ANTHEM BLUE CROSS AND BLUE SHIELD
PROVIDER AGREEMENT

This Provider Agreement (hereinafter "Agreement") is made and entered into by and between Anthem Health Plans of Virginia, Inc. doing business as Anthem Blue Cross and Blue Shield (hereinafter "Anthem") and Provider. In consideration of the mutual promises and covenants herein contained, the sufficiency of which is acknowledged by the parties, the parties agree as follows:

ARTICLE I
DEFINITIONS

"Affiliate" means those Virginia-based entities (i) that are owned or controlled, either directly or through a parent or subsidiary entity, by Anthem, or any entity which is under common control with Anthem; (ii) that access the rates, terms or conditions of this Agreement; and (iii) which are listed on the following web site: http://www.anthem.com/provider/va/4/s0/10/pw_b145749.pdf?refer=ahpprovider&state=va.

"Anthem Rate" means the lesser of Provider's Charges for Covered Services, or the total reimbursement amount that Provider and Anthem have agreed upon as set forth in the Plan Compensation Schedule ("PCS"). The Anthem Rate shall represent payment in full to Provider for Covered Services.

"Capitation" means the amount of pre-payment made by Anthem to a provider or management services organization on a per member per month basis for either specific services or the total cost of care.

"Case Rate" means the all inclusive Anthem Rate for an entire admission or one outpatient encounter. "Global Case Rate" means the all inclusive Anthem Rate which includes facility, professional and physician services for specific Coded Service Identifier(s).

"Claim" means either the uniform bill claim form or electronic claim form in the format prescribed by Plan submitted by a provider for payment by a Plan for Health Services rendered to a Covered Individual. "Complete Claim" means, unless applicable law otherwise requires, an accurate Claim submitted pursuant to this Agreement, for which all information necessary to process such Claim and make a benefit determination is included.

"Coded Service Identifier(s)" means a listing of descriptive terms and identifying codes, updated from time to time by the Centers for Medicare and Medicaid Services ("CMS") or other industry source, for reporting Health Services on the CMS 1500 claim form or its successor. The codes include but are not limited to, American Medical Association Current Procedural Terminology ("CPT®-4"), CMS Healthcare Common Procedure Coding System ("HCPCS"), International Classification of Diseases, 9th Revision, Clinical Modification ("ICD-9-CM"), National Drug Code ("NDC") and ADA Current Dental Terminology ("CDT") or their successors.

"Cost Share" means all amounts which a Covered Individual is required to pay under the terms of the applicable Health Benefit Plan. Such payment may be referred to as an allowance, coinsurance, copayment, deductible, penalty or other Covered Individual payment responsibility, and may be a fixed amount or a percentage of applicable payment for Covered Services rendered to the Covered Individual.

"Covered Individual" means any individual who is eligible, as determined by Plan, to receive Covered Services under a Health Benefit Plan. For all purposes related to this Agreement, including all schedules, attachments, exhibits, manual(s), notices and communications related to this Agreement, the term "Covered Individual" may be used interchangeably with the terms Insured, Covered Person, Member, Enrollee, Subscriber, Dependent Spouse/Domestic Partner, Child or Contract Holder, and the meaning of each is synonymous with any such other.

"Covered Services" means Medically Necessary Health Services, as determined by Plan and described in the applicable Health Benefit Plan, for which a Covered Individual is eligible for coverage. Covered Services do not include the preventable adverse events as set forth in the provider manual(s).

"Emergency Condition" the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in (i) serious jeopardy to the mental or physical health of the individual, (ii) danger of serious impairment of
the individual's bodily functions, (iii) serious dysfunction of any of the individual's bodily organs, or (iv) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

"Health Benefit Plan" means the document(s) describing the partially or wholly insured, underwritten, and/or administered, marketed health care benefits, or services program between the Plan and an employer, governmental entity, or other entity or individual.

"Health Service" means those services or supplies that a health care provider is licensed, equipped and staffed to provide and which he/she/it customarily provides to or arranges for individuals.

"HMO" means HealthKeepers, Inc. and shall be referred to here and after as "HMO".

"Medically Necessary" or "Medical Necessity" means the health care services that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and (c) not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors." The above definition of "Medically Necessary"/"Medical Necessity" shall be inapplicable to the extent that a different definition is required by government contract, or where any applicable law or regulation requires a different definition.

"Network" means a group of providers that support, through a direct or indirect contractual relationship, some or all of the product(s) and/or program(s) in which Covered Individuals are enrolled.

"Network/Participating Provider" means a provider designated by Plan to participate in one or more Network(s).

"Other Payors" means persons or entities, utilizing the Network(s)/Plan Program(s) pursuant to an agreement with Anthem, an Affiliate or any other company that owns or is under common ownership with Anthem, including without limitation: (i) Blue Cross and/or Blue Shield Plans that are under common ownership with Anthem (in addition to those Virginia-based entities that are included under the definition of "Affiliate"); (ii) Blue Cross and/or Blue Shield Plans that are not under common ownership with Anthem, and (iii) employers or insurers providing Health Benefit Plans pursuant to insured, self-administered or self-insured programs.

"Participation Attachment" means the document(s) attached to and made a part of this Agreement which identifies the additional duties and/or obligations related to Network(s) and/or Plan Program(s).

"Percentage Rate" means the Anthem Rate that is expressed as a percentage of allowed Provider Charges.

"Per Diem Rate" means the Anthem Rate that is expressed as the all inclusive fixed payment for Covered Services rendered on a single date of service.

"Per Hour Rate" means the Anthem Rate that is applicable when payment is derived based on an increment of time multiplied by the Anthem Rate in the applicable fee schedule.

"Per Unit Rate" means the Anthem Rate that is applicable when payment is derived based on a unit of service multiplied by the Anthem Rate in the applicable fee schedule(s).

"Per Visit Rate" means the Anthem Rate that is expressed as the all inclusive fixed payment for one outpatient encounter.

"Physician Specialty Society" means a United States medical specialty society that represents diplomats certified by a board recognized by the American Board of Medical Specialties.

"Plan" means Anthem, an Affiliate as designated by Anthem, and/or an Other Payor. For purposes of this
Agreement, when the term "Plan" applies to an entity other than Anthem, "Plan" shall be construed to only mean such entity.

"Plan Compensation Schedule" ("PCS") means the document(s) attached to, or made a part of this Agreement which sets forth the Anthem Rate(s) and compensation related terms for the Network(s) in which Provider participates. The PCS may include additional Provider obligations and specific Anthem compensation related terms and requirements.

