement, to Company of:

2.13.1 Any change in Provider's business address;

2.13.2 Any legal, governmental, or other action involving Provider which could materially impair the ability of Provider to carry out his/her/its duties and obligations under this Agreement, except for temporary emergency diversion situations; or

2.13.3 Any change in accreditation, provider affiliation, insurance, licensure, certification or eligibility status, admitting privileges, or other relevant information regarding Provider's practice or status in the medical community.

2.14 Provider Credentialing. Where applicable, Provider agrees that he/she/it meets Company's credentialing standards or other applicable standards of participation for Networks in which Provider participates. A description of the credentialing program or applicable standards of participation, including any applicable accreditation requirements, is set forth in the provider manual(s).

2.15 Adjustment Requests. If Provider believes a Claim has been improperly adjudicated for a Covered Service for which Provider timely submitted a Claim to Plan, Provider must submit a request for an adjustment to Plan within one hundred eighty (180) days from the date of Plan's payment or explanation of payment, unless otherwise set forth in the provider manual. The request must be submitted in accordance with Plan's payment inquiry process. Requests for adjustments submitted after this date may be denied for payment, and Provider will not be permitted to bill Company, Plan, or the Covered Individual for those services for which payment was denied.

2.16 Blue Cross Blue Shield Out of Area Program. Provider agrees to provide Covered Services to any person who is covered under another BCBSA out of area or reciprocal programs and to submit Claims for payment in accordance with current BCBSA Claims filing guidelines. Provider agrees to accept payment by Plan at the Company Rate for the equivalent Network as payment in full except Provider may bill, collect and accept compensation for Cost Shares. The provisions of this Agreement shall apply to Provider Charges for Covered Services under the out of area or reciprocal programs. Provider further agrees to comply with other similar programs of the BCBSA. For Covered Individuals who are enrolled under BCBSA out of area or reciprocal programs, Provider shall comply with the applicable Plan's utilization management policies.

2.17 Supervision of Services. Provider agrees that all Health Services provided to Covered Individuals under this Agreement shall be provided by Provider or by a qualified person under Provider's direction. Provider shall warrant that any nurses or other health professionals employed by or providing services for Provider shall be duly licensed or certified under applicable law.

2.18 Pass-Through Charges. Provider agrees not to pass through to Plan or the Covered Individual any charges which Provider incurs as a result of providing supplies or making referrals to another provider or entity. Examples include, but are not limited to, pass-through charges associated with laboratory services, pathology

services, radiology services and durable medical equipment. If Company has a direct contract with the subcontractor, the direct contract shall prevail over this Agreement.

2.19 Coordination of Benefits. Provider agrees to cooperate with Plan regarding coordination of benefits, as set forth in the provider manual, and to notify Plan promptly after receipt of information regarding any Covered Individual who may have a Claim involving coordination of benefits.

2.20 Preventable Adverse Events. Notwithstanding any provision in this Agreement to the contrary, when any preventable adverse event as set forth in the provider manual(s) occurs with respect to a Covered Individual, the Provider shall neither bill, nor seek to collect from, nor accept any payment from Plan or Covered Individual for such events. If Provider receives any payment from Plan or Covered Individual for such events, it shall refund such payment within ten (10) business days of becoming aware of such receipt. Further, Provider shall cooperate with Company, to the extent reasonable, in any Company initiative designed to help analyze or reduce such preventable adverse events.

2.21 Cost Effective Care. Provider shall provide Covered Services in the most cost effective setting and manner.

2.22 Admitting Privileges. When required by law applicable to Company, a Plan or a Health Benefit Plan, a Provider who is a physician must have and maintain admitting privileges at a hospital that is a Network/Participating Provider (other than those physicians in a specialty for which privileges are not customary).

ARTICLE III
CONFIDENTIALITY/RECORDS

3.1 Proprietary Information. All information and material provided by either party in contemplation of or in connection with this Agreement remains proprietary to the disclosing party. Neither party shall disclose any information proprietary to the other, or use such information or material except: (1) as otherwise set forth in this Agreement; (2) as may be required to perform obligations hereunder; (3) as required to deliver Health Services or administer a Health Benefit Plan; (4) to Plan or its designees; (5) upon the express written consent of the parties; or (6) as required by law or regulation, except that either party may disclose such information to its legal advisors, lenders and business advisors, provided that such legal advisors, lenders and business advisors agree to maintain confidentiality of such information.

3.2 Confidentiality of Personally Identifiable Information. Both parties agree to abide by state and federal laws and regulations regarding confidentiality of the Covered Individual's personally identifiable information.

