CIVIL CASE INFORMATION STATEMENT
IN THE CIRCUIT COURT OF WOOD COUNTY, WEST VIRGINIA

I. CASE STYLE:

CHARLESTON DIABETES AND ENDOCRINE CONSULTANTS, PLLC, a West Virginia Professional Limited Liability Company, PRASUNA JAMI, M.D., individually and all other similarly situated parties,

Plaintiffs,

v.

Civil Action No. 16-C-457
(Judge _____)

HIGHMARK WEST VIRGINIA, INC., a West Virginia Corporation, formerly known as MOUNTAIN STATE BLUE CROSS & BLUE SHIELD, INC., and formerly known as BLUE CROSS AND BLUE SHIELD OF WEST CENTRAL WEST VIRGINIA, INC.,

Defendant.

Defendant	**Days to Answer**	**Type of Service**
Highmark West Virginia, Inc. c/o J. Fred Earley, II P.O. Box 1948 Parkersburg, WV 26102	30	Secretary of State

FILED IN OFFICE

OCT 31 2016

CAROLE JONES
CLERK CIRCUIT COURT

Original and two (2) copies of complaint enclosed/attached.

PLAINTIFF: Charleston Diabetes and Endocrine Consultants, PLLC and Prasuna Jami, M.D. **DEFENDANT:** Highmark West Virginia, Inc.	**CASE NUMBER:**

II. TYPE OF CASE:

- ☒ General Civil
- ☐ Mass Litigation
  - ☐ Asbestos
  - ☐ Carpal Tunnel Syndrome
  - ☐ Diet Drugs
  - ☐ Environmental
  - ☐ Industrial Hearing Loss
  - ☐ Silicone Implants
  - ☒ Other: Contract
- ☐ Habeas Corpus/Other Extraordinary Writ
- ☐ Other: _____
- ☐ Adoption
- ☐ Administrative Agency Appeal
- ☐ Civil Appeal from Magistrate Court
- ☐ Miscellaneous Civil Petition
- ☐ Mental Hygiene
- ☐ Guardianship
- ☐ Medical Malpractice

III. JURY DEMAND ☒ YES ☐ NO
CASE WILL BE READY FOR TRIAL BY (MONTH/YEAR): 10/2017

IV. DO YOU OR ANY OF YOUR CLIENTS OR WITNESSES IN THIS CASE REQUIRE SPECIAL ACCOMMODATIONS DUE TO A DISABILITY OR AGE? ☐ YES ☒ NO
IF YES, PLEASE SPECIFY:

- ☐ Wheelchair accessible hearing room and other facilities
- ☐ Interpreter or other auxiliary aid for the hearing impaired
- ☐ Reader or other auxiliary aid for the visually impaired
- ☐ Spokesperson or other auxiliary aid for the speech impaired
- ☐ Other: _____

Attorney Name:	Scott S. Segal (WV Bar #4717) C. Edward Amos, II (WV Bar #12362)	Representing:
Firm:	THE SEGAL LAW FIRM, L.C.	☒ Plaintiffs ☐ Defendant
Address:	810 Kanawha Boulevard, East Charleston, WV 25301	☐ Cross-Complainant ☐ Cross- Defendant
Telephone:	(304) 344-9100	
Facsimile:	(304) 344-9105	
E-mail:	scott.segal@segal-law.com edward.amos@segal-law.com	

Dated: October 28, 2016

C. Edward Amos II
Signature

IN THE CIRCUIT COURT OF WOOD COUNTY, WEST VIRGINIA

CHARLESTON DIABETES AND ENDOCRINE CONSULTANTS, PLLC, a West Virginia Professional Limited Liability Company, PRASUNA JAMI, M.D., individually and all other similarly situated parties,

Plaintiffs,

Civil Action No.: 16-C-457
Judge:_____

v.

HIGHMARK WEST VIRGINIA, INC., a West Virginia Corporation, formerly known as MOUNTAIN STATE BLUE CROSS & BLUE SHIELD, INC., and formerly known as BLUE CROSS AND BLUE SHIELD OF WEST CENTRAL WEST VIRGINIA, INC.,

Defendant.

COMPLAINT

NOW COME the Plaintiffs, Charleston Diabetes and Endocrine Consultants, PLLC ("Charleston Diabetes") and Prasuna Jami, M.D. ("Dr. Jami") (hereinafter Charleston Diabetes and Dr. Jami are collectively referred to as the "Plaintiffs"), by and through counsel, Miller & Amos, Attorneys at Law, and the Segal Law Firm, and bring this civil action against Highmark West Virginia, Inc., dba Highmark Blue Cross Blue Shield West Virginia, formerly doing business as Mountain State Blue Cross & Blue Shield and Mountain State Blue Cross Blue Shield ("Defendant Highmark"), alleging the following:

Federal Claims Disclaimed

1. Plaintiffs seek no relief under any federal laws or regulations, assert no federal claims, and withdraw any asserted state claims that are preempted by federal

law. The claims herein are brought solely under state common law and state statutory law. Any and all claims or possible claims under any federal law, code, regulation, rule, and/or otherwise are expressly not brought herein and disclaimed. The United States District Court does not have diversity jurisdiction over this case as complete diversity of citizenship is lacking.

Parties

2. Charleston Diabetes is a West Virginia Professional Limited Liability Company chartered in Kanawha County, West Virginia.

3. Dr. Jami is a licensed medical doctor in West Virginia and a resident of Kanawha County, West Virginia.

4. Defendant Highmark is a West Virginia Corporation chartered in Wood County, West Virginia, and is licensed by the West Virginia Insurance Commissioner.

5. The Plaintiffs and Defendant Highmark entered into a written contract titled "Network Agreement," as amended, which became effective on or about October 29, 2009, in order for the Plaintiffs to become a part of Defendant Highmark's physician network. **(See Exhibit 1)**

Jurisdiction and Venue

6. This Court has jurisdiction pursuant to Section VI. K. of the "Network Agreement," titled "Governing Law, Venue, and Limitation on Actions." This Section provides that "[e]xclusive venue for any action arising from [the "Network Agreement"] shall be before the courts located in Wood County, West Virginia . . . ."

Factual Allegations

7. Defendant Highmark is subject to the provisions of the West Virginia Ethics and Fairness in Insurer Business Practices Act, W. Va. Code § 33-45-1 et seq., otherwise known as the West Virginia Prompt Pay Act (the "Prompt Pay Act").

8. On or about September 23, 2014, Defendant Highmark notified the Plaintiffs, via written correspondence, that it was conducting a preliminary review of their insurance claim submissions.

9. On or about January 15, 2015, Defendant Highmark notified Plaintiffs, via written correspondence, that based upon its findings from the preliminary review of the insurance claims submissions, it would conduct an expanded review of their claim submissions from January 1, 2013 to January 1, 2015. This expanded review was titled a "retrospective post-payment audit."

10. On or about September 9, 2015, Defendant Highmark notified the Plaintiffs, via written correspondence, of the "retrospective post-payment audit" results. Defendant Highmark demanded that the Plaintiffs remit to it an "overpayment" in the amount of One Hundred Forty-Five Thousand Three Hundred Sixty-Seven Dollars ($145,367), through: (1) remittance of the entire refund; (2) offset against future Highmark WV payments; or (3) remittance via installment payments. The Plaintiffs were also provided notice that they may rebut the audit finding by providing clarification and/or supporting documentation, in writing, within ten (10) business days, pursuant to Defendant Highmark's "Provider Manual."

