Capital BlueCross Professional Provider Agreement

This Professional Provider Agreement, including all exhibits attached hereto and references incorporated herein ("Agreement") is entered into between Capital BlueCross, on behalf of itself and its Affiliates ("Capital" or "We" and its derivative forms, "Us" and "Our"), and the entity identified on the signature block below ("Provider"), on behalf of itself and each Covered Location listed on Exhibit B (collectively Capital and the Provider are referred to as the "Parties").

We make available to employers and individuals, or administers on behalf of employers, groups or other entities, various health benefit plans for the benefit of employees and their eligible dependents. We desire to arrange for Covered Services for Members enrolled in Programs (as the terms "Covered Services," "Members," and "Programs" are defined in this Agreement). Provider (or, if Provider is not an individual but is a medical group, partnership, corporation or other entity, each Associated Provider, as such term is defined in this Agreement) is a duly licensed Practitioner and has the capacity and desire to provide or arrange for health care services to Members as set forth in this Agreement. This Agreement is evidence of the Parties' intent to work cooperatively to provide an innovative and efficient health care delivery system to meet the medical needs of the communities they serve.

EFFECTIVE DATE: June 18, 2020 Effectiveness of the Agreement shall be subject to Provider's Practitioners meeting Our credentialing requirements as set forth herein.

INITIAL TERM: Refer to Section 6.2

IN WITNESS WHEREOF, intending to be legally bound and by signing below, the representatives/signatories do hereby warrant and affirm that they: (1) are empowered to enter into this Agreement on behalf of their respective party; (2) are duly authorized to represent and legally bind their respective party; and (3) agree to the terms and conditions of this Agreement.

	Capital BlueCross:		**Tara Helwig Enterprises LLC**
By:		By:	Tara Vining
	Jay Simmons VP, Provider Partnerships Business & Network Development	Name:	Tara Vining
		Title:	Owner
Date:	June 18, 2020	Date:	06/09/2020
		TIN:	472297917
Notice Address:		Notice Address:	
	2500 Elmerton Avenue Harrisburg, PA 17177		1776 Tech Park Dr NE Ste 202 New Philadelphia OH 44663
Attn:	Matthew Varner	Attn:	Tara Vining
Title:	Sr. Director, Network Contracting	Title:	Owner
Phone:	717-541-6939	Phone:	330-536-3042
Fax:	717-651-8464	Fax:	330-649-2001
Copy to:	General Counsel	Copy to:	
Address:	2500 Elmerton Avenue Harrisburg, PA 17177	Address:	
Phone:	717-541-7747	Phone:	
Fax:	717-651-8913	Fax:	

PROFESSIONAL PROVIDER AGREEMENT

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CORE AGREEMENT PROVISIONS

SECTION 1: PROVIDER RESPONSIBILITIES

1.1 Provision of Covered Services.

1.1.1 Medically Necessary and Appropriate Covered Services. Provider agrees to provide and/or arrange for Medically Necessary and Appropriate Covered Services to Members in accordance with the terms of this Agreement in a timely, prompt, efficient and cost effective manner. Provider agrees to provide Covered Services in the same manner, and with the same availability, as stated in the Provider Manual.

1.1.2 Primary Care Provider. With respect to Our managed care Programs, where Practitioner or any Associated Provider is identified as a PCP on Exhibit B to this Agreement then such Practitioner or Associated Provider agrees to abide by requirements applicable to PCPs.

1.1.3 Specialist Provider. With respect to Our managed care Programs, where Practitioner or any Associated Provider is identified as a Specialist Provider on Exhibit B to this Agreement then such Practitioner or Associated Provider agrees to abide by requirements applicable to Specialist Providers.

1.2 Compliance with Capital's Policies, Procedures and Provider Manual. Provider shall be bound by and comply with Our criteria for physician participation and Our other policies and procedures, including without limitation, Our credentialing criteria, accreditation criteria, verification of eligibility, determination of coverage, quality of care standards, quality improvement, utilization management, case management, disease management, clinical management, referral requirements (including notice to Us), prescription benefit program and its requirements, peer review process, payment criteria, Provider and Member complaint and grievance programs and procedures, claims processing, administrative requirements, and other similar policies that We establish and update from time to time, as provided for in the Provider Manual or otherwise (collectively, "Protocols"). If there is a conflict between a provision of the Provider Manual or any Protocol and this Agreement, the provision in the Agreement shall control, except as may be otherwise required by applicable law.

1.3. Provider to Participate in Capital Programs. Provider agrees to participate in all of Our Programs set forth and described in Exhibit A to this Agreement and all Program derivatives.

1.3.1 If We add a Program, and Provider is eligible to participate as a Provider in such new Program, We shall notify Provider about such new Program by providing an amended Exhibit A to Provider. Any amended Exhibit A shall be provided at least sixty (60) days prior to the effective date of such Program addition. The amended Exhibit A shall be deemed to be agreed to by the Parties unless Provider provides written notice to Capital of its election not to participate in any new Program, which notice must be received at least thirty (30) days prior to the effective date of such Program addition.

1.3.2 We may, from time to time, make Our provider network available to third parties. If We add a Program on behalf of such third party, and Provider is eligible to participate as a Provider in such new third party Program, We shall follow the procedure set forth in Section 1.3.1 above. Any material information about such new Program shall be included in a notice from Us.

1.4 Practitioner/Patient Communications. We respect the physician/patient relationship. Nothing in this Agreement is intended or shall be construed to inhibit or limit Practitioner's freedom to communicate with Practitioner's patients who are Members, including (i) discussing a patient's health status, medical care or treatment options; (ii) recommending any procedure or course of treatment that he or she deems medically acceptable; or (iii) recommending that We approve benefits for any procedure or course of treatment. Practitioner is encouraged to discuss all

pertinent details regarding a Member's condition and all care alternatives with Members, including potential risks and benefits, even if a care option is not a Covered Service. Nothing in this Agreement should be construed to create any right of Capital, or any Contract Holder to intervene in the manner, methods or means by which Practitioner renders health care services to patients. In furtherance of the foregoing, We will not sanction, terminate or fail to renew Practitioner's participation in Our Programs for any of the following reasons: (i) advocating for Medically Necessary and Appropriate health care services for a Member; (ii) filing a grievance on behalf of and with the written consent of a Member or helping a Member to file a grievance; (iii) protesting a Capital decision, policy or practice Practitioner believes interferes with his or her ability to provide Medically Necessary and Appropriate health care; (iv) taking another action specifically permitted by the provisions of the Act; and (v) discussing any of the information Practitioner is permitted to discuss under the Act or other information Practitioner reasonably believes is necessary to provide the Member concerning the health care of the Member. In addition, We will not penalize or restrict Practitioner from discussing any of the information Practitioner is permitted to discuss under the Act or other information Practitioner reasonably believes is necessary to provide to a Member full information concerning the health care of the Member.

1.5 Quality of Care. Provider agrees that all duties performed under this Agreement shall be consistent with the proper practice of medicine and that such duties shall be performed in accordance with the customary rules of ethics and conduct of applicable state and professional licensure boards and agencies and in accordance with the Provider Manual.

1.6 Nondiscrimination; Transfer of Patients. Provider agrees (i) to comply with the Member nondiscrimination provisions of the Provider Manual, and (ii) to observe, protect, and promote the rights of Members as patients. Consistent with Provider's obligation to protect and promote the health rights of Members as patients, Practitioner shall only terminate his or her relationship with a Member or transfer a Member to another provider in accordance with the procedures that We establish.

1.7 Verification of Member Eligibility. We shall provide each Member with an identification card, which may be electronic, and provide Provider with Member benefit information. Except in the case of Emergency Services, Provider agrees to verify Member's eligibility as well as coverage for a service in accordance with Protocols.

1.8 General HIPAA and HITECH Compliance. Provider agrees that Provider will adopt such policies and procedures, will execute or has executed such written agreements, and will provide or has provided such further assurances as required to make Provider's activities under this Agreement compliant with the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information and Technology for Economic and Clinical Health Act ("HITECH"). If the regulations adopted pursuant to HIPAA and HITECH are modified in any way that affects the terms of this Agreement or Provider's obligations, Provider agrees to adopt such policies and procedures, execute such written agreements and provide such further assurances as may be required to make Provider's activities under this Agreement compliant on or before the final compliance date of any such modifications.

1.9 Electronic Transactions. The Parties agree that all communications between the Parties that are required to meet the Standards for Electronic Transactions, as defined and set forth at 45 C.F.R. Part 162, shall do so. For any other communications between the Parties, Provider shall use such forms, tape formats or electronic formats as We may approve.

1.10 Participation in National or Regional Networks. All responsibilities and obligations that Provider has to Members or to Us under this Agreement shall also apply to and include members or beneficiaries of the national or regional networks of any Blue Cross, Blue Shield and/or affiliated plan with which Capital has a reciprocal arrangement (making Provider a Participating Provider for that other Blue Cross, Blue Shield and/or affiliated plan). This includes programs of other health

plans to which We have granted access to Our provider network. Provider acknowledges that these responsibilities and obligations include, without limitation, the provisions of this Section 1 (Provider Responsibilities); Section 2 (Capital Responsibilities); Section 3 (Payment); Section 4 (Member Hold Harmless); and Section 5 (Medical Records and Administrative Documents).

1.11 Professional Requirements.

1.11.1 Qualifications and Privileges. Provider shall meet and maintain compliance with all of Our Protocols, including but not limited to credentialing requirements, policies and procedures, and other standards, all as set forth in the Provider Manual. Provider understands and agrees that meeting all of the aforementioned qualifications and privileges is a condition precedent to the execution of this Agreement and is an ongoing condition to any provision of Covered Services to Members and Our payment for Covered Services.

1.11.2 Notice of Adverse Actions. Provider agrees immediately to notify Us in writing if Provider receives notice of (i) any restriction, suspension or revocation of license, certification or DEA number, changes in the status of hospital privileges or any other event that would cause Provider to be out of compliance with Our policies and procedures related to credentialing, hospital privileging, and accreditation criteria, or other professional requirements, (ii) the instituting of any action, suit, or proceeding that involves the provision of health care services by Practitioner, including any action brought by a Member related to the provision of health care services to a Member, (iii) any sanction or disciplinary action by any professional organization, hospital, governmental agency, or Contract Holder, (iv) any criminal indictment of any nature, (v) any civil judgment or criminal conviction, or (vi) exclusion from participating in Medicare, Medicaid, or any other third party, state or federal program.

1.11.3 Provider Representations and Warranties.

(i) Provider represents and warrants that all Practitioner information and statements given to Capital in connection with the application and credentialing process and any information relative to this Agreement are true, accurate, and complete. Provider's application for Program participation is hereby incorporated by reference into this Agreement.

(ii) If Provider is a separate legal entity, Provider represents and warrants that (a) it is duly organized and in good standing in its jurisdiction of organization, (b) it is duly authorized to enter into and perform this Agreement on its behalf and on behalf of any Practitioners and Associated Providers, and (c) its execution, delivery and performance of this Agreement will not violate the terms of any other agreement or order by which Provider is bound.

(iii) Provider represents and warrants that any Practitioner or Associated Providers listed on Exhibit B to this Agreement comprise all of Provider's Practitioners or Associated Providers as of the date this Agreement is executed.

(iv) Provider represents and warrants, on behalf of itself and Practitioners, that it has and will comply with all licensure, accreditation and site visit standards, including the implementation of any Capital corrective action plans.

