COUNT I

Breach of Contract
(Against Highmark WV)

98. MedTest incorporates the allegations set forth in the foregoing paragraphs as though set forth herein.

99. MedTest entered into a contract with Highmark WV when it entered into the Network Agreement. The terms of that contract include the following provision:

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

Network Agreement § VI.U.

100. Highmark WV breached this provision of the Network Agreement by refusing to compensate MedTest for laboratory testing services provided to members of the Blues' health insurance plans with coverage for "National Networks".

101. No provision in the Network Agreement authorizes Highmark WV to refuse to compensate MedTest for these services.

102. Moreover, the Network Agreement provides that, "in the event of any conflict between the terms of this Agreement and the terms of the Provider Manual, the terms of this Agreement shall control, unless otherwise specified." Network Agreement § VI.I. Therefore, any suggestion in the Provider Manual or elsewhere that MedTest should have sought compensation from the other Blues for laboratory testing services provided as part of their National Networks is contrary to, and superseded by, the Network Agreement.

103. MedTest has performed all, or substantially all, of the obligations imposed on it under the Network Agreement.

104. MedTest has incurred millions of dollars in damages as a result of Highmark WV's refusal to compensate it for laboratory testing services provided in breach of the Network Agreement. MedTest has also lost millions of dollars in additional business as a direct consequence of Highmark WV's breaches.

105. Highmark WV's breaches violate both the express terms of the Network Agreement as well as the covenant of good faith and fair dealing and are material in that they have caused MedTest to incur millions of dollars of damages. MedTest is therefore entitled to an award of both compensatory and consequential damages.

COUNT II

Negligence
(Against Highmark WV)

106. MedTest incorporates the allegations set forth in the foregoing paragraphs as though set forth herein.

107. Alternatively, Highmark WV was bound by a duty under the Network Agreement to reimburse MedTest for claims for reimbursement for laboratory testing services performed for members of health insurance plans administered or insured by Highmark WV or its fellow Blues.

108. Highmark breached its duties by negligently mispresenting, and causing its fellow Blues to misrepresent, MedTest's status in its National Networks and by negligently misrepresenting the instructions for properly submitting claims for reimbursement for laboratory testing services.

109. Highmark WV's negligence proximately caused MedTest to sustain millions of dollars in damages, not including interest, consequential damages, attorneys' fees, and costs.

110. Accordingly, Highmark WV is liable in negligence to MedTest, which is entitled to judgment in its favor.

COUNT III

Fraudulent Misrepresentation & Inducement (Against All Defendants)

111. MedTest incorporates the allegations set forth in the foregoing paragraphs as though set forth herein.

112. As alleged above, acting in concert, Defendants devised a scheme to induce MedTest to perform laboratory testing services without compensating it for the services provided.

113. Defendants carried out this scheme by representing to MedTest in the Network Agreement that it was a participating provider in their "National Networks" and by representing to MedTest, health care providers and members of the Blues' health insurance plans on their websites that MedTest was an in-network provider of laboratory testing services, then refusing to compensate MedTest for laboratory testing services provided in reliance upon these representations.

114. MedTest relied upon Defendants' misrepresentations that it was an in-network provider by providing laboratory testing services to members of health insurance plans insured and/or administered by Defendants for which Defendants now refuse to compensate MedTest. MedTest was justified under the circumstances in relying upon these representations.

115. As a direct result of Defendants' conduct, MedTest has provided millions of dollars' worth of laboratory testing services for which it has not been compensated. Accordingly, MedTest is entitled to an award of compensatory damages, consequential damages and punitive damages, as well as interest, attorneys' fees and costs.

COUNT IV

Civil Conspiracy
(Against All Defendants)

116. MedTest incorporates the allegations set forth in the foregoing paragraphs as though set forth herein.

117. Highmark WV and its fellow Defendants combined, through concerted action, to accomplish an unlawful purpose by devising and perpetrating a fraudulent scheme to induce MedTest to provide laboratory testing services to their health insurance plan members without paying for them, carrying out that scheme by representing to MedTest, other health care providers and their health insurance plan members that MedTest was an in-network provider of laboratory testing services but refusing to compensate MedTest for the provision of such services.

118. This fraudulent scheme injured MedTest by inducing it to provide millions of dollars' worth of laboratory testing services for which Defendants have refused to compensate MedTest.

119. Defendants benefitted from their refusal to compensate MedTest for the laboratory testing services by obtaining the services for members of their health insurance plans at no cost.

COUNT V

Joint Venture
(Against All Defendants)

120. MedTest incorporates the allegations set forth in the foregoing paragraphs as though set forth herein.

121. Highmark WV and its fellow Blues associated for the purpose of carrying out a scheme to obtain laboratory testing services from MedTest without compensating it for those services, to MedTest's detriment.

122. By associating, Highmark WV and its fellow Blues colluded and combined their property, money, skill, and knowledge to carry out their scheme, misleading MedTest into performing millions of dollars of laboratory testing services for their members without compensation. Highmark WV and its fellow Blues, which jointly manage and control this scheme, share in the profits generated by this scheme.

123. The combined efforts of Defendants to carry out their scheme make each Defendant in this joint venture responsible and liable for any and all conduct arising therefrom.

124. As a foreseeable, direct, and proximate cause of Defendants' joint venture, MedTest has sustained millions of dollars in damages and is entitled to judgment and appropriate relief, including compensatory and punitive damages, and attorneys' fees and costs.

COUNT VI

Unjust Enrichment
(Against All Defendants)

125. MedTest incorporates the allegations set forth in the foregoing paragraphs as though set forth herein.

126. As alleged above, Defendants' refusal to compensate MedTest for laboratory testing services it provided to members of health insurance plans insured and/or administered by Defendants was in breach of contract, fraudulent and caused MedTest to provide millions of dollars' worth of laboratory testing services to members of Defendants' health insurance plans without compensation.

127. Defendants appreciated that they were obligated to compensate MedTest for the millions of dollars' worth of laboratory services that MedTest provided to members of their health insurance plans yet refused to do so.

128. Defendants have retained and been enriched by the millions of dollars' worth of laboratory testing services that MedTest provided to members of Defendants' health insurance plans for which compensation has not been provided.

129. Because Defendants have been unjustly enriched, it would violate fundamental principles of justice, equity and good conscience for them to retain the millions of dollars they have refused to pay MedTest.

PRAYER FOR RELIEF

WHEREFORE, MedTest requests that this Court:

a. Adjudge and decree that Highmark WV has breached the Network Agreement;

b. Adjudge and decree that Highmark WV acted negligently;

c. Adjudge and decree that all Defendants made fraudulent misrepresentations and inducements;

d. Adjudge and decree that all Defendants engaged in and are jointly and severally liable for their wrongful conduct as participants in a civil conspiracy;

e. Adjudge and decree that all Defendants engaged in and are jointly and severally liable for their wrongful conduct as participants in a joint venture;

f. Adjudge and decree that all Defendants have been unjustly enriched; and

g. Award MedTest compensatory, consequential and/or punitive damages or other economic relief in amounts to be proven at trial;

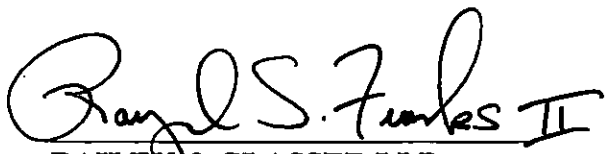
h. Award prejudgment interest, attorneys' fees and costs; and

i. Award any such other and further relief as may be just and proper.

JURY DEMAND

MedTest demands a trial by jury on all issues so triable.

Dated: April, 8, 2019



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Counsel for MedTest Laboratories, LLC, Billy Taylor, Brice Taylor, Muhammad Amjad, Ph.D., Michael Chen, Ph.D., James Taylor, and Vitas Laboratory, LLC

Exhibit A

AGRHMWV
CONTRACT

HIGHMARK WEST VIRGINIA INC., d/b/a HIGHMARK BLUE CROSS BLUE SHIELD WEST VIRGINIA

An Independent Licensee of the Blue Cross and Blue Shield Association

PARTICIPATING NETWORK AGREEMENT
COVER PAGE

Provider (the individual or entity who/that is the party to the Agreement):

MedTest Laboratories LLC

Legal Name (Individual or Entity)

d/b/a Name (If applicable)

Vendor Name	Highmark Blue Shield Number	NPI Number
MedTest Laboratories LLC	3404189	1821471318

LISTING OF PRACTITIONERS

Preferred Provider, by its signature on the execution page of the Highmark West Virginia Inc., d/b/a Highmark Blue Cross Blue Shield West Virginia Participating Provider Agreement to which this Cover Page is attached, hereby certifies that the information provided in the foregoing Listing of Practitioners as prepared by Highmark Blue Cross Blue Shield West Virginia is accurate, true and correct. Participating Provider further understands and agrees that if it and its Practitioners are accepted as Highmark Blue Cross Blue Shield West Virginia Participating Providers, participation will be governed by the terms and conditions of the by Highmark Blue Cross Blue Shield West Virginia Participating Provider Agreement attached hereto as if all are a party thereto and the accompanying Regulations to such Participating Provider Agreement.

Do not add any names or other information to the following list. If information needs to be changed, please contact Highmark Blue Cross Blue Shield West Virginia prior to execution.

Those employed practitioners as credentialed and approved by Highmark Blue Cross Blue Shield West Virginia as of the Effective Date of this Agreement.

HIGHMARK. West Virginia

NETWORK AGREEMENT

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

I. PAYMENTS FOR COVERED SERVICES

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

B. **Annual Review.** Highmark WV shall perform annual reviews of its Reimbursement Allowances.

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

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

II. DEFINITIONS

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

III. CONDITIONS AND LIMITATIONS TO PAYMENTS

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

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

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

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

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

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

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

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

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

Act"), the West Virginia Unclaimed Property Act, and any Highmark WV contractual obligations to self-funded groups and other third parties.

