

PROVIDER MANUAL

PPO USA NETWORK

Updated 3/11

**IMPORTANT CREDENTIALING INFORMATION
AND
RIGHTS FOR PARTICIPATING PROVIDERS**

Once you have been initially accepted in our PPO USA Network, you will be considered to be approved in the recredentialing process we perform every three years unless you are otherwise notified by GEHA. You must continue to meet or exceed our credentialing criteria in order to remain in the network. Material adverse credentialing information received by the networks during your recredentialing process and/or any ongoing monitoring of credentials for you will be considered by our Peer Review Committee and/or Medical Director in accordance with our Credentialing Legal Policies and Procedures.

You will be notified in writing of any change in your status of participation in our network, and you may have the right to appeal certain adverse changes in your status. Your network participation appeal rights are included in our Network Policies and Procedures Policy No. 1, Network Appeals and Grievances, which is included in our Provider Manual. GEHA has the right to determine the composition of its PPO USA Network and any subset thereof.

You have the right to correct any missing, incorrect or conflicting credentialing information that we receive about you. If we determine that you have missing, incorrect or conflicting information, we will notify you in writing within 30 days of our determination. You should notify us in writing by email, facsimile or regular mail of the additional information about your credentials and make sure you send it to the contact person identified in our letter to you. You may also notify us by telephone and we will create a written summary of the information you provide in your call. Any additional information you provide to us will be considered in our credentialing process and placed in your credentialing file.

**IMPORTANT CREDENTIALING INFORMATION
ABOUT
DELEGATED CREDENTIALING**

If GEHA delegates the credentialing process to a third party entity (“Delegated Credentialing Entity”), the following provisions shall be deemed to be included in the Participating Provider Agreement beginning January 1, 2011:

Delegated Credentialing Entity Credentialing and Recredentialing.

1. By virtue of this Agreement and upon GEHA’s review and approval of Delegated Credentialing Entity’s credentialing procedures, and upon Delegated Credentialing Entity’s agreement that it shall perform services in accordance with GEHA’s credentialing requirements, GEHA delegates the credentialing function to Delegated Credentialing Entity for the Delegated Credentialing Entity Participating Providers, while retaining the ultimate credentialing decisions to GEHA. Delegated Credentialing Entity shall maintain current and complete credentialing files for each of the Participating Providers as required by the Delegated Credentialing Entity’s approved credentialing procedures submitted to GEHA. As a condition of this Agreement, Delegated Credentialing Entity agrees to attach to the Participating Provider Agreement its credentialing procedures, including any agreements by which Delegated Credentialing Entity delegates all or part of its credentialing responsibility, and further including any and all revisions to such credentialing procedures upon occurrence. If Delegated Credentialing Entity further delegates all or part of the credentialing responsibility to another party after this Agreement is executed, Delegated Credentialing Entity shall notify GEHA in writing prior to such delegation, and such delegation shall be subject to the terms of this Agreement and in accordance with national accrediting standards that GEHA is required to meet.
2. Delegated Credentialing Entity agrees that for the term of this Agreement, all Participating Providers shall meet all requirements set forth in the Delegated Credentialing Entity’s credentialing policies, as previously approved by GEHA. Upon request, Delegated Credentialing Entity agrees to confirm the credentialing status of a Participating Provider and provide to GEHA in a timely manner the information necessary for GEHA to make a decision regarding the network status of a Participating Provider. In the event a Participating Provider does not continue to meet the Delegated Credentialing Entity’s credentialing policies, Delegated Credentialing Entity shall notify GEHA immediately upon becoming aware of such noncompliance. Such Participating Provider shall immediately cease rendering services to Covered Persons. Notwithstanding anything herein or any subsequently adopted procedure to the contrary, GEHA reserves the right to terminate, suspend, revoke, or reduce the membership or privileges of any Participating Provider as provided in the Credentialing and Recredentialing Policies and Procedures, and Delegated Credentialing Entity agrees to cooperate with GEHA to implement the foregoing.
3. Delegated Credentialing Entity shall promptly notify GEHA of any material change in the Delegated Credentialing Entity’s ability to perform delegated credentialing, which may include loss or replacement of the senior clinical staff person or prolonged interruption of services due to any cause. Should the Delegated Credentialing Entity credentialing procedures approved by GEHA no longer conform with GEHA’s credentialing requirements, GEHA may notify Delegated Credentialing Entity in writing of corrections to be made to Delegated Credentialing Entity’s credentialing program to bring it into compliance within a specific period of time or GEHA may withdraw this delegation at any time upon advance written notice to Delegated Credentialing Entity. If Delegated Credentialing Entity does not make the requested corrections to its credentialing program within the specified timeframe or if GEHA withdraws its delegation, each Participating Provider will then be required to meet GEHA’s Credentialing and Recredentialing Criteria in order to continue to participate under this Agreement.

4. GEHA is responsible for the oversight of its Delegated Credentialing Entities. As such, GEHA must ensure that Delegated Credentialing Entity is continuously in compliance with GEHA's credentialing requirements and may conduct surveys of the Delegated Credentialing Entity or require Delegated Credentialing Entity to submit periodic reports to GEHA regarding the performance of its delegated credentialing responsibilities. Except as required by applicable federal or state law, GEHA agrees to maintain in strict confidence all information it will review in the course of its onsite credentialing reviews, as listed below. Delegated Credentialing Entity agrees and shall cause its Participating Providers to agree to allow GEHA or its agents or designees access, at least every three (3) years and upon ten (10) business days prior notice during normal business hours, to a random sample of complete credentialing files administered by Delegated Credentialing Entity on behalf of GEHA. The sample size will be ten percent (10%) of such files, but in no case less than ten (10) files or more than thirty (30) files.
5. If GEHA delegates the credentialing function to Delegated Credentialing Entity and Delegated Credentialing Entity further delegates the credentialing function to a third party, such third party shall be considered a subdelegated credentialing entity under this Agreement. Such subdelegated credentialing entity shall be subject to all of the terms, conditions and limitations imposed by this Agreement for a delegated credentialing entity. Delegated Credentialing Entity hereby attests that it utilizes the services of such third party for purposes of credentialing all of its Participating Providers and will provide GEHA with a copy of such third party's credentialing policies to attach to this Agreement. If Delegated Credentialing Entity does not subdelegate its credentialing process to a third party, this Section 5 shall be deemed to be "not applicable."
6. If GEHA does not delegate the credentialing function to Delegated Credentialing Entity under this Agreement, Sections 1 through 5 above shall be deemed to be "not applicable" and GEHA will credential Participating Providers as required by GEHA's Credentialing and Recredentialing Policies and Procedures.
7. Delegated Credentialing Entity's delegated or subdelegated credentialing functions under this Agreement are considered to be approved by GEHA and/or any Participating Providers credentialed by GEHA under this Agreement shall be considered to be recredentialed by GEHA unless Delegated Credentialing Entity is otherwise notified in writing by GEHA.

Delegated or subdelegated credentialing services performed by Delegated Credentialing Entity must be performed in accordance with GEHA's credentialing requirements and URAC standards.

Practitioners

- 1) Primary Source Verify license
- 2) Primary Source Verify highest level of education/training/or
- 3) Primary Source Verify board certification
- 4) Copy of DEA certificate if applicable
- 5) State licensing board sanctions – NPDB
- 6) Medicare/Medicaid sanctions - OIG
- 7) Sanction history (5 Years)
- 8) Copy of Insurance face sheet
- 9) Five year work history

Facilities/Hospitals (if applicable)

- 1) Copy of state licensure (if facility type is eligible for a state license)
- 2) Medicare/Medicaid Sanctions - OIG
- 3) State licensing sanctions - NPDB
- 4) Copy of liability insurance face sheet or declaration sheet
- 5) Copy of accreditation status, if applicable

Timeframes for practitioners, hospitals, and facilities

- 1) Recredentialing cycle every three years
- 2) Application signed and dated not more than 180 days prior to credentialing committee review
- 3) Primary and secondary source verification is not collected more than 6 months prior to review
- 4) All documents must be current at the time that it goes to the Credentialing committee

Committee

- 1) Dates and documentation

Ongoing Monitoring

- 1) Reports of disciplinary actions published by state licensing boards and the US department of Health and Human Services, Office of Inspector General (OIG), or National Practitioner Data Bank (NPDB)

Policy and Procedures

- 1) Review of policy and procedures

Application

- 1) Completed application
- 2) Signed and dated application with attestation that the information submitted is complete and accurate

Delegated Credentialing Entity shall submit a copy of its or its third party's credentialing policies and procedures to GEHA on an annual basis and upon request by GEHA. If GEHA determines Delegated Credentialing Entity's or its third party's credentialing policies and procedures no longer meet GEHA's credentialing requirements and URAC standards, GEHA will notify Delegated Credentialing Entity and Delegated Credentialing Entity will have sixty (60) calendar days to make corrections or require its third party to make corrections to the identified problems or GEHA may withdraw its delegation or subdelegation to Delegated Credentialing Entity of the credentialing function.

If Delegated Credentialing Entity further delegates organizational functions pursuant to this Agreement, those functions shall be subject to the terms of this Agreement and in accordance with URAC standards.

WRITTEN AGREEMENTS BETWEEN PPO USA NETWORK AND PROVIDERS

The following items may not be included in the written agreements for the network, are hereby incorporated by reference, and are available to all participating providers upon request.

1. Conditions for participation as a participating provider – All providers must meet GEHA’s minimum professional requirements and credentialing criteria in order to become a participating provider in the network (*see attached*).
2. Obligations and responsibilities of the organization and the participating provider, including any obligations for the participating provider to participate in the organization’s management, complaint, or other programs (*see attached*).
3. Events that may result in the reduction, suspension, or termination of network participation privileges (*see attached*).
4. The specific circumstances under which the network may require access to consumers’ medical records as part of the organization’s programs or health benefits (*see attached*).
5. Health care services to be provided and any related restrictions (*see attached*).
6. Requirements for claims submission and any restrictions on billing of consumers (*see attached*).
7. Mechanisms for dispute resolution by participating providers (*see attached*).
8. Term of the contract and procedures for terminating the contract (*see attached*).
9. Requirements with respect to preserving the confidentiality of patient health information (*see attached*).
10. Prohibitions regarding discrimination against consumers (*see attached*).

GEHA'S MINIMUM PROFESSIONAL REQUIREMENTS FOR PPO USA NETWORK

1. All providers must either sign a written agreement to join the network or have a duly authorized signature party sign a written agreement on behalf of the provider to join the network.
2. All providers must have sufficient staffing and equipment and appropriate office hours necessary to provide Covered Services.
3. Participating Hospitals may substitute Medicare Certification and State Licensure for Certification by the Joint Commission on the Accreditation of Healthcare Organizations.
4. With the exception of providers in United States territories, all providers must carry professional liability insurance, which at a minimum must meet any requirements imposed by state law.
5. Providers must submit claims prior to each Plan's timely filing deadline in order for such claims to be considered for payment.
6. Providers must provide care and services which are of a quality consistent with generally accepted standards and practices in the medical community and comply with the Network's quality assurance program.
7. Providers must be credentialed by the network or credentialed by a contracting party, and must be eligible to participate in Medicare and a state Medicaid program in order to participate in the network. Providers credentialed by the network are recertified every three years. Providers must cooperate with the credentialing and recertification processes.
8. An application to the Network shall be considered complete when a completed and signed Participating Provider Agreement and a completed and signed application, along with the supporting documentation, have been received by the Network.
9. Providers shall use their best judgment with respect to patient care in the provision of Covered Services to a Covered Person.
10. Providers shall notify the Network of changes of name, address, telephone number, tax identification number, office hours, panel closings, changes in practitioners at an office or reduction of services to PPO USA Network by completing a "Contact Us" form at www.ppousanetwork.com or by sending the information in writing to the following address GEHA/PPO USA Network, 310 Northeast Mulberry Street, Lee's Summit, MO 64086, phone number (800) 821-4991; or by facsimile to (816) 257-4437.

QUALITY ASSURANCE PROGRAM

The PPO USA Network will review issues or member complaints regarding a Participating Provider who is engaged in behavior or is practicing in a manner that appears is not of a quality consistent with generally accepted standards and practices in the medical community. In response to quality assurance issues or member complaints, the Network may 1) send a Letter of Concern to the Provider; 2) monitor the Provider; 3) recredential the Provider sooner than the next regularly scheduled date; 4) schedule an onsite visit with the Provider; 5) determine that no action is needed; 6) suspend a Provider; or 7) recommend the Provider be terminated. If, in the opinion of the Medical Director, a Provider is engaged in behavior or is practicing in a manner that appears to pose a significant risk to the health, welfare, or safety of consumers, the Network may suspend, pending investigation, a Provider's participation in the Network (see Network Appeals/Grievances policies and procedures).



Initial Credentialing Criteria

1. **Provider Application** -- A completed, signed, and dated PPO USA Provider Application must be submitted. The application must be signed and dated 180 days or less prior to the Credentialing Peer Review.