11. On or about September 11, 2015, the Plaintiffs notified Defendant Highmark of their disagreement with the audit results and requested that a peer to peer (i.e., endocrinologist to endocrinologist) review be conducted. Based upon reasonable

belief and information, Defendant Highmark has not conducted a peer to peer review and continues to assert that the Plaintiffs are obligated to remit to Defendant Highmark an "overpayment" from its "retrospective post-payment audit" covering claims from as early as 2013.

12. The Section III. K. of the "Network Agreement," titled "Prompt Pay," states that:

> [Defendant Highmark] shall adhere to and comply with the standards for processing and payment of claims for health care service set forth in the Prompt Pay Act [W.Va. Code § 33-45-1 *et seq.*] for claims subject to this law and as set forth in the Provider Manual.

Additionally, Section III. H. of the "Network Agreement," titled "Overpayment," states that:

> [Defendant Highmark] may retroactively deny or negatively adjust a previously paid claim within the time periods specified in the Provider Manual and according to applicable legal requirements governing such actions, including among other things, the West Virginia Ethics and Fairness in Insurer Business Practices Act (commonly referred to as the "Prompt Pay Act"), the West Virginia Unclaimed Property Act, and any [Defendant Highmark] contractual obligations to self-funded groups and other third parties.

Further, Section IV. FF. of the "Network Agreement," titled "Compliance with Applicable Law," states that:

> [n]othing contained in this [Network Agreement] is intended or shall, in any way, reduce eliminate, or supersede any party's obligation to comply with applicable provisions or relevant state and federal laws and regulations.

13. Pursuant to the Prompt Pay Act, W. Va. Code § 33-45-(1)(10), the Plaintiffs satisfy the definition of "provider."

14. Pursuant to the Prompt Pay Act, to W. Va. Code § 33-45-(1)(7), Defendant Highmark satisfies the definition as an "Insurer."

15. Pursuant to the Prompt Pay Act, W. Va. Code § 33-45-(1)(5) "Health Plan" means:

> . . . any individual or group health care plan, subscription contract, evidence of coverage, certificate, health services plan; medical or hospital services plan as defined in article twenty four of this chapter; accident and sickness insurance policy or certificate; managed care health insurance plan, or health maintenance organization subject to state regulation pursuant to article twenty-five-a of this chapter; which is offered, arranged, issued or administered in the state by an insurer authorized under this chapter, a third-party administrator or an intermediary. Health plan does not mean: (A) Coverages issued pursuant to Title XVIII of the Social Security Act, 42 U.S.C. §1395 et seq. (Medicare), Title XIX of the Social Security Act, 42 U.S.C. §1396 et seq. or Title XX of the Social Security Act, 42 U.S.C. §1397 et seq. (Medicaid), 5 U.S.C. §8901 et seq., or 10 U.S.C. §1071 et seq. (CHAMPUS); article sixteen, chapter five of this code (PEIA); (B) accident only, credit or disability insurance, long-term care insurance, CHAMPUS supplement, Medicare supplement, workers' compensation coverages or limited benefits policy as defined in article sixteen-e of this chapter, or (C) any a [sic] third-party administrator or an intermediary acting on behalf of providers as denoted in subparagraphs (A) and (B).

Defendant Highmark operates "Health Plans" which satisfy the statutory definition above.

16. Pursuant to the Prompt Pay Act, W. Va. Code § 33-45-(1)(9), a "Retroactive Denial" (or to "Retroactively Deny") is defined as:

> . . . the practice of denying previously paid claims by withholding or setting off against payments or in any other manner reducing or affecting the future claim payments to the provider, or to seek direct cash reimbursement from a provider for a payment previously made to the provider.

17. The alleged "overpayment" as a result of Defendant Highmark's "retrospective post-payment audit" satisfies the definition of a "Retroactive Denial" under the Prompt Pay Act.

18. Pursuant to the Prompt Pay Act, W.Va. Code § 33-45-2(a)(7):

> A previously paid claim may be retroactively denied only in accordance with this subdivision.
>
> (A) No insurance company may retroactively deny a previously paid claim unless:
>
> (i) The claim was submitted fraudulently;
>
> (ii) The claim contained material misrepresentations;
>
> (iii) The claim payment was incorrect because the provider was already paid for the health care services identified on the claim or the health care services were not delivered by the provider;
>
> (iv) The provider was not entitled to reimbursement;
>
> (v) The service provided was not covered by the health benefit plan; or
>
> (vi) The insured was not eligible for reimbursement.
>
> Further, pursuant to the Prompt Pay Act, W.Va. Code § 33-45-2(a)(7)(C):
>
> A health plan may retroactively deny a claim only for the reasons set forth in subparagraphs (iii), (iv), (v) and (vi), paragraph (A) of this subdivision (7) for a period of one year from the date the claim was originally paid. There shall be no time limitations for retroactively denying a claim for the reasons set forth in subparagraphs (i) and (ii) above.

19. Defendant did not conduct the "retrospective post-payment audit" based upon fraud or intentional misrepresentation. Furthermore, Defendant Highmark did not retroactively deny the Plaintiffs' previously paid insurance claims following the "retrospective post-payment audit" as a result of fraud or intentional

misrepresentation. Therefore, under the Prompt Pay Act, Defendant Highmark can only "Retroactively Deny" the Plaintiffs' insurance claims for a period of one (1) year.

20. Plaintiffs correctly billed insurance claims at all times relevant to the facts alleged herein.

21. Based upon reasonable belief and information, Defendant Highmark is unlawfully "Retroactively Denying" at least sixty percent (60%) of insurance claims consisting of the alleged "overpayment" outside the one (1) year statute of limitations.

22. Based upon reasonable belief and information, Defendant Highmark routinely and systematically unlawfully conducts "retrospective post-payment audits" of providers' insurance claims within their network in the State of West Virginia which are not based upon fraud or intentional misrepresentation for a period greater than one (1) year in violation of the Prompt Pay Act.

23. Based upon reasonable belief and information, Defendant Highmark routinely and systematically unlawfully "Retroactively Denies" insurance claims of providers within their network in the State of West Virginia in violation of the Prompt Pay Act.

Count I
Breach of Written Contract ("Network Agreement")

24. Plaintiffs reallege and incorporate each and every paragraph herein as if repeated verbatim.

25. Defendant Highmark has breached Section III. K. titled "Prompt Pay," Section III. H. titled "Overpayment," and Section IV. FF. titled "Compliance with Applicable Law" of its "Network Agreement" by "Retroactively Denying" the Plaintiffs'

insurance claims covered by the Prompt Pay Act outside the one (1) year statute of limitations.

26. Pursuant to the "Network Agreement" and the Prompt Pay Act, W.Va. Code § 33-45-1, any insurance claims covered by Defendant Highmark's statutorily defined "Health Plans," which it "Retroactively Denies" claims outside of the one (1) year statute of limitations, should be withdrawn from the alleged "overpayment" amount.

27. As a direct and proximate result of Defendant Highmark's breach of the "Network Agreement," as detailed in this Complaint, the Plaintiffs have suffered and are entitled to compensatory damages, pursuant to W.Va. Code § 33-45-3.

