Medica

GENERAL CONTRACTING REQUIREMENTS

Definitions

Credentialing Plan: Medica's plan that outlines the standards, policies, and process for the acceptance, discipline and termination of the participating practitioners and organizational providers, as may be amended by Medica from time to time.

Subcontracted Provider: A health care provider that is properly licensed in the state or states in which the provider renders services, or certified organization, facility, agency or individual that Medica may otherwise contract with or credential (as determined by Medica from time to time), and that renders Health Services to a Member through an arrangement with Provider, including a professional services agreement, management services agreement and similar arrangements, when payment for such Health Services is included in Medica's payment to Provider. An employee of Provider is not a Subcontracted Provider.

1. **Health Services to Members**. Provider will provide Health Services to Members as such Provider's staff and facilities permit. In performing the duties described in this Section, Provider will provide Health Services to Members and accept Members as new patients on the same basis as Provider provides such services to and accepts as new patients persons who receive coverage under another, non-Medica benefit contract or health insurance policy, unless otherwise provided in the Administrative Requirements. Provider will not discriminate against any person based on his or her race,color, creed, religion, national origin, gender, health status including mental and physical medical conditions, marital status, status with regard to public assistance, disability, sexual orientation, age, or any other classification protected by law.

2. Access to Health Services. Provider will comply with all applicable statutes and regulations regarding accessibility and availability of health care services and, if applicable, with the standards set forth below in providing or arranging for the provision of Health Services:

(a) **Emergency Health Services**. Emergency Health Services will be made available to Members immediately, twenty-four (24) hours per day and seven (7) days per week.

(b) **Urgent Health Services**. Urgent Health Services will be made available to Members within twenty-four (24) hours of the time the services are requested.

3. Cooperation with and Participation in Review, Service and Performance Improvement Programs. Provider will participate in and cooperate fully with such programs as are established by Medica to assess, evaluate and improve the ongoing performance of Provider related to (a) the provision of Health Services, and (b) the provision of services designed to improve the health of Members, Member satisfaction or administrative efficiency, including without limitation, quality assurance, health improvement and utilization programs, peer review, Member grievances programs and other Member programs established by Medica, including but not limited to, staff appointed by Medica to review Admissions and discharges of Members at Provider. In the event Medica modifies these programs following the Effective Date of this Agreement, Medica will communicate such changes to Provider.

In the event Medica establishes a Designated Provider Network or Center of Excellence for delivery of certain Health Services, Provider will refer Members seeking such Health Services to Medica's Designated Provider Network or Center of Excellence as communicated to Provider in Medica's Administrative Requirements and provider communications such as *Connections* newsletter and www.medica.com.

During the term of this Agreement, Medica and Provider will confer periodically to review the performance of Provider and Medica under this Agreement.

4. Practice Guideline Compliance. Provider will:

(a) cooperate with the implementation of practice guidelines developed by Medica, and

(b) report to Medica Provider's level of compliance with such guidelines, in the format and within the time frames specified by Medica.

5. Accessibility for Members with Disabilities. Provider will comply with applicable provisions in the Americans with Disabilities Act of 1990, 42 U.S.C. § 12101, *et seq*., regarding accessibility of Provider facilities and services to Members with disabilities.

6. Subcontracted Provider Contracts.

(a) Use of Subcontracted Providers under this Agreement. All Subcontracted Providers must be eligible for participation with Medica. Provider must provide to Medica, on an annual basis and upon request, a list of Provider's Subcontracted Providers. Medica may direct Provider, at any time and in its sole discretion, to terminate any subcontract with respect to the provision of Health Services to Members.

Each subcontract between Provider and a Subcontracted Provider must:

(i) be in writing;

(ii) comply with all applicable laws, regulations (including HIPAA) and accreditation

standards regarding subcontract arrangements;

(iii) acknowledge the Subcontracted Provider's responsibility to comply with Provider's duties under this Agreement, and the duties of Medica under this Agreement and under applicable statutes and regulations;

(iv) acknowledge Medica's right, during reasonable business hours and upon reasonable notice, to obtain access to all information and records of the Subcontracted Providers relative to the provision of Health Services to Members for the purposes of auditing the Subcontracted Provider's compliance with the terms of this Agreement; and

(v) be enforced by Provider as necessary to ensure the Subcontracted Provider's compliance therewith.