1.11.4 Additions and Deletions of Associated Providers and Practitioners. Provider agrees to notify Capital in writing of any changes, including additions and deletions to the list

of Associated Providers and Practitioners set forth on Exhibit B of this Agreement no less than ten (10) days prior to the effective date of each change, but in all events prior to the effective date of each change, by accessing the Provider Portal and submitting all such changes in the form and format required therein. Provider acknowledges and agrees that all the terms of this Agreement (unless clearly inapplicable) shall apply to each Associated Provider and Practitioner, and Provider shall require each Associated Provider and Practitioner: (i) to comply with all the terms of this Agreement (unless clearly inapplicable); the Provider Manual, and any other policies and procedures and billing requirements that We adopt; and (ii) to meet at all times Our credentialing criteria, accreditation criteria and hospital privileging requirements as a condition of Associated Provider's or Practitioner's participation in a Program. Any services rendered by an Associated Provider or Practitioner who is not credentialed, approved and added to Exhibit B shall not be a Covered Service under the terms of this Agreement.

1.11.5 Termination of Associated Provider or Allied Health Professional. Provider shall terminate an Associated Provider's or Practitioner's participation under this Agreement immediately upon Our request if that Associated Provider or Practitioner violates one of the provisions in Section 6.4.2, or:

(i) fails to comply with Our quality management program and/or credentialing criteria; or

(ii) commits any misrepresentation or fraud in processes including, but not limited to, credentialing, hospital privileging, accreditation, and billing; or

(iii) takes any action that, in Our reasonable judgment, constitutes gross misconduct; or

(iv) upon imposition of any civil judgment or criminal conviction related to the provision of health care services; or

(v) without cause upon sixty (60) days' prior written notice to the Provider and the Associated Provider or Practitioner.

1.12 Provider Office Location, Closure or Other Changes. Provider shall give Capital at least thirty (30) days' prior written notice of any applicable changes of Provider, Associated Provider or Practitioner information, pursuant to the requirements in the Provider Manual.

1.13 Use of Provider Information. Provider agrees that We may use Provider's and any Associated Provider's or Practitioner's name, address, telephone number, picture, type of practice, applicable practice restriction, and an indication of Provider's willingness to accept additional Members in Our directory of Providers and other Capital materials. We shall not be responsible or liable for damages arising from any error or omission in Our materials.

1.14 Capital Prior Authorization. Provider shall comply with all of Capital's prior authorization procedures, including but not limited to those described in the Provider Manual. Capital confirms that prior authorization is not required in the case of Emergency Services; provided, however, that Provider meets applicable notification requirements for emergency inpatient admissions as set forth in the Provider Manual.

1.15 Non-Exclusive Arrangement. This Agreement is not exclusive and nothing in this Agreement shall prohibit Provider, Practitioner or Associated Provider from entering into other agreements to provide health care services.

1.16 Coverage. Provider shall make necessary and appropriate on call and emergency arrangements to assure the availability of Covered Services to Members on a twenty-four (24) hour per day, seven

(7) day a week basis as required in the Provider Manual.

1.17 Confidentiality. During the term of this Agreement and any extension thereof, or at any time after termination of the Agreement, the Provider shall (i) comply with all requirements of the Provider Manual regarding confidential and proprietary information, and (ii) take all reasonable steps necessary to ensure that its Associated Providers and/or Practitioners abide by the terms and conditions of this confidentiality provision. The Provider and the Associated Provider and/or Practitioner shall be jointly and severally responsible to Us for any acts or omissions by the Associated Providers and/or Practitioners which result in the unauthorized disclosure or use of such confidential or proprietary information.

1.18 Changes to Business Organization. Provider shall provide sixty (60) days' advance written notice of its business organization changes including, but not limited to, dissolution, Change in Control, division, merger into or consolidation with another entity where the Provider is not the surviving entity, merger into or consolidation with another entity where the Provider is the surviving entity, transfer of substantially all of its assets, formation of other legal entities, or a material reduction in operations or business activities. Provider acknowledges and agrees that it shall not change its business organization (regardless of the survivor thereof) unless any agreement(s) with a successor entity ("Successor Entity") provides that the payment rates applicable to the Provider under this Agreement shall remain the same**.** In the event the Successor Entity has a provider agreement(s) with Us, in effect at the time of a change in Provider's business organization, the agreement for the business organization change must indicate that We, in Our sole discretion, shall determine whether the Provider payment rates or the Successor Entity payment rates will be paid by Us to Successor Entity for Covered Services, regardless of whether such payment rates are paid pursuant to the terms of this Agreement, the applicable Successor Entity's provider agreement with Us, or any other agreement, as We deem appropriate. We reserve all other rights and interests under this Agreement or any other applicable provider agreement.

SECTION 2: CAPITAL RESPONSIBILITIES

In additional to the responsibilities and obligations set forth in the Provider Manual, We shall provide the following:

2.1 Member Eligibility Determination. Access to Member information through the Provider Portal.

2.2 Provider List. A current listing of Practitioners and/or Associated Providers, available to Members both electronically and in paper.

2.3 Group Contracts. At Our sole discretion, We may (i) enter into any Group Contract upon such terms, including but not limited to those terms relating to scope of Covered Services, Members, the amount and application of any Cost Sharing Provisions, or clinical management requirements, as We deem appropriate, (ii) amend such Group Contract, all without prior consultation with or approval of Provider, and (iii) participate in national or regional networks such as Blue Cross or Blue Shield plans with which We have a reciprocal arrangement.

2.4 Coverage Determinations. We or Our designated representative shall have sole authority to determine: (i) what is a Covered Service; (ii) eligibility requirements; (iii) who is a Member; and (iv) the amount and application of Cost Sharing Provisions.

2.5 Clinical Management Programs. Our obligation to pay Provider for the provision of Covered Services to a Member shall be conditioned upon a good faith determination by Us or Our designated representative that Provider is in compliance with Our clinical management programs.

2.6 Medical Necessity. Our obligation to pay Provider for the provision of Covered Services to a Member shall be conditioned upon a determination by Us or Our designated representative that the provision of Covered Services was Medically Necessary and Appropriate. Provider shall have the right to appeal determinations that health care services were or were not Medically Necessary

and Appropriate in accordance with the Provider Manual.

2.7 Payment for Covered Services. We shall pay Provider for Covered Services provided to Members, according to the terms and conditions of Exhibit C. Except as otherwise provided in this Agreement, Our obligation to pay Provider pursuant to this Agreement is conditioned upon the determination that the person receiving services, supplies, products, or accommodations from Provider is a Member and that such services, supplies, products, or accommodations are Covered Services. Provider agrees to accept such determination of the foregoing, which shall be made in accordance with Capital's Protocols.

SECTION 3: PAYMENT

3.1 Claims Submission. Provider shall use best efforts to submit claims for Covered Services rendered to Members in accordance with the Provider Manual. We shall have no obligation to remit payment to Provider for claims (and any adjustments thereto) received more than one hundred eighty (180) days after the date of service or date of discharge, as the case may be. In cases where We are the secondary payer, the foregoing time periods for submission of claims shall commence on the date notice of the primary payer's liability is received by Provider.

3.2 Encounter Reporting. RESERVED.

3.3 Claims Payment. Provider shall be paid for providing Covered Services as detailed in the Schedules attached to this Agreement, and in accordance with the Provider Manual.

3.3.1 Provider will be paid based upon a site-of-service differential in effect and as updated from time to time, which pays Provider based on the place of service differences in expenses between a facility and a non-facility. Capital will follow guidelines set forth by the Center for Medicare and Medicaid Services (CMS) to determine which Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes are subject to the site-of-service differential. For the purposes of this Agreement, the term "CPT code" shall include "HCPCS" codes when applicable.

3.4 Clean Claims. If submitted in accordance with Our policies and procedures, We agree to pay clean claims in accordance with the Provider Manual.

3.5 Conditions for Payment for Services Other than Covered Services. Provider may bill a Member for Non-Covered Services rendered by Provider to such Member only (i) if such services are Non-Covered Services and the Provider satisfies any notification or other requirements that We establish as set forth in the Provider Manual prior to Provider's provision of such services; or (ii) if the patient was not eligible to receive Covered Services on the date such services were provided. We shall not be liable to pay Provider for any service rendered by the Provider to a Member that We determine to be a Non-Covered Service.

3.6 Special Payment Provisions Regarding Self-Insured Accounts. If Member is covered by a Program underwritten by a Self-Insured Account, then Provider shall look solely to the Self-Insured Account for payment for Covered Services rendered to such Member; provided, however, that Member shall be responsible for any applicable Cost Sharing Provisions. In the event of non-payment by a Self-Insured Account, Provider agrees not to bill, charge, seek compensation from, or assert any claims for payment for Covered Services against Us. Notwithstanding the provisions of this Section, payments owed Provider by a Self-Insured Account shall be administered by Us.

3.7 Payment for Participation in National or Regional Networks. Provider shall be paid for health care services provided to members or beneficiaries of networks of any Blue Cross, Blue Shield plan and/or affiliated plan with which We have a reciprocal arrangement based on the Program Fee Schedule otherwise applicable under the Agreement. All provisions of this Section 4 shall also apply to such members or beneficiaries.

SECTION 4: MEMBER HOLD HARMLESS

4.1 Member Hold Harmless. Provider agrees that in no event including, but not limited to, non-payment, Our insolvency or the insolvency of a Self-Insured Account, or Our breach of this Agreement or breach by a Self-Insured Account shall Provider bill, charge, collect a deposit from, seek compensation or payment from, or have any recourse against any Member, Subscriber, enrollees, or persons other than Capital acting on behalf of Member for Covered Services provided pursuant to this Agreement. Provider also agrees that in no event including, but not limited to, non-payment, Our insolvency or the insolvency of a Self-Insured Account, or Our breach of this Agreement or breach by a Self-Insured Account shall Provider bill, charge, collect a deposit from, seek compensation or payment from, or have any recourse against any Member, Subscriber, enrollees, or persons other than Capital acting on behalf of Member for Covered Services provided pursuant to all Programs that We offer or a Self-Insured Account offers regardless of whether the Provider participates in the Program. This provision shall not prohibit collection of payments permitted under a Cost Sharing Provision in accordance with the terms of the applicable Program and Group Contract. It is understood that: (i) this Section shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Member; and that (ii) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Member or persons acting on their behalf. Provider may not change, amend or waive this provision without Our prior written consent. Any attempt to change, amend, or waive this provision is void.

SECTION 5: MEDICAL RECORDS AND ADMINISTRATIVE DOCUMENTS

5.1 Confidentiality. Provider shall safeguard Members' privacy and confidentiality and assure accuracy of a Member's health records. Provider shall abide by all applicable state and federal laws regarding the confidentiality of medical records or other health and enrollment information, including, without limitation, HIPAA, as amended.

5.2 Maintenance of Medical Records. Provider agrees to ensure that medical records are maintained for each Member for whom the Provider has provided health care services. Such records shall be retained and kept confidential by the Provider for the greater of (i) the time period specified by applicable state and federal laws, regulations and requirements, and (ii) seven (7) years for adult Members, and for minor Members, one (1) year after such minor has reached the age of eighteen (18) years of age, but in no event less than seven (7) years.