"Plan Fee Schedule(s)" means the schedule of the maximum amounts that Plan will pay for Covered Services, less Cost Shares if applicable. The Plan Fee Schedule(s) applicable for the Network(s) in which Provider participates is further described in the PCS.

"Plan Program" means any program now or hereafter established, marketed, administered, sold, or sponsored by Plan, or Blue Cross Blue Shield Association ("BCBSA") (and includes the Health Benefit Plans that access, or are issued, or entered into in connection with such program). Plan Program shall include but is not limited to, a health maintenance organization(s), a preferred provider organization(s), a point of service product(s) or program(s), an exclusive provider organization(s), an indemnity product(s) or program(s), and a quality program(s). The term Plan Program shall not include any program excluded by Plan or BCBSA.

"Provider Charges" means the regular, uniform rate or price Provider determines and submits to Anthem as charges for Health Services provided to Covered Individuals. Such Provider Charges shall be no greater than the rate or price Provider submits to any person or other health care benefit payor for the same Health Services provided, regardless of whether Provider agrees with such person or other payor to accept a different rate or price as payment in full for such services.

ARTICLE II
SERVICES/OBLIGATIONS

2.1 Covered Individual Identification. Anthem shall ensure that Plan provides a means of identifying Covered Individual either by issuing a paper, plastic, or other identification document to the Covered Individual or by a telephonic, paper or electronic communication to Provider. This identification need not include all information necessary to determine Covered Individual's eligibility at the time a Health Service is rendered, but shall include information necessary to contact Plan to determine Covered Individual's participation and the applicable Health Benefit Plan. Provider acknowledges and agrees that possession of such identification document or ability to access eligibility information telephonically or electronically, in and of itself, does not qualify the holder thereof as a Covered Individual, nor does the lack thereof mean that the person is not a Covered Individual.

2.2 Provider Non-discrimination. Provider shall provide Health Services to Covered Individuals in a manner similar to and within the same time availability in which Provider provides Health Services to any other individual. Provider will not differentiate, or discriminate against any Covered Individual as a result of his/her enrollment in a Plan, or because of race, color, creed, national origin, ancestry, religion, sex, marital status, age, disability, payment source, state of health, need for health services, status as a litigant, status as a Medicare or Medicaid beneficiary, sexual orientation, gender identity, or any other basis prohibited by law. Provider shall not be required to provide any type, or kind of Health Service to Covered Individuals that he/she/it does not customarily provide to others. Additional requirements may be set forth in the applicable Participation Attachment(s).

2.3 Publication and Use of Provider Information. Provider agrees that Anthem, Plans or their designees may use, publish, disclose, and display, for commercially reasonable general business purposes, either directly or through a third party, information related to Provider, including but not limited to demographic information, information regarding credentialing and affiliations, performance data, Anthem Rates, and any other information related to Provider for transparency initiatives.

2.4 Use of Symbols and Marks. Neither party to this Agreement shall publish, copy, reproduce, or use in any way the other party's symbols, service mark(s) or trademark(s) without the prior written consent of such other party. Notwithstanding the foregoing, the parties agree that they may identify Provider as a participant in the Network(s) in which he/she/it participates.

2.5 Submission and Payment of Claims. Unless otherwise instructed, or required by state or federal law, Provider shall submit Claims to Plan, subject to any applicable HIPAA requirements, using appropriate and
current Coded Service Identifier(s), within one (1) year from the date the Health Services are rendered or Plan will refuse payment. If Plan is the secondary payor, the one (1) year period will not begin until Provider receives notification of primary payor's responsibility.

2.5.1 Provider agrees to provide to Anthem, unless otherwise instructed, at no cost to Anthem, Plan or the Covered Individual, all information necessary for Plan to determine its payment liability. Such information includes, without limitation, accurate and Complete Claims for Covered Services. Once Anthem determines Plan has any payment liability, all Complete Claims will be paid in accordance with the terms and conditions of a Covered Individual's Health Benefit Plan and the PCS.

2.5.2 Provider agrees to submit Claims in a format consistent with industry standards and acceptable to Plan either (a) electronically or (b) if electronic submission is not available, utilizing paper forms.

2.5.3 If Anthem or Plan asks for additional information so that Plan may process the Claim, Provider must provide that information within sixty (60) days, or before the expiration of the one (1) year period referenced above, whichever is longer.

2.5.4 In no event, shall Provider bill, collect, or attempt to collect payment from the Covered Individual for Claims Plan receives after the applicable period(s) as set forth above, regardless of whether Plan pays such Claims.

2.5.5 In all events, however, Provider shall only look for payment (except for applicable Cost Share or other obligations of Covered Individuals) from the Plan that provides the Health Benefit Plan for the Covered Individual for Covered Services rendered.

2.6 Plan Payment Time Frames. Except as otherwise required by law, Anthem shall require Plans or their designees to use best efforts to adjudicate or arrange for adjudication, and where appropriate make payment for all Complete Claims for Covered Services submitted by Provider within sixty (60) days, exclusive of Claims that have been suspended due to the need to determine Medical Necessity, or the extent of Plan's payment liability, if any, because of issues such as coordination of benefits or verification of coverage.

2.7 PaymentinFullandHoldHarmless.

2.7.1 Provider agrees to accept as payment in full, in all circumstances, the applicable Anthem Rate whether such payment is in the form of a Cost Share, a payment by Plan, or payment by another source, such as through coordination of benefits. Provider shall bill, collect, and accept compensation for Cost Shares. Provider agrees to make reasonable efforts to verify Cost Shares prior to billing for such Cost Shares. In no event shall Plan be obligated to pay Provider or any person acting on behalf of Provider for services that are not Covered Services, or any amounts in excess of the Anthem Rate, less Cost Shares or payment by another source, as set forth above. Consistent with the foregoing. Provider agrees to accept the Anthem Rate as payment in full if the Covered Individual has not yet satisfied his/her deductible.

2.7.2 Provider hereby agrees that in no event, including but not limited to, nonpayment by the Plan, insolvency of the Plan or breach of this Provider Agreement, shall the Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Covered Individuals or persons other than the Plan for services provided pursuant to this Provider Agreement. This section shall not prohibit collection of any applicable Cost Shares billed in accordance with the terms of the Health Benefit Plan for the Plan.

