ANTHEM BLUE CROSS AND BLUE SHIELD PROVIDER AGREEMENT

WITH

Centrality Behavioral Support Training

ANTHEM BLUE CROSS AND BLUE SHIELD
PROVIDER AGREEMENT

This Provider Agreement (hereinafter "Agreement") is made and entered into by and between Anthem Insurance Companies, Inc. doing business as Anthem Blue Cross and Blue Shield (hereinafter "Anthem") and Centrality Behavioral Support Training (hereinafter "Provider"), effective as of the date set forth immediately above Anthem's signature (the "Effective Date"). 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 any entity that is: (i) owned or controlled, either directly or through a parent or subsidiary entity, by Anthem, or is under common control with Anthem, and (ii) that is identified as an Affiliate on Anthem's designated web site as referenced in the provider manual(s). Unless otherwise set forth in this Agreement, an Affiliate may access the rates, terms and conditions of this Agreement.

"Agency" means a federal, state or local agency, administration, board or other governing body with jurisdiction over the governance or administration of a Health Benefit Plan.

"Anthem Rate" means the lesser of one hundred percent (100%) of Eligible 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 includes applicable Cost Shares, and shall represent payment in full to Provider for Covered Services.

"Audit" means a post-payment review of the Claim(s) and supporting clinical information reviewed by Anthem to ensure payment accuracy. The review ensures Claim(s) comply with all pertinent aspects of submission and payment including, but not limited to, contractual terms, Regulatory Requirements, Coded Service Identifiers (as defined in the PCS) guidelines and instructions, Anthem medical policies and clinical utilization management guidelines, reimbursement policies, and generally accepted medical practices. Audit does not include medical record review for quality and risk adjustment initiatives, or activities conducted by Anthem's Special Investigation Unit ("SIU").

"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 Member.

"CMS" means the Centers for Medicare & Medicaid Services, an administrative agency within the United States Department of Health & Human Services ("HHS").

"Cost Share" means, with respect to Covered Services, an amount which a Member 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 Member payment responsibility, and may be a fixed amount or a percentage of applicable payment for Covered Services rendered to the Member.

"Covered Services" means Medically Necessary Health Services, as determined by Plan and described in the applicable Health Benefit Plan, for which a Member is eligible for coverage.

"Government Contract" means the contract between Anthem and an applicable party, such as an Agency, which governs the delivery of Health Services by Anthem to Member(s) pursuant to a Government Program.

"Government Program" means any federal or state funded program under the Social Security Act, and any other federal, state, county or other municipally funded program or product in which Anthem maintains a contract to furnish services. For purposes of this Agreement, Government Program does not include the Federal Employees Health Benefits Program ("FEHBP"), or any state or local government employer program.

"Health Benefit Plan" means the document(s) that set forth Covered Services, rules, exclusions, terms and conditions of coverage. Such document(s) may include but are not limited to a Member handbook, a health certificate of coverage, or evidence of coverage.

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

"Medically Necessary" or "Medical Necessity" means the definition as set forth in the applicable Participation Attachment(s).

"Member" 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, provider manual(s), notices and communications related to this Agreement, the term "Member" may be used interchangeably with the terms Insured, Covered Person, Covered Individual, Enrollee, Subscriber, Dependent Spouse/Domestic Partner, Child, Beneficiary or Contract Holder, and the meaning of each is synonymous with any such other.

"Network" means a group of providers that support, through a direct or indirect contractual relationship, one or more product(s) and/or program(s) in which Members are enrolled.

"Other Payors" means persons or entities, pursuant to an agreement with Anthem or an Affiliate, that access the rates, terms or conditions of this Agreement with respect to certain Network(s), excluding Government Programs unless otherwise set forth in any Participation Attachment(s) for Government Programs. Other Payors include, without limitation, other Blue Cross and/or Blue Shield Plans that are not Affiliates, and employers or insurers providing Health Benefit Plans pursuant to partially or wholly insured, self-administered or self-insured programs.

"Participating Provider" means a person or entity, or an employee or subcontractor of such person or entity, that is party to an agreement to provide Covered Services to Members that has met all applicable Plan credentialing requirements, standards of participation and accreditation requirements for the services the Participating Provider provides, and that is designated by Plan to participate in one or more Network(s).

"Participation Attachment(s)" means the document(s) attached hereto and incorporated herein by reference, and which identifies the additional duties and/or obligations related to Network(s), Government Program(s), Health Benefit Plan(s), and/or Plan programs such as quality and/or incentive programs.

"Plan" means Anthem, an Affiliate, 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 (i.e., the financially responsible Affiliate or Other Payor under the Member's Health Benefit Plan).

"Plan Compensation Schedule" ("PCS") means the document(s) attached hereto and incorporated herein by reference, and 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.

"Regulatory Requirements" means any requirements, as amended from time to time, imposed by applicable federal, state or local laws, rules, regulations, guidelines, instructions, Government Contract, or otherwise imposed by an Agency or government regulator in connection with the procurement, development or operation of a Health Benefit Plan, or the performance required by either party under this Agreement. The omission from this Agreement of an express reference to a Regulatory Requirement applicable to either party in connection with their duties and responsibilities shall in no way limit such party's obligation to comply with such Regulatory Requirement.

ARTICLE II
SERVICES/OBLIGATIONS

2.1 Member Identification. Anthem shall ensure that Plan provides a means of identifying Member either by issuing a paper, plastic, electronic, or other identification document to Member or by a telephonic, paper or electronic communication to Provider. This identification need not include all information necessary to determine Member's eligibility at the time a Health Service is rendered, but shall include information necessary to contact Plan to determine Member's participation in 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 Member, nor does the lack thereof mean that the person is not a Member.

2.2 Provider Non-discrimination. Provider shall provide Health Services to Members 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 Member as a result of his/her enrollment in a Health Benefit 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 Members 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, affiliations, performance data, Anthem Rates, and 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 Adjudication of Claims. Provider shall submit, and Plan shall adjudicate, Claims in accordance with the applicable Participation Attachment(s), the PCS, the provider manual(s) and Regulatory Requirements. If Provider submits Claims prior to receiving notice of Anthem's approval pursuant to section 2.13, then such Claims shall be processed as out of network and Plan may not make retroactive adjustments with respect to such Claims.

2.6 Payment in Full and Hold Harmless.

2.6.1 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 a payment by another source, such as through coordination of benefits or subrogation. 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 Member has not yet satisfied his/her deductible.

2.6.2 Except as expressly permitted under Regulatory Requirements, Provider agrees that in no event, including but not limited to, nonpayment by applicable Plan, insolvency of applicable Plan, breach of this Agreement, or Claim payment denials or adjustment requests or recoupments based on miscoding or other billing errors of any type, whether or not fraudulent or abusive, shall Provider, or any person acting on behalf of Provider, bill, charge, collect a deposit from, seek compensation from, or have any other recourse against a Member, or a person legally acting on the Member's behalf, for Covered Services provided pursuant to this Agreement. In the event of nonpayment and/or insolvency of a Plan that is not underwritten by Anthem or an Affiliate, Provider further agrees that it shall not seek compensation from or have any other recourse against Anthem or an Affiliate. Notwithstanding the foregoing, Provider may collect reimbursement from the Member for the following:

2.6.2.1 Cost Shares, if applicable;

2.6.2.2 Health Services that are not Covered Services. However, Provider may seek payment for a Health Service that is not Medically Necessary or is experimental/investigational only if Provider obtains a written waiver that meets the following criteria:

a) The waiver notifies the Member that the Health Service is likely to be deemed not Medically Necessary, or experimental/investigational;

b) The waiver notifies the Member of the Health Service being provided and the date(s) of service;

c) The waiver notifies the Member of the approximate cost of the Health Service;

d) The waiver is signed by the Member, or a person legally acting on the Member's behalf, prior to receipt of the Health Service.

2.6.2.3 Any reduction in or denial of payment as a result of the Member's failure to comply with his/her utilization management program pursuant to his her/her Health Benefit Plan, except when Provider has been designated by Anthem to comply with utilization management for the Health Services provided by Provider to the Member.

2.7 Recoupment/Offset/Adjustment for Overpayments. Anthem shall be entitled to offset and recoup an amount equal to any overpayments or improper payments made by Anthem to Provider against any payments due and payable by Anthem to Provider with respect to any Health Benefit Plan under this Agreement. Provider shall voluntarily refund all duplicate or erroneous Claim payments regardless of the cause, including, but not limited to, payments for Claims where the Claim was miscoded, non-compliant with industry standards, or otherwise billed in error, whether or not the billing error was fraudulent, abusive or wasteful. Upon determination by Anthem that any recoupment, improper payment, or overpayment is due from Provider, Provider must refund the amount to Anthem within thirty (30) days of when Anthem notifies Provider. If such reimbursement is not received by Anthem within the thirty (30) days following the date of such notice, Anthem shall be entitled to offset such overpayment against any Claims payments due and payable by Anthem to Provider under any Health Benefit Plan in accordance with Regulatory Requirements. In such event, Provider agrees that all future Claim payments applied to satisfy Provider's repayment obligation shall be deemed to have been paid in full for all purposes, including section 2.6.1. Should Provider disagree with any determination by Plan that Provider has received an overpayment, Provider shall have the right to appeal such determination under Anthem's procedures set forth in the provider manual, and such appeal shall not suspend Anthem's right to recoup the overpayment amount during the appeal process, unless suspension of the right to recoup is otherwise required by Regulatory Requirements. Anthem reserves the right to employ a third party collection agency in the event of non-payment.

2.8 Use of Subcontractors. Provider and Plan may fulfill some of their duties under this Agreement through subcontractors. For purposes of this provision, subcontractors shall include, but are not limited to, vendors and non-Participating Providers that provide supplies, equipment, staffing, and other services to Members at the request of, under the supervision of, and/or at the place of business of Provider. Provider shall provide Anthem with thirty (30) days prior notice of any Health Services subcontractors with which Provider may contract to perform Provider's duties and obligations under this Agreement, and Provider shall remain responsible to Plan for 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 herein.

2.9 Compliance with Provider Manual(s) and Policies, Programs and Procedures. Provider agrees to cooperate and comply with, Anthem's provider manual(s), and all other policies, programs and procedures (collectively "Policies") established and implemented by Plan applicable to the Network(s) in which Provider participates. Anthem or its designees may modify the provider manual(s) and its Policies by making a good faith effort to provide notice to Provider at least thirty (30) days in advance of the effective date of material modifications thereto.

2.10 Referral Incentives/Kickbacks. 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 Member, 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.

2.11 Networks and Provider Panels. Provider shall be eligible to participate only in those Networks designated on the Provider Networks Attachment of this Agreement. Provider shall not be recognized as a Participating Provider in such Networks until the later of: 1) the Effective Date of this Agreement or; 2) as determined by Plan in its sole discretion, the date Provider has met Plan's applicable credentialing requirements, standards of participation and accreditation requirements. Provider acknowledges that Plan may develop, discontinue, or modify new or existing Networks, products and/or programs. In addition to those Networks designated on the Provider Networks Attachment, Anthem may also identify Provider as a Participating Provider in additional Networks, products and/or programs designated in writing from time to time by Anthem. The terms and conditions of Provider's participation as a Participating Provider in such additional Networks, products and/or programs shall be on the terms and conditions as set forth in this Agreement unless otherwise agreed to in writing by Provider and Anthem.

In addition to and separate from Networks that support some or all of Plan's products and/or programs (e.g., HMO, PPO and Indemnity products), Provider further acknowledges that certain Health Services, including by

way of example only, laboratory or behavioral health services, may be provided exclusively by designated Participating Providers (a "Health Services Designated Network"), as determined by Plan. Provider agrees to refer Members to such designated Participating Providers in a Health Services Designated Network for the provision of certain Health Services, even if Provider performs such services. Notwithstanding any other provision in this Agreement, if Provider provides a Health Service to a Member for which Provider is not a designated Participating Provider in a Health Services Designated Network, then Provider agrees that he/she/it shall not be reimbursed for such services by Anthem, Plan or the Member, unless Provider was authorized to provide such Health Service by Plan.

2.12 Change in Provider Information. Provider shall immediately send written notice, in accordance with the Notice section of this Agreement, to Anthem of:

2.12.1 Any legal, governmental, or other action or investigation involving Provider which could affect Provider's credentialing status with Plan, or 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

2.12.2 Any change in Provider accreditation, affiliation, hospital privileges (if applicable), insurance, licensure, certification or eligibility status, or other relevant information regarding Provider's practice or status in the medical community.

2.13 Provider Credentialing, Standards of Participation and Accreditation. Provider warrants that he/she/it meets all applicable Plan credentialing requirements, standards of participation, and accreditation requirements for the Networks in which Provider participates. A description of the applicable credentialing requirements, standards of participation, and accreditation requirements, are set forth in the provider manual(s) and/or in the PCS. Provider acknowledges that until such time as Provider has been determined to have fully met Plan's credentialing requirements, standards of participation, and accreditation requirements, as applicable, Provider shall not be entitled to the benefits of participation under this Agreement, including without limitation the Anthem Rates set forth in the PCS attached hereto.

2.14 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 in accordance with the provider manual(s).

2.15 Provision and Supervision of Services. In no way shall Anthem or Plan be construed to be providers of Health Services or responsible for, exercise control, or have direction over the provision of such Health Services. Provider shall be solely responsible to the Member for treatment, medical care, and advice with respect to the provision of Health Services. Provider agrees that all Health Services provided to Members under this Agreement shall be provided by Provider or by a qualified person under Provider's direction. Provider warrants that any nurses or other health professionals employed by or providing services for Provider shall be duly licensed or certified under applicable law. In addition, nothing herein shall be construed as authorizing or permitting Provider to abandon any Member.