If the provider submits a standardized application form, it must contain all information according to the credentialing criteria including the last page of PPO USA's application including the provider's signature.

2. **Verification** – All documentation must be provided with the Application, which includes primary or secondary source verification as follows:

- a. **State License** – The applicant must have a current, active, and valid state medical license, which is primary source verified by a state licensing board. License verification must include the expiration date of the license and the date it was verified. The license must be in effect at the time of the credentialing decision. This is subject to individual state requirements.

Primary source verification may include state licensing board, school/residency/training program, board certification via the AMA master file, AOA master file, ABMS, the Education Commission for Foreign Graduates, or Special Board of Registry.

If a state licensing investigation or action has ever been taken against the physician, or if a license has ever been or is currently revoked or suspended, this *dictates review by the Peer Review Committee*.

If a state licensing investigation is dismissed without action *Peer Review is not required*.

- b. **Board Certification, if applicable or highest level of education.** - Certification is verified by accessing the American Board of Medical Specialties from Certifacts On-line Verification Program via the internet, by contacting the applicable board or confirmation is verified directly from the specialty board. The certification must be in effect at the time of the credentialing decision.

NOTE: Other provider types, including but not necessarily limited to, PT, OT, ST may have specialty certificates, and therefore primary source verification of their certification is required if applicable.

- c. **Education/Training** – Primary source verification of applicants most recently completed, highest level of education, of Residency/Internship/Fellowship if not Board Certified. Verified by primary source from a licensing entity, certification board, or highest level of education, via AMA or AOA profile, letter from state licensing board or direct contact with the school.

Primary source verification may include state licensing board, school/residency/training program, board certification via the AMA master file, AOA master file, ABMS, the Education Commission for Foreign Graduates, or Special Board of Registry.

Incomplete verification of internship/fellowship/residency *dictates Peer Review*.

- d. **DEA Certificate, if applicable. Primary** source verified DEA by the National Technical Information Services (NTIS) or by a current copy that is valid at the time of the initial credentialing decision.

If a DEA licensing investigation or action has ever been taken against the physician, this *dictates further review by the Peer Review Committee.*

- e. **Malpractice Insurance** - Current and valid copy that is valid at the time of the initial credentialing decision.

If insurance cover sheet is submitted, then the cover sheet must include the name of the practitioner, the expiration date and the liability covered.

If the cover sheet does not include the name of the practitioner, then a photocopy of those covered under the plan must be submitted on a sheet that includes the insurer's letterhead.

If the provider does not carry professional liability insurance the application does not meet the credentialing criteria. If this is noted the credentialing process is *Automatically Stopped and a letter sent to the provider.*

If professional liability insurance has been denied, canceled, not renewed for unprofessional conduct, these *dictate review by the Peer Review Committee.*

United States territories (American Samoa, Guam, Northern Marianas, Puerto Rico and the Virgin Islands) may be exempt from professional liability insurance. If a provider resides in a United States territory and does not maintain professional liability insurance this *dictates review by the Peer Review Committee.*

3. **Admitting Privileges** -- Provider may or may not have admitting privileges; however, surrendered during investigation or action or suspension or limitation of hospital privileges will *dictate review by the Peer Review Committee.*
4. **Work History** -- Documentation of the immediately preceding five-year work history of the provider must be provided. If there is a gap of six months or more, explanation from the provider is required.
5. **All malpractice issues** during the prior five years must be taken into account in the evaluation of the provider for entry into the network. Verified by National Practitioner Data Bank (NPDB).

Malpractice cases that occur during a physician's internship or residency will be the only exception when the physician was under a licensed physician's supervision during that time period.

Peer Committee review will be required on all providers with malpractice issues involving: Two or more cases closed with payment and/or any one case with a settlement of \$500,000 or more.

6. **Conviction of a felony or misdemeanor under state or federal law** committed in the scope of the provider's professional duties *dictates review by the Peer Review Committee.*
7. **Provider is debarred or suspended by HCFA** from participation in government programs (e.g., Medicare or Medicaid). Verified by reviewing disciplinary actions published by the Office of Inspector General (OIG). If this is noted, the provider's Credentialing process is *Automatically Stopped.*
8. **Provider has chronic illness, physical defects or substance abuse** that would impair his or her ability to practice. If this is discovered, this *dictates review by the Peer Review Committee*

9. **Provider documents destroyed due to a disaster.** If this is discovered, this **dictates review by the Peer Review Committee.**
10. **Provider fails/refuses to submit all required credentialing information** within the 180-day credentialing process deadline. This will result in a deferment of the credentialing process.
11. **Quality Assurance issues-** If the provider has had any issues, this *dictates review by the Peer Review Committee.*
12. **The credentialing staff may dictate review by the Peer Review Committee Chairman** at their discretion.

NOTE: Once a provider has been approved by the PPO USA Peer Review Committee, receipt of the following types of additional information **will warrant immediate review by the Peer Review Committee:**

1. Medical and/or DEA Licensing Revoked and/or not in good standing.
2. Loss of Malpractice Liability Insurance for unprofessional conduct.

All other types of information (i.e.: updated licenses, additional education, insurance certificates, etc.) will be placed in the approved provider's PPO USA credentialing file and will be reviewed at the time the provider is recredentialled.

All documentation supporting the Application that is subject to expiration dates must be current and valid at the time of the Peer Review decision.

All documentation supporting the Application must be within 180 days of the applicant's signature on the attestation page.

All criteria listed above are subject to revisions and/or additions due to changes in federal and state laws, AMA guidelines and the Credentialing Standards of GEHA.

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Recredentialing Criteria

1. **Supporting Documentation** – All documentation must be provided, which includes primary or secondary source verification of the following:

- a. **State License** – The applicant must have a current, active, and valid state medical license, which is primary source verified with a licensing entity. The license must be in effect at the time of the recredentialing decision. This is subject to individual state requirements.

If a state licensing investigation or action has ever been taken against the physician, or if a license has ever been or is currently revoked or suspended, this *dictates review by the Peer Review Committee*.

If a state licensing investigation is dismissed without action *Peer Review is not required*.

- b. **Board Certification, if applicable or highest level of education** - Certification is verified by accessing the American Board of Medical Specialties Certifacts On-line Verification Program via the internet, or by contacting the applicable board.

If the provider has obtained board certification since the last credentialing period, or,

Prior board certification copy is expired.

- c. **Education/Training** – Primary source verification of applicants most recently completed, highest level of education , of Residency/Internship/Fellowship if not Board Certified. Verified by primary source from a licensing entity, certification board, or highest level of education , via internet, by contacting the applicable board.

If the provider has completed additional Residency, Internship, or Fellowship since last credentialing period.

- d. **DEA Certificate, if applicable.** - Primary source verify the DEA by the National Technical Information Services (NTIS) or by a current copy that is valid at the time of the recredentialing decision.

If a DEA licensing investigation or action has ever been taken against the physician, this *dictates further review by the Peer Review Committee*.

- e. **Malpractice Insurance** - Current and valid copy at the time of the recredentialing decision.

If insurance cover sheet is submitted, then the cover sheet must include the name of the practitioner, the expiration date and the liability covered.

If the cover sheet does not include the name of the practitioner, then a photocopy of those covered under the plan must be submitted on a sheet that includes the insurer's letterhead.

If the provider does not carry professional liability insurance the application does not meet the credentialing criteria. If this is noted the credentialing process is *Automatically Terminated and a letter sent to the provider.* .

If professional liability insurance has been denied, canceled, not renewed for unprofessional conduct, or the provider does not carry professional liability insurance these *dictate review by the Peer Review Committee*.

United States territories (American Samoa, Guam, Northern Marianas, Puerto Rico and the Virgin Islands) may be exempt from professional liability insurance. If a provider resides in a United States territory and does not maintain professional liability insurance this *dictates review by the Peer Review Committee*.

2. **Admitting Privileges**

If hospital privileges have been limited since the last credentialing period, this *dictates review by the Peer Review Committee*.

3. **All malpractice issues** during the prior five years must be taken into account in the evaluation of the provider for entry into the network. Verified by the National Practitioner Data Bank (NPDB).

Malpractice cases that occur during a physician's internship or residency will be the only exception when the physician was under a licensed physician's supervision during that time period.

Peer Committee review will be required on all providers with malpractice issues not previously reviewed involving: Two or more cases closed with payment and/or any one case with a settlement of \$500,000 or more.

4. **Conviction of a felony or misdemeanor under state or federal law** committed in the scope of the provider's professional duties *dictates review by the Peer Review Committee*.

5. **Provider is debarred or suspended by HCFA** from participation in government programs (e.g., Medicare or Medicaid) since the last credentialing period. If this is noted, the provider's Credentialing process is *Automatically Terminated*.

Routine monitor reports by reviewing disciplinary reports published by the Office of Inspector General on an ongoing basis. If it is noted that a provider is debarred or suspended by HCFA from participating in government programs, Credentialing process is *Automatically Terminated*.

6. **Provider has developed chronic illness, physical defects or substance abuse** that would impair his or her ability to practice since the last credentialing period. If this is discovered, this *dictates review by the Peer Review Committee*.

7. **Provider documents destroyed due to a disaster**. If this is discovered, this *dictates review by the Peer Review Committee*.

8. **Provider fails/refuses to submit all required recredentialing information** within the 180-day Recredentialing process deadline. This will result in a deferment of the recredentialing process.

9. **Quality Assurance issues-** If the provider has had any new issues not previously reviewed this *dictates review by the Peer Review Committee*.

10. **The credentialing staff may dictate review by the Peer Review Committee** at their discretion.

NOTE: Once a provider has been approved by the PPO USA Credentialing Committee, receipt of the following types of additional information **will warrant immediate review by the PPO USA Credentialing Committee Chairman:**

1. Medical and/or DEA Licensing Revoked and/or not in good standing.
2. Loss of Malpractice Liability Insurance for unprofessional conduct.

All other types of information (i.e.: updated licenses, additional education, insurance certificates, etc.) will be placed in the approved provider's PPO USA credentialing file and will be reviewed at the time the provider is **recredentialed**.

All documentation supporting the Application that is subject to expiration dates must be current and valid at the time of the Peer Review decision.

All documentation supporting the Application must be within 180 days of the applicant's signature on the attestation page.

All criteria listed above are subject to revisions and/or additions due to changes in federal and state laws, AMA guidelines and the Credentialing Standards of GEHA.

**OBLIGATIONS AND RESPONSIBILITIES
OF THE
PPO USA NETWORK AND PARTICIPATING PROVIDER**

The Participating Provider represents and warrants that s/he: (a) is in compliance with applicable laws, regulations, and rules that relate to his or her ability to provide services under the Agreement, including licensing laws and regulations; (b) is eligible to participate as a provider in the Medicare and Medicaid programs; (c) is licensed to prescribe prescription drugs, including any drugs that may be prescribed only under a valid DEA and state controlled drug program number(s); (d) meets all requirements imposed on him or her by the Agreement, including, but not limited to, Credentialing and Recredentialing Criteria; (e) ensures that all health professionals who practice under his or her supervision shall be licensed, board certified, or otherwise eligible, and continually meet all applicable local, state, and federal laws and regulations concerning professional licensing requirements; (f) will be in full compliance with the applicable provisions of the Health Insurance Portability and Accountability Act (HIPAA), and regulations promulgated thereunder, as they may be amended from time to time; (g) shall promptly notify GEHA of any change in information contained in Participating Provider's application or reapplication to become a Participating Provider during the term of the Agreement and any change in circumstance that causes any of the foregoing representations and warranties to no longer be accurate; (h) authorizes GEHA to contract with Payors, or with Entities on behalf of Payors, to make Participating Provider's services available to Payors upon the same terms and conditions that such services are made available to GEHA pursuant to this Agreement, unless otherwise specified in the Agreement; and (i) will remain in compliance with all of the foregoing requirements while the Agreement remains in effect.

Participating Provider shall immediately notify GEHA of, and provide GEHA with, all information pertaining to any disciplinary action, malpractice action, legal action or judgment against Participating Provider; settlement of any such action; any resignation, relinquishment, reduction, termination, or suspension of membership or clinical privileges at any hospital or other health care entity or organization; any adverse change in licensure status or Board certification of physician; any sanction by the Medicare or Medicaid programs; any guilty plea or conviction of a felony; any chronic illness, physical defect or substance abuse that would impair Participating Provider's ability to practice; any use of illegal drugs by Participating Provider; or Participating Provider's failure for any reason to meet the Credentialing Criteria or Recredentialing Criteria of GEHA. Participating Provider shall also promptly notify GEHA of any guilty plea or conviction of a felony, chronic illness, physical defect, or use of any illegal drugs or substance abuse that would impair the ability of Participating Provider to practice.

