HIGHMARK BCBSD HEALTH OPTION

This document is not for signature. Please call our Credentialing Department at 1-866-763-3224 for starting the participation process.

PARTICIPATING PROVIDER AGREEM

I. INTRODUCTION

This Agreement is entered into by and between Highmark BCBSD Health Options Inc. (Health Options), a Corporation duly organized under the Laws of the State of Delaware and

____

(Participating Provider)

duly licensed in ____________________________ , as __________________________________.
(State/Commonwealth) (Specialty)

This Agreement is effective on ______________________________ and and shall apply only to services provided to Members covered under the Diamond State Health Plan (DSHP), Diamond State Health Plan Plus (DSHP Plus) and Diamond State Health Plan Plus Long Term Services and Supports (DSHP Plus LTSS) and administered by Health Options pursuant to a Contract between Health Options and the State of Delaware ("State").

II. DEFINITIONS

Words that have a specific or technical meaning in the interpretation of this Agreement and any Addenda are defined in Appendix A of this Agreement or in the Provider Manual which is incorporated herein by reference. In the event of any conflict between the terms of this Agreement, its Addenda or Appendix and the Provider Manual, the Provider Manual shall control.

III. COMMITMENTS OF HEALTH OPTIONS

A. Health Options agrees that it will furnish each Member an Identification Card which the Member should present to the Participating Provider in order to obtain services covered by Health Options.

B. Health Options agrees to base its payment to the Participating Provider on the lesser of Participating Provider's billed charge for such Medically Necessary Covered Services, or the Health Options DHSP, DSHP Plus or DSHP Plus LTSS Payment Schedule, incorporated herein by reference. Health Options agrees to pay Participating Provider directly for all Covered Services under the Member Benefit Plan and in accordance with applicable benefit policies without Participating Provider requiring an Assignment of Benefits from the Member and without regard to any Member's stated request to receive payment directly from Health Options.

C. Health Options agrees to maintain a professional utilization review process comprised of practicing physicians and health care professionals to conduct case reviews and to assist Health Options in determining the Medical Necessity of services. Health Options further agrees to secure the involvement of appropriate referral physicians and practitioners in its utilization review process when necessary to review unique specialty services. Health Options agrees to notify Participating Provider of denied authorizations.

D. Health Options agrees to notify Participating Provider, upon his/her request, and the Member, of covered services and any applicable Copayment, Coinsurance and Deductible amounts or non-covered services that are the responsibility of the Member. Such notification shall not be deemed as a guarantee of payment. Determination of payment will be made only upon submission and adjudication of Clean Claims.

E. Health Options agrees to maintain the confidentiality of patient information received during the course of any audit/medical review of Participating Provider's records in conformance with the release of information in Member's Application for Coverage, unless compelled to release the information by law, subpoena, or other legal authority.

F. Health Options agrees to adjudicate Clean Claims from Participating Provider in accordance with any applicable statutes or regulations. Notwithstanding the foregoing, Health Options may suspend payment to Participating Provider if directed to do so by the State of Delaware.

G. Health Options agrees to secure and maintain such policies of general and business liability insurance as shall be necessary to insure Health Options and its employees against any claim or claims for damages arising, directly or indirectly, in connection with the performance of this Agreement.

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H. Health Options affirms that incentives, including compensation for any Health Options employee or contractor, are not based on the quantity or type of denial decisions rendered.

I. Health Options agrees to provide a copy of the Member handbook and Provider Manual via web site or an otherwise appropriate manner. Said documents shall be deemed incorporated into this agreement by reference.

IV. COMMITMENTS OF PARTICIPATING PROVIDER

A. Participating Provider agrees to render Medically Necessary Covered Services, as defined in the Provider Manual, to Members covered under the DSHP, DSHP Plus or DSHP Plus LTSS, provided that such services are within the scope of the Provider's practice and competence. Participating Provider agrees that, except for applicable Copayments, Coinsurance or Deductibles, under no circumstances will it bill, charge, collect or receive from any Member, directly or indirectly, a fee or benefit, in any form whatsoever, as a condition for accepting or continuing treatment of a Member. Participating Provider shall provide or arrange for the provision of Medically Necessary services for Members on the same basis as that of all of its other patients.

B. Participating Provider agrees to submit promptly to Health Options through submission of a claim in a manner to be agreed upon by the Parties in accordance with industry standards, the information Health Options deems necessary to identify the Member for whom services have been provided, a description of such services, including primary and other diagnoses, primary and other procedures performed and the related charges. By signing the completed form, transmitting a claim electronically, or billing a Health Options Member for applicable Coinsurance, Copayment, or Deductible amounts, either directly or through an agent, the Participating Provider shall be deemed to certify that the procedures and/or services claimed are adequately documented in both medical and billing records, have been rendered by the Participating Provider and that the Participating Provider is entitled to receive payment from Health Options and/or Member within the terms, conditions, and limitations of this Agreement, the applicable Member Benefit Plan, the applicable benefit policies and Health Options' Provider Manual. Participating Provider shall also ensure that any applicable authorization requirements are met and shall verify that the Member is eligible for services on the date they are rendered. Participating Provider will use best efforts to submit claims electronically, either directly or through an agent. Participating Provider further agrees that submission of each claim constitutes a certification that it has complied with all applicable Federal and State law including, but not limited to, the Federal anti-kickback law and Stark law and program requirements in connection with such claims and the services provided therein.