3.3 Network Provider/Patient Discussions. Notwithstanding any other provision in this Agreement and regardless of any benefit or coverage exclusions or limitations associated with a Health Benefit Plan, Provider shall not be prohibited from discussing fully with a Covered Individual any issues related to the Covered Individual's health including recommended treatments, treatment alternatives, treatment risks and the consequences of any benefit coverage or payment decisions made by Plan or any other party. Nothing in this Agreement shall prohibit Provider from disclosing to the Covered Individual the general methodology by which Provider is compensated under this Agreement. Plan shall not refuse to allow or to continue the participation of any otherwise eligible provider, or refuse to compensate Provider in connection with services rendered, solely because Provider has in good faith communicated with one or more of his/her/its current, former or prospective patients regarding the provisions, terms or requirements of a Health Benefit Plan as they relate to the health needs of such patient.

3.4 Plan Access to and Requests for Provider Records. Provider shall comply with all applicable state and federal record keeping requirements, and, as set forth in the provider manual(s), shall permit Plan or its designees to have, with appropriate working space and without charge, on-site access to and the right to examine, audit, photocopy, excerpt and transcribe any books, documents, papers, and records related to Covered Individual's medical and billing information within the possession of Provider and inspect Provider's operations, which involve transactions relating to Covered Individuals and as may be reasonably required by Plan in carrying out its responsibilities and programs, including but not limited to, assessing quality of care, Medical Necessity, appropriateness of care, accuracy of payment, compliance with this Agreement, and for research. In lieu of on-site access, at Plan's request, Provider shall submit records to Plan, the Covered Individual or their respective designees via photocopy or electronic transmittal, at no charge. Provider shall make such records available to the state and federal authorities involved in assessing quality of care or investigating Covered Individual grievances or complaints. Upon a Plan's reasonable request from time to time, Provider shall certify, in writing, whether it is financially capable and has the legal authority and clinical capability to furnish Health

Services to Covered Individuals and shall provide reasonable evidence to support such certification to the Plan.

3.5 Transfer of Medical Records. Provider shall share a Covered Individual's medical records, and forward medical records and clinical information in a timely manner to other health care providers treating a Covered Individual, at no cost to Company, Plan, a Covered Individual, or other treating healthcare providers.

ARTICLE IV
INSURANCE

4.1 Company Insurance. Company shall self-insure or maintain insurance as shall be necessary to insure Company and its employees, acting within the scope of their duties.

4.2 Provider Insurance. Provider shall self-insure or maintain insurance in types and amounts acceptable to Company as set forth in the provider manual(s).

ARTICLE V
RELATIONSHIP OF THE PARTIES

5.1 Relationship of the Parties. For purposes of this Agreement, Company and Provider are and will act at all times as independent contractors. Nothing in this Agreement shall be construed, or be deemed to create, a relationship of employer or employee or principal and agent, or any relationship other than that of independent entities contracting with each other for the purposes of effectuating this Agreement. In no way shall Company or Plan be construed to be providers of Health Services or responsible for the provision of such Health Services. Provider shall be solely responsible to the Covered Individual for treatment and medical care with respect to the provision of Health Services.

5.2 Blue Cross Blue Shield Association (BCBSA). Provider hereby expressly acknowledges his/her/its understanding that this Agreement constitutes a contract between Provider and Company, that Company is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and/or Blue Shield Plans ("Association"), permitting Company to use the Blue Cross and/or Blue Shield Service Marks in the state (or portion of the state) where Company is located, and that Company is not contracting as the agent of the Association. Provider further acknowledges and agrees that he/she/it has not entered into this Agreement based upon representations by any person other than Company, and that no person, entity or organization other than Company shall be held accountable or liable to Provider for any of Company's obligations to Provider created under this Agreement. Provider has no license to use the Blue Cross and/or Blue Shield names, symbols, or derivative marks (the "Brands") and nothing in the Agreement shall be deemed to grant a license to Provider to use the Brands. Any references to the Brands made by Provider in his/her/its own materials are subject to review and approval by Company. This section shall not create any additional obligations whatsoever on the part of Plan other than those obligations created under other provisions of this Agreement.

5.3 Contracting Party. If Provider is a partnership, corporation, or any other entity other than an individual, all references herein to "Provider" shall also mean and refer to each individual within such entity who has applied for and been accepted by Plan as a Network/Participating Provider.

ARTICLE VI
INDEMNIFICATION AND LIMITATION OF LIABILITY

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

which will not be unreasonably withheld, and cooperating fully with the indemnifying party in connection with such defense and settlement. * Nothing contained herein shall be deemed a waiver of the City's sovereign or governmental immunities under state law.