28. Defendant Highmark's actions were willful, wanton, and/or undertaken with reckless disregard for the rights of the Plaintiffs, thus the Plaintiffs are entitled to punitive damages in an amount to be determined by the jury.

29. As a direct and proximate result of Defendant Highmark's breach of the "Network Agreement," the Plaintiffs are entitled to an award of attorney fees and costs, pursuant to W.Va. Code § 33-45-3.

Count II
Breach of West Virginia Code (W.Va. Code § 33-45-2(a)(7)(C))

30. Plaintiffs reallege and incorporate each and every paragraph herein as if repeated verbatim.

31. Defendant Highmark has breached the Prompt Pay Act, W.Va. Code § 33-45-1, *et seq.*, specifically W. Va. Code§ 33-45-2(a)(7)(C), by "Retroactively Denying" the Plaintiffs' insurance claims covered by the statute outside the one (1) year statute of limitations.

32. Pursuant to the Prompt Pay Act, any insurance claims covered by Defendant Highmark's statutorily defined "Health Plans" that it attempts to "Retroactively Deny" for an "overpayment" outside of the one (1) year statute of limitations, should be withdrawn from the alleged "overpayment" amount.

33. As a direct and proximate result of Defendant Highmark's breach of the Prompt Pay Act, as detailed herein, the Plaintiffs have suffered and are entitled to compensatory damages, pursuant to W.Va. Code § 33-45-3.

34. Defendant Highmark's actions were willful, wanton, and/or undertaken with reckless disregard for the rights of the Plaintiffs, thus the Plaintiffs are entitled to punitive damages in an amount to be determined by the jury.

35. As a direct and proximate result of Defendant Highmark's breach of contract and the Prompt Pay Act, the Plaintiffs are entitled to an award of attorney fees and costs, pursuant to W.Va. Code § 33-45-3.

Count III
Breach of West Virginia Code (W.Va. Code § 33-45-2(a)(5)(B)(ii))

36. Plaintiffs reallege and incorporate each and every paragraph herein as if repeated verbatim.

37. The Prompt Pay Act, W. Va. Code § 33-45-2(a)(5)(B)(ii), requires Insurers to establish and implement reasonable policies governing the process of the "Retroactive Denial" of claims. Furthermore, pursuant to the Prompt Pay Act, W.Va. Code § 33-45-2(a):

> Every provider contract entered into, amended, extended or renewed by an insurer on or after the first day of August, two thousand one, shall contain specific provisions which shall require the insurer to adhere to and comply with the following minimum fair business standards in the

processing and payment of claims for health care services [under W.Va. § 33-45-2(a)(1)-(11) of the Prompt Pay Act].

38. At all relevant times, in addition to the "Network Agreement," Defendant Highmark has implemented a "Provider Manual," also know as an "Office Manual," which details its process for claim audits and the claim audit dispute process.

39. In violation of the Prompt Pay Act, Defendant Highmark's process for claim audits and the claim audit dispute process are not reasonable.

40. Defendant Highmark's claim audit process is unlawful because it violates the Prompt Pay Act and does not implement reasonable policies governing the process of the "Retroactive Denial" of providers' claims. Specifically, among other unlawful actions, Defendant Highmark systematically conducts "Health Plan" audits which "Retroactively Deny" insurance claims covered under the Prompt Pay Act for reasons other than fraud or intentional misrepresentation, for a period longer than one (1) year.

41. Defendant Highmark's claim audit dispute process is unlawful because it violates the Prompt Pay Act and does not implement reasonable policies governing the process of the "Retroactive Denial" of claims. Specifically, among other unlawful actions, Defendant Highmark has implemented an appeal process that ends with a binding, non-appealable decision from a Certified Review Entity ("CRE"), which details that each party waives its right to commence litigation to challenge the results of the CRE.

42. Defendant Highmark's claim audit dispute process amounts to a binding arbitration provision which renders a provider's statutory right, pursuant to W. Va. Code § 33-45-3, to initiate an action against an insurer for damages due to its violation(s) of the Prompt Pay Act void.

43. The Plaintiffs never consented to Defendant Highmark's claim audit dispute process contained in its "Provider Manual," which is unilaterally amended by Defendant Highmark from time to time.

44. As a direct and proximate result of Defendant Highmark's breach of the Prompt Pay Act, as detailed herein, the Plaintiffs have suffered and are entitled to compensatory damages pursuant to W.Va. Code § 33-45-3.

45. Defendant Highmark's actions were willful, wanton, and/or undertaken with reckless disregard for the rights of the Plaintiffs, thus the Plaintiffs are entitled to punitive damages in an amount to be determined by the jury.

46. As a direct and proximate result of Defendant Highmark's breach of contract and the Prompt Pay Act, the Plaintiffs are entitled to an award of attorney fees and costs, pursuant to W.Va. Code § 33-45-3.

Count IV
Breach of West Virginia Code
(W. Va. Code § 33-11-4(9)(c) and W. Va. Code § 33-11-4(9)(n)

47. Plaintiffs reallege and incorporate each and every paragraph herein as if repeated verbatim.

48. Defendant Highmark has breached W. Va. Code § 33-11-4(9)(c) and W. Va. Code § 33-11-4(9)(n) by failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies and failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim on the offer of a compromise settlement.

49. As a direct and proximate result of Defendant Highmark's breach of W. Va. Code § 33-11-4 *et seq.* as detailed herein, the Plaintiffs have suffered and are entitled to damages pursuant to West Virginia law.

50. Defendant Highmark's actions were willful, wanton, and/or undertaken with reckless disregard for the rights of the Plaintiffs, thus the Plaintiffs are entitled to punitive damages in an amount to be determined by the jury.

Allegations under Rule 23 of
The West Virginia Rules of Civil Procedure

51. The prospective class seeks no relief under any federal laws or regulations, assert no federal claims, and withdraw any asserted state claims that are preempted by federal law. The claims herein are brought solely under state common law and state statutory law. Any and all claims or possible claims under any federal law, code, regulation, rule, and/or otherwise are expressly not brought herein and disclaimed. The United States District Court does not have diversity jurisdiction over this case as complete diversity of citizenship is lacking.

52. Plaintiffs reallege and incorporate each and every paragraph herein as if repeated verbatim.

53. Plaintiffs bring Counts I, II, III and IV of this Complaint on behalf of themselves and, pursuant to Rule 23 of the West Virginia Rules of Civil Procedure, on behalf of those similarly situated providers within Defendant Highmark's network.

54. Plaintiffs seek certification of the following class (hereinafter "the Class"):

> All health care professionals and professional health care entities which are "providers" as defined by the West Virginia Prompt Pay Act, domiciled in West Virginia, licensed and providing specific health care services in the State of West Virginia from ten (10) years prior to the filing of this complaint to the present who were within Defendant

Highmark's network, had a contractual relationship with Defendant Highmark in the State of West Virginia and who received an "audit" letter from Defendant Highmark.

55. Further, Plaintiffs allege that some "providers" as defined under the West Virginia Prompt Pay Act and Paragraph 59 herein, have entered into contractual releases with Defendant Highmark after they received an "audit" letter and Plaintiffs wish to specifically exclude these providers from "the Class." Specifically, the class shall consist of any of those "providers" who "refunded" Defendant Highmark without signing a release either through remittance of the entire retroactively denied payment, installment payments of the retroactively denied payment or an offset of the retroactively denied payment against further Highmark WV payments, not those providers who entered into a contractual release with Defendant Highmark.