5.3 Access to Medical Records. Provider shall allow us or Our Designees, the Pennsylvania Department of Health (or any external quality review organization approved by the Department of Health) (collectively, the "DOH"), the Pennsylvania Insurance Department (the "PID") and, when necessary, the Pennsylvania Department of Human Services (the "DHS"), access to records for the purpose of including, without limitation, quality assurance, credentialing and peer review activities, medical practice audits, medical necessity reviews, billing and claims payment audits, investigation of complaints or grievances, risk adjustment, or enforcement or other activities related to compliance with the laws of the Commonwealth of Pennsylvania or other applicable laws, rules and regulations, subject to applicable laws related to confidentiality; provided, however, that such records shall only be accessible to Us or to Our Designees, employees of the DOH, the PID, or the DHS, or agents with direct responsibility for such matters. Provider shall obtain from time to time any necessary releases from a Member or a Member's guardian to permit such access.

5.4 Records and Reports. Provider agrees to provide us or Our Designees access during normal business hours to physician offices and such medical, financial, and administrative information related to the provision of Covered Services to Members as may be necessary for Our compliance with state and federal laws, as well as for Program management purposes. Provider will further provide such record access at no charge to us or to Our Designees and to the DOH, any external quality review organization approved by the DOH, and to any other authorized state and federal

agency for investigation of Member grievance or complaints.

5.5 Copies of Medical Records. If (i) a Member is transferred to another Provider or disenrolls from a Program, or (ii) We or Our Designees reasonably require a record in connection with its medical management or other programs, including but not limited to those purposes set forth in Sections 5.3 and 5.4 above, Provider shall promptly provide a copy of the Member's medical record in a timely manner and without charge to us or to Our Designees and/or the Member's successor health care provider upon Our request or the request of a Member. If We or Our Designees require a copy of Member's medical records in connection with Our medical management or other programs, including but not limited to those purposes set forth in Sections 5.3 and 5.4 above, Provider shall provide one (1) copy per occurrence of the Member's medical record to us or to Our Designees in a timely manner and without charge upon Our request. Subsequent copies provided to us or to Our Designees related to the same occurrence will be subject to 42 Pa. C.S.A. 6152(a)(2)(i). Provider shall provide copies of the Member's medical records to us or to Our Designees in electronic form or the format that We request.

5.6 Survival of Obligations Regarding Medical Records. The obligations of Provider under this Section shall survive the termination of this Agreement.

SECTION 6: EFFECTIVE DATE, TERM AND TERMINATION

6.1 Effective Date. This Agreement shall be effective upon the later to occur of (i) the date on which Provider, including any Associated Provider and/or Practitioner, has been credentialed and approved by Capital, or (ii) the date set forth on the first page of this Agreement.

6.2 Initial Term; Automatic Renewal. The initial term of this Agreement shall be for one (1) year from the date set forth on the signature page of this Agreement. This Agreement shall thereafter be automatically renewed for successive one (1) year periods unless either party gives written notice of voluntary termination.

6.3 Voluntary Termination. This Agreement may be terminated by either party at any time after the Initial Term upon sixty (60) days' prior written notice. Provider may elect to so terminate upon receipt of Our notice of an amendment to the Agreement pursuant to Section 8.3. However, if Provider participates in Our Medicare Advantage Program, voluntary termination can only be effective as of December 31st of any year that this Agreement is in effect.

6.4 Termination for Cause.

6.4.1 By Either Party. Either party shall have the right to terminate this Agreement on thirty (30) days' prior written notice to the other party if the party to whom such notice is given is in breach of any material provision of this Agreement. Such notice shall set forth the facts underlying the alleged breach. If such breach is cured within such thirty (30) day notice period, then the Agreement shall continue in effect for its remaining term, subject to any other provision of this Agreement.

6.4.2 By Capital. We may terminate this Agreement immediately and without possibility of reinstatement upon cure if it determines that one or more Members' health may be impaired by the continuation of this Agreement or if We determine that any of the following events have occurred with respect to Provider , any Associated Provider, or any Practitioner, which determinations shall be made by Us acting in good faith: (i) the restriction, suspension or revocation of any license or, if applicable, the suspension or loss of any DEA number or other right to prescribe controlled substances; (ii) any loss of or failure to maintain general and professional liability insurance as required under this Agreement; (iii) any exclusion from participation in Medicare, Medicaid, or any other third party, state or federal programs; (iv) any felony conviction; (v) impairment of any ability to provide services; or (vi) any failure or inability at any time to satisfy Our credentialing, hospital privileging, and accreditation

criteria, as in effect and as updated from time to time.

6.5 Appeal Rights. Except for a termination pursuant to Section 6.3 or 6.4.2 above, Provider shall have the right to appeal a termination of this Agreement in accordance with the Provider Manual.

6.6 Termination Upon Insolvency. We or Provider (as the case may be) may terminate this Agreement immediately upon giving notice to the other party (i) in the event of the filing of a petition for relief under federal bankruptcy law by or against the other party; or (ii) in the event of any liquidation, rehabilitation, conservation, or similar proceeding of the other party under the laws of the Commonwealth of Pennsylvania.

6.7 Unforeseen Events. If either party's ability to perform that party's obligations under this Agreement is substantially interrupted by war, fire, insurrections, riots, the elements, earthquake, acts of God, or, without limiting the foregoing, any other similar cause beyond the control of either party, the party shall be relieved of that party's obligations only to those affected portions of this Agreement for the duration of such interruption. If such interruption of performance by one party is likely to continue for a substantial period of time, the other party shall have the right to terminate this Agreement upon ten (10) days' prior written notice.

6.8 Continuity of Care. Except where the Agreement is terminated for cause, if a Member requests to continue an ongoing course of treatment when this Agreement is terminated and We have authorized continued treatment, Provider shall continue to provide Covered Services consistent with this Agreement, Our policies and procedures in effect and as updated from time to time and consistent with applicable law**.** We shall honor Our obligations to pay or arrange for payment for Covered Services until the earlier of: (i) the course of treatment is completed; (ii) We provide for the assumption of Medically Necessary and Appropriate treatment by another Provider; (iii) ninety (90) days from the Agreement's termination date; or (iv) We take such actions as otherwise required by law. Provider shall continue to honor the terms of this Agreement with respect to providing Covered Services to such Members.

A Member in the second or third trimester of pregnancy at the time of termination may request to continue her course of treatment with the Provider through the postpartum period following delivery.

If this Agreement terminates because of Our insolvency or discontinuance of operations, Provider shall continue to provide Covered Services to Members as needed to complete any Medically Necessary and Appropriate procedures commenced but unfinished at the time of the termination. If a Member is receiving Medically Necessary and Appropriate inpatient care at a hospital at the time of termination, Provider shall continue to provide Covered Services relating to that inpatient care in accordance with applicable law. Provider is not, however, required to continue to provide Covered Services to Members after occurrence of any of the following:

(i) The end of the Member's period of coverage for contractual prepayment of premiums;

(ii) The Member obtains equivalent coverage with another insurer, or the Member's employer obtains such coverage for the Member; or

(iii) The Member or the Member's employer terminates coverage under the applicable Group Contract.

If We terminate this Agreement for cause in relation to a PCP, we will notify all affected Members and they must select another PCP. We are not responsible for Covered Services provided to Members by such former Provider following the date of termination, and no Member has a right to receive in-network levels of benefits if he/she continues with such former Provider.

6.9 Member Notification. Upon the termination of this Agreement, Provider shall cooperate with Us in

regard to Member notification of such termination. If any Associated Provider or Practitioner is terminated as provided in this Agreement, Provider shall use best efforts to provide written notice to "Affected Members" at least thirty (30) days prior to the effective date of termination of any Associated Provider or Practitioner; provided, however, that Provider shall nonetheless be responsible for providing written notice to "Affected Members." For purposes of this Section 6.9, a termination of an Associated Provider or Practitioner occurs when any Associated Provider or Practitioner no longer practices with Provider or otherwise becomes unavailable to provide Covered Services to a Member. For purposes of this Section 6.9, "Affected Members" shall mean Our Members who have been solely or primarily receiving ongoing care from a terminated Associated Provider(s) or Practitioner(s).

6.10 Effect of Termination. Termination shall have no effect upon the rights and obligations of the Parties arising out of any transaction occurring prior to the effective date of such termination or any provisions of this Agreement that expressly survive termination.

SECTION 7: INQUIRY AND APPEAL PROCEDURE

7.1 Inquiry Procedures. For inquiries regarding claim status, payment, adjustment, and/or denial arising under this Agreement, Provider shall follow the applicable Protocols in effect and as updated from time to time.

7.2 Appeal Procedures. For challenge and appeal of certain policy or administrative decisions, Our determinations of the Medical Necessity of services provided to Members, or as otherwise required by applicable law, Provider shall follow the appropriate appeals procedures set forth in the Provider Manual.

SECTION 8: MISCELLANEOUS

8.1 Amendment or Modification. The terms of this Agreement may be waived, amended, modified or supplemented in writing as agreed by the Parties; provided, however that the Agreement may be amended automatically, without the consent of the Provider, in order to meet applicable local, state or federal statutory or regulatory requirements or to comply with a change in law. As used herein, "Change in Law" shall mean: (i) any legislation enacted by the federal or any state or local government; (ii) any governmental agency law, rule, regulation, guideline or interpretation of a previously enacted law, rule, regulation or guideline; (iii) any judicial or administrative order, decree or decision; or (iv) any interpretation of (i), (ii), or (iii) above that may place either party to this Agreement in jeopardy of being in violation of law. We shall provide Provider with written notice of such amendments for statutory or regulatory compliance. In addition, We may modify, amend or supplement any provision of this Agreement upon thirty (30) days' prior written notice to Provider. If Provider fails to object to such modification in writing within the thirty (30) day notice period, Provider will be deemed to have consented to the amendment, modification, or supplementation of the Agreement. Any such objection shall be deemed to be a notice by Provider of Provider's election to terminate this Agreement pursuant to Section 6.3 of the Agreement. If the Provider chooses to terminate participation due to the amendment or modification made by Us, Provider shall be bound by the new terms during the sixty (60) day termination notification period. Capital may send any amendments to this Agreement electronically to Provider.

8.2 Assignment. This Agreement, being intended to secure the services of and be personal to the Provider, shall not be assigned to, transferred or subcontracted by the Provider without Our prior written consent. Any attempted assignment of this Agreement by the Provider in contravention of this provision shall be void.

8.3 Compliance with Law. Each party shall comply with all relevant state, federal and local laws, rules, statutes, ordinances, orders and regulations that are relevant to the terms and conditions of this Agreement.

8.4 Documents Incorporated. Any exhibits, attachments, tables or schedules, including Protocols, referenced, attached or incorporated by reference in this Agreement, are incorporated herein to the same extent as if set forth in full.

8.5 Effect of Waiver. The waiver by either party of a breach or violation of any provision of this Agreement shall not operate as or be construed to be a waiver of any subsequent breach or violation thereof.

8.6 Entire Agreement. This Agreement, together with any attachments, schedules and exhibits hereto or thereto, constitute the entire agreement between the Parties and supersede all other proposals, understandings or agreements, whether written or oral, regarding the subject matter hereof.

8.7 Governing Law. This Agreement shall be governed in all respects by the laws of the Commonwealth of Pennsylvania.

8.8 Independent Contractor Relationship. The Parties are independent contractors and separate legal entities. The relationship between the Parties is reflected in this Agreement, and neither party, nor the employees, agents or representatives of either, shall be considered the employee, agent or representative of the other party. None of the provisions of this Agreement are intended to create or to be construed as creating any agency, partnership, joint venture or employer-employee relationship between or among the Parties, their respective employees, servants, agents or representatives. Each party shall be responsible for payment of all federal, state and local taxes relating to its business.