The Provider further agrees that (1), this section shall survive the termination of this Provider Agreement regardless of the cause giving rise to such termination and shall be construed to be for the benefit of the Plan's Covered Individuals, and (2), this section supersedes any oral or written agreement to the contrary now existing or hereafter entered into between the Provider and the Covered Individual or persons acting on the Covered Individual's behalf, unless otherwise provided in this Agreement.

Any modifications, additions or deletions to the sections of this hold harmless clause shall become effective on a date no earlier than fifteen (15) days after the Virginia State Corporation Commission has received written notice of such proposed changes.
The Provider will make no charge and render no bill to any Plan, the Covered Individual, or the Covered Individual's guarantor for any services unless such services are certified as Medically Necessary and not Investigational* according to the terms of the utilization management program, a copy of which is included in the provider manual. The Provider also agrees that it will make no charge and render no bill to any Plan, the Covered Individual, or the Covered Individual's guarantor for any penalty or reduction in benefits required under a Covered Individual's Health Benefit Plan for failure to request Medical Necessity pre-authorization or pre-certification of services or extension of such services.

Notwithstanding any other section of the above paragraphs, in the event that any Plan notifies a Covered Individual and the Provider in writing that a service is not considered Medically Necessary, or is considered Investigational and therefore non-Covered, the Provider may bill such Covered Individual for such service if and only if: (a) the Covered Individual is notified, in writing, by the Provider that the services are not Medically Necessary or are Investigational (as applicable) in Plan's opinion and, therefore will not be covered; (b) following such notice, the Covered Individual acknowledges, in advance of receiving such services, his/her consent to receive or continue to receive such services and accept responsibility for payment; and (c) such notice and acknowledgment shall be in writing and contain, at a minimum, the date, time, description of the services to be rendered, the estimated cost of the services to be rendered, and the Covered Individual's signature. The Provider shall make such written notice/acknowledgement a part of the Covered Individual's medical record. Upon request, copies of the written notice/acknowledgement to the Covered Individual by the Provider shall be provided to Plan by the Provider. Nothing in the preceding sentences shall permit the Provider to bill any Plan for any such services. Any such written notice/acknowledgement must be obtained on a case-by-case basis.

*Investigational means any service or supply that is judged to be Investigational at Anthem's sole discretion. Services which do not meet each of the following criteria will be excluded from coverage as Investigational:

Any supply or drug used must have received final approval to market by the U.S. Food and Drug Administration (“FDA”) for the particular indication or application in question. Moreover, quantities of any drug or medication used, except those drugs used in the treatment of cancer pain and prescribed in compliance with established statutes pertaining to patients with intractable cancer pain, must be within recommended maximum daily dose or duration established by the FDA or any of the standard reference compendia defined below. There are two (2) exceptions which apply when a drug has received final approval to market by the FDA, but not for the particular indication or application in question.

a) This criterion will be satisfied if the use of the drug is recognized for treatment of the indication or application in any of the following resources:

i. The following three (3) standard reference compendia defined below:

a) American Hospital Formulary Service – Drug Information
b) National Comprehensive Cancer Network's Drug & Biologics Compendium
c) Elsevier Gold Standard's Clinical Pharmacology

ii. In substantially accepted peer-reviewed medical literature. Peer-reviewed medical literature means a scientific study published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts. This study must appear in a journal that has been determined by the International Committee of Medical Journal Editors to have met the Uniform Requirements for Manuscripts submitted to biomedical journals. Peer-reviewed medical literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier; or

b) In the case where the drug is being used for the treatment of a specific type of cancer, this criterion will be satisfied if the use of the drug is recognized as safe and effective for treatment of the specific type of cancer in any of the standard reference compendia. Despite the above two (2) exceptions, this criterion will not be satisfied if the FDA has
determined that use of the drug is not recommended for the treatment of the specific indication for which it is prescribed.

There must be enough information in the peer-reviewed medical and scientific literature to let Anthem judge the safety and efficacy.

The available scientific evidence must show a good effect on health outcomes outside a research setting.

The service or supply must be as safe and effective outside a research setting as current diagnostic or therapeutic options.

New technologies are evaluated against these criteria to determine if services should be included as a Covered Service or considered Investigational.

Hold Harmless for Non-Covered Services Rendered to HMO Covered Individuals. In the event that the Provider provides non-Covered Services of any type to a Covered Individual enrolled in a Plan that is a health maintenance organization, the Provider shall, prior to the provision of such non-Covered Services, notify such Covered Individual in writing: (i) of the services to be provided, (ii) that no Plan will pay for or be liable for said services, and (iii) that the Covered Individual will be financially liable for such services. Such notice must also contain the date and time such services are to be rendered as well as a description and an estimate of cost of such services. The Provider shall have the Covered Individual sign an acknowledgement that he or she understands these terms contained in the notice. If such Covered Individual is so advised and the notice and acknowledgement is signed, the Provider may bill such Covered Individual for such services. If the Covered Individual is not so advised or if the notice/acknowledgement is not signed by the Covered Individual, then the Provider may not bill the Covered Individual for such services. The Provider shall make such written notice/acknowledgement a part of the Covered Individual's medical record. Upon request, copies of the written notice/acknowledgement shall be provided to Plan by the Provider. Nothing in the preceding sentences shall permit the Provider to bill any Plan for any such services. Any such written notice/acknowledgement must be obtained on a case-by-case basis.

2.8 Adjustments for Incorrect Payments. When the Provider receives an excessive or mistaken payment, including, but not limited to, payments for Claims where the Claim was miscoded or otherwise billed in error, whether or not the billing error was fraudulent, abusive or wasteful from Anthem, a Covered Individual or a Plan, the Provider must promptly notify Anthem or the Plan and reimburse the appropriate entity within thirty (30) days. Anthem or the Plan may recover the overpayment through remittance adjustment or other recovery action, subject to the restrictions as set forth in the provider manual.