56. The claims of the Plaintiffs are typical of the claims of the Class and Plaintiffs will fairly and adequately protect the interest of the Class.

57. Plaintiffs have no conflict with any other Class members and have retained competent counsel experienced in the medical profession, insurance, tort, contract, and class action litigation.

58. Defendant Highmark has acted, or refused to act, on grounds generally applicable to the Class, thereby making relief with respect to the Class as a whole appropriate.

59. The prosecution of separate actions by individual members of the Class would create a risk of inconsistent or varying adjudications with respect to individual members of the Class, which would establish incompatible standards of conduct for the Defendant or adjudications with respect to individual members of the Class, and which would, as a practical matter, be dispositive of the interests of the other members not

parties to the adjudications, or which substantially impair or impede their ability to protect their interests.

60. Common questions of law and fact exist, including, but not limited to:

(a) The relevant contractual, statutory, and legal duties which Defendant Highmark owes the Plaintiffs and the Class;

(b) Whether Defendant Highmark breached contractual, statutory, and legal duties owed to Plaintiffs and the Class; and

(c) The appropriate measure of damages for any and all breaches of contractual, statutory, and legal duties owed to the Plaintiffs and the Class.

61. The aforementioned questions of law and fact are common to the Class and predominate over any questions affecting only individual Class members.

62. Class action treatment is a superior method for the fair and efficient adjudication of the controversy described herein, and a Class action provides the most efficient method for the enforcement of the rights of the Plaintiffs, the Class Members, and Defendant Highmark.

63. Plaintiffs are unaware of any unusual problems of management and notice with respect to the Class.

REQUEST FOR RELIEF

WHEREFORE, Plaintiffs requests that they and the Class be awarded the following:

a. Reformation of Defendant Highmark's audit policy to comport with West Virginia law;

b. Compensatory damages in an amount to be determined by a jury;

c. Punitive damages, to the extent warranted by the evidence and warranted by the law;

d. Pre and post judgment interest as allowed by law;

e. Reasonable attorneys' fees, costs and expenses; and

f. Any other and further relief as this Honorable Court deems just and appropriate under the circumstances.

PLAINTIFFS DEMAND A TRIAL BY JURY ON ALL ISSUES SO TRIABLE.

Dated this 28th day of October, 2016.

By Counsel:

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PROVIDER RELATIONS
Scanning Batch Sheet

(N

Requestor: Internal Provider Relations

Completion Date: 11/6/09

Provider Name: Charleston Diabetes & Endocrine Cons. PLLC
Tax ID #: 264369322
Location: Charleston, Wv
Date Received: 3/31/09
NPI#: 1710128541

PROFESSIONAL PROVIDER:

- ☐ Provider Reimbursement and Change Form
- ☒ Network Agreement
- ☐ Traditional Par Agreement
- ☐ Super Blue Addendum
- ☐ Super Blue Select
- ☐ Medicare Advantage
- ☐ New Provider/Group
- ☐ Add to Staff
- ☐ Tax ID Change
- ☐ Address Change
- ☐ Name Change
- ☐ Cancellation
- ☐ EFT
- ☐ W-9 Form
- ☐ NPI
- ☐ Board of Medicine
- ☐ Credentialing Documents
- ☐ PARE
- ☐ UCR Allowance
- ☐ PCP Back-up Form
- ☐ QC Reports
- ☐ Miscellaneous

INSTITUTIONAL PROVIDER:

- ☐ Provider Demographic Request
- ☐ Rate Update
- ☐ NPI
- ☐ Room Rates
- ☐ Miscellaneous

AFTER QC AND IMAGING
*****PLEASE DESTROY *****

EXHIBIT
1

MOUNTAIN STATE
Blue Cross Blue Shield
A HIGHMARK AFFILIATE

November 06, 2009

Charleston Diabetes & Endocrine Consultants, PLLC
3100 MacCorkle Avenue SE, Suite 810
Charleston, Wv 25304

Re: Group Network Agreement

Dear Provider:

Please find enclosed the executed copy of the signed Network Agreement. This agreement is for organizational NPI Number 1710128541 with an effective date of October 29, 2009.

When a new practitioner is being added to your group practice, it is only necessary to complete the Provider Reimbursement-Change From and the State of West Virginia Credentialing Application.

If you have any questions, please contact our Provider Services Department at (800) 798-7768 / (304) 424-7795 or your Provider Relations Representative.

You may access our Provider Manual, Provider News and Bulletins as well as other useful information via our website at www.mshcbs.com.

Sincerely,

Kristin Delaney

Kristin Delaney
Provider Services Representative

cc: Tifaney Rader
Provider Relations Representative
Provider File

NETWORK AGREEMENT

THIS NETWORK AGREEMENT ("Agreement"), effective on the date set forth on the signature page, is entered into between HIGHMARK WEST VIRGINIA INC. d/b/a MOUNTAIN STATE BLUE CROSS BLUE SHIELD ("MSBCBS") and Charleston Diabetes Education Consultants, PLLC ("Provider"). The Parties agree to be bound by the terms and conditions set forth herein, as well as the terms and provisions of MSBCBS' Provider Manual ("Provider Manual"), including the definitions therein, any revisions thereto, and any other exhibits or documents referenced herein or in the Provider Manual.

I. PAYMENTS FOR COVERED SERVICES

A. Payment Methodology. MSBCBS shall pay to Provider for the provision of Covered Services the lesser of (1) Provider's charge or (2) the MSBCBS Reimbursement Allowance, in either case minus the sum of the amount payable by a Covered Person (e.g., deductible, coinsurance and co-payment amounts) and, if applicable, the amount payable by another payor.

B. Annual Review. MSBCBS shall perform annual reviews of its Reimbursement Allowances.

C. Payee. MSBCBS shall promptly pay Provider (or Provider's agent identified in a Provider Reimbursement Change Form or successor form) in accordance with the Provider Manual.

D. Payment Limits. The payment of the amount payable by or on behalf of the Covered Person and the payment from MSBCBS shall be deemed payment in full. Provider may bill a Covered Person for deductibles at the time Covered Services are rendered unless the Covered Person provides proof that such deductible has been met. Provider may bill the remainder of the Covered Person's liability (e.g., payment to coinsurance, co-payments and deductibles as described in the Provider Manual) for Covered Services rendered only after verifying the Covered Person's liability with MSBCBS. Should the Covered Person pay an amount that is subsequently paid by MSBCBS, Provider will refund said amount to the Covered Person within thirty (30) days after receipt of MSBCBS' payment. Provider shall not bill or hold responsible MSBCBS or any Covered Person for any services deemed by MSBCBS as not Medically Necessary or for any portion of Provider's charge in excess of the MSBCBS Reimbursement Allowance, regardless of whether MSBCBS is primary or secondary, unless otherwise specified in the Provider Manual or Medicare rules. This section shall survive termination of this Agreement.

II. DEFINITIONS

Capitalized terms shall have the meanings ascribed to them in the Provider Manual, unless otherwise defined within this Agreement.