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

6.3 Period of Limitations. Unless otherwise provided for in this Agreement, the provider manual(s) or Policies, neither party shall commence any action at law or equity, including but not limited to, an arbitration demand, against the other to recover on any legal or equitable claim arising out of this Agreement more than two (2) years after the events which gave rise to such claim, unless compliance with this section would compel a party to violate the terms of the Health Benefit Plan. The deadline for initiating an action shall not be tolled by the appeal process, provider dispute resolution process or any other administrative process. To the extent a dispute is timely commenced, it will be administered in accordance with Article VII of this Agreement.

ARTICLE VII
DISPUTE RESOLUTION AND ARBITRATION

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

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

7.2 Arbitration. Any dispute within the scope of subsection 7.1.1 that remains unresolved at the conclusion of the applicable process outlined in subsection 7.1.1 shall be resolved by binding arbitration in the manner as set forth below. Except to the extent as set forth below, the arbitration shall be conducted pursuant to the JAMS Comprehensive Arbitration Rules and Procedures, provided, however, that the parties may agree in writing to further modify the JAMS Comprehensive Arbitration Rules and Procedures. The parties agree to be bound by the findings of the arbitrator(s) with respect to such dispute, subject to the right of the parties to appeal such findings as set forth herein. No arbitration demand shall be filed until after the parties have completed the dispute resolution efforts described in section 7.1 above.

7.2.1 Selection and Replacement of Arbitrator(s). If the total amount in dispute as set forth in the demand letter is less than two million dollars ($2,000,000), exclusive of interest, costs, and attorneys' fees, the dispute shall be decided by a single arbitrator selected, and replaced when required, in the manner described in the JAMS Comprehensive Arbitration Rules and Procedures. If the total amount in dispute as set forth in the demand letter is two million dollars ($2,000,000) or more, exclusive of interest, costs, and attorneys' fees, the dispute shall be decided by an arbitration panel consisting of three arbitrators, unless the parties agree in writing that the dispute shall be decided by a

single arbitrator.

7.2.2 Appeal. If the total amount of the arbitration award is five million dollars ($5,000,000) or more, inclusive of interest, costs, and attorneys' fees, the parties shall have the right to appeal the decision of the arbitrator(s) pursuant to the JAMS Optional Arbitration Appeal Procedure. In reviewing a decision of the arbitrator(s), the appeal panel shall apply the same standard of review that a United States Court of Appeals would apply in reviewing a similar decision issued by a United States District Court in the jurisdiction in which the arbitration hearing was held.

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

ARTICLE VIII
TERM AND TERMINATION

8.1 Term of Agreement. The term of this Agreement shall commence at 12:01 AM on the Effective Date and shall continue in effect until such time it is terminated as provided herein, unless either party gives the other party written notice of non-renewal of this Agreement not less than ninety (90) days prior to the renewal date, or either party terminates this Agreement as provided herein.

8.2 Termination Upon Notice. At any time, either party may terminate this Agreement at any time by giving at least ninety (90) days prior written notice of termination to the other party. A non-renewal shall not constitute a termination for purposes of this section.

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

8.4 Termination With Cause.

8.4.1 Company may, at its option, terminate this Agreement immediately or suspend Provider's participation pending investigation if:

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

8.4.1.2 Provider commits a fraud or makes any material misstatements or omissions on any documents related to this Agreement which it submits to Company or to a third party; or

8.4.1.3 Provider files for bankruptcy, or makes an assignment for the benefit of its creditors without Company's written consent, or if a receiver is appointed; or

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

8.4.1.5 Provider fails to maintain compliance with Company's credentialing standards or other applicable standards of participation; or

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

8.4.1.7 Provider has been abusive to a Covered Individual, an Company employee or representative; or

8.4.1.8 Provider and/or his/her/its employees, contractors, subcontractors, or agents are identified as ineligible persons on the General Services Administration list of Parties Excluded from Federal Programs and/or HHS/OIG List of Excluded Individuals/Entities, and in the case of an employee, contractor, subcontractor or agent fails to remove such individual from responsibility for, or involvement with, the Provider's business operations related to this Agreement; or

8.4.1.9 Provider is convicted of a felony or misdemeanor.

8.4.2 This Agreement may be terminated by Provider if:

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

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

8.4.2.3 Company files for bankruptcy, or if a receiver is appointed; or

8.4.2.4 Company's insurance coverage as required by this Agreement lapses for any reason.

8.4.3 In the event that Provider is suspended as provided above, Provider shall, as directed by Company during such suspension, either discontinue treating Covered Individuals or discontinue providing a particular Health Service to Covered Individuals. During the term of any suspension, the Provider shall notify Covered Individuals that its status as a Participating Provider has been suspended. Such suspension will continue pending Company's full investigation.