Provider will notify Medica of any arrangements under which Health Services will be provided by Subcontracted Providers. Such notice will be provided at least one hundred twenty-five (125) days in advance of the effective date of such arrangement or as soon as reasonably practical. In the event that the Subcontracted Provider holds a current provider participation agreement with Medica, the reimbursement for Health Services rendered by the Subcontracted Provider will remain under their existing Medica contract, including the reimbursement provisions.

Provider is responsible for payment to all Subcontracted Providers. Provider will ensure that no Subcontracted Provider bills or attempts to collect from Medica or any Member for Subcontracted Provider's services. Provider will be responsible for any additional financial liability that Medica incurs as a result of Provider's noncompliance with this Section 3.10.

(b) Provision of Health Services as a Subcontracted Provider. Provider will notify Medica of any arrangements under which Provider will be performing Health Services as a Subcontracted Provider of a different health care provider who also holds a provider participation agreement with Medica. Such notice will be provided at least one hundred twenty-five (125) days in advance of the effective date of such arrangement or as soon as reasonably practical. The reimbursement for Health Services rendered by Provider in its capacity as Subcontracted Provider will remain under this Agreement, including the reimbursement provisions, unless otherwise provided in the Administrative Requirements.

7. No Relationship with Excluded Providers. Provider will not employ or contract with any individual or entity that is excluded from participation in Medicare, Medicaid or other government programs or with an entity that employs or contracts with such an excluded individual or entity.

8. Patient Safety Program and Medical Error Reporting. Provider will develop and implement a patient safety program that establishes and monitors compliance with patient safety and medical

error reduction policies and procedures that, at a minimum, are consistent with applicable industry standards. Medica encourages Provider to report medical errors through national patient safety initiatives. Provider will provide Medica with documentation of its patient safety program upon request.

9. Submission of and Adjustments to Claims for Health Services. For purposes of complying with HIPAA electronic data interchange, Provider will submit claims for Health Services to Medica in a manner and format prescribed by Medica or in another manner acceptable to Medica that complies with the HIPAA data interchange standards and according to applicable uniform billing statutes. Additionally, Provider will submit claims electronically in accordance with state and federal Uniform Electronic Transaction Standards. Medica will provide assistance and support to Provider to facilitate electronic claims submission. Claims must be received by Medica as follows:

(a) For inpatient Health Services, no more than one hundred eighty (180) days from the last day of the Admission, unless a longer timeframe is allowed under the Administrative Requirements for a specific payer or program.

(b) For outpatient Health Services, no more than one hundred eighty (180) days from the date such outpatient Health Services were rendered, unless a longer timeframe is allowed under the Administrative Requirements for a specific payer or program.

(c) For all other Health Services, no more than one hundred eighty (180) days from the last day of the Admission, unless a longer timeframe is allowed under the Administrative Requirements for a specific payer or program. Provider agrees that claims received after the above time periods may, at Medica's discretion, be rejected for payment. Provider will not bill the Member for Health Services in the event Provider fails to submit claims in accordance with the above provisions. In order for any outstanding (not paid or denied by Medica) claim to be considered for payment by Medica after the claim submission time frame described in this Section, Provider must provide to Medica appropriate documentation to verify that Provider did previously submit such claim to Medica. Unless otherwise directed by Medica, Provider will submit claims according to applicable uniform billing statutes using current applicable electronic form with current ICD, CPT, National Revenue Codes, and MS-DRG coding, when applicable, and will include in each claim Provider's Customary Charges for the Health Services rendered to a Member during a single instance of service or a single Admission, as applicable; provided, however, that late or additional charges associated with such claim will be accepted by Medica if made within sixty (60) days from receipt of the initial claim. Medica will have the right to initiate and Provider will have the right to request corrective adjustments to any previous payment for a claim for Health Services. Provider must request any corrective adjustments and Medica must identify and make any corrective adjustments or notify Provider of the need for any corrective adjustments within twelve (12) months from the date the claim for