C. Participating Provider agrees that Health Options or its Member will not be liable for any claims which are submitted more than one hundred twenty (120) days after the date which the services were rendered to a Member. In situations where the Participating Provider is pursuing third party benefits through subrogation or coordination of benefits, the maximum timeframes for filing a claim shall begin on the date that the Third Party documented resolution of the claim. If a Member is enrolled in Health Options' MCO with a retroactive eligibility date, the timeframes for filing a claim shall begin on the date Health Options receives notification from the State of the Member's eligibility or enrollment.

D. Participating Provider agrees to bill Health Options directly for all Medically Necessary Covered Services under the Member Benefit Plan and to accept payment pursuant to the lesser of Participating Provider's charge or Health Options' Payment Schedule. Any Member Copayments should be collected at the time of service. Participating Provider may bill and collect from Member any outstanding balance for Coinsurance or Deductibles at the time of service only if: 1. Participating Provider contacts Health Options prior to charging or collecting any Coinsurance or Deductible amounts to determine the Member's actual remaining outstanding Coinsurance or Deductible liability; 2. Participating Provider bases any applicable Coinsurance or Deductible on the lesser of Participating Provider's charge or the Health Options Payment Schedule for the specific procedure performed and shall never collect or charge any amount which exceeds the Member's remaining Coinsurance or Deductible liability; and, 3. Participating Provider submits a Clean Claim to Health Options even if no further payment is due from Health Options.

Participating Provider agrees that the Health Options payment plus any applicable Copayments, Coinsurance or Deductibles will be full compensation to the Participating Provider for professional services, support staff and all office/overhead expenses. Participating Provider's failure to abide by the terms of this paragraph shall be deemed to be a material breach of the Participation Agreement which may lead to termination of the Agreement.

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E. Participating Provider agrees to give to Health Options, the State of Delaware, any Federal oversight agency or other Federal agency or their duly authorized agents, immediate on-site or off-site access to the billing and medical records of Participating Provider which support or relate to the services rendered to Health Options Members. Such access shall be granted without charge to those entities provided the inspection or audit is carried out during regular business hours. Such audit may include tests of the records and such other auditing procedures or medical reviews, including but not limited to statistically valid sampling techniques of Participating Provider, as considered necessary to ensure that Participating Provider has complied with the terms and conditions of this Agreement and that payment has been made according to the terms and conditions of the applicable Member Benefit Plan. Such audits/reviews may be made at any time during the term of this Agreement and within five (5) years following its expiration. Participating Provider agrees to retain all applicable medical, billing and financial records related to services rendered to Members for five (5) years from the close of this Agreement or until all evaluations, audits, reviews, investigations or prosecutions are completed if longer than five (5) years. Participating Provider agrees to cooperate with any State or Federal inspection, evaluation, review, audit or investigation.

F. Participating Provider agrees to cooperate with Health Options' utilization review activities and to accept the decisions of Health Options with respect to the appropriateness of the services rendered and the site of rendering of that service. Participating Provider may appeal any such decision(s) made by Health Options in accordance with Health Options' Utilization Management Program Appeal Process. Further, in circumstances where a preauthorization for services from Health Options is required, Participating Provider agrees not to bill Members for services denied by Health Options as not Medically Necessary. Participating Provider agrees to be responsible for ensuring that all applicable authorization requirements are met and for verifying that the Member is eligible for services on the date of service. Notwithstanding the foregoing, the parties agree that Emergency Services shall be rendered without the requirement of prior authorization of any kind.

G. Participating Provider agrees to participate and cooperate with Health Options, the State of Delaware, Federal agencies, and their duly authorized representatives by permitting access to the premises during normal business hours for purposes of peer review, utilization review, quality improvement, medical records audits, credentialing and other activities as deemed appropriate or required by Health Options, the State of Delaware or Federal agencies for assuring quality, cost effectiveness and patient satisfaction and agrees to be bound by all final determinations of such programs subject to the terms of Section V: Dispute Resolution. Participating Provider acknowledges that Health Options may designate other organization(s) to perform Utilization Management, Case Management and/or Quality Improvement functions and may, at its sole discretion, select such organization(s) and substitute one such organization for another Participating Provider agrees that Health Options shall monitor the quality of services delivered under the Participating Provider Agreement, including the collection and evaluation of data and participation related to Health Options' quality improvement programs, and initiate corrective action where necessary to improve quality of care, in accordance with that level of medical, behavioral health, or LTSS that is recognized as acceptable professional practice in the respective community in which the Participating Provider practices or the standards established by the State of Delaware. Participating Provider agrees to participate and cooperate in any remediation, correction or quality improvement activities as a result of said monitoring. Further, Health Options reserves the right at its sole discretion, to amend, modify or alter the Health Options processes.

