ANTHEM BLUE CROSS AND BLUE SHIELD
PROFESSIONAL PROVIDER AGREEMENT

This Professional Provider Agreement (hereinafter "Agreement"), is effective as set forth on the signature page and entered into by and between Anthem Insurance Companies, Inc., doing business as Anthem Blue Cross and Blue Shield (hereinafter "*ANTHEM*") and Centrality Behavior Support Training, LLC (hereinafter "*PROVIDER*"), located at 3725 E Southport Rd Ste F, Indianapolis, IN 46227. 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

1.1 "Affiliate" means any entity which owns or is owned by *ANTHEM*, directly or indirectly, and any entity which is under common ownership directly or indirectly, by WellPoint, Inc. or subsidiary corporation. Upon execution of this Agreement, *ANTHEM* shall provide to *PROVIDER* a current list of Affiliates. This list will be updated not less than quarterly and a copy will be provided to *PROVIDER* upon request. *ANTHEM* will make best efforts to have a current listing available through a commonly available web site.

1.2 "Anthem Rate" means the lesser of the *PROVIDER's* billed charges or the total reimbursement amount to which *PROVIDER* and *ANTHEM* have agreed as set forth in the Participation Attachment and shall represent payment in full to *PROVIDER* for Covered Services rendered.

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

1.4 "Claim" means either the uniform bill claim form or electronic claim form in the format prescribed by *ANTHEM* submitted for payment by a Provider for Health Services rendered to a Covered Individual.

1.5 This provision intentionally left blank.

1.6 "Courtesy Room" means an area in a hospital where a professional provider is permitted to provide Health Services to Covered Individuals, which could otherwise be provided in an office setting.

1.7 "Covered Individual" means any individual who is eligible, as determined by Plan, to receive Covered Services under a Health Benefit Plan.

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

1.9 This provision intentionally left blank.

1.10 "Encounter Data" means Claims information submitted by a Provider under capitated or risk-sharing arrangements, for Health Services rendered to Covered Individuals.

1.11 "Emergency" or "Emergency Services" means, unless otherwise set forth in the Health Benefit Plan, or required by statute or regulation, or as set forth in the State Specific Provisions Attachment, a serious medical condition resulting from injury or sickness which arises suddenly and requires immediate medical care or treatment to avoid serious physical impairment or loss of life, for which the Covered Individual secures medical attention immediately after onset (usually within twenty-four (24) hours).

1.12 "Health Service" means those services or supplies that a professional provider is licensed to provide and which he/she/it customarily provides to individuals; or those inpatient and outpatient services or supplies that a health care facility is licensed, equipped and staffed to provide, and which it customarily provides to individuals.

1.13 "Health Benefit Plan" means the document(s) describing the partially or wholly insured, underwritten and/or administered, health care benefits or services program between the Plan and an employer or other entity or individual; or, in the case of a self-funded arrangement, the plan document, which describes the Covered Services for a Covered Individual or Individuals.

1.14 "Medically Necessary" or "Medical Necessity" means, unless otherwise set forth in the Health Benefit Plan, or required by statute or regulation, the applicable definition set forth in the State Specific Provisions Attachment.

1.15 "Network" means a group of providers that support, through a direct or indirect contractual relationship, the product(s) and/or program(s) in which Covered Individuals are enrolled. *PROVIDER* will participate in the Network(s) designated on the signature page and/or Participation Attachment(s).

1.16 "Network Provider" means a provider who *ANTHEM* has designated to participate in one or more Networks. *PROVIDER* is a Network Provider as designated on the signature page and/or Participation Attachment(s).

1.17 "Participation Attachment" means the document(s) attached to or made a part of this Agreement which identifies the Network(s) in which *PROVIDER* participates.

1.18 "Plan" means: (1) *ANTHEM*; (2) an Affiliate as designated by *ANTHEM*; or (3) any Blue Cross and/or Blue Shield Plan.

1.19 "Plan Fee Schedule" means the schedule established by *ANTHEM* which sets forth the applicable Anthem Rate for the Network(s) in which *PROVIDER* participates.

1.20 "Primary Care Provider" / "Specialty Care Provider" means a Provider so designated by *ANTHEM* with responsibilities as specified on either the Primary Care Provider Attachment or Specialty Care Provider Attachment to this Agreement.

1.21 "Provider" means an individual physician or other professional, a partnership of professionals or a professional corporation, along with the individual providers within such partnership or professional corporation, duly licensed to practice medicine in the state(s) where they practice, and that Plan has accepted for participation in one or more Networks.

1.22 "Provider Manual" means that document or set of documents which set forth in detail Plan rules. For purposes of this Agreement and any attachments or Exhibits hereto, Provider Manual may include, without limitation, any applicable Network Provider Manual or provider communications. The Provider Manual is incorporated into and made a part of this Agreement.

1.23 "Quality Improvement Program" means a program which may include, without limitation, evaluation of and efforts to improve the quality and efficiency of the use of Health Services, procedures and facilities on a prospective, concurrent or retrospective basis.

1.24 "Utilization Management Program" means a program which may include, without limitation, evaluation of the necessity, appropriateness, and efficiency of the use of Health Services, procedures, and facilities on a prospective, concurrent, or retrospective basis.

1.25 "Central Region Network" means the Central Region Network or Networks, as listed on the signature page and/or Participation Attachment(s) to this Agreement, for products identified as "Blue" products, for example Blue Preferred and Blue Access.

1.26 This provision intentionally left blank.

ARTICLE II
SERVICES/OBLIGATIONS

2.1 Covered Individual Identification. *ANTHEM* shall require that Plan will issue Covered Individuals a means of identification which includes information necessary to elicit who to contact to determine Covered Individuals' participation in the applicable Health Benefit Plan. *PROVIDER* acknowledges and agrees that possession of such identification, in and of itself, does not qualify the holder thereof as a Covered Individual, nor does the lack thereof mean that the person is not a Covered Individual. *ANTHEM* encourages *PROVIDER* to check eligibility electronically.

2.2 Provider Non-discrimination. *PROVIDER* shall provide Health Services to Covered Individuals in a manner similar to and within the same time availability in which *PROVIDER* provides Health Services to any other individual. *PROVIDER* will not differentiate or discriminate against any Covered Individual as a result of his/her enrollment in a Plan or because of race, color, creed, national origin, ancestry, religion, sex, marital status, age, disability, payment source, state of health, need for health services, status as a litigant, status as a Medicare or Medicaid beneficiary, sexual orientation, or any other basis prohibited by law. *PROVIDER* shall not be required

to provide any type or kind of Health Service to Covered Individuals that *PROVIDER* does not customarily provide to others. Because the *PROVIDER*-patient relationship is a personal one and may become unacceptable to either party, *PROVIDER* may decline to continue treating a Covered Individual. In that event, *PROVIDER* shall notify *ANTHEM* and the Covered Individual. *PROVIDER* shall not however, decline to treat a Covered Individual because of the amount of Health Services required by the Covered Individual or because of the physical condition of the Covered Individual. *PROVIDER* acknowledges that Covered Individuals have a contractual right to request to be transferred to another Network Provider. All such transfers shall be made effective as soon as administratively feasible but not later than sixty (60) days from the date Plan receives the request.

2.3 Provider's Inability to Carry Out Duties. *PROVIDER* shall immediately send written notice to *ANTHEM* of any legal, governmental, or other action involving *PROVIDER* which *PROVIDER* reasonably believes could materially impair the ability of *PROVIDER* to carry out his/her/its duties and obligations under this Agreement.

2.4 Covered Individual's Rights. *PROVIDER* shall observe, protect, and promote the rights of the Covered Individual as set forth in any state or federal law and the "Members' Rights and Responsibilities" published in Plan documents and/or on the Plan web site.

2.5 This provision intentionally left blank.

2.6 Publish Provider's Name. For the term of this Agreement, *PROVIDER* agrees to provide and authorizes Plan to identify and publish his/her/its name, address, telephone number, provider identification number, other information required by an account, and available services in Plan marketing materials and informational materials. *ANTHEM* agrees that *PROVIDER* may identify itself as a participant in the Network(s) in which he/she/it participates; provided, however, that *ANTHEM* shall have the right of prior approval of any use of Plan symbols, trademarks, or service marks. Except as provided in this provision, each party reserves the right to control the use of his/her/its name and all symbols, trademarks, or service marks presently existing or later established.

2.6.1 Consent to Advertise. *PROVIDER* may only use the name of a Plan for purposes of identifying *PROVIDER* as a Participating *PROVIDER* in the programs in which he/she/it participates. *PROVIDER* shall obtain Plan's written consent prior to distributing to Covered Individual, any type of *PROVIDER* advertising, marketing or any other material related to Plan or a Health Benefit Plan.

2.7 Cost Effective Care. *PROVIDER* shall provide Covered Services to Covered Individuals in the most cost effective setting and manner.

2.8 Availability of Care to Covered Individuals. A *PROVIDER* who is a Primary Care Provider, or a gynecologist or obstetrician, shall provide Health Services or make arrangements for the provision of Health Services to Covered Individuals on a twenty-four (24) hour per day, seven (7) day a week basis to assure availability, adequacy, and continuity of care to Covered Individuals. In the event a *PROVIDER* is not one of the foregoing described Providers, then *PROVIDER* shall provide Health Services to Covered Individuals on a twenty-four (24) hour per day, seven (7) day a week basis or at such times as Health Services are typically provided by similar providers to assure availability, adequacy, and continuity of care to Covered Individuals. If *PROVIDER* is unable to provide Health Services as described in the previous sentence, *PROVIDER* will arrange for another Network Provider to cover *PROVIDER*'s patients in *PROVIDER*'s absence.