2.16 Coordination of Benefits/Subrogation. Subject to Regulatory Requirements, Provider agrees to cooperate with Plan regarding subrogation and coordination of benefits, as set forth in Policies and the provider manual(s), and to notify Plan promptly after receipt of information regarding any Member who may have a Claim involving subrogation or coordination of benefits.

2.17 Cost Effective Care. Provider shall provide Covered Services in the most cost effective, clinically appropriate setting and manner. In addition, in accordance with the provider manual(s) and Policies, Provider shall utilize Participating Providers, and when Medically Necessary or appropriate, refer and transfer Members to Participating Providers for all Covered Services, including but not limited to specialty, laboratory, ancillary and supplemental services.

ARTICLE III
CONFIDENTIALITY/RECORDS

3.1 Proprietary and Confidential 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 and confidential to the disclosing party. This Agreement, including but not limited to the Anthem Rates, is Anthem's proprietary and confidential information. Neither party shall disclose any information proprietary or confidential 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 designees; (5) upon the express written consent of the parties; or (6) as required by Regulatory Requirements. Notwithstanding the foregoing, 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. Provider and Anthem shall each have a system in place that meets all applicable Regulatory Requirements to protect all records and all other documents relating to this Agreement which are deemed confidential by law. Any disclosure or transfer of proprietary or confidential information by Provider or Anthem will be in accordance with applicable Regulatory Requirements. Provider shall immediately notify Anthem if Provider is required to disclose any proprietary or confidential information at the request of an Agency or pursuant to any federal or state freedom of information act request.

3.2 Confidentiality of Member Information. Both parties agree to comply with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act ("HITECH Act"), and as both may be amended, as well as any other applicable Regulatory Requirements regarding confidentiality, use, disclosure, security and access of the Member's personally identifiable information ("PII") and protected health information ("PHI"), (collectively "Member Information"). Provider shall review all Member Information received from Anthem to ensure no misrouted Member Information is included. Misrouted Member Information includes but is not limited to, information about a Member that Provider is not currently treating. Provider shall immediately destroy any misrouted Member Information or safeguard the Member Information for as long as it is retained. In no event shall Provider be permitted to misuse or re-disclose misrouted Member Information. If Provider cannot destroy or safeguard misrouted Member Information, Provider must contact Anthem to report receipt of misrouted Member Information.

3.3 Network Provider/Patient Discussions. 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 Member any issues related to the Member'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. In addition, nothing in this Agreement shall be construed to, create any financial incentive for Provider to withhold Covered Services, or prohibit Provider from disclosing to the Member 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 perform an Audit, examine, copy, excerpt and transcribe any books, documents, papers, and records related to Member's medical and billing information within the possession of Provider and inspect Provider's operations, which involve transactions relating to Members and as may be reasonably required by Plan in carrying out its responsibilities and programs including, but not limited to, assessing quality of care, complying with quality initiatives/measures, Medical Necessity, concurrent review, appropriateness of care, accuracy of Claims coding and payment, risk adjustment assessment as described in the provider manual(s), including but not limited to completion of the Encounter Facilitation Form (also called the "SOAP" note), 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, or its designees via photocopy or electronic transmittal, within thirty (30) days, at no charge to Plan from either Provider or its designee. Provider shall make such records available to the state and federal authorities involved in assessing quality of care or investigating Member grievances or complaints in compliance with Regulatory Requirements. 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 Member in any of the foregoing circumstances.

3.5 Transfer of Medical Records. Following a request, Provider shall transfer a Member's medical records in a timely manner, or within such other time period required under applicable Regulatory Requirements, to other

health care providers treating a Member at no cost to Anthem, Plan, the Member, or other treating health care providers.

3.6 Clinical Data Sharing. Anthem and Provider desire to collaborate by sharing data, including Member Information, to enhance certain health care operations activities, primarily to help improve quality and efficiency of health care. Each party's access to better clinical and administrative data is critical to the mutual goal of Anthem and Provider improving health care quality as it relates to their respective Members and patients. Therefore and upon request, Provider agrees to provide data to Anthem for treatment purposes, for payment purposes, for health care operations purposes consistent with those enumerated in the first two paragraphs of the health care operations definition in HIPAA (45 CFR 164.501), or for purposes of health care fraud and abuse detection or compliance. Provider shall provide data as set forth in Policies or the provider manual(s), as applicable.

ARTICLE IV
INSURANCE

4.1 Anthem Insurance. Anthem shall self-insure or maintain insurance as required under applicable Regulatory Requirements 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 reasonably determined by Provider, or as required under applicable Regulatory Requirements.

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, partnership, joint venture, or any relationship other than that of independent entities contracting with each other for the purposes of effectuating this Agreement.

5.2 Provider Representations and Warranties. Provider represents and warrants that it is the duly authorized agent of, and has the corporate power and authority to, execute and deliver this Agreement on its own behalf, and as agent for any other individuals or entities that are owned, employed or contracted with or by Provider to provide services under this Agreement. Accordingly, if Provider is a partnership, corporation, or any other entity, other than an individual, all references herein to "Provider" may also mean and refer to each individual within such entity who Provider certifies is contracted or employed by Provider, and who has applied for and been accepted by Plan as a Participating Provider. Provider further certifies that individuals or entities that are owned, employed or contracted with Provider agree to comply with the terms and conditions of this Agreement.

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, Affiliates and subsidiaries ("Representatives"), from and against any and all losses, claims, damages, liabilities, costs and expenses (including without limitation, reasonable attorneys' fees and costs) arising from third party claims resulting from the indemnifying party's or his/her/its Representative's failure to perform the indemnifying party's obligations under this Agreement, and/or the indemnifying party's or his/her/its Representative'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.

ARTICLE VII
DISPUTE RESOLUTION AND ARBITRATION

7.1 Dispute Resolution. All disputes between Anthem and Provider arising out of or related in any manner to this Agreement shall be resolved using the dispute resolution and arbitration procedures as set forth below. Provider shall exhaust any other applicable provider appeal/provider dispute resolution procedures under this Agreement and any applicable exhaustion requirements imposed by Regulatory Requirements as a condition precedent to Provider's right to pursue the dispute resolution and arbitration procedures as set forth below.

7.1.1 In order to invoke the dispute resolution procedures in this Agreement, a party first shall send to the other party a written demand letter that contains a detailed description of the dispute and all relevant underlying facts, a detailed description of the amount(s) in dispute and how they have been calculated and any other information that the Anthem provider manual(s) may require Provider to submit with respect to such dispute. If the total amount in dispute as set forth in the demand letter is less than two hundred thousand dollars ($200,000), exclusive of interest, costs, and attorneys' fees, then within twenty (20) days following the date on which the receiving party receives the demand letter, representatives of each party's choosing shall meet to discuss the dispute in person or telephonically in an effort to resolve the dispute. If the total amount in dispute as set forth in the demand letter is two hundred thousand dollars ($200,000) or more, exclusive of interest, costs, and attorneys' fees, then within ninety (90) days following the date of the demand letter, the parties shall engage in non-binding mediation in an effort to resolve the dispute unless both parties agree in writing to waive the mediation requirement. The parties shall mutually agree upon a mediator, and failing to do so, Judicial Arbitration and Mediation Services ("JAMS") shall be authorized to appoint a mediator.

7.2 Arbitration. Any dispute within the scope of subsection 7.1.1 that remains unresolved at the conclusion of the applicable process outlined in subsection 7.1.1 shall be resolved by binding arbitration in the manner as set forth below. Except to the extent as set forth below, the arbitration shall be conducted pursuant to the JAMS Comprehensive Arbitration Rules and Procedures, provided, however, that the parties may agree in writing to further modify the JAMS Comprehensive Arbitration Rules and Procedures. The parties agree to be bound by the findings of the arbitrator(s) with respect to such dispute, subject to the right of the parties to appeal such findings as set forth herein. No arbitration demand shall be filed until after the parties have completed the dispute resolution efforts described in section 7.1 above. If the dispute resolution efforts described in section 7.1 cannot be completed within the deadlines specified for such efforts despite the parties' good faith efforts to meet such deadlines, such deadlines may be extended as necessary upon mutual agreement of the parties. Enforcement of this arbitration clause, including the waiver of class actions, shall be determined under the Federal Arbitration Act ("FAA"), including the FAA's preemptive effect on state law. The parties agree that the arbitration shall be conducted on a confidential basis pursuant to Rule 26 of the JAMS Comprehensive Arbitration Rules and Procedures. Subject to any disclosures that may be required or requested under Regulatory Requirements, the parties further agree that they shall maintain the confidential nature of the arbitration, including without limitation, the existence of the arbitration, information exchanged during the arbitration, and the award of the arbitrator(s). Nothing in this provision, however, shall preclude either party from disclosing any such details regarding the arbitration to its accountants, auditors, brokers, insurers, reinsurers or retrocessionaires.

7.2.1 Location of Arbitration. The arbitration hearing shall be held in the city and state in which the Anthem office identified in the address block on the signature page of this Agreement is located, except that if there is no address block on the signature page, then the arbitration hearing shall be held in the city and state in which the Anthem entity that is a party to this Agreement has its principal place of business. Notwithstanding the foregoing, both parties can agree in writing to hold the arbitration hearing in some other location.

7.2.2 Selection and Replacement of Arbitrator(s). If the total amount in dispute is less than four million dollars ($4,000,000), exclusive of interest, costs, and attorneys' fees, the dispute shall be decided by a single arbitrator selected, and replaced when required, in the manner described in the JAMS Comprehensive Arbitration Rules and Procedures. If the total amount in dispute is four million dollars ($4,000,000) or more, exclusive of interest, costs, and attorneys' fees, the dispute shall be decided

by an arbitration panel consisting of three (3) arbitrators, unless the parties agree in writing that the dispute shall be decided by a single arbitrator.

7.2.3 Appeal. If the total amount of the arbitration award is five million dollars ($5,000,000) or more, inclusive of interest, costs, and attorneys' fees, or if the arbitrator(s) issues an injunction against a party, the parties shall have the right to appeal the decision of the arbitrator(s) pursuant to the JAMS Optional Arbitration Appeal Procedure. A decision that has been appealed shall not be enforceable while the appeal is pending. In reviewing a decision of the arbitrator(s), the appeal panel shall apply the same standard of review that a United States Court of Appeals would apply in reviewing a similar decision issued by a United States District Court in the jurisdiction in which the arbitration hearing was held.

7.2.4 Waiver of Certain Claims. The parties, on behalf of themselves and those that they may now or hereafter represent, each agree to and do hereby waive any right to join or consolidate claims in arbitration by or against other individuals or entities or to pursue, on a class basis, any dispute; provided however, if there is a dispute regarding the applicability or enforcement of the waiver provision in this subsection 7.2.4, that dispute shall be decided by a court of competent jurisdiction. If a court of competent jurisdiction determines that such waiver is unenforceable for any reason with respect to a particular dispute, then the parties agree that section 7.2 shall not apply to such dispute and that such dispute shall be decided instead in a court of competent jurisdiction.

7.2.5 Limitations on Injunctive Relief. The parties, on behalf of themselves and those that they may now or hereafter represent, each agree that any injunctive relief sought against the other party shall be limited to the conduct relevant to the parties to the arbitration and shall not be sought for the benefit of individuals or entities who are not parties to the arbitration. The arbitrator(s) are not authorized to issue injunctive relief for the benefit of an individual or entity who is not a party to the arbitration. The arbitrator shall be limited to issuing injunctive relief related to the specific issues in the arbitration.

7.3 Attorney's Fees and Costs. The shared fees and costs of the non-binding mediation and arbitration (e.g. fee of the mediator, fee of the independent arbitrator) will be shared equally between the parties. Each party shall be responsible for the payment of its own specific fees and costs (e.g. the party's own attorney's fees, the fees of the party selected arbitrator, etc.) and any costs associated with conducting the non-binding mediation or arbitration that the party chooses to incur (e.g. expert witness fees, depositions, etc.). Notwithstanding this provision, the arbitrator may issue an order in accordance with Federal Rule of Civil Procedure Rule 11.

7.4 Period of Limitations. Unless otherwise provided for in this Agreement, or a Participation Attachment(s), neither party shall commence any action at law or equity, including but not limited to, an arbitration demand, against the other to recover on any legal or equitable claim arising out of this Agreement ("Action") more than two (2) years after the events which gave rise to such Action; provided, however, this two (2) year limitation shall not apply to Actions by Anthem against Provider related to fraud, waste or abuse which shall be subject to the period of limitations set forth in applicable Regulatory Requirements. In the situation where Provider believes that Anthem underpaid a Claim, the Action arises on the date when Anthem first denies the Claim or first pays the Claim in an amount less than expected by Provider. In the situation where Anthem believes that it overpaid a Claim, the Action arises when Provider first contests in writing Anthem's notice to it that the overpayment was made. The deadline for initiating an Action shall not be tolled by the appeal process, provider dispute resolution process or any other administrative process. To the extent an Action is timely commenced, it will be administered in accordance with Article VII of this Agreement.

ARTICLE VIII
TERM AND TERMINATION

8.1 Term of Agreement. This Agreement shall commence at 12:01 AM on the Effective Date for a term of one (1) year, and shall continue automatically in effect thereafter for consecutive one (1) year terms unless otherwise terminated as provided herein.

8.2 Termination Without Cause. Either party may terminate this Agreement without cause at any time by giving at least one hundred eighty (180) days prior written notice of termination to the other party. Notwithstanding the foregoing, should a Participation Attachment(s) contain a longer without cause termination period, the Agreement shall continue in effect only for such applicable Participation Attachment(s) until the termination without cause notice period in the applicable Participation Attachment(s) ends.