H. Participating Provider acknowledges and agrees that certain provisions are required to be in contracts between Health Options and Participating Providers for compliance with the accreditation standards of the National Committee for Quality Assurance (NCQA). Pursuant to such NCQA compliance requirements, Participating Provider agrees to acknowledge and cooperate with Health Options' quality initiative activities. Health Options may utilize Participating Provider's performance data for activities including, but not limited to, quality improvement activities, public reporting to consumers and/or transparency activities, preferred status designations in the network (tiering) for narrow network activities, reduced Member cost sharing activities, and/or any other activity of or relating to Health Options' compliance with the accreditation standards of the NCQA.

I. Participating Provider agrees to comply with Federal and State policy including, but not limited to, refunding within sixty (60) calendar days from the date the overpayments are identified to Health Options amounts determined by Participating Provider, its agent or by Health Options, to have been paid in error. Overpayments which are not reported and returned within sixty (60) calendar days from the date the overpayment was identified may result in a penalty pursuant to State or Federal law.

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In the absence of a prompt refund, the Participating Provider agrees that Health Options may, without prior demand, make payment adjustments by deducting such amounts from future payments. Health Options shall provide information to Participating Provider regarding any adjustments, including the name of the Member on whose behalf payments were in error, the amount of adjustment, relevant service dates and the reason for post-payment recovery. Health Options agrees to promptly pay over to Participating Provider any sums found by Health Options to have not been paid, denied or otherwise limited by Health Options in error.

J. Participating Provider agrees to comply with DSHP, DSHP Plus or DSHP Plus LTSS integrity requirements described more fully in the Provider Manual, including, but not limited to, identification and reporting of suspected fraud, waste and abuse.

K. Participating Provider agrees to bill for services in accordance with rules for Coordination of Benefits and assist Health Options in identifying the party with primary responsibility for payment for treatment of a Member by instructing its office personnel or his/her authorized billing agent to collect all available information regarding the existence of other health insurance coverage for each Member, including Medicare and long term care insurance, as applicable, and to seek payment from the party with primary liability before submitting claims to Health Options, and to notify Health Options of such coverage. In the event of duplicate payments to the Participating Provider by another party, the Participating Provider agrees to promptly refund to Health Options the amount of overpayment received from Health Options in those instances where Health Options is determined to be the secondary payor. In the absence of a prompt refund, the Participating Provider agrees that Health Options may, without prior demand, make payment adjustments by deducting such amounts from future payments. Health Options shall provide information to Participating Provider regarding any adjustments, including the name of the Member on whose behalf payments were made in error, the amount of adjustment, relevant service dates and the reason for post-payment recovery. If no future payments are due to Provider, Provider shall reimburse Health Options an amount equal to such overpayment within thirty (30) days of demand by Health Options.

L. Participating Provider acknowledges that Health Options is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans, permitting Health Options to use the Blue Cross and Blue Shield service marks in the State of Delaware, and that Health Options is not contracting as the agent of the Association. Participating Provider further acknowledges and agrees that it has not entered into this Agreement based upon representations by any person other than Health Options and that no person, entity, or organization other than Health Options shall be held accountable or liable to Participating Provider for any of Health Options' obligations to Participating Provider created under this Agreement. This paragraph shall not create any additional obligations whatsoever on the part of Health Options other than those obligations created under other provisions of this Agreement.

M. Participating Provider agrees not to arbitrarily deny or reduce the amount, duration or scope of required services under this Agreement on the basis of race, gender, age, religion, place of residence, diagnosis, type of illness, condition, source of payment, or enrollment in DSHP, DSHP Plus or DSHP Plus LTSS.

N. Participating Provider agrees that all duties performed hereunder shall be consistent with the proper practice of medicine, and that such duties shall be performed in accordance with the customary rules of ethics and conduct and the applicable regulatory board of the state in which Participating Provider practices. Participating Provider agrees to comply with the requirements of the Delaware Prescription Monitoring Program (PMP) and to query the PMP to view information about client usage before prescribing Schedule II or III controlled substances.

O. In the event of the termination of this Agreement, Participating Provider shall continue treatment of current patients where medically necessary for one hundred twenty (120) days under the reimbursement rates and terms and conditions established by this Agreement and Health Options shall continue coverage for Members under such conditions. Payments shall be made directly by Health Options to Participating Provider.

P. Participating Provider shall secure and maintain such policies of general and professional liability and malpractice insurance as shall be necessary to insure Participating Provider and his/her employees against any claim or claims for damages arising by reason of personal injuries or death occasioned, directly or indirectly, in connection with the performance of any Covered Service by Participating Provider. The amounts and extent of such insurance coverage shall be subject to the approval of Health Options but shall not be less than one million dollars ($1,000,000) per claim and three million dollars ($3,000,000) aggregate per year. Participating Provider shall provide memorandum copies of such insurance coverage to Health Options upon execution of this Agreement and on an annual basis. Participating Provider shall notify Health Options of

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any changes, termination, lapse or claims against such policy within thirty (30) days of any such occurrence.

Q. Participating Provider agrees to cooperate with Health Options' periodic recredentialing procedures, which include, but are not limited to, provision to Health Options of: current state licenses, evidence of specialty Board Certification, documentation of hospital privileges, State and Federal Drug Enforcement Administration permits or verifications, statement of malpractice experience, Disclosure of Related Interests, office survey, patient satisfaction surveys, treatment patterns and proof of liability insurance.