8.9 No Third Party Beneficiaries. Except as expressly set forth in this Agreement, there are no third party beneficiaries of this Agreement.

8.10 Notice. Except as otherwise provided for in this Agreement, any notice required to be given pursuant to this Agreement shall be in writing and shall be hand delivered (with a signed receipt), or sent by: prepaid, certified mail, return receipt requested; overnight mail delivery; or U.S. Postal Service Express Mail to the address listed on the signature page to this Agreement. Any notice concerning changes to Exhibit C may be given electronically upon thirty (30) days' advance notice. Notice shall be deemed to be effective as of the date mailed or transmitted. Either party may at any time change or amend its address by mailing a notice, as required above. Any notice provided by Us to Provider shall be deemed to have been given to any Associated Provider or Practitioner.

8.11 Notice of Claims, Settlement or Judgments. Provider agrees promptly to notify Us of any settlement, judgment or other disposition of any malpractice or similar claim against Provider or any Associated Provider or Practitioner.

8.12 Professional and General Liability Insurance. For all individuals rendering Covered Services through Provider, Provider shall obtain and maintain policies of general and professional liability insurance, that have minimum levels of coverage equal to the greater of (i) the coverage levels required by applicable law.

8.12.1 Evidence of Coverage; Notice of Change. Provider shall provide Us with current evidence of coverage for the required insurance policies upon Our request and shall notify Us at least ten (10) days prior to any change to, or amendment or cancellation of Provider's insurance policies. Coverage under Provider's insurance policies shall survive the termination of this Agreement as such coverage relates to acts arising during the term of this Agreement.

8.13 Regulatory Approval. If We have not received any necessary license or regulatory approval to provide Covered Services in connection with a particular Program or has not received all required regulatory approvals for use of this Agreement with respect to a particular Program prior to the implementation of the Program, this Agreement shall be deemed to be a binding letter of intent with respect to any such Program. In such event, this Agreement shall become effective with respect

to any such Program on the date that the required licensure and regulatory approvals are obtained. If We are unable to obtain such licensure or regulatory approvals, We shall notify Provider, and both Parties shall be released from any liability under this Agreement with respect to the Program in question; provided, however, that if such licensure or regulatory approval is conditioned upon amendment of this Agreement, then this Agreement shall be amended automatically pursuant to Section 8.3 hereof.

8.14 Relationship to Blue Cross/Blue Shield Association. Provider hereby expressly acknowledges its understanding that this Agreement constitutes a contract between the Parties, that We are 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 us to use the Blue Cross service mark in Central Pennsylvania and the Lehigh Valley, and that We are not contracting as the agent of the Association. Provider further acknowledges and agrees that it has not entered into this Agreement based upon representations by any person other than Capital and that no person, entity, or organization other than Capital shall be held accountable or liable to Provider for any of Our obligations to Provider created under this Agreement. This Section shall not create any additional obligations whatsoever on Our part other than those obligations created under other provisions of this Agreement.

8.15 Severability. The invalidity or unenforceability of any terms or conditions hereof shall in no way affect the validity or enforceability of any other terms or provisions.

8.16 Use of Capital Name, Trademarks and Materials. Provider may not use Our or any Capital Affiliate's name or service marks without Our prior written consent. The Parties agree that all written materials, including but not limited to, the Provider Manual, administrative manuals, administrative bulletins, administrative notices, alerts, peer review program, financial reports, this Agreement, as well as all of the terms herein, and other policies and procedures developed by Us, and lists of Members shall be kept confidential and are considered proprietary to Us. Such materials shall not be used or disclosed by Provider to anyone without the Our express prior written consent.

8.17 Other Versions of this Document. The following shall have the same legal force and effect as an original of this document: a facsimile, photocopy, imaged or other electronic version.

SECTION 9: DEFINITIONS

9.1 Act 68 – Pennsylvania's Quality Health Care Accountability and Protection Act (40 P.S. Section 991.2101 et seq.) and supporting regulations, and any successor statute and regulations.

9.2 Affiliate(s) – Any entity that controls, or is directly or indirectly controlled by, or is under common control with Us. An entity shall be deemed to control another entity if such entity owns a majority or more by value or by vote of any class of stock or other equity interest of the "controlled" entity, or possesses, directly or indirectly, the power to direct or cause the direction of the management and policies of the controlled entity, whether through ownership of stock, partnership, or other equity interests, by contract or otherwise.

9.3 Allied Health Professional - (i) an ancillary non-physician professional health care provider duly licensed in the Commonwealth of Pennsylvania, including, without limitation, a physician assistant, certified registered nurse practitioner, certified registered nurse anesthetist, acupuncturist, chiropractor, optometrist, physical therapist, occupational therapist, licensed dietitian-nutritionist, speech language pathologist, audiologist, certified nurse midwife, licensed psychologist, licensed social worker, licensed clinical social worker, licensed professional counselor, licensed marital and family therapist, clinical psychiatric nurse practitioner, licensed behavior specialist, licensed genetic counselor, other master's degree prepared therapist, or other provider of health care services approved by Us; and (ii) who is a shareholder, partner, affiliate, or employee of Provider, in cases where Provider is not an individual but organized as a separate legal entity or otherwise employs or contracts with professional health care providers.

9.4 Associated Provider - Any shareholder, partner, affiliated physician, physician employee of Provider, or Allied Health Professional in cases where Provider is not an individual but organized as a separate legal entity or otherwise employs or contracts with physicians.

9.5 Capital – Capital BlueCross, an independent licensee of the Association. Unless otherwise specified in this Agreement, references to Capital shall include the applicable Affiliates, Designees, agents and representatives.

9.6 Change in Control – (i) entering into a definitive agreement with an unrelated third party providing for a merger, consolidation, sale of substantially all assets, recapitalization or other business combination; (ii) entering into a definitive agreement under the terms of which a party transfers or delegates its operations to an unrelated third party; or (iii) any change in the composition of the Board of Directors of the party that would result in the replacement of a majority of the directors, such that an unrelated third party could exercise control over the affairs of that party.

9.7 Clean Claim – A claim for payment for a health care service which has no defect or impropriety and is consistent with any applicable federal or state laws or regulations. A defect or impropriety will include a failure to provide any of the data elements necessary to complete a UB-04 or CMS 1500 form (or any replacement form) in accordance with industry standards, the Provider Manual, lack of required substantiating documentation or a particular circumstance requiring special treatment which prevents timely payment from being made on the claim. The term will not include (i) a claim from a health care provider who is under investigation for fraud or abuse regarding that claim or (ii) a claim that requires investigation pursuant to OPL.

9.8 Coinsurance – Financial responsibility by a Member to a health care provider that generally is equal to a fixed percentage of allowed charges after a Deductible has been met as described in the applicable Group Contract.

9.9 Contract Holder – An individual, organization, firm or governmental entity, or Self-Funded Account that has executed a Group Contract with Us for benefits or access to health care services for such person or its Members, employees, retirees, their spouses and dependents, or others.

9.10 Copayment – Financial responsibility by a Member to a health care provider that is typically equal to a specified fixed fee for a specific service as described in the applicable Group Contract.

9.11 Cost Sharing Provisions – Any applicable Coinsurance, Copayment, or Deductible or other Member financial responsibility, including penalties, as set forth in the applicable Group Contract.

9.12 Covered Location – A physical site where Covered Services are provided pursuant to this Agreement.

9.13 Covered Services – Services provided to a Member that are Medically Necessary and Appropriate and to which the Member is entitled under the terms and conditions of the applicable Group Contract and for which We are obligated to pay.

9.14 DEA - The United States Drug Enforcement Agency or any successor agency responsible for the regulation of the prescription of drugs.

9.15 Deductible – The total amount of aggregated payments (as described in the applicable Group Contract) that must be made by a Member to one or more health care providers before benefits become payable by Us.

9.16 Dependent – Family member of a Subscriber or other person who meets all applicable eligibility requirements of the Group Contract, who has been enrolled in accordance with the requirements thereof, and for whom the payment required by such agreement actually has been received by Us.

9.17 Designee – An entity that performs services permitted or required by this Agreement on Our behalf and pursuant to a written delegation agreement. When required by law, a Designee shall be

appropriately licensed.

9.18 Effective Date - The date upon which this Agreement goes into effect as set forth in Section 6.1 of this Agreement.

9.19 Emergency - The sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or 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: (i) placing the health of a Member, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; or (ii) serious impairment to bodily functions, (iii) serious dysfunction of any bodily organ or part, or (iv) other serious medical consequences.

9.20 Emergency Services - Any health care services provided to a Member in case of an Emergency. Emergency transportation and related emergency service provided by a licensed ambulance service will constitute Emergency Services.

9.21 Group Contract – As applicable, the group or individual policy, group or individual application, certificate of insurance, enrollment form, summary plan description, certificate of coverage or evidence of coverage or other agreement between Us (or national or regional plan such as a BlueCross or BlueShield plan with which We have a reciprocal arrangement, or the Federal Employee Program) and a Contract Holder that expresses the agreed upon contractual rights and obligations of the Parties thereto, and that describes the costs, procedures, benefits, conditions, limitations, exclusions and other obligations to which Members are subject under each of the Programs, as applicable, which agreement is made before, on or after the Effective Date, as the same may be amended, modified or supplemented from time to time.

9.22 Inpatient Services – Covered Services provided to a Member who is registered as an inpatient in an acute care facility with the expectation of staying overnight.

9.23 Joint and Several Obligations - The obligations of all individual physicians, medical groups, partnerships, corporations, or other entities participating in this Agreement as the Provider hereunder shall be several, except that:

(i) Provider hereby agrees that for participation in Programs and to the extent not prohibited by law, it shall be jointly and severally liable for both the reporting of adverse actions involving any hospital, the reporting of erroneous payments under the Agreement, and the taking of any actions required under this Agreement relating to quality of care and corrective action;

(ii) Provider shall be treated jointly and severally for purposes of Notices; and

(iii) Provider is acting jointly and severally on behalf of each Covered Location, and each Program.

9.24 Low Income Program – Coverage to Members who would otherwise not have access to health benefits due to income. To qualify for a Low Income Program, a Member must meet eligibility requirements established by state and/or federal agencies, which typically are based on a Member's, or Member's family, income.

9.25 Managed Care Program - A primary care or managed care plan offered by Capital which (i) utilizes designated providers who act as gatekeepers; and (ii) is approved by the DOH and the PID.

9.26 Medical Management – Administrative services and Programs related to Providers' provision of services to a Member, including care management, Preauthorization, Utilization Management, and Quality Management.

9.27 Medically Necessary and Appropriate ("Medical Necessity") - Services or supplies provided by a Provider that Capital or its designee determines are: (i) n ecessary and appropriate for the

diagnosis and/or the direct care and treatment of the Member's medical condition, disease, illness or injury; (ii) in accordance with generally accepted standards of good medical practice; (iii) consistent with Capital's or its designee's clinical protocols and utilization guidelines; (iv) not primarily for the convenience of the Member, the Member's family, the Member's physician or other health care provider; and (v) provided at the most appropriate level of service, supply, or setting to safely diagnose or treat the Member. When applied to hospital services, this means that the Member requires care in an emergency room or as an inpatient due to the symptoms presented or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient in another setting.