III. CONDITIONS AND LIMITATIONS TO PAYMENTS

Payments pursuant to this Agreement are conditioned upon and/or limited by satisfaction of each of the following:

A. Timely Filing. Except as otherwise described in the Provider Manual, Provider shall submit all claims within twelve (12) months from the date services were rendered or the date a primary payor paid or denied the claim, using a standard billing form in a completed, appropriate and approved format, in accordance with the requirements specified in the Provider Manual, or in an electronic format in accordance with the requirements of MSBCBS' electronic claims submission program. Additionally, neither MSBCBS nor the Covered Person will be held liable for claims submitted more than twelve (12) months after the date of service or the date a primary payor paid or denied the claim.

B. **Covered Person Determinations.** Reimbursement to Provider will be made for Covered Services rendered to persons determined by MSBCBS to be Covered Persons, whether such determination is rendered before, on or after the provision of, or payment for, such Covered Services.

C. **Liability of Covered Person and Other Payors.** MSBCBS shall not be liable to Provider for any amount of money payable by a Covered Person or another payor if Provider is unable to collect such amount of money from a Covered Person or another payor.

D. **MSBCBS Policies and Medical Necessity.** Provider shall comply with MSBCBS' determinations respecting payment and interpretations of Policies, including MSBCBS' determination of Medical Necessity, without limitation, regardless of whether such determinations are made before, on or after the provision of, or payment for, Covered Services.

E. **Health Payor and Supervised Health Care Professionals.** MSBCBS shall not reimburse Provider for the provision of any Covered Services to the extent that it has reimbursed or may become responsible to reimburse another health care professional for such Covered Services. Also, when the supervising Provider bills for a service, other health care professionals under the supervision of such Provider may not bill for the same service. Provider agrees to disclose to MSBCBS the identity of those individuals supervised.

F. **Defective Services and Supplies.** MSBCBS shall not reimburse Provider for the provision of any Covered Services to the extent that MSBCBS' expense for Covered Services would be increased by Defective Services or Supplies rendered or ordered by Provider.

G. **Licenses and Legal Compliance.** Payment to Provider for Covered Services will be made only if Provider is licensed, Covered Services are within the scope of such license and Provider is otherwise in compliance with federal and state laws at the time services were rendered.

H. **Overpayments.** Except as otherwise described in the Provider Manual, Provider shall repay MSBCBS, through a refund or automatic adjustment, monies paid to Provider in the following events: (1) MSBCBS reimburses Provider for the provision of services that MSBCBS determines are not Covered Services, are not medically necessary or for Defective Services or Supplies; (2) MSBCBS reimburses Provider for the provision of services to a person that MSBCBS determines is not a Covered Person; (3) MSBCBS has made a payment to Provider for the provision of Covered Services more than once, made payments due to coding or billing errors or otherwise incorrectly or inadvertently made a payment to Provider. MSBCBS may retroactively deny or negatively adjust a previously paid claim within the time periods specified in the Provider Manual and according to applicable legal requirements governing such actions, including among other things, the West Virginia Ethics and Fairness in Insurer Business Practices Act (commonly referred to as the "Prompt Pay Act"), the West Virginia Unclaimed Property Act, and any MSBCBS contractual obligations to self-funded groups and other third parties.

I. **Cost and Quality Management Programs.** Provider shall participate in and comply with MSBCBS' cost and quality management programs, as set forth in the Provider Manual, including but not limited to (1) Preauthorization; (2) Ambulatory Surgery; (3) Office Surgery; (4) Peer/Medical/Utilization Review Programs; (5) Second Surgical Opinion; and (6) Credentialing and Recredentialing.

J. **Claim Appeals.** Provider may appeal an adverse claim determination as specified in the Provider Manual.

K. **Prompt Pay.** MSBCBS shall adhere to and comply with the standards for processing and payment of claims for health care services set forth in the Prompt Pay Act for claims subject to this law and as set forth in the Provider Manual.

L. **Coordination and Other Party Liability.** Provider agrees to provide to MSBCBS information for the collection and coordination of benefits or other party liability and to abide by MSBCBS' coordination of benefits, subrogation, workers' compensation and duplicate coverage policies.

IV. RECORD REVIEW

A. **Medical Records.** Provider shall keep accurate and current medical records for each Covered Person in accordance with the requirements of generally accepted standards of the medical profession and as required by law, and shall furnish such records to MSBCBS or its agent or designee, upon request, without charge, alteration or condition. Provider shall secure the consent and release of any Covered Person when such is necessary for the disclosure of the Covered Person's medical records to MSBCBS.

B. **Records Reviews and Audits.** MSBCBS reserves the right to have its representatives conduct on-site or off-site audits, without charge, examine such original records of Provider as may be necessary to verify performance under this Agreement, or under any contract between MSBCBS and its Accounts, and make necessary copies thereof and remove such copies to MSBCBS' place of business. Such audits shall take place during normal business hours of Provider and shall be conducted in such a manner as to minimize disruption of Provider's normal business routines. No cost or fee will be charged to Provider for normal audit activities. Except as may otherwise be specified in the Provider Manual, MSBCBS shall provide at least seven (7) days notice of any audit to Provider.

C. **Survival.** The right of MSBCBS or its representatives to audit or to request and receive records will survive termination of this Agreement with respect to those services rendered by Provider during the term of this Agreement.

D. **Furnishing Records to Other Providers.** Provider agrees to transfer copies of the Covered Person's medical records, x-rays or other medical data to another provider, when requested to do so in writing by MSBCBS or the Covered Person, at no charge to the Covered Person or to MSBCBS.

V. TERM AND TERMINATION

A. **Credentialing and Acceptance Conditions.** This Agreement is specifically conditioned upon Provider's successful completion and MSBCBS' approval of the Provider's credentialing application. The Agreement shall be effective only upon MSBCBS' written acceptance by its authorized representative on the date designated on the signature page and shall remain in effect until terminated as provided herein.

B. **Termination without Cause.** Except where specified in Section V, Paragraphs C and F and Section VI, Paragraphs G and R, either party may terminate this Agreement upon providing at least sixty (60) calendar days written notice to the other party hereto. Upon termination, Provider shall not represent himself/herself as a Network Provider.

C. **Automatic Termination.** This Agreement will automatically terminate upon any of the following events: (1) Provider's license and/or certification is suspended or revoked (termination effective as of the date of suspension or revocation); (2) Provider is convicted of a felony or any offense involving MSBCBS; or (3) Provider is prohibited by any law, rules or regulations (federal, state, or local) from providing services or participation in a governmental program. Provider shall notify MSBCBS immediately in writing of any suspension or revocation of Provider's license or certificate, or exclusion of participation in the Medicare or Medicaid Programs.

D. **Effect of Termination.** Termination of this Agreement shall be made without further liability on the part of MSBCBS, except as otherwise provided herein, and shall be without prejudice to any rights or claims which MSBCBS may otherwise have against Provider.

E. **Termination of Affiliated Providers.** MSBCBS reserves the right to terminate this Agreement as provided for herein with respect to any Affiliated Providers, as defined in Section VI, Paragraph 8.1, of a Group Provider, as defined in Section VI Paragraph 8.2, without termination of this Agreement as to the Group Provider.