Health Options will give Participating Provider reasonable notice of its request for the provision of such documents.

R. Participating Provider agrees that it shall notify Health Options within five (5) days of any change in Participating Provider's State professional license or certification permits.

S. Participating Provider shall not be prohibited from discussing with patients various treatment options available to them, including alternative medications, whether or not such treatments are covered or otherwise limited pursuant to the Member's Benefit Plan. Notwithstanding the foregoing, Participating Providers are not permitted to encourage or suggest, in any way, that children be placed into State custody in order to receive medical, behavioral or LTSS benefits covered by the State.

T. Participating Provider agrees to keep confidential all protected health information of Members and limit access to that information to its staff or other providers involved in the Members' care in accordance with State and Federal law. Participating Provider agrees to implement a confidentiality policy which addresses issues such as when a Member's consent is necessary for the release of protected health information, whether Members have access to their medical records and the manner in which those records will be kept secure. Participating Provider further agrees to ensure that all Members' protected health information that is sent to or received from referral providers is accomplished in such a manner that will not compromise its confidential nature regardless of the media used to transmit that data. Participating Provider further agrees to inform its staff of the confidentiality policy and train them to understand, enforce and abide by it. Participating Provider agrees that HIPAA does not bar disclosure of protected health information (PHI) to the State, authorized Federal agencies or authorized representatives of the State or Federal agency.

U. Participating Provider agrees to enroll in Electronic Funds Transfer (EFT) for the DSHP, DSHP Plus or DSHP Plus LTSS program within thirty (30) days of signing the agreement.

V. Except for Copayments, Coinsurances and Deductibles, Participating Provider shall look only to Health Options for the payment of Covered Services rendered to Members. In no event, including, without limitation, nonpayment by Health Options, insolvency of Health Options or Health Plan or breach of this Agreement by Health Options or Participating Provider, shall Participating Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against the State and/or Member or any persons acting on Member's behalf for Covered Services provided pursuant to this Agreement. The preceding provisions do not prohibit the collection of Copayments, Coinsurance and Deductibles from Members, as set forth in the applicable Member Benefit Plan. Participating Provider agrees that these provisions shall survive the termination of this Agreement, regardless of the cause giving rise to the termination, including, without limitation, insolvency of Health Options or the State, and shall be construed for the benefit of Members. These provisions shall supersede any oral or written contrary agreement now in existence or hereafter entered into between Participating Provider and Members or persons acting on their behalf or on whose behalf they are acting hereunder insofar as such contrary agreement relates to liability for payment for, or continuation of, Covered Services provided under the terms and conditions hereof. In the event Health Options receives notice that Participating Provider has received or collected money from a Member for any services rendered in violation of the terms of this paragraph, Health Options may, in its sole discretion, refund the amount to the Member, require Participating Provider to refund the amount to the Member, offset such amount from any future payments owed to Participating Provider and/or take any other action against Participating Provider authorized under this Agreement or Health Options policies and procedures, or as otherwise permitted by Law. If no future payments are due to Participating Provider, Participating Provider shall reimburse Health Options or the Member, as the case may be, an amount equal to such amounts received in violation of this paragraph within thirty (30) days of demand by Health Options. Participating Provider will provide Health Options with documentation of any such Member reimbursement upon request.

W. If applicable, Participating Provider shall maintain active staff privileges with at least one hospital that is a Health Options Participating Network Hospital that is the closest hospital to the Participating Physician's office location or within a twenty (20) mile radius of its office.

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X. Participating Provider shall make such necessary and appropriate arrangements to assure the availability of services in the same specialty as Participating Provider on a twenty-four (24) hour per day, seven (7) day per week basis, including arrangements to assure coverage for treatment of Members after-hours or when Participating Provider is otherwise absent or unavailable and consistent with Health Options' administrative requirements and on the same basis as all of Participating Provider's patients. The Participating Provider will maintain weekly appointment hours which are sufficient and convenient to serve Members and, if applicable, will maintain at all times, emergency and on-call services provided at a hospital that is a Health Options Participating Network Hospital.

Unless otherwise approved by Health Options, covering arrangements shall be with another provider who is also a Participating Provider with Health Options' DHSP, DSHP Plus or DSHP Plus LTSS. For services rendered by any covering provider on behalf of Participating Provider, Participating Provider assures that the covering provider will accept the terms of this Participation Agreement and any Addendum. Participating Provider hereby agrees to indemnify and hold harmless Members and Health Options against charges for Covered Services rendered by providers who are covering on behalf of Participating Provider. In addition to the foregoing, access requirements, including, but not limited to, appointment and wait times are more specifically referenced in the Provider Manual.

Y. In the event that a Member needs to be referred to another provider, Participating Provider agrees to refer the Member to a provider who participates with Health Options unless no Participating Provider is available or one is not available in a reasonable amount of time.

Z. Participating Provider shall report suspected abuse, neglect and financial exploitation of adults and suspected abuse or neglect of children in accordance with State law.

AA. Participating Provider agrees that for all DSHP Plus Long Term Services and Support (LTSS) Members it shall facilitate notification of the Member's case manager by notifying Health Options, in accordance with its processes, as expeditiously as warranted by the Member's circumstances, of any known significant changes in the Member's condition or care, hospitalizations or recommendations for additional services.