8.4.4 If applicable, Company reserves the right to terminate individual providers under the terms hereof while continuing the Agreement for one or more providers in a group.

8.4.5 Company shall have the right to terminate this Agreement upon thirty (30) days prior written notice to Provider as set forth in subsection 9.3.2

8.5 Transactions Prior to Termination. Termination shall have no effect on the rights and obligations of the parties arising out of any transaction occurring prior to the date of such termination.

8.6 Continuance of Care-Termination. Unless otherwise set forth in the Health Benefit Plan, or required by statute or regulation, Continuance of Care-Termination shall apply as follows: Provider shall, upon termination of this Agreement for reasons other than the grounds set forth in the "Termination With Cause" section of this Agreement, continue to provide and be compensated for Covered Services rendered to Covered Individuals under the terms and conditions of this Agreement until the earlier of ninety (90) days or such time that: (1) the Covered Individual has completed the course of treatment and if applicable, was discharged; or (2) reasonable and medically appropriate arrangements have been made for a Network/Participating Provider to render Health Services to the Covered Individual. Notwithstanding the foregoing, for Covered Individuals who: (i) have entered the second or third trimester of pregnancy at the time of such termination, or (ii) are defined as terminally ill under § 1861 (dd) (3) (A) of the Social Security Act at the time of such termination, this continuance of care section and all other provisions of this Agreement shall remain in effect for such pregnant Covered Individuals through the provision of postpartum care directly related to their delivery, and for such terminally ill Covered Individuals for the remainder of their life for care directly related to the treatment of the terminal illness.

8.7 Patient List Upon Termination. When required by law applicable to Company, a Plan or a Health Benefit Plan, Provider shall provide Company with a list of his, her or its patients and customers who are Covered Individuals and a list of Covered Individuals, including but not limited to, Covered Individuals, who are seen on a regular basis within fifteen (15) business days of the date that such Provider either gives or receives notice of termination, or within such shorter period of time as may be required by applicable state law. When required by law or deemed appropriate by the Plan, the Plan will give, within the time period required by law, if any, notice of such termination or nonrenewal to Covered Individuals seen on a regular basis by Provider.

8.8 Continuation of Care Upon Insolvency or Cessation of Operations. When required by law applicable to Company, a Plan or a Health Benefit Plan, Provider agrees that in the event of Company's or a Plan's insolvency, Provider shall continue to provide Covered Services to Covered Individuals in accordance with this Agreement until the later of: (i) the expiration of the period through which the premium or membership due has been paid for coverage under the applicable Health Benefit Plan, (ii) the date on which the Covered Individual is discharged from an inpatient facility, or (iii) the expiration of such other period as may be required by laws and regulations applicable to Company, a Plan, the Health Benefit Plan or the Covered Individual, whichever is greater. This provision will be construed in favor of a Covered Individual and supersedes any oral or written contrary agreement between Provider and a Covered Individual or the representative of a Covered Individual if the contrary agreement is inconsistent with this provision and the provisions of this Agreement regarding the continuation of care after termination of this Agreement. This provision shall survive termination of this Agreement.

8.9 Termination Procedures. When expressly required by applicable law, Company will include an explanation for the reasons for the proposed termination in any notice of termination given by Company; and if timely requested by Provider, Company will provide Provider with an opportunity for review or hearing as required by law, not less than thirty (30) days from the date of notification and in accordance with Company's applicable procedures.

8.10 Survival. In the event of termination of the Agreement, the following provisions shall survive:

8.10.1 Payment in Full and Hold Harmless (Section 2.7);

8.10.2 Adjustments for Incorrect Payments (Section 2.8);

8.10.3 Confidentiality/Records (Article III);

8.10.4 Indemnification and Limitation of Liability (Article VI);

8.10.5 Dispute Resolution and Arbitration (Article VII);

8.10.6 Continuance of Care-Termination (Section 8.6); and

8.10.7 Continuation of Care Upon Insolvency or Cessation of Operations (Section 8.8).

ARTICLE IX
GENERAL PROVISIONS

9.1 Amendment. Except as otherwise provided for in this Agreement, Company retains the right to amend this Agreement, the Company Rate, any attachments or addenda by making a good faith effort to provide notice to Provider at least forty five (45) days in advance of the effective date of the amendment. If Provider decides not to accept the amendment, Provider has the right to terminate this Agreement without the amendment taking effect by providing written notice within thirty (30) days from receipt of such notice from Company. Provider's termination shall take effect on the later of the amendment effective date identified by Company or ninety (90) days from the date Provider has provided notice of his/her/its intention to terminate pursuant to this section. Failure of Provider to provide such notice to Company within the time frames described herein will constitute acceptance of the amendment by Provider.