When GEHA or Payor is the primary Payor, the Participating Provider agrees that: (a) Except for the collection of any Copayments, Coinsurance and Deductibles, or for services not covered by the Payor, Participating Provider will accept the lesser of the applicable Fee Schedule or the Participating Provider's usual billed charge as payment in full and not balance bill Covered Persons for any amount in excess of the lesser of the Fee Schedule or the Participating Provider's usual billed charge; (b) The Fee Schedule applies to all services billed to the Payors by any other health care provider who legally uses the Federal Tax Identification Number designated to or used by the Participating Provider and who elects to participate with the PPO USA Network or the Medicare billing number used by the Participating Provider. All changes in Tax Identification Numbers for Participating Provider will be applied to Participating Provider's network status unless otherwise notified by Participating Provider; and (c) When Payor requires Covered Persons to pay copayments for certain Covered Services, it is the responsibility of the

Participating Provider to collect such amount, and it is the responsibility of the Covered Person to pay such amount at the time services are received.

In the event of insolvency of GEHA or Payor or other cessation of operations, benefits to Covered Persons will continue through the period for which the premium has been paid, if applicable, and benefits for Covered Persons confined in an inpatient facility continue until discharge. Participating Provider will cooperate in the transition of administrative duties and records to the succeeding company or provider, as the case may be. The liability of a party to the Agreement may not be transferred to another party or to Covered Persons. Nothing in this paragraph, however, shall in any way affect or limit Participating Provider's right or obligation to collect Deductibles, Coinsurance, or Copayments, as specifically provided in the Plan, or fees for non-Covered Services delivered to Covered Persons so long as Covered Persons are informed of their payment responsibility prior to the delivery of non-Covered Services. This provision shall survive the termination of the Agreement and is for the benefit of Covered Persons.

The Participating Provider shall have sufficient staffing and equipment and appropriate office hours necessary to provide Covered Services.

When a Covered Person requires a non-emergency hospital admission, Participating Provider agrees to secure authorization for such admission prior to the admission. In case an emergency admission occurs, Participating Provider agrees to notify GEHA or Payor.

Participating Provider shall make necessary and appropriate arrangements to assure the availability of Covered Services to Covered Persons who are patients of Participating Provider, on a twenty-four (24) hours per day, seven (7) days per week basis, including arrangements to assure coverage after hours.

Participating Provider agrees to cooperate, participate in, and comply with Policies and Procedures and in such review and service programs as may be established by GEHA or Payor.

The Participating Provider agrees to maintain all patient medical records in strictest confidence and not disclose any such patient information, except with the patient's written consent or as otherwise required by law. The Participating Provider shall maintain and preserve such records as required by applicable law and regulations.

Participating Provider and GEHA agree that Participating Provider shall maintain a physician/patient relationship with Covered Persons that are treated pursuant to the Agreement, and that Participating Provider shall be responsible for the quality and utilization of Covered Services provided pursuant to the Agreement. Participating Provider and GEHA agree that nothing in the Agreement shall limit or otherwise restrict Participating Provider's medical judgment with respect to Participating Provider's ultimate responsibility for patient care in the provision of medical services to a Covered Person or any other person.

Participating Provider agrees not to discriminate in the treatment of his/her Covered Persons or in the quality of services delivered to Covered Persons on the basis of race, color, creed, ancestry, sex, sexual orientation, age, religion, marital status, national origin, physical, mental or sensory disability, health status, type of medical benefit plan, or source of payment, including publicly financed programs, and to provide care and services which are of a quality consistent with generally accepted standards and practices in the medical community.

The Participating Provider agrees to maintain comprehensive general liability and malpractice insurance in amounts that conform to prevailing standards in the Participating Provider's industry and service area. Such amounts shall at least meet any minimum amounts required by state law(s). The Participating Provider agrees to notify GEHA within five (5) business days of its receipt of notice of any material adverse change in such coverage. GEHA, any other Payor or Entity, the Participating Provider or any of their respective employees or physicians shall not be liable for any negligence or intentional wrongdoing on the part of another or for any costs, expenses or attorneys' fees associated therewith.

The Participating Provider agrees that Payor may establish cost utilization programs and/or utilization management programs unique to Payor's Plan, such as, but not limited to, review of billed charges for upcoding, unbundling, overutilization and same day multiple surgeries. The Participating Provider agrees not to balance bill the Covered Person for any Payor reduction of billed charges as a result of such cost utilization programs. This provision does not affect the Participating Provider's right to appeal such reductions.

Participating Provider shall comply with and participate in any applicable appeal or grievance procedure available to Covered Persons, including Medicare appeal procedures and processes when Medicare is primary. At the request of Participating Provider, GEHA will cause its designee to represent Participating Provider at Payor's grievance hearings to the greatest extent possible. Participating Provider shall provide to GEHA all information related to such grievance procedures, including the outcome of such procedures.

Participating Provider agrees to allow GEHA, Payor, or their agents or designees, including utilization management personnel access, upon ten (10) business days prior notice and during normal business hours, to the applicable medical and billing records and information regarding Covered Services to Covered Persons for inspection and copying in such a manner as may be reasonably requested for purposes of evaluating Participating Provider's qualification and competence, utilization review, claims payment, and other administrative functions required hereunder. Participating Provider further agrees to allow periodic review of its offices and records by GEHA or Payor for compliance with applicable accreditation agencies, as required by an applicable government entity with authority to do so, in compliance with applicable law, including the state entity responsible for regulating the business of insurance where it has jurisdiction. Participating Provider consents to the release by GEHA of any information derived as a result of these activities to any employer of Participating Provider or any group with which he or she practices.

The Participating Providers agree to refund any overpayments, which were made by Payor to the Participating Provider, to Payor within thirty (30) calendar days of its receipt of Payor's notice of overpayment, and Payor agrees to remit to Participating Provider underpayment amounts within thirty (30) calendar days of its receipt of Participating Provider's notice of underpayment if it has been agreed upon by both parties that an underpayment has been made.

The Participating Provider agrees that GEHA, its subsidiaries, and other Payors may use the Participating Provider's name, office address and telephone numbers, practice information and other pertinent information about the Participating Provider in its marketing and directory information and materials and for regulatory purposes. The Participating Provider will provide notice to GEHA within ten (10) business days of changes that affect such information. Participating Provider shall not reference GEHA in any publicity, advertisements, notices, or promotional material or in any announcement to Covered Persons without prior written approval of GEHA. If a Participating Provider moves to another state after initial contracting, the Fee

Schedule will change to that applicable to the new state in which the Participating Provider will be practicing. If a Participating Provider moves or closes his or her office after initial contracting and the Participating Provider does not notify GEHA in writing, GEHA will make a good faith attempt to locate the Participating Provider; however, if GEHA is unable to locate the Participating Provider, this Agreement may be terminated by GEHA without written notice or cause.

The Participating Provider agrees to request, accept and maintain written assignment of benefits from Covered Persons and authorization to release medical records.

Participating Provider shall not knowingly employ any management staff or person who has been convicted of criminal offenses related to their involvement in Medicaid, Medicare, or social service programs under Title XX of the Social Security Act as amended.

Participating Provider agrees to comply with all applicable state and federal laws, rules and regulations. All information made available to Participating Provider in accordance with the requirements of applicable state or federal law shall be confidential and shall not be disclosed to any individual or entity not involved in the contracting entity, provider's practice or the administration of either without the prior written consent of GEHA.

GEHA agrees not to interfere or intervene and shall use best efforts to require other Payors not interfere or intervene in any manner in the diagnosis or treatment rendered by a Participating Provider to a Covered Person or with the communication between a Participating Provider and a Covered Person. Benefit determinations made by GEHA or a Payor shall not constitute interference.

GEHA shall administer and, in its sole discretion, determine the composition of the PPO USA Network and any subset thereof.

GEHA agrees to negotiate financial incentives with other Payors for its Covered Persons to use Participating Provider. GEHA will require other Payors to maintain at least a ten percent (10%) benefit differential or actuarial equivalent.

GEHA agrees to market its PPO USA Network to other Payors. GEHA will make its best efforts to bind other Payors and Entities to the terms of the Agreement including, but not limited to, health plan financial incentives, identification card provisions and provider directory availability for steerage to Participating Providers.

GEHA agrees to: (a) maintain an administrative staff to assist the Participating Provider and its staff members and to provide administrative reference materials to the Participating Provider; and (b) maintain a toll-free telephone number for the use of the Participating Provider and its staff members.

GEHA agrees to make available to its Covered Persons, other Payors, and Participating Providers a directory of Participating Providers who participate in the PPO USA Network. Directory information may be made available via paper or electronic mediums and/or toll-free telephone service. GEHA shall use its best efforts to provide current, accurate directory information.

GEHA agrees to arrange for the distribution of appropriate identification cards that will include the PPO USA Network logo and appropriate claim filing and eligibility inquiry information.

GEHA agrees to maintain any patient medical records in its possession in strictest confidence in accordance with applicable law and require the same provision in its contracts with other Payors.

Participating Provider does not consent to GEHA making available, either directly or indirectly, the Agreement to individuals or organizations who are not a Covered Person(s) with GEHA or Enrollee(s) with another Entity or Payor unless GEHA's or the appropriate Payor's health plan offers incentives to use the Participating Provider.

GEHA represents to Participating Provider that it carries comprehensive liability insurance against claims relating to its PPO USA Network.

GEHA shall not reference Participating Provider in any publicity, advertisements, or promotional material without prior written approval of Participating Provider.

GEHA shall comply and shall use best efforts to require other Payors to comply with all applicable federal and state laws, rules and regulations, including applicable provisions of the Health Insurance Portability and Accountability Act (HIPAA), and regulations promulgated thereunder, as they may be amended from time to time. With regard to the operation of the GEHA Plans in the Federal Employees Health Benefits Program, state law is specifically preempted and all matters relating to benefits or the payment of benefits by GEHA shall be resolved by the United States Office of Personnel Management ("OPM") in accordance with the disputed claims procedures in the Federal Employees Health Benefits Act and the regulations of the OPM. Any applicable federal and state laws, rules and regulations not specifically mentioned in the Agreement are contained in PPO USA Network's State Specific Policies & Procedures in its Provider Manual as may be amended from time to time, are hereby incorporated by reference into the Agreement, and are available at www.ppousanetwork.com or upon request. If the terms of the Agreement conflict with the State Specific Policies & Procedures established by GEHA with regard to applicable federal and state laws, rules and regulations, the State Specific Policies & Procedures shall prevail.

Participating Provider shall make its best efforts to submit a Clean Claim for Covered Services to GEHA, Payor, or Payor's agent within sixty (60) calendar days of the date the service is provided, and shall use the CMS-1500 form, or other forms or other medium as determined by GEHA or Payor to be appropriate.

The Participating Provider shall cooperate with GEHA and Payors in coordination of payments with other Payors. When Payor is primary according to standard coordination of benefits rules, Payor is required to pay the payments applicable under its Plan and the Agreement. When Payor is not primary, Payor is required to pay only those payments which, when added to benefits from other Payors, are equal to one hundred percent (100%) of the lesser of the Participating Provider's usual billed charge, agreed-upon charge with other Payors, or the Fee Schedule amount. This provision does not alter Participating Provider's right consistent with the Agreement, in such circumstances, to seek and obtain payment from sources other than Payor and Covered Person.

Except where subrogation or coordination of benefits applies, GEHA or Entities shall make all payments due to the Participating Provider with respect to the GEHA Plan within thirty (30) days following receipt of a Clean Claim. If a Clean Claim is not paid within forty-five (45) days of receipt by GEHA, no discount shall be taken. Except for the GEHA Plan, GEHA shall not be responsible or liable for any claims decision or for the payment of any claims for Covered Services provided by a Participating Provider to a Covered Person who is entitled to benefits payable under any Plan other than the GEHA plan, which operates pursuant to FEHBA. GEHA

shall not be an insurer, guarantor, or underwriter of the responsibility or liability of any Payor to provide payments pursuant to any Plan.

Payor shall provide to the Participating Provider an EOB that contains pertinent information regarding claims payment. GEHA will submit and will use its best efforts to require other Payors to submit an explanation of benefits or remittance advice that identifies the contractual source of any discount to the Participating Provider.

The initial term of the Agreement (“Initial Term”) shall commence on the Effective Date of the Agreement and shall expire on December 31 immediately preceding the Anniversary Date. The Agreement shall automatically renew on the Anniversary Date and on each January 1 thereafter for a period of twelve months (“Renewal Term”) unless either party shall give written notice of its intent to terminate the Agreement to the other party at least sixty (60) calendar days prior to the end of the Initial Term or Renewal Term. If this Agreement is terminated at the end of the then current term or if a Participating Provider voluntarily terminates from the PPO USA Network, the Participating Provider shall not be entitled to the procedural rights set forth in the Network Appeals/Grievances policy.

The Agreement may be terminated at any time without cause by either party upon at least sixty (60) calendar days prior written notice. Termination shall be effective on the last day of the month in which the sixty (60) day notice requirement is met.

