Medica

CREDENTIALING PLAN

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I. INTRODUCTION

Medica Health Plans and its affiliates (Medica) shall determine which physicians and allied health professionals (collectively "practitioners") and facilities ("organizational providers") shall be accepted for participation in Medica networks. This Credentialing Plan outlines the standards, policies, and process for the acceptance, discipline, and termination of participating practitioners and organizational providers (collectively referred to as "providers"). Credentialing determinations are guided by an evaluation of each practitioner's capability to provide comprehensive, safe, effective, efficient, and quality care to Medica members, based on the practitioner's background, credentials and qualifications.

Nothing in this Credentialing Plan limits Medica's discretion in accepting, disciplining or terminating providers. Medica may deny or suspend participation by a provider, terminate a provider's participation or impose other disciplinary action in accordance with the provider's written participation agreement, this Credentialing Plan and the credentialing policies and procedures adopted from time to time by Medica.

Participation criteria as set forth in this Credentialing Plan are applied uniformly to all applicants for initial participation and continued participation. Medica will not discriminate against any provider who is acting within the scope of his or her license under state law based on race, religion, gender, sexual orientation, national origin, age, or on any other basis prohibited by state or federal law.

This Credentialing Plan may be changed at any time upon approval by the Medica Quality Committee. Any change in legal, regulatory or accreditation requirements shall automatically be incorporated into this Credentialing Plan as of the requirement's effective date. Changes shall be effective for all new and existing providers from the effective date of the change.

The Medical Committee, the Credentialing Committee, the Quality Committee, the Quality of Care Oversight Committee and the Appeals Committee operate as a review organization pursuant to Minn. Stat. § 145.61 et seq., Wisc. Stat. § 146.38 et seq., and professional review organizations pursuant to the Health Care Quality Improvement Act of 1986, 42 U.S.C. § 11101 et seq.

Medica maintains as confidential all information obtained and generated in the credentialing process. Credentialing information will not be released except (1) to another review organization under Minn. Stat. § 145.61 or Wisc. Stat. § 146.38 to further the purposes of a review organization as specified by state law; and (2) as otherwise required or permitted by law.

II. BOARD OF DIRECTORS AND COMMITTEES

A. Board of Directors and Medical Committee. The Medica Board of Directors ("Board of Directors") has responsibility and authority for the acceptance, discipline

and termination of Medica providers. Medica Health Plans and its affiliated networks have delegated their respective credentialing authority to the Medica Board of Directors. The Medica Board of Directors has formally delegated the authority for acceptance, discipline and termination of participating providers to the Medical Committee of the Board and the operation of the credentialing function to the Credentialing Committee and Medica credentialing staff, all to be completed in accordance with this Credentialing Plan.

B. Credentialing Committee. The Credentialing Committee is a standing committee responsible for evaluating the background, credentials and qualifications of practitioners who apply for and/or are granted participation status with Medica, subject to review by the Medical Committee. The Credentialing Committee may also take action upon referral from the Quality and Provider Connectivity department.

A Medical Director, designated by the Medica Chief Medical Officer or the Medical Committee of the Medica Board of Directors, is responsible for chairing the Credentialing Committee and appointing its members. The Credentialing Committee shall be composed of 9-17 individuals; up to three of these may be Medica-employed medical directors, with 1-2 additional Medica-employed licensed non-physician practitioners. The Medical Director may appoint an alternate Medica medical director, who is not appointed to the Credentialing Committee, to serve on an ad hoc basis. If the chair is unable to attend a Committee meeting, he/she shall designate a member of the Committee to serve as acting chair. No other voting members shall be Medica employees. The other members shall be participating practitioners in good standing with Medica and represent a mix of medical specialties.

Credentialing Committee meetings and decisions may take place in real-time, virtual meetings (i.e., through video conference or web conference with audio), but may not be conducted only through email.

C. Appeals Committee. An Appeals Committee shall be composed of no fewer than three (3) individuals selected on an ad hoc basis by the Medical Director or his/her Designee. The Appeals Committee shall hear appeals from practitioners after the Credentialing Committee has recommended denial, suspension or termination of participation status or other adverse action based on professional conduct or competence. The Appeals Committee may conduct hearings and recommend upholding, rejecting, or modifying the decisions of the Credentialing Committee and may exercise other powers given to it by the Medica Board of Directors, in accordance with Section IX of this Credentialing Plan. The Appeals Committee decision shall be forwarded to the Quality Committee, along with the decision of the Credentialing Committee, for final review and action.

D. Medica Credentialing Staff. Medica Credentialing Staff, in support of the Credentialing Committee, shall develop credentialing policies and procedures, review and process application materials in accordance with this Credentialing Plan and associated policies and procedures, present applicants to the Credentialing Committee

and identify for the Credentialing Committee those applicants who satisfy all participation criteria, and perform other duties assigned by the Credentialing Committee.

E. Medical Director. The Medical Director, designated by the Medica Chief Medical Officer or the Medical Committee of the Medica Board of Directors, (also referred to herein as the "Medical Director" unless that term specifically refers to other medical director(s) of Medica in context) serves as the Credentialing Committee Chair and is directly responsible for the Medica credentialing program. He or she (1) leads the implementation of the credentialing program according to the Credentialing Plan and its associated policies and procedures; (2) leads Medica in overseeing the activities of delegates performing credentialing and recredentialing functions; and (3) otherwise serves as a resource to Medica Credentialing Staff.

Medica medical directors appointed to the Credentialing Committee are voting members of the Committee. All such medical directors have the authority to assist the Medical Director with the responsibilities set forth above.

F. Designee. The Designee may be a medical director of Medica who is appointed by the Medical Director from time to time to act as his/her Designee. The Medical Director may also delegate certain functions to a Committee Member, who may act as the Designee. The Designee may act on behalf of the Medical Director in his/her absence, unavailability or abstention.

III. ACCEPTANCE OF PRACTITIONERS

A. Application Process.

1. Practitioners Subject to Credentialing Plan[1]. The following types of practitioners shall be subject to this Credentialing Plan:
    - physicians (MDs and DOs)
    - pharmacists (PharmD and RPh) performing face to face medication therapy management
    - dentists
    - podiatrists
    - chiropractors
    - acupuncturists
    - optometrists
    - certified nurse midwives
    - certified traditional midwives

[1] Notwithstanding the foregoing, physical therapists, occupational therapists, speech language pathologists, audiologists and registered doulas are not subject to this Credentialing Plan to the extent credentialing is not required by regulatory and accreditation standards. Without limiting the foregoing, and with the exception of certified nurse midwives and certified traditional midwives who practice at licensed birthing centers, practitioners who (a) practice exclusively within the inpatient setting or exclusively within freestanding facilities other than urgent care centers and (b) who provide care to members only as a result of the members being directed to the hospital or facility are not subject to this Credentialing Plan.

- independent nurse practitioners
- clinical nurse specialists
- physician assistants
- licensed psychologists
- psychotherapists[2]
- behavioral therapists[2]
- substance abuse counselors
- physical therapists[1]
- occupational therapists[1]
- speech language pathologists[1]
- audiologists[1]

Except as noted below, all practitioners must be fully credentialed pursuant to this Credentialing Plan prior to submitting claims as a participating provider for a Medica member. Notwithstanding the above, locum tenens practitioners hired by Medica participating practitioners to provide services to Medica members for ninety (90) days or less may be credentialed under the abbreviated credentialing process for short term locum tenens practitioners set forth in Section V of this Credentialing Plan.

2. Application Process. Each practitioner seeking acceptance as a participating provider must complete in its entirety an application form provided or approved for use by Medica, which shall include:

   a. an unaltered signed and dated release granting Medica and affiliated entities permission to review the records of and to contact any licensing entity, medical society, medical school, hospital, clinic, insurance company or other entity, institution or organization that does or may have records concerning the applicant;

   b. an unaltered signed and dated release relieving any person, entity, institution or organization that provides information as part of the application process from liability;

   c. a statement informing the applicant that the National Practitioner Data Bank ("NPDB"), the relevant state licensing board(s) and the Medicare and Medicaid Sanctions and Reinstatement Report will be queried and reviewed as part of the application review process;

   d. a statement that a report may be submitted to appropriate state licensing boards and the NPDB in the event that the application is denied; and

   e. a signed and dated attestation of the applicant that the application is complete and correct.

[2] Includes master's- or doctoral-level licensed social workers; psychiatric clinical nurse specialists; registered nurses; marriage and family therapists; and professional counselors.