8.3 Breach of Agreement. Except for circumstances giving rise to the Immediate Termination 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. The effective date of such termination shall be no sooner than sixty (60) days after such notice of termination.

8.4 Immediate Termination.

8.4.1 This Agreement or any Participation Attachment(s) 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 fraud or makes any material misstatements or omissions on any documents related to this Agreement which Provider submits to Anthem or to a third party; or

8.4.1.3 Provider files a petition in bankruptcy for liquidation or reorganization by or against Provider, if Provider becomes insolvent, or makes an assignment for the benefit of its creditors without Anthem's written consent, or if a receiver is appointed for Provider or its property; 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 Plan's applicable credentialing requirements, accreditation requirements or standards of participation; or

8.4.1.6 Anthem reasonably believes based on Provider's conduct or inaction, or the conduct or inaction of a line therapist or other non-licensed individual under Provider's supervision, 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 Member, an Anthem employee or representative; or

8.4.1.8 Provider and/or his/her/its employees, contractors, subcontractors, or agents are ineligible, excluded, suspended, terminated or debarred from participating in a Government Program, and in the case of an employee, contractor, subcontractor or agent, Provider fails to remove such individual from responsibility for, or involvement with, the Provider's business operations related to this Agreement, or if Provider has voluntarily withdrawn his/her/its participation in any Government Program as the result of a settlement agreement; or

8.4.1.9 Provider is convicted or has been finally adjudicated to have committed a felony or misdemeanor, other than a non-DUI related traffic violation.

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 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.

8.5 Termination of Individual Providers. If applicable, Anthem reserves the right to terminate individual providers from any or all Network(s) under the terms of this Article VIII while continuing the Agreement for one or more providers in a group.

8.6 Transactions Prior to Termination. Except as otherwise set forth in this Agreement, termination shall have no effect on the rights and obligations of the parties arising out of any transaction under this Agreement occurring prior to the date of such termination.

8.7 Continuation of Care Upon Termination.

8.7.1 Unless otherwise set forth in the Health Benefit Plan or required by Regulatory Requirements, Provider shall, upon termination of this Agreement or any Participation Attachment for reasons other than the grounds set forth in the "Immediate Termination" section of this Agreement, continue to provide Covered Services rendered to all designated Members receiving treatment at the time of termination, under the terms and conditions of this Agreement or any terminating Participation Attachment, and as authorized by Anthem under the Anthem continuation of care procedure, until the earlier of ninety (90) days or such time that: (1) the Member has completed the course of treatment and if applicable, was discharged; or (2) reasonable and medically appropriate arrangements have been made for a Participating Provider to render Covered Services to the Member. However, for HMO and POS Health Benefit Plans issued in Indiana, such continuation period shall run for up to sixty (60) days following termination, or, if Provider is providing pregnancy-related care to a Member who is in her third trimester of pregnancy at the time this Agreement or any Participation Attachment terminates, throughout the term of that pregnancy and through the postpartum period (six weeks post-delivery). During such continuation period, Provider agrees to: (i) accept reimbursement from Anthem for all Covered Services furnished hereunder in accordance with this Agreement and at the rates set forth in the PCS attached hereto; and (ii) Provider shall adhere to Anthem's Policies, including but not limited to, Policies regarding quality assurance requirements, referrals, pre-authorization and treatment planning.

8.7.2 Notwithstanding the foregoing, for Members 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 or any Participation Attachment shall remain in effect for such pregnant Members through the provision of postpartum care directly related to their delivery, and for such terminally ill Members for the remainder of their life for care directly related to the treatment of the terminal illness.

8.8 Survival. The provisions of this Agreement set forth below shall survive termination or expiration of this Agreement or any Participation Attachment(s):

8.8.1 Publication and Use of Provider Information;

8.8.2 Payment in Full and Hold Harmless;

8.8.3 Recoupment/Offset/Adjustment for Overpayments;

8.8.4 Confidentiality/Records;

8.8.5 Indemnification and Limitation of Liability;

8.8.6 Dispute Resolution and Arbitration;

8.8.7 Continuation of Care Upon Termination; and

8.8.8 Any other provisions required in order to comply with Regulatory Requirements.

ARTICLE IX
GENERAL PROVISIONS

9.1 Amendment. Except as otherwise provided for in this Agreement, Anthem retains the right to amend this Agreement, the Anthem Rate, any attachments or addenda by providing notice to Provider at least forty five (45) days in advance of the effective date of the amendment. Except to the extent that Anthem determines an amendment prior to its effective date is necessary to effectuate Regulatory Requirements, if Provider objects to the amendment, prior to its effective date, then Provider has the right to terminate this Agreement, and such termination shall take effect on the later of the amendment effective date identified by Anthem or

one hundred eighty (180) days from the date Provider has provided notice of his/her/its intention to terminate the Agreement pursuant to this section. Failure of Provider to provide such notice to Anthem within the time frames described herein will constitute acceptance of the amendment by Provider.

9.2 Assignment. This Agreement may not be assigned by Provider without the prior written consent of Anthem. Any assignment by Provider without such prior consent shall be voidable at the sole discretion of Anthem. Anthem may assign this Agreement in whole or in part. In the event of a partial assignment of this Agreement by Anthem, the obligations of the Provider shall be performed for Anthem with respect to the part retained and shall be performed for Anthem's assignee with respect to the part assigned, and such assignee is solely responsible to perform all obligations of Anthem with respect to the part assigned. The rights and obligations of the parties hereunder shall inure to the benefit of, and shall be binding upon, any permitted successors and assigns of the parties hereto.

9.3 Scope/Change in Status.

9.3.1 Anthem and Provider agree that this Agreement applies to Health Services rendered by Provider at the Provider's location(s) on file with Anthem. Anthem may, in its discretion, limit this Agreement to Provider's locations, operations, business or corporate form, status or structure in existence on the Effective Date of this Agreement and prior to the occurrence of any of the events set forth in subsections 9.3.1.1 – 9.3.1.5. Unless otherwise required by Regulatory Requirements, Provider shall provide at least ninety (90) days prior written notice of any such event.

9.3.1.1 Provider (a) sells, transfers or conveys his/her/its business or any substantial portion of his/her/its business assets to another entity through any manner including but not limited to a stock, real estate or asset transaction or other type of transfer; (b) is otherwise acquired or controlled by any other entity through any manner, including but not limited to purchase, merger, consolidation, alliance, joint venture, partnership, association, or expansion; or

9.3.1.2 Provider transfers control of his/her/its management or operations to any third party, including Provider entering into a management contract with a physician practice management company or with another entity which does not manage Provider as of the Effective Date of this Agreement, or there is a subsequent change in control of Provider's current management company; or

9.3.1.3 Provider acquires or controls any other medical practice, facility, service, beds or entity; or

9.3.1.4 Provider changes his/her/its locations, business or operations, corporate form or status, tax identification number, or similar demographic information; or

9.3.1.5 Provider creates or otherwise operates a licensed health maintenance organization or commercial health plan (whether such creation or operation is direct or through a Provider affiliate).

9.3.2 Notwithstanding the termination provisions of Article VIII, and without limiting any of Anthem's rights as set forth elsewhere in this Agreement, Anthem shall have the right to terminate this Agreement by giving at least sixty (60) days written notice to Provider if Anthem determines, that as a result of any of the transactions listed in subsection 9.3.1, Provider cannot satisfactorily perform the obligations hereunder, or cannot comply with one or more of the terms and conditions of this Agreement, including but not limited to the confidentiality provisions herein; or Anthem elects in its reasonable business discretion not to do business with Provider, the successor entity or new management company, as a result of one or more of the events as set forth in subsection 9.3.1.

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

9.3.3.1 Addition or removal of individual provider(s) who are employed or subcontracted with Provider, if applicable. Any new individual providers must meet Plan's credentialing requirements or other applicable standards of participation prior to being designated as a Participating Provider; or

9.3.3.2 A change in mailing address.

9.3.4 If Provider is acquired by, acquires or merges with another entity, and such entity already has an agreement with Anthem, Anthem will determine in its sole discretion which Agreement will prevail.

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, the provider manual(s) and Policies.

9.5 Entire Agreement. This Agreement, exhibits, attachments, appendices, and amendments hereto, and the provider manual(s), together with any items incorporated herein by reference, constitute 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 is an inconsistency between any of the provisions of this Agreement and the provider manual(s), then, this Agreement shall govern. In addition, if there is an inconsistency between the terms of this Agreement and the terms provided in any attachment to this Agreement, then the terms provided in that attachment shall govern.

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 due to natural or man-made disasters, including fire, flood, earthquake, terrorism, or any similar unforeseeable act beyond its reasonable control, 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 Regulatory Requirements. Anthem and Provider agree to comply with all applicable Regulatory Requirements, as amended from time to time, 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 warrants that as of the Effective Date, he/she/it is and shall remain licensed and certified for the term of this Agreement in accordance with all Regulatory Requirements (including those applicable to utilization review and Claims payment) relating to the provision of Health Services to Members. Provider shall supply evidence of such licensure, compliance and certifications to Anthem upon request. If there is a conflict between this section and any other provision in this Agreement, then 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, principals or agents are ineligible, excluded, suspended, terminated or debarred from participating in a Government Program ("Ineligible Person"). Provider shall remain continuously responsible for ensuring that his/her/its employees, contractors, subcontractors, principals or agents are not Ineligible Persons. If Provider or any employees, subcontractors, principals 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, 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 has its primary place of business, 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, or in a Participation Attachment(s).

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 Members.

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 hand, facsimile, electronic mail, or mail. Notice shall be deemed to be effective: (a) when delivered by hand, (b) upon transmittal when transmitted by facsimile transmission or by

electronic mail, (c) upon receipt by registered or certified mail, postage prepaid, (d) on the next business day if transmitted by national overnight courier, or (e) if sent by regular mail, five (5) days from the date set forth on the correspondence. Unless specified otherwise in writing by a party, Anthem shall send Provider notice to an address that Anthem has on file for Provider, and Provider shall send Anthem notice to Anthem's address as set forth on the signature page. Notwithstanding the foregoing, and unless otherwise required by Regulatory Requirements, Anthem may post updates to its provider manual(s) and Policies on its web site.

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 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.

9.15 Counterparts and Electronic Signatures.

9.15.1 This Agreement and any amendment hereto may be executed in two (2) or more counterparts, each of which shall be deemed to be an original and all of which taken together shall constitute one and the same agreement.

9.15.2 Either party may execute this Agreement or any amendments by valid electronic signature, and such signature shall have the same legal effect of a signed original.

ARTICLE X
BCBSA REQUIREMENTS

10.1 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 ("BCBSA"), an association of independent Blue Cross and/or Blue Shield Plans, 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 BCBSA. 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.

10.2 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 program, and to submit Claims for payment in accordance with current BCBSA Claims filing guidelines. 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 Eligible Charges as defined in the PCS for Covered Services under the out of area or reciprocal programs. Provider further agrees to comply with other similar programs of the BCBSA. For Members who are enrolled under BCBSA out of area or reciprocal programs, Provider shall comply with the applicable Plan's utilization management policies.

Each party warrants that it has full power and authority to enter into this Agreement and the person signing this Agreement on behalf of either party warrants that he/she has been duly authorized and empowered to enter into this Agreement.

THIS AGREEMENT CONTAINS A BINDING ARBITRATION PROVISION WHICH MAY BE ENFORCED BY THE PARTIES

Provider shall be designated as a Participating Provider in the Networks set forth on the Provider Network Attachment on the later of: (1) the Effective Date of this Agreement or; (2) as determined by Plan in its sole discretion, the date Provider has met applicable credentialing requirements, standards of participation and accreditation requirements.

PROVIDER LEGAL NAME: Centrality Behavioral Support Training

By: Paul McDonald — Signature, Authorized Representative of Provider(s)
06/17/2021 — Date

Printed: Paul McDonald — Name
CFO — Title

Address: 27777 Inkster Rd, Ste 100 — Street
Farmington Hills, MI 48334 — City State Zip

Tax Identification Number (TIN): 464197524

(Note: if any of the following is not applicable, please leave blank)

Phone Number: 248-299-0030

Anthem Insurance Companies, Inc. doing business as Anthem Blue Cross and Blue Shield

THE EFFECTIVE DATE OF THIS AGREEMENT IS:

By: _____ — Signature, Authorized Representative of Anthem
_____ — Date

Printed: David T. Lee, M.D. — Name
Regional Vice President, Provider Solutions — Title

Address: PO Box 7171 — Street
Indianapolis — City
IN — State
46207-7171 — Zip

(Note: if any of the following is not applicable, please leave blank)

Facsimile Number: 317-287-5183

Web Site: www.anthem.com

PROVIDER NETWORKS ATTACHMENT

Provider shall be designated as a Participating Provider in the following Networks on the later of: 1) the Effective Date of this Agreement or; 2) as determined by Plan in its sole discretion, the date Provider has met applicable credentialing requirements, standards of participation and accreditation requirements:

Commercial lines of business:

- HMO
- HealthSync
- PPO
- Pathway
- Indemnity/Traditional/Standard

Governmental lines of business:

- Healthy Indiana Plan
- Medicaid Hoosier Healthwise and Hoosier Care Connect

COMMERCIAL BUSINESS
PARTICIPATION ATTACHMENT TO THE
ANTHEM BLUE CROSS AND BLUE SHIELD
PROVIDER AGREEMENT

This is a Commercial Business Participation Attachment ("Attachment") to the Anthem Blue Cross and Blue Shield Provider Agreement ("Agreement"), entered into by and between Anthem and Provider and is incorporated into the Agreement.