2.9 Credentialing. When applicable, *PROVIDER* must meet *ANTHEM*'s credentialing standards for Networks in which *PROVIDER* is participating. A description of the credentialing program is set forth in the Provider Manual. *PROVIDER* warrants that he/she/it has all licenses required to provide Health Services in accordance with the applicable licensing provisions of the laws and regulations of the state(s) in which *PROVIDER* renders services. *PROVIDER* additionally warrants that, if applicable, it is certified by CMS and maintains current participation with CMS. *PROVIDER* agrees to immediately notify *ANTHEM* of any change in its certification or participation status.

2.9.1 Failure to Meet Licensure and/or Credentialing Standards. *PROVIDER* agrees to immediately notify *ANTHEM* if *PROVIDER* loses or voluntarily surrenders such licensure, accreditation, permits, authorizations or approvals, or when applicable no longer meets *ANTHEM*'s credentialing standards, during the term of this Agreement.

2.9.2 Recredentialing. When applicable, *PROVIDER* shall cooperate fully with *ANTHEM* and its designees and will provide such information as may be reasonably necessary to assist *ANTHEM* and its designees in determining whether *PROVIDER* meets *ANTHEM*'s recredentialing standards.

2.9.3 Quality of Care. *PROVIDER* authorizes *ANTHEM* and its designees to, at any time, solicit information regarding certifications or accreditations, qualifications, and malpractice history from any source as long as this Agreement remains in effect. *PROVIDER* agrees to execute any necessary release of information forms as may be necessary. Upon request, *PROVIDER* agrees to provide *ANTHEM* and its designees with the same data regarding quality of care that it provides to any other third party payor with whom it contracts. Upon request, *PROVIDER* shall also provide *ANTHEM* and its designees with reasonable data, at least annually, that is commonly accepted to be an indicator of *PROVIDER*'s quality of care. If the information *PROVIDER* provides or *ANTHEM*'s own information is reasonably interpreted by *ANTHEM* to indicate that *PROVIDER* has deviated from good medical or professional practice and therefore requires further investigation, *PROVIDER* agrees to cooperate with *ANTHEM* and its designees in further evaluating the data, including, without limitation: (1) participating in meetings and/or discussions intended to determine a satisfactory explanation and/or devise a corrective course of action; and (2) providing *ANTHEM* and its designees with additional information including any consultant reports and any other reasonable information which will allow *ANTHEM* and its designees to further analyze the data and draw conclusions which would be shared with *PROVIDER*.

2.9.4 Scope of Information. *PROVIDER* shall not be required to release the names or other identifying information of patients or any proprietary negotiated rates with other third party payors under this provision. Information reasonably believed to be subject to the immunity available under the applicable state peer review statute shall be shared in a manner which preserves immunity.

2.9.5 Sharing of Credentialing and Quality Information. *PROVIDER* authorizes *ANTHEM* to share credentialing, recredentialing and quality information with Plan. Information reasonably believed to be subject to the immunity available under the applicable state peer review statute shall be shared in a manner which preserves immunity.

2.9.6 Certification. By executing this Agreement, *PROVIDER* hereby certifies that, to the best of its, his or her knowledge and belief, all claims information, encounter data and other information submitted by or on behalf of *PROVIDER* to *ANTHEM and/or Plan* will be and are accurate, complete, and truthful. *PROVIDER* hereby acknowledges that *ANTHEM* will rely on such information and certification when *ANTHEM* and/or Plan prepares and submits its data, reports, notices and filings to state and federal regulatory entities and other applicable persons and entities.

2.10 Plan's Quality Improvement and Utilization Management Programs. *PROVIDER* agrees to abide by the terms of the Provider Manual, and to participate in and comply with Plan's Quality Improvement Programs and Utilization Management Programs. Further, *PROVIDER* agrees to comply with Plan's policies and procedures which shall be communicated to *PROVIDER* from time to time.

2.11 Provider Represented Information. *PROVIDER* represents that to the best of *PROVIDER*'s knowledge and belief, all documents, information, records and claims provided by *PROVIDER* to *ANTHEM* or *ANTHEM*'s designees relating to entering into this Agreement and information submitted during the term of this Agreement, contain true and correct information, and acknowledges that *ANTHEM* is relying on such information.

2.12 In Network Referrals. *PROVIDER* shall refer Covered Individual only to Network Providers in order for the Covered Individual to be eligible for the highest benefit level under his/her Health Benefit Plan. Except in the case of an Emergency, *PROVIDER* will refer/admit only to Network Providers. In the event necessary Health Services are not available from Network Providers, prior to such admittance/referral to a non-network provider, *PROVIDER* will obtain *ANTHEM*'s approval for admittance/referral to a non-network provider. In the case of a Covered Individual who is enrolled in a Traditional product, *PROVIDER* shall make best efforts to comply with the foregoing.

2.13 Separate Provider Network. *ANTHEM* reserves the right to establish a separate provider network or other provider referral panel which has its own set of selection criteria. If *PROVIDER* does not meet the selection criteria, *PROVIDER* understands and agrees that he/she/it will cooperate in the transfer of the Covered Individual to a provider within the separate provider network. In the event *PROVIDER* renders Covered Services to the Covered Individual that should have been rendered by the separate provider network, then *PROVIDER* agrees that it will be deemed an out of network provider under the Covered Individual's Health Benefit Plan, for the rendition of said services; and in such case, *PROVIDER*'s compensation will be pursuant to the Out of Network Compensation provision of this Agreement unless otherwise specified in the Covered Individual's Health Benefit Plan. *ANTHEM* will give *PROVIDER* at least ninety (90) days advance notice of the implementation of a separate provider network.

2.14 Designated Provider Networks. *PROVIDER* acknowledges that certain Health Services, including by way of example only, laboratory services, shall be provided exclusively by designated Network Providers, as determined by Plan. *PROVIDER* agrees to use such designated Network Providers for the provision of certain Health Services to Covered Individuals, even if *PROVIDER* typically could have performed such services in *PROVIDER*'s office. Notwithstanding the Out of Network Compensation provision of this Agreement, in the event of the foregoing, *PROVIDER* agrees there will be no reimbursement to *PROVIDER* for such services and *PROVIDER* agrees not to bill Covered Individual, *ANTHEM*, or Plan for any such services.

2.15 Covered Individual Grievance Procedure. *PROVIDER* agrees to cooperate fully with any applicable Covered Individual grievance procedure. Disputes of medical malpractice are outside the scope of this Agreement. This provision shall survive termination of this Agreement with respect to Covered Services rendered to Covered Individuals prior to termination.

2.16 Provider Appeals Procedure. *PROVIDER* agrees to comply with *ANTHEM*'s appeal(s) procedure. Disputes of medical malpractice, except for Indemnification, are outside the scope of this Agreement. This provision shall survive termination of this Agreement.

2.17 Open Practice. For those Providers who participate in a HMO/HIC Network, *PROVIDER* agrees to accept a minimum of one hundred (100). Covered Individuals in his/her/its practice and will notify Plan when *PROVIDER* no longer accepts new patients. If *PROVIDER* is in a group, then each individual *PROVIDER* in the group shall abide by this section. *PROVIDER* agrees not to close his/her practice and/or business to Covered Individuals if *PROVIDER* is offering Health Services to new non-Plan members. *PROVIDER* shall give Plan sixty (60) days prior written notice when *PROVIDER* no longer accepts new patients.

2.18 State Specific Provisions. The State Specific Provisions Attachment is incorporated in this Agreement and *PROVIDER* will comply with the provisions of such attachment in accordance with Provision 8.7 of the Agreement.

2.19 Provider Subcontractors. *PROVIDER* may subcontract Health Services so long as such subcontractor is acceptable to *ANTHEM*. *PROVIDER* shall provide *ANTHEM* with at least sixty (60) days prior notice of any Health Services subcontractors with which *PROVIDER* may contract to perform *PROVIDER*'s duties and obligations under this Agreement. *PROVIDER* shall provide *ANTHEM* with a sample copy of any agreement between *PROVIDER* and such subcontractors at least sixty (60) days prior to the commencement of such subcontractor(s)' services. *PROVIDER* shall require such subcontractors to abide by the terms and conditions of this Agreement, and shall indemnify *ANTHEM*, Plan, and Covered Individuals for any failure of any subcontractor to so comply. If *ANTHEM* has a direct contract with the subcontractor ("direct contract"), the direct contract will prevail over this Agreement.

2.20 Compliance Programs. *ANTHEM* intends to comply with all applicable federal and state laws and regulations, and to that end maintains an effective Compliance Program and Standards of Business Conduct, and expects *PROVIDER* to respect and observe the existence of these. The Compliance Program and Standards of Business Conduct is available at www.wellpoint.com or its successor.

2.21 Ineligible Persons. *PROVIDER* warrants and represents that at the time of entering into this Agreement and for the term of this Agreement, neither it nor any of his/her/its employees, contractors, subcontractors or agents are ineligible persons identified on the General Services Administrations' List of Parties Excluded from Federal Programs (available through the internet at http://www.arnet.gov/epls) and the HHS/OIG List of Excluded Individuals/Entities (available through the internet at http://oig.hhs.gov/fraud/exclusions/listofexcluded.html). In the event *PROVIDER* or any employee, subcontractor or agent thereof becomes an ineligible person after entering into this Agreement or otherwise fails to disclose his/her/its ineligible person status, *PROVIDER* shall have an obligation to (1) immediately notify *ANTHEM* of such ineligible person status and (2) within ten (10) days of such notice, remove such individual from responsibility for, or involvement with, the *PROVIDER*'s business operations related to this Agreement. *PROVIDER* acknowledges that violation of this provision is material breach of the Agreement and is grounds for immediate termination pursuant to Provision 7.4.