3. Primary Verification. Medica Credentialing Staff shall collect and verify all credentials in accordance with National Committee for Quality Assurance ("NCQA") standards for primary verification. Applicants shall fully cooperate with Medica in obtaining all documents requested by Medica Credentialing Staff to satisfy primary verification requirements.

4. Site Visits. Medica may conduct site visits at clinics or facilities within Medica's service area. Such visits shall be conducted in accordance with regulatory and accreditation standards for site visits.

5. Practitioner Access to Credentialing Information. Applicants are notified of their right to review information obtained by Medica to evaluate their credentialing application. Medica shall provide prompt written notice to an applicant of any information obtained by Medica during the credentialing process that varies substantially from the information provided by the practitioner. Each practitioner shall be entitled, upon request, to information obtained by Medica to evaluate the practitioner's credentialing application from outside sources such as state licensing boards and malpractice carriers. Medica may, at its discretion, provide redacted copies or summaries of information if required to protect an individual's confidentiality. If a practitioner believes, upon review of the information, that any information contained therein is misleading and/or erroneous, the practitioner may submit a corrective statement in writing within 30 days of credentialing staff notification, to the attention of the credentialing team, which Medica shall place in the practitioner's credentialing file. The foregoing does not require Medica to alter or delete any information contained in the practitioner's credentialing file, nor does it require Medica to disclose to a practitioner references, decisions, or other peer review protected information.

B. Review of Practitioner.

1. Criteria for Participation. Upon receipt of a completed application, Medica Credentialing Staff and the Credentialing Committee shall consider the application based on the participation criteria set forth in this Section. The criteria for participation contained in this Section must be continually satisfied by each applicant and participating provider. As a general rule, the Credentialing Committee may accept noncompliance with one or more participation criteria if the Credentialing Committee determines, in its sole discretion, that one or more requirements are not relevant to a particular applicant or that noncompliance with one or more participation criteria does not indicate a potential or existing administrative or professional performance issue. Notwithstanding the foregoing, all applicants and participating providers must comply with the requirements set forth in Sections III(B)(1)(a)-(e) and III(B)(1)(n) below.

   The criteria for participation include, but are not limited to:

a. the practitioner is or reasonably believes he or she will be in active practice at a participating clinic that has contracted with Medica, maintains an individual contract with Medica, or is in the process of negotiating an individual contract with Medica;

b. the practitioner's level of professional liability insurance meets or exceeds minimum levels established by Medica;

c. the practitioner's application has not previously been denied by Medica within the preceding twenty-four (24) months, nor has the practitioner previously resigned or been terminated by Medica within the preceding twenty-four (24) months, other than for (1) relocation purposes, (2) suspension or loss of license based solely upon reasons unrelated to the practitioner's professional performance, (3) failure to return recredentialing documents to Medica in a timely manner; or (4) failure to reply to a request for information to investigate a quality or safety concern identified in the course of provider credentialing.[3]

d. the practitioner is currently licensed or registered to practice in the applicant's profession in the state(s) where the applicant will render services to Medica members;

e. the practitioner has completed appropriate post-graduate training, as defined by the appropriate state licensing or registration agency of the applicant's profession, or as otherwise defined by Medica, and has sufficient qualifications and training for the practice area for which the practitioner seeks participating provider status, as determined by Medica, in its sole discretion;

f. if the practitioner's practice requires clinical privileges that allow for hospital admission, the practitioner (1) maintains such privileges in good standing at a hospital acceptable to Medica, (2) provides evidence acceptable to Medica that the practitioner has made satisfactory arrangements for another Medica participating practitioner to admit Medica members needing hospitalization or (3) requests a waiver from this requirement, with an explanation as to why the clinical privileges required by this subdivision are not necessary for the practitioner's care and treatment of Medica members;

g. the practitioner has a current and valid Drug Enforcement Administration ("DEA") registration or prescriptive authority, unless the practitioner's license does not allow prescription of controlled substances and therefore the practitioner does not maintain DEA registration or prescriptive authority, or unless the practitioner requests a waiver from this requirement, with an

[3] Per Minn. Stat. 62Q.097, enacted in 2021 Session Law 30, Art. 6, Sec. 1

explanation as to why the prescriptive authority required by this subdivision is not necessary for the care and treatment of Medica members;

h. upon request by Medica, the practitioner has signed a consent or release of information necessary to permit Medica to monitor a practitioner's compliance with stipulations, orders or corrective action plans of a state licensing board, hospital or other health care organization;

i. the practitioner has not misrepresented, misstated or omitted a relevant or material fact on the practitioner's application, disclosure statements or any other documents provided as part of the credentialing process;

j. the practitioner has not engaged in any conduct resulting in a felony or gross misdemeanor conviction. For purposes of this provision, a plea of guilty or a plea of no contest to a felony or gross misdemeanor charge constitutes a conviction;

k. the practitioner has not engaged in any unprofessional conduct, including willful or negligent disregard of patient health, safety or welfare, professionally incompetent medical practice, failure to conform to minimal standards of acceptable and prevailing medical practice, or failure to maintain appropriate professional boundaries;

l. the practitioner has not engaged in any sexual misconduct, nor in any behavior toward a patient that could be reasonably interpreted by the patient as physical, emotional or sexual abuse or harassment;

m. the practitioner has not engaged in any unethical conduct, including actions likely to deceive, defraud or harm patients or the public;

n. the practitioner has not personally engaged in or otherwise contributed to the submission of claims for payment that were false, negligently incorrect, intentionally duplicated or indicated other abusive billing practices;

o. the practitioner has not been sanctioned by federal, state or local government programs;

p. the practitioner is not currently excluded from federal, state or local government programs;

q. the practitioner has not been the subject of professional disciplinary action by a managed care plan, insurer, clinic, hospital, medical review board, peer review organization, or other health care organization, administrative body or government agency, excluding the imposition of disciplinary or administrative sanctions for inappropriate, inadequate or tardy completion of medical records;

r. the practitioner has not been the subject of disciplinary action by a licensing board. The Credentialing Committee shall evaluate the facts and circumstances surrounding any disciplinary actions to determine whether such disciplinary action constitutes evidence of ongoing substandard professional performance. Notwithstanding any other provision of this Credentialing Plan, a practitioner shall be denied participation status or terminated, whichever is applicable, if such practitioner has been subject to three or more professional licensing board orders or stipulations each of which the Credentialing Committee determines constitutes continued evidence of probable ongoing substandard professional performance;

s. the practitioner is not the subject of any reports of an "adverse action" against the practitioner, as defined in the Health Care Quality Improvement Act and its implementing regulations;

t. the practitioner does not have a history of professional liability lawsuits or other incidents, or the practitioner's application does not disclose other facts about the practitioner, that constitutes a pattern and/or indicates a potential competency or quality of care problem. For purposes of this provision, a single professional liability lawsuit or other incident can be sufficient for the Credentialing Committee to conclude the practitioner has a potential competency or quality of care problem;

u. the practitioner has not been involuntarily terminated from professional employment or a hospital medical staff or resigned from professional employment or a hospital medical staff after knowledge of an investigation into the practitioner's conduct, or in lieu of disciplinary action;

v. the practitioner has not disclosed an ongoing medical or physical condition likely to adversely affect the practitioner's ability to perform the essential functions of the practitioner's profession with or without reasonable accommodation;

w. the practitioner has not disclosed an ongoing medical or physical condition that could adversely affect the practitioner's ability to practice safely and/or constitute a direct threat to the health and safety of others;

x. the practitioner has not used illegal drugs during the past three (3) years;

y. the practitioner has not engaged in disruptive behavior as specified in Medica credentialing policies that inhibits the performance of the job responsibilities of Medica staff;

z. the practitioner has not engaged in other behavior, whether or not related to the practitioner's role as a health care provider, that calls into question the practitioner's judgment, honesty, character, and/or suitability to provide care

to Medica members; and

aa. If a practitioner's licensure requires supervision by a licensed practitioner, the supervising practitioner is a credentialed, actively-participating practitioner in good standing.

2. Medica Credentialing Staff Review. Medica Credentialing Staff will review all applications and determine whether they are complete. If an application is not complete upon receipt, Medica Credentialing Staff will contact the applicant to request the missing information. Medica Credentialing Staff will process all complete applications. Medica Credentialing Staff will present applicants to the Credentialing Committee and identify for the Credentialing Committee those practitioners who satisfy all participation criteria (Level 1 applications) and those practitioners that require review and decision (Level 2 applications). All practitioners shall be forwarded to the Credentialing Committee either for decision or as notification of participation.