ARTICLE I
DEFINITIONS

The following definitions shall apply to this Attachment. Terms not otherwise defined in this Attachment shall carry the meaning set forth in the Agreement.

"Commercial Business" means certain Health Benefit Plans, including individual and employer groups, partially or wholly insured or administered by Plan, under which Members have access to a network of providers and receive an enhanced level of benefits when they obtain Covered Services from Participating Providers. Commercial Business does not include Government Programs as defined in the Agreement, but does include the FEHBP as well as state and local government employer programs.

"Commercial Business Covered Services" means, for purposes of this Attachment, only those Covered Services provided under Plan's Commercial Business products.

"Commercial Business Member" means, for purposes of this Attachment, a Member who is covered under one of Plan's Commercial Business products.

"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.

"Medically Necessary" or "Medical Necessity" means the definition set forth in the Health Benefit Plan, unless a different definition is required by Regulatory Requirements.

ARTICLE II
SERVICES/OBLIGATIONS

2.1 Participation-Networks Supporting Commercial Business. As a participant in one or more Networks supporting Plan's Commercial Business as set forth on the Provider Networks Attachment of the Agreement, Provider will render Commercial Business Covered Services to Commercial Business Members in accordance with the terms and conditions of the Agreement and this Attachment. Except as set forth in this Attachment, or the PCS, all terms and conditions of the Agreement will apply to Provider's participation in Networks supporting Plan's Commercial Business. The terms and conditions set forth in this Attachment are limited to the provision of and payment for Health Services provided to Commercial Business Members.

2.1.1 This provision intentionally left blank.

2.1.2 Provider agrees to participate in Anthem's exchange network(s) set forth on the Provider Networks Attachment, which may support both products or programs offered by Anthem through state-based, regional or federal health insurance exchanges ("Exchanges") established by the Patient Protection and Affordable Care Act and products or programs offered by Anthem outside of Exchanges. Provider acknowledges and understands that products or programs offered through or outside of the Exchanges may differ, and that such products or programs are subject to Regulatory Requirements. Provider agrees to abide by all Regulatory Requirements of the Exchanges as they exist and as they may be amended or changed from time to time. Should Anthem change the name of the exchange network(s) set forth on the Provider Networks Attachment, it shall notify Provider.

2.2 This provision intentionally left blank.

2.3 Submission and Adjudication of Commercial Business Claims. Unless otherwise instructed, or required by Regulatory Requirements, Provider shall submit Claims to Plan, using appropriate and current Coded Service Identifier(s), within ninety (90) days from the date the Health Services are rendered or Plan will refuse

payment. If Plan is the secondary payor, the ninety (90) day period will not begin until Provider receives notification of primary payor's responsibility.

2.3.1 Provider agrees to provide to Anthem, unless otherwise instructed, at no cost to Anthem, Plan or the Commercial Business Member, all information necessary for Plan to determine its payment liability. Such information includes, without limitation, accurate and Complete Claims for Commercial Business 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 Commercial Business Member's Health Benefit Plan, the PCS, and the provider manual(s).

2.3.2 Provider agrees to submit Claims in a format consistent with industry standards and acceptable to Plan either (a) electronically through electronic data interchange ("EDI"), or (b) if electronic submission is not available, utilizing paper forms as defined by the National Uniform Claim Committee ("NUCC"), the National Uniform Billing Committee ("NUBC"), or as otherwise set forth in the PCS.

2.3.3 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 ninety (90) day period referenced in section 2.3 above, whichever is longer.

2.3.4 In no event, shall Provider bill, collect, or attempt to collect payment from the Commercial Business Member for Claims Plan receives after the applicable period(s) as set forth in section 2.3 above, regardless of whether Plan pays such Claims.

2.3.5 In all events, however, Provider shall only look for payment (except for applicable Cost Shares or other obligations of Commercial Business Members) from the Plan that provides the Health Benefit Plan for the Commercial Business Member for Commercial Business Covered Services rendered.

2.4 Plan Payment Time Frames. Anthem shall require Plans or their designees to use commercially reasonable efforts to adjudicate or arrange for adjudication and where appropriate make payment for all Complete Claims for Commercial Business Covered Services submitted by Provider within ninety (90) 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, subrogation or verification of coverage.

2.5 Out of Network Referrals and Transfers. In addition to the Cost Effective Care provision in the Agreement, Provider may refer or transfer a Commercial Business Member to a non-Participating Provider after obtaining a written acknowledgement (e.g. written waiver form) from the Commercial Business Member, prior to the provision of the service, indicating that: (1) the Commercial Business Member was advised that no coverage, or only out-of-network coverage would be available from Plan; and (2) the Commercial Business Member agreed to be financially responsible for additional costs related to such service.

2.6 Pass-Through Charges. Provider agrees not to pass through to Plan or the Commercial Business Member 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 the Agreement.

2.7 Plan and Commercial Business Member Access. Only Plans administering Commercial Business and Commercial Business Members may access the terms and conditions of this Attachment and the Commercial Business rates set forth in the PCS.

ARTICLE III
TERMINATION

3.1 Termination-Commercial Business Attachment and/or Network(s). At any time either party may terminate, without cause, Provider's participation in one or more Commercial Network(s) designated on the Provider Networks Attachment, or this Attachment by giving at least one hundred eighty (180) days prior written notice of termination to the other party. Following any termination as described herein, the remainder of the Agreement shall remain in full force and effect, if applicable. This provision shall not apply to Provider's participation in Anthem's Indemnity/Standard/Traditional products.

3.2 Survival. The provisions of this Attachment set forth below shall survive termination or expiration of the Agreement:

3.2.1 Any provisions required in order to comply with Regulatory Requirements.

3.3 Effect of Termination. Following termination of this Attachment, the remainder of the Agreement shall continue in full force and effect, if applicable. In addition, upon termination of this Attachment but subject to the Continuation of Care provision(s) and applicable Regulatory Requirements, any references to services, reimbursement, or participation in Networks related to Commercial Business are hereby terminated in full and shall have no further force and effect.

ARTICLE IV
GENERAL PROVISIONS

4.1 This provision intentionally left blank.

4.2 Inconsistencies. In the event of an inconsistency between terms of this Attachment and the terms and conditions as set forth in the Agreement, the terms and conditions of this Attachment shall govern. Except as set forth herein, all other terms and conditions of the Agreement remain in full force and effect.

INDIANA MEDICAID
PARTICIPATION ATTACHMENT TO THE
ANTHEM BLUE CROSS AND BLUE SHIELD
PROVIDER AGREEMENT

This is a Medicaid Participation Attachment ("Attachment") to the Anthem Provider Agreement ("Agreement"), entered into by and between Anthem and Provider and is incorporated into the Agreement.

ARTICLE I
DEFINITIONS

The following definitions shall apply to this Attachment. Terms not otherwise defined in this Attachment shall carry the meaning set forth in the Agreement.

"Clean Claim" means a claim submitted by a Provider for payment under the Medicaid Program that can be processed without obtaining additional information from: (1) the provider of the service; or (2) a third party. This includes a claim with errors originating in the state's claims processing system; and does not include a claim: (a) from a provider who is under investigation for fraud or abuse (as used in 42 CFR 447.45(b)); or (b) under review for medical necessity.

"Medicaid" means medical assistance provided under a state plan approved under Title XIX of the Social Security Act. Hoosier Healthwise ("HHW"), Healthy Indiana Plan ("HIP") and Hoosier Care Connect ("HCC") are the medical assistance programs provided in Indiana. Such programs are defined on the Agency's website.

"Medicaid Program(s)" means a medical assistance provided under a Health Benefit Plan approved under Title XVI, Title XIX and/or Title XXI of the Social Security Act or any other federal or state funded program or product as designated by Anthem. HHW, HIP and HCC shall be considered Medicaid Programs. All uses of Medicaid Program(s) shall apply to HHW, HIP and HCC as applicable.

"Medicaid Covered Services" means those Covered Services provided under Anthem's Medicaid Program(s). All uses of Medicaid Covered Service(s) shall apply to HHW, HIP and HCC as applicable.

"Medicaid Member" means a Member who is enrolled in Anthem's Medicaid Program(s). All uses of Medicaid Member(s) shall apply to HHW, HIP and HCC as applicable.

"Medically Necessary/Medical Necessity" means a Covered Service if, in a manner consistent with accepted standards of medical practice, it is reasonably expected to (i) prevent or diagnose the onset of an illness, injury, condition, primary disability or secondary disability; (ii) cure, correct, reduce or ameliorate the physical, mental, cognitive or developmental effects of an illness, injury or disability; or (iii) reduce or ameliorate the pain or suffering caused by an illness, injury, condition or disability.

ARTICLE II
SERVICES/OBLIGATIONS

2.1 Provider Network Participation.

2.1.1 As applicable, Provider agrees to participate as a Network Provider in Anthem's managed care Healthy Indiana Plan Network ("Healthy Indiana Plan Network") and to provide Health Services to Medicaid Members who are enrolled in HIP.

2.1.2 As applicable, Provider agrees to participate as a Network Provider in Anthem's managed care Hoosier Healthwise Network including Hoosier Care Connect, ("Hoosier Healthwise Network") and to provide Health Services to Medicaid Members who are enrolled in HHW and HCC.

2.1.3 For the purposes of this Attachment, Hoosier Healthwise Network and Healthy Indiana Plan Network, shall be individually or collectively referred to as "Anthem's Medicaid Network", as applicable.

2.1.4 As a participant in Anthem's Medicaid Network, Provider will render Medicaid Covered Services to Medicaid Members enrolled in Anthem's Medicaid Network in accordance with the terms and conditions of the Agreement and this Attachment. Such Medicaid Covered Services provided shall be within the scope of Provider's licensure, expertise, and usual and customary range of services

pursuant to the terms and conditions of the Agreement and this Attachment, and Provider shall be responsible to Anthem for his/her/its performance hereunder. Except as set forth in this Attachment or the Plan Compensation Schedule ("PCS"), all terms and conditions of the Agreement will apply to Provider's participation in Anthem's Medicaid Network. The terms and conditions set forth in this Attachment are limited to the provision of and payment for Health Services provided to Medicaid Members.

2.2 Duties and Obligations to Medicaid Members. All of Provider's duties and obligations to Members set forth in the Agreement shall also apply to Medicaid Members. To the extent mandated by Regulatory Requirements, Provider shall ensure that Medicaid Members have access to twenty-four (24) hour-per-day, seven (7) day-per-week urgent and Emergency Services, as defined in the PCS. Provider shall not discriminate in the acceptance of Medicaid Members for treatment, and shall provide to Medicaid Members the same access to services as Provider gives to all other patients. Provider shall furnish Anthem with at least ninety (90) days prior written notice if Provider plans to close its practice to new patients or ceases to continue in Provider's current practice.

2.3 Provider Responsibility. Plan shall not be liable for, nor will it exercise control or direction over, the manner or method by which Provider provides Health Services to Medicaid Members. Provider shall be solely responsible for all medical advice and services provided by Provider to Medicaid Members. Provider acknowledges and agrees that Plan may deny payment for services rendered to a Medicaid Member which it determines are not Medically Necessary, are not Medicaid Covered Services under the applicable Medicaid Program(s), or are not otherwise provided or billed in accordance with the Agreement and/or this Attachment. A denial of payment or any action taken by Plan pursuant to a utilization review, referral, discharge planning program or claims adjudication shall not be construed as a waiver of Provider's obligation to provide appropriate Health Services to a Medicaid Member under applicable Regulatory Requirements and any code of professional responsibility. However, this provision does not require Provider to provide Health Services if Provider objects to such service on moral or religious grounds.

2.4 Reporting Fraud and Abuse. Provider shall cooperate with Anthem's anti-fraud compliance program. If Provider identifies any actual or suspected fraud, abuse or misconduct in connection with the services rendered hereunder in violation of Regulatory Requirements, Provider shall promptly report such activity directly to the compliance officer of Anthem or through the compliance hotline in accordance with the provider manual(s). In addition, Provider is not limited in any respect in reporting other actual or suspected fraud, abuse, or misconduct to Anthem.

2.5 Plan Marketing/Information Requirements. Provider agrees to abide by Plan's marketing/information requirements. Provider shall forward to Plan for prior approval all flyers, brochures, letters and pamphlets Provider intends to distribute to Medicaid Members concerning its payor affiliations, or changes in affiliation or relating directly to the Medicaid population. Provider will not distribute any marketing or recipient informing materials without the consent of Plan or the applicable Agency.

2.6 Schedule of Benefits and Determination of Medicaid Covered Services. Anthem shall make available upon Provider's request schedules of Medicaid Covered Services for applicable Medicaid Program(s), and will notify Provider in a timely manner of any material amendments or modifications to such schedules.

2.7 Medicaid Member Verification. Provider shall establish a Medicaid Member's eligibility for Medicaid Covered Services prior to rendering services, except in the case of an Emergency Condition, as defined in the PCS, where such verification may not be possible. In the case of an Emergency Condition, Provider shall establish a Medicaid Member's eligibility as soon as reasonably practical. Plan shall provide a system for Providers to contact Plan to verify a Medicaid Member's eligibility twenty-four (24) hours a day, seven (7) days per week. Nothing contained in this Attachment or the Agreement shall, or shall be construed to, require advance notice, coverage verification, or pre-authorization for Emergency Services, as defined in the PCS, provided in accordance with the federal Emergency Medical Treatment and Active Labor Act ("EMTALA") prior to Provider's rendering such Emergency Services.

2.8 Hospital Affiliation and Privileges. To the extent required under Plan's credentialing requirements, Provider or any Participating Providers employed by or under contract or subcontract with Provider shall maintain privileges to practice at one or more of Plan's participating hospitals. In addition, in accordance with the Change in Provider Information Section of the Agreement, Provider shall immediately notify Anthem in the event any such hospital privileges are revoked, limited, surrendered, or suspended at any hospital or health care facility.