9.28 Medicare Program – Any benefit plan established or sponsored by the Centers for Medicare and Medicaid Services ("CMS"), which meets the CMS qualifications for such program (e.g. Medicare Advantage, Medicare Supplement).

9.29 Member – A Subscriber or Dependent or other person who is entitled to benefits under the terms and conditions of a Group Contract.

9.30 Member Acknowledgement – For non-Covered Services, of which Provider has reasonable advance knowledge, whether through notice, the Preauthorization process or otherwise, a Member Acknowledgement shall be necessary and shall mean a signed acknowledgement (and not a general release at the time of admission) in a Member's file with Provider prior to but at the time of treatment acknowledging the following: (i) the service(s) to be provided; (ii) that We will not pay for or be liable for said services; and (iii) that a Member will be financially liable for such. From time to time, We may issue a form for obtaining such acknowledgement, and if such a form is required, then a Member Acknowledgement must utilize such form.

9.31 Non-Covered Services – Those health care services, treatment and supplies that are not Covered Services under the terms and conditions of the applicable Group Contract.

9.32 OPL ("Other Party Liability") – The coordination of health care benefits with motor vehicle and workers' compensation insurance carriers, or other parties that are, by statute, contract or agreement, legally responsible for the payment for Covered Services.

9.33 Overpayments – A payment or payments greater in amount than actually due Provider under the Agreement or a payment or payments to which Provider was not entitled hereunder regardless of the reason and no matter how We or Provider learns of such error.

9.34 Participating Provider – A Practitioner, Associated Provider, hospital, long-term acute care hospital, skilled nursing facility, rehabilitation hospital, home health agency, or any other health care provider or practitioner which: (i) has entered into an agreement with any other BlueCross and/or BlueShield entity servicing a geographic area outside Capital's service area; (ii) is licensed by the appropriate regulatory agency; and (iii) provides Covered Services to Members. Unless specifically stated otherwise, the use of the term "Provider" includes Participating Providers. A Practitioner or Associated Provider qualifies as a Participating Provider to the extent that it provides Covered Services to a Member who has coverage through any other Blue Cross and/or Blue Shield entity which only services a geographic area outside of Our service area.

9.35 Practitioner – An individual who is duly licensed to practice in the Commonwealth of Pennsylvania (or such other jurisdiction approved by Capital) whose license is without limitation or restriction as a (i) doctor of medicine ("M.D."); (ii) doctor of osteopathy ("D.O."); (iii) doctor of chiropractic medicine ("D.C."); (iv) doctor of dental surgery ("D.D.S.") or doctor of dental medicine ("D.M.D.") who is board certified in Oral Maxillofacial Surgery or is practicing as a prosthodontist; or an (v) Allied Health Professional; and who: (a) satisfies Capital's policies and procedures related to credentialing, hospital privileging, and accreditation criteria; and (b) is providing Covered Services to Members under this Agreement.

9.36 Preauthorization – Activities performed by us or Our Designee or another BlueCross and/or BlueShield entity through the BlueCard® program in advance of treatment to determine whether certain proposed services are a Medical Necessity and Covered Service under a Member's Group Contract. This may sometimes be referred to as "prior authorization."

9.37 Primary Care Provider ("PCP") - A provider who We designate to provide primary care services and who meets all Our requirements and criteria for PCPs and who, within the scope of the PCP's practice, supervises, coordinates, prescribes or otherwise provides or proposes to provide health care services to a Member, initiates Member referrals for specialist care, and maintains continuity of Member care.

9.38 Program – Each of the health benefit coverage designs applicable to Members, as applicable, listed on Exhibit A as it may be amended and modified from time to time. Where appropriate, "Program" shall also include "Specialty Programs".

9.39 Program Fee Schedule - The fee schedule or other payment terms specified for the rendering of Covered Services for each Program. The fee schedule will vary depending on the type of provider who renders the Covered Service.

9.40 Provider Manual - The reference manual or manuals, as updated annually and supplemented by bulletins and other provider communications, the terms of which are incorporated herein and which Capital makes available to Providers that delineate Capital's policies, procedures, and administrative requirements.

9.41 Provider Portal – The electronic access point for Providers to verify Member eligibility, make referrals, update Provider information, access Our Provider directory, access Our medical policies, obtain information about Covered Services requiring Preauthorization, initiate Preauthorization requests, and obtain other information about Our Programs. Providers may also access payment schedules for Covered Services.

9.42 Quality Management - Activities performed by Us that: (i) evaluate and monitor patient care and services from Associated Providers or Practitioners; (ii) take appropriate action when quality issues are found; and (iii) credential and re-credential Associated Providers or Practitioners.

9.43 Self-Insured Account – An entity which: (i) is contracted with Us to provide certain administrative functions and access to Our Provider network through a Group Contract to Members; (ii) is self-insured in whole or in part; and (iii) has agreed to be responsible for funding benefit payments for Covered Services.

9.44 Specialist Provider - A provider who is designated by Us as a Specialist Provider and who provides non-primary care Covered Services to Members within the scope of his or her medical specialty in accordance with the policy and procedures for each Program and who meets all Our requirements for Specialist Providers as We may adopt from time to time.

9.45 Specialty Program - A Capital-established or sponsored program for a targeted group of Members with certain types of illnesses, conditions, cost or risk factors (e.g., organ transplants, women's health, other disease management programs, etc.).

9.46 Subscriber – An individual who meets all applicable eligibility requirements of a Group Contract and who enrolls in accordance with the requirements and for whom the payment required by such Group Contract actually has been received by Us.

9.47 Underpayments – A payment or payments lesser in amount than actually due Provider under the Agreement or a payment or payments to which Provider was entitled hereunder regardless of the reason and no matter how We or Provider learns of such error.

9.48 Utilization Management – Activities that We perform to review and determine whether certain services are a Medical Necessity.

EXHIBIT A

PROGRAMS

Any variations of the following Programs underwritten or administered by Capital BlueCross or its family of companies, including Capital Advantage Insurance Company® ("CAIC"), Capital Advantage Assurance Company® ("CAAC") and/or Keystone Health Plan® Central, Inc. ("KHP Central"): Provider acknowledges that We, as a part of Our mission as a Not-For-Profit plan, may provide coverage to Members who would otherwise not have access to health care benefits through Low Income Programs, which may be added from time to time.

PREFERRED PROVIDER ORGANIZATION ("PPO") PROGRAM (which includes any Exclusive Provider Organization Program ("EPO") designated on Schedule C-3)

POINT OF SERVICE ("POS") PROGRAM

TRADITIONAL PROGRAM

COMPREHENSIVE PROGRAM

HEALTH MAINTENANCE ORGANIZATION ("HMO")

MEDICARE SUPPLEMENT

MEDICARE ADVANTAGE HMO (which includes any Special Needs Program ("SNP") designated on Schedule C-2)

MEDICARE ADVANTAGE PPO

CHILDREN'S HEALTH INSURANCE PROGRAM ("CHIP")

BLUE CARD

AVALON INSURANCE COMPANY PRODUCTS

Any variation of the following Program jointly underwritten or administered by Capital BlueCross or Highmark BlueShield:

FEDERAL EMPLOYEE PROGRAM ("FEP")

Capital may change these Programs from time to time, by providing appropriate electronic notice to Provider, without amending the Agreement.

EXHIBIT B

ASSOCIATED PROVIDERS, PRACTITIONERS AND COVERED LOCATIONS

Provider, by its signature on the execution page of this Agreement to which this Exhibit B is attached, hereby certifies that the information provided in the below listing of Associated Providers, Practitioners and Covered Locations is accurate, true and correct. Provider further understands and agrees that the provision of Covered Services by Provider, its Associated Providers and/or Practitioners shall be governed by the terms and conditions of the Agreement as if all are a party thereto.

The following Covered Locations, Associated Providers and Practitioners are covered by this Agreement.

Name	Specialty	NPI Number	PCP or Specialist or Both	Location/ Address
Tara Vining	SLP	1194080614	Specialist	418 Railroad St Danville PA 17821

The Parties agree that once this Agreement has been executed, this Agreement does not have to be amended to change the information contained on this Exhibit. Provider may update this Exhibit's information by submitting any updates on Our Provider Portal, as required by the Provider Manual.

(Attach additional pages if needed)

EXHIBIT C

PROGRAM PROVISIONS, PAYMENT FORMULAS AND RATE SCHEDULES

All provisions in the core Agreement are applicable to all Programs unless specifically stated in the Exhibits below.

EXHIBIT C-1 –COMMERCIAL PROVISIONS

(TRADITIONAL, COMPREHENSIVE, PPO, AND FEP)

EXHIBIT C-2 – MANAGED CARE PROVISIONS

(HMO, POS, AND CHIP)

ATTACHMENT TO EXHIBIT C-2 – NONDISCRIMINATION/SEXUAL HARASSMENT PROVISIONS APPLICABLE TO CHIP PROGRAM

EXHIBIT C-3 – MEDICARE ADVANTAGE PPO AND HMO PROVISIONS

SCHEDULE C-1 – COMMERCIAL AND MANAGED CARE PAYMENT RATES

SCHEDULE C-2 – MEDICARE ADVANTAGE PAYMENT RATES

SCHEDULE C-3 –RESERVED

EXHIBIT C-1

COMMERCIAL PROVISIONS

(TRADITIONAL, COMPREHENSIVE, PPO, AND FEP)

All Program provisions applicable to Traditional, Comprehensive or PPO Programs, are contained in the core Agreement.

EPO PROVISIONS

An EPO Program is an Exclusive Provider Organization where the Member has no out of network benefits. EPO Programs are a part of Capital's PPO Programs, and payment provisions, if applicable, would be included on Schedule C-3.

EXHIBIT C-2

MANAGED CARE PROVISIONS

To the extent of any inconsistency between the terms and conditions of this Exhibit C-2 and the terms and conditions of the Agreement, the terms and conditions of this Exhibit C-2 shall govern.

To the extent applicable, We and Provider will comply with the following provisions, which are required by State law to be included in the Agreement, as such provisions may be amended from time to time by the State.

1. As used in this Exhibit, the term “State” refers to the Commonwealth of Pennsylvania

2. The compensation payable to Provider under this Agreement is not designed to directly or indirectly provide incentives to Provider to deny, limit or discontinue Medically Necessary and Appropriate Covered Services to any Member.

3. We may not penalize or restrict a Provider from discussing:

   3.1 the process that We or any entity contracting with Us uses or proposes to use to deny payment for a health care service;

   3.2 Medically Necessary and Appropriate care with or on behalf of a Member, including information regarding the nature of treatment; risks of treatment; alternative treatments; or the availability of alternate therapies, consultation or tests; or

   3.3 Our decision to deny payment for a health care service.

4. We shall have the right to immediately terminate Provider if Provider is found to be harming Members.

ADDITIONAL HMO AND POS PROVISIONS

The following is a description of the role of the PCP in an HMO or POS program. The HMO and POS programs include a Provider gatekeeper. The Member must select (or Capital may designate in certain circumstances) a provider who has been credentialed as a PCP to act as that Member’s designated PCP. The PCP has primary responsibility for providing, arranging and coordinating the overall health care of a Member, including the appropriate referral to Specialist Providers or other providers for certain health care services, and shall adhere to procedures established by Capital and requirements set forth in 28 Pa. Code § 9.678. PCPs shall provide all primary care services, which shall include, as applicable, and without limitation the following services:

1. Office visits for primary care services.

2. Preventive medicine – child and adult health maintenance examination, patient education, tests, and counseling including risk factor reduction intervention.