9.2 Assignment. This Agreement shall be binding upon and inure to the benefit of the respective legal successors and assignees of the parties. However, neither this Agreement, nor any rights or obligations hereunder may be assigned, either by operation of law or otherwise, transferred in whole or in part, without the prior written consent of the other party, except that Company retains the right to assign, either by operation of law or otherwise, transfer in whole or in part, this Agreement to an Affiliate or to delegate any rights or obligations under this Agreement to a designee.

9.3 Scope/Change in Status.

9.3.1 Company and Provider agree that this Agreement applies to Health Services rendered at the Provider's location(s) on file with Company. Company may, if in Company's judgment the circumstances require such, limit this Agreement to Provider's locations, operations or business or corporate form, status or structure in existence on the Effective Date of this Agreement and prior to the occurrence of any of the following events:

9.3.1.1 Provider sells all or substantially all of his/her/its assets; or

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

9.3.1.3 Provider acquires or controls any other medical practice or entity or is in any manner otherwise acquired or controlled by any other party, whether by purchase, merger, consolidation, alliance, joint venture, partnership, association or expansion; or

9.3.1.4 Provider otherwise changes his/her/its locations, business or operations, or business or corporate form or status; or

9.3.1.5 Provider creates or otherwise operates a licensed health maintenance organization or commercial health plan (whether such creation or operation is direct or through a Provider affiliate).

9.3.2 Without limiting any of Company's rights as set forth elsewhere in this Agreement, Company shall have the right to terminate this Agreement upon thirty (30) days written notice to Provider if Company determines, that as a result of any of the transactions listed in subsection 9.3.1, Provider cannot satisfactorily perform the obligations of Provider hereunder, or cannot comply with one or more of the terms and conditions of this Agreement, including but not limited to the confidentiality provisions herein; or Company elects in its reasonable business discretion not to do business with Provider, the successor entity or new management company, as a result of one or more of the events as set forth in subsection 9.3.1.

9.3.3 Provider shall provide Company with thirty (30) days prior written notice of:

9.3.3.1 A change in providers who are part of the group, if applicable. Any new providers must meet Company's credentialing standards or other applicable standards prior to being designated as a Network/Participating Provider; or

9.3.3.2 Any new physical location, tax identification number, mailing address or similar demographic information; or

9.3.3.3 A change in operations, business or corporate form as set forth in subsections 9.3.1.1 through 9.3.1.5 above.

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

9.5 Entire Agreement. This Agreement (including items incorporated herein by reference) constitutes the entire understanding between the parties and supersedes all prior oral or written agreements between them with respect to the matters provided for herein. If there are any inconsistencies between this Agreement and the provider manual, this Agreement will take precedence.

9.6 This provision intentionally left blank.

9.7 Compliance with Federal and State Laws. Company and Provider agree to comply with all requirements of the law relating to their obligations under this Agreement, and maintain in effect all permits, licenses and governmental and board authorizations and approvals as necessary for business operations. Provider agrees that he/she/it shall be and remain licensed and certified (including Medicare certification in unqualified, unrestricted status) in accordance with all state and federal laws and regulations (including those applicable to utilization review and Claims payment) relating to the provision of provider services to Covered Individuals. Provider shall supply evidence of such licensure, compliance and certifications to Company upon request. Provider further agrees to immediately notify Company if he/she/it loses or voluntarily surrenders such licensure, accreditation, permits, authorizations or approvals, or when applicable no longer meets Company's credentialing standards. From time to time legislative bodies, boards, departments or agencies may enact, issue or amend laws, rules, or regulations pertinent to this Agreement.

Both parties agree to immediately abide by all said laws, rules, or regulations to the extent applicable, and to cooperate with the other to carry out any responsibilities placed upon the other by said laws, rules, or regulations, subject to the other's right to terminate as set forth under this Agreement. In the event of a conflict between this section and any other provision in this Agreement, this section shall control.