F. **Termination for Immunity from CMS Fee Schedule Changes.** If an annual revision made by the Centers for Medicare & Medicaid Services ("CMS") results in a reduction in the fees in a MSBCBS fee schedule that is directly tied to the CMS fee schedules, as established and maintained by MSBCBS, a Provider shall have the right to terminate this Agreement by giving MSBCBS written notice of termination within thirty (30) days of the date on which CMS published notice of the annual revision, which termination shall be effective ninety (90) days after the date that such notice was published.

G. **Transition of Patient Care.** Upon termination of this Agreement, Provider shall arrange for the orderly transfer of Covered Persons to other providers who participate with MSBCBS, if and when appropriate. Upon termination, Provider shall not represent himself/herself as a participant in the MSBCBS networks.

VI. GENERAL PROVISIONS

A. **Charge Increases.** Provider agrees not to increase charges to Covered Persons for any procedure more than once in any twelve (12)-month period.

B. **Non-Assignment.** Provider shall not assign or transfer this Agreement, whether by conduct or operation of law, without MSBCBS' prior written consent.

C. **Charge Limitation and Reimbursement Agreement.** Any charges submitted by Provider to MSBCBS for services rendered to Covered Persons shall be less than or equal to the charges for identical services or procedures to patients who are not Covered Persons, except as otherwise required by law. Provider agrees that no other reimbursement agreement shall be made with Covered Persons.

D. **Professional Responsibility.** 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 of the applicable state professional licensure boards and agencies. Provider shall be solely responsible for the quality of services, including Covered Services, rendered to and/or treatment of Covered Persons. No action by MSBCBS pursuant to any provision of this Agreement or in relation to determinations of benefits for Covered Persons has, or is intended to have, the effect of infringing upon Provider's care and treatment of such Covered Persons and such actions are not a substitute for the medical judgment of Provider. Provider must exercise his/her own independent medical judgment regarding the administration, treatment or discharge of Covered Persons.

E. **Claim Representations and Provider Information.** Statements made in any claim submitted to MSBCBS shall be considered statements made by Provider, whether or not such statements are prepared by Provider directly or by an agent of Provider.

F. **Provider Roster.** MSBCBS may make information available to Accounts and Covered Persons identifying Network Providers and the services provided thereby.

G. **Modification.** MSBCBS shall furnish Provider with ninety (90) days written notice if it intends to make

a material adverse change in the terms of this Agreement. If Provider objects to the change that is subject to the notice, the Provider may, within thirty (30) days of receipt of the notice of material adverse change, terminate this Agreement by furnishing MSBCBS with written notice of such termination intent. The effective date of termination shall be the end of the notice period of the material adverse change, unless within sixty-five (65) days of the original notice of material adverse change, MSBCBS gives written notice to Provider that it will not implement, as to the objecting Provider, the material adverse change. For changes that are not materially adverse, MSBCBS may amend this Agreement, subject Section V, Paragraph E, upon sixty (60) days written notice. Notwithstanding the foregoing, this Agreement or any provision hereof may be amended by MSBCBS immediately upon written notice to Provider in order to comply with applicable laws and the directives of government bodies.

H. **Entire Agreement.** This Agreement, together with Addendum I, Addendum II (if applicable) and the Provider Manual, is the entire agreement between the parties and supersedes all prior agreements, writings and representations.

I. **Construction.** In the event of any conflict between the terms of this Agreement and the terms of the Provider Manual, the terms of this Agreement shall control, unless otherwise specified.

J. **Provider Information.** Provider certifies that any information provided to MSBCBS, including that contained in a Provider Reimbursement Change Form, or successor forms, is correct and accurate. Provider shall promptly notify MSBCBS of any changes to this information.

K. **Governing Law, Venue and Limitation on Actions.** This Agreement shall be governed by, and construed in accordance with, the laws of West Virginia. Exclusive venue for any action arising from this Agreement shall be before the courts located in Wood County, West Virginia, and any action against MSBCBS must be brought within two (2) years of the event giving rise to the action.

L. **Use of MSBCBS or Blue Cross Blue Shield Association Name and Symbols.** Provider shall not use any name, symbol, trademark, or service mark held by or licensed to MSBCBS in advertising, promotional materials or otherwise without the prior, written consent of MSBCBS or the Blue Cross and Blue Shield Association.

M. **Independent Parties and Indemnification.** Neither of the parties, nor their respective employees, agents, or representatives, shall be deemed or construed to be the employee, agent or representative of the other party and shall not be held liable for any acts of omission or commission, or liability, on the part of the other party. Provider, its employees, contractors and agents shall indemnify and hold harmless MSBCBS and its agents, officers and employees against any injuries, death, losses, damages, claims, suits, liabilities, actions, judgments, costs and expenses (including reasonable attorney fees) as a result of any negligent or intentional omission or commission in connection with the delivery of services provided by Provider, its employees, contractors, or agents to Covered Persons.

N. **Waiver.** Waiver by either party of any provision of this Agreement, or waiver of any breach of any provision of this Agreement, shall not be deemed to be a waiver of that provision in the future or for future breaches of any provision.

O. **Acceptance.** This Agreement shall not be binding on MSBCBS until accepted at its principal place of business by an authorized officer.

P. **Severability.** The invalidity or unenforceability of any term or provision of this Agreement shall in no way affect the validity or enforceability of any other term or provision of this Agreement.

Q. **Counterparts.** This Agreement may be executed in duplicate, each of which shall be deemed an original

and which shall constitute one and the same instrument.

R. Provider Manual. Upon acceptance of this Agreement by MSBCBS, a fully executed copy of this Agreement shall be sent to Provider, along with the Provider Manual, if the Provider Manual has not been previously supplied to Provider. Provider acknowledges the Provider Manual is part of this Agreement and that, if Provider is not in agreement with all of the terms and conditions thereof, Provider may terminate this Agreement within seven (7) days after receipt of the Provider Manual.

S. Groups and Affiliated Providers. If Provider is a Group Provider, then it represents and warrants that it has the authority to act on behalf of any Affiliated Providers of that Group Provider. Group Provider further represents and warrants that all Affiliated Providers of that Group Provider shall be bound by, agree to and shall comply with all terms and provisions of this Agreement. If a Provider is a Group Provider, any reference in this Agreement to Provider shall be interpreted as applying to both the Group Provider and all Affiliated Providers of Group Provider. A Group Provider may add additional Affiliated Providers by submitting documentation required by MSBCBS. The Group Provider represents and warrants that this Agreement shall apply to such additional Affiliated Providers to the same extent as they apply to existing Affiliated Providers of the Group Provider.

1. "Affiliated Providers" shall mean those professional providers (a) affiliated with a Group Provider through an employer-employee relationship, partnership, medical corporation membership or similar relationship; (b) who are currently or will become Network Providers with MSBCBS via an agreement between Group Provider and MSBCBS; and (c) on whose behalf the Group Provider has entered this Agreement.
2. "Group Provider" shall mean a Provider that is a group practice or other affiliation of individual Affiliated Providers.

T. Allied Health Providers. Provider agrees that, to the extent feasible, he/she will utilize such additional MSBCBS network allied health and other qualified personnel as are available and appropriate for effective and efficient delivery of health care consistent with the terms of this Agreement.

U. National Networks. To the extent that MSBCBS participates in national or interregional networks, Provider shall provide services as defined by said program to persons who have coverage under such programs. Compensation for such services shall be based on the payment methodology set forth in Section I, Paragraph A of this Agreement and shall be obtained from MSBCBS upon submission of a properly completed claim form or electronic record/format documenting the services provided.