ARTICLE III
BILLING/COMPENSATION

3.1 Coordination of Benefits/Subrogation. *PROVIDER* agrees to cooperate with Plan regarding subrogation and coordination of benefits and to notify Plan promptly after receipt of information regarding any Covered Individual who may have a Claim involving subrogation or coordination of benefits. When payment for Covered Services is subject to either coordination of benefits or subrogation between two or more sources of

payment, and *ANTHEM* is not the primary source, payment shall be based upon the Anthem Rate for the applicable network/program in which the Covered Individual participates, reduced by the amount paid for the Covered Services by the other source(s). *PROVIDER* agrees to accept such amount as payment in full for the Covered Services and shall not balance bill the Covered Individual. Notwithstanding the foregoing, this provision shall not be construed to require *PROVIDER* to waive Cost Shares in contravention of any Medicare rule or regulation, nor shall this provision be construed to supercede any other Medicare rule or regulation.

3.2 Covered Service/Individual Determination. Plan shall have sole authority to determine whether a service is a Covered Service, and whether an individual is a Covered Individual.

3.3 Submission of Claims. *PROVIDER* shall submit Claims to Plan for payment within one hundred eighty (180) days from the date the Health Services are rendered except where expressly otherwise set forth in the Provider Manual, *PROVIDER* agrees to provide to Plan, at no cost to Plan, *ANTHEM*, or Covered Individual all information necessary for Plan to determine its liability, including, without limitation, accurate and complete Claims for Covered Services, utilizing forms consistent with industry standards and approved by Plan or, if available, electronically through a medium approved by Plan. Plan is not obligated to pay Claims received after this one hundred eighty (180) day period. *PROVIDER* shall not bill, collect or attempt to collect from Covered Individual for Claims Plan receives after this one hundred eighty (180) day period regardless of whether Plan pays such Claims. *PROVIDER* shall use best efforts to submit claims electronically to the Plan and shall submit at least ninety percent (90%) of the Plan's claims electronically.

3.4 Acceptable Claim Forms and Coding. *PROVIDER* agrees to provide to Plan, at no cost to Plan, *ANTHEM*, or the Covered Individual, all information necessary for Plan to determine his/her/its liability including, without limitation, accurate and complete Claims for Covered Services, utilizing Claim forms and coding acceptable to Plan.

3.5 CPT/HCPC Codes. *PROVIDER* agrees to use the most appropriate code and/or appropriate anesthesia codes when billing for services rendered and not to unbundle charges into separate codes when a single code is more appropriate. *PROVIDER* agrees that if Plan reassigns or re-bundles codes, *PROVIDER* shall accept the applicable Anthem Rate for those services as reassigned or rebundled by Plan as payment in full.

3.6 Non-Capitated Services. For Providers reimbursed pursuant to a capitation payment, said Provider shall accept Plan's Fee Schedule for the applicable Network for Covered Services not included in the capitation fee.

3.7 Payment in Full. Unless otherwise set forth by statute, regulation, or the Covered Individual's Health Benefit Plan, *PROVIDER* agrees to accept the applicable Anthem Rate as payment in full, as specified on the applicable Plan Fee Schedule, for Covered Services provided to Covered Individual. *PROVIDER* shall bill, collect and accept compensation for services from Covered Individual for Covered Individual's Cost Share.

3.7.1 *PROVIDER* agrees that the maximum compensation, in all circumstances, shall be the applicable Anthem Rate for Covered Services provided to Covered Individuals. *PROVIDER* shall bill, collect and accept compensation for services, as payment in full, from Covered Individuals for the Covered Individual's Cost Share. Only the *PROVIDER*, Plan and Covered Individuals will be entitled to access the Anthem Rate. The Covered Individual's Cost Share and any monies due from the Plan are considered payment in full. Notwithstanding any provision, in no event shall the *PROVIDER*, Covered Individuals or Plan be obligated to pay *PROVIDER* or any person acting on behalf of *PROVIDER* for Health Services, any amounts in excess of the Anthem Rate, and any amount that is not a Covered Service for a professional service, including, without limitation, charges for (i) overhead and maintenance of office infrastructure, administrative fees (including, without limitation, fees for training of staff, fees for equipment maintenance or calibration, ensuring compliance with applicable regulations or other requirements, efforts to maintain certifications, etc.), (ii) charges for preferred access to services (e.g., "concierge" or "boutique" practice fees), malpractice premiums, costs or surcharges, fees for referrals or fees for completing claim forms or submitting additional information, or (iii) any amount for any service that *PROVIDER* is not licensed to perform under the laws of the jurisdiction where the services are provided.

3.8 Plan Payment Time Frames. *ANTHEM* shall require Plans or their designees to use best efforts to make payment or arrange for payment within the time frames set forth in the Provider Manual.

3.9 Hold Harmless. Except as otherwise stated below, *PROVIDER* agrees that in no event, including but not limited to, nonpayment by Plan, insolvency of Plan, or breach of this Agreement, shall *PROVIDER* bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any other recourse against a Covered Individual, or a person acting on the Covered Individual's behalf, for Covered Services provided pursuant to this Agreement. This provision does not prohibit *PROVIDER* from collecting Cost Shares, as specifically provided under the Covered Individual's Health Benefit Plan, or fees for non-Covered Services delivered on a fee-for-service basis to Covered Individuals, nor from pursuing any recourse against the Plan or its successor, except as provided for below.

3.9.1 In the case of a Covered Individual whose Health Benefit Plan is not underwritten by *ANTHEM* or an Affiliate, *PROVIDER*'s cause of action, if any, shall lie strictly with the sponsor of said Covered Individual's Health Benefit Plan.

3.9.2 Except as provided for below, in no event shall *PROVIDER* directly or indirectly collect, attempt to collect, or accept compensation, remuneration or reimbursement from a Covered Individual, including but not limited to, the Health Service not being Medically Necessary or *PROVIDER* failing to comply with the Provider Manual.

3.9.3 *PROVIDER* may seek payment from the Covered Individual for Health Services which are not payable under the Covered Individual's Health Benefit Plan when the non-coverage is due to reasons other than lack of Medical Necessity. *PROVIDER* may seek payment from the Covered Individual for Health Services which are non-Covered Services because the services have been deemed not Medically Necessary only if the Covered Individual has requested the Health Services to be provided notwithstanding Plan's determination, and only if *PROVIDER* has provided to Covered Individual notice in writing, prior to the rendition of the services, of the approximate charge said Covered Individual will incur, and Covered Individual has agreed to the rendition of the service having had the benefit of said information. In such event, *PROVIDER* may bill the Covered Individual at his/her/its customary rate for such services.

3.9.4 In the event *PROVIDER* provides Covered Services to a Covered Individual enrolled in a Central Region Network, and *PROVIDER* is not a Network Provider for the Covered Individual's Central Region Network product, *PROVIDER* may be entitled to seek payment of additional compensation, remuneration and/or reimbursement from the Covered Individual, but only as provided in the Out of Network Compensation provision.

3.9.5 This hold harmless provision shall survive termination of this Agreement with respect to Covered Services rendered under this Agreement during the time this Agreement is in effect, regardless of the reason for termination, including insolvency of the Plan, and shall be for the benefit of Covered Individuals.

3.10 Overpayment Refunds. *PROVIDER* shall refund to Plan all duplicate or erroneous Claim payments regardless of the cause, with or without request from Plan. In lieu of a refund, Plan may offset future Claim payments.

3.11 Courtesy Room/Interview. *PROVIDER* shall not bill *ANTHEM*, Plan, and/or Covered Individuals for any charges for the use of a Courtesy Room in the provision of Health Services to a Covered Individual. *PROVIDER* agrees not to bill *ANTHEM*, Plan, or Covered Individuals for interview visits that do not require *PROVIDER* to render Health Services. Interview visit is defined as an initial consultation between Network Provider and Covered Individual wherein no Health Services are rendered.

3.12 Blue Cross Blue Shield Out of Area Program. *PROVIDER* agrees to provide Covered Services to any person who is covered under another Blue Cross and Blue Shield Plan under the Blue Cross and Blue Shield Association ("BCBSA") out of area or reciprocal programs and to submit Claims for payment to Plan. *PROVIDER* agrees to accept payment by Plan at the Anthem Rate as payment in full except *PROVIDER* may bill, collect and accept compensation for services for the Covered Individual's Cost Share. The provisions of this Agreement shall apply to charges for services under the out of area or reciprocal programs. *PROVIDER* further agrees to comply with other similar programs of the Blue Cross and Blue Shield Association.

3.13 Continuance of Care-Termination. Unless otherwise set forth in the Health Benefit Plan, or required by statute or regulation, or as set forth in the State Specific Provisions Attachment, Continuance of Care-Termination shall apply as follows: *PROVIDER* shall, upon termination of this Agreement for reasons other than the grounds set forth in the Termination With Cause provision of this Agreement, continue to provide and be compensated for Covered Services rendered to Covered Individuals under the terms and conditions of this

Agreement until the earlier of such time that: (1) the Covered Individual has completed the course of treatment; or (2) reasonable and medically appropriate arrangements have been made for a Network Provider to render Health Services to the Covered Individual.