2.9 Participating Provider Requirements. If Provider is a group provider, Provider shall require that all Participating Providers employed by or under contract or subcontract with Provider comply with all terms and conditions of the Agreement and this Attachment. Notwithstanding the foregoing, Provider acknowledges and agrees that Anthem is not obligated to accept as Participating Providers all providers employed by or under contract or subcontract with Provider.

2.10 Coordinated and Managed Care. Provider shall participate in utilization management and care management programs designed to facilitate the coordination of services as referenced in the applicable provider manual(s).

2.11 Representations and Warranties. Provider represents and warrants that all information provided to Plan is true and correct as of the date such information is furnished, and that Provider is unaware of any undisclosed facts or circumstances that would make such information inaccurate or misleading. Provider further represents and warrants that Provider: (i) is legally authorized to provide the services contemplated hereunder; (ii) is qualified to participate in all applicable Medicaid Program(s); (iii) is not in violation of any licensure or accreditation requirement applicable to Provider under Regulatory Requirements; (iv) has not been convicted of bribery or attempted bribery of any official or employee of the jurisdiction in which Provider operates, nor made an admission of guilt of such conduct which is a matter of record; (v) is capable of providing all data related to the services provided hereunder in a timely manner as reasonably required by Plan to satisfy its internal requirements and Regulatory Requirements, including, without limitation, data required under the Health Employer Data and Information Set ("HEDIS") and National Committee for Quality Assurance ("NCQA") requirements; and (vi) is not, to Provider's best knowledge, the subject of an inquiry or investigation that could foreseeably result in Provider failing to comply with the representations set forth herein. In accordance with the Change in Provider Information Section of the Agreement, Provider shall immediately provide Anthem with written notice of any material changes to such information.

ARTICLE III
COMPENSATION AND AUDIT

3.1 Submission and Adjudication of Medicaid Claims. Unless otherwise instructed, or required by Regulatory Requirements, Provider shall submit Claims to Plan, using appropriate and current Coded Service Identifier(s), within ninety (90) days from the date the Health Services are rendered or Plan may refuse payment. If Plan is the secondary payor, the ninety (90) day period will not begin until Provider receives notification of primary payor's responsibility. Anthem shall waive the timely filing requirement in the case of Claims for Medicaid Members with retroactive coverage, such as presumptively eligible pregnant women and newborns.

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

3.1.2 Provider agrees to submit Claims in a format consistent with industry standards and acceptable to Plan either (a) electronically through electronic data interchange ("EDI"), or (b) if electronic submission is not available, utilizing paper forms as defined by the National Uniform Claim Committee ("NUCC").

3.1.3 If Anthem asks for additional information so that Anthem may process the Claim, Provider must provide that information within sixty (60) days, or before the expiration of the ninety (90) day period referenced in section 3.1 above, whichever is longer.

3.1.4 Anthem shall adjudicate a Clean Claim, in accordance with, and within the time frames under, the Regulatory Requirements applicable to Anthem's Medicaid Program(s).

3.2 Medicaid Affiliate Services. Provider acknowledges that Anthem is affiliated with health plans that offer similar benefits under similar programs as the programs covered hereunder ("Medicaid Affiliates"). The parties acknowledge that Provider is not a Participating Provider in Medicaid Affiliate's Network for purposes of rendering services to Medicaid Members. However, in the event Provider treats a Medicaid Member of a Medicaid Affiliate, subject to Regulatory Requirements, Provider shall accept as payment in full the rates established by the Medicaid Affiliate's state program governing care to Medicaid Members. Such services must be Medicaid Covered Services under the Medicaid Affiliate's state program, and shall require prior authorization, except for Emergency Services and services for which a Medicaid Member is entitled to self-

refer. Upon request, Anthem shall coordinate and provide information as necessary between Provider and Medicaid Affiliate for services rendered to Medicaid Member. Only Medicaid Affiliates shall have access to the Medicaid rates under this Agreement.

3.3 Audit for Compliance with CMS Guidelines. Notwithstanding any other terms and conditions of the Agreement, this Attachment, or the PCS, Anthem has the same rights as CMS, to review and/or Audit and, to the extent necessary recover payments on any claim for Medicaid Covered Services rendered pursuant to this Agreement to ensure compliance with CMS Regulatory Requirements.

3.3.1 Anthem will suspend all payments to Provider if Agency determines that there is credible allegation of fraud and provides written notice of a payment suspension to Anthem.

ARTICLE IV
COMPLIANCE WITH REGULATORY REQUIREMENTS

4.1 Indemnification of State. In addition to the Indemnification provision of the Agreement, Provider shall indemnify and hold harmless the state, its agencies, officers, and employees from all claims and suits, including court costs, attorney's fees, and other expenses, brought because of injuries or damages received or sustained by any person, persons, or property that is caused by any act or omission of Provider.

4.2 Medicaid Hold Harmless.

4.2.1 Provider agrees that Anthem's payment constitutes payment in full for any Medicaid Covered Services rendered to Medicaid Members as a condition of participation in Anthem's Medicaid Program(s). Provider agrees it shall not seek payment from the Medicaid Member, his/her representative or the state for any Health Services rendered pursuant to this Attachment, with the exception of Cost Shares, if any, or payment for non-Medicaid Covered Services otherwise requested by, and provided to, the Medicaid Member if the Medicaid Member agrees in writing to pay for the service prior to the service being rendered. The form of agreement must specifically state the admissions, services or procedures that are non-Medicaid Covered Services and the approximate amount of out of pocket expense to be incurred by the Medicaid Member. Provider agrees to use best commercial efforts to collect any required Cost Shares for Covered Services rendered to Medicaid Members. Provider agrees not to bill Medicaid Members for missed appointments while enrolled in the Medicaid programs. This provision shall remain in effect even in the event Anthem becomes insolvent.

4.2.2 In addition, Medicaid Members may not be held liable for any of the following:

4.2.2.1 Any payments for Medicaid Covered Services furnished under a contract, referral or other arrangement, to the extent that those payments are in excess of the Anthem Rate;

4.2.2.2 Medicaid Covered Services provided to the Medicaid Members for which Agency does not pay Anthem;

4.2.2.3 Medicaid Covered Services provided to the Medicaid Members for which Agency or Anthem does not pay the Provider that furnishes the Medicaid Covered Services under a contractual, referral or other arrangement;

4.2.2.4 Anthem's debts in the event of Anthem's insolvency; and

4.2.2.5 Provider shall be prohibited from balance billing Medicaid Members or their family members for any amount not paid as billed for a Medicaid Covered Service, i.e., charge the Medicaid Members for Medicaid Covered Services above the amount paid to Provider by Anthem.

4.2.3 A Provider can bill a Medicaid Member only when the following conditions have been met:

4.2.3.1 The service rendered must be determined to be non-covered by Anthem; or

4.2.3.2 The Medicaid Member has exceeded the program limitations for a particular service; and

4.2.3.3 The Medicaid Member must understand, before receiving the service, that the service is not covered by Anthem, and that the Medicaid Member is responsible for the charges associated with the service.

4.2.3.4 The Provider must maintain documentation that the Medicaid Member voluntarily chose to receive the service, knowing that Anthem did not cover the service. A generic consent form is not acceptable unless it identifies the specific procedure to be performed, and the Medicaid Member signs the consent before receiving the service. See the Indiana Health Coverage Programs ("IHCP") Provider Reference Modules and/or Medicaid Policy Manual for more information.

4.2.4 In cases where prior authorization is denied, Provider can bill a Medicaid Member for services if;

4.2.4.1 Provider establishes that authorization has been requested and denied prior to rendering the service;

4.2.4.2 Provider has an opportunity to request review of the authorization decision by Anthem;

4.2.4.3 If authorization is denied upon review, Provider must inform the Medicaid Member that the service requires authorization, and that authorization has been denied;

4.2.4.4 The Medicaid Member must be informed of the right to contact Anthem to file an appeal if the Medicaid Member disagrees with the decision to deny authorization;

4.2.4.5 Provider must inform the Medicaid Member of his/her responsibility for payment if the Medicaid Member chooses to or insists on receiving the services without authorization;

4.2.4.6 If a waiver is used to establish Medicaid Member responsibility for payment, use of such a waiver must meet the following requirements:

4.2.4.6.1 The waiver is signed only after the Medicaid Member receives the appropriate notification.

4.2.4.6.2 The waiver does not contain any language or condition to the effect that if authorization is denied, the Medicaid Member is responsible for payment.

4.2.4.6.3 Providers must not use non-specific patient waivers. A waiver must be obtained for each encounter or patient visit that falls under the scenario of non-Medicaid Covered Services.

4.2.4.6.4 The waiver must specify the date the services are provided and the services that fall under the waiver's application.

4.3 Agency Contract. Provider shall comply with the terms applicable to providers set forth in the Government Contract, including incorporated documents, between Anthem and the Agency, which applicable terms are incorporated herein by reference. Anthem agrees to provide Provider with a description of the applicable terms upon request.

4.4 Provider Regulatory Requirements. Provider agrees to the following with respect to Medicaid Members:

4.4.1 Maintain a current IHCP provider agreement and comply with all IHCP regulations;

4.4.2 Maintain medical care standards and practice guidelines as set forth and detailed in the IHCP Provider Reference Modules and/or Medicaid Policy Manual, but not limited to utilizing the Indiana Health Coverage Program Prior Authorization Form available on the Indiana Medicaid website for submission of prior authorization requests to Anthem;

4.4.3 Respond to cultural, racial and linguistic needs of Medicaid Members;

4.4.4 Be duly licensed in accordance with the applicable state licensing board of the State of Indiana. Provider further agrees to remain in good standing with said board;

4.4.5 Comply with the terms applicable to Providers set forth in (1) the Request for Services issued by the State of Indiana in connection with the Medicaid Program, (2) the Government Contract between Anthem and the State of Indiana, which applicable terms are incorporated herein by reference and (3) the IHCP Provider Reference Modules and/or Medicaid Policy Manual;

4.4.6 Cooperate and comply with Anthem's Provider appeals process as set forth in the provider manual for purposes of Claims dispute resolution;

4.4.7 Cooperate with any program designed to monitor Medicaid Program compliance by Providers who participate in Anthem's Medicaid Network and comply with any corrective actions related thereto if Provider is out of compliance with the Agency's or Anthem's standards;

4.4.8 Submit all encounter Claims for Health Services rendered to Medicaid Members in accordance with Anthem's specifications for the submission of such encounter data; this provision shall survive termination of this Attachment for services rendered to Medicaid Members while Provider is a Network Provider;

4.4.9 Provide a copy of a Medicaid Member's medical record at no charge upon reasonable request by the Medicaid Member;

4.4.10 Facilitate the transfer of the Medicaid Member's medical record to another provider at said Medicaid Member's request, at no charge;

4.4.11 Cooperate with and permit evaluations, through on-site inspection or other means, during normal business hours, of the quality, appropriateness, and timeliness of Health Services rendered to Medicaid Members. Such evaluations may be conducted by Anthem, Agency, or other duly authorized agent of the state or Agency;

4.4.12 Cooperate with and permit inspections upon reasonable notice and at reasonable times of any records, medical or financial, pertinent to Provider's delivery of Health Services to Medicaid Members. Such inspections may be conducted by Anthem, Agency, or other duly authorized agent of the state or Agency;

4.4.13 Maintain an adequate record keeping system for recording services, charges, date and other commonly accepted information elements for Health Services rendered to Medicaid Members, including, without limitation, the following:

4.4.13.1 Prescriptions for medications;

4.4.13.2 Inpatient discharge summaries;

4.4.13.3 Patient histories (including immunizations) and physicals;

4.4.13.4 A list of substances used and/or abused, including alcohol, smoking and legal and illegal drugs; and

4.4.13.5 A record of outpatient, inpatient and emergency care, specialist referrals, ancillary care, laboratory and x-ray tests and findings.

Such medical records must be maintained in a detailed and comprehensive manner that conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and facilitates an accurate system for follow-up treatment. Medical records must be legible, signed and dated and maintained for at least seven (7) years as required by state and federal regulations. Confidentiality of, and access to, medical records must be provided in accordance with the Health Insurance Portability and Accountability Act ("HIPAA") Privacy Rule and all other state and federal requirements;

4.4.14 Participate in any internal and external quality assurance, utilization review, peer review, and grievance procedures established by Anthem for Medicaid Members;

4.4.15 Comply with the requirements of 42 CFR 489, Subpart I, related to maintaining and distributing written policies and procedures respecting advance directives;

4.4.16 Observe and protect the rights of Medicaid Members;

4.4.17 Provide Health Services to Medicaid Members for a minimum of thirty (30) calendar days or until the Medicaid Member finds another source of primary care, if Provider is designated by Anthem as a Primary Care Provider ("PCP") and Provider no longer participates in the Medicaid Network but continues to be an IHCP provider;

4.4.18 Prepare and submit reports as requested by an Agency by the completion date established by an Agency. Such requests will be limited to situations in which the desired data is considered essential and cannot be reasonably obtained through standard Anthem reports;

4.4.19 In the event of Anthem's insolvency, continue to provide Health Services to Medicaid Members until the end of the month in which insolvency has occurred and to provide inpatient Health Services until the date of discharge for any Medicaid Member institutionalized when insolvency occurs;

4.4.20 Maintain all books, documents, papers, accounting records, and other evidence pertaining to all costs incurred under this Attachment and make such materials available at the respective offices at all reasonable times during the term of this Attachment, and for three (3) years from the date of final payment under this Attachment, for inspection by the state or its authorized designees. Copies shall be furnished at no cost to the state if requested;

4.4.21 If Provider renders lab services in the office, it must maintain a valid Clinical Laboratory Improvement Amendments ("CLIA") certificate for all laboratory testing sites and comply with CLIA regulations at 42 CFR Part 493 for all laboratory testing sites performing Health Services pursuant to this Attachment; and

4.4.22 Provider shall ask and encourage Medicaid Members to sign a consent that permits release of substance abuse treatment information to Anthem and other providers.

