HIGHMARK BLUE SHIELD REVIEW COMMITTEE GUIDELINES

Highmark Inc. ("Highmark"), doing business as Highmark Blue Shield, operates under the provisions of Act 271 of 1972 (40 PA. C.S. Section 6301 et seq.). Section 6324 (c) of the Act requires that all matters, disputes or controversies relating to professional health service doctors or any questions involving professional ethics shall be considered and determined only by health service doctors selected in a manner prescribed in the Bylaws of the professional health service corporation involved.

The Bylaws of Highmark Inc. (Article VIII) stipulates that the Medical Review Committee be formed to consider and determine all matters, disputes or controversies relating to the professional health services (as defined in 40 Pa.C.S.A. § 6302(a)) rendered by Health Service Doctors to subscribers who have coverage under contracts issued by Highmark, and any questions involving the professional ethics of such providers. The Bylaws of Highmark Inc. further direct that the Medical Review Committee shall maintain written procedural guidelines, which are set forth below.

The matters referred to the Medical Review Committee generally concern disputes with respect to overutilization and/or misutilization of services, coding of services rendered, professional ethics, credentialing, claims overpayments, failure to document services and other controversies relating to professional health services.

The following procedural guidelines are applicable to the Medical Review Committee:

1. For matters involving potential overutilization and/or misutilization of services or inappropriate quality of care, a review is conducted of the provider's practice pattern prior to referral to the Medical Review Committee. During this process, a sample of patient records, statistics, diagnostic aids, and/or other informational sources is reviewed. The results of such review, as well as the methodology used, will be made available to the provider when any adverse findings result. Should the provider disagree with the results of the review due to the sample size, the provider may request an expanded review.

2. If it is determined that an overpayment has been made, the amount of the overpayment will be calculated for a period of time not to exceed that permitted by the four-year Statute of Limitations governing contract claims. The results of such overpayment calculations will be made available to the provider. The provider will be furnished with the methodology used to calculate the overpayment.

3. If it is discovered in the review process that an underpayment has occurred, the provider may seek reimbursement, through the appropriate appeal mechanisms, for all claims involved during the same time period as the review by Highmark. Such claims must be supported by clinical records.

4. If the matter is not referred for prosecution, and does not involve the proposed suspension or termination of a participating/preferred/network provider, a Highmark representative will send a letter to the provider summarizing all findings and advising the provider of available appeal rights. The provider is furnished with a written statement outlining the basis of any refund demand. The provider is also advised of the repayment options available to him or her, and is provided with a copy of these Review Committee Guidelines. The provider will be encouraged to submit any additional information which could have a bearing on the matter and/or create the basis for an adjustment to the refund amount demanded, if any. If Highmark and the provider are unable to reach an agreement concerning the amount of any overpayment or any other matter relating to the review, Highmark will send a certified mail letter to the provider, furnishing at least thirty (30) calendar days' advance notice of the date of the Medical Review Committee meeting at which the provider's case will be considered and determined. Highmark's letter shall also notify the provider of his or her rights to appear before the Medical Review Committee and be represented by legal counsel. The provider will again be encouraged to provide any information which may be pertinent to the resolution of the matter, dispute or controversy. Accompanying the letter is another copy of the basis of any refund demand, the applicable sections of the Bylaws of Highmark Inc. pertaining to the Medical Review Committee, the Review Committee Guidelines and, if applicable, the Preferred Provider Agreement and/or Regulations for Preferred Providers and/or credentialing policies.

5. At least fifteen (15) calendar days prior to the date of the Medical Review Committee meeting at which the provider's case will be considered and determined, the provider will be given either a hard or electronic copy of the documentation to be provided to the Medical Review Committee.

6. A provider may forward information to the Medical Review Committee and/or may appear before the Medical Review Committee. A provider who chooses to appear before the Medical Review Committee will be notified of the date and time of his or her appearance at least fifteen (15) calendar days prior to the meeting. Such notification will inform the provider of the proceeding and the provider's right to appear before the Medical Review Committee to express the reasons why he or she disagrees with Highmark's determination and/or to provide any other information which will aid the Medical Review Committee in its determination of the matter, dispute or controversy.

7. Upon providing Highmark with at least ten (10) calendar days' advance written notice, a provider may request that the Medical Review Committee postpone consideration of the matter, dispute or controversy until the next scheduled Medical Review Committee meeting. If, due to an emergency or other unanticipated circumstance, the provider's request is delivered to Highmark fewer than ten (10) calendar days before the meeting, the Medical Review Committee Chairperson will decide whether there is good cause to grant a postponement. As a general rule, a provider shall be granted only one postponement to hear a particular matter, dispute or controversy. A second postponement may be granted by the Chairperson only if the second request results from unanticipated circumstances beyond the provider's control.

Within thirty (30) calendar days after the Medical Review Committee meeting, the provider will be advised in writing of all determinations made by the Medical Review Committee as to the matter, dispute or controversy. Such notification will include, but not be limited to, the amount of any overpayment or underpayment at issue and any other information the Medical Review Committee deems appropriate.

8. If the provider fails to refund any overpayment amounts within thirty (30) calendar days after notification of the Medical Review Committee's determination, Highmark shall be authorized to withhold payments otherwise due the provider and to assess interest. Interest will also be assessed on installment payment arrangements.

   Interest shall accrue on any unpaid balance at a rate equal to the then-prevailing United States Prime Rate as published in the "Money Rates" section of the *Wall Street Journal* print edition on January 1 of each year. If the *Wall Street Journal* is not published on January 1, then the next available edition of the *Wall Street Journal* will be used. The Prime Rate as determined by the *Wall Street Journal* on January 1 (or the next available edition, if necessary) shall be fixed as the interest rate for the entire calendar year until the following year's Prime Rate is published by the *Wall Street Journal*.

9. If the Medical Review Committee determines that a hearing should be held to consider a question involving professional ethics or to determine whether a provider should be suspended or terminated as a participating provider, the proceedings will be conducted as set forth in Article VIII, Section 8.7, of the Bylaws of Highmark Inc., and in the manner described in these guidelines.