3. Medical Director and Credentialing Subgroup Review. The Medical Director, his/her Designee or a subgroup of the Credentialing Committee may approve applicants who satisfy all participation criteria as set forth in Section III(B). Medica Credentialing Staff will review all applications, identify Level 1 applications and forward to the Medical Director, Designee or a subgroup of the Credentialing Committee for approval. Medica Credentialing Staff maintain documentary evidence of Medical Director, Designee and subgroup review of Level 1 applications.

4. Credentialing Committee Action. The Credentialing Committee has complete discretion in reviewing applications and deciding upon the acceptance, conditional acceptance, recommended denial or final denial of the application. Acceptance options include, but are not limited to:

    a. Credentialing granted for three years;
    b. Credentialing granted for three years with focus flag (internal reminder at three, six, nine or twelve months for Medica Credentialing Staff to follow up on outstanding questions or issues);
    c. Credentialing granted for one year; practitioner required to apply for recredentialing before the one-year period expires.

    The Committee may request further information from the applicant, table an application pending the outcome of an investigation of the practitioner by any licensing authority organization or institution or take any other action it deems appropriate. If the Committee votes to recommend denial, Medica shall notify the applicant of the recommendation in writing and offer an opportunity to provide additional information before the Committee votes on final denial. Applicants have no right to appear before the Credentialing Committee.

The Credentialing Committee may base its decision on any facts and circumstances it deems appropriate and relevant. Medica shall notify applicants of the Credentialing Committee's decision in writing. The Credentialing Committee's decision will be forwarded to the Quality Committee for review, in the manner set forth in this Credentialing Plan.

5. Appeals and Administrative Reconsideration. Medica Credentialing Staff shall determine if any adverse decision is based on professional conduct or competence. Such determination shall be made in accordance with applicable Medica policies and procedures. If the adverse decision is based on professional competence or conduct, which could adversely affect patient care, the applicant shall be offered the right to appeal such decision prior to presentation of such decision to the Quality Committee. If the applicant appeals the Credentialing Committee's decision, the decision will be forwarded to the Appeals Committee for review pursuant to the appeals process set forth in Section IX. The Appeals Committee decision shall be forwarded to the Quality Committee, along with the decision of the Credentialing Committee, for final review and action.

   If the adverse decision is not based on professional competence or conduct which could adversely affect patient care, such decision will not be subject to appeal pursuant to Section IX. Medica may, in its sole discretion, make an administrative reconsideration process available to practitioners denied participation status for reasons unrelated to professional conduct or competence, in accordance with Section X.

6. Reporting. Medica shall determine, based upon the provisions of the Health Care Quality Improvement Act of 1986, 42 U.S.C. § 401 et seq., Minn. Stat. § 147.111, and any other relevant federal and state statutes and regulations, whether and when any adverse decision shall be reported to the National Practitioner Data Bank or any other appropriate licensing board or agency. Medica shall be entitled to make its determination in its sole discretion, in accordance with Medica's policies and procedures. The determination shall be made in good faith. The Credentialing Committee shall notify the affected practitioner, in writing, in the event such a report is made and such notification is required.

7. Rescission of Previous Committee Decision. The Credentialing Committee shall rescind a credentialing action to approve a practitioner for participation in the event the practitioner is not in active practice at a participating facility that has contracted with Medica within 180 calendar days of the Committee's decision.

C. Quality Committee Action. Action by the Quality Committee upon the decision of the Credentialing Committee or the recommendation of the Appeals Committee regarding any application or participation status shall be final. Applicants have no right to appear before the Quality Committee. Any acceptance of an applicant by the Quality Committee is conditioned upon the applicant's or associated clinic's execution of a participation agreement with Medica, whenever applicable.

Notwithstanding the foregoing, in the event the Quality Committee makes a decision adverse to the applicant in the absence of such a decision by the Credentialing Committee, and the applicant has therefore not been provided the opportunity to pursue an appeal or administrative reconsideration, the applicant may be offered the right to an appeal or administrative reconsideration, in accordance with the provisions of Section III.B.5 above. If the applicant appeals the Quality Committee's decision, the decisions of both the Credentialing Committee and the Quality Committee will be forwarded to the Appeals Committee for review pursuant to the appeals process set forth in Section IX. Notwithstanding anything to the contrary in Section IX, the Appeals Committee decision, along with the decisions of the Credentialing Committee and the Quality Committee, shall be forwarded to the Medica Board of Directors, or a subset of the Board of Directors, as determined in the sole discretion of the Board, for final review and action. Members of the Medical Committee shall not participate in such final review and action. Applicants shall have no right to appear before the Board.

D. Medical Director Action in Declared Emergency or Disaster. In case of a government-declared emergency or disaster necessitating urgent network capacity expansion, the Medical Director or designee has authority to alter standard processes for approving applicants who satisfy all participation criteria as set forth in Section III(B). The Medical Director or designee may also convene the Credentialing Committee on an ad hoc basis for expedited review of applicants who fail to satisfy all participation criteria as set forth in Section III(B), yet are needed for urgent services resulting from a declared emergency or disaster. If the Credentialing Committee is unable to reach quorum due to emergency or disaster circumstances, the Committee may convene with no fewer than three voting members, but shall be empowered only to approve applications; any recommendations to deny, terminate or suspend participation shall be tabled until a quorum convenes. Any above actions by the Medical Director shall be consistent with any waivers or guidance issued by federal or state governments and/or applicable accrediting bodies. All authority described in this section shall expire upon termination or suspension of the emergency or disaster declaration.

IV. EXPEDITED PROCESS

A. Definition. "Expedited Process" refers to the process used at Medica's discretion when a practitioner subject to this Credentialing Plan has submitted all required application materials to Medica, Medica Credentialing Staff has determined that such practitioner meets all of the participation criteria set forth in Section III(B), and Medica has the capability to complete the credentialing process for the practitioner before the next scheduled meeting of the Credentialing Committee. Such practitioner's completed Level 1 application shall be submitted for review by the Medical Director or Designee. A Level 2 application that does not meet all participation criteria shall be reviewed by a subgroup of the Credentialing Committee, consisting of no fewer than four members of the Credentialing Committee. No more

than two of these subgroup members shall be Medica medical directors. An applicant desiring expedited process review must be practicing in good standing at a participating facility or clinic.

B. Expedited Process Review. An applicant must submit a completed application form, signed and dated release, and signed and dated attestation and must supply any additional information requested by Credentialing Staff, the Medical Director, Designee or subgroup of the Credentialing Committee. The Medical Director or Designee may approve an applicant for participation in the event the Medical Director or Designee determines such practitioner meets all of the participation criteria set forth in Section III(B). The Credentialing Committee subgroup may approve a Level 2 application if, in its sole discretion, it determines that one or more requirements are not relevant to a particular applicant or that noncompliance with one or more participation criteria does not indicate a potential or existing administrative or professional performance issue. In the event the Medical Director, Designee or subgroup does not approve a practitioner's application for participation, such application shall proceed to the Credentialing Committee for review, as set forth in Section III.

V. SHORT TERM LOCUM TENENS PROCESS

A. Definition. The "Short Term Locum Tenens Process" refers to the abbreviated process used to credential a locum tenens practitioner that has been hired by a Medica participating practitioner to provide services to Medica members for 90 days or less and whose completed application meets all of the participation criteria set forth in Section V(C), as determined by Medica Credentialing Staff. Such practitioner's completed application shall be submitted for review by the Medical Director, Designee or a subgroup of the Credentialing Committee. That subgroup shall be constituted by no fewer than four members of the Credentialing Committee. No more than two of these shall be Medica medical directors.

B. Short-Term Locum Tenens Review. An applicant must submit a completed application form, signed release, and signed attestation and must supply any additional information requested by Credentialing Staff, the Medical Director, Designee or subgroup of the Credentialing Committee. The Medical Director, Designee or subgroup may approve locum tenens applications if the criteria set forth in Section V(C) are met. A subgroup of the Credentialing Committee (a minimum of four members) will review the application and all pertinent information if any of the criteria are not met. In the event the Medical Director, Designee or subgroup does not approve a practitioner's application for participation, such application shall proceed to the Credentialing Committee for review, as set forth in Section III. Additionally, although the Credentialing Committee may accept non-compliance with one or more of such criteria if the Credentialing Committee determines, in its sole discretion, that one or more requirements are not relevant to a particular applicant or that noncompliance with one or more criteria does not indicate a potential or existing administrative or

professional performance issue, all applicants and participating providers must comply with the requirements set forth in Section III(B).