4.4.23 Behavioral Health Services. If Provider is a behavioral health provider or providing behavioral health services, the following provisions shall also apply:

4.4.23.1 Provider shall ensure that Medicaid Members receiving inpatient psychiatric services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge and that such follow-up and/or continuing treatment is within seven (7) calendar days from the date of the Medicaid Member's discharge. If the Medicaid Member misses the follow-up and/or continuing treatment that was scheduled within seven (7) calendar days from the date of the Medicaid Member's discharge, Provider shall contact the Medicaid Member within three (3) business days of the notification of the missed appointment.

4.4.23.2 Provider shall notify Anthem and the Medicaid Member's PCP within five (5) calendar days of a Medicaid Member who is at risk for hospitalization or who has had a hospitalization, and submit the following information to Anthem and the Medicaid Member's PCP;

4.4.23.2.1 A written summary of the initial assessment session;

4.4.23.2.2 Primary and secondary diagnoses;

4.4.23.2.3 Medication prescribed;

4.4.23.2.4 Psychotherapy prescribed; and

4.4.23.2.5 Any other relevant information.

4.4.23.3 Provider shall notify Anthem and the Medicaid Member's PCP of a Medicaid Member who is not at risk for hospitalization, and submit the following information to Anthem and the Medicaid Member's PCP within five (5) calendar days of the initial session:

4.4.23.3.1 A written summary of the initial visit and a summary of the findings, including:

4.4.23.3.2 Provider's contact information;

4.4.23.3.3 Visit Date;

4.4.23.3.4 Presenting problem and diagnosis;

4.4.23.3.5 Medication prescribed;

4.4.23.3.6 Psychotherapy prescribed; and

4.4.23.3.7 Any other relevant information.

4.4.23.4 Provider shall notify Anthem and the Medicaid Member's PCP of any significant changes in the Medicaid Member's status and/or a change in the level of care.

4.4.24 Maintain quality improvement goals and performance activities specific to the types of Health Services performed by Provider.

4.5 Primary Care Provider ("PCP") Requirements.

4.5.1 PCPs must accept a panel of Medicaid Members of at least one hundred (100) individuals. The foregoing does not require PCP to maintain a panel size as indicated, but merely prohibits PCP from closing his/her practice to new Medicaid Members unless the panel size is reached. PCP is also not prohibited from accepting more Medicaid Members than the indicated panel size. For group practices, the panel size indicated is for each PCP within the group but the total panel is calculated in the aggregate for the group*;

4.5.2 This provision intentionally left blank.

4.5.3 PCPs must provide or arrange for coverage of services twenty four (24) hours a day, seven (7) days a week;

4.5.4 All PCPs must coordinate Medicaid Member's physical and behavioral health care and make any referrals necessary for services required when Medicaid Member receives services from any provider other than the PCP unless the service is a self-referral service;

4.5.5 All PCPs must have a mechanism in place to offer Medicaid Members direct contact with their PCP, or the PCP's qualified clinical staff person, through a toll-free telephone number twenty four (24) hours a day, seven (7) days a week;

4.5.6 Each PCP must be available to see Medicaid Members at least three (3) days per week for a minimum of twenty (20) hours per week at any combination of no more than two (2) locations;

4.5.7 All PCPs must provide "live voice" coverage after normal business hours. After hours coverage for the PCP may include an answering service or a shared-call system with other medical providers.

PCP group panel size is established on a per PCP basis but calculated in the aggregate for the group. Each PCP in the group is not required to have equal panel size. Thus a panel assignment of one hundred (100) Medicaid Members for a group with three (3) PCPs means that the group as a whole must have three hundred (300) Medicaid Members before it may close its practice to new Medicaid Members. The panel of three hundred (300) Medicaid Members may be distributed among the three (3) PCPs in any configuration. All of the following configurations satisfy the requirement for a per PCP panel of one hundred (100) Medicaid Members for a group of three (3)PCPs.

Ex. A.	PCP 1: 100	Ex. B.	PCP 1: 150	Ex. C.	PCP 1: 300
	PCP 2: 200		PCP 2: 150		PCP 2: 0
	PCP 3: 300		PCP 3: 0		PCP 3: 0

4.6 Compliance with Healthy Indiana Plan.

4.6.1 Provider agrees to the following with respect to HIP Members:

4.6.1.1 Provider shall be compensated pursuant to the PCS. Provider acknowledges that HIP Members shall have access to Provider's rates. Such rates, as well as quality information regarding Provider, may be made available on Anthem's Member website.

4.6.1.2 PCPs must coordinate HIP Member's physical and behavioral health care.

4.7 Compliance with Other Laws. In addition to the provisions in the Agreement, Provider agrees to comply with:

4.7.1 I.C. 22-9-1-10 and the Civil Rights Act of 1964, as amended, and any other applicable state or federal law, regulations and executive orders prohibiting discrimination, in that Provider shall not discriminate against any employee or applicant for employment in the performance of this Attachment. Provider shall not discriminate with respect to the hire, tenure, terms, conditions or privileges of employment or any matter directly or indirectly related to employment, because of race, color, religion, sex, disability, national origin, ancestry or status as a veteran. Breach of this provision shall be considered default.

4.7.2 All requirements applicable to Provider under the Health Insurance Portability and Accountability Act ("HIPAA") of 1996.

4.8 Federal Funds. Provider acknowledges that payments Provider receives from Plan to provide Medicaid Covered Services to Medicaid Members are, in whole or part, from federal funds. Therefore, Provider and any of his/her/its subcontractors are subject to certain laws that are applicable to individuals and entities receiving federal funds, which may include but are not limited to, Title VI of the Civil Rights Act of 1964 as implemented by 45 CFR Part 84; the Age Discrimination Act of 1975 as implemented by 45 CFR Part 91; the Americans with Disabilities Act; the Rehabilitation Act of 1973, lobbying restrictions as implemented by 45 CFR Part 93 and 31 USC 1352, Title IX of the Educational Amendments of 1972, as amended (30 U.S.C. sections 1681, 1783, and 1685-1686) and any other regulations applicable to recipients of federal funds.

4.9 Surety Bond Requirement. If Provider provides home health services or durable medical equipment, Provider shall comply with all applicable provisions of Section 4724(b) of the Balanced Budget Act of 1997, including, without limitation, any applicable requirements related to the posting of a surety bond.

ARTICLE V
TERMINATION

5.1 Termination of Medicaid Participation Attachment. Either party may terminate this Attachment or Provider's participation in a Medicaid Network without cause by giving at least ninety (90) days prior written notice of termination to the other party without affecting the Agreement, amendments, addenda, or other attachments, or Provider's participation in the other Medicaid Network(s).

5.2 Termination of Government Contract. If a Government Contract between Agency and Anthem terminates or expires or ends for any reason or is modified to eliminate a Medicaid Program, this Attachment shall have no further force or effect with respect to the applicable Medicaid Program(s).

5.3 Effect of Termination. Following termination of this Attachment, the remainder of the Agreement shall continue in full force and effect, if applicable.

5.4 Automatic Termination of Medicaid Participation Attachment. In addition to the provisions of the Agreement, this Attachment shall automatically terminate upon the occurrence of any one of the following:

5.4.1 Termination of Provider's license;

5.4.2 Termination of Provider's IHCP provider agreement;

5.4.3 Failure to maintain all required permits, licenses and approvals and comply with all applicable health, safety and environmental statutes, rules, regulations or ordinances necessary for the performance of Health Services;

5.4.4 Termination/expiration of Anthem's contract with the State of Indiana in accordance with IC 12-15-30-5.

ARTICLE VI
GENERAL PROVISIONS

6.1 Regulatory Amendment. Notwithstanding the Amendment provision in the Agreement, this Attachment shall be automatically modified to conform to required changes to Regulatory Requirements related to Medicaid Members or Medicaid Programs without the necessity of executing written amendments.

6.2 Inconsistencies. In the event of an inconsistency between terms and conditions of this Attachment and the terms and conditions as set forth in the Agreement, the terms and conditions of this Attachment shall govern. Except as set forth herein, all other terms and conditions of the Agreement remain in full force and effect.

6.3 Disclosure Requirements. In addition to the Provider Subcontractors provision in the Agreement, Provider:

6.3.1 Certifies that neither it nor its principals nor any of its subcontractors are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from entering into this Attachment by any Federal agency or by any department, agency or political subdivision of the state. For purposes of this Attachment, "principal" means an officer, director, owner, partner, key employee, or other person with primary management or supervisory responsibilities, or a person who has a critical influence or substantive control over Provider's operations (42 CFR 438.610).

6.3.2 Shall immediately notify Anthem if it or any of its principals becomes debarred or suspended, and Anthem shall, at the state's request, take all steps required by the state to terminate its contractual relationship with Provider for work to be performed under this Attachment.

6.3.3 In accordance with Regulatory Requirements, Provider agrees to disclose to Anthem complete ownership, control and relationship information ("Disclosure") in accordance with 42 CFR 455.100 through 455.106. Provider shall provide required Disclosures to Anthem at the time of initial contract, upon contract renewal, and/or upon request by Anthem. Provider further agrees to notify Anthem within fourteen (14) days of any changes to the Disclosures. Failure to provide Disclosures as required under Regulatory Requirements shall be deemed a material breach of this Attachment and the Agreement.

6.4 Survival of Attachment. Provider further agrees that: (1) the hold harmless and continuation of care sections shall survive the termination of this Attachment or disenrollment of the Medicaid Member; and (2) these provisions supersede any oral or written contrary agreement now existing or hereafter entered into between Provider and a Medicaid Member or persons acting on their behalf that relates to liability for payment for, or continuation of, Medicaid Covered Services provided under the terms and conditions of these provisions.

PLAN COMPENSATION SCHEDULE ("PCS")

I. DEFINITIONS

The definitions set forth below shall apply with respect to all of the terms outlined in this PCS. Terms not otherwise defined in this PCS and defined elsewhere in the Agreement shall carry the meanings set forth in the Agreement.

"Anthem Medicare Advantage Rate" shall mean the Anthem Rate that is used for Medicare Advantage.

"Capitation" means the amount paid 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 for Covered Services.

"Case Rate" means the all-inclusive Anthem Rate for an entire admission or one outpatient encounter for Covered Services.

"Coded Service Identifier(s)" means a listing of descriptive terms and identifying codes, updated from time to time by CMS or other industry source, for reporting Health Services on the CMS 1500 or CMS 1450/UB-04 claim form or its successor as applicable based on the services provided. 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, 10th Revision ("ICD-10"), National Uniform Billing Committee ("Revenue Code") and National Drug Code ("NDC") or their successors.

"Diagnosis-Related Group" ("DRG") means Diagnosis Related Group or its successor as established by CMS or other grouper, including but not limited to, a state mandated grouper or other industry standard grouper.

"DRG Rate" means the all-inclusive dollar amount which is multiplied by the appropriate DRG Weight to determine the Anthem Rate for Covered Services.

"DRG Weight" means the weight applicable to the specific DRG methodology set forth in this PCS, including but not limited to, CMS DRG weights as published in the Federal Register, state agency weights, or other industry standard weights.

"Eligible Charges" means those Provider Charges that meet Anthem's conditions and requirements for a Health Service to be eligible for reimbursement. These conditions and requirements include but are not limited to: Member program eligibility, Provider program eligibility, benefit coverage, authorization requirements, provider manual specifications, Anthem administrative, clinical and reimbursement policies and methodologies, code editing logic, coordination of benefits, Regulatory Requirements, and this Agreement. Eligible Charges do not include Provider Charges for any items or services that Provider receives and/or provides free of charge.

"Emergency Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the health of the individual, or in the case of a pregnant woman, the health of the woman or her unborn child; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

"Emergency Services" means those Covered Services furnished by a provider qualified to furnish emergency services, and which are needed to evaluate or treat an Emergency Condition.

"Encounter Data" means Claim information and any additional information submitted by a provider under capitated or risk-sharing arrangements for Health Services rendered to Members.

"Encounter Rate" means the Anthem Rate that is all-inclusive of professional, technical and facility charges including evaluation and management, pharmaceuticals, routine surgical and therapeutic procedures, and diagnostic testing (including laboratory and radiology) capable of being performed on site.

"Fee Schedule(s)" means the complete listing of Anthem Rate(s) for specific services that is payment for each unit of service allowed based on applicable Coded Service Identifier(s) for Covered Services.

"Global Case Rate" means the all-inclusive Anthem Rate which includes facility, professional and physician services for specific Coded Service Identifier(s) for Covered Services.

"Inpatient Services" means Covered Services provided by a facility to a Member who is admitted and treated as a registered inpatient, is assigned a licensed bed within the facility, remains assigned to such bed and for whom a room and board charge is made.

"Outpatient Services" means Covered Services provided by a facility to a Member who is admitted and treated as a registered outpatient within the facility.

"Percentage Rate" means the Anthem Rate that is a percentage of Eligible Charges billed by a provider for Covered Services.

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

"Per Hour Rate" means the Anthem Rate that is payment based on an increment of time for Covered Services.

"Per Relative Value Unit" ("RVU") means the Anthem Rate for each unit of service based on the CMS, Agency or other (e.g., American Society of Anesthesiologists (ASA)) defined Relative Value Unit (RVU).