BB. Participating Provider agrees that for all Members participating in Promoting Optimal Mental Health for Individuals through Supports and Empowerment Program (PROMISE) it shall facilitate notification of the Member's Delaware Division of Substance Abuse and Mental Health (DSAMH) case manager by notifying Health Options, in accordance with DSMAH's processes, as expeditiously as warranted by the Member's circumstances, of any known significant changes in the Member's condition or care, hospitalizations or recommendations for additional services.

CC. Participating Provider agrees, pursuant to 42 CFR 438.6(f)(2), that it shall comply with identifying and reporting to Health Options of provider preventable conditions (PPCs) as a condition of payment under this contract. Participating Provider further agrees that no payment shall be made for PPCs except as specified in the Provider Manual.

DD. Participating Provider agrees to have written procedures for providing language interpretation services for any Member who needs such services, including, but not limited to, Members with Limited English Proficiency (LEP).

EE. If Participating provider is a Primary Care Provider (PCP), it agrees to comply with the responsibilities more fully described in the Provider Manual.

FF. If Participating Provider performs laboratory services, the provider shall meet all applicable requirements of the Clinical Laboratory Improvement Amendments (CLIA) of 1988, including either a CLIA certification or waiver of certification with a CLIA identification number.

V. DISPUTE RESOLUTION

The Dispute Resolution procedures are fully set forth in the Provider Manual.

VI. GENERAL PROVISIONS

A. This document along with the Provider Manual, attachments, exhibits or appendices constitutes the entire Agreement between the Participating Provider and Health Options, and will be interpreted in accordance with the laws of the State of Delaware.

B. Participating Provider agrees to submit all applicable Federal disclosure forms as may be required for participation in this Agreement. This Agreement may be amended at any time by mutual consent of the

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parties expressed in a written amendment executed by the parties. In addition, Health Options may modify any provision of this Agreement upon thirty (30) days prior written notice to Participating Provider. Unless Participating Provider notifies Health Options in writing within the thirty (30) day notice period, Participating Provider's acceptance of Health Options' payments subsequent to such thirty (30) day notice shall be deemed to constitute acceptance of Health Options' modification.

C. In the event Participating Provider objects to such modification, the parties agree that such objection shall be deemed a notification by Participating Provider of its intent to terminate this Agreement and such termination shall be effective ninety (90) days after receipt of such objection. The invalidity or enforceability of any terms or conditions hereof shall in no way affect the validity or unenforceability of any other terms or provisions. The waiver by either party of a breach or violation of any provision of this Agreement shall not operate as, or be construed to be, a waiver of any subsequent breach thereof.

D. This Agreement shall be binding upon and inure to the benefit of the Parties hereto, their respective heirs, successors and/or approved assignees, and it may not be assigned, subcontracted or otherwise delegated in any manner inconsistent with this Agreement by either Participating Provider or Health Options without prior written consent of the other; provided however, that the Participating Provider or Health Options may assign this Agreement to a person or entity who controls, is controlled by, or is under its common control. Notwithstanding the foregoing, any purported assignment of payment by Participating Provider must be made in accordance with 42 CFR 447.10. All tax-reporting provider entities shall not be permitted to assign State funds or payments to billing agents or alternative payees without executing a billing agent or alternative payee assignment agreement. The billing agents and alternative payees are subject to initial and monthly Federal exclusion and debarment screening by the assignee if the alternative assignment is on-going. Direct and indirect payments to out of country individuals or entities are prohibited.

E. Participating Provider shall screen its employees and contractors initially and on an ongoing monthly basis to determine whether any of them has been excluded from participation in Medicare, Medicaid, CHIP, or any Federal health care programs (as defined in Section 1128B(f) of the Social Security Act) and not employ or contract with an individual or entity that has been excluded or barred. Participating Provider shall immediately report to Health Options any exclusion information discovered. Civil monetary penalties may be imposed against Participating Provider if it employs or enters into contracts with excluded individuals or entities to provide items or services to Members.

F. Health Options reserves the right to control the use of the Blue Cross and Blue Shield name(s), symbol(s), trademark(s), or service mark(s) presently existing or later established. Participating Provider shall not use Health Options' or Blue Cross and Blue Shield Association's name, symbols, trademarks or service marks in advertising or promotional materials or otherwise, without the prior written consent of Health Options, and shall cease any such usage immediately upon written notice. In the event Health Options had granted prior written consent pursuant to this paragraph, said permission shall be revoked immediately upon termination of this Agreement without further notice to Participating Provider.

G. Participating Provider shall not use the State's name or logos for any materials intended for dissemination to patients unless said material has been submitted to the State by Health Options for review and has been approved by the State. This prohibition shall not include references to whether or not Participating Provider accepts Medicaid.

H. Both Parties agree that this Agreement is confidential and is not to be disseminated or the provisions contained herein revealed to parties other than to regulatory agencies that have a right of review or otherwise pursuant to requirements imposed by law, court order or subpoena and to others as may be mutually agreed to in writing by the Parties and as may be necessary for administration of DSHP, DSHP Plus or DSHP Plus LTSS. Participating Provider agrees that it shall not disclose or use in any manner inconsistent with this Agreement, Health Options' or its authorized agents' trade secrets, including all manuals, processing instructions, or forms, while this Agreement remains in force and following the termination of this Agreement. Participating Provider agrees never to use Health Options' list of Members or other information for competitive purposes, nor to provide Member lists or information to others for Participating Provider's pecuniary gain or any other purpose. This obligation shall survive termination of this Agreement regardless of the cause of such termination.

