PLAN COMPENSATION SCHEDULE ("PCS")

I. PROVIDER TYPE

"Specialty Physician Group" means one or more licensed or certified medical practitioners who have specialized education, training or experience in accordance with the law of the state in which Health Services are rendered.

Provider is designated as a Specialty Physician for those Network(s) indicated on the signature page of the Agreement for which Provider did not opt-out.

Provider agrees to provide within the scope of his/her practice Covered Services to Covered Individuals subject to any applicable referral and/or authorization requirements in Covered Individual's Health Benefit Plan or in this Agreement.

Except in case of an emergency, or as otherwise set forth in the Covered Individual's Health Benefit Plan, or required by statute or regulation, prior to treating a Covered Individual, Provider agrees to obtain a referral, in accordance with Covered Individual's Health Benefits Plan, from the Primary Care Physician ("PCP") who is primarily responsible for providing or authorizing the professional services as set forth in the Health Benefit Plan. For Covered Individuals who are covered by an HMO Health Benefits Plan, Health Services provided by Provider without proper referral or prior authorization from the HMO shall not be considered Covered Services. Also, in the event that services required by a Covered Individual covered by an HMO Health Benefits Plan, including an open access Covered Individual, are not available from Network/Participating Providers, other providers may be utilized with the prior authorization of the HMO. Should Provider refer a Covered Individual to another provider, whether that provider is a Network/Participating Provider or not, without the prior authorization of the Covered Individual's PCP or the HMO, as specified above, the HMO may elect to pay the Covered Individual for the Covered Service or to pay the provider of the service and to deduct the amount paid in such cases from any payment due Provider.

Provider agrees to make necessary and appropriate arrangements to ensure the availability of Health Services to Covered Individuals on a twenty-four (24) hour per day, seven (7) day per week basis, including arrangements to ensure coverage for Covered Individuals after hours or when Provider is otherwise absent. Provider will use best efforts to ensure that covering providers participate with the Network specified in the Covered Individuals Health Benefit Plan. Additionally, Provider agrees to (i) ensure the availability of routine appointments for non-emergency or non-urgent care within two (2) weeks of the Covered Individual's request and preventive care appointments, including routine physical examinations, within sixty (60) days of the Covered Individual's request; and (ii) provide clear notice to Covered Individuals of provisions for urgent care or emergency services when Provider is not available after hours.

HMO may contract with a limited number of laboratory services providers to provide outpatient lab services. Provider agrees to use any laboratory designated by HMO for HMO Covered Individuals. HMO will reimburse for a limited list of lab services when performed in Provider's office. These lab codes and the related reimbursement are included in this PCS Attachment. Provider further agrees not to bill Covered Individuals for covered lab services that are determined as ineligible for compensation to Provider by HMO.

To the extent required by law or an accrediting body, upon termination without cause, Provider will provide timely, sixty (60) day, notice to affected Covered Individual(s) of termination of this Agreement or termination of an individual Network participation. As required by Virginia Code Section 38.2-3407.10D, if Provider terminates this Agreement for any reason, Provider must furnish reasonable notice of such termination to Provider's patients who are Covered Individuals.

II. SPECIFIC REIMBURSEMENT TERMS

For Covered Services provided by or on behalf of Provider to a Covered Individual who is enrolled in a product and/or program that is supported by a Network in this Agreement, Provider agrees to accept the lesser of Provider's Charges or the applicable Plan Fee Schedule. The PCS Attachment attached hereto and made a part hereof contains information that further describes the reimbursement for Covered Services.

III. GENERAL PROVISIONS

Billing Form and Claims Reporting Requirements. Provider shall submit all Claims on a CMS 1500 claim form or its successor. Provider shall report all Health Services in accordance with the reporting guidelines
and instructions contained in the AMA CPT, CPT Assistant, and HCPCS publications. Plan audits that result in identification of Health Services that are not reported in accordance with the AMA CPT, and CPT Assistant publications, will be subject to recovery through remittance adjustment or other recovery action. In addition, updates to Anthem’s Claims processing filters and edits, as a result of changes in AMA CPT, and CPT Assistant reporting guidelines and instructions, shall take place automatically and do not require any notice, disclosure or amendment to Provider.

**Claim Submissions for Pharmaceuticals.** Provider agrees that the NDC must be listed on each Claim that includes Federal Legend Drugs.

**Coding Updates.** Coded Service Identifier(s) used to define specific rates are updated from time to time to reflect new, deleted or replacement codes. Anthem shall use commercially reasonable efforts to update all applicable Coded Service Identifiers within sixty (60) days of release by CMS or other applicable authority. If an update is delayed beyond the sixty (60) days, Anthem shall notify Provider. Claims processed prior to the implementation of the revised codes shall not be reprocessed. In addition, Claims with codes which have been deleted will be rejected.

**Not Otherwise Classified Codes (NOC) and/or Individual Consideration Codes (IC).** Anthem reserves the right to price NOC and/or IC codes individually, and may require the submission of medical records prior to the adjudication of such Claims.

**System Updates.** Unless otherwise required by law or applicable regulation, any updates to the Anthem Rates tied to any governmental agency, vendor, or other entity shall be effective no later than sixty (60) days after Anthem’s receipt of such rate changes. Examples include, but are not limited to, CMS state specific fee schedules and pharmaceutical rates.

The parties recognize and agree that Anthem payment systems cannot be modified immediately when the above changes are made, but must instead be modified during a timeframe of sufficient length to allow for the loading of payment system changes and updates, including changes and updates that allow for the recognition of new fees and codes. Anthem shall use reasonable efforts to load such payment system changes as quickly as practicable following the release date of such changes. Claims processed prior to the implementation of the new Anthem Rates shall not be reprocessed.

Notwithstanding the foregoing, Plan will automatically update its allowance for injectable drugs in accordance with CMS quarterly updates to the Drug Pricing File. Retroactive adjustments made by CMS to the Drug Pricing File or the Medicare Fee Schedule shall not be made to Anthem’s Drug Pricing File or the applicable Plan Fee Schedule.

**Dismissing a Covered Individual.** If Provider believes that a reasonable provider/patient relationship cannot be established or maintained between Provider and a Covered Individual as a result of the Covered Person’s:

- Display of hostility or improper behavior towards Provider, Provider staff, or other patients;
- Unreasonable refusal to cooperate with Provider's diagnosis or treatment or refusal to follow Provider's instructions;
- Failure to pay applicable Cost Shares; or
- Making unreasonable or unnecessary demands on Provider or Provider's staff, then Provider may refuse to accept such Covered Individual as a patient or terminate the Covered Individual as a patient.

Written notice of any such refusal and/or termination must be promptly sent to Anthem. Provider will continue to provide care for the Covered Individual until care has been transitioned to a new provider.

**Open Access Covered Individual.** Covered Individuals who are enrolled under an HMO Health Benefit Plan that does not require the Covered Individual to obtain a referral from his/her Provider in order to receive Covered Services from Network/Participating Providers.