"Per Service Rate" means the Anthem Rate that is payment for each service allowed based on applicable Coded Service Identifier(s) for Covered Services.

"Per Unit Rate" means the Anthem Rate that is payment for each unit of service allowed based on applicable Coded Service Identifier(s) for Covered Services.

"Per Visit Rate" means the Anthem Rate that is the all-inclusive fixed payment for one encounter for Covered Services.

"Provider Charges" means the regular, uniform rate or price Provider determines and submits to Anthem as charges for Health Services provided to Members. 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.

II. GENERAL PROVISIONS

Billing Form and Claims Reporting Requirements. Provider shall submit all Claims on a CMS 1500 or CMS 1450/UB-04 claim form or its successor form(s) as applicable based on the Health Services provided in accordance with Policies or applicable Regulatory Requirements. Provider shall report all Health Services in accordance with the Coded Service Identifier(s) reporting guidelines and instructions using HIPAA compliant billing codes. In addition, Plan shall not pay any Claim(s) nor accept any Encounter Data submitted using non-compliant codes. Plan audits that result in identification of Health Services that are not reported in accordance with the Coded Service Identifier(s) guidelines and instructions, will be subject to recovery through remittance adjustment or other recovery action as may be set forth in the provider manual(s).

Claim Submissions for Pharmaceuticals. Each Claim submitted for a pharmaceutical product must include standard Coded Service Identifier(s), a National Drug Code ("NDC") number of the covered medication, a description of the product, and dosage and units administered. Unless otherwise required under Regulatory Requirements, Plan shall not reimburse for any pharmaceuticals that are not administered to the Member and/or deemed contaminated and/or considered waste.

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. When billing codes are updated, Provider is required to use appropriate replacement codes for Claims for Covered Services, regardless of whether this Agreement has been amended to reflect changes to standard billing codes. If Provider bills a new, replacement or revised code prior to the effective date of such code, the Claim will be rejected or denied and the Provider shall resubmit Claim with correct code. In addition, Claims with codes which have been deleted will be rejected or denied.

Coding Software. Updates to Anthem's Claims processing filters, code editing software, pricers, and any edits related thereto, as a result of changes in Coded Service Identifier(s) reporting guidelines and instructions, shall take place automatically and do not require any notice, disclosure or amendment to Provider.

Modifiers. All appropriate modifiers must be submitted in accordance with Regulatory Requirements, industry standard billing guidelines and Policies. If appropriate modifiers are not submitted, Claims may be rejected or denied.

New/Expanded Service or New/Expanded Technology. In accordance with the Scope/Change in Status section of the Agreement, as of the Effective Date of this Agreement, any New/Expanded Service or New/Expanded Technology (defined below) is not reimbursable under this Agreement. Notwithstanding the foregoing, Provider may submit the following documentation to Anthem at least sixty (60) days prior to the implementation of any New/Expanded Service or New/Expanded Technology for consideration as a reimbursable service: (1) a description of the New/Expanded Service or New/Expanded Technology; (2) Provider's proposed charge for the New/Expanded Service or New/Expanded Technology; (3) such other reasonable data and information required by Anthem to evaluate the New/Expanded Service or New/Expanded Technology. In addition, Anthem may also need to obtain approval from applicable Agency prior to Anthem making determination that New/Expanded Service or New/Expanded Technology can be considered a reimbursable service. If Anthem agrees that the New/Expanded Service or New/Expanded Technology may be reimbursable under this Agreement, then Anthem shall notify Provider, and both parties agree to negotiate in good faith, a new Anthem Rate for the New/Expanded Service or New/Expanded Technology within sixty (60) days of Anthem's notice to Provider. If the parties are unable to reach an agreement on a new Anthem Rate for the New/Expanded Service or New/Expanded Technology before the end of the sixty (60) day period, then such New/Expanded Service or New/Expanded Technology shall not be reimbursed by Anthem, and the Payment in Full and Hold Harmless provision of this Agreement shall apply.

a. "New/Expanded Service" shall be defined as a Health Service: (a) that Provider was not providing to Members as of the Effective Date of this Agreement and; (b) for which there is not a specific Anthem Rate as set forth in this PCS.

b. "New/Expanded Technology" shall be defined as a technological advancement in the delivery of a Covered Service which results in a material increase to the cost of such service. New/Expanded Technology shall not include a new device, or implant that merely represents a new model or an improved model of a device or implant used in connection with a service provided by Provider as of the Effective Date of this Agreement.

Non-Priced Codes for Covered Services. Anthem reserves the right to establish a rate for codes that are not priced in this PCS or in the Fee Schedule(s), including but not limited to, Not Otherwise Classified Codes ("NOC"), Not Otherwise Specified ("NOS"), Miscellaneous, Individual Consideration Codes ("IC"), and By Report ("BR") (collectively "Non-Priced Codes"). Anthem shall only reimburse Non-Priced Codes for Covered Services in the following situations: (i) the Non-Priced Code does not have a published dollar amount on the then current applicable Plan, State or CMS Fee Schedule, (ii) the Non-Priced Code has a zero dollar amount listed, or (iii) the Non-Priced Code requires manual pricing. In such situations, such Non-Priced Code shall be reimbursed at a rate established by Anthem for such Covered Service. Notwithstanding the foregoing, Anthem shall not price Non-Priced Codes that are not Covered Services under the Members Health Benefit Plan. Anthem may require the submission of medical records, invoices, or other documentation for Claims payment consideration.

Reimbursement for Anthem Rate Based on Eligible Charges. Notwithstanding any reimbursement amount set forth herein, Provider shall only be allowed to receive such reimbursement if such reimbursement is for an Eligible Charge. In addition, if Provider reimbursement is under one or more of the following methodologies: Capitation, Case Rate, DRG Rate, Encounter Rate, Global Case Rate, Per Diem Rate, Per Relative Value Unit (RVU), and Per Visit Rate, then individual services billed shall not be reimbursed separately, unless otherwise specified in Article IV of this PCS.

Reimbursement for Subcontractors. If Anthem has a direct contract with the subcontractor, 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, or unless otherwise agreed to by the parties. The subcontracted entity shall bill Anthem directly under the subcontracted entity's Anthem agreement for the subcontracted services. Provider shall not bill Anthem for such subcontracted entity's services. Provider acknowledges and agrees that the reimbursement Anthem has

agreed to pay the subcontracted entity as set forth in the subcontracted entity's agreement shall represent payment in full for such subcontracted entity's services.

Tax Assessment and Penalties. The Anthem Rates in this Agreement include all sales and use taxes and other taxes on Provider revenue, gross earnings, profits, income and other taxes, charges or assessments of any nature whatsoever (together with any related interest or penalties) now or hereafter imposed against or collectible by Provider with respect to Covered Services, unless otherwise required by Agency pursuant to Regulatory Requirements. Neither Provider nor Plan shall add any amount to or deduct any amount from the Anthem Rates, whether on account of taxes, assessments, tax penalties or tax exemptions.

Updates to Anthem Rate(s) Based on External Sources. Unless otherwise required by Regulatory Requirements, and notwithstanding any proprietary fee schedule(s)/rate(s)/methodologies, Anthem shall use commercially reasonable efforts to update the Anthem Rate(s) based on External Sources, which include but are not limited to, i) CMS Medicare fee schedule(s)/rate(s)/methodologies; ii) Medicaid or Agency fee schedule(s)/rate(s)/methodologies; iii), vendor fee schedule(s)/rate(s)/methodologies; or iv) or any other entity's published fee schedule(s)/rate(s)/methodologies ("External Sources") no later than sixty (60) days after Anthem's receipt of the final fee schedule(s)/rate(s)/methodologies change from such External Sources, or on the effective date of such final fee schedule(s)/rate(s)/methodologies change, whichever is later. The effective date of such final fee schedule(s)/rate(s)/methodologies change shall be the effective date of the change as published by External Sources. Claims processed prior to the implementation of the new Anthem Rate(s) in Anthem's payment system shall not be reprocessed, however, if reprocessing is required by Regulatory Requirements, and such reprocessing could result in a potential under and/or over payment to a Provider, then Plan may reconcile the Claim adjustments to determine the remaining amount Provider owes Plan, or that Plan owes to Provider. Any resultant overpayment recoveries (i.e. Provider owes Plan) shall occur automatically without advance notification to Provider. Unless otherwise required by Regulatory Requirements, Anthem shall not be responsible for interest payments that may be the result of a late notification by External Sources to Anthem of fee schedule(s)/rate(s)/methodologies change.

III. PROVIDER TYPE

"Specialty Provider Group (Non-MD or DO)" means one or more licensed or certified medical practitioner who has specialized education, training or experience in accordance with the Regulatory Requirements of the state in which Health Services are rendered.

To the extent required by Regulatory Requirements or an accrediting body, upon termination without cause, Provider will provide timely, sixty (60) day, notice to affected Member(s) of termination of this Agreement or termination of individual Network participation.

"Health Professional Practitioner (Employed)" means any state or nationally licensed or certified health professional such as Nurse Practitioners, Midwives, Registered Nurse Anesthetists, Clinical Nurse Specialists, Physician Assistants, Registered Nurse First Assistant.

"National Identification Number" (NPI) means a standard unique identifier for health care providers as mandated in The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

All Health Professional Practitioners and any Health Professional Practitioners hereafter added to this Agreement shall be bona fide employees of Provider and as such shall be included under Provider's general and professional liability insurance.

Health Professional Practitioners shall clearly represent themselves and their appropriate designation to Members and in no circumstances shall Health Professional Practitioners hold themselves out or represent themselves as physicians.

Unless otherwise noted in the Agreement, Health Professional Practitioners shall be subject to all provisions in the Agreement and all Attachments thereto and the term "Provider" throughout the Agreement and all Attachments thereto shall be construed to include Health Professional Practitioners.

Health Professional Practitioners shall be included in those Networks designated on the Provider Networks Attachment of the Agreement. Health Professional Practitioners shall be subject to the same requirements and restrictions to which the Provider is subject by virtue of Provider's participation in any Network and the designation of Specialty Care Provider or Primary Care Provider, except that Health Professional Practitioners

shall not be designated as Primary Care Providers. The following Health Professional Practitioners: who participate in the Indiana state sponsored Medicaid program may be designated as a PCP: Nurse Practitioners, Midwives, Clinical Nurse Specialist and Physician Assistants.

Health Professional Practitioners shall perform only those Health Services that are strictly within the scope of their respective licensure, education, certification and collaborative or supervision agreement.

Plan shall only reimburse Health Professional Practitioners for those Covered Services rendered to Members which are within the scope of the respective licensure, education, certification and collaborative or supervision agreement.

Following the Effective Date of this Agreement, all Claims for services rendered by Health Professional Practitioners shall be submitted to Anthem solely under the Health Professional Practitioners NPI number. Claims submitted under an NPI other than that of the individual Health Professional Practitioner or physician personally rendering the service to a Member shall be considered invalid. Notwithstanding the foregoing, Nurse Practitioners and Physician Assistants who participate in the Indiana state sponsored Medicaid program(s) and are designated as a SCP, may submit Claims under the NPI assigned to the supervising physician when providing Medicaid Covered Services that meet the billing policies outlined in the Indiana Health Coverage Programs ("IHCP") Provider Reference Modules and/or Medicaid Policy Manual in effect at the time of service.

To the extent required by Regulatory Requirements or an accrediting body, upon termination without cause, Provider will provide timely, sixty (60) day, notice to affected Member(s) of termination of this Agreement or termination of an individual Network participation.

"Behavioral Health Practitioner" means a licensed or certified mental health and/or substance abuse practitioner, or a group of licensed or supervised practitioners with varying specialties, who work either in an independent private practice, a group setting in one or more locations, or at an appropriately licensed clinic/facility or agency providing behavioral health and/or substance abuse Health Services.

Behavioral Health Practitioner may also mean a Board Certified Behavioral Analyst ("BCBA") or Board Certified Assistant Behavioral Analyst ("BCaBA") in the state(s) where they practice, and that Plan has accepted for participation in one or more Networks.

The parties acknowledge that as of the Effective Date of the Agreement, for a Provider who is a Board Certified BCBA or a Board Certified BCaBA, Anthem has not verified the qualifications of Provider through its credentialing process. Provider represents and warrants that it has obtained and will maintain their BCBA or BCaBA certification from the nationally accredited Behavioral Analyst Certification Board ("BACB"). Notwithstanding the foregoing, if Indiana establishes a licensure process for BCBAs and/or BCaBAs, Provider shall obtain his/her Indiana license within six (6) months after the Indiana Behavior Analyst Advisory Board begins accepting license applications.

Provider agrees that all Health Services provided to Members under this Agreement shall be provided by Provider or by a qualified person under Provider's supervision. A Provider who supervises qualified persons performing Applied Behavior Analysis ("ABA") services shall meet face to face with the patient and family a minimum of once a month and shall provide training and/or education to the parents or caregivers at each face to face meeting. Provider warrants that any nurses or other health professionals employed by or providing services for Provider shall be duly licensed or certified under applicable law, as applicable. Provider represents and warrants that he or she shall assume sole responsibility for the training and supervision of any line therapist or other non-licensed individual providing services under this agreement. Anthem shall not be liable for the actions of line therapists in the performance of their duties. Provider agrees to provide all Health Services in accordance with the BACB ethical and certification guidelines.

Claims must be billed with appropriate codes and by the Provider or qualified supervised person performing the face to face services; no "incident-to" billing is allowed.