V. Professional Liability Insurance. Provider shall maintain professional liability insurance with limits of at least one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) per year in aggregate or such other aggregate limits as may be required to maintain staff privileges at any hospital that is a participant in a MSBCBS network. Provider shall immediately notify MSBCBS of any reduction or termination of such coverage. Provider shall furnish MSBCBS with continuing proof of such coverage when required by MSBCBS.

W. Medical Staff Privileges. Provider shall maintain active staff privileges with at least one hospital that is a Network Provider. Provider agrees to notify MSBCBS immediately if any change occurs regarding the status of hospital privileges.

X. Non-Discrimination. Provider shall make available services to Covered Persons on the same basis as his/her services are available to non-Covered Persons. Provider further agrees not to discriminate in the treatment of his/her patients or in the quality of services delivered to Covered Persons on the basis of race, sex, religion, place of residence, health status or source of payment and to observe, protect and promote the rights of Covered Persons as patients.

Y. **Blue Cross, Blue Cross Blue Shield Association Disclosure.** Provider expressly acknowledges its understanding that this Agreement constitutes a contract between Provider and MSBCBS, that MSBCBS 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 (the "Association"), permitting MSBCBS to use the Blue Cross and Blue Shield Service Marks in the state of West Virginia and a portion of the state of Ohio, and that MSBCBS is not contracting as the agent of the Association. Provider further acknowledges and agrees that it has not entered into this Agreement based upon representations by any person other than MSBCBS and that no person, entity, or organization other than MSBCBS shall be held accountable or liable to Provider for any of MSBCBS' obligations to Provider created under this Agreement. This paragraph shall not create any additional obligations whatsoever on the part of MSBCBS other than those obligations created under other provisions of this Agreement.

Z. **Confidentiality.** Provider agrees to maintain the confidentiality of all information relative to fees, charges, expenses and utilization derived from, through, or provided by MSBCBS.

AA. **Gag Clauses.** No Provision in this Agreement will be interpreted to limit the free, open and unrestricted exchange of information between Provider and a Covered Person regarding the nature of the Covered Person's medical conditions or treatment and provider options and the relative risks and benefits and costs to the Covered Person of such options, whether or not such treatment is covered under Covered Person's benefit plan, and any right to appeal any adverse decision by MSBCBS regarding coverage of treatment that has been recommended or rendered. MSBCBS shall not penalize or sanction Provider in any way for engaging in any free, open and unrestricted communication with a Covered Person with respect to the foregoing subjects or for advocating for any service on behalf of a Covered Person.

BB. **Force Majeure.** No party hereto shall be required to meet an obligation under this Agreement where the inability to meet such obligation is the result of any act of God, governmental act, act of terrorism, war, fire, flood, or other natural disaster, epidemic, explosion or civil commotion ("Force Majeure"). The performance of a party's obligations under this Agreement, to the extent affected by the delay, shall be suspended for the period during which the cause, or the party's inability to perform arising from the cause, persists. If the performance of any obligation under this Agreement is excused or delayed by Force Majeure and that obligation is a condition precedent for the performance of an obligation by another party, performance of the obligation by the second party shall be excused or delayed to the same extent as the performance of the obligation by the first party.

CC. **Third Party Beneficiaries.** This Agreement is for the sole and exclusive benefit of the parties hereto and is not intended to, nor does it, confer any benefit upon any third party.

DD. **Captions.** The captions used in this Agreement are for convenience purposes only and shall not otherwise constitute a part of this Agreement.

EE. **Notice.** Any notice required to be given pursuant to the terms and provisions hereof shall be sent by regular mail to MSBCBS at its Corporate Headquarters, P.O. Box 1948, Parkersburg, WV 26102-1948; or to the Provider at the mailing address provided to MSBCBS by the Provider. Notice shall be deemed to be effective when mailed, but notice of change of address shall be effective upon receipt.

FF. **Compliance with Applicable Law.** Nothing contained in this Agreement is intended to or shall, in any way, reduce, diminish, or supersede any party's obligation to comply with applicable provisions of relevant state and federal laws and regulations. The obligations hereunder shall be fulfilled by MSBCBS to the extent permissible under applicable laws and regulations, the terms and conditions of current and future government contracts, and applicable governmental directives. To the extent state or federal law or regulation imposes, with respect to a specific obligation created in this Agreement, a greater obligation

than that specifically set forth in this Agreement, MSBCBS shall comply with said law or regulation. Further, if, and during such time as, MSBCBS is unable to fulfill an obligation hereunder to the extent contemplated by this Agreement because to do so would require governmental approval or action, MSBCBS shall perform such obligation to the extent permissible under applicable laws and regulations, the terms and conditions of current and future government contracts, and applicable governmental directives, and MSBCBS shall continue to fulfill its other obligations hereunder to the extent permitted under applicable laws and regulations, the terms and conditions of current and future government contracts, and applicable governmental directives.

Signature of Applicant

MD/Owner
Title

3/19/09
Date

26-4369322
Tax Identification Number

Accepted by:
HIGHMARK WEST VIRGINIA INC. d/b/a MOUNTAIN STATE BLUE CROSS BLUE SHIELD

By:

Title: PRESIDENT

Date: 10-29-09
Agreement Effective Date
(Assigned by MSBCBS)

MAR 31 2009

ADDENDUM I
TO NETWORK AGREEMENT FOR SUPERBLUE PPO AND POS PARTICIPANTS

This Addendum I applies to Providers in MSBCBS' SuperBlue PPO and Super Blue Select® POS networks (individually and collectively referred to as "PPO"). Except as set forth in this Addendum I, the terms and conditions of the Network Agreement and the Provider Manual are unchanged by this Addendum I and this Addendum I shall only apply when Providers provide Covered Services to Covered Persons under a PPO policy.

A. Payment of SuperBlue Fee. The following shall be substituted for Section I, Paragraph A of the Network Agreement:

MSBCBS shall pay to Provider for the provision of Covered Services the lesser of (1) Provider's charge or (2) the SuperBlue Fee, in either case minus the sum of the amount payable by Covered Person (e.g., deductibles, coinsurance, co-payments, etc.) and the amount payable by another payer.

B. SuperBlue Fees. The following shall be substituted for Section I, Paragraph B of the Network Agreement:

MSBCBS shall perform annual reviews of the SuperBlue Fees.

C. Participation in SuperBlue Programs. In addition to the cost management programs specified in the Network Agreement and the Provider Manual, Provider shall actively participate in and comply with all cost management programs specifically established for the SuperBlue PPO.

D. Referrals. Except where provided in Section E below, all referrals of Covered Persons by Provider shall be made to other providers that participate in the SuperBlue PPO and who are qualified to render such services. MSBCBS shall make available to Provider, and periodically update, a roster of those providers who participate in the SuperBlue PPO.

E. Referrals to Non-SuperBlue Providers. If, in Provider's medical judgment, it is appropriate to refer a Covered Person to a provider that is not a participant in the SuperBlue PPO, Provider shall seek and obtain prior authorization from MSBCBS in a manner and/or format specified by MSBCBS, for any such referral. Prior authorization is not required for referrals for emergency services. MSBCBS, however, reserves the right to require Provider to refer Covered Persons to specific qualified providers for certain specified Covered Services, whether or not such providers are participants in or are designated as participants in the SuperBlue PPO.