3.14 Continuance of Care-Insolvency. Unless otherwise set forth in the Health Benefit Plan, or required by statute or regulation, the applicable Continuance of Care-Insolvency provision shall be as set forth in the State Specific Provisions Attachment.

3.15 Failure to Comply With Utilization Management Program. If a reduction in or denial of payment is imposed for failure of the Covered Individual to comply with the Utilization Management Program as specified in the Covered Individual's Health Benefit Plan, *PROVIDER* agrees that *ANTHEM* and Plan are not responsible for the amount of such reduction or denial. However, *PROVIDER* shall seek payment from the Covered Individual for such amount. If a reduction in or denial of payment is imposed for failure of *PROVIDER* to comply with Plan's Utilization Management Program, as set forth in the Provider Manual, *PROVIDER* agrees that *ANTHEM*, Plan, and Covered Individual are not responsible for the amount of such reduction or denial.

3.16 Out of Network Compensation. Except for state and federal health programs, in the event *PROVIDER* renders services to a Covered Individual who accesses a Network in which *PROVIDER* does not participate, *PROVIDER* will receive compensation as follows:

3.16.1 Plan shall compensate *PROVIDER* for Covered Services authorized by either Plan or the Covered Individual's Primary Care Provider according to the Covered Individual's Health Benefit Plan. Plan's payment will be based on the applicable Traditional Anthem Rate. *PROVIDER* agrees to accept the Traditional Anthem Rate as payment in full and shall bill the Covered Individual only for the applicable Cost Share.

3.16.2 Plan shall compensate *PROVIDER* for Emergency Covered Services based on the applicable Traditional Anthem Rate. *PROVIDER* agrees to accept the Traditional Anthem Rate as payment in full and shall bill the Covered Individual only for the applicable Cost Share.

3.16.3 Except as described in 3.16.1 and 3.16.2, if the Covered Individual's Health Benefit Plan has out-of-network benefits, Plan will compensate *PROVIDER* for Covered Services based on the Anthem Rate established for the Network that supported the Covered Individual's Health Benefit Plan. For example, if the Covered Individual's access is supported by Blue Preferred Primary Network, compensation is based on the applicable Anthem Rate for Blue Preferred Primary. *PROVIDER* shall only bill the Covered Individual for the applicable Cost Share as well as any amount designated as the Covered Individual's responsibility on the provider payment voucher (or other written notice of explanation of payment). In no event shall payment from Plan and the Covered Individual exceed *PROVIDER*'s customary rate for such services..

3.16.4 Except as described in 3.16.1 and 3.16.2, if the Covered Individual's Health Benefit Plan does not have out-of-network benefits, Plan shall have no liability for services rendered. *PROVIDER* shall bill the Covered Individual for services rendered at *PROVIDER*'s customary charge.

3.17 Pass-Through Charges. *PROVIDER* agrees not to pass-through to Plan or the Covered Individual any charges which *PROVIDER* incurs as a result of providing supplies or making referrals to another provider or entity. Examples include, but are not limited to, pass-through charges associated with laboratory services and durable medical equipment. If *ANTHEM* has a direct contract with the professional subcontractor, then our direct agreement will prevail over the subcontract.

ARTICLE IV
CONFIDENTIALITY/RECORDS

4.1 Confidentiality - Patient Identifiable Information. *PROVIDER* and *ANTHEM* understand and agree that all information and records related to Covered Individuals are privileged and confidential. To the extent provided by law, the parties agree to keep confidential and not disclose patient identifiable information to any third party, without the prior written consent of the Covered Individual, except that information required for utilization management, quality improvement and Claims adjudication will be released to the appropriate Plan or its designees.

4.2 Proprietary Information. All information and material provided by either party to the other remains proprietary to the disclosing party. For *ANTHEM,* such proprietary information and material includes, but is not limited to, this Agreement, other contracts, payment rates, data and methodologies, the Provider Manual and any operations manuals. For *PROVIDER*, such proprietary information and material includes anything, other than the foregoing *ANTHEM* proprietary information, which *PROVIDER* has notified *ANTHEM* in writing is proprietary to *PROVIDER.* Neither party shall disclose any information proprietary to the other or use such information or material except: (1) as otherwise set forth in this Agreement; (2) as may be required to perform obligations hereunder; (3) as required to deliver Health Services; (4) to Plan or its designees; (5) upon the express written consent of the parties; or (6) as required by law, except that *either party* may disclose such information to its legal advisors, lenders and business advisors, and *ANTHEM* may make such disclosures as are required or appropriate under the Securities Act of 1933, the Securities Exchange Act of 1934, as amended, other applicable securities laws, and rules of the New York Stock Exchange.

4.3 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 Covered Individual any issues related to the Covered Individual's health including recommended treatments, treatment alternatives, treatment risks and the consequences of any benefit coverage or payment decisions made by Plan or any other party. Nothing in this Agreement shall prohibit *PROVIDER* from disclosing to the Covered Individual the general methodology by which *PROVIDER* is compensated under this Agreement, provided no dollar amounts or other specific terms of the compensation arrangement are mentioned to the Covered Individual. 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 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.

4.4 Provider Records. *PROVIDER* shall prepare and maintain all appropriate medical, financial, administrative, and other records as may be needed for Covered Individuals receiving Health Services. All of *PROVIDER*'s records on Covered Individuals shall be maintained in accordance with prudent record-keeping procedures and as required by any applicable federal, state, or local laws, rules or regulations.

4.5 Plan Access to Provider Records. *PROVIDER* shall permit Plan or its designees, upon reasonable notice during normal business hours, to have, without charge, access to and the right to examine, audit, excerpt and transcribe any books, documents, papers, and records related to Covered Individual's medical and billing information within the possession of *PROVIDER* and inspect *PROVIDER*'s operations, which involve transactions relating to Covered Individuals and as may be reasonably required by Plan in carrying out its responsibilities and programs including, but not limited to, assessing quality of care, Medical Necessity, appropriateness of care, and accuracy of payment. *PROVIDER* shall make such records available to the state and federal authorities involved in assessing quality of care or investigating Covered Individual grievances or complaints. *PROVIDER* agrees to provide Plan or its designees with appropriate working space. Upon reasonable request, photocopies of such records shall be provided to Plan, the Covered Individual, or their respective designees at no charge.

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

4.7 This provision intentionally left blank.

4.8 Survival of Article. This Article shall survive termination of this Agreement.

ARTICLE V
INSURANCE/ACCOUNTABILITY

5.1 Anthem Liability Insurance. *ANTHEM* shall self-insure or maintain coverage of comprehensive general liability and other insurance as shall be necessary to insure *ANTHEM* and its agents, servants and employees, acting within the scope of their duties, against any claim or claims for damages arising by reason of personal injuries or death occasioned directly or indirectly in connection with the performance or non-performance of any service provided under this Agreement by *ANTHEM,* its agents, servants, or employees. *ANTHEM* agrees to be responsible for its acts and omissions.

5.2 Provider Liability Insurance. *PROVIDER* shall self-insure or maintain policies of general liability insurance and other insurance in amounts acceptable to Plan as shall be necessary to insure against claims for damages occasioned directly or indirectly in connection with the use of any property and facilities provided by *PROVIDER*, and activities performed by *PROVIDER* in connection with this Agreement. Evidence of all such policies shall be provided to Plan on request. *PROVIDER* shall notify Plan of a change in coverage within ten (10) days of the change. *PROVIDER* shall take all steps necessary to become a "qualified health care provider" under the Indiana Medical Malpractice Act. *PROVIDER* shall also participate in the Indiana Patient's Compensation Fund. *PROVIDER* shall provide *ANTHEM* with proof of status as a "qualified health care provider" under the Indiana Medical Malpractice Act and of participation in the Indiana Patient's Compensation Fund. *PROVIDER* agrees to be responsible for his/her acts and omissions.

ARTICLE VI
RELATIONSHIP OF THE PARTIES

6.1 Relationship of the Parties. For purposes of this Agreement, *ANTHEM* and *PROVIDER* are and will act at all times as independent contractors. None of the provisions of this Agreement is intended to create, nor shall be deemed or construed to create any relationship other than that of independent entities contracting with each other for the purposes of effectuating this Agreement. The provisions of this Agreement shall not establish or be deemed or construed to establish any partnership, agency, employment agreement or joint venture between the parties. Neither of the parties, nor any of their respective officers, directors, employees, agents, or representatives shall be construed to be the agent, employee, or representative of the other. *PROVIDER* shall be solely responsible to Covered Individuals for providing Health Services and the quality of those services. In no way shall *ANTHEM* or Plan be construed to be providers of Health Services. Nothing in this Agreement is intended to create any right for *ANTHEM* to intervene in any manner with the provision of Health Services to Covered Individuals. *PROVIDER* has a duty to exercise independent medical judgment irrespective of whether a Plan determines a Health Service is a Covered Service, and irrespective of the Utilization Management Program and Quality Improvement Program.

6.2 Contracting Party. If *PROVIDER* is a partnership, corporation, or any other entity other than an individual professional Provider, all references herein to "*PROVIDER*" shall also mean and refer to each Provider of such entity individually who has applied for and been accepted by Plan as a Network Provider.

ARTICLE VII
TERM AND TERMINATION

7.1 Initial Term of Agreement. The initial term of this Agreement shall commence at 12:01 AM on the Effective Date and shall continue in effect for a term of one year, automatically renewing for consecutive one year terms unless otherwise terminated as provided herein.

7.2 Termination Without Cause. Either party may terminate this Agreement at any time after the initial term, without cause, by giving at least one hundred eighty (180) days prior written notice to the other party.