2.9 Provider Subcontractors. Provider may fulfill some of his/her/its duties under this Agreement through subcontractors or delegates. Hereinafter, subcontractors and delegates are referred to collectively as "subcontractors", and for purposes of this provision include, but are not limited to, vendors and non-Network/Participating Providers that provide supplies, equipment, staffing, and other services to Covered Individuals at the request of, under the supervision of, and/or at the place of business of Provider. Provider shall assure the compliance of his/her/its subcontractors with the terms and conditions of this Agreement as applicable, including, but not limited to, the Payment in Full and Hold Harmless provisions of section 2.7 hereof, and Provider shall indemnify Anthem, Plan and Covered Individuals for any failure of any subcontractor to so comply. Anthem shall not be liable for any reimbursement in addition to the applicable Anthem Rate as a result of Provider's use of a subcontractor. Provider shall be solely responsible to pay subcontractor for any Health Services and shall, via written contract, contractually prohibit such subcontractor from billing, collecting or attempting to collect from Anthem, Plan or Covered Individuals. Notwithstanding the foregoing, if Anthem has a direct contract with the subcontractor ("direct contract"), the direct contract shall prevail over this Agreement and the subcontractor shall bill Anthem under the direct contract for any subcontracted services, with the exception of nursing services provided for Home Infusion Therapy.

In any subcontract or delegation agreement entered into between Provider and any other entity for the provision of services to Covered Individuals, Provider shall include the following hold harmless section:

[Subcontractor] hereby agrees that in no event, including but not limited to, non-payment by Plan or
Provider, Plan or Provider insolvency or breach of this Agreement, shall [Subcontractor] bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Covered Individuals or persons other than Plan or Provider for services provided pursuant to the Agreement. This section shall not prohibit collection of any applicable Cost Shares billed in accordance with the terms of the Covered Individual agreement for the Plan.

[Subcontractor] further agrees that (1) this section shall survive the termination of this Agreement regardless of the cause giving rise to such termination and shall be construed to be for the benefit of the Plan's Covered Individuals and (2) this section supersedes any oral or written agreement to the contrary now existing or hereafter entered into between [Subcontractor] and the Covered Individuals or persons acting on the Covered Individual's behalf.

Any modifications, additions, or deletions to the sections of this hold harmless clause shall become effective on a date no earlier than fifteen (15) days after the Virginia State Corporation Commission has received written notice of such proposed changes.

2.10 Compliance with Provider Manual(s) and Policies, Programs, Procedures. Policies, programs and procedures included in Anthem's provider manual are incorporated by reference into this Provider Agreement and Provider agrees to adhere to the policies, programs and procedures stated therein.

2.11 In Network Referrals and Transfers. Provider shall use best efforts when medically appropriate, to utilize Network/Participating Providers, and shall refer and transfer Covered Individuals to Network/Participating Providers. Additionally, Provider represents and warrants that Provider does not give, provide, condone or receive any incentives or kickbacks, monetary or otherwise, in exchange for the referral of a Covered Individual, and if a Claim for payment is attributable to an instance in which Provider provided or received an incentive or kickback in exchange for the referral, such Claim shall not be payable and, if paid in error, shall be refunded to Anthem.

2.12 Programs and Provider Panels. Provider acknowledges that as of the Effective Date, he/she/it participates only in those Networks designated on the signature page for which provider did not opt out. Provider acknowledges that Plan may have, develop or contract to develop various networks or programs that have a variety of provider panels, program components and other requirements, and that Plan may discontinue or modify such networks or programs in its discretion. If such provider panels or programs are developed, they may include economic and/or other incentives for Covered Individuals to use the providers in those provider panels or programs. Plan shall notify Provider of its inclusion in a Plan Program or Network in which Provider did not previously participate pursuant to this Agreement. Additionally, Plan shall notify Provider if it does not meet the criteria of a particular Plan Program or Network. Plan will give the Provider the opportunity to be included in these separate networks or sub-networks if Provider meets Plan's terms and conditions, if required by applicable Virginia law. HMO is not required by Virginia law to include providers in any networks even if Provider meets HMO's terms and conditions.

2.12.1 Provider further acknowledges and understands that Anthem participates in the Federal Employees Health Benefit Program ("FEHBP") - the health insurance plan for federal employees. Provider further understands and acknowledges that the FEHBP is a federal government program and the requirements of the program are subject to change at the sole direction and discretion of the United States Office of Personnel Management. Provider agrees to abide by the rules, regulations and other requirements of the FEHBP as they exist and as they may be amended or changed from time to time. Provider further agrees that in the event of a conflict between this Agreement and/or the provider manual, and the rules/regulations/other requirements of the FEHBP, the terms of the rules/regulations/other requirements of the FEHBP shall control.

2.12.2 Provider agrees that any product(s) ("Exchange Style Products") developed by HMO, in conformity with the requirements of state-based, regional or federal health insurance exchanges ("Exchange(s)"), established consistent with the requirements of the Patient Protection and Affordable Care Act, shall be "Health Benefit Plans" that are covered under the terms of this Agreement. Such Exchange Style Products may be offered by HMO (i) through Exchanges or (ii) outside of Exchanges. With respect to those Exchange Style Products that are offered through Exchanges, Provider agrees to abide by all applicable rules, regulations and other requirements of the Exchanges as they may be amended or changed from time to time.

2.13 Provider's Inability to Carry Out Duties. Provider shall promptly send written notice, in accordance with the Notice section of this Agreement, to Anthem of:
2.13.1 Any change in Provider's business address;

2.13.2 Any legal, governmental, or other action involving Provider which could materially impair the ability of Provider to carry out his/her/its duties and obligations under this Agreement, except for temporary emergency diversion situations; or

2.13.3 Any change in accreditation, provider affiliation, insurance, licensure, certification or eligibility status, or other relevant information regarding Provider's practice or status in the medical community.

2.14 **Provider Credentialing.** Provider agrees that he/she/it meets all applicable Anthem credentialing standards and any other applicable standards of participation for Networks in which Provider participates. A description of the credentialing program or applicable standards of participation, including any applicable accreditation requirements, is set forth in the provider manual(s).

2.15 **Adjustment Requests.** If Provider believes a Claim has been improperly adjudicated for a Covered Service for which Provider timely submitted a Claim to Plan, Provider must submit a request for an adjustment to Plan within one (1) year from the date of Plan's payment or explanation of payment, unless otherwise set forth in the provider manual. The request must be submitted in accordance with Plan's payment inquiry process. Requests for adjustments submitted after this date may be denied for payment, and Provider will not be permitted to bill Anthem, Plan, or the Covered Individual for those services for which payment was denied.

2.16 **Blue Cross Blue Shield Out of Area Program.** Provider agrees to provide Covered Services to any person who is covered under another BCBSA out of area or reciprocal programs and to submit Claims to Anthem for payment or as otherwise instructed in the provider manual. Provider agrees to accept payment by Plan at the Anthem Rate for the equivalent Network as payment in full except Provider may bill, collect and accept compensation for Cost Shares. The provisions of this Agreement shall apply to Provider Charges for Covered Services under the out of area or reciprocal programs. Provider further agrees to comply with other similar programs of the BCBSA. For Covered Individuals who are enrolled under BCBSA out of area or reciprocal programs, Provider shall comply with the applicable Plan's utilization management policies.