such Health Services was paid or denied by Medica. For purposes of this Section, corrective adjustments will not include: (1) payments subject to Coordination of Benefits recovery; (2) payments subject to subrogation recovery; (3) duplicate claims payments; (4) adjustments due to fraud or abuse, including without limitation adjustments due to determination by Medica through the Special Investigations Unit's (SIU) investigative process that Provider was overpaid as a result of erroneous, abusive or fraudulent billing; and (5) retroactive terminations due to a retroactive determination of a Member's eligibility for a government program or subsidy, and Medica may make such adjustments at any time and such adjustments are not subject to the time frame set forth above.

Provider will promptly identify, report and return overpayments to Medica.

10. Cost, Quality and Accessibility of Health Services. In an effort to facilitate the provision of cost effective, good quality and accessible Health Services, Provider will:

(a) Cooperate in good faith with a Member who is seeking Health Services from another Participating Provider; and

(b) Other than as required by the Member's Benefit Contract, not discourage a Member from investigating the quality and/or cost of Health Services at Provider or at other Participating Providers, nor will Provider prohibit Members from receiving Health Services from a Participating Provider of Member's choice.

(c) Refrain from knowingly referring a Member to a non-participating provider, unless the Health Services needed can only be obtained from the non-participating provider or the referral to the non-participating provider is necessary to maintain geographic accessibility. This includes rendering Health Services only at Participating Provider facilities.

11. Disclosure of Transactions and Ownership Information. Provider, Clinic Providers, and Subcontractors must comply with CMS requirements (at 42 C.F.R. § 455.105(b)), to the extent applicable, for disclosure of business transactions and ownership information in accordance with the Administrative Requirements.

12. Business Continuity Disaster Recovery Plan. Provider will develop and implement a Business Continuity Disaster Recovery Plan ("BC/DR Plan") that is consistent with industry best practices and conforms to the terms of this Agreement and applicable law. Provider will maintain, review and annually test its BC/DR Plan throughout the term of this Agreement. Provider will provide Medica with a copy of its BC/DR Plan no later than ten (10) days after Medica's request.

13. Member Access to Medical Records. Provider will allow Members to access their "Protected Health Information" (PHI), as defined in C.F.R. Parts 160, 162 and 164, to request to amend PHI contained within a designated record set, and to receive an accounting of certain disclosures of PHI as required by HIPAA regulations and applicable state law.

14. Termination of Medica's Medicare Contract. To the extent applicable, in the event the Medicare contract between CMS and Medica is terminated or non-renewed, the contracts between Medica and the applicable state agency for the provision of Health Services to Medicare beneficiaries will be terminated unless CMS and the state agree to the contrary. Such termination will be carried out in accordance with the termination requirements set forth in 42 C.F.R. §§ 422.506 and 422.512. In the event of such termination, this Agreement will no longer apply to Provider's provision of Health Services to Medicare beneficiaries.

15. Off-Shore Services. If Provider, Facility Provider or Clinic Provider or any subcontractor of Provider, Facility Provider or Clinic Provider performs or intends to perform any portion of the services pursuant to this Agreement, outside the territory of the United States of America ("Off-Shore Services"), Provider, Facility Provider or Clinic Provider must obtain Medica's prior written consent, which may be conditioned upon requirements in regulation or law. If Medica gives consent to Provider, Facility Provider or Clinic Provider, or any subcontractor of Provider, to provide Off-Shore Services, Medica still reserves the right to later revoke that consent if Medica is compelled to do so due to any regulatory or other legal requirement.