3. After hours professional services.

4. Laboratory and miscellaneous services such as specimen collection; routine urinalysis with and without microscopy; urinalysis microscopic only; occult blood (feces) screening; blood glucose/dip strip; hemoglobin; WBC count; quick strep test; streptococcus, screen, direct, PPD smear/routine stain; wet mount; EKG; venipuncture; and pulmonary function testing (peak flow).

5. Case management services (team conferences and telephone calls).

6. Care plan oversight services.

7. Home visits, as appropriate.

8. Immunizations and injections including the administration of therapeutic injections and general musculoskeletal injections.

9. Surgery and procedures including the removal of uncomplicated foreign bodies; simple abscess drainage; benign lesion removal; repair of small skin lacerations; some uncomplicated fractures; cauterization of nasal passages; suture removal; sigmoidoscopy (rigid); and urinary catheterization.

10. Screenings (vision and hearing).

11. Hospital visits and consultations, as appropriate.

The following is a description of the role of the Specialist Provider in an HMO or POS program. Service provision expectations for a Specialist Provider include, but are not limited to the following:

1. Upon referral from a Member's PCP, the Specialist Provider shall provide Covered Services within the scope of his or her specialty and practice as may be authorized by the PCP or, as appropriate, by the Capital.

2. If the Member seeks care without a referral, the Specialist Provider shall provide Covered Services within the scope of his or her specialty and collect any applicable Cost Sharing Provisions from the Member.

ADDITIONAL GATEKEEPER PPO PROVISIONS

To the extent a Gatekeeper PPO Program requires a PCP, the provisions applicable to an HMO or POS Program, as stated above, shall be applicable.

CHILDREN'S HEALTH INSURANCE PROGRAM ("CHIP") PROVISIONS

This Schedule is part of the Professional Provider Agreement (the "Agreement") entered into between the Parties and is in effect from the Effective Date through end of the term. All capitalized terms in this Exhibit C-2 shall have the meanings set forth in Section 9 (Definitions) of the Agreement or in this Exhibit C-2. In the event of a conflict between a term's definition as provided in Section 9 and as provided in this Exhibit C-2, this Exhibit C-2 shall control.

This Exhibit C-2 sets forth the terms that govern the Children's Health Insurance Program for which Capital has contracted to provide Member services and for which Provider shall provide Program Services under the Agreement. The requirements identified in this Exhibit C-2 are in addition to any reports identified in the Agreement or in another Exhibit. In the event of a conflict between this Exhibit C-2 and the terms of the Agreement, this Exhibit C-2 shall govern vis-à-vis the specific federal health care program.

These provisions shall apply only with respect to services provided to CHIP Members by Provider.

1. Terms.

   (a) "CHIP" means the Children's Health Insurance Program, a program offered by the Commonwealth of Pennsylvania to provide free and subsidized health care services to uninsured children pursuant to Title XXI of the Social Security Act as amended to include the State Children's Health Insurance Act (42 U.S.C. §§ 1397aa *et seq*., as amended) and the Pennsylvania Children's Health Care Act (40 P.S. §§ 991.2301 *et seq*., as amended).

   (b) "CHIP Member" means a person who qualifies for and is enrolled by Sponsor in CHIP.

   (c) "Contract" means the agreement in effect between the PID and Sponsor (in this case, KHP Central, a subsidiary of Capital BlueCross), including the Request for Proposal ("RFP") and all other attachments thereto, pursuant to which Sponsor provides health benefit coverage to CHIP Members, as well as any subsequent agreements entered into by the PID and Sponsor for same.

   (d) "PID" means the Pennsylvania Insurance Department.

   (e) "Sponsor" means Keystone Health Plan Central ("KHP Central"), a subsidiary of Capital.

2. Basic Duties of Provider. Provider agrees to perform all duties as set forth in the Agreement for CHIP Members for the term set forth in the Agreement, unless the Contract is terminated earlier.

3. Assumption of Terms and Conditions of the Contract. Pursuant to paragraph 20f of Appendix A to the RFP, Standard Contract Terms and Conditions, Provider agrees to be legally bound by all of the applicable terms and conditions of the Contract, which may include, but not be limited to: Article IV-5.C.3 (Records Retention) of the RFP; paragraph 3, Compliance with Laws, of Appendix A of the RFP, which laws, if applicable, may include, but not be limited to, the federal Violent Crime Control and Law Enforcement Act, Gramm-Leach-Bliley, the Health Insurance Portability and Accountability Act ("HIPAA"), and Pennsylvania's Act 68 of 1998; paragraph 21f, Nondiscrimination/Sexual Harassment, of Appendix A of the RFP; paragraph 22, Contractor Integrity Provisions, of Appendix A of the RFP, including the confidentiality provisions of paragraphs 22 b and c; Appendix F, Management Directive 215.9 Amended (Contractor Responsibility Program) of the RFP; Appendix G, Management Directive 215.12 (Provisions for Commonwealth Contracts Concerning the Americans with Disabilities Act) of the RFP; and Appendix H, No. 305.16 (Lobbying Certification and Disclosure) of the RFP. Provider specifically agrees to adhere to the Nondiscrimination/Sexual Harassment Provisions, as applicable, set forth in the Attachment to Exhibit C-2 attached hereto and incorporated herein by reference. Provider may subcontract certain duties or obligations under the Agreement in accordance with the terms of the Agreement. In the event Provider subcontracts certain of its duties or obligations under the Agreement, it shall be the responsibility of Provider to ensure that its subcontractor agreement includes any and all applicable provisions required by the Contract.

4. Receipt of Federal and State Funds. Pursuant to Article IV-5.C.4 (Fraud and Abuse) of the RFP, Provider acknowledges that payments it receives from Sponsor under the Agreement for CHIP Members are, in whole or in part, derived from federal and/or state funds and that any false or fraudulent claim or statement in any document, or any concealment of a material fact, or any other form of fraudulent activity relating to Provider's involvement with CHIP may be cause for prosecution under applicable laws. In the event of a successful prosecution of Provider related to CHIP, Capital may, in its discretion, suspend or terminate Provider from participation in CHIP.

5. Suspension or Debarment. Pursuant to paragraph 23a of Appendix A to the RFP, Standard Contract Terms and Conditions, of Exhibit A (RFP) to the Contract, Provider certifies that it is not currently suspended or debarred by the Commonwealth or any governmental entity, instrumentality or authority and that it does not employ suspended or debarred individuals and that it has no tax liabilities or other Commonwealth obligations. Provider agrees that if it becomes suspended or debarred by the Commonwealth or any governmental entity, instrumentality or authority during the term of the Agreement, or if any of its employees become suspended or debarred during such time frames, it shall notify Sponsor within five (5) business days of such suspension or debarment. Provider acknowledges that upon such suspension or debarment, the Commonwealth may require Capital to terminate Provider's administration of prescription drug services for CHIP.

6. Confidentiality of Member Information. Provider confirms that the terms of the HIPAA Business Associate Addendum with Sponsor in effect is applicable to CHIP Members.

7. Basic Duties of Capital. Capital shall comply with all terms and conditions of the Contract. Capital acknowledges that as the prime contractor under the Contract it is responsible for the acts and omissions of all of its subcontractors, including Provider.

8. Conflict Between the Agreement and the Contract. If there is any conflict between the terms and conditions of the Agreement (including this Addendum) and the Contract, the terms and conditions of the Contract shall prevail.

EXHIBIT C-3

MEDICARE ADVANTAGE PPO AND HMO PROVISIONS

Medicare Advantage Managed Care Program. The Provider hereby agrees to provide Covered Services to participants in the Medicare Advantage Managed Care Program pursuant to the terms and conditions set forth in the Agreement. Participants in the enrolled in the Medicare Advantage PPO Program and/or Medicare Advantage HMO Program are "Enrollees" for the purposes of this Exhibit, but qualify as a "Member", as such term is used within the meaning of the Agreement. The Medicare Advantage Managed Care Program is a "Managed Care Program" within the meaning of the Agreement.

Medicare Advantage Provisions. As a First Tier Entity (as defined below) responsible for performing services under the Agreement, and in recognition of Capital's responsibility to implement, oversee, and monitor compliance activities and delegated functions, Provider agrees to the requirements set forth below in "Medicare Advantage Requirements." Provider and any related entity, contractor or subcontractor will comply with all applicable Medicare laws, regulations, and CMS instructions. [42 C.F.R. §§ 422.504(i)(4)(v)]

Medicare Advantage Requirements apply only to Covered Services rendered to Members enrolled in the Medicare Advantage Managed Care Program. This Exhibit supersedes any inconsistent terms in the Agreement, but only as the Medicare Advantage Requirements relate to Covered Services rendered to Enrollees, or to the extent otherwise required by law or regulation. If there is any conflict between the Agreement and Medicare Advantage laws, regulations or guidelines, the Medicare Advantage laws, regulations and guidelines shall control to the extent applicable. In the event of a conflict between the terms and conditions of this Exhibit and the terms of a related agreement, the terms above control.

CMS Required Provisions. CMS requires that any health plan which provides services to Enrollees have certain contractual provisions in their arrangements with providers. To the extent that any of the Medicare Advantage Requirements are broader than the requirements of the applicable Medicare regulations as determined by a written transmittal or pronouncement from CMS headquarters' office (as opposed to a written transmittal or pronouncement from a CMS regional office, a carrier or an intermediary), then the Parties will interpret the Medicare Advantage Requirements more narrowly in accordance with the scope of the applicable CMS transmittal.

These provisions may be supplemented by Capital's policies, procedures and Provider Manual provisions, as the same may be updated from time to time (collectively, "Protocols"). To the extent that Protocols create or establish any greater rights or obligations between the Parties than are in the Agreement, such rights and obligations shall only apply to Covered Services provided under the Medicare Advantage Managed Care Program.

DEFINITIONS

For purposes of Provider's participation in the Medicare Advantage Program, the following capitalized terms shall have the meanings set forth below. All other capitalized terms shall have the meaning set forth in 42 C.F.R. §§ 422.500(b) (e.g., Clean Claim, First Tier Entity, Downstream Entity) or 423.501 or, if not defined in those sections, the Agreement.

1. "Affiliated Parties" means Provider's employees, affiliates, subsidiaries, members of its board of directors, key management, executive staff, or persons owning 5% or more of Provider.
2. "Capital" means Capital BlueCross, as administrator on behalf of CAIC, a Medicare Advantage Organization offering a Medicare Advantage PPO, and KHP Central, a Medicare Advantage Organization offering a Medicare Advantage HMO.
3. "Centers for Medicare and Medicaid Services" ("CMS") means the federal agency within the Department of Health and Human Services responsible for administration of the Medicare Program.

4. "Completion of Audit" means completion of audit by the Department of Health and Human Services, the Government Accountability Office, or their designees of a Medicare Advantage Organization, Medicare Advantage Organization contractor or related entity.

5. "Downstream Entity" means any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit, below the level of the arrangement between an MA organization (or applicant) and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

6. "Dual Eligible" means an Enrollee who is eligible for both Medicare and Medicaid benefits.

7. "Enrollee" means a Medicare Advantage eligible individual who has enrolled in or elected coverage through one of Capital's Medicare Advantage Organizations.