9.7.1 In addition to the foregoing, Provider warrants and represents that at the time of entering into this Agreement, neither he/she/it nor any of his/her/its employees, contractors, subcontractors or agents are ineligible persons identified on the General Services Administrations' List of Parties Excluded from Federal Programs (available through the internet at http://www.epls.gov/ or its successor) and the HHS/OIG List of Excluded Individuals/Entities (available through the internet at http://www.oig.hhs.gov/fraud/exclusions.asp or its successor), or as otherwise designated by the Federal government. If Provider or any employees, subcontractors or agents thereof becomes an ineligible person after entering into this Agreement or otherwise fails to disclose his/her/its ineligible person status, Provider shall have an obligation to (1) immediately notify Company of such ineligible person status and (2) within ten (10) days of such notice, remove such individual from responsibility for, or involvement with, the Provider's business operations related to this Agreement.

9.8 Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the state where Company is located, as identified by the legal entity name in the preamble, unless such state laws are otherwise preempted by federal law. However, coverage issues specific to a Health Benefit Plan are governed by the state laws where the Health Benefit Plan is issued, unless such state laws are otherwise preempted by federal law.

9.9 Intent of the Parties. It is the intent of the parties that this Agreement is to be effective only in regards to their rights and obligations with respect to each other; it is expressly not the intent of the parties to create any independent rights in any third party or to make any third party a third party beneficiary of this Agreement, except to the extent Company utilizes a designee, which in such event shall give rights only within the scope of such designation, and to the extent specified in the Payment in Full and Hold Harmless section of this Agreement.

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

9.11 Notice. Any notice required to be given pursuant to the terms and provisions of this Agreement shall be in writing and shall be delivered by electronic mail, by facsimile, by hand, or by mail. Unless specified otherwise in writing by a party, Company shall send Provider notice to an address that Company has on file for Provider, and notice initiated by Provider shall be sent to Company's address as set forth on the signature page. Notice shall be effective upon the marked date associated with the corresponding delivery method noted above. Notwithstanding the foregoing, Company may post updates to its provider manual(s) and Policies on its web site.

9.12 Severability. In case any one or more of the provisions of this Agreement shall be invalid, illegal, or unenforceable in any respect, the remaining provisions shall be construed liberally in order to effectuate the purposes hereof, and the validity, legality and enforceability of the remaining provisions shall not in any way be affected or impaired thereby. If one or more provisions of the Agreement are invalid, illegal or unenforceable and an amendment to the Agreement is necessary to maintain its integrity, the parties shall make commercially reasonable efforts to negotiate an amendment to this Agreement and any attachments or addenda to this Agreement which could reasonably be construed not to contravene such statute, regulation, or interpretation. In addition, if such invalid, unenforceable or materially affected provision(s) may be severed from this Agreement and/or attachments or addenda to this Agreement without materially affecting the parties' intent when this Agreement was executed, then such provision(s) shall be severed rather than terminating the Agreement or any attachments or addenda to this Agreement.

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

9.14 Abandonment. Nothing herein shall be construed as authorizing or permitting Provider to abandon any patient.

9.15 Provision Intentionally Left Blank.

9.16 Review. Provider hereby acknowledges that Provider was allowed at least thirty (30) days to review this Agreement prior to Provider's execution hereof.

9.17 Network Access. Unless otherwise provided in the Health Benefit Plan or expressly permitted by state law, neither party shall act in a manner that restricts Covered Individuals access to an entire network. To the extent expressly required by applicable state law, Provider shall provide Covered Services to Covered Individuals on a twenty four (24) hour per day, seven (7) day per week basis.

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

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

PROVIDER LEGAL NAME City of Columbia, Missouri on behalf of its Columbia-Boone County Department of Public Health and Human Services

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

Printed: _____ _____
Name Title

Address: _____ _____
Street City State Zip

Tax Identification Number (TIN): _____

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

License #: _____

NPI#: _____

Medicare #: _____

Facsimile Number: _____

Email Address: _____

Web Site: _____

RightCHOICE Managed Care, Inc.

COMPANY INTERNAL USE ONLY

THE EFFECTIVE DATE OF THIS AGREEMENT IS: _____

By: _____ _____
Signature, Authorized Representative of Company Date

Printed: Ruth Meyer Hollenback Vice President, Health Services
Name Title

Address: 1831 Chestnut St. St. Louis MO 63103
Street City State Zip

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

Facsimile Number: 314-923-4919

Email Address: providercontractadmin@bcbsmo.com

Web Site: www.Anthem.com

As of the Effective Date of this Agreement, Provider will be designated as Network/Participating Provider in the following Networks and any substantially equivalent successor Networks:

_x_ Blue Access
_x_ Blue Preferred
_x_ Traditional
_x_ Pathway/Pathway X

Other Plan Program(s)

PLAN COMPENSATION SCHEDULE ("PCS")

I. PROVIDER TYPE

FLU CLINICS/IMMUNIZATION SERVICES

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

Provider agrees to administer immunizations to Covered Individuals at employer group work-sites, promotional health events, local health departments and/or other sites designated by Company, as applicable.