F. Selection of Providers. All providers who participate in the SuperBlue PPO shall be selected by MSBCBS in its sole discretion. MSBCBS reserves the right to designate other providers as participants in the SuperBlue PPO without entering into a written agreement with such other providers.

ADDENDUM II
TO NETWORK AGREEMENT FOR
SUPERBLUE SELECT® PRIMARY CARE PHYSICIAN

This Addendum II applies to Primary Care Physician ("PCP") participants in MSBCBS' POS network. Except as set forth in this Addendum II, the terms and conditions of the Network Agreement, Addendum I and the Provider Manual are unchanged by this Addendum II and this Addendum II shall only apply when PCP Provides Covered Services to Covered Persons under a POS policy.

I. DEFINITIONS

Except as set forth below, defined terms herein shall have the same meaning as stated in the Network Agreement, Addendum I and the Provider Manual.

A. Covered Person. For purposes of this Addendum II, Covered Person means an individual, and their eligible dependents, who has entered into a POS PPO contract with MSBCBS (or on whose behalf a contract has been entered into) for the provision of medical and hospital services who have selected or been assigned to a PCP.

B. Physician means a doctor of medicine or osteopathy duly licensed to practice in the state where the service is provided.

C. Primary Care Physician (or PCP) means the person who, through the execution of this Agreement, is required to provide Primary Care Services to Covered Persons who have selected or have been assigned to PCP, and to assume primary responsibility for arranging and coordinating the overall health care of such Covered Persons. For purposes of this Agreement, family practitioners, general practitioners, internists and pediatricians who satisfy POS PPO credentialing criteria shall be eligible to participate as PCPs.

D. Primary Care Services means those medical services, which the PCP provides directly to the Covered Person without referral to another Physician; or arranging for services by a back-up Physician(s).

II. OBLIGATIONS OF MSBCBS

Eligibility Report. MSBCBS shall make available to the PCP a listing of eligible Covered Persons who have selected or have been assigned to PCP.

III. OBLIGATIONS OF PCP

A. Health Services. PCP agrees to provide Primary Care Services to Covered Persons. PCP shall have the primary responsibility for arranging and coordinating the overall health care of Covered Persons, including appropriate referral for non-Primary Care Services, and managing and coordinating the performance of administrative functions relating to the delivery of health services to Covered Persons in accordance with this Agreement.

B. POS Referral Notification. In addition to the obligations of Section I, Paragraphs D and E of Addendum I, PCP shall provide notice to MSBCBS upon any referral of a Covered Person for a non-Primary Care Service.

C. PCP's Covered Persons. The PCP shall accept as patients those Covered Persons who have selected or have been assigned to PCP without regard to the health status or health care needs of such Covered Persons. PCP may, upon sixty (60) days prior written notice to MSBCBS, request that he/she does not

MAR 31 2009

wish to accept additional Covered Persons (excluding persons already in PCP's practice that enroll in a POS PPO as Covered Persons), MSBCBS may suspend, upon thirty (30) days prior written notice to PCP, any further selection of PCP by Covered Persons who are not PCP's Covered Persons at the time of such suspension. PCP agrees to initiate closure of his/her practice to additional Covered Persons only if his/her practice, as a whole, is to be closed to additional patients, unless this requirement is waived by MSBCBS.

D. **Provision of Services and Professional Requirements.** PCP shall make necessary and appropriate arrangements to ensure the availability of services to the PCP's Covered Persons on a twenty-four (24) hours per day, seven (7) days per week basis, including arrangements to assure coverage of the PCP's Covered Persons after hours or when PCP is otherwise absent, consistent with MSBCBS' administrative requirements. PCP agrees that scheduling of appointments for Covered Persons shall be done in a timely manner. The PCP will maintain weekly appointment hours which are sufficient and convenient to serve Covered Persons and will maintain at all times emergency and on-call services. Coverage arrangements extending beyond thirty (30) days shall be with another Physician who is also a Network Provider or who has otherwise been approved by MSBCBS.

E. **Medical Record Transfer.** In the event of: (a) termination of this Agreement; (b) the selection by a Covered Person of another PCP in accordance with MSBCBS' procedures; or (c) the approval by MSBCBS of PCP's request to transfer a Covered Person from his/her practice, PCP agrees to transfer copies of the Covered Person's medical records, x-rays or other medical data when requested to do so in writing by MSBCBS or the Covered Person at no charge to the Covered Person or to MSBCBS.

MOUNTAIN STATE Blue Cross Blue Shield

HIGH MARK FREEDOMBLUE PPO

TRADITIONAL PARTICIPATION

Any provider may sign a Network Agreement. Members have less out of pocket expense as long as they choose a traditional participating provider. Payment is sent directly to the professional provider and the provider agrees to accept MSBCBS' allowed amount with no balance billing to the member. Provider may collect co-payments, coinsurance, deductibles and any noncovered benefits.

SUPER BLUE® PLUS PREFFERED PROVIDER (PPO)

Members having this product must choose a Super Blue Preferred Provider in order receive the highest level of benefits with less out of pocket expense. Members may choose their provider, Primary Care Physician (PCP) or Specialist. NO REFERRAL IS NECESSARY.

SUPER BLUE® SELECT PREFERRED PROVIDER (PDS)

Members having this product must select a Primary Care Physician (PCP) as their gatekeeper. A Provider is considered a PCP if his/her specialty is General Practice, Family Medicine, Internal Medicine or Pediatrician. All care must be managed and coordinated by the PCP. Generally, a member can only go to a specialty provider with a referral from their selected PCP, unless otherwise specified in the members benefit plan. Specialists who are in the Super Blue® Plus Network are the providers which PCP's may refer to.

MEDICARE ADVANTAGE (PPO) FREEDOM BLUE

Freedom Blue is a Medicare Advantage Preferred Provider Organization (PPO).
A provider must be Medicare Eligible in order to be a Medicare Advantage Provider (PPO) participating provider. Providers must agree to the terms outlined in the Medicare Advantage PPO contract. If a provider elects not to participate in the Medicare Advantage PPO they must submit the request in writing to MSBCBS.

MEDICARE ADVANTAGE PRIVATE FEE FOR SERVICE (PFFS)

Although the Medicare Advantage PFFS product shares the FreedomBlue name it is different from the FreedomBlue PPO product. FreedomBlue PFFS is a non-network plan with no contracted providers that allows a member to see any licensed Medicare eligible professional provider and be treated at any facility that is eligible to receive Medicare payment, as long as the provider and/or facility has not opted out of the Original Medicare program and accepts the plan's Terms and Condition of Participation. The plan is also available nationwide to retirees of employer groups who offer FreedomBlue PFFS benefit options.

WEST VIRGINIA SMALL BUSINESS PLAN

West Virginia Small Business Plan is a managed care product that MSBCBS provides to uninsured small businesses providing comprehensive health insurance coverage for their employees. A provider must be in all MSBCBS provider networks in order to be a West Virginia Small Business Plan provider. A provider may choose not to participate in the WVSBP by submitting an OPT-out letter to the director of PEIA by the requested deadline provided by PEIA on an annual basis.

For further network obligations and requirements please refer to the Provider Manual or contact the Department of Provider Relations at 1-800-798-7768 or your assigned External Provider Relations Representative.