7.3 Default of Agreement. If either party fails to comply with or perform when due any term or condition of this Agreement, the other party shall notify the defaulting party of its default in writing, and the defaulting party shall have thirty (30) days to cure the default. If the default is not cured within said thirty (30) day period, the non-defaulting party may declare, with thirty (30) days additional notice that this Agreement is terminated. *PROVIDER*'s failure to maintain *ANTHEM*'s credentialing standards, other than those listed in the Termination With Cause provision of this Agreement, shall constitute default under this provision.

7.4 Termination With Cause. This Agreement shall terminate automatically and immediately: (1) in the event either party 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 are lost or voluntarily surrendered; (2) in the event *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 to provide Health Services are lost or voluntarily surrendered; (3) in the event *PROVIDER* and/or its/his/her employees, contractors, subcontractors, or agents are identified as ineligible persons on the General Services Administration list of Parties Excluded from Federal Programs and/or HHS/OIG List of Excluded Individuals/Entities, and in the case of an employee, contractor, subcontractor or agent fails to remove such individual from responsibility for, or involvement with, the *PROVIDER*'s business operations related to this Agreement; (4) in the event either party commits a fraud or otherwise makes any material misstatements or omissions on any documents which he/she/it submits to the other party or to a third party; (5) in the event *PROVIDER* fails to maintain the minimum standards of quality set forth in the Quality Improvement Program beyond the time parameters established in any corrective action/rehabilitation plan set forth in the Quality Improvement

Program; (6) in the event either party's insurance coverage as required by this Agreement lapses or level of coverage is reduced below acceptable levels for any reason; (7) upon notice by *ANTHEM*, in the event *PROVIDER* is convicted of a felony or misdemeanor; or (8) upon notice by *ANTHEM*, in the event *ANTHEM* reasonably believes that *PROVIDER*'s conduct or inaction jeopardizes the well-being of patients or that *PROVIDER* has been abusive to a Covered Individual. *ANTHEM* reserves the right to terminate individual Providers under the terms hereof while continuing the Agreement for one or more Providers in a group.

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

7.6 Termination - Regulatory Issues. This Agreement and any attachments or addenda to this Agreement may be terminated by either party if any portion of them are determined to be contrary to laws or are materially affected by the federal or state statutes or regulations, or court or agency interpretations of said statutes and regulations, including antitrust laws. This Agreement and any attachments or addenda to this Agreement shall terminate under said circumstances after thirty (30) days written notice to the other party, provided that the termination shall be effective before the new statute or regulation affecting this Agreement and any attachments or addenda to this Agreement is in effect. Before exercising any right to terminate under this provision, the parties shall make their best 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.

7.7 Termination - Participation Attachments. Except for *PROVIDER*'s participation in *ANTHEM*'s Traditional products, *ANTHEM* or *PROVIDER* may terminate, without cause, *PROVIDER*'s participation in one or more Network(s) designated on the Network Participation Attachment or one or more Participation Attachment(s) attached to this Agreement without affecting this Agreement, amendments, addenda, or other attachments, or *PROVIDER*'s participation in other Network(s), by giving at least one hundred eighty (180) days prior written notice of termination to the other party. Termination of *PROVIDER*'s participation in *ANTHEM*'s Traditional products can only occur upon the termination of this Agreement.

7.8 Termination - Attachments and Addenda. All attachments and addenda to this Agreement shall terminate automatically upon termination of this Agreement.

7.9 Notice of Termination. To the extent required by an accrediting body, *PROVIDER* will provide timely notice to affected Covered Individual(s) of termination of this Agreement or termination of an individual Network participation.

ARTICLE VIII
GENERAL PROVISIONS

8.1 Abandonment. Nothing herein shall be construed as authorizing or permitting *PROVIDER* to abandon any patient.

8.2 Amendment. *ANTHEM* retains the right to amend this Agreement, the applicable Anthem Rate, the Provider Manual, any attachments or addenda, by providing notice to *PROVIDER* not less than forty-five (45) days before the effective date of the amendment. If *PROVIDER* decides not to accept the amendment, *PROVIDER* has the right to terminate this Agreement by providing written notice not later than fifteen (15) days from *PROVIDER*'s receipt of the proposed amendment from *ANTHEM*. *PROVIDER*'s termination shall take effect sixty (60) days from the date *PROVIDER* has provided notice of his/her/its intention to terminate pursuant to this provision. Failure of *PROVIDER* to provide such notice to *ANTHEM* within the time frames described herein will constitute acceptance of the amendment by *PROVIDER*. In the event that *PROVIDER* serves notice of termination pursuant to this provision, the proposed amendment shall not go into effect as to *PROVIDER*. Except in the event of an emergency, if *PROVIDER* elects to terminate pursuant to this provision, prior to providing Health Services to a Covered Individual, *PROVIDER* shall notify the Covered Individual that the Agreement has been or will be terminated.

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

8.4 Change in Status. *ANTHEM* may, if in *ANTHEM*'s judgment the circumstances require such, limit this Agreement to *PROVIDER*'s operations or business or corporate form, status or structure in existence prior to the occurrence of any of the following events: (1) *PROVIDER* sells all or substantially all of its assets; (2) *PROVIDER* transfers control of its management or operations to any third party; or (3) *PROVIDER* acquires or controls any other medical facility for service or is in any manner otherwise acquired or controlled by any other party, whether by purchase, merger, consolidation, alliance, joint venture, partnership, association, material expansion or *PROVIDER* otherwise, materially changes its catchment area, service area, business or operations, or business or corporate form or status. *PROVIDER* shall provide *ANTHEM* thirty (30) days prior written notice of: (1) change in Providers who are part of the group, however, any new providers must meet *ANTHEM*'s credentialing standards prior to being designated as a Network Provider; (2) any new physical location, tax identification number, mailing address, or similar demographic information; or (3) change in operations, business or corporate form as described above.

8.5 Counterparts. This Agreement may be executed in any number of counterparts, each of which shall be deemed an original, and all of which together shall constitute one and the same instrument.

8.6 Descriptive Headings. The headings contained in this Agreement are for reference purposes only and shall not affect in any way the meaning or interpretation of this Agreement.

8.7 Entire Agreement. This Agreement and any amendments, addenda, attachments constitute the entire understanding between the parties and supersedes all prior oral or written agreements or understanding between them with respect to the matters provided for herein. With respect to the Plans covered by this Agreement, this Agreement supersedes any agreement in effect as of the effective date of this Agreement between or among *PROVIDER* and Plan with respect to *PROVIDER's* participation in such Plans, except with respect to the rates of reimbursement that are applicable to the services furnished by *PROVIDER* to Covered Individuals prior to such effective date. In the case of any inconsistency with this Agreement for any of the following, the order of precedence will be as follows: federal law, state law, State Specific Provision Attachment, Health Benefit Plan, changes subsequent to the Effective Date of this Agreement by amendment, changes subsequent to the Effective Date of this Agreement to *ANTHEM's* policies, procedures, manuals and programs.

8.8 Force Majeure. Neither party shall be deemed to be in violation of this Agreement if such party is prevented from performing any of its obligations hereunder for any reason beyond its reasonable control, including without limitation, acts of God, acts of any public enemy, floods, statutory or other laws, regulations, rules, or orders of the federal, state, or local government or any agency thereof.

8.9 Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the state where *ANTHEM* is located, unless such state laws are otherwise preempted by federal law. However, coverage issues specific to a Health Benefit Plan or to the delivery of Health Services are governed by the state laws where the Health Benefit Plan is issued, unless such state laws are otherwise preempted by federal law. Any legal action or proceeding with respect to this Agreement or any document related hereto, or any action to enforce or challenge an arbitration award, may be brought in the courts in the state *ANTHEM* is located and/or Federal Court as applicable, in the city or county in which *ANTHEM* has its principal executive offices, and, by execution and delivery of this Agreement, each party hereby accepts for itself and in respect of its property, generally and unconditionally, the jurisdiction of such courts. The parties irrevocably waive any objection, including any objection to the laying of venue or based on the grounds of forum non conveniens, which any of them may now or hereafter have to the bringing of any such action or proceeding in such respective jurisdictions. Each party irrevocably consents to service of process issued from any such court in any such action or proceeding.

8.10 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 a Plan utilizes a designee, which in such event shall give rights only within the scope of such designation and to the extent specified in the Hold Harmless provision of this Agreement.

8.11 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, or any other health delivery or insurance program. *PROVIDER* acknowledges that *ANTHEM* does not warrant or guarantee that *PROVIDER* will be utilized by any particular number of Covered Individuals.

8.12 Notice. Any notice required to be given pursuant to the terms and provisions of this Agreement shall be in writing and shall be delivered by electronic mail, by facsimile, by hand or sent postage prepaid by regular mail,

to the parties at the addresses set forth on the signature page, except that notice of breach of contract or termination shall be in writing and either hand delivered or sent postage prepaid by certified mail, return receipt requested, to the parties at the addresses set forth on the signature page. Such address may be changed from time to time by written notice to the other party. Notwithstanding the foregoing, *ANTHEM* may post updates to policies, programs and procedures on its web site. Notice shall be effective upon the marked date with the corresponding delivery method noted above.

8.13 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.

8.14 Replacement Agreements. From time to time, *ANTHEM* may issue a replacement agreement which represents this Agreement, together with any amendments, addenda, attachments, appendices, and exhibits. The replacement agreement shall not contain any new provisions. *PROVIDER* agrees to execute the replacement agreement without reopening negotiations.