I. None of the provisions of this Agreement are intended to create nor shall be deemed or construed to create any relationship between the parties hereto other than that of independent entities contracting with each other hereunder solely for the purpose of effecting the provisions of this Agreement. Neither of the parties hereto, nor any of their respective employees, shall be construed to be the agent, servant, employee, employer or

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representative of the other. Neither party shall have any expressed or implied right of authority to assume or create any obligation or responsibility on behalf of or in the name of the other party. Neither Participating Provider nor Health Options shall be liable to any other party for any act, or any failure to act, of the other party to the Agreement.

J. Health Options is an Equal Opportunity Employer which maintains an Affirmative Action Program. The parties agree that they will comply with Executive Order 11246, the Vietnam Era Veterans Readjustment Act of 1974, the Drug Free Workplace Act of 1988, and the Vocational Rehabilitation Act in transactions relating to any government contract.

K. Any notice required to be given pursuant to the terms and provisions hereof shall be sent by Certified Mail, Return Receipt Requested, postage prepaid, to Health Options at:

Highmark BCBSD Health Options Inc.	and to Participating Provider at:
ATTENTION: Provider Relations & Contracting	
800 Delaware Avenue	________________________________
Suite 900	
Wilmington, Delaware 19801	________________________________

L. The provisions of this Agreement relating to compensation, effect of termination, confidentiality, insurance and indemnification shall survive the termination of this Agreement to the extent necessary to give full effect thereto.

M. Participating Provider agrees to abide by all State and Federal law and program requirements applicable to the Participating Provider and that the Agreement incorporates by reference all applicable Federal and State law and revisions of applicable Federal and State law shall automatically be incorporated into this Agreement as they become effective.

N. By signing this Agreement, Participating Provider certifies, to the best of its knowledge and belief, that Federal funds have not been used for lobbying as prohibited by 31 USC 1352 and 45 CFR Part 93. Participating Provider shall disclose any lobbying activities using non-Federal funds in accordance with 45 CFR Part 93.

O. Participating Provider represents and agrees that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services under this Agreement. Participating Provider further covenants that, in the performance of this Agreement, no person having such known interests shall be employed by Participating Provider.

P. Participating Provider agrees that it shall indemnify and hold Health Options and the State harmless from all claims, damages or losses, including legal expenses, incurred by any person or firm or property injured or damaged by erroneous, negligent or willful acts, including disregard of State or Federal law or breach of this Agreement by Participating Provider, its officers, agents, employees or subcontractors relating to services rendered pursuant to this Agreement. This indemnification shall include, but is not limited to, any claims, damages, losses or costs associated with legal expenses incurred by or on behalf of Health Options or the State in connection with the defense of claims for such injuries, damages, losses or claims specified above.

Q. As more fully described in the Provider Manual, Health Options may assess sanctions or reductions in payment on Participating Provider for specific failures to comply with provider participation requirements. This shall include, but may not be limited to, Participating Provider's failure or refusal to respond to Health Options' request for information such as medical records. At Health Options' discretion or as directed by the State, Health Options shall impose financial consequences against Participating Provider as appropriate.

R. Participating Provider agrees that no person on the grounds of handicap, disability, age, race, color, religion, sex, national origin, or any other status protected by Federal or State law, shall be excluded from participation in, or be denied benefits of, or be otherwise subjected to discrimination in the performance of Participating Provider's obligation under this Agreement or in the employment practices of Participating Provider.

S. In the event it is determined by the State that any provision of this Agreement conflicts with the Contract between the State and Health Options such provision shall be null and void and all other provisions shall remain in full force and effect.

VII. HOME AND COMMUNITY BASED SERVICES

A. HCBS Participating Provider shall provide at least thirty (30) calendar days advance notice to Health Options

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when the Participating Provider is no longer willing or able to provide services to a Member, including the reason for the decision, and to cooperate with the Member's case manager to facilitate a seamless transition to alternate providers.

B. In the event that an HCBS Participating Provider change is initiated for a Member, the transferring HCBS Participating Provider shall continue to provide services to the Member in accordance with the Member's plan of care until the Member has been transitioned to a new provider, as determined by Health Options, or as otherwise directed by Health Options, which may exceed thirty (30) calendar days from the date of notice to Health Options.

C. Reimbursement of an HCBS Participating Provider shall be contingent upon the provision of services to an eligible Member in accordance with applicable Federal and State requirements and the Member's plan of care as authorized by Health Options, and must be supported by detailed documentation of service delivery to support the amount of services billed, including at a minimum, the date, time and location of service, the specific HCBS provided, the name of the Member receiving the service, the name of the staff person who delivered the service, the detailed tasks and functions performed as a component of each service, notes for other Caregivers (whether paid or unpaid) regarding the Member or his/her needs (as applicable), and the initials or signature of the staff person who delivered the service.

