ARIZONA PROVIDER REQUIREMENTS

To the extent that this Agreement governs Health Services covered pursuant to a Benefit Contract issued in Arizona, this Agreement is amended to add the following provisions and supersede any contrary provisions in the main body of the Agreement:

1. In the Event of Medica Insolvency.

In the event of Medica declaring insolvency, an individual or group of providers covered by this contract shall continue to provide services to Members at the same rates and subject to the same terms and conditions established in the Agreement for the duration of the period after Medica is declared insolvent, until the earliest of the following:

a. A determination by the relevant court that Medica cannot provide adequate assurance it will be able to pay the provider's claims for covered services rendered after Medica is declared insolvent;
b. A determination by the relevant court that Medica is unable to pay the provider's claims for covered services rendered after Medica is declared insolvent;
c. A determination by the relevant court that continuation of the Agreement would constitute undue hardship to the provider; or
d. A determination by the court that Medica has satisfied its obligations to all Members under its health care plans.

2. Liability Insurance Requirements.

A. **Providers/Practitioners/Facility.**

All Providers must have a professional liability policy with a minimum limit of $1,000,000 per occurrence/$3,000,000 aggregate, except for practitioner types like Public Health Service as discussed below;

Public Health Service: Federally-supported health centers are deemed to be employees of the federal government and as such, are protected under the Federal Tort Claims Act (FTCA). These may include specified community health centers and Indian reservations. There are no liability limits specified, but FTCA meets any malpractice insurance coverage limits that may be required.

3. Continued Provision of Health Services for Certain Members after Termination of the Agreement or Termination of Facility Provider or Clinic Provider Participation.

A. Unless otherwise provided in the Administrative Requirements, in the event the Provider Participation Agreement is terminated by Provider for any reason, the

Agreement is terminated by Medica without cause, or, notwithstanding anything herein to the contrary, in any the event of any removal of Provider or a Provider location from Medica's networks that gives rise to a legal continuity of care obligation with regard to the services of a Provider or a Provider location, Provider will continue to provide Health Services according to the terms of the Agreement to Members covered under a Benefit Contract after such termination. Such continuation of care will apply when requested by a Member and Medica determines that such Member meets the statutory criteria for in network benefits or continuity of care. Health Services provided in accordance with this subsection 9.4.3 of the Provider Participation Agreement will be provided for:

i. Up to ninety (90) days if the Member was undergoing a current course of treatment for one or more of the following conditions at the time of termination:

    a. An ongoing course of treatment for a serious acute condition, such as chemotherapy for the treatment of cancer;

    b. An ongoing course of treatment for a chronic condition;

    c. Undergoing a course of institutional or inpatient care from the Provider or facility;

    d. Scheduled non-elective surgery, including postoperative care;

    e. Pregnant and undergoing a course of treatment for pregnancy. Health Services may continue to be provided through the postpartum period; or

    f. An ongoing course of treatment for a health condition for which a treating Provider attests that discontinuing care by that treating Provider would worsen the condition or interfere with anticipated outcomes.

ii. The remainder of the Member's life if a physician certifies that the Member has an expected lifetime of one hundred eighty (180) days or less.

iii. Continuity of care is also available to new Medica Members whose health care Provider is not a network provider and who are in an active course of treatment with that non-network provider for the following conditions:

    a. A life-threatening condition. Coverage will continue for not more than 30 days after the effective date of the Member's benefit plan.

    b. Pregnant and in the third trimester of pregnancy on the effective date of enrollment. Coverage includes the delivery and any delivery-related care up to six weeks after the delivery.

B. Health Services provided in accordance with Subsections 9.4.3 of the Provider Participation Agreement will be reimbursed by Medica in accordance with the terms of the Appendices to the Agreement.
C. As stated in your Provider Participation Agreement, Provider will accept as payment in full Medica's reimbursement to Provider for such Health Services at the contracted rates applicable prior to termination, as set forth in the Appendices to the Agreement.

4. Prompt Pay.

Medica will pay claims that are clean within 30 calendar days after the date upon which Medica or its Affiliate adjudicate the claim.

If a clean claim is not paid timely (within 30 calendar days), the rate of interest paid by Medica or Affiliate shall be 10 percent per annum.

"Clean claim" means a written or electronic claim for health care services or benefits that may be processed without obtaining additional information, including coordination of benefits information, from the health care provider, the enrollee or a third party, except in cases of fraud.

5. No Gag Clause.

Neither Medica nor Sponsor shall restrict or prohibit Provider's good faith communication with the Provider's patients concerning any such patient's health care or medical needs, treatment options, health care risks or benefits. Medica shall not terminate or refuse to renew the Agreement, or Provider's participation in a product, solely because the Provider in good faith does any of the following: (a) advocates in private or in public on behalf of a patient, (b) assists a patient in seeking reconsideration of a decision made by Medica or Sponsor to deny coverage for Health Services; or (c) reports a violation of law to an appropriate authority

6. Medical Records.

Medica does not reimburse participating providers for the cost of collecting, copying or delivering requested medical records, except when required by law. Participating providers, and any subcontractors or third parties who may collect, copy and/or deliver records for such providers, may not bill Medica or any Medica Member for expenses related to a records request from Medica.

REV 1/2024