8.15 Waiver. Neither the waiver by either of the parties of a breach or a default 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 or default of any of the provisions of this Agreement.

8.16 Definitions. Unless otherwise specifically noted, the definitions set forth in this Agreement will have the same meaning when used in the Provider Manual and Participation Attachments.

8.17 Compliance. Both parties shall comply with all requirements of the law relating to their obligations under this Agreement, and maintain in effect all permits, licenses, and governmental and board authorizations and approvals as necessary for business operations.

8.18 BCBSA Affiliation. *PROVIDER* hereby expressly acknowledges his/her/its understanding that this Agreement constitutes a contract between *PROVIDER* and *ANTHEM*, that *ANTHEM* is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans ("Association"), permitting *ANTHEM* to use the Blue Cross and Blue Shield Service Marks in the state where *ANTHEM* is located, and that *ANTHEM* is not contracting as the agent of the Association. *PROVIDER* further acknowledges and agrees that it has not entered into this Agreement based upon representations by any person other than *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 its own materials are subject to review and approval by *ANTHEM*. This paragraph shall not create any additional obligations whatsoever on the part of *ANTHEM* other than those obligations created under other provisions of this Agreement.

8.19 Dispute Resolution. Except as provided below or superseded by applicable law, any controversy, claim or dispute ("Dispute") between or involves the parties must be resolved or settled in accordance with this Provision 8.19. If the Dispute pertains to a matter which is generally administered by a Plan's programs or policies, such as a credentialing, utilization management or quality improvement program, the procedures set forth as part of that policy or program must be fully exhausted by *PROVIDER* before *PROVIDER* may pursue the dispute resolution procedures hereafter contained in this Provision 8.19.

8.19.1 If the Dispute is not resolved to the reasonable satisfaction of a party after exhausting the procedures under the Plan's program or policy, either party may request, in writing, within the thirty (30) day period following the date on which the final determination is made under the applicable program or policy that the parties meet and confer in good faith to resolve the Dispute. If no program or policy pertains to the subject matter of the Dispute, either party may request, in writing, such a meeting at any time after the applicable business personnel of the parties are unable to reach an acceptable resolution of the Dispute. After the making of any such request, the parties will meet and confer, in good faith, at a time and place mutually acceptable to them, in an effort to resolve the Dispute.

8.19.2 In the event that the Dispute is not satisfactorily resolved pursuant to Provision 8.19.1 above within the thirty (30) day period following the date on which the request for a meeting was given, the

Dispute shall only be pursued by either or both parties through binding arbitration conducted in accordance with the Commercial Arbitration Rules of the American Arbitration Association, except as set forth below or otherwise agreed in writing by the parties. If a party intends to pursue arbitration of the Dispute, such person must notify the other(s), in writing, of its intent to arbitrate the Dispute at least thirty (30) days before submitting the Dispute to binding arbitration. Such written notice must be given prior to the date when under relevant law the institution of a legal, equitable or administrative proceeding or action with respect to the Dispute would be barred under the applicable statute of limitations (or a similar limitation). Arbitration under this provision will be final and binding, and conducted in a mutually agreeable location. Each person shall bear its, his or her respective arbitration expenses and each shall pay its, his or her pro rata portion of the arbitrator's charges and expenses, unless otherwise required by law. The arbitrator(s) may construe or interpret, but shall not vary or ignore, the provisions of this Agreement and shall be bound by and follow controlling law. The arbitrator(s) shall not award punitive or exemplary damages of any kind, except those expressly authorized by a statute that is directly applicable to the Dispute. 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 pursue, on a class basis, any Dispute. The parties hereby consent to the jurisdiction of the courts in the state(s) in which *PROVIDER* practices and of the United States District Courts in the state(s) in which *PROVIDER* practices for injunctive, specific enforcement, or other relief in furtherance of the arbitration proceedings or to enforce judgment of the award in such arbitration proceeding. Judgment on the award rendered may be entered in any court having jurisdiction thereof.

8.19.3 Notwithstanding the foregoing, a Dispute involving the termination of *PROVIDER* is not subject to this Provision 8.19, but is subject to the hearing and appeal procedures referenced in the other applicable provisions of this Agreement, if any, and neither party is prohibited from seeking injunctive relief to prevent, or upon the occurrence of, any actual or perceived breach of or default under Provision 4.2 of this Agreement.

8.19.4 In the event any provision of this Provision 8.19 will render invalid or unenforceable the other provisions of this Provision 8.19, such provision will be construed by limiting or reducing it as necessary for this Provision 8.19 to be enforceable, or such provision will be removed if it cannot be limited or reduced for this Provision 8.19 to be enforceable, and the remaining provisions of this Provision 8.19 will remain in full force and effect. This provision survives the termination of this Agreement.

8.20 Statutory Responsibility. Unless otherwise set forth in the Health Benefit Plan or required by statute or regulation, the applicable Statutory Responsibility provision shall be as set forth in the State Specific Provisions Attachment.

8.21 Statutory/Regulatory Compliance. From time to time legislative bodies, boards, departments or agencies may enact or issue laws, rules, or regulations pertinent to this Agreement. In such event, and upon written notice to *PROVIDER* by Plan, *PROVIDER* agrees to immediately abide by all said laws, rules, or regulations and to cooperate with Plan to carry out any responsibilities placed upon Plan or *PROVIDER* by said laws, rules, or regulations, subject to *PROVIDER*'s right to terminate, as set forth under this Agreement. In the event of a conflict between this provision and any other provision in this Agreement, this provision shall control.

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

Each party to this Agreement 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.

PROVIDER LEGAL NAME Centrality Behavior Support Training, LLC
(Must match Provider Name on front page of the Agreement)

By: _____ Signature _____ Date

Printed: Meagan Pant Name _____ owner Title

Address: 3385 E Southport Rd. Suite F Street Indianapolis, IN 46227 City State Zip

Tax Identification Number (TIN) 46-4197524

As of the effective date of this Agreement, Provider will be designated as Participating Provider in the following Programs:

CENTRAL REGION

- [X] **Blue Priority/Priority**
- [X] **Blue Preferred Primary/Preferred Primary**
- [X] **Blue Access/Access**
- [ ] **Healthy Indiana Plan**
- [ ] **Medicare Advantage HMO**
- [X] **Blue Priority Plus/Priority Plus**
- [X] **Blue Preferred Primary Plus/Preferred Primary Plus**
- [X] **Blue Traditional/Traditional**
- [ ] **Medicaid**
- [ ] **Medicare Advantage PPO**

ATTACHMENTS:

- [ ] Audiology Provider Attachment
- [ ] Employee Assistance Professional Service Attachment
- [X] Employed Health Professional Practitioner Attachment
- [X] Health Maintenance Organization Participation Attachment
- [ ] Independent Health Professional Practitioner Attachment
- [ ] Healthy Indiana Plan Participation Attachment
- [ ] Medicaid Participation Attachment
- [ ] Medicare Advantage Participation Attachment
- [X] Preferred Provider Organization Participation Attachment
- [X] Primary Care Provider Attachment
- [X] Specialty Care Provider Attachment
- [X] Traditional Participation Attachment

Anthem Insurance Companies, Inc. d/b/a
Anthem Blue Cross and Blue Shield

ANTHEM INTERNAL USE ONLY

THE EFFECTIVE DATE OF THIS AGREEMENT IS: _____

By: _____ Signature _____ Date

Printed: David T. Lee, MD Name VP Provider Engagement & Contracting Title

Address: P.O. Box 7171 Street Indianapolis IN 46207-7171 City State Zip

STATE SPECIFIC PROVISIONS ATTACHMENT
TO THE
ANTHEM BLUE CROSS AND BLUE SHIELD
PROFESSIONAL PROVIDER AGREEMENT

This is a State Specific Provisions Attachment to the Anthem Blue Cross and Blue Shield Professional Provider Agreement (the "Agreement"), entered into by and between *ANTHEM* and *PROVIDER* and is incorporated into the Agreement. These provisions are specific to the individual states and are required either by Plan, by statute, or by regulation.

OHIO STATE SPECIFIC PROVISIONS

The following provisions are required terms and conditions for certain fully insured Health Benefit Plans that are issued in the State of Ohio.

Effective October 1, 1998, the following Emergency definition shall apply to all Health Maintenance Organization/Health Insuring Corporation (HMO/HIC) Health Benefit Plans issued in the State of Ohio, unless otherwise set forth by statute, regulation, or the Covered Individual's Health Benefit Plan.

1.11 "Emergency" or "Emergency Services" is defined as a medical condition that manifests itself by such 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 any of the following: (1) placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

The following Medical Necessity definition shall apply to all Health Benefit Plans issued in the State of Ohio, unless otherwise set forth by statute, regulation, or the Covered Individual's Health Benefit Plan.

1.14 "Medically Necessary" or "Medical Necessity", unless otherwise set forth in the Health Benefit Plan or as otherwise required by statute or by regulation, means that a Health Service is compensable, as determined by *ANTHEM* or another entity with responsibility for medical management, for the treatment of an injury, sickness, or other health condition and is: (1) appropriate and consistent with the diagnosis or symptoms, and consistent with accepted medical standards; (2) not chiefly custodial in nature; (3) not investigational, experimental or unproven; (4) not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment and as to institutional care, cannot be provided in any other setting, such as a physician's office or the outpatient department of a hospital without adversely affecting the patient's condition; and (5) not provided only as a convenience to the Covered Individual or professional provider or health care facility.