Provider represents that it and any affiliated entity which delivers services under this PCS is fully licensed and qualified to provide immunization services in any state in which it operates.

Provider agrees to provide immunization services in accordance with the terms and conditions of this PCS, and the Agreement, and within the scope of Provider's professional license or certification, including but not limited to, responsibility for all preparation and administration of immunizations, and clean-up and removal of waste materials related to the services, including but not limited to hazardous waste materials.

Provider's administering immunization clinics must meet the following standards: (a) have written policies and procedures for the operation of immunization clinics; and (b) operate the clinics in accordance with current Center for Disease Control (CDC) guidelines and suggested protocol, in addition to any product specifications. Current administration guidelines can be found at http://www.cdc.gov/vaccines/pubs/pinkbook/default.htm.

Provider agrees that all immunization services provided under this PCS will be provided by a qualified person under Provider's direct supervision.

Provider shall hold harmless Company, its officers, agents, and employees from and against any and all liability arising out of or related to Provider's provision of immunization services under the terms and conditions of this Agreement.

Provider will be compensated for its immunization services provided under the terms and conditions of this PCS. Provider agrees to accept the Plan Fee Schedule rate specified in this PCS as payment in full for immunization services, including but not limited to, all services and supplies for the preparation and administration of immunizations, vaccine, educational materials, wages and travel time and expenses of Provider's personnel, and cleanup and removal of waste materials. Provider agrees not to bill or collect this amount or any charge in excess of this amount from any other party, including a Covered Individual who receives such services.

Provider shall submit immunization Claims on the appropriate Claim form under the specific provider identification number assigned. Reimbursement shall be made in accordance with the Agreement.

II. **SPECIFIC REIMBURSEMENT TERMS** - VACCINE SAMPLE FEE SCHEDULE

Vaccine Administration

Code	Fee
90460	$10.00
90461	$4.00
90471	$15.00
90472	$5.00
90473	$10.00
90474	$5.00

Vaccines

Code	Fee
90633	$27.47
90647	$21.74
90648	$25.04
90649	$129.91
90655	$13.86
90656	$10.44
90658	$10.14
90660	$19.75
90669	$80.41
90670	$122.91
90680	$72.07
90696	$45.60
90698	$76.61
90700	$19.76
90702	$32.39
90707	$51.54
90710	$138.35
90713	$26.22
90714	$18.17
90715	$35.69
90716	$86.81
90721	$45.26
90723	$67.30
90732	$60.93
90734	$108.30
90744	$20.39
90748	$41.58

Vaccines updated twice a year based on 80% AWP.

III. GENERAL PROVISIONS

Billing Form and Claims Reporting Requirements. Provider shall submit all Claims on a CMS 1500 claim form or its successor. Provider shall report all Health Services in accordance with the reporting guidelines and instructions contained in the AMA CPT, CPT Assistant, and HCPCS publications. Plan audits that result in identification of Health Services that are not reported in accordance with the AMA CPT, and CPT Assistant publications, will be subject to recovery through remittance adjustment or other recovery action. In addition, updates to Company's Claims processing filters and edits, as a result of changes in AMA CPT, and CPT Assistant reporting guidelines and instructions, shall take place automatically and do not require any notice, disclosure or amendment to Provider.

Claim Submissions for Pharmaceuticals. Provider agrees that the NDC must be listed on each Claim that includes Federal Legend Drugs.

Coding Updates. Coded Service Identifier(s) used to define specific rates are updated from time to time to reflect new, deleted or replacement codes. Company shall use commercially reasonable efforts to update all applicable Coded Service Identifiers within sixty (60) days of release by CMS or other applicable authority. If an update is delayed beyond the sixty (60) days, Company shall notify Provider. Claims processed prior to the implementation of the revised codes shall not be reprocessed. In addition, Claims with codes which have been deleted will be rejected.

Not Otherwise Classified Codes (NOC) and/or Individual Consideration Codes (IC). Company reserves the right to price NOC and/or IC codes individually, and may require the submission of medical records prior to the adjudication of such Claims.