A Participating Provider’s participation in the PPO USA Network shall be automatically terminated as described herein as of the date of the occurrence of the event described herein. This action shall be final except when a bona fide dispute exists as to whether the circumstances have occurred. No provider shall be entitled to the procedural rights set forth in the Network Appeals/Grievances policy as the result of an automatic termination imposed pursuant to this Section. (a) The Participating Provider’s license/authorization to practice or to prescribe controlled substances is currently revoked in any state in which the Participating Provider is or will be providing services pursuant to this Participating Provider Agreement. (b) The Participating Provider has been finally adjudicated and found guilty, or entered a plea of guilty or nolo contendere, in a criminal prosecution under the laws of any state or of the United States, for any felony or any offense reasonably related to the qualifications, functions or duties of the medical profession, for any offense an essential element of which is fraud, dishonesty or an act of violence. (c) The Participating Provider has been excluded, debarred, suspended or otherwise prohibited from participation in any state or federal health care reimbursement program including Medicare, Medicaid, TriCare or FEHBP. (d) The Participating Provider fails to have, carry or maintain professional liability insurance as required by GEHA.

GEHA may terminate the Agreement immediately for any of the following reasons: (a) Any falsification of any information on the Participating Provider’s application submitted to GEHA or fraud committed on any documentation; or (b) Any finding of unlawful or unprofessional conduct, as defined by state or federal law(s); or (c) Institution of bankruptcy, receivership, insolvency, liquidation or other similar proceedings by or against the Participating Provider; or (d) Any finding that a Participating Provider committed professional misconduct or caused a patient harm; or (e) Membership in the PPO USA Network and/or privileges granted to Participating Provider are terminated, revoked, restricted, suspended, discontinued or not renewed pursuant to GEHA Credentialing and Recredentialing Policies and Procedures; or (f) Noncompliance with HIPAA.

Except as otherwise provided, the Agreement may be terminated if there is a default in the performance of the terms and conditions of the Agreement which default has not been cured within sixty (60) calendar days following the effective date of written notice of such default. The written notice of default shall constitute notice of termination. Nothing in the Agreement shall be construed to limit either party's lawful remedies in the event of default of the Agreement.

The Agreement may be terminated upon sixty (60) calendar days prior written notice by GEHA to Participating Provider in the event Participating Provider rejects an amendment made to the Agreement by GEHA pursuant to a change in state or federal law.

Except as otherwise provided, the Agreement may be terminated if there is a default in the performance of the terms and conditions of this Agreement which default has not been cured within sixty (60) calendar days following the effective date of written notice of such default. The written notice of default shall constitute notice of termination. Nothing in the Agreement shall be construed to limit either party's lawful remedies in the event of default of this Agreement.

Unless termination is without cause, written notice of termination shall include an explanation of why the Agreement is being terminated. In the case of termination of Participating Provider by GEHA, such notice shall include notice of any right to an appeal that may be available to Participating Provider if such notice is required by Participating Provider's state law.

Upon the termination of the Agreement by either party for any reason, whether for cause or not for cause, whether voluntary or involuntary, Participating Provider shall: (a) continue to fulfill all of his/her obligations with respect to Covered Persons under Participating Provider's care as of the date of termination until the current course of treatment is complete, until discharge if Covered Person is in the midst of receiving inpatient care, until care of the Covered Person is transferred to another Participating Provider, or as otherwise required by state or federal law. Participating Provider shall be paid for such services in accordance with the provisions of the Plan, and each Plan will allow Covered Persons to continue receiving care for sixty (60) days from the date a Participating Provider is terminated without cause by GEHA, if applicable. Covered Persons shall not be liable to Participating Provider for any amounts owed for such services, other than deductibles or copayment amounts or for services not covered by the Plan, as specifically provided in the Plan. GEHA shall use reasonable efforts in locating another Participating Provider to treat such Covered Persons so that upon termination of the Agreement, Participating Provider may cease providing services to Covered Persons under the Agreement as soon as possible. GEHA, Payors and Participating Provider agree to adhere to any applicable state or federal laws with respect to termination; (b) immediately discontinue use of any and all signs, plaques, letterheads, forms or other materials identifying Participating Provider as a member of PPO USA Network; and (c) use best efforts to immediately disclose to each Covered Person in Participating Provider's care and to GEHA the possible adverse economic consequences such as the individual's responsibility to pay for services if he or she continues to receive care from the Participating Provider after Participating Provider's termination. GEHA shall have the right to waive any of the obligations of Participating Provider in this Section.

GEHA and Participating Provider agree to abide by the laws of any applicable state which may apply to termination.

The Participating Provider agrees that: (a) payment of benefits for Covered Services shall be the sole remedy in any dispute with GEHA or other Payors concerning nonpayment of benefits for such Covered Services, should the Participating Provider prevail in any such dispute; and (b) no Payor shall be liable for any damages of any kind or nature, legal fees or any other expenses

incurred as a result of claims disputes with another Payor. Participating Provider hereby waives any right to collect any such damages from GEHA and other Payors.

The parties agree that each has developed certain trademarks, service marks, membership data, processes, procedures and information that are proprietary to it. The parties agree that neither shall sell, use or distribute any such proprietary information, except as required by the performance of the Agreement, without the prior written consent of the affected party. The parties agree to cease use of such proprietary information upon termination of the Agreement.

Participating Provider acknowledges that GEHA develops and maintains a non-risk bearing network, PPO USA Network, and makes it available to Payors for access by Covered Persons. Participating Provider acknowledges and accepts that the PPO USA Network is not an insurer, indemnifier or provider of health care benefits. GEHA and the Participating Provider agree that both parties shall at all times be acting and performing as independent contractors. The Agreement shall not be construed to create any relationship of employer and employee, partners, joint venturer or principal and agent.

The Agreement and attached Exhibit(s) represent the entire agreement and understanding between GEHA and the Participating Provider. GEHA may amend the Agreement by providing prior written notice to Participating Provider. Such amendment shall be deemed accepted by the Participating Provider unless Participating Provider provides written notice of nonacceptance to GEHA within thirty (30) days of Participating Provider's receipt of such amendment. Notwithstanding any other provision of this Section, the Agreement shall automatically be amended to comply with changes in state or federal law. Except as provided above, no amendment to the Agreement shall be valid unless it is in writing and duly executed by GEHA and Participating Provider.

Except for website notices, notices shall be written and personally delivered, effective on delivery, or sent by United States mail, postage prepaid, effective on the fifth (5th) day following the date deposited in the mail, or by email, addressed to the parties listed under the signature block of the Agreement, or to any other name or address specified in writing by such party. Website notices will be posted on GEHA's PPO USA Network website at www.ppousanetwork.com. GEHA will accept changes to Participating Provider's license or credentialing information, malpractice insurance or other practice information in writing through its website form at www.ppousanetwork.com under "Contact Us," by facsimile at (816) 257-4437, or by regular mail at the address below the signature block of this Agreement.

If any provision of the Agreement is found to be invalid or unenforceable, the remainder of the provisions shall remain in full force and effect.

Nothing in the Agreement shall be construed to prevent either GEHA or the Participating Provider from entering into similar agreements with other Payors or providers.

GEHA shall be permitted to license its PPO USA Network to other Entities or Payors directly or through GEHA's wholly-owned subsidiary, PPO USA, Inc. Except for assigning the Agreement to PPO USA, Inc., the Agreement may not be assigned without the express written consent of GEHA and the Participating Provider. In addition, the rights and responsibilities under this Agreement may not be assigned or delegated by Participating Provider without the written consent of GEHA.

In the event that any dispute arises with regard to the performance or interpretation of any of the provisions of the Agreement, the parties agree to use best efforts to work together to resolve any such disputes. In the event that a dispute cannot be resolved between GEHA and the Participating Provider, such disputes shall be settled by arbitration in accordance with the arbitration rules of the American Health Lawyers Association Alternative Dispute Resolution Service, or its successor, in effect on the date the claim arose. Demand for arbitration shall be within thirty (30) calendar days after the claim or controversy has arisen, but in no event after the date when institution of legal or equitable proceedings based upon such claim or controversy would be barred by any applicable statute of limitations. Failure to timely institute arbitration shall be an absolute bar to the institution of any proceedings regarding such controversy or claim, and a waiver thereof. A single arbitrator shall be selected in accordance with the procedures of the American Health Lawyers Association Alternative Dispute Resolution Service. Arbitration shall take place in Lee's Summit, Missouri. Neither party shall cease or diminish its performance under the Agreement pending dispute resolution. The arbitrator shall be authorized to apportion the costs of arbitration, including attorneys' fees, as part of the award, taking into consideration which, if any, party is the prevailing party in such arbitration. Judgment upon the award rendered by the arbitrator shall be binding, enforceable and final and may be entered in any court having jurisdiction thereof. The Participating Provider agrees that causes of action for medical malpractice and disputes regarding benefits or the payment of benefits for services provided to GEHA Covered Persons are excluded from this provision. GEHA Covered Persons are participants in the Federal Employees Health Benefits Program, and benefit matters for such participants shall be resolved by the United States Office of Personnel Management ("OPM") in accordance with the disputed claims procedures in the Federal Employees Health Benefits Act and the regulations of the OPM. Reinstatement to the PPO USA Network shall be the sole remedy in any dispute concerning network participation status, should the Participating Provider prevail in any such dispute.

The Agreement shall bind and benefit GEHA and the Participating Provider and their respective successors or assigns. However, the parties have not created and do not create by the Agreement any rights in third parties, including, but not limited to, Covered Persons and Payors.

The Agreement shall apply to all health care services and supplies that are provided to a Covered Person prior to the date of termination of the Agreement by either party.

To the extent that this Agreement allows for sub-contracting with providers and facilities, all sub-contracts will be subject to the terms of this Agreement.

The Agreement shall be governed by and construed in accordance with the laws of the State of Missouri and any applicable federal law(s). The substantive law of Missouri shall solely govern the Agreement and no cause of action not specifically recognized in the State of Missouri shall be implied or construed to exist.

**EVENTS THAT MAY RESULT IN THE REDUCTION, SUSPENSION,
OR TERMINATION OF
PPO USA NETWORK PARTICIPATION PRIVILEGES**

The initial term of the Agreement (“Initial Term”) shall commence on the Effective Date of the Agreement and shall expire on December 31 immediately preceding the Anniversary Date. The Agreement shall automatically renew on the Anniversary Date and on each January 1 thereafter for a period of twelve months (“Renewal Term”) unless either party shall give written notice of its intent to terminate the Agreement to the other party at least sixty (60) calendar days prior to the end of the Initial Term or Renewal Term. If this Agreement is terminated at the end of the then current term or if a Participating Provider voluntarily terminates from the PPO USA Network, the Participating Provider shall not be entitled to the procedural rights set forth in the Network Appeals/Grievances policy.

The Agreement may be terminated at any time without cause by either party upon at least sixty (60) calendar days prior written notice. Termination shall be effective on the last day of the month in which the sixty (60) day notice requirement is met.

A Participating Provider’s participation in the PPO USA Network shall be automatically terminated as described herein as of the date of the occurrence of the event described herein. This action shall be final except when a bona fide dispute exists as to whether the circumstances have occurred. No provider shall be entitled to the procedural rights set forth in the Network Appeals/Grievances policy as the result of an automatic termination imposed pursuant to this Section. (a) The Participating Provider’s license/authorization to practice or to prescribe controlled substances is currently revoked in any state in which the Participating Provider is or will be providing services pursuant to this Participating Provider Agreement. (b) The Participating Provider has been finally adjudicated and found guilty, or entered a plea of guilty or nolo contendere, in a criminal prosecution under the laws of any state or of the United States, for any felony or any offense reasonably related to the qualifications, functions or duties of the medical profession, for any offense an essential element of which is fraud, dishonesty or an act of violence. (c) The Participating Provider has been excluded, debarred, suspended or otherwise prohibited from participation in any state or federal health care reimbursement program including Medicare, Medicaid, TriCare or FEHBP. (d) The Participating Provider fails to have, carry or maintain professional liability insurance as required by GEHA.

GEHA may terminate the Agreement immediately for any of the following reasons: (a) Any falsification of any information on the Participating Provider’s application submitted to GEHA or fraud committed on any documentation; or (b) Any finding of unlawful or unprofessional conduct, as defined by state or federal law(s); or (c) Institution of bankruptcy, receivership, insolvency, liquidation or other similar proceedings by or against the Participating Provider; or (d) Any finding that a Participating Provider committed professional misconduct or caused a patient harm; or (e) Membership in the PPO USA Network and/or privileges granted to Participating Provider are terminated, revoked, restricted, suspended, discontinued or not renewed pursuant to GEHA Credentialing and Recredentialing Policies and Procedures; or (f) Noncompliance with HIPAA.

Except as otherwise provided, the Agreement may be terminated if there is a default in the performance of the terms and conditions of the Agreement which default has not been cured within sixty (60) calendar days following the effective date of written notice of such default. The

written notice of default shall constitute notice of termination. Nothing in the Agreement shall be construed to limit either party's lawful remedies in the event of default of the Agreement.