The following Statutorily Defined Terms provision shall apply to all HMO/HIC Health Benefit Plans issued in the State of Ohio, unless otherwise set forth by statute, regulation, or the Covered Individual's Health Benefit Plan. Additionally, those terms used in this Agreement and that are defined by O.R.C. §1751.01 et. seq., shall be construed in a manner consistent with the definitions in O.R.C. §1751.01 et. seq.

The following Continuance of Care-Insolvency provision shall apply to all HMO/HIC Health Benefit Plans issued in the State of Ohio, unless otherwise set forth by statute, regulation, or the Covered Individual's Health Benefit Plan.

3.14 Continuance of Care-Insolvency. In the event of the Plan's insolvency or other cessation of operations, *PROVIDER* agrees to continue to provide Covered Services to Covered Individuals as needed to complete Medically Necessary procedures commenced but unfinished at the time of Plan's insolvency or other cessation of operations. The completion of a Medically Necessary procedure commenced but unfinished at the time of the Plan's insolvency or cessation of operations includes the rendition of all Covered Services that constitute Medically Necessary follow-up care for that procedure. If a Covered Individual is receiving Medically Necessary inpatient care at a hospital or facility at the time of Plan's insolvency or other cessation of operations, *PROVIDER* agrees to continue to provide Covered Services to Covered Individuals as needed to complete Medically Necessary care until the Covered Individual is discharged from the hospital or facility or until there is a determination by the Covered Individual's attending physician that inpatient care is no longer medically indicated for the Covered Individual. However, nothing in this provision precludes Plan from engaging in utilization review as described in the Covered Individual's Health Benefit Plan. No provider is required to continue to provide any Covered Services after the occurrence of any of the following: (1) the end of the Covered Individual's period of coverage for which the premium has been paid; (2) the end of the thirty (30) day period following the entry of a liquidation order under Chapter 3903 of the

Revised Code; (3) the Covered Individual obtains equivalent coverage with another Health Insuring Corporation or insurer, or the Covered Individual's employer obtains such coverage; (4) the Covered Individual or the Covered Individual's employer terminates coverage under the contract; and (5) a liquidator effects a transfer of the Plan's obligations under the contract under division (A) (8) of Section 3903.21 of the Revised Code. This provision shall survive termination of this Agreement, regardless of the reason for termination, including insolvency of the Plan, and shall be for the benefit of Covered Individuals.

The following Statutory Responsibility provision applies to all HMO/HIC Health Benefit Plans issued in the State of Ohio, unless otherwise set forth by statute, regulation, or the Covered Individual's Health Benefit Plan.

8.20 Statutory Responsibility. *ANTHEM* and/or Plan has statutory responsibility to monitor and oversee the offering of Covered Services to Covered Individuals.

COMMONWEALTH OF KENTUCKY STATE SPECIFIC PROVISIONS

The following provisions are required terms and conditions for certain fully insured Health Benefit Plans that are issued in the Commonwealth of Kentucky.

The following Emergency definition shall apply to all Health Benefit Plans issued in the Commonwealth of Kentucky, unless otherwise set forth by statute, regulation, or the Covered Individual's Health Benefit Plan.

1.11 "Emergency" or "Emergency Services" is defined as a medical condition that manifests itself by such acute symptoms of sufficient severity, including severe pain, that a prudent layperson could reasonably expect the absence of immediate medical attention to result in any of the following: (1) placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part. With respect to a pregnant woman who is having contractions, "Emergency" means: (1) a situation in which there is inadequate time to effect a safe transfer to another hospital before delivery; or (2) a situation in which transfer may pose a threat to the health or safety of the woman or the unborn child.

The following Medical Necessity definition shall apply to all Health Benefit Plans issued in the Commonwealth of Kentucky, unless otherwise set forth by statute, regulation, or the Covered Individual's Health Benefit Plan.

1.14 "Medically Necessary" or "Medical Necessity" unless otherwise set forth in the Health Benefit Plan, means a Health Service furnished by a provider that is required to identify or treat the Covered Individual's condition, illness or injury and which the Plan determines is: (1) consistent with the symptom or diagnosis and treatment of the Covered Individual's condition, disease, ailment, or injury; (2) appropriate with regard to standards of good medical practice; (3) not solely for the convenience of the Covered Individual or provider; (4) the most appropriate supply or level of service which can be safely provided to the Covered Individual; and (5) not investigational, experimental or unproven. When applied to the care of an inpatient, it means that the Covered Individual's medical symptoms or conditions require that the services cannot be safely provided to the Covered Individual as an outpatient.

The following Provider Subcontractors provision shall apply to all Health Benefit Plans issued in the Commonwealth of Kentucky, unless otherwise set forth by statute, regulation, or the Covered Individual's Health Benefit Plan.

2.19 Provider Subcontractor. *PROVIDER* shall provide *ANTHEM* with at least sixty (60) days prior notice of any Health Services subcontractors with which *PROVIDER* may contract to perform *PROVIDER*'s duties and obligations under this Agreement. *PROVIDER* shall provide *ANTHEM* with a sample copy of any agreement between *PROVIDER* and such subcontractors at least sixty (60) days prior to the commencement of such subcontractor(s)' services, for the purpose of *ANTHEM*'s filing such agreement with the Kentucky Office of Insurance, as required by KRS 304.17A-527(1)(e). *PROVIDER* shall require such subcontractors to abide by the terms and conditions of this Agreement, including the provisions of KRS 304.17A, and shall indemnify *ANTHEM*, Plan, and Covered Individuals for any failure of any subcontractor to so comply.

The following Plan Payment Time Frames provision shall be added to the Agreement, and shall be given effect unless otherwise required by statute or regulation.

3.8 Plan Payment Time Frames. *ANTHEM* shall require Plans or their designees to make payment or arrange for payment for all complete and accurate Claims for Covered Services submitted by *PROVIDER* in accordance and within the time frames established by KRS 304.17A-702 or KRS 304.12-235 as applicable or other applicable state or federal statute or regulation. For Claims that are neither subject to KRS 304.17A-702 nor KRS 304.12-235, nor other applicable state or federal statute or regulation, *ANTHEM* shall require Plans or

their designees to make a good faith attempt to make payment or arrange for payment for all such complete and accurate Claims for 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 *ANTHEM*'s payment liability, if any, because of issues such as coordination of benefits, subrogation or verification of coverage.

The following Overpayment Refunds provision shall be added to the Agreement, and shall be given effect unless otherwise required by statute or regulation.

3.10 Overpayment Refunds. *PROVIDER* shall refund to Plan all duplicate or erroneous Claim payments regardless of the cause, with or without request from Plan. In lieu of a refund, Plan may offset future Claim payments in accordance with and within the time frames established by KRS 304.17A-714, or other applicable state or federal statute or regulation. For Claims that are not subject to KRS 304.17A-714 or other applicable state or federal statute or regulation, Plan may offset future Claim payments at any time.

The following Continuance of Care-Termination provision shall be added to the Agreement, and shall be given effect unless otherwise required by statute or regulation.

3.13 Continuance of Care-Termination. *PROVIDER* shall, upon termination of this Agreement for reasons other than a quality of care issue or fraud, continue to provide and be compensated for Covered Services to Covered Individuals under the terms and conditions of this Agreement until such Covered Individuals are discharged, or the active course of treatment is completed, whichever time is greater, and in the case of a pregnant woman, *PROVIDER* shall continue to provide services through the end of the post-partum period if the pregnant woman is in her fourth or later month of pregnancy. For the purposes of this provision, "discharge" shall mean the Covered Individual's physical release from an in-patient facility. In addition, *PROVIDER* agrees to accept compensation under this Agreement for those Covered Individuals receiving outpatient treatment at the time of termination of the Agreement for which compensation for such outpatient treatment was contemplated on a case rate or other financial arrangement that constitutes a prepayment arrangement. This Continuance of Care-Termination provision shall survive termination of this Agreement with respect to Covered Services rendered under this Agreement and commenced during the time this Agreement is in effect, regardless of the reason for termination, including insolvency of the Plan but excluding a quality of care issue or fraud, and shall be for the benefit of Covered Individuals.

The following Request for Fees provision shall be added to the Agreement, and shall be given effect unless otherwise required by statute or regulation.

3.18 Request for Fees. Upon request by *PROVIDER*, Plan shall provide *PROVIDER* with specific reimbursement fees associated with billing codes that are applicable to the services provided and compensation *PROVIDER* receives under this Agreement, if not otherwise set forth in this Agreement. Plan shall provide such fee information within thirty (30) days of *PROVIDER*'s request.

The following Termination-Participation Attachments provision shall be added to the Agreement, and shall be given effect unless otherwise required by statute or regulation.

7.7 Termination-Participation Attachments. Except for *PROVIDER*'s participation in *ANTHEM*'s Traditional products, *PROVIDER* may terminate, without cause, *PROVIDER*'s participation in one or more Network(s) designated on the Network Participation Attachment or one or more Participation Attachment(s) attached to this Agreement without affecting this Agreement, amendments, addenda, or other attachments, or *PROVIDER*'s participation in other Network(s), by giving at least one hundred eighty (180) days prior written notice of termination to *ANTHEM*. Termination of *PROVIDER*'s participation in *ANTHEM*'s Traditional products can only occur upon the termination of this Agreement.

INDIANA STATE SPECIFIC PROVISIONS

The following provisions are required terms and conditions for certain fully insured Health Benefit Plans that are issued in the State of Indiana.

The following Emergency definition shall apply to all HMO Health Benefit Plans that are issued in the State of Indiana, unless otherwise set forth by statute, regulation, or the Covered Individual's Health Benefit Plan.