8. "Final Contract Period" means the final term of the contract between CMS and the Medicare Advantage Organization.

9. "First Tier Entity" means any party that enters into a written arrangement, acceptable to CMS, with an MA organization or applicant to provide administrative services or health care services for a Medicare eligible individual under the MA program.

10. "Medicare Advantage" ("MA") means an alternative to the traditional Medicare program in which private plans run by health insurance companies provide health care benefits that eligible beneficiaries would otherwise receive directly from the Medicare program.

11. "Medicare Advantage Contract" means the contract(s) between CMS and CAIC for a Medicare Advantage PPO, and between CMS and KHP Central for a Medicare Advantage HMO.

12. "Medicare Advantage Organization" means a public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the MA contract requirements. For the purpose of this **[**Exhibit**]**, references to "Capital" shall include reference to one of the Medicare Advantage Organizations for which it provides administration.

13. "Provider" means (1) any individual who is engaged in the delivery of health care services in a State and is licensed or certified by the State to engage in that activity in the State; and (2) any entity that is engaged in the delivery of health care services in a State and is licensed or certified to deliver those services if such licensing or certification is required by State law or regulation.

14. "Related Entity" means any entity that is related to the MA organization by common ownership or control and (1) performs some of the MA organization's management functions under contract or delegation; (2) furnishes services to Medicare enrollees under an oral or written agreement; or (3) leases real property or sells materials to the MA organization at a cost of more than $2,500 during a contract period.

ARTICLE 1. PROVIDER RESPONSIBILITIES

1.1 Advance Directives. Provider shall comply with all State and federal laws and regulations relating to advance directives, including but not limited to 42 C.F.R. §§ 422.128 and 489.100 *et. seq*.

1.2 Consistency with Medicare Advantage Contract. Provider shall perform Covered Services and shall ensure that Downstream Entities perform Covered Services in a manner that complies and is consistent with Capital's obligations under its Medicare Advantage Contract.

1.3 Quality Review and Improvement. Provider participates in Capital's quality assessment and improvement programs through the Agreement. Should there be any quality issues, Provider shall investigate and respond immediately to all quality issues and shall work with CMS and/or Capital to resolve accessibility and other quality issues related to Covered Services provided to Enrollees. Provider shall remedy, as soon as reasonably possible, any condition related to patient care, which

CMS, Capital or any government or accrediting agency has determined to be unsatisfactory. Such remedy may include compliance with a corrective action plan instituted by Capital.

1.4 Hold Harmless.

1.4.1 Provider agrees that in no event, including but not limited to non-payment by CMS and/or Capital, insolvency of Capital or breach of this Agreement, shall Provider bill, charge, collect a deposit from, impose surcharges or have any recourse against an Enrollee or a person acting on behalf of an Enrollee for Covered Services provided pursuant to this Agreement. The Agreement does not prohibit Provider from collecting Enrollee Cost Share amounts, or fees for non-covered services as long as an Enrollee has been informed in advance of what services are not covered and has agreed to be financially responsible. This provision shall survive termination of the Agreement, regardless of the reason for termination, including the insolvency of Capital, and shall supersede any oral or written agreement between Provider and an Enrollee.

1.4.2 Cost Sharing Responsibility of Dual Eligibles. Provider agrees that in no event, including but not limited to non-payment by the State, shall Provider bill, charge, collect a deposit from, impose surcharges or have any recourse against a Dual Eligible Enrollee for Medicare Part A and Part B Cost Sharing that is the responsibility of the State Medicaid program. To ensure compliance, Provider agrees to either (i) accept Capital's Medicare Advantage Program payments as payment in full, or (ii) bill the State Department of Public Welfare (DPW) for the amounts that are the responsibility of the State Medicaid program.

1.5 Payments from Federal Funds. Provider acknowledges that payments to Provider under this Agreement are, in whole or in part, from federal funds. Therefore, Provider and any of its subcontractors are subject to certain laws that are applicable to individuals and entities receiving federal funds, which may include but are not limited to, Title VI of the Civil Rights Act of 1964 as implemented by 45 CFR Part 80; the Age Discrimination Act of 1975 as implemented by 45 CFR Part 91; the Americans with Disabilities Act; Section 504 of the Rehabilitation Act of 1973 as implemented by 45 CFR Part 84; and Section 1557 of the Patient Protection and Affordable Care Act as implemented by 45 CFR Part 92.

1.6 Data Reporting and Accuracy. Provider agrees to provide Capital with all information necessary for Capital to meet its data reporting and submission obligations, including data necessary to characterize the context and purpose of each encounter between an Enrollee and Provider or Capital, and data necessary for Capital to meet its reporting obligations under 42 C.F.R. §§422.516 and 422.310. Such data includes encounter data, payment data, and any other information provided to Capital by Provider or its Downstream Entities. Provider represents and warrants that such data shall be accurate, complete and truthful, and Provider acknowledges that Capital may use the data for the purpose of obtaining federal funds. Upon request, Provider shall make such certification in the form and in the manner specified by CMS and/or Capital.

1.7 Confidentiality. Provider will comply with the confidentiality and enrollee record accuracy requirements, including: (1) abiding by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information, (2) ensuring that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas, (3) maintaining the records and information in an accurate and timely manner, and (4) ensuring timely access by enrollees to the records and information that pertain to them. [42 C.F.R. §§ 422.504(a)(13) and 422.118]

1.8 Maintenance and Provision of Certain Information. Provider shall maintain all records and reports reasonably requested by CMS and/or Capital and shall provide such records and reports to CMS and/or Capital as reasonably requested, to enable Capital to meet its obligation to submit such

information to CMS and to disclose certain information to Enrollees as required by applicable law and regulations.

1.9 Continuation of Covered Services. Provider shall continue to provide Covered Services (a) to all Enrollees, for the duration of the contract period for which CMS payments have been made, (b) for Enrollees who are hospitalized (i) on the date the CMS contract terminates, or (ii) in the event of Capital's insolvency, through the date of discharge.

1.10 Binding Requirements. If Provider contracts with a subcontractor or Downstream Entity to fulfill Provider's obligations hereunder, subcontractor shall be bound by any provisions of this Agreement required by Medicare law and regulations that relate to Provider as if subcontractor were a party to this Agreement. Provider will only delegate any of its activities or responsibilities under this Agreement if such delegation is set forth in a written contract that:

1.10.1 Specifies the delegated activities and reporting responsibilities;

1.10.2 Provides for revocation of the delegated activities and reporting requirements, or specifies other remedies in instances where CMS or Capital determines that the delegated entity has not performed satisfactorily;

1.10.3 Specifies that the performance of the delegated entity is monitored by Capital on an ongoing basis;

1.10.4 Specifies that delegated entity must comply with all applicable Medicare laws, regulations, CMS instructions, and CMS requirements;

1.10.5 Specifies that any delegated service or activity shall be consistent with and comply with the MA Agreement;

1.10.6 Requires the delegated entity will comply with all obligations applicable to downstream entities as set forth in this Agreement; and

1.10.7 Provides that Capital has the right to approve, suspend, or terminate the agreement between provider and a selected Downstream Entity with respect to services provided under these Medicare Advantage Requirements.

1.11 Excluded Persons.

1.11.1 Certification. Provider represents and certifies that neither it, nor its Affiliated Parties or Downstream Entities have been suspended or excluded from participation in the Medicare program or any other federal health care program (as defined in 42 U.S.C. § 1320a-7b(f)). Provider shall require its Affiliated Parties and Downstream Entities to certify each year that they have not been suspended or excluded from participation in the Medicare program or any other federal health care program.

1.11.2 Federal Exclusion Screening. Provider shall check appropriate databases at least monthly to determine whether any Affiliated Party or Downstream Entity has been suspended or excluded from participation in the Medicare program or any other federal health care program. Databases include the U.S. Department of Health and Human Services ("HHS") Office of Inspector General List of Excluded Individuals/Entities, the Healthcare Integrity and Protection Data Bank and the General Service Administration Lists of parties Excluded from Federal Procurement and Nonprocurement Programs.

1.11.3 State Exclusion Screening. Provider shall also check appropriate databases at least monthly to determine whether any Affiliated Party or Downstream Entity has been suspended or excluded from participation in any state contracts or Medical Assistance Program by the Pennsylvania Department of General Services (PA GSA) and the Office of Medical Assistance Programs (OMAP). The PA GSA debarment listing is maintained online. The OMAP listing is maintained online.

1.11.4 Notification of Capital. Provider shall notify Capital immediately in writing if Provider, an Affiliated Party, or any Downstream Entity is suspended or excluded from the Medicare program, or any other federal or state program monitored as described in Sections 1.11.2 or 1.11.3.

1.11.5 Prohibition of Excluded Persons. Provider shall prohibit any Affiliated Party or Downstream Entity that appears on any of the above-listed databases or who has opted out of Medicare from doing any work directly or indirectly related to the Covered Services.

1.11.6 Annual Attestation. Provider shall annually provide a written attestation to Capital certifying that Provider has complied with Sections 1.11.1 – 1.11.5 above.

1.11.7 Penalties. Provider agrees that it and its Affiliated Parties are subject to 2 C.F.R. Part 376 (relating to excluded persons). Provider shall require its Downstream Entities to agree that they are subject to 2 C.F.R. Part 376.

1.11.8 Cease Payment Upon Exclusion. Capital shall immediately cease making all payments to Provider for Covered Services provided to Enrollees by Excluded Persons as of the date Provider, or any Affiliated Party or Downstream Entity employed by Provider has been excluded from participation under Medicare as determined by CMS, subject to the following:

1.11.8.1 Notice to Enrollees. If a Provider is placed on the federal preclusion list (but has not yet been excluded by the OIG), Capital must send an advance written notice within thirty (30) days to any Enrollee that has received Covered Services from that Provider, notifying the Enrollee that the Provider will be removed from participation under this Agreement. [43 C.F.R. §422.222(a)(1)(ii)(A)]

1.11.8.2 During a sixty (60) day period after Capital sends such notice, Capital will continue to pay for Covered Services provided to an Enrollee by that Provider. [42 C.F.R. §422.222(a)(1)(C)]

1.11.8.3 After this sixty (60) day notice period has expired: (a) Provider will no longer be eligible for payment from Capital and will be prohibited from pursuing payment from the Enrollee; and (b) Provider will retain financial liability for services, items, and drugs that are furnished, ordered, or prescribed. [42 C.F.R. §422.504(g)(1)]

1.12 Fraud, Waste and Abuse Prevention.

1.12.1 Code of Conduct. Provider shall adopt and follow and Provider shall require its Downstream Entities to adopt and follow a code of conduct that reflects a commitment to detecting, preventing, and correcting fraud, waste, and abuse in administration of both the Medicare Part C and Part D programs as applicable.

1.12.2 Freedom from Conflicts of Interest. Provider shall collect from those of its managers, officers, and directors who are responsible for the administration or delivery of Medicare Part C and Part D benefits as applicable, a signed statement, attestation, or certification stating that the person is free of any conflict of interest in administering or delivering such benefits. Provider shall collect these statements, attestations, or certifications (1) within a reasonable time after, as applicable, (a) the effective date of the Agreement or (b) an individual's first day of employment or board service and (2) annually thereafter. Provider shall maintain such statements, attestations, or certifications in accordance with this Section 1.17.2 and make them available to Capital upon request.