The Agreement may be terminated upon sixty (60) calendar days prior written notice by GEHA to Participating Provider in the event Participating Provider rejects an amendment made to the Agreement by GEHA pursuant to a change in state or federal law.

If a Participating Provider moves or closes his or her office after initial contracting and the Participating Provider does not notify GEHA in writing, GEHA will make a good faith attempt to locate the Participating Provider; however, if GEHA is unable to locate the Participating Provider, this Agreement may be terminated by GEHA without written notice or cause.

**SPECIFIC CIRCUMSTANCES UNDER WHICH THE PPO USA NETWORK
MAY REQUIRE ACCESS TO CONSUMERS' MEDICAL RECORDS
AS PART OF THE NETWORK'S PROGRAMS OR HEALTH BENEFITS**

Participating Provider agrees to allow GEHA, Payor, or their agents or designees, including utilization management personnel access, upon ten (10) business days prior notice and during normal business hours, to the applicable medical and billing records and information regarding Covered Services to Covered Persons for inspection and copying in such a manner as may be reasonably requested for purposes of evaluating Participating Provider's qualification and competence, utilization review, claims payment, and other administrative functions required hereunder. Participating Provider further agrees to allow periodic review of its offices and records by GEHA or Payor for compliance with applicable accreditation agencies, as required by an applicable government entity with authority to do so, in compliance with applicable law, including the state entity responsible for regulating the business of insurance where it has jurisdiction. Participating Provider consents to the release by GEHA of any information derived as a result of these activities to any employer of Participating Provider or any group with which he or she practices.

The Participating Provider agrees to request, accept and maintain written assignment of benefits from Covered Persons and authorization to release medical records.

**HEALTH CARE SERVICES TO BE PROVIDED AND
ANY RELATED RESTRICTIONS FOR THE PPO USA NETWORK**

Participating Provider and GEHA agree that Participating Provider shall maintain a physician/patient relationship with Covered Persons that are treated pursuant to the Agreement, and that Participating Provider shall be responsible for the quality and utilization of Covered Services provided pursuant to the Agreement. Participating Provider and GEHA agree that nothing in the Agreement shall limit or otherwise restrict Participating Provider's medical judgment with respect to Participating Provider's ultimate responsibility for patient care in the provision of medical services to a Covered Person or any other person.

Participating Provider agrees not to discriminate in the treatment of his/her Covered Persons or in the quality of services delivered to Covered Persons on the basis of race, color, creed, ancestry, sex, sexual orientation, age, religion, marital status, national origin, physical, mental or sensory disability, health status, type of medical benefit plan, or source of payment, including publicly financed programs, and to provide care and services which are of a quality consistent with generally accepted standards and practices in the medical community.

**REQUIREMENTS FOR CLAIMS SUBMISSION AND
ANY RESTRICTIONS ON BILLING OF CONSUMERS
FOR PPO USA NETWORK**

When GEHA or Payor is the primary Payor, the Participating Provider agrees that: (a) Except for the collection of any Copayments, Coinsurance and Deductibles, or for services not covered by the Payor, Participating Provider will accept the lesser of the applicable Fee Schedule or the Participating Provider's usual billed charge as payment in full and not balance bill Covered Persons for any amount in excess of the lesser of the Fee Schedule or the Participating Provider's usual billed charge; (b) The Fee Schedule applies to all services billed to the Payors by any other health care provider who legally uses the Federal Tax Identification Number designated to or used by the Participating Provider and who elects to participate with the PPO USA Network or the Medicare billing number used by the Participating Provider. All changes in Tax Identification Numbers for Participating Provider will be applied to Participating Provider's network status unless otherwise notified by Participating Provider; and (c) When Payor requires Covered Persons to pay copayments for certain Covered Services, it is the responsibility of the Participating Provider to collect such amount, and it is the responsibility of the Covered Person to pay such amount at the time services are received.

The Participating Provider agrees that Payor may establish cost utilization programs and/or utilization management programs unique to Payor's Plan, such as, but not limited to, review of billed charges for upcoding, unbundling, overutilization and same day multiple surgeries. The Participating Provider agrees not to balance bill the Covered Person for any Payor reduction of billed charges as a result of such cost utilization programs. This provision does not affect the Participating Provider's right to appeal such reductions.

For Medical Network Providers with Fee Schedule Reimbursement Structure Only:

Outpatient Drug Therapies - Chemotherapy, growth hormone, intravenous gamma globulin, antibiotics, and other drugs administered by the Participating Provider will be reimbursed based on the lesser of its usual billed charge, the Fee Schedule amount, or the usual and customary fee for such services as determined by GEHA.

Medicare Patients - GEHA uses the payment rules published by CMS for Medicare patients. The Participating Provider reimbursement shall be based upon the lesser of its usual billed charge, Medicare-approved amount or the Fee Schedule amount.

If a Participating Provider moves to another state after initial contracting, the Fee Schedule will change to that applicable to the new state in which the Participating Provider will be practicing.

**MECHANISMS FOR DISPUTE RESOLUTION
BY PARTICIPATING PROVIDERS
IN PPO USA NETWORK**

1. Administrative and Network Participation Disputes. Please see the Network Appeals/Grievances Policies and Procedures included within this Provider Manual.
2. Appeal and Grievance Procedures for Covered Persons. Any applicable appeal or grievance procedure available to Covered Persons, including Medicare appeal procedures and processes when Medicare is primary. At the request of Participating Provider, GEHA will cause its designee to represent Participating Provider at Payor's grievance hearings to the greatest extent possible. Participating Provider shall provide to GEHA all information related to such grievance procedures, including the outcome of such procedures.
3. Specific Remedies. The Participating Provider agrees that: (a) payment of benefits for Covered Services shall be the sole remedy in any dispute with GEHA or other Payors concerning nonpayment of benefits for such Covered Services, should the Participating Provider prevail in any such dispute; and (b) no Payor shall be liable for any damages of any kind or nature, legal fees or any other expenses incurred as a result of claims disputes with another Payor. Participating Provider hereby waives any right to collect any such damages from GEHA and other Payors. Reinstatement to the PPO USA Network shall be the sole remedy in any dispute concerning network participation status, should the Participating Provider prevail in any such dispute.
4. Arbitration. In the event that any dispute arises with regard to the performance or interpretation of any of the provisions of the Agreement, the parties agree to use best efforts to work together to resolve any such disputes. In the event that a dispute cannot be resolved between GEHA and the Participating Provider, such disputes shall be settled by arbitration in accordance with the arbitration rules of the American Health Lawyers Association Alternative Dispute Resolution Service, or its successor, in effect on the date the claim arose. Demand for arbitration shall be within thirty (30) calendar days after the claim or controversy has arisen, but in no event after the date when institution of legal or equitable proceedings based upon such claim or controversy would be barred by any applicable statute of limitations. Failure to timely institute arbitration shall be an absolute bar to the institution of any proceedings regarding such controversy or claim, and a waiver thereof. A single arbitrator shall be selected in accordance with the procedures of the American Health Lawyers Association Alternative Dispute Resolution Service. Arbitration shall take place in Lee's Summit, Missouri. Neither party shall cease or diminish its performance under the Agreement pending dispute resolution. The arbitrator shall be authorized to apportion the costs of arbitration, including attorneys' fees, as part of the award, taking into consideration which, if any, party is the prevailing party in such arbitration. Judgment upon the award rendered by the arbitrator shall be binding, enforceable and final and may be entered in any court having jurisdiction thereof. The Participating Provider agrees that causes of action for medical malpractice and disputes regarding benefits or the payment of benefits for services provided to GEHA Covered Persons are excluded from this provision.
5. Claims Disputes. GEHA Covered Persons are participants in the Federal Employees Health Benefits Program, and benefit matters for such participants shall be resolved by the United States Office of Personnel Management ("OPM") in accordance with the disputed claims procedures in the Federal Employees Health Benefits Act and the regulations of the OPM.

**TERM OF THE CONTRACT AND PROCEDURES
FOR TERMINATING THE CONTRACT
FOR PPO USA NETWORK**

The initial term of the Agreement (“Initial Term”) shall commence on the Effective Date of the Agreement and shall expire on December 31 immediately preceding the Anniversary Date. The Agreement shall automatically renew on the Anniversary Date and on each January 1 thereafter for a period of twelve months (“Renewal Term”) unless either party shall give written notice of its intent to terminate the Agreement to the other party at least sixty (60) calendar days prior to the end of the Initial Term or Renewal Term. If this Agreement is terminated at the end of the then current term or if a Participating Provider voluntarily terminates from the PPO USA Network, the Participating Provider shall not be entitled to the procedural rights set forth in the Network Appeals/Grievances policy.

The Agreement may be terminated at any time without cause by either party upon at least sixty (60) calendar days prior written notice. Termination shall be effective on the last day of the month in which the sixty (60) day notice requirement is met.

A Participating Provider’s participation in the PPO USA Network shall be automatically terminated as described herein as of the date of the occurrence of the event described herein. This action shall be final except when a bona fide dispute exists as to whether the circumstances have occurred. No provider shall be entitled to the procedural rights set forth in the Network Appeals/Grievances policy as the result of an automatic termination imposed pursuant to this Section. (a) The Participating Provider’s license/authorization to practice or to prescribe controlled substances is currently revoked in any state in which the Participating Provider is or will be providing services pursuant to this Participating Provider Agreement. (b) The Participating Provider has been finally adjudicated and found guilty, or entered a plea of guilty or nolo contendere, in a criminal prosecution under the laws of any state or of the United States, for any felony or any offense reasonably related to the qualifications, functions or duties of the medical profession, for any offense an essential element of which is fraud, dishonesty or an act of violence. (c) The Participating Provider has been excluded, debarred, suspended or otherwise prohibited from participation in any state or federal health care reimbursement program including Medicare, Medicaid, Tri Care or FEHBP. (d) The Participating Provider fails to have, carry or maintain professional liability insurance as required by GEHA.

GEHA may terminate the Agreement immediately for any of the following reasons: (a) Any falsification of any information on the Participating Provider’s application submitted to GEHA or fraud committed on any documentation; or (b) Any finding of unlawful or unprofessional conduct, as defined by state or federal law(s); or (c) Institution of bankruptcy, receivership, insolvency, liquidation or other similar proceedings by or against the Participating Provider; or (d) Any finding that a Participating Provider committed professional misconduct or caused a patient harm; or (e) Membership in the PPO USA Network and/or privileges granted to Participating Provider are terminated, revoked, restricted, suspended, discontinued or not renewed pursuant to GEHA Credentialing and Recredentialing Policies and Procedures; or (f) Noncompliance with HIPAA.

Except as otherwise provided, the Agreement may be terminated if there is a default in the performance of the terms and conditions of the Agreement which default has not been cured within sixty (60) calendar days following the effective date of written notice of such default. The

written notice of default shall constitute notice of termination. Nothing in the Agreement shall be construed to limit either party's lawful remedies in the event of default of the Agreement.

The Agreement may be terminated upon sixty (60) calendar days prior written notice by GEHA to Participating Provider in the event Participating Provider rejects an amendment made to the Agreement by GEHA pursuant to a change in state or federal law.

Unless termination is without cause, written notice of termination shall include an explanation of why the Agreement is being terminated. In the case of termination of Participating Provider by GEHA, such notice shall include notice of any right to an appeal that may be available to Participating Provider if such notice is required by Participating Provider's state law.

Upon the termination of the Agreement by either party for any reason, whether for cause or not for cause, whether voluntary or involuntary, Participating Provider shall: (a) continue to fulfill all of his/her obligations with respect to Covered Persons under Participating Provider's care as of the date of termination until the current course of treatment is complete, until discharge if Covered Person is in the midst of receiving inpatient care, until care of the Covered Person is transferred to another Participating Provider, or as otherwise required by state or federal law. Participating Provider shall be paid for such services in accordance with the provisions of the Plan, and each Plan will allow Covered Persons to continue receiving care for sixty (60) days from the date a Participating Provider is terminated without cause by GEHA, if applicable. Covered Persons shall not be liable to Participating Provider for any amounts owed for such services, other than deductibles or copayment amounts or for services not covered by the Plan, as specifically provided in the Plan. GEHA shall use reasonable efforts in locating another Participating Provider to treat such Covered Persons so that upon termination of the Agreement, Participating Provider may cease providing services to Covered Persons under the Agreement as soon as possible. GEHA, Payors and Participating Provider agree to adhere to any applicable state or federal laws with respect to termination; (b) immediately discontinue use of any and all signs, plaques, letterheads, forms or other materials identifying Participating Provider as a member of PPO USA Network; and (c) use best efforts to immediately disclose to each Covered Person in Participating Provider's care and to GEHA the possible adverse economic consequences such as the individual's responsibility to pay for services if he or she continues to receive care from the Participating Provider after Participating Provider's termination. GEHA shall have the right to waive any of the obligations of Participating Provider in this Section.