2.17 **Supervision of Services.** Provider agrees that all Health Services provided to Covered Individuals under this Agreement shall be provided by Provider or by a qualified person under Provider's direction. Provider shall warrant that any nurses or other health professionals employed by or providing services for Provider shall be duly licensed or certified under applicable law.

2.18 **Pass-Through Charges.** Provider agrees not to pass through to Plan or the Covered Individual any charges which Provider incurs as a result of providing supplies or making referrals to another provider or entity. Examples include, but are not limited to, pass-through charges associated with laboratory services, pathology services, radiology services and durable medical equipment. If Anthem has a direct contract with the subcontractor, the direct contract shall prevail over this Agreement.

2.19 **Coordination of Benefits.** Provider agrees to cooperate with Plan regarding coordination of benefits, as set forth in the provider manual, and to notify Plan promptly after receipt of information regarding any Covered Individual who may have a Claim involving coordination of benefits.

2.20 **Preventable Adverse Events.** Notwithstanding any provision in this Agreement to the contrary, when any preventable adverse event as set forth in the provider manual(s) occurs with respect to a Covered Individual, Provider shall neither bill, nor seek to collect from, nor accept any payment from Plan or Covered Individual for such event. If Provider receives any payment from Plan or Covered Individual for such event, he/she/it shall refund such payment within ten (10) business days of becoming aware of such receipt. Further, Provider shall cooperate with Anthem, to the extent reasonable, in any Anthem initiative designed to help analyze or reduce such preventable adverse events.

2.21 **Cost Effective Care.** Provider shall provide Covered Services in the most cost effective, clinically appropriate setting and manner.

2.22 **Ethics and Fairness in Carrier Business Practices.** Anthem and Affiliates will comply with Section 38.2-3407.15 of the Code of Virginia (known as the Ethics and Fairness in Carrier Business Practices Act ("Act").) to the full extent that the Act is applicable to Anthem or the Affiliate. The Act, a copy of which is attached in
the provider manual, sets forth certain provisions which are required to be included in this Agreement by the Act for applicable parties. If any provision of this Agreement is inconsistent with the Act as it may be updated or amended from time to time and impacts parties covered by the Act, then the Act shall control with respect to such parties and such provisions shall be construed and enforced in a manner consistent with the Act.

2.23 Restrictions. This Agreement applies to all Covered Services that Provider provides to Covered Individuals, regardless of the time or place. When Provider renders Covered Services to Covered Individuals, Provider will not charge the Affiliate or the Covered Individual: (i) Any amount that is not a charge for a professional service, including without limitation, charges for overhead and maintenance of office infrastructure, administrative fees (including without limitation, fees for training of staff, fees for equipment maintenance or calibration, ensuring compliance with applicable regulations or other requirements, efforts to maintain certifications, etc.), charges for preferred access to services (e.g., "concierge" or "boutique" practice fees), malpractice premiums, costs or surcharges, fees for referrals or fees for completing claim forms or submitting additional information, or (ii) any amount for any service that Provider is not licensed to perform under the laws of the jurisdiction where the services are provided. Provider will not charge the Covered Individual any additional amount because goods or services are provided outside Providers posted business hours, except for any additional copayments or deductibles that may be permitted under the Covered Individual’s Contract.

2.24 Prior Authorization for Drug Benefits. Anthem and Affiliates will comply with the carrier requirements contained in Section 38.2-3407.15:2. of the Code of Virginia (the “Code Section”), (carrier contracts; required provisions regarding prior authorization) to the full extent that the Code Section is applicable to Anthem or an Affiliate. The Code Section, a copy of which is attached to the provider manual, sets forth certain provisions that are required to be included in this Agreement by the Code Section for applicable parties. If any provision of this Agreement is inconsistent with the Code Section as it may be updated or amended from time to time, and impacts parties covered by the Code Section, then the Code Section shall control with respect to such parties, and such provisions shall be construed and enforced in a manner consistent with the Code Section.

ARTICLE III
CONFIDENTIALITY/RECORDS

3.1 Proprietary Information. Except as otherwise provided herein, all information and material provided by either party in contemplation of or in connection with this Agreement remains proprietary to the disclosing party. This Agreement, including but not limited to the Anthem Rates, is Anthem's proprietary information. Neither party shall disclose any information proprietary to the other, or use such information or material except: (1) as otherwise set forth in this Agreement; (2) as may be required to perform obligations hereunder; (3) as required to deliver Health Services or administer a Health Benefit Plan; (4) to Plan or its designee; (5) upon the express written consent of the parties; or (6) as required by law or regulation, except that either party may disclose such information to its legal advisors, lenders and business advisors, provided that such legal advisors, lenders and business advisors agree to maintain confidentiality of such information.

3.2 Confidentiality of Personally Identifiable Information. Both parties agree to abide by state and federal laws and regulations regarding confidentiality of the Covered Individual's personally identifiable information. Provider shall review all Covered Individual's personally identifiable information received from Anthem to ensure no misrouted Protected Health Information ("PHI") is included. Misrouted PHI includes information about Covered Individuals that Provider is not currently treating. Provider shall immediately destroy any misrouted PHI or safeguard the PHI for as long as it is retained. In no event shall Provider be permitted to misuse or re-disclose misrouted PHI. If Provider cannot destroy or safeguard misrouted PHI, Provider must contact Anthem to report receipt of misrouted PHI.

3.3 Network Provider/Patient Discussions. As required by Virginia Code Section 38.2-3407.10 K., Provider shall freely communicate with Covered Individuals regarding the individual treatment options available to them, including alternative medications. Medical management decisions by Provider must be based on sound clinical judgments and the appropriateness of care and services. Nothing in this Agreement is intended to require Provider to deny or withhold Covered Services to Covered Individuals that Provider knows to be Medically Necessary and appropriate. Notwithstanding any other provision in this Agreement and regardless of any benefit or coverage exclusions or limitations associated with a Health Benefit Plan, Provider shall not be prohibited from discussing fully with a Covered Individual any issues related to the Covered Individual’s health including recommended treatments, treatment alternatives, treatment risks and the consequences of any benefit coverage or payment decisions made by Plan or any other party. Nothing
in this Agreement shall prohibit Provider from disclosing to the Covered Individual the general methodology by which Provider is compensated under this Agreement, such as for example whether Provider is paid on a fee for service, capitation, or Percentage Rate basis. Plan shall not refuse to allow or to continue the participation of any otherwise eligible provider, or refuse to compensate Provider in connection with services rendered, solely because Provider has in good faith communicated with one or more of his/her/its current, former or prospective patients regarding the provisions, terms or requirements of a Health Benefit Plan as they relate to the health needs of such patient. Nothing in this section shall be construed to permit Provider to disclose Anthem Rates or specific terms of the compensation arrangement under this Agreement.