D. HCBS Participating Providers shall immediately report any deviations from a Member's service schedule to the Member's case manager.

E. Upon acceptance by the HCBS Participating Provider to provide approved services to a Member as indicated in the Member's plan of care, the provider shall ensure that it has staff sufficient to provide the service(s) authorized by Health Options in accordance with the Member's plan of care, including the amount, frequency, duration and scope of each service in accordance with the Member's service schedule.

F. HCBS Participating Provider shall provide back-up for their own staff if they are unable to fulfill their assignment for any reason and ensure that back-up staff meets the qualifications for the authorized service.

G. HCBS Participating Provider is prohibited from requiring a Member to choose the provider as a provider of multiple services as a condition of providing any service to the Member.

H. HCBS Participating Provider is prohibited from soliciting Members to receive services from the provider including:

1. Communicating with existing HCBS Members via telephone, face-to-face or written communication for the purpose of petitioning the Member to change HCBS Participating Provider; or,

2. Communicating with hospitals, discharge planners or other institutions for the purposes of soliciting potential HCBS Members that should instead be referred to the Member's MCO as applicable.

I. HCBS Participating Provider shall comply with Critical Incident reporting requirements as more specifically set forth in the Provider Manual.

VIII. TERM AND TERMINATION

A. This Agreement shall take effect on ______________________________, and remain in effect thereafter unless terminated by either party for any reason, upon written notice to the other by Certified Mail - Return Receipt Requested. Such termination shall be effective ninety (90) days after receipt of such written notice by Certified Mail. In addition to the foregoing, Health Options may terminate this agreement at the direction of the State when the State determines it to be in the best interest of the State.

B. Either party shall have the right to terminate this Agreement for cause, such termination to be effective upon receipt of written notice thereof clearly stating the reason for termination.

C. This Agreement shall be deemed terminated immediately if the Participating Provider ceases to be duly licensed in Delaware is terminated from the Delaware Medicaid Program, another State's Medicaid Program or loses its Medicare certification for breach of the Provider Agreement and any violation of State or Federal law.

D. Termination shall not affect the existing rights of either party enumerated under this Agreement.

E. In the event Participating Provider is acquired by, merged into or affiliated with any other entity this Agreement shall become null and void for all services rendered on and after the effective date of said termination, acquisition, merger or affiliation. In order to be deemed a Participating Provider subsequent to

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these actions the Provider must become associated with another Participating Provider, subject to the terms of that agreement, or enter into a new agreement with Health Options.

F. In the event of a termination of the Contract between the State and Health Options, this Agreement shall also terminate. Upon said termination, Participating Provider shall immediately make available to the State, or its designated representative, in a usable form, any and all records, whether medical or financial, related to the Participating Provider's activities undertaken pursuant to this Agreement. The provision of such records shall be at no expense to the State.

G. This Agreement may be terminated if it is determined that Participating Provider, its officers, agents, employees or subcontractors offered or gave wages, compensation, gratuities or gifts of any kind to any officials or employees of the State. Participating Provider further certifies that no member of or delegate to Congress, or employee of any federal agency has or will benefit financially or materially from this Agreement.

H. If this Agreement is terminated for violations of Subsections F or G of this Section, Health Options or the State shall be entitled to pursue the same remedies each could pursue in the event of a breach of this Agreement by Participating Provider. The rights and remedies provided for in this subsection are in addition to any rights and remedies provided under law.

IN WITNESS WHEREOF the parties hereto have executed this Agreement on the date first above written.

Participating Provider **Highmark BCBSD Health Options Inc.**

This document is not for signature.
Please call our Credentialing Department
at 1-866-763-3224 for starting the
participation process.

____
(Signature)

____
Relations

____
(Date)

____
(Printed Name)

____
(Address)

____
(City, State Zip)

____
(Telephone Number)

____
(Facsimile Number)

____
(Tax ID Number or Social Security Number)

____
(State Licensed In)

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APPENDIX A

DEFINITIONS

Words which have a specific or technical meaning in the interpretation of this Agreement and its Addenda are defined as follows:

Ambulatory Surgical Center means a center which is established, equipped and operated only for the purpose of providing elective ambulatory surgical care and in which the patient is admitted and discharged within the same day and is not part of a hospital.

Ambulatory Surgical Procedures are those surgical or diagnostic procedures which require utilization of a sterile surgical operating room and post-operative recovery room and which may require the administration of local or general anesthesia.

Case Management means any utilization review or pre-certification program(s) administered by Health Options or its subsidiaries that require authorization of benefits before or during the rendering of care.

Clean Claim means a completed claim submitted on paper or electronically by a Participating Provider that contains all information necessary for Health Options to calculate the proper payment to the Participating Provider.

Coinsurance means a payment liability which is calculated as a percentage of the Payment Schedule that a Member is required to make to a Participating Provider for Covered Services.

Coordination of Benefits means those methods by which a Participating Provider, or Health Options, either jointly or separately, seek to recover costs relating to an incident of sickness of, or accident to Member, from another insurer, service plan, government payor, or other payor organization, in accordance with the uniform coordination of benefits guidelines adopted by the National Association of Insurance Commissioners (NAIC), and subject to any limitations imposed by law preventing such recovery.