16. Member Protection Provisions.

(a) The following provisions are incorporated into the Provider Participation Agreement unless other state law applies:

PROVIDER AGREES NOT TO BILL, CHARGE, COLLECT A DEPOSIT FROM, SEEK REMUNERATION FROM, OR HAVE ANY RECOURSE AGAINST ANY MEMBER OR PERSONS ACTING ON HIS OR HER BEHALF FOR SERVICES PROVIDED UNDER THE PROVIDER PARTICIPATION AGREEMENT. THIS PROVISION APPLIES TO, BUT IS NOT LIMITED TO, THE FOLLOWING EVENTS: (1) NONPAYMENT BY MEDICA OR (2) BREACH OF THE PROVIDER PARTICIPATION AGREEMENT. THIS PROVISION DOES NOT PROHIBIT PROVIDER FROM COLLECTING COPAYMENTS, COINSURANCE, DEDUCTIBLES OR FEES FOR UNCOVERED SERVICES.

THIS PROVISION SURVIVES THE TERMINATION OF THE PROVIDER PARTICIPATION AGREEMENT FOR AUTHORIZED SERVICES PROVIDED BEFORE THE AGREEMENT TERMINATES, REGARDLESS OF THE REASON FOR TERMINATION. THIS PROVISION IS FOR THE BENEFIT OF MEMBERS. THIS PROVISION DOES NOT APPLY TO SERVICES PROVIDED AFTER THE AGREEMENT TERMINATES.

THIS PROVISION SUPERSEDES ANY CONTRARY ORAL OR WRITTEN AGREEMENT EXISTING NOW OR ENTERED INTO IN THE FUTURE BETWEEN PROVIDER AND MEMBER OR PERSONS ACTING ON HIS OR HER BEHALF REGARDING LIABILITY FOR PAYMENT FOR SERVICES PROVIDED UNDER THE AGREEMENT.

FOR PURPOSES OF THIS PROVISION, NONPAYMENT BY MEDICA WILL INCLUDE NONPAYMENT BY MEDICA IN THE EVENT OF ITS INSOLVENCY.

(b) The following provision is incorporated into the Provider Participation Agreement as required by the federal regulations promulgated by the Secretary of Health and Human Services pursuant to authority granted to the Secretary under the Health Insurance for the Aged Act, 42 U.S.C. § 1395hh, which regulations are codified at 42 C.F.R. § 417.122(b):

i. Provider agrees that in the event of Medica's insolvency, Provider will continue to provide any Member with Health Services from the date of Medica's insolvency for the duration of the contract period for which premium payment has been made by such Member. Furthermore, Provider will continue to provide Health Services to those Members who are confined in an inpatient facility until such Members are discharged.

17. Verification of Eligibility. Provider will verify a Member's eligibility for Health Services in accordance with state and federal law. Provider may verify member eligibility by speaking with a representative in our Provider Service Center during hours posted on Medica.com. Eligibility can also be verified by utilizing Medica's Interactive Voice Recognition (IVR) phone application by calling 1 (800) 458-5512 or by logging in to the Provider Portal generally available 24 hours a day, 7 days a week. Provider can call Provider Service Center with questions regarding Medica's Provider Portal.

In the event a member states they have Medica coverage, but Provider is unable to verify eligibility via the Provider Portal or IVR, Provider should call Provider Service Center at 1 (800) 458-5512.

18. Verification of Cost Sharing. Provider may verify in any manner prescribed by Medica the amount of Cost Sharing, if any, applicable to Health Services. Provider may verify member cost sharing by speaking with a representative in our Provider Service Center during hours posted on Medica.com. Provider may also utilize Medica's Interactive Voice Recognition (IVR) phone application by calling 1 (800) 458-5512 or by logging in to the Provider Portal generally available 24 hours a day, 7 days a week. Provider can call Provider Service Center with questions regarding Medica's Provider Portal.

19. Solicited Enrollment. Provider and its agents or subcontractors agree to not solicit or encourage any person to enroll in any Benefit Contract or pay the premiums of a patient during a special enrollment period which would directly or indirectly benefit Provider except as specifically authorized by law.

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