3.4 **Plan Access to and Requests for Provider Records.** Provider and its designees shall comply with all applicable state and federal record keeping and retention requirements, and, as set forth in the provider manual(s) and/or Participation Attachment(s), shall permit Plan or its designees to have, with appropriate working space and without charge, on-site access to and the right to examine, audit, photocopy, excerpt and transcribe any books, documents, papers, and records related to Covered Individual's medical and billing information within the possession of Provider and inspect Provider's operations, which involve transactions relating to Covered Individuals and as may be reasonably required by Plan in carrying out its responsibilities and programs, including but not limited to, assessing quality of care, Medical Necessity, concurrent review, appropriateness of care, accuracy of payment, compliance with this Agreement, and for research. In lieu of on-site access, at Plan's request, Provider or its designees shall submit records to Plan, the Covered Individual or their respective designees via photocopy or electronic transmittal, at no charge. Provider shall make such records available to the state and federal authorities involved in assessing quality of care or investigating Covered Individual grievances or complaints. Any examination or audit of Provider records shall be performed using generally accepted, statistically valid or industry standard methodology. Provider acknowledges that failure to submit records to Plan in accordance with this provision and/or the provider manual(s), and/or Participation Attachment(s) may result in a denial of a Claim under review, whether on pre-payment or post-payment review, or a payment retraction on a paid Claim, and Provider is prohibited from balance billing the Covered Individual in any of the foregoing circumstances.

3.5 **Transfer of Medical Records.** Provider shall share a Covered Individual's medical records, and forward medical records and clinical information in a timely manner to other health care providers treating a Covered Individual, at no cost to Anthem, Plan, a Covered Individual, or other treating healthcare providers.

**ARTICLE IV**

**INSURANCE**

4.1 **Anthem Insurance.** Anthem shall self-insure or maintain insurance as shall be necessary to insure Anthem and its employees, acting within the scope of their duties.

4.2 **Provider Insurance.** Provider shall self-insure or maintain insurance in types and amounts acceptable to Anthem as set forth in the provider manual(s).

**ARTICLE V**

**RELATIONSHIP OF THE PARTIES**

5.1 **Relationship of the Parties.** For purposes of this Agreement, Anthem and Provider are and will act at all times as independent contractors. Nothing in this Agreement shall be construed, or be deemed to create, a relationship of employer or employee or principal and agent, or any relationship other than that of independent entities contracting with each other for the purposes of effectuating this Agreement. In no way shall Anthem or Plan be construed to be providers of Health Services or responsible for the provision of such Health Services. Provider shall be solely responsible to the Covered Individual for treatment and medical care with respect to the provision of Health Services.

5.2 **Blue Cross Blue Shield Association (BCBSA).** Provider hereby expressly acknowledges his/her/its understanding that this Agreement constitutes a contract between Provider and Anthem, that Anthem is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and/or Blue Shield Plans ("Association"), permitting Anthem to use the Blue Cross and/or Blue Shield Service Marks in the state (or portion of the state) where Anthem is located, and that Anthem is not contracting as the agent of the Association. Provider further acknowledges and agrees that he/she/it has not entered into this Agreement based upon representations by any person other than Anthem, and that no person, entity or organization other than Anthem shall be held accountable or liable to Provider for any of Anthem's obligations to Provider created under this Agreement. Provider has no license to use the Blue Cross and/or Blue Shield names, symbols, or derivative marks (the "Brands") and
nothing in the Agreement shall be deemed to grant a license to Provider to use the Brands. Any references to the Brands made by Provider in his/her/its own materials are subject to review and approval by Anthem. This section shall not create any additional obligations whatsoever on the part of Plan other than those obligations created under other provisions of this Agreement.

5.3 **Contracting Party.** If Provider is a partnership, corporation, or any other entity other than an individual, all references herein to “Provider” shall also mean and refer to each individual within such entity who Provider certifies is employed by Provider, and who has applied for and been accepted by Plan as a Network/Participating Provider.

**ARTICLE VI**

INDEMNIFICATION AND LIMITATION OF LIABILITY

6.1 **Indemnification.** Anthem and Provider shall each indemnify, defend and hold harmless the other party, and his/her/its directors, officers, employees, agents and subsidiaries, from and against any and all losses, claims, damages, liabilities, costs and expenses (including without limitation, reasonable attorneys’ fees and costs) arising from three party claims resulting from the indemnifying party's failure to perform his/her/its obligations under this Agreement, and/or the indemnifying party's violation of any law, statute, ordinance, order, standard of care, rule or regulation. The obligation to provide indemnification under this Agreement shall be contingent upon the party seeking indemnification providing the indemnifying party with prompt written notice of any claim for which indemnification is sought, allowing the indemnifying party to control the defense and settlement of such claim, provided however that the indemnifying party agrees not to enter into any settlement or compromise of any claim or action in a manner that admits fault or imposes any restrictions or obligations on an indemnified party without that indemnified party's prior written consent which will not be unreasonably withheld, and cooperating fully with the indemnifying party in connection with such defense and settlement.

6.2 **Limitation of Liability.** Regardless of whether there is a total and fundamental breach of this Agreement or whether any remedy provided in this Agreement fails of its essential purpose, in no event shall either of the parties hereto be liable for any amounts representing loss of revenues, loss of profits, loss of business, the multiple portion of any multiplied damage award, or incidental, indirect, consequential, special or punitive damages, whether arising in contract, tort (including negligence), or otherwise regardless of whether the parties have been advised of the possibility of such damages, arising in any way out of or relating to this Agreement. Further, in no event shall Plan be liable to Provider for any extracontractual damages relating to any claim or cause of action assigned to Provider by any person or entity.