C. Short-Term Locum Tenens Participation Criteria. Medica shall assess a short-term locum tenens practitioner based on the participation criteria set forth in Section III(B). Failure to continuously satisfy any of the participation criteria may be grounds for termination of participation status or other disciplinary action.

VI. DISCIPLINARY ACTION

A. Imposition of Disciplinary Action. The Credentialing Committee, on its own initiative or following a recommendation from Medica Credentialing Staff, may forward a decision to the Quality Committee regarding the imposition upon a practitioner of any disciplinary action it deems appropriate due to substandard professional performance or failure to comply with the participation criteria set forth in Section III(B) or V(C). Examples of such disciplinary action include but are not limited to:

1. monitoring the practitioner for a specified period of time, followed by a determination as to whether noncompliance with Medica requirements is continuing;

2. warning the practitioner that disciplinary action will be taken in the future if noncompliance with Medica requirements continues or recurs;

3. requiring the practitioner to submit and adhere to a corrective action plan;

4. levying a monetary fine against the practitioner;

5. the recoupment of overpayments to a practitioner as determined by an internal or external claims audit or review;

6. administrative suspension or termination of the practitioner's participation status for noncompliance with the participation criteria set forth in Section III(B)(1)(a), (b), (d) and (n);

7. requiring the practitioner to obtain training or use peer consultation in specified type(s) of care;

8. temporarily suspending the practitioner as a Medica participating provider;

9. requiring the practitioner or the practitioner’s clinic or facility to execute an amendment to a participation agreement or a separate agreement related to the disciplinary action; and

10. terminating the practitioner's participation status as described in Section VII.

The practitioner shall be informed in writing of the imposition of any disciplinary action. Medica shall determine if any adverse decision is based on professional conduct or competence. Such determination shall be made in accordance with Medica's policies and procedures. If the adverse decision is based on professional competence or conduct, which could adversely affect patient care, the applicant shall be offered the right to appeal such decision prior to presentation of such decision to the Quality Committee. If the applicant appeals the Credentialing Committee's decision, the decision will be forwarded to the Appeals Committee for review pursuant to the appeals process set forth in Section IX. The Appeals Committee decision shall be forwarded to the Quality Committee, along with the decision of the Credentialing Committee, for final review and action. Medica may, in its sole discretion, provide an administrative reconsideration of disciplinary action, suspension or termination not related to professional conduct or competence, in accordance with the terms and conditions set forth in Section X.

B. Summary Suspension or Restriction. If the Medical Director determines that the health or safety of any Medica member is in actual or potential danger because of the actions or inaction of any practitioner, the Medical Director may summarily suspend the participation status of such practitioner. The Medical Director may also suspend or otherwise discipline any participating provider for not longer than thirty (30) calendar days, during which time an investigation shall be conducted to determine if further action is required. All summary suspensions or restrictions shall be promptly referred to the Credentialing Committee for further action. A practitioner who is summarily suspended for reasons related to professional conduct or competence affecting patient care shall be offered an appeal pursuant to Section IX. Such appeal may be held post-suspension or restriction. A practitioner who is summarily suspended for reasons unrelated to professional conduct or competence may request an administrative reconsideration of such suspension under certain circumstances, as set forth in Section X. Any such administrative reconsideration may be held post-suspension or restriction.

C. Reporting. Medica shall determine, based upon the provisions of the Health Care Quality Improvement Act of 1986, 42 U.S.C. § 401 et seq., and any other relevant federal and state statutes and regulations, whether and when any disciplinary action shall be reported to the National Practitioner Data Bank or any other appropriate licensing board or agency. Medica shall be entitled to make such determinations in its sole discretion, in accordance with applicable Medica policies and procedures provided, however, that the determination shall be made in good faith. The Credentialing Committee shall notify the affected practitioner, in writing, in the event such a report is made and such notification is legally required.

VII. TERMINATION OF PRACTITIONERS

A. Termination by Medica Credentialing Staff. Notwithstanding any provision in this Credentialing Plan, Medica Credentialing Staff may terminate the participation status of any practitioner in accordance with the practitioner's provider agreement with Medica. Medica Credentialing Staff may administratively suspend a practitioner if a clinic with which the practitioner is associated has placed the practitioner on a leave of absence. Medica Credentialing Staff may also administratively terminate a practitioner if such leave of absence exceeds the remainder of the practitioner's current 36-month recredentialing cycle. Medica Credentialing Staff may terminate the participation status of any practitioner for failure to complete the recredentialing process.

Medica Credentialing Staff shall immediately terminate a practitioner upon notice that: the practitioner's license has been revoked, suspended, or surrendered; the practitioner has been excluded from any federal, state or local government program(s); the practitioner does not practice, or no longer practices, at a Medica-contracted site; or the practitioner fails to meet Medica's minimum malpractice insurance requirements. If the practitioner's license is suspended pursuant to the licensing body's authority to suspend or revoke a license due to delinquent tax obligations, Medica may immediately suspend the practitioner's participation until the practitioner's license is reinstated provided the reinstatement occurs within 90 days of the suspension. If the license suspension exceeds 90 days, the practitioner's participation will be administratively terminated.

Medica Credentialing Staff shall provide the Credentialing Committee with a written summary of all terminations and suspensions effected by Credentialing Staff. Medica Credentialing Staff shall provide a practitioner who is terminated or suspended pursuant to this Section VII(A) with written notice of such termination or suspension and the reasons for such action. Medica Credentialing Staff's decision may be reviewed by the Credentialing Committee. Medica Credentialing Staff terminations shall not be subject to appeal pursuant to Section IX, but may be subject to administrative reconsideration under the terms and conditions set forth in Section X.

B. Termination by Credentialing Committee. The Credentialing Committee may decide to terminate the participation status of any practitioner and will forward its decision to the Quality Committee. Consideration of termination may be initiated by any information the Credentialing Committee deems relevant and appropriate.

C. Criteria for Termination. The Credentialing Committee may consider any of the following criteria as a basis for termination:

1. the practitioner has failed to continuously meet one or more of the participation criteria set forth in Section III(B); or

2. the practitioner engages in uncooperative, unprofessional or abusive behavior towards Medica members, Medica employees, or a member of the Credentialing Committee, Quality Committee, Medical Committee or Board of Directors.

VIII. PROCEDURES FOR DISCIPLINE AND TERMINATION

A. Credentialing Committee Review. When Medica receives information suggesting that discipline or termination of a practitioner may be warranted, Medica Credentialing and/or Quality and Provider Connectivity Staff shall compile all relevant information and refer the matter to the Credentialing Committee, or if information otherwise comes to the Credentialing Committee 's attention which it believes suggests that discipline or termination may be appropriate, the Credentialing Committee may direct Medica Credentialing Staff or Quality and Provider Connectivity Staff to investigate the matter and forward the information obtained to the Credentialing Committee.

If the Credentialing Committee believes that further information is needed, it may obtain it from the practitioner or other sources. The Credentialing Committee may elect to request or permit the practitioner to appear before the Credentialing Committee to discuss any issue relevant to the investigation. The Credentialing Committee shall consider the information received and determine whether disciplinary action or termination is appropriate. The Credentialing Committee has complete discretion in determining actions regarding disciplinary or termination matters and may base its decisions on any factors it deems appropriate, whether or not those factors are mentioned in this Credentialing Plan. The practitioner shall be notified in writing of any decision by the Credentialing Committee to discipline or terminate. The Committee's decision shall be forwarded to the Quality Committee for review, subject to any appeal rights provided herein.

B. Notice and Effective Date of Discipline or Termination. In the event the Credentialing Committee decides to discipline or terminate the participation status of a practitioner, the practitioner shall be provided with written notice of such decision. Such written notice shall set forth the Credentialing Committee's decision, the proposed effective date of the disciplinary action or termination, a summary of the basis of the decision, the time limit within which to request an administrative reconsideration or appeal, if applicable, and a general description of the review process. A termination, summary suspension or other disciplinary action related to professional conduct or competence shall be subject to appeal pursuant to the process set forth in Section IX. A termination, summary suspension or other disciplinary action unrelated to professional conduct or competence may be subject to administrative reconsideration under certain circumstances, as set forth in Section IX. Medica may, in its sole discretion, provide an opportunity for appeal or reconsideration of disciplinary action other than termination or suspension.