Out-of-Network Compensation. Except for state and federal health programs, if Provider renders services to a Covered Individual who accesses a Network in which Provider does not participate, Provider will receive compensation as follows:

a. Plan shall compensate Provider for Emergency Services rendered to a Covered Individual based on the applicable Indemnity/Traditional/Standard Company Rate. Provider agrees to accept the Indemnity/Traditional/Standard Company Rate as payment in full and shall only bill for the applicable Cost Share.

b. Except for Emergency Services, if the Covered Individual's Health Benefit Plan requires authorization by the Plan or a Provider for out of Network Covered Services in order for the Covered Individual to have the highest level of benefits, and such authorization has been given, then Plan shall compensate Provider for such authorized Covered Services based on the applicable Network/Participating Provider ("Indemnity/Traditional/Standard") Company Rate. Provider agrees to accept the Indemnity/Traditional/Standard Company Rate as payment in full and shall only bill for the applicable Cost Share. Except for Emergency Services, if the Covered Individual's Health Benefit Plan does not have out-of-network benefits unless authorized by the Plan or Provider, Plan shall have no liability for services rendered without such authorization. In that event, Provider shall bill the Covered Individual for Health Services rendered.

c. Except for Emergency Services, if the Covered Individual's Health Benefit Plan has out-of-network benefits without authorization being required by the Plan or Provider, and no authorization has been given, then Plan will compensate Provider for Covered Services based on the Company Rate established for the Network and/or Plan Program that supports the Covered Individual's Health Benefit Plan. For example, if the Covered Individual's access is supported by PPO Network, compensation is based on the applicable Company Rate for the PPO Network. Provider shall only bill for the applicable Cost Share as well as any amount designated as the Covered Individual's responsibility on the provider payment voucher (or other written notice of explanation of payment). In no event shall payment from Plan and the Covered Individual exceed Provider's Charge for such Covered Services.

DEMOGRAPHIC INFORMATION SHEET FOR HEALTH DEPARTMENT

IDENTIFYING INFORMATION

Facility Name _____

Tax ID Number _____ NPI Number _____

Medicare Number _____ Medicaid Number _____

SITE ADDRESS

Street Address _____

_____

City State Zip

County _____

Phone Number _____

Fax Number _____

Contact Person _____

Email Address _____

BILLING ADDRESS

Street Address _____

_____

City State Zip

County _____

Phone Number _____

Fax Number _____

Contact Person _____

Email Address _____

REQUIRED DOCUMENTATION

- W-9 Form
- Limited Liability Insurance
- State License (if applicable)

TYPES OF SERVICE that apply

Flu Clinic/Immunization Services [X]

Source: Health

Agenda Item No:

To: City Council

From: City Manager and Staff

Council Meeting Date: Apr 7, 2014

Re: Anthem Blue Cross/Blue Shield Provider Agreement

EXECUTIVE SUMMARY:

A resolution authorizing the City Manager to sign the Provider Agreement between the City of Columbia and Anthem Blue Cross/Blue Shield. The effective date for this agreement is based on agency signature and will continue unless terminated in writing by either party.

DISCUSSION:

This agreement allows clients covered by Anthem Blue Cross/Blue Shield to utilize the Department of Public Health and Human Services for covered clinical services while also allowing the Department to obtain reimbursement for those services provided. Reimbursement rates are based on the fee schedule provided.

FISCAL IMPACT:

This is a new agreement. Revenues will be dependent on the number of Anthem Blue Cross/Blue Shield participants who seek services from Public Health and Human Services. No appropriation is necessary.

VISION IMPACT:
http://www.gocolumbiamo.com/Council/Meetings/visionimpact.php

11.3 Goal: Columbia will be a healthy community. All residents will have timely access to appropriate health care. Effective prevention initiatives will contribute to a healthy community.

SUGGESTED COUNCIL ACTIONS:

Should the Council agree with the staff recommendation, an affirmative vote is in order.

FISCAL and VISION NOTES:					
City Fiscal Impact Enter all that apply		**Program Impact**		**Mandates**	
City's current net FY cost	$0.00	New Program/ Agency?	Yes	Federal or State mandated?	No
Amount of funds already appropriated	$0.00	Duplicates/Epands an existing program?	Yes	**Vision Implementation impact**	
Amount of budget amendment needed	$0.00	Fiscal Impact on any local political subdivision?	No	Enter all that apply: Refer to Web site	
Estimated 2 year net costs:		**Resources Required**		Vision Impact?	Yes
One Time	$0.00	Requires add'l FTE Personnel?	No	Primary Vision, Strategy and/or Goal Item #	11.3
Operating/ Ongoing	$0.00	Requires add'l facilities?	No	Secondary Vision, Strategy and/or Goal Item #	
		Requires add'l capital equipment?	No	Fiscal year implementation Task #	