GEHA and Participating Provider agree to abide by the laws of any applicable state which may apply to termination.

Except for website notices, notices shall be written and personally delivered, effective on delivery, or sent by United States mail, postage prepaid, effective on the fifth (5th) day following the date deposited in the mail, or by email, addressed to the parties listed under the signature block of this Agreement, or to any other name or address specified in writing by such party. Website notices will be posted on GEHA's PPO USA Network website at www.ppousanetwork.com. GEHA will accept changes to Participating Provider's license or credentialing information, malpractice insurance or other practice information in writing through its website form at www.ppousanetwork.com under "Contact Us," by facsimile at (816) 257-4437, or by regular mail at the address below the signature block of this Agreement.

The Agreement shall apply to all health care services and supplies that are provided to a Covered Person prior to the date of termination of the Agreement by either party.

If a Participating Provider moves or closes his or her office after initial contracting and the Participating Provider does not notify GEHA in writing, GEHA will make a good faith attempt to locate the Participating Provider; however, if GEHA is unable to locate the Participating Provider, this Agreement may be terminated by GEHA without written notice or cause.

**REQUIREMENTS WITH RESPECT TO
PRESERVING THE CONFIDENTIALITY OF
PATIENT HEALTH INFORMATION
FOR PPO USA NETWORK**

The Participating Provider represents and warrants that s/he will be in full compliance with the applicable provisions of the Health Insurance Portability and Accountability Act (HIPAA), and regulations promulgated thereunder, as they may be amended from time to time.

The Participating Provider agrees to maintain all patient medical records in strictest confidence and not disclose any such patient information, except with the patient's written consent or as otherwise required by law. The Participating Provider shall maintain and preserve such records as required by applicable law and regulations.

GEHA agrees to maintain any patient medical records in its possession in strictest confidence in accordance with applicable law and require the same provision in its contracts with other Payors.

GEHA shall comply and shall use best efforts to require other Payors to comply with all applicable federal and state laws, rules and regulations, including applicable provisions of the Health Insurance Portability and Accountability Act (HIPAA), and regulations promulgated thereunder, as they may be amended from time to time. With regard to the operation of the GEHA Plans in the Federal Employees Health Benefits Program, state law is specifically preempted and all matters relating to benefits or the payment of benefits by GEHA shall be resolved by the United States Office of Personnel Management ("OPM") in accordance with the disputed claims procedures in the Federal Employees Health Benefits Act and the regulations of the OPM. Any applicable federal and state laws, rules and regulations not specifically mentioned in the Agreement are contained in PPO USA Network's State Specific Policies & Procedures in its Provider Manual as may be amended from time to time, are hereby incorporated by reference into the Agreement, and are available at www.ppousanetwork.com or upon request. If the terms of the Agreement conflict with the State Specific Policies & Procedures established by GEHA with regard to applicable federal and state laws, rules and regulations, the State Specific Policies & Procedures shall prevail.

**PROHIBITIONS REGARDING DISCRIMINATION
AGAINST CONSUMERS
FOR PPO USA NETWORK**

Participating Provider agrees not to discriminate in the treatment of his/her Covered Persons or in the quality of services delivered to Covered Persons on the basis of race, color, creed, ancestry, sex, sexual orientation, age, religion, marital status, national origin, physical, mental or sensory disability, health status, type of medical benefit plan, or source of payment, including publicly financed programs, and to provide care and services which are of a quality consistent with generally accepted standards and practices in the medical community.

With regard to PPO USA Network's selection, oversight and termination processes, the network shall not discriminate against Participating Providers on the basis of race, color, creed, ancestry, sex, sexual orientation, age, religion, marital status, national origin, physical, mental or sensory disability or health status unrelated to the ability to fulfill patient care.

GEHA Policies & Procedures
PPO USA/CONNECTION DENTAL Networks
General Policies & Procedures

NETWORK APPEALS/GRIEVANCES

The Networks have in place appeals processes that address the following:

Contract disputes between the Network and Participating Providers (reimbursement rates, contract language, etc.).

Participating Provider's failure to meet the Network's standards or requirements for ongoing participation.

Adverse actions taken by the Network committee(s) responsible for utilization management and quality assurance.

Any disciplinary action taken by the Network.

Contract/Claims Payment Disputes

This particular policy addresses contract disputes between the Network and Participating Providers.

1. Participating Provider appeal must be in writing.
 - a. Appeal must be submitted within six months from the date of the decision.
 - b. Included with the appeals letter shall be the EOB, copy of the actual claim and description of the dispute.
2. Participating Provider appeal must be sent directly to the Network and not the Payor.
3. Network shall respond in writing within 90 days of receipt of Participating Provider's appeal.
4. Network shall respond in writing to insurer and Participating Provider with a letter of decision.

The Network reserves the right to request additional information deemed necessary in order to settle the dispute in a timely manner. If the Participating Provider disagrees with GEHA's response to its appeal, the dispute shall be resolved by arbitration in accordance with the Participating Provider's agreement with GEHA, unless a different mechanism is required by applicable state law or regulation.

GEHA Benefits Disputes

GEHA health plan members are participants in the Federal Employees Health Benefits Program, and benefit matters for such participants shall be resolved by the United States Office of Personnel Management ("OPM") in accordance with the disputed claims procedures in the Federal Employees Health Benefits Act and the regulations of the OPM. State law is specifically preempted with regard to the operation of GEHA health plans. With regard to the operation of the GEHA dental plans, state law is specifically preempted and all matters relating to benefits or the payment of benefits by GEHA shall be resolved by the OPM with respect to the Federal Employee Dental and Vision Benefits Program dental plan, and in accordance with the disputed claims procedures and the regulations of the OPM or in accordance with the GEHA benefit plan dispute resolution procedures with respect to the Connection Dental *Plus* dental plan.

Network Participation

I. Termination and Suspension Process

- A. **Voluntary Termination.** A Participating Provider's participation in the Network shall be considered voluntarily terminated by the Participating Provider as described herein as of the date of the occurrence of any of the events described herein or the date GEHA discovers the event, whichever is later, and Participating Provider's Provider Agreement shall automatically terminate. This action shall be final and no Participating Provider shall be entitled to the procedural rights set forth in Article II below as the result of a voluntary termination by the Participating Provider.
1. The Participating Provider fails/refuses to submit all required recredentialing information within the 180-day recredentialing process deadline, as required by the Recredentialing Criteria.
 2. The Participating Provider retires.
 3. The Participating Provider dies.
 4. The Participating Provider moves to a state in which the network does not operate (PPO USA Network only).
 5. The Network is unable to locate the Participating Provider following a good faith attempt.
 6. The Participating Provider voluntarily terminates his or her Provider Agreement.
 7. The Provider Agreement is terminated at the end of an initial or renewal term.
- B. **Automatic Termination.** A Participating Provider's participation in the Network shall be automatically terminated as described herein as of the date of the occurrence of the event described herein or the date GEHA discovers the event, whichever is later. This action shall be final except when a bona fide dispute exists as to whether the circumstances have occurred. No Participating Provider shall be entitled to the procedural rights set forth in Article II below, as the result of an automatic termination imposed pursuant to this section.
1. **Occurrences Affecting Licensure:** The Participating Provider's license to practice in any state in which the Participating Provider is or will be providing services pursuant to a Provider Agreement is revoked, limited or restricted, suspended, or expired.
 2. **Occurrences Affecting Controlled Substances Regulation:** The Participating Provider's DEA or other controlled substances number in any state in which the Participating Provider is or will be providing services pursuant to a Provider Agreement is revoked, suspended, restricted, or expired.
 3. **Conviction of a Crime:** The Participating Provider has been finally adjudicated and found guilty, or entered a plea of guilty or nolo contendere, in a criminal prosecution under the laws of any state or of the United States, for any felony or any offense reasonably related to the qualifications, functions or duties of the medical or dental profession, for any offense an essential element of which is fraud, dishonesty or an act of violence.
 4. **Exclusion from State or Federal Health Care Reimbursement Programs:** The Participating Provider has been excluded, debarred, suspended or otherwise prohibited from participation in any state or federal health or dental care reimbursement program including Medicare, Medicaid, TRICARE, the Federal Employees Health Benefits Program, or any other state or federal health care reimbursement program.
 5. **Professional Liability Insurance:** The Participating Provider fails to have, carry or maintain professional liability insurance as required by GEHA.
- C. **Summary Suspension.** If, in the opinion of the Medical Director, Peer Review Committee Chairperson or Peer Review Committee Co-Chair, a Participating Provider is engaged in behavior or is or may be practicing in a manner that appears to pose a significant risk to the health, welfare, or safety of consumers, the Medical Director may suspend, pending investigation, a Participating Provider's participation in the Network. Such investigation shall be conducted by the Network's internal department(s) or designee. Notification will be given to the Participating Provider by signature confirmation mail. Summary suspensions shall be effective immediately. Due to the nature of summary suspensions, the investigation and notification processes will be handled on an expedited basis, including promptly notifying Participating Provider of the summary suspension

by signature confirmation mail. If a Participating Provider is placed in summary suspension status, the Participating Provider may appeal the action within 30 days of receipt of the summary suspension letter and pursuant to the procedures set forth in Article II below; however, if a termination event for that Participating Provider occurs during that summary suspension period, the summary suspension status will end on the date immediately prior to the date of the termination event and no further review or appeals will be considered for the summary suspension.

D. Immediate Termination.

1. The Medical Director, Peer Review Committee Chairperson, or Peer Review Committee Co-Chair may decide to terminate a Participating Provider's participation in the Network for the following immediate termination reasons not related to administrative matters:
 - a. Any finding that a Participating Provider committed professional misconduct or caused a patient harm; and
 - b. Membership in the GEHA PPO USA Network and/or privileges granted to Participating Provider are terminated, revoked, restricted, suspended, discontinued or not renewed pursuant to GEHA Credentialing and Recredentialing Policies and Procedures.

Notification of immediate terminations not related to administrative matters shall be given to the Participating Provider by signature confirmation mail. Immediate terminations not related to administrative matters shall be final and binding upon the Participating Provider unless the Participating Provider files a written notice of appeal within 30 days of receipt of the termination letter and pursuant to the procedures set forth in Article II below.

2. The Medical Director, Peer Review Committee Chairperson, or Peer Review Committee Co-Chair may decide to terminate a Participating Provider's participation in the Network for the following immediate termination reasons related to administrative matters, which are reviewed by GEHA's legal and/or compliance department personnel in order to make a recommendation to the Medical Director, Peer Review Committee Chairperson, or Peer Review Committee Co-Chair:

- a. Any falsification of any information on the Participating Provider's Credentialing Application or Recredentialing Application or fraud committed on any documentation; and

2. Any finding of unlawful or unprofessional conduct, as defined by state or federal law(s).

Notification of immediate terminations related to administrative matters shall be given to the Participating Provider by signature confirmation mail. Immediate terminations related to administrative matters shall be final and binding upon the Participating Provider unless the Participating Provider files a written notice of appeal within 30 days of receipt of the termination letter. Appeals for immediate terminations related to administrative matters are not subject to the procedures set forth in Article II below and shall instead be resolved pursuant to the following procedures:

If a Participating Provider appeals an immediate termination related to an administrative matter, the appeal must be submitted to the Network within 30 days of the Participating Provider's receipt of his/her/its termination letter from the Network. The Provider Network Manager shall meet with another member of management who was not involved in the initial decision to review the appeal in a fair and impartial manner and, if needed, shall seek advice from legal counsel. The Provider Network Manager shall respond to the Participating Provider's administrative appeal in a timely manner but in no event later than 90 days following the date of receipt of the administrative appeal from the Participating Provider.

The Medical Director, Peer Review Committee Chairperson, Peer Review Committee Co-Chair, or Peer Review Committee may decide to terminate a Participating Provider's participation in the Network for any reason set forth in this Article I and/or the Credentialing Legal Policies and Procedures. All summary suspension processes and/or summary suspension appeals shall be discontinued for a Participating Provider upon the occurrence of a termination event. If an automatic termination event occurs, any other

termination processes and/or appeals that were already started shall also be discontinued for a Participating Provider.