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

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

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

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

IV. RECORD REVIEW

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

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

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

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

V. TERM AND TERMINATION

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

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

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

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

E. **Termination of Affiliated Providers.** Highmark WV reserves the right to terminate this Agreement as provided for herein with respect to any Affiliated Providers, as defined in Section VI, Paragraph S.1, of a Group Provider, as defined in Section VI Paragraph S.2, without termination of this Agreement as to the Group Provider.

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

VI. GENERAL PROVISIONS

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

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

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

Persons.

D. **Professional Responsibility.** Provider agrees that all duties performed hereunder shall be consistent with the proper practice of medicine and that such duties shall be performed in accordance with the customary rules of ethics and conduct of the applicable state professional licensure boards and agencies. Provider shall be solely responsible for the quality of services, including Covered Services, rendered to and/or treatment of Covered Persons. No action by Highmark WV pursuant to any provision of this Agreement or in relation to determinations of benefits for Covered Persons has, or is intended to have, the effect of infringing upon Provider's care and treatment of such Covered Persons and such actions are not a substitute for the medical judgment of Provider. Provider must exercise his/her own independent medical judgment regarding the administration, treatment or discharge of Covered Persons.

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

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

G. **Modification.** Highmark WV will use its best efforts to furnish Provider with written notification of material adverse changes in the terms of the Agreement at least sixty (60) days in advance of the effective date of the change but no less than thirty (30) days prior to the effective date of the change.

For changes that are not materially adverse, Highmark WV may amend the Agreement, except Section V, Paragraph B, upon thirty (30) days written notice. Notwithstanding the preceding, this Agreement or any provision hereof may be amended by Highmark WV immediately upon written notice to Provider in order to comply with applicable laws and the directives of government bodies.

Written notice may include paper or electronic notification.

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

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

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

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

L. **Use of Highmark WV or Blue Cross Blue Shield Association Name and Symbols.** Provider shall not

use any name, symbol, trademark or service mark held by or licensed to Highmark WV in advertising, promotional materials or otherwise without the prior, written consent of Highmark WV or the Blue Cross and Blue Shield Association.

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

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

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

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

Q. **Counterparts.** This Agreement may be executed in duplicate, each of which shall be deemed an original and which shall constitute one and the same instrument.

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

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

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

2. "Group Provider" shall mean a Provider that is a group practice or other affiliation of individual Affiliated Providers.

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

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

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

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

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

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

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

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

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

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

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

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

FF. **Compliance with Applicable Law.** Nothing contained in this Agreement is intended to or shall, in any way, reduce eliminate, or supersede any party's obligation to comply with applicable provisions of relevant state and federal laws and regulations. The obligations hereunder shall be fulfilled by Highmark WV to the extent permissible under applicable laws and regulations, the terms and conditions of current and future government contracts, and applicable governmental directives. To the extent state or federal law or regulation imposes, with respect to a specific obligation created in this Agreement, a greater obligation than that specifically set forth in this Agreement, Highmark WV shall comply with said law or regulation. Further, if, and during such time as, Highmark WV is unable to fulfill an obligation hereunder to the extent contemplated by this Agreement because to do so would require governmental approval or action, Highmark WV shall perform such obligation to the extent permissible under applicable laws and regulations, the terms and conditions of current and future government contracts, and applicable governmental directives, and Highmark WV shall continue to fulfill its other obligations hereunder to the extent permitted under applicable laws and regulations, the terms and conditions of current and future government contracts, and applicable governmental directives.

PREFERRED PROVIDER

Signature

1821471319
NPI Number

Muhammad Amjad, PhD
Printed name

Director
Title, if signing as the authorized representative of a group practice

PO Box 4100
Barboursville, WV 25504-4100
Mailing Address:

PO Box 4100
Barboursville, WV 25504-4100
Check Address:

08/15/2016
Execution Date

ACCEPTED BY:

HIGHMARK WEST VIRGINIA INC. d/b/a HIGHMARK BLUE CROSS BLUE SHIELD WEST VIRGINIA

Signature

Thomas J. Fitzpatrick, Senior Vice President, Provider Contracts and Relations
Printed name Title

Provider Information Management
PO Box 898842
Camp Hill, PA 17089-8842

Execution Date

Agreement Effective Date

Name: MedTest Laboratories LLC
Vendor Number: 3404189
Federal Tax ID: 47-4213979

ADDENDUM I
TO NETWORK AGREEMENT FOR SUPERBLUE PPO AND POS PARTICIPANTS

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

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

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

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

a. Highmark WV shall perform annual reviews of the SuperBlue Fees.

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

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

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

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

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

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

I. DEFINITIONS

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

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

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

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

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

II. OBLIGATIONS OF HIGHMARK WV

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

III. OBLIGATIONS OF PCP

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

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

C. **PCP's Covered Persons.** The PCP shall accept as patients those Covered Persons who have selected or have been assigned to PCP without regard to the health status or health care needs of such Covered Persons. PCP may, upon sixty (60) days prior written notice to Highmark WV, request that he/she does not wish to accept additional Covered Persons (excluding persons already in PCP's practice that enroll in a POS PPO as Covered Persons). Highmark WV may suspend, upon thirty (30) days prior written notice to PCP, any further selection of PCP by Covered Persons who are not PCP's Covered Persons at the time of such suspension. PCP agrees to initiate closure of his/her practice to additional Covered Persons only if his/her practice, as a whole, is to be closed to additional patients, unless this requirement is waived by Highmark WV.

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

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

Fax

To:	Credentialing	From:	Provider Maintenance
Fax:	304-399-2526	Fax:	
Company:	MedStat Laboratories LLC	Voice:	866-763-3224

Date: August 15, 2016
Subject: Highmark WV Medicare Agreement 3404189

Comments:

Please review, sign and date the attached agreement. Once completed, please fax back to 800-236-8641. Thank you!

AGRHMWVMA
CONTRACT

AMENDMENT TO PARTICIPATION AGREEMENT FOR MEDICARE ADVANTAGE PPO PROGRAM(S)

COVER PAGE

Participating Network Provider (the individual or entity who/that is the party to the Agreement):

MedTest Laboratories LLC

Legal Name (Individual or Entity)

d/b/a Name (if applicable)

Vendor Name	Highmark Blue Shield Number	NPI Number
MedTest Laboratories LLC	340418B	1821471319

LISTING OF PRACTITIONERS

Preferred Provider, by its signature on the execution page of the Highmark West Virginia Inc., d/b/a Highmark Blue Cross Blue Shield West Virginia Participating Provider Amendment to which this Cover Page is attached, hereby certifies that the information provided in the foregoing Listing of Practitioners as prepared by Highmark Blue Cross Blue Shield West Virginia is accurate, true and correct. Participating Provider further understands and agrees that if it and its Practitioners are accepted as Highmark Blue Cross Blue Shield West Virginia Participating Providers, participation will be governed by the terms and conditions of the by Highmark Blue Cross Blue Shield West Virginia Participating Provider Amendment attached hereto as if all are a party thereto and the accompanying Regulations to such Participating Provider Amendment.

Do not add any names or other information to the following list. If information needs to be changed, please contact Highmark Blue Cross Blue Shield West Virginia prior to execution.

Those employed practitioners as credentialed and approved by Highmark Blue Cross Blue Shield West Virginia as of the Effective Date of this Amendment.

HIGHMARK. West Virginia

AMENDMENT TO PARTICIPATION AGREEMENT FOR MEDICARE ADVANTAGE PPO PROGRAM(S)

THIS AMENDMENT (hereinafter "Amendment"), effective February 1, 2005, amends the Participation Agreement (hereinafter "Agreement") between Provider and Highmark West Virginia, Inc., d.b.a. Highmark Blue Cross Blue Shield West Virginia ("Highmark WV").

WHEREAS, Highmark WV and Provider have entered into an Agreement and also an Addendum to Participation Agreement, pursuant to which Provider participates in Highmark WV's commercial indemnity, preferred provider organization ("PPO") and point of service ("POS") networks and products; and

WHEREAS, Highmark WV desires to amend the Agreement to include Provider as a Preferred Provider in the network for new Medicare Advantage PPO Program(s) to become effective on or after June 1, 2005; and

WHEREAS, the Agreement authorizes Highmark WV to amend the Agreement upon advance written notice;

NOW THEREFORE, the Agreement is hereby amended as follows:

1. DEFINITIONS

Unless otherwise defined, capitalized terms as used in this Amendment shall have the meanings assigned to them below or elsewhere in the Amendment.

1.1. **"Affiliated Providers"** shall mean those professional providers (a) affiliated with a Group Provider through an employer-employee relationship, partnership, medical corporation membership or similar relationship; (b) who are currently participating providers via the Agreement between the Group Provider and Highmark WV; and (c) on whose behalf the Group Provider has entered into this Amendment.

1.2. **"Auxiliary Personnel"** shall mean non-physician personnel who assist in rendering Provider Services to Members under the supervision of Provider in accordance with applicable Laws and Highmark WV policies and procedures.

1.3. **"Clean Claim"** shall mean a claim (a) that has no material defect or impropriety, including all reasonably required information and substantiating documentation, to determine eligibility or to adjudicate the claim; or (b) with respect to which Highmark WV has failed timely to notify the person submitting the claim of any such defect or impropriety. The term shall not include a claim from a health care provider who is under investigation for fraud and/or abuse regarding that claim. This term shall also not include billings where the Member is not eligible under the terms of the Medicare Advantage PPO Program(s).

1.4. **"CMS"** shall mean the Centers for Medicare & Medicaid Services, a division of the United States Department of Health and Human Services, or a successor agency.

1.5. **"Coinsurance"** shall mean the percentage or portion of fees and charges payable by a Member.

1.6. **"Copayment"** shall mean the fixed, up-front dollar amount payable by a Member.

1.7. **"Covered Services"** shall mean those Provider Services rendered to Members which qualify for payment or reimbursement pursuant to the terms of the applicable Evidence of Coverage and any regulations and appeal procedures established by CMS or Highmark WV. Benefit maximums and exclusions for each Member shall be referenced in the Evidence of Coverage applicable to a Member.

1.8. **"Deductible"** shall mean an amount of fees and/or charges for Covered Services, usually stated in dollars, for which a Member is responsible before Highmark WV's payment responsibilities begin.