"Physical Therapy (PT)" means corrective rehabilitation provided by licensed practitioners through the use of physical, chemical and other properties of heat, light, water, electricity, sound, massage and active, passive and resistive exercise. Physical therapist assistants ("PTA"s) provide physical therapist services under the direction and supervision of a physical therapist. PTAs implement components of patient care, obtain data related to the treatments provided, and collaborate with the physical therapist to modify care as necessary.

"Occupational Therapy (OT)" means the development of adaptive skills, increased performance capacity, and those factors that may impede or restrict ability to function provided by licensed practitioners. Occupational therapy assistants ("OTA"s) work under the guidance of an occupational therapist in various practice areas and settings. While the occupational therapist evaluates and develops treatment plans for clients/patients, the OTA puts those plans into action, teaching individuals how to overcome the challenges of performing daily activities because of an injury, illness, or disability.

"Speech Therapy (ST)" means the evaluation and treatment of disorders that result in impaired or ineffective communication provided by licensed practitioners.

IV. SPECIFIC REIMBURSEMENT TERMS

COMMERCIAL BUSINESS

For Covered Services provided by or on behalf of Provider to a Member who is enrolled in a product and/or program that is supported by a Network designated in this Agreement, Provider agrees to accept as the Anthem Rate, the lesser of Eligible Charges or the applicable Fee Schedule.

Allowances for Injectable/Infusible/Oral Drugs, Vaccines and Radiopharmaceutical Agents. Plan shall automatically update its allowance for injectable/infusible/oral drugs, vaccines and radiopharmaceutical agents on a quarterly basis in accordance with the quarterly updates made by CMS to its drug pricing file or any other external or internal source as set forth in this PCS. Retroactive adjustments made by CMS to its drug pricing file shall be inapplicable to Anthem's fee allowances and payment responsibility.

Out-of-Network Compensation. Except for Government Programs, if Provider renders services to a Member who accesses a Network in which Provider does not participate, Provider will receive compensation as follows:

Plan shall compensate Provider for Emergency Services rendered to a Member based on the applicable Indemnity/Traditional/Standard Anthem Rate. Provider agrees to accept the Indemnity/Traditional/Standard Anthem Rate as payment in full and shall only bill for the applicable Cost Share.

Except for Emergency Services, if the Member's Health Benefit Plan requires authorization by the Plan or a Provider for out of Network Covered Services in order for the Member to have the highest level of benefits, and such authorization has been given, then Plan shall compensate Provider for such authorized Covered Services based on the applicable Participating Provider ("Indemnity/Traditional/Standard") Anthem Rate. Provider agrees to accept the Indemnity/Traditional/Standard Anthem Rate as payment in full and shall only bill for the applicable Cost Share. Except for Emergency Services, if the Member's Health Benefit Plan does not have out-of-network benefits unless authorized by the Plan or Provider, Plan shall have no liability for Health Services rendered without such authorization. In that event, Provider shall bill the Member for Health Services rendered.

Except for Emergency Services, if the Member's Health Benefit Plan has out-of-network benefits without authorization being required by the Plan or Provider, and no authorization has been given, then Plan will compensate Provider for Covered Services based on the Anthem Rate established for the Network and/or product that supports the Member's Health Benefit Plan. For example, if the Member's access is supported by PPO Network, compensation is based on the applicable Anthem Rate for the PPO Network. Provider shall only bill for the applicable Cost Share as well as any amount designated as the Member's responsibility on the Provider payment voucher (or other written notice of explanation of payment). In no event shall payment from Plan and the Member exceed Provider's Charge for such Covered Services.

INDIANA MEDICAID PROGRAM(S)

Hoosier Healthwise (HHW) and Hoosier Care Connect (HCC):

Primary Care Provider ("PCP"). For PCPs, the Anthem Rate for the Hoosier Healthwise Networks is based on one hundred three percent (103%) of the applicable Anthem Indiana Medicaid Fee Schedule on file with Anthem, as of the effective date of the Medicaid Participation Attachment, except for those Coded Service Identifiers set forth in the attached Government Program(s) PCS Attachment or Provider's Charges, whichever is less. Payment for Medicaid Covered Services submitted with the Coded Service Identifier(s) set forth in the attached Government Program(s) PCS Attachment, will be reimbursed based on the Anthem Rate corresponding to the Coded Service Identifier(s). For purposes of this PCS, PCP means the following types

of health care physicians: internal medicine physicians, general practice physicians, family practice physicians, pediatricians, obstetric/gynecology physicians, endocrinologists (if primarily engaged in internal medicine), physician assistants and advanced practice nurse practitioners who elect to be a PCP. All other professional health care providers, including obstetric/gynecology physicians or advance nurse practitioners who do not elect to be a PCP, will be deemed to be a Specialty Care Provider ("SCP"), unless Provider is an ancillary provider as set forth below.

Specialty Care Provider (SCP). For SCPs, the Anthem Rate for the Hoosier Healthwise Network is based on one hundred percent (100%) of the applicable Anthem Indiana Medicaid Fee Schedule on file with Anthem, as of the effective date of the Medicaid Participation Attachment except for those Coded Service Identifier(s) set forth in the attached Government Program(s) PCS Attachment, or Provider's Charges, whichever is less. Payment for Medicaid Covered Services submitted with the Coded Service Identifier(s) set forth in the attached Government Program(s) PCS Attachment will be reimbursed based on the Anthem Rate corresponding to the Coded Service Identifier(s).

Ancillary Providers (if applicable). For Ancillary Provider(s), the Anthem Rate for the Medicaid Network is based on one hundred percent (100%) of the applicable Anthem Indiana Medicaid Fee Schedule on file with Anthem as of the effective date of the Medicaid Participation Attachment except for those Coded Service Identifier(s) set forth in the attached Government Program(s) PCS Attachment or Provider's Charges, whichever is less. Payment for Covered Services submitted with the Coded Service Identifiers set forth in the attached Government Program(s) PCS Attachment will be reimbursed based on the Anthem Rate corresponding to the Coded Service Identifiers.

Healthy Indiana Plan (HIP):

Rates are based on one hundred percent (100%) of the CMS Medicare Fee Schedule or one hundred thirty percent (130%) of the Indiana State Medicaid Fee Schedule if the service does not have a Medicare reimbursement rate on file with Anthem, as of the effective date of the Medicaid Participation Attachment except for those Coded Service Identifiers set forth in the attached Government Program(s) PCS Attachment or Provider's Charges, whichever is less. Payment for Medicaid Covered Services submitted with the Coded Service Identifier(s) set forth in the attached Government Program(s) PCS Attachment, will be reimbursed based on the Anthem Rate corresponding to the Coded Service Identifier(s).

Provider acknowledges that reimbursement for some Medicaid Covered Services may first be made from the HIP Member's POWER Account, with any remaining balance payable by Anthem. Provider agrees that under no circumstances shall he/she/it balance bill the HIP Member. For purposes of this Attachment, "POWER Account" means an individual health care account funded by, at a minimum, the State of Indiana and the HIP Member and used by that Member to purchase Medicaid Covered Services before their deductible is met.

Nothing in this Attachment shall be interpreted as interfering with Provider's ability to hold HIP Members liable for the Emergency Services copayment or payment of Medicaid Covered Services with POWER Account funds before the HIP Member's deductible has been met.

Government Program(s) PCS Attachment

Hoosier Healthwise (HHW) and Hoosier Care Connect (HCC) - Primary Care Provider (PCP) and Specialty Care Provider (SCP)	
Coded Service Identifier(s)/Provider Type(s)	**Anthem Rate**
Emergency Room Evaluation & Management Codes for SCPs only 99281 99282 99283 99284 99285	$50.00
Lab Codes for PCP & SCPs 80047 – 89356	Fee Schedule for the Preferred Provider Organization Network Blue Access/Access
Drugs billed with J codes for PCP and SCPs	Reimbursement for drugs billed with J codes will be based on the CMS Medicare Fee Schedule. Anthem's reimbursement will adjust as the CMS Medicare Fee Schedule for these codes adjusts without further notice.
Advance Practice Nurse and/or Physician Assistant – Primary Care Provider (PCP) – billing with the NPI assigned to the Advance Practice Nurse or Physician Assistant	75% of the Anthem Medicaid Fee Schedule - Other codes set forth on this Exhibit A shall be reimbursed in accordance with the applicable Anthem Rate identified. 100% of the Anthem Medicaid Fee Schedule for the following Covered Services billed with the applicable codes: Radiology (70010 – 79999) Pathology and Lab (89357 – 89399) Immunizations (90281-90799) Level II HCPC codes (A0021-A9999,B4034-B9999, C1010-C9711, D0120-D9999, EE0100-E2599, G0001-G9016, K0001-K0620, L0100-L9900, P2028-P9615, Q0035- Q4077, R0070-R0076, and S0012-S9999)
Advance Practice Nurse and/or Physician Assistant - Specialty Care Physician SCP - when billing with NPI assigned to Advance Practice Nurse or Physician Assistant	75% of the Anthem Medicaid Fee Schedule - Other codes set forth on this Exhibit A shall be reimbursed in accordance with the applicable Anthem Rate identified. 100% of the Anthem Medicaid Fee Schedule for the following Covered Services billed with the applicable codes: Radiology (70010 – 79999) Pathology and Lab (89357 – 89399) Immunizations (90281-90799) Level II HCPC codes (A0021-A9999,B4034-B9999, C1010-C9711, D0120-D9999, EE0100-E2599, G0001-G9016, K0001-K0620, L0100-L9900, P2028-P9615, Q0035- Q4077, R0070-R0076, and S0012-S9999)
Advance Practice Nurse and/or Physician Assistant working as a Specialty Care Physician (SCP) employed by and billing with the NPI assigned to a supervising physician using the modifier SA, HN or HO, as applicable	100% of the Anthem Medicaid Fee Schedule - Other codes set forth on this Exhibit A shall be reimbursed in accordance with the applicable Anthem Rate identified.

Healthy Indiana Plan (HIP)	
Coded Service Identifier(s)/Provider Type(s)	**Anthem Rate**
Advance Practice Nurse and/or Physician Assistant working as a Primary Care Provider (PCP) – billing with the NPI assigned to the Advance Practice Nurse or Physician Assistant	85% of the HIP Anthem Rate 100% of the HIP Anthem Rate for the following Covered Services billed with the applicable codes: Radiology (70010 – 79999) Pathology and Lab (80048 – 89399) Immunizations (90281-90799) Level II HCPC codes (A0021-A9999,B4034-B9999, C1010-C9711, D0120-D9999, EE0100-E2599, G0001-G9016, J0120-J9999, K0001-K0620, L0100-L9900, P2028-P9615, Q0035-Q4077, R0070-R0076, and S0012-S9999)
Advance Practice Nurse and/or Physician Assistant working as a Specialty Care Provider (SCP) - when billing with NPI assigned to Advance Practice Nurse or Physician Assistant	85% of the HIP Anthem Rate - Other codes set forth on this Exhibit A shall be reimbursed in accordance with the applicable Anthem Rate identified. Radiology (70010 – 79999) Pathology and Lab (80048 – 89399) Immunizations (90281-90799) Level II HCPC codes (A0021-A9999,B4034-B9999, C1010-C9711, D0120-D9999, EE0100-E2599, G0001-G9016, J0120-J9999, K0001-K0620, L0100-L9900, P2028-P9615, Q0035-Q4077, R0070-R0076, and S0012-S9999)
Advance Practice Nurse and/or Physician Assistant working as a Specialty Care Physician (SCP) employed by and billing with the NPI assigned to a supervising physician using the modifier SA, HN or HO, as applicable	100% of the HIP Anthem Rate - Other codes set forth on this Exhibit A shall be reimbursed in accordance with the applicable Anthem Rate identified.
All other provider types not specifically identified otherwise	100% of the HIP Anthem Rate

Applied Behavioral Analysis (ABA) Services **Covered ABA Services for Provider Types below:** **All other codes will be denied.**	
Coded Service Identifier(s)/Provider Type(s)	**Anthem Rate**
97151	Behavior identification assessment, administered by a physician or other qualified healthcare professional, each 15 minutes of the physician's or other qualified healthcare professional's time face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan $16.80/unit
97152	Behavior identification supporting assessment, administered by one technician under the direction of a physician or other qualified healthcare professional, face-to-face with the patient, each 15 minutes $16.00/unit

97153	Adaptive behavior treatment by protocol, administered by a technician under the direction of a physician or other qualified healthcare professional, face-to-face with one patient, every 15 minutes $12.60/unit
97154	Group adaptive behavior treatment by protocol, administered by a technician under the direction of a physician or other qualified healthcare professional, with two or more patients, every 15 minutes $3.35/unit
97155	Adaptive behavior treatment with protocol modification, administered by a physician or other qualified healthcare professional, which may include simultaneous direction of a technician, face-to-face with one patient, every 15 minutes $10.84/unit
97156	Family adaptive behavior treatment guidance, administered by a physician or other qualified healthcare professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s), every 15 minutes $16.80/unit
97157	Multiple-family group adaptive behavior treatment guidance, administered by a physician or other qualified healthcare professional (without the patient present), face-to-face with multiple sets of guardians/caregivers, every 15 minutes $2.54/unit
97158	Group adaptive behavior treatment with protocol modification, administered by a physician or other qualified healthcare professional, face-to-face with multiple patients, every 15 minutes $2.54/unit
0362T	Behavior identification supporting assessment, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administered by the physician or other qualified healthcare professional who is on site; with assistance of two or more technicians; for a patient who exhibits destructive behavior; completed in an environment that is customized to the patient's behavior $34.29/unit
0373T	Adaptive behavior treatment with protocol modification, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administered by the physician or other qualified healthcare professional who is on site; with the assistance of two or more technicians; for a patient who exhibits destructive behavior; completed in an environment that is customized to the patient's behavior $86.69/unit