II. Reconsideration and Appeal Process

- A. Any dispute concerning the summary suspension or immediate termination not related to administrative matters, which results in revocation of a Participating Provider's participation in the Network, shall be resolved by the procedures set forth in this Article II and shall be the sole and exclusive method to resolve such disputes. The Participating Providers shall be bound by any final decision rendered in accordance with said procedures.
 1. Adverse Action.
 - a. The following actions shall be deemed to be an adverse action and shall entitle the Participating Provider, thereby affected, to a reconsideration and appeal under this Section II.
 - i. Summary suspension of a Participating Provider's participation in the Network;
 - ii. Immediate termination of a Participating Provider that is not related to an administrative matter;
 - b. Voluntary termination under Section I. A. or automatic termination under Section I. B. shall not be considered an adverse action that entitles the Provider to a reconsideration or appeal.
 - c. Immediate termination related to administrative matters under Section I.D.2. shall not be considered an adverse action that entitles the Participating Provider to a reconsideration or appeal under this Section II.
 2. If an adverse action is based on the professional competence or conduct of a health or dental professional, then the Participating Provider may seek a reconsideration review as set forth in Section II.
- B. Dispute Resolution Appeal.
 1. Notice of Adverse Action. A Participating Provider against whom an adverse action has been made shall be given notice of the same within 30 days. The notice shall describe the action and the reason for it. The notice shall also state that the Participating Provider has the right to request an appeal within the time limits specified in Section II.B.2. and shall contain a summary of the Participating Provider's rights in such an appeal.
 2. Request for Dispute Resolution Appeal. A Participating Provider shall have 30 days after his/her/its receipt of notice pursuant to Section II.B.1. above to file a written request for an appeal. Such request shall be delivered to a Supervisor for the Network, or his or her designee. A Participating Provider who fails to request an appeal within the time and in the manner specified herein waives any right to such an appeal and to any arbitration to which he/she might otherwise be entitled and the action shall be final upon the expiration of the 30 day period. Such waiver shall constitute acceptance of the adverse action.
 3. Informal Meeting. The Dispute Resolution Committee shall have the ability to approve an appeal reconsideration in an informal meeting before a scheduled formal appeal is heard.
 4. Time and Place of Appeal. The appeal review will take place at a Dispute Resolution Committee Meeting. The Participating Provider will be notified of the time, place and date of the appeal meeting to be held. This meeting may be held telephonically, so long as all parties can hear and communicate with each other.
 5. Dispute Resolution Committee. The appeal shall be heard by the Dispute Resolution Committee. The Dispute Resolution Committee shall be required to objectively consider and decide the case with good faith. A Dispute Resolution Committee Chairperson will be appointed prior to the meeting and will preside over the appeal process and determine the order of the appeal procedure. The meetings of the Committee and the files will be considered confidential. The Chair will remind the Dispute Resolution Committee prior to each Committee meeting of the necessity of confidentiality. This file shall not be subject to discovery, subpoena or other means of legal compulsion of their release.
 6. Conduct of Dispute Resolution Appeal.

- a. During a Dispute Resolution Committee appeal meeting, the following information will be presented to the Dispute Resolution Committee members for examination:
 - i. Participating Provider's file.
 - ii. Adverse action exhibits with Medical Director's, Peer Review Committee Chairperson's, Peer Review Committee Co-Chair's or Peer Review Committee's rationale for denial/termination.
 - iii. Participating Provider appeal documentation including but not limited to any relevant evidence from Participating Provider or other applicable sources.
 - b. The Dispute Resolution Committee shall review all submitted documentation objectively and decide the case with good faith. In reaching a decision, the Dispute Resolution Committee shall be entitled to consider any pertinent material contained on file with the Network, and all other information that can be considered in connection with the Application for Credentialing or the recredentialing process.
 - c. A record of the appeal shall be kept with sufficient accuracy such that an informed and valid judgment can be made by any group that may later be called upon to review the record and render a decision in the matter. The Dispute Resolution Committee may select the method to be used for making the record, such as electronic recording unit, detailed transcription, or minutes of the proceedings.
 - d. The Dispute Resolution Committee shall be entitled to monitor a Participating Provider for a period of time determined by the Committee. During the monitoring period, the Participating Provider's credentials will be reviewed based on the decision made by the Committee.
 - e. The Dispute Resolution Committee Chairman upon a showing of good cause may grant requests for postponement of the appeal review. The Dispute Resolution Committee may recess the appeal proceedings and reconvene it without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of a presentation of oral and written evidence, the appeal review shall be concluded.
7. Report of Monitoring Period. If adverse information is received during a Participating Provider's monitoring period or if at the end of a monitoring period, no adverse information was received, a teleconference shall be held with the Dispute Resolution Committee, ensuring that all parties can hear and communicate with each other, and the committee shall determine the basis for any decisions. Within 15 days after the monitoring period review is concluded, a written report of the committee's decisions and findings shall be placed in the Participating Provider's File.
 8. Report of Dispute Resolution Appeal. Within 15 days after the dispute resolution appeal review is concluded, a Network Supervisor, or his or her designee, shall make a written report of the Dispute Resolution Committee's findings and decisions in the matter, and such report shall be placed in the Participating Provider's File. The report shall include a statement of the basis for the Dispute Resolution Committee's decision(s).
 9. Effect of Result.
 - a. If a decision of the Dispute Resolution Committee is favorable to the Participating Provider, notice shall promptly be sent to the Provider involved informing him/her of action taken. Copy of notice will be kept in the Participating Provider's file.
 - b. If a decision of the Dispute Resolution Committee is favorable to the Participating Provider, such results shall become the final decision of the Dispute Resolution Committee and the matter shall be closed.
 - c. If the decision of the Dispute Resolution Committee continues to be adverse to the Participating Provider, the Dispute Resolution Committee shall cause notice of the decision to be given to the Participating Provider via signature confirmation mail, within 30 days. The notice shall describe the action from the Dispute Resolution Committee and the reason for it. The notice shall also state that the Participating Provider has the right to request an appeal within the time limits specified in Section II.C.2. below and shall contain a summary of the Participating Provider's rights in such an appeal. A copy of the notice will be kept in the Participating Provider's file.

- C. Reconsideration Appeal.
1. Notice of Adverse Action. A Participating Provider against whom an adverse action has been made shall be given notice of the same within 30 days. The notice shall describe the action from the Dispute Resolution Committee and the reason for it. The notice shall also state that the Participating Provider has the right to request an appeal within the time limits specified in Section II.C.2. below and shall contain a summary of the Participating Provider's rights in such an appeal.
 2. Request for Appeal Reconsideration. A Participating Provider shall have 30 days after his/her receipt of notice pursuant to Section II.C.1. above to file a written request for an appeal. Such request shall be delivered to a Supervisor for the Network, or his or her designee, and shall be forwarded to the Appeal Reconsideration Committee. A Participating Provider who fails to request an appeal within the time and in the manner specified herein waives any right to such an appeal and to any arbitration to which he/she might otherwise be entitled and the action shall be final upon the expiration of the 30 day period. Such waiver shall constitute acceptance of the adverse action.
 3. Informal Meeting. The Appeal Reconsideration Committee shall have the ability to approve an appeal reconsideration in an informal meeting before a scheduled formal appeal is heard.
 4. Time and Place of Appeal Reconsideration. The appeal review will take place at an Appeal Reconsideration Committee meeting. The Participating Provider will be notified of the time, place and date of the appeal meeting to be held.
 5. Appeal Reconsideration Committee. The appeal shall be heard by the Appeal Reconsideration Committee. The Appeal Reconsideration Committee shall be required to objectively consider and decide the case with good faith. The Appeal Reconsideration Committee Chairman will reside over the appeal process and determine the order of the appeal procedure. The meetings of the Committee and the files will be considered confidential. The Chair will remind the Appeal Reconsideration Committee prior to each Committee meeting of the necessity of confidentiality. This file shall not be subject to discovery, subpoena or other means of legal compulsion of their release.
 6. Conduct of Appeal Reconsideration.
 - a. During an Appeal Reconsideration Committee meeting, the following information will be presented to the Appeal Reconsideration Committee members for examination:
 - i. Participating Provider's file.
 - ii. Adverse action exhibits with Medical Director's, Peer Review Committee Chairperson's, Peer Review Committee Co-Chair's or Peer Review Committee's rationale for denial/termination.
 - iii. Participating Provider reconsideration and appeal documentation including but not limited to any relevant evidence from Participating Provider or other applicable sources.
 - b. The Appeal Reconsideration Committee shall review all submitted documentation objectively and decide the case with good faith. In reaching a decision, the Appeal Reconsideration Committee shall be entitled to consider any pertinent material contained on file with the Network, and all other information that can be considered, pursuant to these Credentialing Policies and Procedures in connection with an Application for Credentialing or the recredentialing process.
 - c. A record of the appeal shall be kept with sufficient accuracy such that an informed and valid judgment can be made by any group that may later be called upon to review the record and render a decision in the matter. The Appeal Reconsideration Committee may select the method to be used for making the record, such as electronic recording unit, detailed transcription, or minutes of the proceedings.
 - d. The Appeal Reconsideration Committee shall be entitled to suspend a Participating Provider's termination for a period of time determined by the Appeal Reconsideration Committee. During the suspended termination period, the Participating Provider's credentials will be reviewed based on the decision made by the Appeal Reconsideration Committee.

- e. The Appeal Reconsideration Committee Chairman upon a showing of good cause may grant requests for postponement of the appeal review. The Appeal Reconsideration Committee may recess the appeal proceedings and reconvene it without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of a presentation of oral and written evidence, the appeal review shall be concluded.
7. Report of Monitoring Period for Summary Suspensions. If adverse information is received during a Participating Provider's monitoring period or if at the end of a monitoring period, no adverse information was received, a teleconference shall be held with the Appeal Reconsideration Committee, ensuring that all parties can hear and communicate with each other, and the committee shall determine the basis for any decisions. Within 15 days after the monitoring period review is concluded, a written report of the committee's decisions and findings shall be placed in the Participating Provider's File.
 8. Report of Appeal Reconsideration Appeal for Summary Suspensions. Within 15 days after the appeal reconsideration appeal review is concluded, a Network Supervisor, or his or her designee, shall make a written report of the Appeal Reconsideration Committee's findings and decisions in the matter, and such report shall be placed in the Participating Provider's File. The report shall include a statement of the basis for the Appeal Reconsideration Committee's decision(s).
 9. Effect of Result for Summary Suspensions.
 - a. If a decision of the Appeal Reconsideration Committee is favorable to the Participating Provider, notice shall promptly be sent to the Provider involved informing him/her of action taken. Copy of notice will be kept in the Participating Provider's File.
 - b. If a decision of the Appeal Reconsideration Committee is favorable to the Participating Provider, such results shall become the final decision of the Appeal Reconsideration Committee and the matter shall be closed.
 - c. If the decision of the Appeal Reconsideration Committee continues to be adverse to the Participating Provider, the Appeal Reconsideration Committee shall cause notice of the decision to be given to the Participating Provider via signature confirmation mail, within 30 days. The notice shall describe the action from the Appeal Reconsideration Committee and the reason for it. The notice shall also state the network will continue to monitor the Participating Provider's credentials until such time the network has enough information regarding the summary suspension event to review the matter in full and make a decision about the Participating Provider's network participation status. A copy of the notice will be kept in the Participating Provider's file.
 10. Appeal Reconsideration Requirements for Participating Provider Terminations.
 - a. Notice of Time and Place for Appeal. Upon receipt from a Participating Provider of a timely and proper request for an appeal, a Supervisor for the Network or his or her designee shall schedule and arrange for an appeal. At least 30 days prior to the appeal, the Supervisor shall send the Participating Provider written notice of the time, place and date of the hearing, by Signature Confirmation mail, which date shall be not less than 30 days after the date of the notice. The notice of the hearing provided to the Provider shall include a list of witnesses (if any) expected to testify at the appeal in support of the proposed action and a summary of the Participating Provider's rights according to these policies and procedures.
 - b. Statement of Issues and Events. The notice of appeal shall contain a concise statement of the Participating Provider's alleged acts or omissions and/or a concise statement of any other reasons or subject matter forming the basis for the adverse action which is the subject of the hearing.
 - c. Conduct of Appeal. The appeal shall be heard by the Appeal Reconsideration Committee.
 - d. List of Witnesses. In addition to the list of witnesses required in the notice of appeal, at least 10 days prior to the scheduled date for commencement of the appeal, each party shall provide the other with a list of names of the individuals who, as far as then reasonably known, will give testimony or evidence in support of that party at the appeal. Admissibility of testimony to be presented by a witness not so listed shall be at the discretion of the Hearing Officer.