The termination date of the practitioner's participation status shall be thirty (30) days following the date the practitioner is notified of the Credentialing Committee’s decision, unless the practitioner is offered and seeks review of the Credentialing Committee’s decision pursuant to Section IX or X, or the Credentialing Committee in

its sole discretion determines that an alternative termination date is warranted. The date of any other disciplinary action shall be the date specified by the Credentialing Committee, unless the practitioner is offered and seeks review of the Credentialing Committee's decision pursuant to Section IX or X.

C. Review of Credentialing Committee Decision. If the Credentialing Committee decides to discipline or terminate the participation of a practitioner and offers the practitioner an opportunity for reconsideration or appeal, the practitioner must submit a written request for an administrative reconsideration or an appeal, as appropriate. Such request must be received by Medica within thirty (30) calendar days of the date the written notice of the proposed action was sent to the practitioner.

D. Quality Committee Action. Action by the Quality Committee following a decision of the Credentialing Committee or the Appeals Committee regarding any disciplinary or termination matter shall be final. Practitioners shall have no right to appear before the Quality Committee.

Notwithstanding the foregoing, in the event the Quality Committee makes a decision adverse to the practitioner in the absence of such a decision by the Credentialing Committee, and the practitioner has therefore not been provided the opportunity to pursue an appeal or administrative reconsideration, the practitioner may be offered the right to an appeal or administrative reconsideration, in accordance with the provisions of Section VIII.B. above. If the practitioner appeals the Quality Committee's decision, the decisions of both the Credentialing Committee and the Quality Committee will be forwarded to the Appeals Committee for review pursuant to the appeals process set forth in Section IX. Notwithstanding anything to the contrary in Section IX, the Appeals Committee decision, along with the decisions of the Credentialing Committee and the Quality Committee, shall be forwarded to the Medica Board of Directors, or a subset of the Board of Directors, as determined in the sole discretion of the Board, for final review and action. Members of the Medical Committee shall not participate in such final review and action. Practitioners shall have no right to appear before the Board.

IX. APPEALS COMMITTEE PROCEDURE

A. General Nature of the Appeals Committee Procedure. If the applicant/practitioner is offered an opportunity to appeal to the Appeals Committee and submits a timely written request to appeal, Medica shall follow the procedure set forth in this section or an alternative hearing procedure determined by the Credentialing Committee.

Medica shall appoint an Appeals Committee made up of qualified practitioners, who otherwise meet the criteria set forth in this provision. Where possible, Medica will seek to include on the Appeals Committee practitioners who practice in the same area or specialty as the practitioner who is the subject of the hearing. Members of the Appeals Committee may be network practitioners or members of Medica's Medical Policy Committee or other advisory bodies. Members of the Appeals Committee for

any particular appeal will be individuals who are not, in the judgment of Medica, in direct economic competition with the practitioner who is the subject of the hearing. Medica employees, Credentialing Committee members, Quality Committee members, Medical Committee members and members of the Medica Board of Directors shall not serve on the Appeals Committee. The Appeals Committee shall elect a chairperson from among its members. Appeals Committee members are expected to attend the hearing in person, though remote attendance via telephone and/or online conferencing may be permitted in extraordinary circumstances.

B. Practitioner's Request to Appeal to Appeals Committee. Upon receipt of a practitioner's written appeal request, Medica Credentialing Staff shall notify the practitioner that an appeal hearing will be scheduled in the near future, and that Medica will provide further information when a hearing date is set. Any hearing will occur prior to the effective date of the termination or other disciplinary action, except in the case of (a) actual or potential danger to a Medica member or a summary suspension or (b) other disciplinary action limited to less than thirty (30) days.

When a hearing is scheduled, Medica will provide written notice to the practitioner stating the date, time, and place of the hearing, and a list of the witnesses (if any) expected to be called by Medica at the hearing, and the composition of the Appeals Committee.

The hearing date will be not less than thirty (30) days from the date the practitioner receives the hearing notice, unless a shorter period is mutually agreed to by the parties. Postponements and extensions may be granted by the Medical Director or his/her Designee on a showing of good cause.

C. Pre-Hearing Matters. The Appeals Committee and the practitioner will be afforded the opportunity to review Medica's exhibits prior to the hearing. Medica and the practitioner shall exchange any documents to be presented at the hearing and a list of witnesses at least five (5) business days before the hearing. There shall be no other discovery in connection with the hearing. A pre-hearing conference may be held at the request of either party for the purpose of resolving procedural questions and/or the exchange of witness lists and documentary evidence. The failure to distribute a document shall not render it inadmissible at the hearing. Medica shall provide the Appeals Committee with a copy of the letter to the practitioner notifying him or her of the recommended action and a copy of the practitioner's written response, if any.

D. The Hearing.

1. Representation by Counsel. The practitioner, Medica and the Appeals Committee may be represented by counsel.

2. Recording Hearings. Medica Credentialing Staff shall arrange for a record to be made of the hearing via transcript produced by a court reporter. Copies of this record shall be made available to the practitioner upon payment of a reasonable

charge. The cost of the reporter's fees and services shall be borne by Medica.

3. Chairperson's Statement of the Procedure. Prior to the presentation of evidence or testimony by either party, the Chairperson of the Appeals Committee shall announce the purpose of the hearing and the procedure that will be followed for the presentation of evidence.

4. Presentation of Evidence by Medica. Medica may present any relevant oral testimony or written evidence to the Appeals Committee for consideration. The practitioner or the practitioner's counsel shall have the opportunity to cross-examine any witness testifying on behalf of Medica. The practitioner may be called and cross-examined by Medica.

5. Presentation of Evidence by Practitioner. After the completion of Medica's submission of evidence, the practitioner shall present any relevant oral or written evidence to rebut or explain the situation or events described by Medica as constituting the basis for the recommended action. Medica shall have the opportunity to cross-examine any witness testifying on behalf of the practitioner.

6. Plan Rebuttal. Medica may present any additional witnesses or submit additional documents to rebut the practitioner's evidence. The practitioner shall have the opportunity to cross-examine any additional witnesses testifying on behalf of Medica.

7. Summary Oral Statements. Upon the completion of Medica's and the practitioner's submission of testimony and evidence, first Medica and then the practitioner shall have the opportunity to make a brief closing statement.

8. Summary Written Statements. Upon the close of the hearing, Medica and the practitioner shall have the opportunity to submit written statements to the Appeals Committee. The Appeals Committee shall establish a reasonable time frame for the submission of such statements.

9. Examination by Appeals Committee. Throughout the course of the hearing, the Appeals Committee may examine or question any witness giving oral testimony for Medica or the practitioner.

E. Evidentiary Standards.

1. Admissibility of Evidence. The oral testimony and documentary evidence provided by Medica and the practitioner shall be reasonably related to the specific issues or matters involved in the recommended action. The Appeals Committee has the right to refuse to consider testimony or evidence that it does not deem useful in making a decision. The rules of evidence applicable in a court of law shall not apply to the hearing. If a party objects to the presentation of any testimony or evidence, the grounds shall be stated for the objection and the

Appeals Committee shall have sole discretion to determine whether this evidence shall be considered. The Appeals Committee shall have the ability to determine the relative weight to be given to various items of testimony or evidence submitted.

2. Official Notice. The Appeals Committee may take official notice of any matters, either technical or scientific, relating to issues under consideration that could be judicially noticed by the courts of this state. Participants shall be informed of the matters to be officially noticed and such matters shall be noted in the record of the hearing. Either party may request that a matter be officially noticed or refute the noticed matter by presentation of oral or written evidence.

F. Appeals Committee's Decision.

1. Basis of Decision. The Appeals Committee shall make its determination based on the information and evidence produced at the hearing, including the oral testimony of witnesses, summary oral and written statements, all officially noticed matters, and all documentary evidence submitted to the Credentialing Committee and at the hearing.

2. Burden of Proof. Medica shall have the initial burden of going forward to present evidence in support of its decision. Thereafter, the practitioner shall have the burden of demonstrating by clear and convincing evidence that Medica's decision lacks any factual basis or is arbitrary and capricious.

3. Review of Evidence and Vote. After the hearing and the receipt of any written statements, the Appeals Committee shall convene and privately discuss the evidence presented and the decision of the Credentialing Committee. The Appeals Committee may uphold, reject, or modify the action. The Appeals Committee's decision shall be by the affirmative vote of the majority of the members of the Appeals Committee.

4. Action of the Appeals Committee. The practitioner shall be notified in writing of the Appeals Committee's decision. Such notice shall include a statement of the basis for the decision.