Copayment means a payment liability which is calculated as a fixed dollar payment that a Member is required to make to a Participating Provider for Covered Services pursuant to the terms and conditions of a Member Benefit Plan and subtracted from the agreed upon payment due Provider for such Covered Services.

Covered Services means those medical, surgical, pharmaceutical and other health care services which are Medically Necessary and to which Members are entitled under the terms of the DSHP, DSHP Plus or DSHP Plus LTSS Member Benefit Plan as may be amended by the State from time to time.

Credentialing means the collection, review and verification of various professional documentation and ability to properly practice in his/her specialty including license and certificates to support Health Options participation status.

Deductible means a specified amount for which the Member is responsible pursuant to the terms and conditions of a Certificate in a specific period of time for covered services before Health Options will assume any liability for all or part of the remaining covered service charges.

Diamond State Health Plan (DSHP) – The program that provides services through a managed care delivery system to individuals who receive TANF (including children who qualify for Title IV-E foster care and adoption assistance and pregnant women), individuals who receive SSI but are not eligible for Medicare, adults age 19 to 64 who are not eligible for Medicare with income levels up to 133% FPL, and children in DHCP.

Diamond State Health Plan Plus (DSHP Plus) – The program that provides services through a managed care delivery system to SSI children and adults with Medicare, and individuals participating in the Medicaid for Workers with Disabilities (Medicaid Buy-in) program.

Diamond State Health Plan Plus Long Term Services and Supports (DSHP Plus LTSS) – The program that provides services, including long term services and supports, through a managed care delivery system to DSHP Plus Members who meet nursing facility level of care or are "at risk" for nursing facility level of care, DSHP Plus Members who meet the hospital level of care criteria and have HIV/AIDS, and DSHP Plus Members under age 21 who meet nursing facility level of care and reside in a nursing facility.

Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
(ii) serious impairment to bodily functions; or
(iii) serious dysfunction of any bodily organ or part.

Hospital means an inpatient Provider which is a duly licensed and accredited medical institution.

Hospital-Based Physician shall mean a physician who renders services primarily at the Hospital or one of Hospital's facilities.

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Identification Card means a card issued to a Member bearing the name of the Member and such other information as Health Options or any other Blue Cross or Blue Shield may place thereon.

Medical Director means a duly licensed Physician or his/her designee who has been engaged by Health Options to monitor the provision of Medically Necessary Covered Services to Members.

Medically Necessary means services or supplies received by a Member which are determined by Health Options to be: (a) consistent with the symptoms or diagnosis and treatment of the patient's condition, disease, ailment or injury; (b) appropriate with regard to standards of good medical practice within the community; (c) not solely for the convenience of the patient, his or her physician, hospital, or other health care provider; and (d) the most appropriate supply, site and level of service which can be safely provided to the patient.

Member means those Members entitled to receive services pursuant to DSHP, DSHP Plus or DSHP Plus LTSS.

Member Benefit Plan means the applicable Medicaid plan through which a Member is covered.

Non-Covered Services means those services which exceed any limit on, or are outside the scope of health care coverage of Member Benefit Plans.

Participating Provider means a health professional or any other entity or institutional health care provider who has entered into an agreement with Health Options.

Patient Management Programs means any program administered by Health Options or its subsidiaries that require pre-authorization and Case Management of benefits for those Members who have incentives to seek care from Participating Providers, or which embody such plan characteristics.

Payment means the total amount to be collected by a Participating Provider from Health Options for a Medically Necessary Covered Service rendered to a Member calculated as the lower of the Participating Provider's actual billed charge or the Payment Schedule less any applicable Copayments, coinsurance and/or deductibles.

Payment Schedule means the schedule of specified maximum allowable payment amounts for Medically Necessary Covered Services applicable to certain Member contracts as calculated by various methodologies, including but not limited to RBRVS, as determined by Health Options.

Point of Service (POS) means a benefit program in which Members select a primary care physician and maximize benefit coverage when securing care directly from, or under authorization by, the selected Physician. Conversely, Members may incur additional out-of-pocket costs or reduced benefits for using non-network providers.

Preferred Provider Organization (PPO) means a benefit program in which Members receive higher benefit levels when care is obtained from a network Participating Provider than if the Member were to receive care from a non-network provider.

Primary Care Services means those services determined by the State for routine office care including preventive care, immunizations, routine diagnostic testing and office visits.

Provider Manual means the compilation of Health Options' operating policies and procedures for Participating Providers regarding such topics as utilization review, case management, billing and general administrative matters for the Medicaid Program.

Sponsor means any employer, corporation, labor union, health and welfare fund, trade or professional association, partnership, government agency or other entity which provides health insurance benefits to its Members, employees and dependents.

State shall mean the State of Delaware and all departments and agencies responsible for administering the Medicaid program.

Subrogation means the collection of payments from third parties after payments have been made by Health Options requiring assistance of the Participating Provider, such as Workers Compensation or automobile policies.

Utilization Management means that part of a quality assurance program that supports and assures a comprehensive effort to monitor effective, efficient and timely utilization of health care resources.

Utilization Review means the process adopted by Health Options to review and determine whether certain health care services provided or to be provided to Members are Medically Necessary Covered Services.

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