11. Appeal Procedure for Participating Provider Terminations.
- a. Forfeiture of Hearing. A Participating Provider who requests an appeal pursuant to this Article but fails to appear at the hearing without good cause, as determined by the Hearing Officer, shall forfeit his or her rights to such appeal to which he or she might otherwise have been entitled. If the Hearing Officer determines that the failure to appear is without good cause, the decisions shall become final upon the expiration of 30 days from the decision of the Hearing Officer. The Supervisor shall notify the Participating Provider of the decision of the Hearing Officer.
 - b. Hearing Officer. The Hearing Officer shall be the presiding officer. He or she shall act to maintain decorum and to assure that all participants in the appeal process are provided a reasonable opportunity to present relevant oral and documentary evidence. He or she shall be entitled to determine the order of procedure during the appeal and shall make all rulings on matters of law, procedure, and the admissibility of evidence.
 - c. Representation. The Participating Provider who requested the appeal shall be entitled to be accompanied and represented at the hearing by a member of his or her professional society, and/or by an attorney. The Network may designate an attorney to represent it at the appeal to present the facts in support of its adverse action, and to examine witnesses.
 - d. Rights of Parties. During the appeal each party may:
 - i. Call, examine and cross-examine witnesses;
 - ii. Introduce any relevant evidence, including exhibits;
 - iii. Question any witness on any matter relevant to the issues that are the subject of the hearing;
 - iv. Impeach any witness;
 - v. Offer rebuttal of any evidence;
 - vi. Have a record made of the hearing in accordance with Section h. of this Article; and
 - vii. Submit a written statement at the close of the hearing.If a Participating Provider who requested the appeal does not testify in his or own behalf, he or she may be called and examined as if under cross-examination.
 - e. Procedure and Evidence. At the appeal, the rules of law relating to examination of witnesses or presentation of evidence need not be strictly enforced, except that oral evidence shall be taken only on oath or affirmation. The Hearing Officer may consider any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs regardless of whether such evidence would be admissible in a court of law. Prior to or during the hearing, any party may submit memoranda concerning any procedural or factual issue, and such memoranda shall be included in the hearing record.
 - f. Information Pertinent to Appeal. In reaching a decision, the Appeal Reconsideration Committee shall be entitled to consider any pertinent material contained on file in the Network and information that can be considered pursuant to these Policies and Procedures. The Appeal Reconsideration Committee may at any time take official notice of any generally accepted technical or scientific principles relating to the matter at hand of any facts that may be judicially noticed by Missouri courts. The parties to the appeal shall be informed of the principles or facts to be noticed and the same shall be noted in the hearing record. Any party shall be given the opportunity, upon timely request, to request that a principle or fact be officially noticed or to refute any officially noticed principle or fact by evidence or by written or oral presentation of authority in such manner as determined by the Hearing Officer.
 - g. Burden of Proof. When an appeal relates to an adverse action a Committee Co-Chair shall have the initial obligation to present evidence in support thereof, but the Participating Provider thereafter is responsible for supporting his or her challenge that the adverse action lacks any substantial factual basis or that the basis or the conclusions drawn there from are arbitrary, unreasonable, or capricious.
 - h. Record of Appeal. A record of the appeal shall be kept of sufficient accuracy that an informed and valid judgment can be made by any group that may later be called upon to review the record and render a decision in the matter. The Hearing Officer shall select the method to be used for making the record, such as a court report, electronic recording unit, detailed transcription, or minutes of the proceedings. Upon written request, the

- Participating Provider shall be entitled to obtain a copy of the record or use an alternative recording method, at his or her own expense.
- i. Postponement. Requests for postponement of an appeal may be granted by the Hearing Officer upon showing of good cause and only if the request is made as soon as is reasonably practical.
 - j. Presence of Hearing Committee Members and Vote. A majority of the Appeal Reconsideration Committee shall be present at all times during the appeal and deliberations. If a Committee member is absent from any part of the proceedings, the Hearing Officer in his or her discretion may rule that such member be excluded from further participation in the proceedings or decisions of the Committee.
 - k. Recesses and Adjournment. The Appeal Reconsideration Committee may recess the hearing and reconvene it without additional notice if the Committee deems such recess necessary for the convenience of the participants, to obtain new or additional evidence, or if consultation is required for resolution of the matter. When presentation of oral and written evidence is complete, the hearing shall be closed. The Appeal Reconsideration Committee shall deliberate outside the presence of the parties and at such time and in such location as is convenient to the committee. The Hearing Officer shall not participate in the deliberations. Upon conclusion of the Appeal Reconsideration Committee's deliberations, the appeal shall be adjourned.
12. Report of Suspended Termination Period for Participating Provider Terminations. If adverse information is received during a Participating Provider's suspended termination period, or if at the end of a suspended termination period, no adverse information was received, a teleconference shall be held with the Committee, ensuring that all parties can hear and communicate with each other, and the Committee shall determine the basis for any decision. Within 15 days after the suspended termination review is concluded, a written report of the Committee's decisions and findings shall be placed in the Participating Provider's file.
 13. Report of Appeal Review for Participating Provider Terminations. Within 15 days after the appeal review is concluded, the Supervisor shall make a written report of the Appeal Reconsideration Committee's findings and decisions in the matter, and such report shall be placed in the Participating Provider's file. The report shall include a statement of the basis for the Appeal Reconsideration Committee's decision(s).
 14. Effect of Result for Participating Provider Terminations.
 - a. If a decision of the Appeal Reconsideration Committee is favorable to the Participating Provider, notice shall promptly be sent to the Participating Provider involved informing him/her of action taken. Copy of notice will be kept in the Participating Provider's file.
 - b. If a decision of the Appeal Reconsideration Committee is favorable to the Participating Provider, such results shall become the final decision of the Appeal Reconsideration Committee and the matter shall be closed.
 - c. If the decision of the Appeal Reconsideration Committee continues to be adverse to the Provider, the Appeal Reconsideration Committee shall cause notice of the decision to be sent to the Participating Provider via Signature Confirmation mail. Such results shall become the final decision of the Appeal Reconsideration Committee. Copy of notice to the Participating Provider shall be kept in the Provider's file. Additionally, the Network shall (i) report this adverse action to the Healthcare Integrity and Protection Data Bank as required by Federal Law; and (ii) terminate the Provider Agreement with the Provider.

III. Ability to Reapply

If any action under these Policies and Procedures is deemed final and is an adverse action with respect to a Participating Provider, the Participating Provider may not reapply to the Network until after a one-year waiting period from the date the Participating Provider is notified of the final denial action. The Participating Provider shall not be permitted to reapply prior to the end of such one-year period.

Note: A clinical peer of the Participating Provider who filed the dispute will be included on the Dispute Resolution and Appeal Reconsideration Committees.

Grievances

All Network Participating Provider grievances and/or complaints should be sent to:

For the PPO USA Network:

PPO USA Network
Attn: Provider Relations Supervisor
P.O. Box 6707
Lee's Summit, MO 64064-6707
(800) 821-4991

For the CONNECTION Dental Network:

CONNECTION Dental Network
Attn: Supervisor
P.O. Box 6707
Lee's Summit, MO 64064-6707
(800) 505-8880

COMPOSITION OF NETWORK

GEHA shall administer and, in its sole discretion, determine the composition of the PPO USA Network and any subset thereof. In the event a provider is contracted through more than one Participating Provider Agreement, GEHA shall, in its sole discretion, determine the contract with which the provider shall be contracted. GEHA can approve or disapprove of new providers becoming Participating Providers. In the event a Participating Provider fails to satisfy any of the requirements of an applicable Participating Provider Agreement or if a Participating Provider is terminated pursuant to a Participating Provider Agreement, said Participating Provider must cease providing Covered Services under the Participating Provider Agreement upon written notice from GEHA.

PPO USA NETWORK'S PROVIDER PAYMENT POLICIES
Participating Provider Agreement

Fee and Billing Restrictions. When GEHA or Payor is the primary Payor, the Participating Provider agrees that:

- a. Except for the collection of any Copayments, Coinsurance and Deductibles, or for services not covered by the Payor, Participating Provider will accept the lesser of the applicable Fee Schedule or the Participating Provider's usual billed charge as payment in full and not balance bill Covered Persons for any amount in excess of the lesser of the Fee Schedule or the Participating Provider's usual billed charge;
- b. The Fee Schedule applies to all services billed to the Payors by any other health care provider who legally uses the Federal Tax Identification Number designated to or used by the Participating Provider and who elects to participate with the PPO USA Network or the Medicare billing number used by the Participating Provider. All changes in Tax Identification Numbers for Participating Provider will be applied to Participating Provider's network status unless otherwise notified by Participating Provider; and
- c. When Payor requires Covered Persons to pay copayments for certain Covered Services, it is the responsibility of the Participating Provider to collect such amount, and it is the responsibility of the Covered Person to pay such amount at the time services are received.

Beneficiary Hold Harmless. The liability of a party to this Agreement may not be transferred to another party or to Covered Persons, and this provision shall survive termination of the Agreement.

Compliance with Policies and Procedures. Participating Provider agrees to cooperate, participate in, and comply with Policies and Procedures and in such review and service programs as may be established by GEHA or Payor.

Cost Utilization. The Participating Provider agrees that Payor may establish cost utilization programs and/or utilization management programs unique to Payor's Plan, such as, but not limited to, review of billed charges for upcoding, unbundling, overutilization and same day multiple surgeries. The Participating Provider agrees not to balance bill the Covered Person for any Payor reduction of billed charges as a result of such cost utilization programs. This provision does not affect the Participating Provider's right to appeal such reductions.

Appeal and Grievance Procedures. Participating Provider shall comply with and participate in any applicable appeal or grievance procedure available to Covered Persons, including Medicare appeal procedures and processes when Medicare is primary. At the request of Participating Provider, GEHA will cause its designee to represent Participating Provider at Payor's grievance hearings to the greatest extent possible. Participating Provider shall provide to GEHA all information related to such grievance procedures, including the outcome of such procedures.

Overpayments. The Participating Providers agree to refund any overpayments, which were made by Payor to the Participating Provider, to Payor within thirty (30) calendar days of its receipt of Payor's notice of overpayment, and Payor agrees to remit to Participating Provider underpayment amounts within thirty (30) calendar days of its receipt of Participating Provider's notice of underpayment if it has been agreed upon by both parties that an underpayment has been made.

Assignment of Benefits. The Participating Provider agrees to request, accept and maintain written assignment of benefits from Covered Persons and authorization to release medical records.

Claims Submission. Participating Provider shall make its best efforts to submit a Clean Claim for Covered Services to GEHA, Payor, or Payor's agent within sixty (60) calendar days of the date the service is provided, and shall use the CMS-1500 form, or other forms or other medium as determined by GEHA or Payor to be appropriate.

Coordination of Payments. The Participating Provider shall cooperate with GEHA and Payors in coordination of payments with other Payors. When Payor is primary according to standard coordination of benefits rules, Payor is required to pay the payments applicable under its Plan and this Agreement. When Payor is not primary, Payor is required to pay only those payments which, when added to benefits from other Payors, are equal to one hundred percent (100%) of the lesser of the Participating Provider's usual billed charge, agreed-upon charge with other Payors, or the Fee Schedule amount. This provision does not alter Participating Provider's right consistent with this Agreement, in such circumstances, to seek and obtain payment from sources other than Payor and Covered Person.

Claims Processing. Except where subrogation or coordination of benefits applies, GEHA or Entities shall make all payments due to the Participating Provider with respect to the GEHA Plan within thirty (30) days following receipt of a Clean Claim. If a Clean Claim is not paid within forty-five (45) days of receipt by GEHA, no discount shall be taken. Except for the GEHA Plan, GEHA shall not be responsible or liable for any claims decision or for the payment of any claims for Covered Services provided by a Participating Provider to a Covered Person who is entitled to benefits payable under any Plan other than the GEHA plan, which operates pursuant to FEHBA. GEHA shall not be an insurer, guarantor, or underwriter of the responsibility or liability of any Payor to provide payments pursuant to any Plan.

Explanation of Benefits (EOB). Payor shall provide to the Participating Provider an EOB that contains pertinent information regarding claims payment. GEHA will submit and will use its best efforts to require other Payors to submit an explanation of benefits or remittance advice that identifies the contractual source of any discount to the Participating Provider.

Procedure Upon Termination. After the Agreement is terminated, the Participating Provider shall be paid for such services in accordance with the provisions of the Plan, and each Plan will allow Covered Services to continue receiving care for sixty (60) days from the date a Participating Provider is terminated without cause by GEHA, if applicable.

Remedies. The Participating Provider agrees that:

- a. payment of benefits for Covered Services shall be the sole remedy in any dispute with GEHA or other Payors concerning nonpayment of benefits for such Covered Services, should the Participating Provider prevail in any such dispute; and
- b. no Payor shall be liable for any damages of any kind or nature, legal fees or any other expenses incurred as a result of claims disputes with another Payor. Participating Provider hereby waives any right to collect any such damages from GEHA and other Payors.

Arbitration. The Participating Provider agrees that causes of action for medical malpractice and disputes regarding benefits or the payment of benefits for services provided to GEHA Covered Persons are excluded from this provision. GEHA Covered Persons are participants in the Federal Employees Health Benefits Program, and benefit matters for such participants shall be resolved by the United States Office of Personnel Management ("OPM") in accordance with the disputed claims procedures in the Federal Employees Health Benefits Act and the regulations of the OPM.

Fee Schedule Provisions.

Outpatient Drug Therapies - Chemotherapy, growth hormone, intravenous gamma globulin, antibiotics, and other drugs administered by the Participating Provider will be reimbursed based on the lesser of its usual billed charge, the Fee Schedule amount, or the usual and customary fee for such services as determined by GEHA.

Medicare Patients - GEHA uses the payment rules published by CMS for Medicare patients. The Participating Provider reimbursement shall be based upon the lesser of its usual billed charge, Medicare-approved amount or the Fee Schedule amount.

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