G. Medical Committee Action. The Quality Committee shall review the decision of the Appeals Committee and approve, reject or modify the decision. When reviewing the Appeals Committee’s decision, the Quality Committee shall apply the arbitrary and capricious standard of review. The practitioner shall have no right to appear before the Quality Committee.

H. Notice and Effective Date of Action. If the Quality Committee affirms a decision to terminate, suspend, restrict, discipline or otherwise modify the practitioner's participation status, the Quality Committee’s decision shall be effective immediately, unless otherwise provided. Medica shall provide the practitioner with written notice

of the decision within five (5) business days of the decision. Such notice shall include a statement of the basis for the Quality Committee's decision.

I. Notification of Members. In the event of termination or suspension of participation status, Medica shall, in accordance with applicable Medica policies and procedures, notify the members who regularly obtained health services from or who are assigned to the practitioner.

J. Reporting Requirements. Any final action following an appeal shall be reported by Medica in accordance with Section VI(C) of this Credentialing Plan.

K. Notice. Throughout this Credentialing Plan, "Notice" means depositing the correspondence in the United States mail, using first class or certified mail, postage prepaid, addressed to the other party at the office address given in the application or at the most up-to-date address currently on file at Medica, personal delivery of written notice to the other party, or notice by e-mail or facsimile.

X. ADMINISTRATIVE RECONSIDERATION

A. Availability of Review Process. Medica shall make an administrative reconsideration process available to practitioners whose participation status is suspended or terminated for reasons unrelated to professional conduct or competence if (1) the practitioner notifies Medica that he or she disputes the facts upon which the action was based, or (2) the practitioner notifies Medica that he or she has additional information bearing on the action to provide to Medica for further consideration. Medica may, in its sole discretion, make an administrative reconsideration process available to practitioners whose participation status has been denied or who have been disciplined (other than through termination or suspension) for reasons unrelated to professional conduct or competence. Administrative reconsideration is not available to practitioners whose participation status is administratively terminated for failure to complete the recredentialing process.

B. Notice of Availability of Reconsideration. Medica shall provide the practitioner with a written statement of the reasons for the practitioner's denial, termination or suspension and the circumstances under which the practitioner may request an administrative reconsideration. If an administrative reconsideration process is offered to the practitioner, the practitioner shall submit a written request for reconsideration within thirty (30) calendar days of the date notice of the action is provided to the practitioner.

C. Reconsideration Process. If the practitioner's request for reconsideration is consistent with Section X (A), Medica will provide the practitioner with further information regarding how the reconsideration process will proceed. Any reconsideration will occur prior to the effective date of the termination or other disciplinary action, except in the case of actual or potential danger to a Medica member or a summary suspension, other disciplinary action limited to less than thirty

(30) days, administrative suspension or termination pursuant to Section VII (A) above, or administrative termination as a result of failure to return recredentialing documents.

Medica shall provide the practitioner with a copy of the information and evidence considered by Medica Credentialing Staff, the Credentialing Committee, and/or the Quality Committee in reaching its decision. The practitioner shall then have the opportunity to submit a written statement and any relevant written evidence to the Credentialing Committee or the Quality Committee, whichever made the decision under reconsideration. In Medica's sole discretion, the reconsideration process may include a meeting between the practitioner and one or more representatives of Medica. A practitioner may be represented by legal counsel during any such meeting. The Credentialing Committee or the Quality Committee, as applicable, shall consider the practitioner's statement and evidence presented in making a final decision on the action and may uphold, rescind or modify its previous action.

D. Written Decision. Within ten (10) business days after the Credentialing Committee or Quality Committee, as applicable, makes a decision on the action, Medica shall provide the practitioner with a written statement of its reconsideration decision and the reason(s) for its decision.

E. No Further Appeal. After completion of the administrative reconsideration process, a practitioner shall have no further right to appeal pursuant to Section IX or to appear before the Quality Committee or the Medica Board of Directors.

XI. RECREDENTIALING

A. Triennial Process. The recredentialing process set forth in this section shall be repeated at least every 36 months for participating practitioners as determined by Medica. Continued participation by a practitioner is conditioned upon the practitioner's or clinic's continued execution of a participation agreement with Medica and continued compliance with all Medica administrative and contractual requirements.

B. Recredentialing Process.

1. Medica Credentialing Staff shall send each participating practitioner a questionnaire with attachments, requesting updated professional information. The practitioner must return the completed questionnaire with attachments or provide all such required information in a form acceptable to Medica. Failure to return all requested recredentialing documents to Medica in a timely manner may result in the administrative termination by Medica Credentialing Staff of the practitioner's participation status with Medica. Any administrative termination pursuant to this section shall not be subject to appeal pursuant to Section IX, but may be subject to administrative reconsideration, pursuant to Section X, upon the practitioner's submission of all requested recredentialing documents to Medica in a timely manner.

2. Each participating practitioner shall sign and date an unaltered release granting Medica and affiliated entities permission to review the records of and to contact any licensing entity, medical society, medical school, hospital, clinic, insurance company, or other entity, institution or organization that does or may have records concerning the practitioner.

3. Each participating practitioner shall sign and date an unaltered release relieving from liability any person, entity, institution or organization that provides information as part of the recredentialing process.

4. Each participating practitioner shall be informed that the National Practitioner Data Bank ("NPDB"), the relevant state licensing board and the Medicare and Medicaid Sanctions and Reinstatement Report will be queried and reviewed as part of the application process.

5. Each participating practitioner shall be informed that a report may be submitted to appropriate state licensing boards and/or the NPDB in the event the practitioner's recredentialing application is rejected.

6. Each participating practitioner shall sign and date an attestation of the practitioner that the recredentialing information is complete and correct.

C. Primary Verification. Medica shall collect and verify all credentials in accordance with NCQA standards for primary verification for recredentialing. Practitioners shall fully cooperate with Medica in obtaining all documents requested by Medica to satisfy primary verification requirements.

D. Performance Appraisal. Medica may assess a practitioner's performance through review of relevant data obtained from various sources, potentially including, but not limited to, member complaints, quality reviews, utilization management and member satisfaction surveys.

E. Recredentialing Criteria. Medica shall evaluate a practitioner based on the participation criteria set forth in Section III (B). Failure to continuously satisfy any of the participation criteria may be grounds for termination of participation status or other disciplinary action.

F. Medical Director or Credentialing Subgroup Review. The Medical Director, Designee or a subgroup of the Credentialing Committee may approve applicants who satisfy all participation criteria as set forth in Section III (B). Medica Credentialing Staff will review all applications and identify those practitioners and forward to the Medical Director, Designee or a subgroup of the Credentialing Committee for approval.

G. Credentialing Committee Action. The Credentialing Committee has complete

discretion in reviewing recredentialing applications and deciding upon the continued participation, conditional participation or termination of participation status. The Credentialing Committee may request further information from the practitioner, table a decision pending the outcome of an investigation of the practitioner by any licensing authority, organization or institution, or take any other action it deems appropriate. The Credentialing Committee may base its decision on any facts and circumstances it deems appropriate and relevant. Medica Credentialing Staff shall notify practitioners of the Credentialing Committee's decision regarding termination, or conditional participation based on the participation criteria set forth in Section III (B).

H. Appeals and Administrative Reconsideration. If the Credentialing Committee recommends termination or other adverse action and offers the practitioner an opportunity to seek review of the decision, the practitioner must submit a written request for review. Such request must be received by Medica within thirty (30) calendar days of the date notice of the proposed action was provided to the practitioner.

If the practitioner requests review of the Credentialing Committee's decision, such decision will be reviewed pursuant to either the appeals process set forth in Section IX or the reconsideration process set forth in Section X, as provided under this Credentialing Plan.

I. Quality Committee Action. Action by the Quality Committee upon the decision of the Credentialing Committee or the Appeals Committee regarding any practitioner shall be final. Practitioners have no right to appear before the Quality Committee.

Notwithstanding the foregoing, in the event the Quality Committee makes a decision adverse to the practitioner in the absence of such a decision by the Credentialing Committee, and the practitioner has therefore not been provided the opportunity to pursue an appeal or administrative reconsideration, the practitioner may be offered the right to an appeal or administrative reconsideration, in accordance with the provisions of Section XI.H above. If the practitioner appeals the Quality Committee’s decision, the decisions of both the Credentialing Committee and the Quality Committee will be forwarded to the Appeals Committee for review pursuant to the appeals process set forth in Section IX. Notwithstanding anything to the contrary in Section IX, the Appeals Committee decision, along with the decisions of the Credentialing Committee and the Quality Committee, shall be forwarded to the Medica Board of Directors, or a subset of the Board of Directors, as determined in the sole discretion of the Board, for final review and action. Members of the Medical Committee shall not participate in such final review and action. Practitioners shall have no right to appear before the Board.