1.9. **"Effective Date"** shall mean the day and year stated at the beginning of this Amendment that the Amendment becomes effective.

1.10. **"Emergency Medical Condition"** shall mean a medical condition that is revealed by acute symptoms of sufficient severity (including severe pain) that a prudent layperson with an average knowledge of health and medicine could expect the absence of immediate attention to result in (a) serious jeopardy to the health of the Member (or an unborn child); (b) serious impairment to bodily functions; or (c) serious dysfunction of a bodily organ or part.

1.11. **"Emergency Services"** shall mean Covered Services that are (a) furnished by a qualified provider and (b) needed to evaluate or stabilize an Emergency Medical Condition.

1.12. **"Evidence of Coverage"** shall mean the document approved by CMS and issued by Highmark WV to Members that contains the rights and responsibilities of a Medicare beneficiary as a member of a Medicare Advantage PPO plan.

1.13. **"Group Provider"** shall mean a Provider that is a group practice or other affiliation of individual Affiliated Providers and that has an Agreement with Highmark WV.

1.14. **"HIPAA"** shall mean the Health Insurance Portability and Accountability Act of 1996, its regulations and any subsequent amendments thereto.

1.15. **"HIPAA Privacy Rule"** shall mean the regulations adopted under HIPAA by the United States Department of Health and Human Services (45 CFR Parts 160, 162 and 164).

1.16. **"Law"** or **"Laws"** shall mean any applicable federal or state statute, regulation, rule, code, ordinance, order, policy, directive, injunction, writ, decree, award or the like of any Official Body that is then in effect. Without in any way limiting the generality of the foregoing, any reference to any specific law herein or any specific sections or provisions thereof shall include existing provisions and all amendments, modifications or replacements of such law or the applicable specific sections or provisions which are adopted, issued, enacted or promulgated after the Effective Date.

1.17. **"Medical Necessity and Appropriateness"** shall mean a service or supply that is required to diagnose or treat an injury, ailment, condition, disease, disorder or illness and which

Highmark WV determines is:

- Appropriate with regard to the standards of good medical practice.
- Not primarily for the convenience of the Member or a provider.
- The most appropriate supply or level of service, which can be safely and adequately provided to the Member in the most cost-effective setting.

1.18. **"Medicare Advantage PPO Preferred Provider"** or **"Preferred Provider"** shall mean a provider of health care services who/which has entered into the necessary agreement(s) with and who/which meets the criteria established by Highmark WV to participate as a network provider in the Highmark WV Medicare Advantage PPO Program(s).

1.19. **"Medicare Advantage PPO Program," "Medicare Advantage PPO Programs"** or **"Medicare Advantage PPO"** shall mean the health care service PPO program or programs offered pursuant to a contract involving Highmark WV and CMS which complies with all applicable requirements of Part C of the Social Security Act, as amended from time to time, and which is available to individuals entitled to Medicare or any successor program(s) thereto regardless of the name(s) thereof.

1.20. **"Member"** shall mean a person who is an enrollee in a Highmark WV Medicare Advantage PPO Program.

1.21. **"Highmark WV"** shall mean (a) Highmark West Virginia, Inc., d.b.a. Highmark Blue Cross Blue Shield West Virginia; (b) any affiliate of Highmark WV; and (c) any entity or arrangement created by Highmark WV and another organization for the purposes of offering Medicare Advantage PPO Programs in Highmark WV's service area or within a region established by CMS that includes Highmark WV's service area.

1.22. **"Official Body"** or **"Official Bodies"** shall mean any governmental or political subdivision or any agency, authority, bureau, commission, department or instrumentality of either, or any court, tribunal, grand jury or arbitrator, in each case, which has jurisdiction over Highmark WV or Provider.

1.23. **"Overpayment"** shall mean a payment or payments greater in amount than actually due Provider under this Amendment or a payment or payments to which Provider was not entitled hereunder regardless of the reason and no matter how Highmark WV or Provider learns of such error. "Overpayment" shall also include any payments to Provider for Provider Services provided during any period in which Provider failed to satisfy applicable participation criteria as set forth in Section 2 and Section 7.2 of this Amendment.

1.24. **"Preferred Provider"** see 1.18."

1.25. **Protected Member Information"** shall mean all personally identifiable information about Members.

1.26. **"Provider"** shall mean the party to this Amendment and the underlying Agreement that is responsible for the provision of Provider Services to Members of Highmark WV's products.

1.27. **"Provider Services"** shall mean those services within the scope of Provider's practice and license and as customarily furnished to patients by Provider.

1.28. **"Term"** shall mean the term of this Amendment.

1.29. **"Usual Charges"** shall mean the amount that Provider bills other payors and/or patients for the same services.

No definition shall conflict with the definitions set forth in the Evidence of Coverage or any applicable provisions of federal or state Law. In the event of a conflict, the definitions contained in the Evidence of Coverage or any applicable provisions of federal or state Law shall control.

2. MEDICARE ADVANTAGE PPO PARTICIPATION CRITERIA

2.1. General Criteria. Provider shall meet the following general criteria as well as the criteria in Section 7.2 of this Amendment:

a. Have and maintain throughout the Term an active license from the appropriate Official Body in the State of West Virginia (or the state in which Provider practices) to render Provider Services; and

b. Participate, and throughout the Term continue to meet any and all applicable conditions necessary to participate, in the Medicare program where CMS would allow for Medicare participation by a practitioner within the same specialty and practice as Provider; and

c. As applicable to Provider and as required by Highmark WV, maintain active hospital admitting privileges in a hospital that is a Medicare Advantage PPO Preferred Provider; and

d. Not be sanctioned or excluded from participation under a federal health care program as described in Section 1128B(f) of the Social Security Act; and

e. Meet, and continue to meet, all other credentialing and recredentialing requirements as established by Highmark WV and set forth in Highmark WV's policies and procedures.

2.2. Notification of Status Changes. Provider shall promptly advise Highmark WV of: (a) any changes in the general criteria as applicable to Provider and as described in this Section 2 and Section 7.2 of this Amendment; (b) any changes in his or her credentialing criteria; (c) any changes in his or her identification information, including, but not limited to, any changes in the address of Provider's professional office or place of practice; and (d) any intent to close his or her practice to additional Members by providing Highmark WV with at least sixty (60) days' advance written notice.

2.3. Condition Precedent. Provider understands and agrees that having and maintaining said license and Medicare participation, as well as meeting other selection and general criteria as described in this Section 2 and Section 7.2 of this Amendment are a condition precedent to this Amendment and are an ongoing condition to Provider's provision of Provider Services to Members and Highmark WV's payment for Covered Services. Any change in such criteria can result in termination of this Amendment by Highmark WV in its sole discretion. Further, any such change may result, in the sole discretion of Highmark WV, in repayment by Provider to Highmark WV or setoff of future amounts due to Provider of any Overpayment made to Provider on or after the date of such change for Provider's failure to meet such criteria.

3. HIGHMARK WV GENERAL OBLIGATIONS AND AGREEMENTS

3.1. Eligibility and Payment Determinations. Highmark WV shall provide each Member with an identification card and provide Provider upon request with information such as benefit maximums and certain exclusions to inform Provider about the Member's specific benefits.

Highmark WV shall also provide determinations as to eligibility and authorization for Provider Services in accordance with applicable Highmark WV policies and procedures. Highmark WV shall comply with any time frames and procedures for expedited determinations set forth by applicable Laws.

3.2. Applicable Laws. Highmark WV agrees to operate, and perform its obligations under this Amendment, in accordance with all applicable Laws.

3.3. Operational Policies and Procedures. Highmark WV shall make available to Provider information concerning the operational policies and procedures in the form of a manual or otherwise with which Provider must comply, including prior notice of changes to such policies and procedures.

3.4. Provider Listings. Highmark WV will make listings or directories of Medicare Advantage PPO Preferred Providers available to Provider.

4. PROVIDER GENERAL OBLIGATIONS AND AGREEMENTS

4.1. Program Participation. Provider shall participate in all Medicare Advantage PPO Programs under the terms and conditions in this Amendment.

4.2. Provision of Services. Provider agrees that it will provide to Members all Provider Services and make reports to Highmark WV as reasonably required concerning such Provider Services. Provider agrees to render Provider Services in a manner consistent with professionally recognized standards of health care and consistent with Highmark WV's: (a) standards for timely access to care and Member services as described in this Section 4; (b) policies and procedures that allow for individual Medical Necessity and Appropriateness determinations; and (c) policies and procedures for Provider's consideration of the input of Members in the establishment of treatment plans. In addition, Provider will render Provider Services in a manner consistent with the proper practice of professionally recognized standards of care that govern Provider. To the extent applicable, Provider shall provide Members receiving Provider Services with advance directive notifications as required by Law, as well as document in a prominent part of the individual's current medical record whether or not the individual has executed an advance directive. Provider must ensure that services are provided in a culturally competent manner to all Members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds.

Provider shall render Provider Services in the most efficient manner and in the least costly setting for the appropriate treatment of the Member, and, to the extent feasible, he/she will utilize such additional Auxiliary Personnel as are available and appropriate for effective and efficient delivery of health care consistent with the terms of this Amendment. In rendering Provider Services, Provider can freely communicate with Members regarding the appropriate treatment options and alternatives available to them, including medication treatment options, regardless of benefit coverage limitations.

4.3. Availability of Provider Services. As applicable, Provider will maintain weekly appointment hours that are sufficient and convenient to serve Members. Provider agrees that scheduling of appointments for Members shall be done in a timely manner. As applicable and consistent with Highmark WV's administrative requirements, Provider shall make necessary and appropriate covering arrangements to assure the availability of Provider Services for Members on a 24 hour per day, 7 days per week basis. This includes covering arrangements to assure Provider Services can be rendered to Members after-hours or when Provider is otherwise absent. All such covering arrangements shall comply with and be made in accordance with Highmark WV's policies and procedures.