6.3 **Period of Limitations.** Unless otherwise provided for in this Agreement, neither party shall commence any action at law or equity against the other to recover on any legal or equitable claim arising out of this Agreement more than two (2) years after the events which gave rise to such claim, unless compliance with this section would compel a party to violate the terms of the Health Benefit Plan. The deadline for initiating an action shall not be tolled by the appeal process or any other administrative process.

**ARTICLE VII**

THIS ARTICLE INTENTIONALLY LEFT BLANK

**ARTICLE VIII**

TERM AND TERMINATION

8.1 **Term of Agreement.** The term of this Agreement shall commence at 12:01 AM on the Effective Date and shall continue in effect until such time it is terminated as provided herein.

8.2 **Termination Without Cause.** Either party may terminate this Agreement or Provider’s participation in a Network(s) without cause at any time by giving at least one hundred twenty (120) days prior written notice of termination to the other party, except as otherwise provided in section 9.1 of this Agreement.

8.3 **Breach of Agreement.** Except for circumstances giving rise to the Termination With Cause section, if either party fails to comply with or perform when due any material term or condition of this Agreement, the other party shall notify the breaching party of its breach in writing stating the specific nature of the material breach, and the breaching party shall have thirty (30) days to cure the breach. If the breach is not cured to the reasonable satisfaction of the non-breaching party within said thirty (30) day period, the non-breaching party may terminate this Agreement by providing written notice of such termination to the other party.
effective date of such termination shall be no sooner than sixty (60) days after such notice of termination.

8.4 **Termination With Cause.**

8.4.1 This Agreement may be terminated immediately by Anthem if:

8.4.1.1 Provider commits any act or conduct for which his/her/its license(s), permit(s), or any governmental or board authorization(s) or approval(s) necessary for business operations or to provide Health Services are lost or voluntarily surrendered in whole or in part; or

8.4.1.2 Provider commits a fraud or makes any material misstatements or omissions on any documents related to this Agreement which it submits to Anthem or to a third party; or

8.4.1.3 Provider files for bankruptcy, or makes an assignment for the benefit of its creditors without Anthem’s written consent, or if a receiver is appointed; or

8.4.1.4 Provider's insurance coverage as required by this Agreement lapses for any reason; or

8.4.1.5 Provider fails to maintain compliance with Anthem's credentialing standards or other applicable standards of participation; or

8.4.1.6 Anthem reasonably believes based on Provider's conduct or inaction, or allegations of such conduct or inaction, that the well-being of patients may be jeopardized; or

8.4.1.7 Provider has been abusive to a Covered Individual, an Anthem employee or representative; or

8.4.1.8 Provider and/or his/her/its employees, contractors, subcontractors, or agents are identified as ineligible persons on the General Services Administration list of Parties Excluded from Federal Programs and/or HHS/OIG List of Excluded Individuals/Entities, and in the case of an employee, contractor, subcontractor or agent fails to remove such individual from responsibility for, or involvement with, the Provider's business operations related to this Agreement; or

8.4.1.9 Provider is convicted of a felony or misdemeanor.

8.4.2 This Agreement may be terminated immediately by Provider if:

8.4.2.1 Anthem commits any act or conduct for which its license(s), permit(s), or any governmental or board authorization(s) or approval(s) necessary for business operations are lost or voluntarily surrendered in whole or in part; or

8.4.2.2 Anthem commits a fraud or makes any material misstatements or omissions on any documents related to this Agreement which it submits to Provider or to a third party; or

8.4.2.3 Anthem files for bankruptcy, or if a receiver is appointed; or

8.4.2.4 Anthem's insurance coverage as required by this Agreement lapses for any reason.

8.4.3 If applicable, Anthem reserves the right to terminate individual providers under the terms hereof while continuing the Agreement for one or more providers in a group.

8.4.4 Notwithstanding any other provision in this Article VIII to the contrary, if the Provider terminates the Agreement for any reason, the Provider shall give the HMO at least sixty (60) days advance notice of termination as required by Virginia Code Section 38.2-5805 C.1 relating to HMOs.

8.5 **Transactions Prior to Termination.** Termination shall have no effect on the rights and obligations of the parties arising out of any transaction occurring prior to the date of such termination.

8.6 **Continuance of Care-Termination.** Unless otherwise set forth in the Health Benefit Plan, or required by statute or regulation, Continuance of Care-Termination shall apply as follows: Provider shall, upon termination of this Agreement for reasons other than the grounds set forth in the “Termination With Cause”
section of this Agreement, continue to provide and be compensated for Covered Services rendered to Covered Individuals under the terms and conditions of this Agreement until the earlier of ninety (90) days or such time that: (1) the Covered Individual has completed the course of treatment and if applicable, was discharged; or (2) reasonable and medically appropriate arrangements have been made for a Network/Participating Provider to render Health Services to the Covered Individual. Notwithstanding the foregoing, for Covered Individuals who: (i) have entered the second or third trimester of pregnancy at the time of such termination, or (ii) are defined as terminally ill under § 1861 (dd) (3) (A) of the Social Security Act at the time of such termination, this continuance of care section and all other provisions of this Agreement shall remain in effect for such pregnant Covered Individuals through the provision of postpartum care directly related to their delivery, and for such terminally ill Covered Individuals for the remainder of their life for care directly related to the treatment of the terminal illness.

8.7 Survival. In the event of termination of the Agreement, the following provisions shall survive:

8.7.1 Publication and Use of Provider Information (Section 2.3) excluding transparency information;
8.7.2 Payment in Full and Hold Harmless (Section 2.7);
8.7.3 Adjustments for Incorrect Payments (Section 2.8);
8.7.4 Confidentiality/Records (Article III);
8.7.5 Indemnification and Limitation of Liability (Article VI);
8.7.6 This provision intentionally left blank; and
8.7.7 Continuance of Care-Termination (Section 8.6).

ARTICLE IX
GENERAL PROVISIONS

9.1 Amendment. Anthem retains the right to amend this Agreement, the Anthem Rate, or any attachments or addenda or the provider manual by providing Provider with a written copy of the applicable portion of the amendment. If Provider is unwilling to accept the amendment, Provider may terminate this Agreement by giving Anthem written notice of termination within forty (40) calendar days after the marked date associated with the corresponding delivery method of the amendment, and such termination shall become effective sixty (60) calendar days after the expiration of this forty (40) calendar day period without the amendment taking effect. If Provider does not give Anthem notice of termination within this forty (40) calendar day period, then the amendment will become effective sixty (60) calendar days after the expiration of this forty (40) calendar day period.