J. Information Updates. Medica will regularly review additional information with respect to its participating practitioners. This information may be obtained from any relevant source, including state licensing authorities, other government entities, third-party payers, health care providers and professional liability carriers. Medica may

take whatever action it deems appropriate in view of the information obtained.

K. Practitioner Access to Credentialing Information. Each practitioner shall have the right, upon request, to review information obtained by Medica from outside sources to evaluate the practitioner's recredentialing application and to submit corrective statements as outlined in Section III(A)(5) with respect to the initial application. The foregoing does not require Medica to alter or delete any information contained in the practitioner's credentialing file, nor does it require Medica to disclose to a practitioner references, decisions, or other peer review protected information.

XII. DELEGATED CREDENTIALING.

A. Delegation Permitted. Medica may delegate certain credentialing and recredentialing functions to specific participating providers ("Delegated Providers"). Medica may also accept delegation of certain credentialing and recredentialing activities from other health plans and providers. The credentialing activities of Delegated Providers shall comply with the Health Care Quality Improvement Act of 1986, NCQA credentialing standards and applicable federal and state laws. Medica shall retain full and final authority for all delegated credentialing activities.

B. Credentialing Committee Oversight.

1. Delegation Committee Approval. All requests to become a Delegated Provider shall be approved by Medica Credentialing Staff with notice to Medica's Delegate and Subcontractor Oversight Committee, which supports the Credentialing Committee.

2. Written Reports. Delegated Providers shall submit written reports to Medica Credentialing Staff as set forth in the Delegated Credentialing Agreement or Provider Agreement between Medica and the Delegated Provider. The Delegated Credentialing Agreement or Provider Agreement shall set forth the credentialing responsibilities of both parties, including but not limited to primary verification.

3. Investigative and Audit Authority. Medica may conduct an audit of the Delegated Provider's credentialing files and procedures to evaluate the Delegated Provider's credentialing process prior to entering into a Delegated Credentialing Agreement. Medica may also audit the Delegated Provider's credentialing status at any other time, as determined by Medica to be necessary and prudent. Medica may also conduct an annual audit of the Delegated Provider's credentialing files to verify consistency with Medica credentialing policies and procedures. If deficiencies are found during the audit, Medica may develop a corrective action plan for the Delegated Provider, to correct deficiencies in its credentialing process. Medica may conduct an independent investigation into the credentials and/or professional conduct of any applicant or participating provider. Delegated Providers shall permit Medica timely and reasonable access to all credentialing documents and related files.

4. Contracts and Indemnification. All contracts with Delegated Providers shall specifically reflect the assumption of delegated credentialing responsibilities and include appropriate indemnification clauses specific to these functions.

C. Credentialing Plan and Other Documents.

1. Plan Approval. A Delegated Provider shall submit its Credentialing Plan and other related documents to Medica for review and approval on an annual basis. Such documents may include the Delegated Provider's application forms, disclosure questions, releases of information, credentialing policies and other relevant documents. All Credentialing Plans and other documents must satisfy standards established by NCQA, state and federal laws and regulations, and Medica.

2. Amendment Approval. A Delegated Provider shall submit all material amendments to such documents to Medica for approval. Medica may require amendments and/or revisions to the Delegated Provider's Credentialing Plan and related documents in order to satisfy legal and regulatory requirements, NCQA standards or to conform to Medica documents and procedures.

3. Confidentiality. Medica and the Delegated Provider shall treat all credentialing data as confidential, peer review information and shall maintain the confidentiality of such information in accordance with all applicable law.

D. Delegated Credentialing Activities.

1. Primary Verification. A Delegated Provider shall verify credentials in accordance with NCQA standards for primary verification, Medica standards (if different), and the Delegated Credentialing or Provider Agreement, whichever is applicable.

2. Acceptance. Medica may elect to delegate acceptance decisions to Delegated Providers. In the case of each Delegated Provider, Medica shall determine the scope of the Delegated Provider's activities. The Delegated Credentialing or Provider Agreement shall specify the reporting requirements for all credentialing decisions. Applicants shall not submit claims as a participating provider for Medica members until approved by the Credentialing Committee or the Delegated Provider, as appropriate. Applicants denied participation status by the Credentialing Committee shall have the right to appeal the denial pursuant to the appeal procedures set forth in Section IX. Applicants denied participation status by the Delegated Provider may pursue an appeal pursuant to the Delegated Provider’s appeal process.

3. Disciplinary Actions. Delegated Providers shall report all disciplinary actions to Medica Credentialing Staff within seven (7) business days of the date notice of the disciplinary action was given to the provider. Disciplinary actions include

but are not limited to termination, suspension, mandatory supervised practice or consultation, limiting the scope of a provider's practice, warnings related to a provider's professional behavior, the institution of any type of corrective action plan and any action requiring a report to state licensing authorities or the National Practitioner Data Bank. All terminations and suspensions due to concerns regarding concerns regarding actual or potential threats to patient safety shall be reported to Medica Credentialing Staff within 24 hours of the date notice of the disciplinary action was given to the provider. Medica Credentialing Staff may request additional information and shall be provided reasonable, timely access to any medical or other records related to the disciplinary or termination action. Medica Credentialing Staff shall inform the Credentialing Committee of all disciplinary or termination actions by Delegated Providers. Providers disciplined or terminated by a Delegated Provider shall have no right to appeal such action pursuant to the Medica Credentialing Plan. Such providers may have the right to appeal such action pursuant to the Delegated Provider's appeal process.

E. Provider Acceptance, Discipline and Termination. The Credentialing Committee retains decision-making authority to accept, discipline, restrict, suspend or terminate the participation status of a Medica participating provider, including provider's credentialed by Delegated Providers. Any practitioner rejected, disciplined and/or terminated by Medica may appeal such action pursuant to the Medica Credentialing Plan or the Delegated Provider's Credentialing Plan, as applicable. This provision shall not entitle a provider credentialed by a Delegated Provider who also directly participates with Medica to bring multiple appeals from the same adverse action.

F. Revocation or Termination of Delegation. Medica may revoke the delegation of specific credentialing responsibilities at any time upon appropriate written notice to the Delegated Provider, or, in lieu of such revocation, may impose a corrective action plan or other requirements for improvement of the Delegated Provider's credentialing process. The Delegated Provider may terminate the delegation upon appropriate written notice to Medica. If delegation is revoked or terminated, all participating providers associated with the Delegated Provider shall be immediately subject to Medica's Credentialing Plan and procedures. Delegation shall automatically terminate upon termination either of the participation agreement or the Delegated Credentialing Agreement between Medica and the Delegated Provider.

G. Reporting. Medica shall submit all required reports to state and federal authorities. Delegated Providers may submit reports on their own behalf, but shall not submit any reports on behalf of Medica.

XIII. ACCEPTANCE OF ORGANIZATIONAL PROVIDERS

A. Organizational Providers Subject to Credentialing Plan. All hospitals, home health agencies, skilled nursing facilities, nursing homes, free standing ambulatory surgical centers (including abortion clinics), and licensed birthing centers, and all inpatient, residential and ambulatory behavioral health care facilities ("organizational

providers") shall be subject to this Credentialing Plan.

B. Application Process. All organizational providers shall complete in its entirety the organizational provider credentialing application and/or other application materials developed by Medica.

C. Primary Verification. Medica shall collect and verify all credentials in accordance with NCQA standards for primary verification. Applicants shall fully cooperate with Medica in obtaining all documents requested by Medica to satisfy this primary verification requirement.

D. Criteria for Participation.

1. The criteria contained in this section must be continuously satisfied by each organizational provider applicant and all participating organizational providers. As a general rule, the Credentialing Committee may accept noncompliance with one or more criteria, if the Credentialing Committee determines, in its sole discretion, that one or more requirements are not relevant to a particular applicant or that noncompliance with one or more criteria does not indicate a potential or existing quality of care issue. Notwithstanding the foregoing, all applicants and participating providers must comply with the requirements set forth in Section XIII (D) (1) (n) and (o).