4.4. Use of Other Medicare Advantage PPO Preferred Providers. Except for Emergency Services, by a Member's specific request or the unavailability of a Medicare Advantage PPO Preferred Provider, Provider shall direct Members as needed for additional health care services to, and when ordering drugs and medical items or supplies for Members, Provider shall use, only other Medicare Advantage PPO Preferred Providers. Provider shall document in the Member's records any and all reasons why a Member was directed by Provider to a non-Medicare Advantage PPO Preferred Provider, and shall inform the Member that there may be additional costs to the Member resulting from such direction.

4.5. Guidelines, Policies and Procedures. In performance of his or her responsibilities under this Amendment, Provider agrees to comply with Highmark WV's guidelines, instructions and policies and procedures, as in effect from time to time and about which Provider receives notice, and the terms of any and all applicable Evidences of Coverage as heretofore or hereafter adopted or entered into by Highmark WV each of which are incorporated into this Amendment by reference. If Provider fails to comply with any applicable policies, procedures, guidelines, billing or other instructions, or other requirements, Highmark WV shall have the right in appropriate circumstances to pursue remedial actions as appropriate including, but not limited to, rejection of claims and/or review of claims on a retrospective basis and collection of any Overpayments. In such event, Provider will hold Highmark WV and the Member harmless with respect to fees and/or charges for Provider Services, except for the collection of applicable Copayments, Coinsurance and Deductibles.

4.6. Medical, Quality Improvement and Utilization Management Policies and Programs. Provider agrees to participate in, cooperate and comply with, and abide by decisions of Highmark WV with respect to Highmark WV's medical policies and medical management programs, procedures or activities; quality improvement and performance improvement programs, procedures and activities; and utilization and management review. Provider further agrees to comply and cooperate with an independent quality review and improvement organization's activities pertaining to the provision of Provider Services for Members.

Highmark WV agrees to consult with Medicare Advantage PPO Preferred Providers such as participating physicians and other health care professionals regarding its medical policies, quality improvement program and medical management programs and ensure that practice guidelines and utilization management guidelines:

a. are based on reasonable medical evidence or a consensus of health care professionals in the particular field;

b. consider the needs of the enrolled population;

c. are developed in consultation with participating physicians;

d. are reviewed and updated periodically; and

e. are communicated to Medicare Advantage PPO Preferred Providers and, as appropriate, to Members.

Highmark WV also agrees to ensure that decisions with respect to utilization management, Member education, coverage of services, and other applicable areas are consistent with the guidelines.

4.7. Prohibition of Fees For Directing Members. Provider is prohibited from paying or receiving a fee, rebate or any other consideration in return for (a) directing a Member to another provider or (b) furnishing services to a Member directed to him or her by another provider.

4.8. Reporting to CMS. Provider shall provide to Highmark WV all data and information in Provider's possession, to the extent applicable and as necessary, for Highmark WV to meet its data reporting and submission obligations to CMS. Such information includes, but is not limited to, the following:

a. any data necessary to characterize the context and purposes of each encounter between a Member and Provider;

c. any information necessary for CMS to administer and evaluate the program; as requested by Highmark WV, any information necessary (i) to show establishment and facilitation of a process for current and prospective Members to exercise choice in obtaining Covered Services; (ii) to report disenrollment rates of Members enrolled in Highmark WV for the previous two years; (iii) to report Member satisfaction; and (iv) to report health outcomes;

d. any information and data necessary for Highmark WV to meet the physician incentive disclosure obligations under Medicare Laws and CMS instructions and policies; and

e. any data necessary for Highmark WV to meet its reporting obligations under 42 C.F.R. § 422.516 and 42 C.F.R. § 422.257.

Further, Provider shall certify the accuracy, completeness and truthfulness of Provider generated encounter data that Highmark WV is obligated to submit to CMS.

5. PAYMENT AND BILLING

5.1. Payment. Subject to the limitations in this Section 5, Highmark WV agrees to pay Provider for Provider Services provided to eligible Members and determined to be Covered Services the lesser of: (a) payment due in accordance with Highmark WV's payment schedule(s) as applicable to Medicare Advantage PPO Program(s) and as currently in effect at the time Provider Services are rendered or (b) one hundred percent (100%) of Provider's Usual Charges. Such limitation will be calculated on a claim-by-claim basis.

All payments shall be subject to all payment terms and conditions set forth in this Section 5. In addition, all payments shall be subject to and net of applicable Copayments, Coinsurance and Deductibles. Further, all payments shall be subject to the terms of the Member's Evidence of Coverage or plan requirements, as well as to all applicable Highmark WV policies, procedures and reimbursement guidelines, as well as Medical Necessity and Appropriateness determinations, Highmark WV medical policies and, where applicable, Medicare guidelines.

5.2. Review and Adjustments to Payment Schedules. Highmark WV may review and adjust, in its sole discretion and from time to time during the Term, the payment schedule(s). Highmark WV will make payment schedules or summaries thereof and any changes thereto available by mailing notice, posting on its internet site or by other readily accessible means, and will further provide samplings of payment allowances applicable to Provider upon request.

5.3. Payment Data/Billing. Provider will submit encounter, claim and/or certain clinical data to Highmark WV or, as appropriate, to other providers, using such forms, media, format and coding structures as may from time to time be acceptable to and required by Highmark WV. Billings shall include all patient identification information and itemization of Provider Services in a standardized format acceptable to Highmark WV. Information identifying Provider Services provided to Members shall include standard references (CPT-4, HCPCS, ICD-9-CM or their successors) or such other more specific references as may be established

and required by Highmark WV. In unusual cases, a description of a Provider Service, a copy of the Member's records, or other appropriate documentation should be submitted. Over the Term of this Amendment, Medicare Advantage PPO Preferred Provider billing instructions will be issued periodically and made available to Provider to update and clarify the billing requirements of Highmark WV.

Provider shall be fully and completely responsible for all statements made on any claim form submitted to Highmark WV with respect to such services, regardless of the mode of execution or verification of such report that may be accepted by Highmark WV. If Provider misreports services to Highmark WV, Provider shall immediately notify Highmark WV in writing of such misreporting and shall be responsible for reimbursing Highmark WV for all payments which were caused by such misreporting.

5.4. Member Hold Harmless and Continuation of Benefits. Except for Copayments, Coinsurances and Deductibles, Provider shall look only to Highmark WV for the payment of Covered Services rendered to Members. In no event, including, but not limited to, nonpayment by Highmark WV, insolvency of Highmark WV or breach of this Amendment by Highmark WV or Provider, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from or have any recourse against Member or any persons acting on Member's behalf for Covered Services provided pursuant to this Amendment. This does not prohibit the collection of Copayments, Coinsurance and Deductibles from Members, as set forth in the Evidence of Coverage. Provider agrees that in the event of Highmark WV's insolvency or other cessation of operations, benefits to Members will continue through the period for which a premium has been paid, and benefits to Members confined in an inpatient facility on the date of insolvency or other cessation of operations will continue until their discharge. Provider further agrees that:

a. these provisions shall survive the termination of this Amendment, regardless of the cause giving rise to the termination, including, without limitation, insolvency of Highmark WV, and shall be construed for the benefit of Members; and

b. these provisions shall supersede any oral or written contrary agreement now in existence or hereafter entered into between Provider and Members or persons acting on their behalf insofar as such contrary agreement relates to liability for payment for, or continuation of, Covered Services provided under the terms and conditions hereof.

5.5. Copayments, Coinsurance and Deductibles. Provider will collect Copayments, Coinsurance and Deductibles as required by the Member's Evidence of Coverage except where such collection is prohibited or restricted by applicable Laws, and Highmark WV will reduce its payment for Covered Services to Provider by such amounts. Highmark WV will provide the necessary information to Provider so that Provider can collect the appropriate Copayments, Coinsurance and Deductibles from Member. Highmark WV shall have no responsibility for the collection of any Copayment, Coinsurance and Deductibles required by any Member's Evidence of Coverage.

5.6. Restrictions on Collection of Payment. Provider shall not collect charges from Members for Covered Services, with the exception of applicable Copayments, prior to receipt of claims disposition from Highmark WV. Further, Provider shall not bill or collect from a Member or Highmark WV charges itemized and distinguished from the Provider Services provided. Such charges include, but are not limited to, insurance surcharges, charges for overhead fees or facility fees, or fees for completing claim or other forms or submitting additional information to persons requested by Member or Highmark WV.

5.7. Prompt Payment. Highmark WV agrees to promptly pay Provider for Clean Claims submitted

for Covered Services within thirty (30) days after receipt of an electronic Clean Claim, and forty (40) days after receipt of a manually submitted Clean Claim. If Provider has any questions or concerns regarding a submitted claim, including, but not limited to, whether the claim is a Clean Claim or why the submitted claim has not been paid, Provider hereby agrees to contact Highmark WV regarding such questions and concerns.

5.8. Timely Filing. All claim forms for Provider Services performed for Members shall be submitted as soon as possible, but in no event later than three hundred sixty-five (365) days after the date of service. Fees and/or charges for Provider Services rejected as being over the applicable time limit shall not be collected from the Member.

5.9. Assignability of Accounts Receivables. Provider may assign his or her rights to payment for Covered Services performed for Members only in accordance with such procedure as Highmark WV may prescribe.

5.10. Overpayments. If Provider receives an Overpayment, Highmark WV shall be entitled to setoff any such Overpayment against any future payments due Provider and/or take any other action against Provider authorized under this Amendment or as otherwise permitted by Law or the Agreement. If no future payments are due to Provider, Provider shall reimburse Highmark WV an amount equal to such Overpayment within thirty (30) days of demand by Highmark WV. Provider shall report the receipt of any Overpayment it receives from Highmark WV as soon as practicable after learning of such Overpayment.

The above provisions will survive the expiration or earlier termination of this Amendment regardless of the reason.

5.11. Coordination of Benefits. If a Member's Evidence of Coverage contains a provision requiring coordination of benefits or non-duplication of benefits, Highmark WV will determine, in accordance with the terms of the Member's Evidence of Coverage, whether Highmark WV's liability for payment to Provider will be either primary or secondary. Payment to Provider will be made under the terms of the Member's Evidence of Coverage. Should the Member's Evidence of Coverage not provide for coordination of benefits or non-duplication of benefits, Provider will accept Highmark WV's payments made in accordance with the terms of this Amendment in full satisfaction for Covered Services. Provider will collect and provide to Highmark WV other payor information as requested.