9.2 Assignment. This Agreement shall be binding upon and inure to the benefit of the respective legal successors and assignees of the parties. However, neither this Agreement, nor any rights or obligations hereunder may be assigned, either by operation of law or otherwise, transferred in whole or in part, without the prior written consent of the other party, except that Anthem retains the right to assign, either by operation of law or otherwise, transfer in whole or in part, this Agreement to an Affiliate or to delegate any rights or obligations under this Agreement to a designee.

9.3 Scope/Change in Status.

9.3.1 This provision intentionally left blank.

9.3.2 Provider shall provide Anthem with thirty (30) days prior written notice of:

9.3.2.1 A change in providers who are part of the group, if applicable. Any new providers must meet Anthem’s credentialing standards or other applicable standards prior to being designated as a Network/Participating Provider; or

9.3.2.2 Any new physical location, tax identification number, mailing address or similar demographic information.

9.4 Definitions. Unless otherwise specifically noted, the definitions as set forth in Article I of this Agreement will
have the same meaning when used in any attachment and the provider manual(s).

9.5 **Entire Agreement.** This Agreement (including items incorporated herein by reference) constitutes the entire understanding between the parties and supersedes all prior oral or written agreements between them with respect to the matters provided for herein. If there are any conflicts between any of the provisions of this Agreement and the provider manual, this Agreement will take precedence.

9.6 **Force Majeure.** Neither party shall be deemed to be in violation of this Agreement if such party is prevented from performing any of his/her/its obligations hereunder for any reason beyond his/her/its reasonable control, including without limitation, acts of God, natural or man-made disasters, acts of any public enemy, statutory or other laws, regulations, rules, orders, or actions of the federal, state, or local government or any agency thereof.

9.7 **Compliance with Federal and State Laws.** Anthem and Provider agree to comply with all requirements of the law relating to their obligations under this Agreement, and maintain in effect all permits, licenses and governmental and board authorizations and approvals as necessary for business operations. Provider agrees that he/she/it shall be and remain licensed and certified (including Medicare certification in unqualified, unrestricted status) in accordance with all state and federal laws and regulations (including those applicable to utilization review and Claims payment) relating to the provision of provider services to Covered Individuals. Provider shall supply evidence of such licensure, compliance and certifications to Anthem upon request. Provider further agrees to immediately notify Anthem if he/she/it loses or voluntarily surrenders such licensure, accreditation, permits, authorizations or approvals, or when applicable no longer meets Anthem's credentialing standards. From time to time legislative bodies, boards, departments or agencies may enact, issue or amend laws, rules, or regulations pertinent to this Agreement. Both parties agree to immediately abide by all said laws, rules, or regulations to the extent applicable, and to cooperate with the other to carry out any responsibilities placed upon the other by said laws, rules, or regulations, subject to the other's right to terminate as set forth under this Agreement. In the event of a conflict between this section and any other provision in this Agreement, this section shall control.

9.7.1 In addition to the foregoing, Provider warrants and represents that at the time of entering into this Agreement, neither he/she/it nor any of his/her/its employees, contractors, subcontractors or agents are ineligible persons identified on the General Services Administrations' List of Parties Excluded from Federal Programs (available through the internet at http://www.epis.gov/ or its successor) and the HHS/OIG List of Excluded Individuals/Entities (available through the internet at http://www.oig.hhs.gov/fraud/exclusions.asp or its successor), or as otherwise designated by the Federal government. If Provider or any employees, subcontractors or agents thereof becomes an ineligible person after entering into this Agreement or otherwise fails to disclose his/her/its ineligible person status, Provider shall have an obligation to (1) immediately notify Anthem of such ineligible person status and (2) within ten (10) days of such notice, remove such individual from responsibility for, or involvement with, the Provider's business operations related to this Agreement.

9.8 **Governing Law.** This Agreement shall be governed by and construed in accordance with the laws of the state where Anthem is located, as identified by the legal entity name in the preamble, unless such state laws are otherwise preempted by federal law. However, coverage issues specific to a Health Benefit Plan are governed by the state laws where the Health Benefit Plan is issued, unless such state laws are otherwise preempted by federal law.

9.9 **Intent of the Parties.** It is the intent of the parties that this Agreement is to be effective only in regards to their rights and obligations with respect to each other; it is expressly not the intent of the parties to create any independent rights in any third party or to make any third party a third party beneficiary of this Agreement, except to the extent specified in the Payment in Full and Hold Harmless section of this Agreement.

9.10 **Non-Exclusive Participation.** None of the provisions of this Agreement shall prevent Provider or Plan from participating in or contracting with any provider, preferred provider organization, health maintenance organization/health insuring corporation, or any other health delivery or insurance program. Provider acknowledges that Plan does not warrant or guarantee that Provider will be utilized by any particular number of Covered Individuals.

9.11 **Notice.** Any notice required to be given pursuant to the terms and provisions of this Agreement shall be in writing and shall be delivered by electronic mail, by facsimile, by hand, or by mail. Unless specified otherwise in writing by a party, Anthem shall send Provider notice to an address that Anthem has on file for
9.12 Severability. In case any one or more of the provisions of this Agreement shall be invalid, illegal, or unenforceable in any respect, the remaining provisions shall be construed liberally in order to effectuate the purposes hereof, and the validity, legality and enforceability of the remaining provisions shall not in any way be affected or impaired thereby. If one or more provisions of the Agreement are invalid, illegal or unenforceable and an amendment to the Agreement is necessary to maintain its integrity, the parties shall make commercially reasonable efforts to negotiate an amendment to this Agreement and any attachments or addenda to this Agreement which could reasonably be construed not to contravene such statute, regulation, or interpretation. In addition, if such invalid, unenforceable or materially affected provision(s) may be severed from this Agreement and/or attachments or addenda to this Agreement without materially affecting the parties’ intent when this Agreement was executed, then such provision(s) shall be severed rather than terminating the Agreement or any attachments or addenda to this Agreement.

9.13 Waiver. Neither the waiver by either of the parties of a breach of any of the provisions of this Agreement, nor the failure of either of the parties, on one or more occasion, to enforce any of the provisions of this Agreement, shall thereafter be construed as a waiver of any subsequent breach of any of the provisions of this Agreement.

9.14 Abandonment. Nothing herein shall be construed as authorizing or permitting Provider to abandon any patient.

9.15 This provision intentionally left blank.

9.16 Construction. This Agreement shall be construed without regard to any presumption or other rule requiring construction against the party causing this Agreement to be drafted.