1.12.3 Training.

(i) Compliance Training. Provider shall provide Medicare Part C and Part D compliance training for all persons involved in administration or delivery of

Medicare Part C and Part D benefits, as applicable. Compliance training shall address matters related to the Provider's compliance responsibilities, including, but not limited to the Provider's code of conduct, applicable compliance policies and procedures, disciplinary and legal penalties for non-compliance, and procedures for addressing compliance questions and issues.

(ii) Specialized Training. Provider shall provide specialized training to appropriate personnel for issues posing compliance risks based on job function upon initial hire or contracting, and annually thereafter. Provider shall also provide specialized training when job function or job requirements change and when an employee works in an area previously found to be non-compliant or implicated in past misconduct. As applicable, areas of specialized training include compliance program administration, prevention of fraud, waste and abuse ("FWA"), FWA laws and regulations, recognizing and reporting FWA, consequences and penalties of FWA, available FWA resources, and areas requiring specialized knowledge of applicable Medicare Part C and Part D procedures and requirements in order for Provider to perform or provide services under this Agreement.

(iii) Training Records. Provider shall maintain records of the date, time, attendance, topics, training materials and results of training. Provider shall maintain such records in accordance with Section 1.17.2 and make the records available to Capital upon request.

1.12.4 Annual Attestation. Provider shall annually provide a written attestation to Capital certifying that it has provided training in accordance with Section 1.17.3.

1.12.5 Reporting Compliance Concerns. Provider shall promptly report, and shall cause Affiliated Parties and Downstream Entities to promptly report, compliance concerns and suspected or actual misconduct to Capital. Provider may not retaliate against any Affiliated Party or Downstream Entity for reporting in good faith compliance concerns and suspected or actual misconduct. Provider acknowledges that such retaliation constitutes a material breach of the Agreement.

1.12.6 Cooperation with Compliance Activities. Provider shall cooperate with Capital's compliance program, including, but not limited to inquiries, preliminary and subsequent investigations, and implementation of corrective actions. Provider shall cooperate with CMS' compliance activities, including investigations, audits, inquiries by CMS or its designees, and implementation of any corrective action. Upon completion of any audit that Provider performs pursuant to the Agreement (including these Medicare Advantage Requirements), Provider shall provide Capital a copy of audit results and shall make all audit materials available to Capital upon request.

1.12.7 Fraud and Abuse Statutes. Provider shall comply with federal statutes and regulations designed to prevent fraud, waste, and abuse, including without limitation applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. § 3729 et seq.), the Anti-Kickback statute (42 U.S.C. § 1320a-7b(b)), the Beneficiary Inducement Civil Monetary Penalty law (42 U.S.C. § 1320a-7a(a)(5)), and the Stark statute (42 U.S.C. § 1395nn).

1.13 Inspection, Evaluation, Audit and Document Retention.

1.13.1 HHS, the Comptroller General, or their designees have the right to audit, evaluate, collect, and inspect any pertinent information for any particular contract period, including, but not limited to, any books, contracts, computer or other electronic systems (including medical records and documentation of the first tier, downstream, and entities related to CMS' contract with Capital through ten (10) years from the final date of the final contract period

of the contract entered into between CMS and the MA organization or from the date of completion of any audit, whichever is later. [42 C.F.R. §§ 422.504(i)(2)(i) and (iv)]

1.13.2 HHS, the Comptroller General, or their designees have the right to audit, evaluate, collect, and inspect any records directly from any First Tier, Downstream, or Related Entity. For records subject to review, except in exceptional circumstances, CMS will provide notification to Capital that a direct request for information has been initiated. [42 C.F.R. §§ 422.504(i)(2)(ii) and (iii)]

1.14 Retention Period. Provider shall maintain the Records for ten (10) years from the longer of (i) the termination or expiration of the Agreement or (ii) completion of final audit by CMS, unless otherwise required by law.

1.15 Additional Contract Terms Required by CMS. These Medicare Advantage Requirements shall automatically amend to include terms and conditions necessary to implement additional contract terms required by CMS, unless Provider notifies Capital that the additional contract terms required by CMS may have a material adverse effect upon Provider. The Parties shall attempt to reasonably adjust such terms in a mutually satisfactory manner to resolve the material adverse effect and maintain compliance with the Medicare Advantage Contract. If the Parties are unable to so resolve the material adverse effect, either party may elect to terminate Provider's participation in the Medicare Advantage Program by giving the other party written notice of such termination within forty-five (45) days after CMS' instruction to implement such additional required contract terms.

1.16 Offshore Operations. Provider shall not disclose any Enrollee's health or enrollment information, including any medical records or other protected health information (as defined in 45 C.F.R. § 160.103), to, or allow the creation, receipt or use of any of Capital's protected health information by any Downstream Entity for any function, activity or purpose to be performed outside of the United States, without Capital's prior written approval.

ARTICLE 2. OTHER PROVISIONS

2.1 Enrollees will not be held liable for payment of any fees that are the legal obligation of Capital. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]

2.2 Any services or other activity performed in accordance with a contract or written agreement by Provider are consistent and comply with Capital's contractual obligations. [42 C.F.R. § 422.504(i)(3)(iii)]

2.3 Effect of Termination of Medicare Advantage Contract. In the event the Medicare Advantage Contract is terminated or not renewed, Capital is required to send a prior written notice to Enrollees at least ninety (90) days before the non-renewal effective date, and at least sixty (60) days prior to termination of the Agreement, including a description of alternatives available for obtaining Medicare services and other options. In the event of such termination or non-renewal, Provider will no longer be paid for health services rendered to Enrollees with the exception of services required by law to be provided post-termination, including services provided in the event of Capital's insolvency or Enrollee being hospitalized on the date of termination.

2.4 Payments for Services to Medicare-Eligible Individuals with Other Medicare Coverage.

2.4.1 If a Medicare-eligible individual is ineligible as an Enrollee on the date of service, Capital shall not be liable for payments. Provider may seek payment from the Medicare-eligible individual's primary payor.

2.4.2 If Capital erroneously identifies a Medicare-eligible individual as an Enrollee, Capital shall be liable for payments if Provider cannot seek payment from the Medicare-eligible individual's primary payor.

2.4.3 Capital shall be liable to Provider for Covered Services rendered to an Enrollee who erroneously represented to the Provider that the Enrollee had coverage under another private health plan's Medicare program ("Other Medicare Coverage"), so long as the circumstances satisfy the following conditions: (i) Provider can document that the Enrollee was previously covered under Other Medicare Coverage; (ii) Provider provided Covered Services on the good faith belief that the Enrollee was covered under such Other Medicare Coverage as of the date of service; (iii) relying on conditions (i) and (ii), Provider was unaware of the application of Capital's Preauthorization requirements; (iv) Providers services satisfy Capital's Medical Necessity and Appropriateness criteria; and (v) under the circumstances, Capital would have otherwise approved a Preauthorization request for the services provided to the Enrollee.

2.5 Capital's Compliance with Requirements of the Social Security Act. As a requirement of its participation in the Medicare Advantage Managed Care Program, Capital agrees to comply with all applicable provider requirements in 42 C.F.R. §422, Subpart E, including provider certification requirements, anti-discrimination requirements, provider participation and consultation requirements, the prohibition on interference with provider advice, limits on provider indemnification, rules governing payments to providers, limits on physician incentive plans, and preclusion list requirements in 42 C.F.R. §422.222 & 422.224.

ATTACHMENT TO EXHIBIT C-2

NONDISCRIMINATION/SEXUAL HARASSMENT PROVISIONS APPLICABLE TO CHIP PROGRAM

1. Provider, and any person acting on behalf of Provider, shall furnish all necessary employment documents and records to and permit access to its books, records, and accounts by the contracting officer of the PID and the Pennsylvania Department of General Services, Bureau of Contract Administration and Business Development, for purposes of investigation to ascertain compliance with these provisions. If Provider does not possess documents or records reflecting the necessary information requested, it shall furnish such information on reporting forms supplied by the contracting officer of the PID or the Bureau of Contract Administration and Business Development.

2. In the hiring of any employees for the manufacture of supplies, performance of work, or any other activity required under the Contract, Provider, and any person acting on behalf of Provider, shall not by reason of gender, race, creed, or color discriminate against any citizen of the Commonwealth of Pennsylvania who is qualified and available to perform the work to which the employment relates.

3. Provider, and any person acting on behalf of Provider, shall not in any manner discriminate against or intimidate any employee involved in the manufacture of supplies, the performance of work or any other activity required under the Contract on account of gender, race, creed, or color.

4. Provider, and any person acting on behalf of Provider, agrees to establish and maintain a written sexual harassment policy and shall inform its employees of the policy. The policy must contain a notice that sexual harassment shall not be tolerated and employees who practice it shall be disciplined.

5. Provider, and any person acting on behalf of Provider, shall not discriminate by reason of gender, race, creed, or color against any subcontractor or supplier who is qualified to perform the work to which the Contract relates.

6. Provider, and any person acting on behalf of Provider, shall include these provisions in every subcontract so that such provisions shall be binding on each subcontractor.

7. Provider acknowledges that the Commonwealth of Pennsylvania may cancel or terminate the Contract and all money due or to become due under the Contract may be forfeited for a violation of the foregoing terms and conditions of the Nondiscrimination/Sexual Harassment Provisions. In addition, Provider acknowledges that the agency may proceed with debarment or suspension or may place Provider in the Contractor Responsibility file.

SCHEDULE C-1

COMMERCIAL AND MANAGED CARE PAYMENT RATES

(Applies to Traditional, Comprehensive, PPO, CHIP and Managed Care Programs)

Capital shall pay Provider for all Covered Services provided to Members under the Commercial and Managed Care Programs at the lower of (i) Provider's billed charges or (ii) Capital's standard, applicable Program Fee Schedule in effect and as updated from time to time and available via the Provider Portal, less any Cost Sharing Provisions due from a Member. Payment shall be subject to Capital's then current, applicable Protocols.

FEP PAYMENT RATES

Providers under this Agreement are not paid by Capital for services provided to FEP members. Providers should refer to their agreements with Highmark BlueShield.

SCHEDULE C-2

MEDICARE ADVANTAGE PAYMENT RATES

MEDICARE ADVANTAGE PPO PAYMENT RATES

Capital shall pay Provider for all Covered Services provided to Members under the Medicare Advantage PPO Program at the lower of (i) Provider's billed charges or (ii) Capital's standard, applicable Program Fee Schedule in effect and as updated from time to time and available via the Provider Portal, less any Cost Sharing Provisions due from a Member. Payment shall be subject to Capital's then current, applicable Protocols.

MEDICARE ADVANTAGE HMO PAYMENT RATES

Capital shall pay Provider for all Covered Services provided to Members under the Medicare Advantage HMO Program at the lower of (i) Provider's billed charges or (ii) Capital's standard, applicable Program Fee Schedule in effect and as updated from time to time and available via the Provider Portal, less any Cost Sharing Provisions due from a Member. Payment shall be subject to Capital's then current, applicable Protocols.

BLUE JOURNEY ALLIANCE SPECIAL NEEDS PROGRAMS ("SNP")

All Blue Journey Alliance SNP are a part of the Medicare Advantage HMO Program.

Capital shall pay Provider the same payment for Covered Services provided to Members in the Blue Journey Alliance SNP, less any applicable Cost Sharing Provisions due from a Member, as paid for the Medicare Advantage HMO Program.

Provider must complete annual training and an attestation of completion for the Blue Journey Alliance SNP.

SCHEDULE C-3

RESERVED