5.12. Subrogation. Provider will cooperate with Highmark WV in efforts to pursue subrogation claims against others where recognized Law or contractual standards indicate that a person or entity other than Highmark WV has primary responsibility for payment.

6. DATA, RECORDS, REVIEWS AND AUDITS

6.1. Records System. Provider will maintain in a current, detailed, comprehensive, accurate and timely manner an adequate system for the collection, processing, maintenance, storage, retrieval and distribution of administrative, medical and financial records of all Provider Services rendered by Provider and his or her Auxiliary Personnel to Members. Provider agrees to maintain records, documents and any other information relating to Members and this Amendment for ten (10) years or such longer period as required by Law. With respect to each Member receiving Provider Services, Provider will maintain a single standard medical record in such form containing such information as required by all applicable Laws that govern his or her operations and the performance of this Amendment.

Provider agrees to (a) abide by all federal and state Laws regarding confidentiality and disclosure for medical records, other health information, and patient information; (b) protect

and maintain the confidentiality of all information and records relative to Members; (c) safeguard the privacy of any information that identifies a particular Member in compliance with all applicable Laws and Highmark WV policies and procedures governing the use and disclosure of such information and records; and (d) abide by all confidentiality requirements established by Highmark WV and the Medicare Advantage PPO Program requirements. Provider will ensure timely access by Members to the records and information that pertain to them and not disclose such information to any third party without the consent of the Member, except for dissemination as further described in this Section 6. In all such cases, information from, or copies of, records may be released only to authorized individuals. Provider must ensure that unauthorized individuals cannot gain access to or alter patient records. Original medical records must be released only in accordance with federal or state Laws, court orders or subpoenas.

6.2. Protected Member Information. All Protected Member Information is subject to various statutory privacy standards, including, without limitation, the regulations of the HIPAA Privacy Rule. Provider shall treat all such information in accordance with those standards, and shall use or disclose Protected Member Information only for the purposes stated in this Amendment or to comply with judicial process or any applicable Law.

Provider further agrees that Provider will adopt such policies and procedures, will execute or has executed such written agreements, and will provide or has provided such further assurances as required to make Provider's activities under this Amendment compliant on or before the final compliance date of any regulations of the Department of Health and Human Services adopted pursuant to HIPAA, including, without limitation, the following:

Business Associate Agreements	45 C.F.R. §164.504(e);
Information Safeguards	45 C.F.R. §164.530(c);
Standard Transactions	45 C.F.R. Part 162; and
Data Security	45 C.F.R. Part 164.

If the regulations adopted pursuant to HIPAA are modified in any way that affects the terms of this Amendment, this Amendment or Provider's obligations hereunder or thereunder, Provider agrees to adopt such policies and procedures, execute such written agreements and provide such further assurances as may be required to make Provider's activities under this Amendment compliant on or before the final compliance date of any such modifications.

The parties agree that all communications between Provider and Highmark WV that are required to meet the Standards for Electronic Transactions, as defined and set forth at 45 C.F.R. Part 162, shall do so. For any other communications between Highmark WV and Provider, Provider shall use such forms, tape formats or electronic formats as Highmark WV may approve.

The parties acknowledge and agree that the HIPAA Privacy Rule permits Provider to provide Protected Member Information to Highmark WV for purposes of Treatment, Payment and Health Care Operations (each as defined by the HIPAA Privacy Rule) without a consent or authorization, except for psychotherapy notes. The definition of Health Care Operations includes, but is not limited to, quality assessment and improvement activities, activities related to improving health or reducing health care costs, case management and care coordination, credentialing of providers and evaluating provider performance. Upon request by Highmark WV, Provider agrees to provide information, including Protected Member Information, to Highmark WV for purposes of Treatment, Payment and Health Care

Operations activities, in accordance with the requirements of HIPAA, without the authorization or consent of Members who are the subject of the Protected Member Information, unless such consent is otherwise required by state or federal Law, including, but not limited to, Laws regarding disclosure of mental health records, HIV-related information, and information regarding drug or alcohol abuse or dependence. In those instances where the Member's consent is required Provider agrees to obtain any and all consents and releases from a Member necessary for the disclosure of medical or other confidential information to Highmark WV for disclosures necessary under this Amendment or the underlying Agreement.

6.3. Use of Information and Data. Provider agrees, except as required by Laws or to the extent information is otherwise publicly available, not to utilize or disclose any information gathered or provided regarding the cost and utilization of health care services by Members (whether Member specific, account specific or aggregate) or software data which is the property of Highmark WV without the prior written consent of Highmark WV. Further, Provider will not disclose or permit the disclosure of any information, including fees, expenses and utilization derived from, through or provided by Highmark WV. Notwithstanding the foregoing, during the Term, Provider, in accordance with Laws, may use data regarding Members which is not individual Member specific or account specific if such data is included with similar data in a form which will not allow the party to whom disclosure is made to identify the Member from the information. Highmark WV, in accordance with Laws, may use and/or include data generated by Provider for studies and reports (including reports to his or her customers) on a customer-specific or aggregate basis. Highmark WV may also disclose the terms of this Amendment or provide a third party with a copy of this Amendment and information regarding terms of payment where a disclosure of terms is required for an audit.

6.4. Reviews, Access and Audits. Provider acknowledges that, in accordance with 42 CFR §422.502(e)(4), the U.S. Secretary of Health and Human Services, the Comptroller General, or their designees have the right to audit, evaluate or inspect any books, contracts, medical records, patient care documentation, and other records of Provider or his or her subcontractors or transferees involving transactions related to Highmark WV's Medicare Advantage PPO contract(s) and Members thereunder through ten (10) years (a) from the final date of the contract period, (b) from the date of the completion of any audit or (c) for such longer period provided for in other applicable Law, whichever is later, unless (i) CMS determines there is a special need to retain a particular record or group of records for a longer period and notifies Highmark WV at least thirty (30) days before the normal disposition date; (ii) there has been a termination, dispute or fraud or similar fault by Highmark WV, in which case the retention may be extended to six (6) years from the date of any resulting final resolution of the termination, dispute or fraud or similar fault; or (iii) CMS determines that there is a reasonable possibility of fraud, in which case it may inspect, evaluate and audit Highmark WV at any time. Provider agrees to make available Provider's premises, physical facilities, equipment, records relating to Members, and any additional relevant information that CMS may require.

Highmark WV or its designated agent or agents (herein for purposes of this Section 6.4, collectively "Highmark WV") shall have access at all reasonable times, upon reasonable demand, to the books, medical records, other records and papers of Provider relating to Provider Services rendered to Members, the records regarding the charges made by Provider for Provider Services, and payments received by Provider from Members or other third-party payers for Members. Further, Highmark WV may perform any and all reviews (on-site or otherwise) and audits of Provider that it deems necessary to include, but not be limited to, credentialing and peer review program activities, medical practice audits, medical necessity reviews, data validation reviews, billing and claims payment audits, coding audits

and quality improvement audits. Provider agrees to permit and cooperate in such reviews and audits, participate in any special studies requested by Highmark WV, provide Highmark WV access to all records and reports and facilities related to such activities, and participate in any corrective action plan required by Highmark WV. Such records are to be provided to Highmark WV at no cost. Based on such review, Highmark WV shall have the right to deny payment, to reject claims and/or review claims on a retrospective basis and collect any Overpayments. In such event, Provider will hold Highmark WV and the Member harmless with respect to payment for Provider Services, except for the collection of applicable Copayments, Coinsurance and Deductibles.

The obligations of the Provider set out in this Section 6.4 shall extend to other Official Bodies and employees or agents of Official Bodies. Provider agrees to make available to Official Bodies: Provider's premises, physical facilities, equipment, records relating to Members, and any additional relevant information that Highmark WV or Official Body may require. The Provider understands and acknowledges that the medical records referred to in this Section 6.4 shall be and remain the property of Provider and shall not be removed or transferred from Provider except in accordance with applicable Laws

6.5. Provision of Records for Treatment. In the event of (a) termination of this Amendment, (b) the selection by a Member of another provider or (c) as otherwise necessary and appropriate for treatment of a Member, Provider agrees to transfer copies of the Member's medical records, x-rays, or other data when requested to do so in writing by Highmark WV, another provider or the Member. Such records are to be provided to Highmark WV at no cost.

6.6. Survival. Obligations under this Section 6 shall survive the expiration or termination of this Amendment.

7. ADDITIONAL MEDICARE ADVANTAGE PPO REQUIREMENTS

In addition to all other terms and conditions contained in this Amendment, the following additional Medicare Advantage PPO Requirements shall apply to Provider's provision of Provider Services and Highmark WV's payment for Covered Services to Members:

7.1. Adequate Network. Both parties acknowledge and agree that Highmark WV contracts with providers to create a network of Medicare Advantage PPO Preferred Providers in order to provide adequate access to health services for Members enrolled in Medicare Advantage PPO Program(s).

7.2. Medicare Participation Requirements. Neither Provider nor Highmark WV may employ or subcontract with an individual, or with an entity that employs or contracts with an individual, who is excluded from participation in Medicare under Section 1128 or 1128A of the Social Security Act or from participation in a federal health care program for the provision of any of the following: (a) health care, (b) utilization review, (c) medical social work or (d) administrative services. Provider acknowledges that this Amendment shall be automatically terminated if Provider, or a person with an ownership or control interest in Provider, is excluded from participation in Medicare under Section 1128 or 1128A of the Social Security Act or from participation in any other federal health care program. Any payments received by Provider hereunder on or after the date of such exclusion shall constitute Overpayments.

7.3. Affiliated Provider Credentials. To the extent applicable and required, Provider agrees that the credentials of any of Provider's Affiliated Providers and any Auxiliary Personnel will be reviewed by Highmark WV.