   The criteria relevant to a Medica organizational provider[4] credentialing decision are set forth below:

   a. a signed attestation of an agent authorized to sign for the organizational provider that the application is complete and correct;

   b. either: (1) current Joint Commission accreditation, Det Norske Veritas (DNV) Healthcare accreditation, Healthcare Facilities Accreditation Program (HFAP) or, in the case of an ambulatory surgical center, accreditation by the American Association of Ambulatory Health Care ("AAAHC") or the American Association for Ambulatory Surgery Facilities ("AAASF"), or in the case of a home health care agency, accreditation by the Community Health Accreditation Program ("CHAP") or in the case of a licensed birthing center accreditation by the Commission for the Accreditation of Birth Centers ("CABC"); or (2) accreditation by a CMS-approved accrediting body not listed in (1), including Accreditation Commission for Health Care, Inc. (ACHC), Center for Improvement in Healthcare Quality (CIHQ), DNV-GL Healthcare (DNV GL), Institute for Medical Quality (IMQ), National Dialysis Accreditation Commission (NDAC) and The Compliance Team (TCT); (3) Continuing Care Accreditation Commission (CCAC) or Council on Accreditation (COA); or

[4] References to "organizational provider" in the participation criteria shall also refer to the organizational provider's officers, directors, employees and agents, as applicable.

(4) Medica has conducted a quality assessment site visit to the organizational provider's site(s) and found the results to be satisfactory or has found the results of the State Department of Health's review or the review by the State Department of Health acting as an agent for CMS to be acceptable;

c. the organizational provider's level of professional and general liability insurance meets or exceeds minimum levels established by Medica;

d. the organizational provider is currently licensed or registered in good standing with the appropriate state agency in the state where the applicant is located (including Provisional, Temporary, and Probationary licensure);

e. the organizational provider is in good standing with state and federal regulatory bodies;

f. upon request by Medica, the organizational provider's authorized agent has signed a consent or release of information necessary to permit Medica to monitor the organization's compliance with stipulations or orders of a state licensing board;

g. the organizational provider's authorized agent has not misrepresented, misstated or omitted a relevant or material fact on the organization's application, disclosure statements or any other documents provided as part of the credentialing process;

h. the organizational provider has not engaged in any conduct resulting in a felony or gross misdemeanor conviction. For purposes of this provision, a plea of guilty or a plea of no contest to a felony or gross misdemeanor charge constitutes a conviction;

i. the organizational provider's participation with Medica demonstrates a satisfactory quality assurance and member satisfaction record as determined by Medica;

j. the organizational provider has not engaged in any unprofessional conduct, including willful or negligent disregard of patient health, safety or welfare, professionally incompetent medical practice, failure to conform to minimal standards of acceptable and prevailing medical practice, or failure to maintain appropriate professional boundaries;

k. the organizational provider has not engaged in any sexual misconduct, nor in any behavior toward a patient that could be reasonably interpreted by the patient as physical, emotional or sexual abuse or harassment;

l. the organizational provider has not engaged in any unethical conduct, including actions likely to deceive, defraud or harm patients or the public;

m. the organizational provider has not been the subject of professional disciplinary action by a managed care plan, insurer, licensing board, peer review organization, or other health care organization, administrative body or government agency;

n. the organizational provider has not been sanctioned by federal, state or local government programs;

o. the organizational provider has not engaged in the submission of claims for payment that were false, negligently incorrect, intentionally duplicated or indicated other abusive billing practices;

p. the organizational provider does not have a history of incidents that constitutes a pattern and/or indicates a potential competency or quality of care problem. For purposes of this provision, a single incident can be sufficient for the Credentialing Committee to conclude the organizational provider has a potential competency or quality of care problem;

q. the organizational provider does not employ or contract with any person or entity that has been excluded from federal, state or local government program(s); and

r. the organizational provider is not currently excluded from any federal, state or local government program(s).

s. the organizational provider has not engaged in other behavior, whether or not related to the organizational provider's role as a medical provider, that calls in to question the organizational provider's judgment, honesty, character, and suitability to provide care to Medica members.

E. Recredentialing Criteria. Medica shall evaluate the organizational provider every three (3) years. Medica shall send each participating organizational provider a recredentialing application. The organizational provider must return the fully completed application with attachments or provide all such required information in a form acceptable to Medica. In the event the organizational provider fails to return all requested recredentialing documents to Medica within the timeframe communicated by Medica, Medica Credentialing Staff may administratively terminate the organizational provider's participation status with Medica. Any such termination is not subject to appeal, although the organizational provider may reapply for participation at any time after such administrative termination. Recredentialing shall be based on the organizational provider's continued compliance with the criteria set forth in Section XIII.D.

Failure to continuously satisfy any of the organizational provider criteria may be grounds for any of the following actions, at the discretion of the Credentialing

Committee:

1. monitoring the organizational provider for a specified period of time, followed by a determination as to whether noncompliance with Medica requirements is continuing;

2. warning the organizational provider that disciplinary action will be taken in the future if noncompliance with Medica requirements continues or reoccurs;

3. requiring the organizational provider to submit and adhere to a corrective action plan;

4. levying a monetary fine against the organizational provider;

5. the recoupment of overpayments to an organizational provider as determined by an internal or external claims audit or review;

6. suspension of participation status until the problem is corrected; or

7. termination of participation status.

F. Medical Director or Credentialing Subgroup Review. The Medical Director, his/her Designee or a subgroup of the Credentialing Committee may approve organizational provider applicants who satisfy all participation criteria as set forth in Section XIII (D). Medica Credentialing Staff will review all applications and identify those organizational providers and forward to the Medical Director, Designee or a subgroup of the Credentialing Committee for approval.

G. Credentialing Committee Action. The Credentialing Committee has complete discretion in reviewing applications and making decisions regarding the credentialing/recredentialing of organizational providers. The Credentialing Committee may request further information from the organizational provider, table an application pending the outcome of an investigation of the organizational provider by any organization or institution, or process the application in any other manner it deems appropriate.

The Credentialing Committee may base its decision on any facts and circumstances it deems appropriate and relevant. The Credentialing Committee may accept an organizational provider application, accept the application with restrictions or contingent upon the development of a corrective action plan for the organizational provider, deny the request for participation status or take any other action the Credentialing Committee deems appropriate. Medica shall notify organizational provider applicants in writing of the Committee Committee's decision. The Credentialing Committee will forward its decisions to the Quality Committee.

H. Quality Committee Action. Action by the Quality Committee upon review of the

decision of the Credentialing Committee regarding any organizational provider application shall be final. Organizational provider applicants have no right to appear before the Medical Committee or to appeal the Credentialing Committee's or Quality Committee's decision.

I. Site Visit. Medica shall conduct a quality assessment site visit to any site that is unable to prove acceptable Joint Commission; AAASF; CHAP; or AAAHC accreditation; or acceptable CMS or State review. Medica may conduct a site visit to any other facility. Such visits shall be conducted in accordance with NCQA standards for site visits. All applicants shall fully cooperate with any site visit request.

J. Expedited Organizational Process.

1. **Definition.** "Expedited Organizational Process" describes the process used when an organizational provider (hospital, home health care agency, nursing home, skilled nursing facility, free standing ambulatory surgery center or abortion clinic) indicates a need for participation prior to the next scheduled Credentialing Committee meeting and Medica Credentialing Staff has determined that such organizational provider meets all of the participation criteria set forth in Section XIII (D). Such organizational provider's completed application, which has not yet been subject to the full credentialing process, shall instead be submitted for review by the Medical Director, Designee or a subgroup of the Credentialing Committee. That subgroup shall be composed of no fewer than four members of the Credentialing Committee. No more than two of these shall be Medica medical directors.

2. **Expedited Process Review.** An applicant must submit completed application materials and a signed attestation and must supply any additional information requested by the Medical Director, Designee or subgroup of the Credentialing Committee. The Medical Director, Designee or subgroup may approve an applicant for participation in the event it is determined such organizational provider meets all of the participation criteria set forth in Section XIII (D). In the event the Medical Director, Designee or subgroup does not approve an organizational provider's application for participation, such application shall proceed to the Credentialing Committee for review, as set forth previously in this Section XIII.

K. Reporting Requirements. Medica shall determine, based upon the provisions of applicable federal and state statutes and regulations, whether and when any adverse decisions shall be reported to the applicable licensing agency or any other appropriate agency or entity. Medica shall be entitled to make its determination in its sole discretion in accordance with such policies and procedures as the Credentialing Committee shall adopt provided, however, that the determination shall be made in good faith. When required by law, the Credentialing Committee shall notify the affected organizational provider, in writing, in the event such a report is made.

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