7.4. Delegation. Highmark WV delegates to Provider its responsibility under its Medicare Advantage PPO contract with CMS, as applicable, to render Provider Services to Members as set forth in this Amendment. Highmark WV may revoke this delegation, including, if applicable, the delegated responsibility to meet CMS reporting requirements, and thereby terminate this Amendment if CMS or Highmark WV determines that Provider has not performed satisfactorily or if Provider's reporting and disclosure obligations under this Amendment are not fully met in a timely manner. Such revocation shall be consistent with the termination provisions of this Amendment. Highmark WV shall monitor performance of Provider on an ongoing basis.

Provider acknowledges that Highmark WV shall oversee and is accountable to CMS for the functions and responsibilities described in the regulatory standards governing the Medicare Advantage PPO Program(s) on an on-going basis and is ultimately responsible to CMS for the performance of all services. Further, Provider acknowledges that Highmark WV may only delegate such functions and responsibilities in a manner consistent with the standards set forth under 42 CFR §422.502(i)(4).

7.5. Equal Access and Non-Discrimination. Provider shall not deny, limit, discriminate or condition the furnishing of Provider Services to Members on the basis of any factor that is related to race, color, national origin, ancestry, religion, sex, marital status, sexual preference, disability, age, source of payment, cost, anticipated cost, membership in a Medicare Advantage PPO Program, or health status (to include, but not be limited to, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, conditions arising out of acts of domestic violence or disability). In accordance with the preceding sentence, Provider agrees that under no circumstance will Provider refuse to render Provider Services based on the assumption that the anticipated cost that will be incurred by Provider will be in excess of Highmark WV's payment of Covered Services. Further, Provider shall provide Members with equal access at all times during the Term to those Provider Services that are made available to other persons who are not Members.

7.6. Treatment Plans, Health Assessments, Follow-Up Care and Self-Care. Provider acknowledges that Highmark WV has or will have procedures approved by CMS to (a) identify Members with complex or serious medical conditions; (b) assess those conditions, including medical procedures to diagnose and monitor them on an ongoing basis; and (c) establish and implement a treatment plan appropriate to those conditions with an adequate number of direct access visits to specialists to accommodate the treatment plan. To the extent applicable, Provider agrees to assist in the development and implementation of the treatment plans. In addition, and to the extent applicable, Provider agrees to cooperate with conducting a health assessment of all new Members within ninety (90) days of the effective date of their enrollment. Further and in accordance with Highmark WV policies and procedures, Provider will, to the extent applicable, inform Members of follow-up care and/or provide Members with training in self-care.

7.7. Subcontractors. Provider agrees that if Provider enters into subcontracts to render any Provider Services to Members that are permitted under the terms of this Amendment, Provider's subcontracts shall include the following:

a. an agreement by the subcontractor to comply with all of Provider's obligations in this Amendment;

b. a prompt payment provision as negotiated by Provider and the subcontractor;

c. a provision setting forth the terms of payment and any incentive arrangements;

d. a provision setting forth the term of the subcontract (preferably one year or longer); and

e. dated signatures of all parties to the subcontract.

7.8. Interpretation of Amendment. Provider and Highmark WV agree that the terms of this Amendment, as they relate to the provision of Provider Services under the Medicare Advantage PPO Program(s), shall be interpreted in a manner consistent with applicable requirements under Medicare Laws and CMS instructions and policies.

7.9. Compliance with Laws, Contractual Obligations and Policies and Procedures. Provider agrees to comply, and to require any of his or her permitted subcontractors to comply, with all applicable Laws, including, but not limited to, Medicare Laws and CMS instructions and policies. Provider also agrees that any Provider Services or other activity performed by Provider, his or her Auxiliary Personnel or his or her permitted subcontractors on Members will be consistent with and will comply with the contractual obligations of Highmark WV as a Medicare Advantage PPO organization.

7.10. Member Grievances and Appeals. Highmark WV shall establish and maintain fair and efficient procedures in accordance with applicable Laws to handle Members' grievances and appeals. Provider agrees to comply with Medicare requirements regarding Member appeals and grievances and to cooperate with Highmark WV in meeting his or her obligations regarding Member appeals, grievances and expedited appeals, including the gathering and forwarding of information in a timely manner as well as compliance with appeals decisions.

7.11. Emergency Services. To the extent required by Law, Highmark WV provides coverage of Emergency Services for Members. Where applicable, Highmark WV shall pay Provider for Emergency Services rendered to Members without regard to prior authorization. Provider also hereby agrees to notify Highmark WV of Emergency Services provided to any Member in accordance with the terms and conditions contained in applicable Laws and Highmark WV policies and procedures.

7.12. Federal Funds. Provider acknowledges payments that Provider receives from Highmark WV for Covered Services provided to Members are, in whole or part, from federal funds. Therefore, Provider and any of his or her subcontractors are subject to certain Laws that are applicable to individuals and entities receiving federal funds, including, but not limited to, Title VI of the Civil Rights Act of 1964 as implemented by 45 C.F.R. Part 84; the Age Discrimination Act of 1975 as implemented by 45 C.F.R. Part 91; the Rehabilitation Act of 1973; and the Americans with Disabilities Act.

7.13. Incentives. In the event that the compensation paid to Provider under this Amendment provides for incentives in connection with Covered Services, Provider further acknowledges and agrees as follows:

a. Highmark WV rewards decision making based on appropriateness of care and service as well as actively discourages barriers to such care and service; and

b. Highmark WV does not compensate and does not provide direct or indirect incentives to practitioners or other individuals conducting utilization review for approvals or denials of payment or coverage for the delivery of any health care service; and

c. Incentives for decision makers are in no way meant to encourage them to compromise decisions about appropriate Member care.

8. TERM AND TERMINATION

8.1. This Amendment shall be effective on the date first stated herein and shall continue in effect thereafter until terminated (a) by either party according to the following provisions of this Section 8 or (b) by termination of the underlying Amendment.

8.2. This Amendment may be terminated by either party with or without cause upon sixty (60) days prior written notice.

8.3. This Amendment may be terminated by Highmark WV immediately as follows:

a. Provider's failure to meet any or all of the general participation criteria set forth in Section 2 or Section 7.2 of this Amendment; or

b. The determination by Highmark WV, in its sole judgment, that continuation of this Amendment may negatively affect patient care or an occurrence which, in Highmark WV's sole judgment, may jeopardize the health, safety or well-being of Members or impair Provider's ability to perform his or her duties hereunder; or

c. The failure of Highmark WV to participate in the Medicare Advantage PPO Program(s) and/or withdrawal, expiration, non-renewal, suspension, modification, sanction, or termination of Highmark WV's participation in the Medicare Advantage PPO Program(s) in effect as of the date hereof; or

d. CMS or Highmark WV, in its sole discretion, determines that: (i) Provider has not performed satisfactorily or (ii) Provider's reporting and disclosure obligations under this Amendment are not fully met in a timely manner; or

e. Provider's failure to comply with the equal access and non-discrimination requirements set forth in Section 7.5 of this Amendment.

8.4. Highmark WV reserves the right to terminate this Amendment, as set forth in this Section 8 or as otherwise provided for in this Amendment, with respect to any individual Affiliated Provider, without termination of the Amendment as to either the Group Provider or other Affiliated Providers.

8.5. An existing Provider shall have the right to appeal a termination initiated by Highmark WV (other than for failure to meet initial credentialing requirements). Such appeals shall be in writing and be addressed to the Highmark WV credentialing committee as indicated in the applicable Highmark WV credentialing policies and procedures.

8.6. In addition to the rights stated herein, the non-defaulting party shall have any and all remedies otherwise available at law or in equity, including, without limitation, specific performance.

9. OBLIGATIONS UPON TERMINATION

9.1. Return of Highmark WV Documents. Subject to the any applicable continuation of benefits provisions, Provider will immediately return all forms, policies, procedures, manuals and materials of every kind, if any, provided by Highmark WV upon termination of this Amendment. Highmark WV and Provider acknowledge that any procedures, forms, policies, manuals and materials developed by Provider are the property of Provider and are not subject to this Section 9.1.

9.2. General Cooperation with Highmark WV. Subject to any applicable continuation of benefits provisions, Provider shall cooperate with Highmark WV upon this Amendment's termination with the following:

a. Highmark WV's obtaining information regarding Members that may be affected by such termination because they are undergoing an ongoing course of treatment or are otherwise active patients of Provider including the name, address and identification number of affected Members; and/or

b. The orderly transfer of Members to other Medicare Advantage PPO Preferred Providers or other providers designated by Highmark WV, as applicable; and/or

c. The continued care of a Member until discharge from an inpatient facility or, for a Member undergoing an ongoing course of treatment, until clinically appropriate as designated by Highmark WV, to be provided and paid in accordance with the terms and conditions of this Amendment; and/or

d. The orderly transfer of Member records as applicable; and/or

e. The resolution of any administrative and/or financial matter related to Provider's provision of Provider Services and Highmark WV's payment for Covered Services hereunder.

10. INSURANCE

Provider shall, at his or her sole cost and expense, maintain at all times during the Term such policies of general liability and professional liability (malpractice) insurance to insure Provider against any claim or claims for damages arising by reason of personal injury or death occasioned, directly or indirectly, in connection with the performance of any Provider Service by Provider. The amounts and extent of such insurance coverage shall be subject to the determination and approval of Highmark WV in accordance with Highmark WV's credentialing and recredentialing policies and procedures but shall not be less than the amounts required by applicable state Laws. Provider shall provide evidence of such insurance coverage to Highmark WV upon request. In addition, Provider shall notify Highmark WV at least ten (10) days in advance of any reduction or termination of such coverage.

11. RELATIONSHIP OF THE PARTIES

Both Provider and Highmark WV expressly understand and agree that no provision of this Amendment or this Amendment is intended to create, nor shall be deemed or construed to create, the relationship of agent, servant, employee, partnership, joint venture, association or any other relationship between the parties other than that of independent contractors contracting with each other hereunder solely for the purpose of effecting the provisions of this Amendment. Neither Provider nor Highmark WV shall be liable to any other party for any act, or any failure to act, of the other party. Provider when performing Provider Services for Members is not an employee of Highmark WV, and Highmark WV shall do nothing to interfere with the customary provider-patient relationship in such cases. Highmark WV shall not be liable or responsible to anyone or any person whatsoever as a result of any negligence, misfeasance, malfeasance or malpractice on the part of Provider or his or her Auxiliary Personnel when they are performing Provider Services for Members.

12. USE OF NAMES

Provider agrees to allow his or her name, office address, telephone number and similar information to be listed in Highmark WV's marketing materials and its roster and/or directory of Medicare Advantage PPO Preferred Providers that is given to Members and prospective Members or as available on internet web-sites. Provider shall not reference Highmark WV in any publicity, advertisements, notices, or promotional material or in any announcement to the Members without prior review and written approval of Highmark WV.

13. BLUE CROSS AND BLUE SHIELD ASSOCIATION LIABILITY AND DISCLAIMER

Provider hereby expressly acknowledges his or her understanding that this Amendment and the underlying Agreement constitute a contract between Provider and Highmark WV, that Highmark WV is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, permitting Highmark WV to use the Blue Cross and Blue Shield Service Marks in the State of West Virginia and Washington County, Ohio, and that Highmark WV is not contracting as the agent of the Blue Cross and Blue Shield Association. Provider further acknowledges and agrees that he or she has not entered into this Amendment or the underlying Agreement based upon any representations by any person other than Highmark WV and that no person, entity, or organization other than Highmark WV shall be held accountable or liable to Provider for any of Highmark WV's obligations to Provider as created under this Amendment and the underlying Agreement. This paragraph shall not create any additional obligations whatsoever on the part of Highmark WV other than those obligations created under other provisions of this Amendment and the underlying Agreement.

14. ENTIRE AGREEMENT

This Amendment, all other documents incorporated by reference into this Amendment, and the Agreement contain all of the terms and conditions agreed upon by the parties hereto regarding the subject matter of this Amendment. Any prior agreements, understandings, promises, negotiations or representations of or between the parties, either oral or written, relating to the subject matter of this Amendment are null and void and of no further force or effect, unless otherwise stated. This Amendment applies only to Members, as such term is defined herein, and shall not be deemed to replace or terminate any other agreement between the Provider, on the one hand, and Highmark WV and/or an affiliate, on the other hand, for Provider Services rendered to other subscribers or members of Highmark WV and/or such affiliate. In the case of any conflict(s) between this Amendment and the underlying Agreement, this Amendment shall take precedence.

15. PARTIES TO THE AMENDMENT/AGREEMENT: GROUP PROVIDER AND AFFILIATED PROVIDERS

If Provider is a Group Provider, then it represents and warrants that it has the authority to act on behalf of any Affiliated Providers of that Group Provider. Group Provider further represents and warrants that all Affiliated Providers of that Group Provider shall be bound by, agree to, and shall comply with all terms and provisions of this Amendment and the Agreement. If a Provider is a Group Provider, any reference in this Amendment or Agreement to Provider shall be interpreted as applying to both the Group Provider and all individual Affiliated Providers of that Group Provider. A Group Provider may add additional Affiliated Providers by submitting a credentialing application and other documents/information as required by Highmark WV, including a designation of the Group Provider-Affiliated Provider relationship. The Group Provider represents and warrants that this Amendment and Agreement shall apply to such additional Affiliated Providers to the same extent as they apply to existing Affiliated Providers of that Group Provider.

16. AMENDMENTS

This Amendment may be amended by the mutual written consent of the parties. In addition, Highmark WV may amend any provision of this Amendment upon forty-five (45) days prior written notice to Provider. Notwithstanding the foregoing, this Amendment may be amended from time to time upon written notice to Provider in order to comply with applicable Laws or the directives of CMS or other Official Bodies or applicable accrediting bodies, with such amendment being effective immediately upon written notice.

17. GOVERNING LAWS AND VENUE

This Amendment shall be governed in all aspects by the Laws of the State of West Virginia and, where applicable, federal Law. Exclusive venue for any action arising from this Amendment shall be before the courts of Wood County, West Virginia.

18. NOTICES

Any notice which either party must give under this Amendment shall be given in writing and shall be faxed or sent by first class mail, postage prepaid and shall be sent to the other party at its respective place of business as designated pursuant to the Agreement.

19. ASSIGNMENT

No assignment of this Amendment or the rights, duties or obligations under this Amendment shall be made by Provider, without the written consent of Highmark WV, which consent shall not be unreasonably withheld. Highmark WV may, in its sole discretion, assign this Amendment or any of its rights, duties or obligations hereunder without the consent of Provider. Highmark WV does hereby assign this Amendment, and its rights, duties and obligations hereunder, to Highmark Health Insurance Company ("HHIC") to be effective as of the date of execution. HHIC may, at its sole discretion, assign this Amendment or its rights, duties or obligations under this Amendment without consent of the Provider.

(Signatures on Next Page)

This Amendment may be executed in duplicate, each of which shall be deemed an original and which shall constitute one and the same instrument. Upon acceptance of this Amendment by Highmark WV, a fully executed copy of this Amendment shall be sent to Provider.

By signing hereunder, I certify that I have full authority to bind all members of the group practice referenced above, if applicable.

PREFERRED PROVIDER

Signature

1821471319
NPI Number

Muhammad Amjad, PhD
Printed name

Director
Title, if signing as the authorized representative of a group practice

PO Box 4100
Barboursville, WV 25504-4100
Mailing Address:

PO Box 4100
Barboursville, WV
Check Address:

08/15/2016
Execution Date

ACCEPTED BY:

HIGHMARK WEST VIRGINIA INC. d/b/a HIGHMARK BLUE CROSS BLUE SHIELD WEST VIRGINIA

Signature

Thomas J. Fitzpatrick, Senior Vice President, Provider Contracts and Relations
Printed name Title

Provider Information Management
PO Box 898842
Camp Hill, PA 17089-8842

Execution Date

Agreement Effective Date

Name: MedTest Laboratories LLC
Vendor Number: 3404189
Federal Tax ID: 47-4213979

AMENDMENT TO PARTICIPATION AGREEMENT FOR MEDICARE ADVANTAGE PPO PROGRAM(S)

COVER PAGE

Participating Network Provider (the individual or entity who/that is the party to the Agreement):

MedTest Laboratories LLC

Legal Name (Individual or Entity)

d/b/a Name (if applicable)

Vendor Name	Highmark Blue Shield Number	NPI Number
MedTest Laboratories LLC	3404189	1821471319

LISTING OF PRACTITIONERS

Preferred Provider, by its signature on the execution page of the Highmark West Virginia Inc., d/b/a Highmark Blue Cross Blue Shield West Virginia Participating Provider Amendment to which this Cover Page is attached, hereby certifies that the information provided in the foregoing Listing of Practitioners as prepared by Highmark Blue Cross Blue Shield West Virginia is accurate, true and correct. Participating Provider further understands and agrees that if it and its Practitioners are accepted as Highmark Blue Cross Blue Shield West Virginia Participating Providers, participation will be governed by the terms and conditions of the by Highmark Blue Cross Blue Shield West Virginia Participating Provider Amendment attached hereto as if all are a party thereto and the accompanying Regulations to such Participating Provider Amendment.

Do not add any names or other information to the following list. If information needs to be changed, please contact Highmark Blue Cross Blue Shield West Virginia prior to execution.

Those employed practitioners as credentialed and approved by Highmark Blue Cross Blue Shield West Virginia as of the Effective Date of this Amendment.

HIGHMARK. West Virginia

AMENDMENT TO PARTICIPATION AGREEMENT FOR MEDICARE ADVANTAGE PPO PROGRAM(S)

THIS AMENDMENT (hereinafter "Amendment"), effective February 1, 2005, amends the Participation Agreement (hereinafter "Agreement") between Provider and Highmark West Virginia, Inc., d.b.a. Highmark Blue Cross Blue Shield West Virginia ("Highmark WV").

WHEREAS, Highmark WV and Provider have entered into an Agreement and also an Addendum to Participation Agreement, pursuant to which Provider participates in Highmark WV's commercial indemnity, preferred provider organization ("PPO") and point of service ("POS") networks and products; and

WHEREAS, Highmark WV desires to amend the Agreement to include Provider as a Preferred Provider in the network for new Medicare Advantage PPO Program(s) to become effective on or after June 1, 2005; and

WHEREAS, the Agreement authorizes Highmark WV to amend the Agreement upon advance written notice;

NOW THEREFORE, the Agreement is hereby amended as follows:

1. DEFINITIONS

Unless otherwise defined, capitalized terms as used in this Amendment shall have the meanings assigned to them below or elsewhere in the Amendment.

1.1. **"Affiliated Providers"** shall mean those professional providers (a) affiliated with a Group Provider through an employer-employee relationship, partnership, medical corporation membership or similar relationship; (b) who are currently participating providers via the Agreement between the Group Provider and Highmark WV; and (c) on whose behalf the Group Provider has entered into this Amendment.

1.2. **"Auxiliary Personnel"** shall mean non-physician personnel who assist in rendering Provider Services to Members under the supervision of Provider in accordance with applicable Laws and Highmark WV policies and procedures.

1.3. **"Clean Claim"** shall mean a claim (a) that has no material defect or impropriety, including all reasonably required information and substantiating documentation, to determine eligibility or to adjudicate the claim; or (b) with respect to which Highmark WV has failed timely to notify the person submitting the claim of any such defect or impropriety. The term shall not include a claim from a health care provider who is under investigation for fraud and/or abuse regarding that claim. This term shall also not include billings where the Member is not eligible under the terms of the Medicare Advantage PPO Program(s).

1.4. **"CMS"** shall mean the Centers for Medicare & Medicaid Services, a division of the United States Department of Health and Human Services, or a successor agency.

1.5. **"Coinsurance"** shall mean the percentage or portion of fees and charges payable by a Member.

1.6. **"Copayment"** shall mean the fixed, up-front dollar amount payable by a Member.

1.7. **"Covered Services"** shall mean those Provider Services rendered to Members which qualify for payment or reimbursement pursuant to the terms of the applicable Evidence of Coverage and any regulations and appeal procedures established by CMS or Highmark WV. Benefit maximums and exclusions for each Member shall be referenced in the Evidence of Coverage applicable to a Member.

1.8. **"Deductible"** shall mean an amount of fees and/or charges for Covered Services, usually stated in dollars, for which a Member is responsible before Highmark WV's payment responsibilities begin.

1.9. **"Effective Date"** shall mean the day and year stated at the beginning of this Amendment that the Amendment becomes effective.

1.10. **"Emergency Medical Condition"** shall mean a medical condition that is revealed by acute symptoms of sufficient severity (including severe pain) that a prudent layperson with an average knowledge of health and medicine could expect the absence of immediate attention to result in (a) serious jeopardy to the health of the Member (or an unborn child); (b) serious impairment to bodily functions; or (c) serious dysfunction of a bodily organ or part.

1.11. **"Emergency Services"** shall mean Covered Services that are (a) furnished by a qualified provider and (b) needed to evaluate or stabilize an Emergency Medical Condition.

1.12. **"Evidence of Coverage"** shall mean the document approved by CMS and issued by Highmark WV to Members that contains the rights and responsibilities of a Medicare beneficiary as a member of a Medicare Advantage PPO plan.

1.13. **"Group Provider"** shall mean a Provider that is a group practice or other affiliation of individual Affiliated Providers and that has an Agreement with Highmark WV.

1.14. **"HIPAA"** shall mean the Health Insurance Portability and Accountability Act of 1996, its regulations and any subsequent amendments thereto.

1.15. **"HIPAA Privacy Rule"** shall mean the regulations adopted under HIPAA by the United States Department of Health and Human Services (45 CFR Parts 160, 162 and 164).

1.16. **"Law"** or **"Laws"** shall mean any applicable federal or state statute, regulation, rule, code, ordinance, order, policy, directive, injunction, writ, decree, award or the like of any Official Body that is then in effect. Without in any way limiting the generality of the foregoing, any reference to any specific law herein or any specific sections or provisions thereof shall include existing provisions and all amendments, modifications or replacements of such law or the applicable specific sections or provisions which are adopted, issued, enacted or promulgated after the Effective Date.

1.17. **"Medical Necessity and Appropriateness"** shall mean a service or supply that is required to diagnose or treat an injury, ailment, condition, disease, disorder or illness and which

Highmark WV determines is:

- Appropriate with regard to the standards of good medical practice.
- Not primarily for the convenience of the Member or a provider.
- The most appropriate supply or level of service, which can be safely and adequately provided to the Member in the most cost-effective setting.

1.18. **"Medicare Advantage PPO Preferred Provider"** or **"Preferred Provider"** shall mean a provider of health care services who/which has entered into the necessary agreement(s) with and who/which meets the criteria established by Highmark WV to participate as a network provider in the Highmark WV Medicare Advantage PPO Program(s).

1.19. **"Medicare Advantage PPO Program,"** **"Medicare Advantage PPO Programs"** or **"Medicare Advantage PPO"** shall mean the health care service PPO program or programs offered pursuant to a contract involving Highmark WV and CMS which complies with all applicable requirements of Part C of the Social Security Act, as amended from time to time, and which is available to individuals entitled to Medicare or any successor program(s) thereto regardless of the name(s) thereof.

1.20. **"Member"** shall mean a person who is an enrollee in a Highmark WV Medicare Advantage PPO Program.

1.21. **"Highmark WV"** shall mean (a) Highmark West Virginia, Inc., d.b.a. Highmark Blue Cross Blue Shield West Virginia; (b) any affiliate of Highmark WV; and (c) any entity or arrangement created by Highmark WV and another organization for the purposes of offering Medicare Advantage PPO Programs in Highmark WV's service area or within a region established by CMS that includes Highmark WV's service area.

1.22. **"Official Body"** or **"Official Bodies"** shall mean any governmental or political subdivision or any agency, authority, bureau, commission, department or instrumentality of either, or any court, tribunal, grand jury or arbitrator, in each case, which has jurisdiction over Highmark WV or Provider.

1.23. **"Overpayment"** shall mean a payment or payments greater in amount than actually due Provider under this Amendment or a payment or payments to which Provider was not entitled hereunder regardless of the reason and no matter how Highmark WV or Provider learns of such error. "Overpayment" shall also include any payments to Provider for Provider Services provided during any period in which Provider failed to satisfy applicable participation criteria as set forth in Section 2 and Section 7.2 of this Amendment.

1.24. **"Preferred Provider"** see 1.18. "

1.25. **Protected Member Information"** shall mean all personally identifiable information about Members.

1.26. **"Provider"** shall mean the party to this Amendment and the underlying Agreement that is responsible for the provision of Provider Services to Members of Highmark WV's products.

1.27. **"Provider Services"** shall mean those services within the scope of Provider's practice and license and as customarily furnished to patients by Provider.

1.28. **"Term"** shall mean the term of this Amendment.

1.29. **"Usual Charges"** shall mean the amount that Provider bills other payors and/or patients for the same services.

No definition shall conflict with the definitions set forth in the Evidence of Coverage or any applicable provisions of federal or state Law. In the event of a conflict, the definitions contained in the Evidence of Coverage or any applicable provisions of federal or state Law shall control.

2. MEDICARE ADVANTAGE PPO PARTICIPATION CRITERIA

2.1. General Criteria. Provider shall meet the following general criteria as well as the criteria in Section 7.2 of this Amendment:

a. Have and maintain throughout the Term an active license from the appropriate Official Body in the State of West Virginia (or the state in which Provider practices) to render Provider Services; and

b. Participate, and throughout the Term continue to meet any and all applicable conditions necessary to participate, in the Medicare program where CMS would allow for Medicare participation by a practitioner within the same specialty and practice as Provider; and

c. As applicable to Provider and as required by Highmark WV, maintain active hospital admitting privileges in a hospital that is a Medicare Advantage PPO Preferred Provider; and

d. Not be sanctioned or excluded from participation under a federal health care program as described in Section 1128B(f) of the Social Security Act; and

e. Meet, and continue to meet, all other credentialing and recredentialing requirements as established by Highmark WV and set forth in Highmark WV's policies and procedures.

2.2. Notification of Status Changes. Provider shall promptly advise Highmark WV of: (a) any changes in the general criteria as applicable to Provider and as described in this Section 2 and Section 7.2 of this Amendment; (b) any changes in his or her credentialing criteria; (c) any changes in his or her identification information, including, but not limited to, any changes in the address of Provider's professional office or place of practice; and (d) any intent to close his or her practice to additional Members by providing Highmark WV with at least sixty (60) days' advance written notice.

2.3. Condition Precedent. Provider understands and agrees that having and maintaining said license and Medicare participation, as well as meeting other selection and general criteria as described in this Section 2 and Section 7.2 of this Amendment are a condition precedent to this Amendment and are an ongoing condition to Provider's provision of Provider Services to Members and Highmark WV's payment for Covered Services. Any change in such criteria can result in termination of this Amendment by Highmark WV in its sole discretion. Further, any such change may result, in the sole discretion of Highmark WV, in repayment by Provider to Highmark WV or setoff of future amounts due to Provider of any Overpayment made to Provider on or after the date of such change for Provider's failure to meet such criteria.

3. HIGHMARK WV GENERAL OBLIGATIONS AND AGREEMENTS

3.1. Eligibility and Payment Determinations. Highmark WV shall provide each Member with an identification card and provide Provider upon request with information such as benefit maximums and certain exclusions to inform Provider about the Member's specific benefits.

Highmark WV shall also provide determinations as to eligibility and authorization for Provider Services in accordance with applicable Highmark WV policies and procedures. Highmark WV shall comply with any time frames and procedures for expedited determinations set forth by applicable Laws.

3.2. Applicable Laws. Highmark WV agrees to operate, and perform its obligations under this Amendment, in accordance with all applicable Laws.

3.3. Operational Policies and Procedures. Highmark WV shall make available to Provider information concerning the operational policies and procedures in the form of a manual or otherwise with which Provider must comply, including prior notice of changes to such policies and procedures.

3.4. Provider Listings. Highmark WV will make listings or directories of Medicare Advantage PPO Preferred Providers available to Provider.

4. PROVIDER GENERAL OBLIGATIONS AND AGREEMENTS

4.1. Program Participation. Provider shall participate in all Medicare Advantage PPO Programs under the terms and conditions in this Amendment.

4.2. Provision of Services. Provider agrees that it will provide to Members all Provider Services and make reports to Highmark WV as reasonably required concerning such Provider Services. Provider agrees to render Provider Services in a manner consistent with professionally recognized standards of health care and consistent with Highmark WV's: (a) standards for timely access to care and Member services as described in this Section 4; (b) policies and procedures that allow for individual Medical Necessity and Appropriateness determinations; and (c) policies and procedures for Provider's consideration of the input of Members in the establishment of treatment plans. In addition, Provider will render Provider Services in a manner consistent with the proper practice of professionally recognized standards of care that govern Provider. To the extent applicable, Provider shall provide Members receiving Provider Services with advance directive notifications as required by Law, as well as document in a prominent part of the individual's current medical record whether or not the individual has executed an advance directive. Provider must ensure that services are provided in a culturally competent manner to all Members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds.

Provider shall render Provider Services in the most efficient manner and in the least costly setting for the appropriate treatment of the Member, and, to the extent feasible, he/she will utilize such additional Auxiliary Personnel as are available and appropriate for effective and efficient delivery of health care consistent with the terms of this Amendment. In rendering Provider Services, Provider can freely communicate with Members regarding the appropriate treatment options and alternatives available to them, including medication treatment options, regardless of benefit coverage limitations.

4.3. Availability of Provider Services. As applicable, Provider will maintain weekly appointment hours that are sufficient and convenient to serve Members. Provider agrees that scheduling of appointments for Members shall be done in a timely manner. As applicable and consistent with Highmark WV's administrative requirements, Provider shall make necessary and appropriate covering arrangements to assure the availability of Provider Services for Members on a 24 hour per day, 7 days per week basis. This includes covering arrangements to assure Provider Services can be rendered to Members after-hours or when Provider is otherwise absent. All such covering arrangements shall comply with and be made in accordance with Highmark WV's policies and procedures.