1.11 "Emergency" or "Emergency Services" is defined as a medical condition that manifests itself by such 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 any of the following: (1) placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

The following Medical Necessity definition shall apply to all Health Benefit Plans issued in the State of Indiana, unless otherwise set forth by statute, regulation, or the Covered Individual's Health Benefit Plan.

1.14 "Medically Necessary" or "Medical Necessity", unless otherwise set forth in the Health Benefit Plan or as otherwise required by statute or by regulation, means that a Health Service is compensable, as determined by *ANTHEM* or another entity with responsibility for medical management, for the treatment of an injury, sickness, or other health condition and is: (1) appropriate and consistent with the diagnosis or symptoms, and consistent with accepted medical standards; (2) not chiefly custodial in nature; (3) not investigational, experimental or unproven; (4) not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment and as to institutional care, cannot be provided in any other setting, such as a physician's office or the outpatient department of a hospital without adversely affecting the patient's condition; and (5) not provided only as a convenience to the Covered Individual or professional provider or health care facility.

The following Continuation of Care-Termination provision shall apply to all Health Benefit Plans issued in the State of Indiana, unless otherwise set forth by statute, regulation, or the Covered Individual's Health Benefit Plan.

3.13 Continuation of Care-Termination. In the event that this Agreement is terminated for any reason other than the grounds set forth in the Termination With Cause provision of the Agreement, a Covered Individual may elect to continue to receive care from *PROVIDER* for a period of time as set forth below following termination of this Agreement. Such continuation period shall run for up to sixty (60) days following termination, or, if *PROVIDER* is providing pregnancy-related care to a Covered Individual who is in her second or third trimester of pregnancy at the time this Agreement terminates, throughout the term of that pregnancy and through the postpartum period (six weeks post-delivery). In addition to the foregoing, *PROVIDER* agrees to continue care to any Covered Individual receiving an active course of treatment for an acute episode of chronic illness or acute medical condition until the later of: (a) and additional thirty (30) days (a total of ninety (90) days following termination); or (b) completion of the course of treatment. During the applicable continuation period, *PROVIDER* shall continue to provide care to those Covered Individuals who have elected continuation in compliance with all provisions of this Agreement and of any amendments, attachments, and incorporated documents hereto. Such compliance shall include without limitation acceptance of the applicable Anthem Rate as required in the Payment in Full provision of the Agreement and forbearance from balance billing as required in the Hold Harmless provision of the Agreement.

Provision 3.14 - Continuance of Care-Insolvency is not applicable to services rendered to Covered Individuals enrolled in Health Benefit Plans issued in the State of Indiana, unless otherwise set forth by statute, regulation, or the Covered Individual's Health Benefit Plan.

Anthem Insurance Companies, Inc. d/b/a
Anthem Blue Cross and Blue Shield

TRADITIONAL
PARTICIPATION ATTACHMENT TO THE
ANTHEM BLUE CROSS AND BLUE SHIELD
PROFESSIONAL PROVIDER AGREEMENT

This is an Attachment to the Anthem Blue Cross and Blue Shield Professional Provider Agreement ("Agreement") entered into by and between *ANTHEM* and *PROVIDER* and is incorporated into the Agreement.

1. *PROVIDER* agrees to be a Network Provider in Plan's Traditional product and/or programs and provide Covered Services to Covered Individuals.

2. For Covered Services provided by or on behalf of *PROVIDER* to Covered Individuals, *PROVIDER* agrees to accept payment in accordance with the applicable Traditional Plan Fee Schedule.

   Notwithstanding the foregoing, *ANTHEM* reserves the right to price Not Otherwise Classified (NOC) codes in accordance with its NOC reimbursement policies.

3. In the event of a conflict between the terms and conditions of this Attachment and the terms and conditions of the Agreement, the terms and conditions of this Attachment shall control. Except as set forth herein, all other terms and conditions of the Agreement remain in full force and effect.

4. *ANTHEM* agrees to accept *PROVIDER* agrees to participate in the following Plan Traditional Network(s) designated below:

CENTRAL REGION

[X] **Blue Traditional/Traditional**

THIS ATTACHMENT IS EFFECTIVE: _____

PREFERRED PROVIDER ORGANIZATION
PARTICIPATION ATTACHMENT TO THE
ANTHEM BLUE CROSS AND BLUE SHIELD
PROFESSIONAL PROVIDER AGREEMENT

This is an 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.

1. *PROVIDER* agrees to be a Network Provider in the Plan Preferred Provider Organization ("PPO") Network(s) designated below.

2. For purposes of this Participation Attachment, "Plan PPO" refers to any and all PPO Networks established by Plan.

3. For Covered Services provided by or on behalf of *PROVIDER* to a Covered Individual who is enrolled in a Plan PPO product and/or program that is supported by a Network designated below, and thus *PROVIDER* is a Network Provider for that specific Plan PPO product and/or program, *PROVIDER* agrees to accept compensation in accordance with the applicable Plan Fee Schedule established for that Network or established for a specific account.

   Notwithstanding the foregoing, *ANTHEM* reserves the right to price Not Otherwise Classified (NOC) codes in accordance with its NOC reimbursement policies.

4. For Covered Services provided by or on behalf of *PROVIDER* to a Covered Individual who is enrolled in a Plan PPO product and/or program that is NOT supported by a Network designated below, and thus *PROVIDER* is not a Network Provider for that specific Plan PPO product and/or program, *PROVIDER* agrees to accept compensation in accordance with the Out of Network Compensation provision of the Agreement, or as otherwise provided for in the Covered Individual's Health Benefit Plan.

5. In the event of a conflict between the terms and conditions of this Attachment and the terms and conditions of the Agreement, the terms and conditions of this Attachment shall control. Except as set forth herein, all other terms and conditions of the Agreement remain in full force and effect.

6. *ANTHEM* agrees to accept and *PROVIDER* agrees to participate in the following Plan PPO Network(s) as designated below:

CENTRAL REGION

X **Blue Access/Access**

THIS ATTACHMENT IS EFFECTIVE: _____

HEALTH MAINTENANCE ORGANIZATION
A/K/A/ HEALTH INSURING CORPORATION
PARTICIPATION ATTACHMENT TO THE
ANTHEM BLUE CROSS AND BLUE SHIELD
PROFESSIONAL PROVIDER AGREEMENT

This is an Attachment to the Anthem Blue Cross and Blue Shield Professional Provider Agreement ("Agreement"), entered into by and between *ANTHEM* and *PROVIDER* and is incorporated into the Agreement.

1. *PROVIDER* agrees to be a Network Provider in the Plan Health Maintenance Organization/Health Insuring Corporation ("HMO/HIC") Network(s) designated below.

2. For purposes of this Participation Attachment, Plan HMO/HIC refers to any and all HMO/HIC Networks established by Plan.

3. For Covered Services provided by or on behalf of *PROVIDER* to a Covered Individual who is enrolled in a Plan HMO/HIC product and/or program that is supported by a Network designated below, and thus *PROVIDER* is a Network Provider for that specific Plan HMO/HIC product and/or program, *PROVIDER* agrees to accept compensation in accordance with the applicable Plan Fee Schedule for that Network.

   Notwithstanding the foregoing, *ANTHEM* reserves the right to price Not Otherwise Classified (NOC) codes in accordance with its NOC reimbursement policies.

4. For Covered Services provided by or on behalf of *PROVIDER* to a Covered Individual who is enrolled in a Plan HMO/HIC product and/or program that is NOT supported by a Network designated below, and thus *PROVIDER* is not a Network Provider for that specific Plan HMO/HIC product and/or program, *PROVIDER* agrees to accept compensation in accordance with the Out of Network Compensation provision of the Agreement, or as otherwise provided for in the Covered Individual's Health Benefit Plan.

5. This provision intentionally left blank.

6. In the event of a conflict between the terms and conditions of this Attachment and the terms and conditions of the Agreement, the terms and conditions of this Attachment shall control. Except as set forth herein, all other terms and conditions of the Agreement remain in full force and effect.

7. *ANTHEM* agrees to accept and *PROVIDER* agrees to participate in the following Plan HMO/HIC Network(s) designated below:

CENTRAL REGION

[X] **Blue Priority/Priority - HSA** _____

[X] **Blue Priority Plus/Priority Plus - HSA** _____

[X] **Blue Preferred Primary/Preferred Primary**

[X] **Blue Preferred Primary Plus/Preferred Primary Plus**

THIS ATTACHMENT IS EFFECTIVE: _____

PRIMARY CARE PROVIDER
ATTACHMENT TO THE
ANTHEM BLUE CROSS AND BLUE SHIELD
PROFESSIONAL PROVIDER AGREEMENT

This is an Attachment to the Anthem Blue Cross and Blue Shield Professional Provider Agreement ("Agreement"), entered into by and between *ANTHEM* and *PROVIDER* and is incorporated into the Agreement.

1. *PROVIDER* is designated as a Primary Care Provider ("PCP" or "Primary Care Provider") for those Network(s) designated on the Participation Attachment.

2. As a Primary Care Provider, *PROVIDER* agrees to be primarily responsible for managing and coordinating the overall health care needs of Covered Individuals.

3. In the event of a conflict between the terms and conditions of this Attachment and the terms and conditions of the Agreement, the terms and conditions of this Attachment shall control. Except as set forth herein, all other terms and conditions of the Agreement remain in full force and effect.

THIS ATTACHMENT IS EFFECTIVE: _____

SPECIALTY CARE PROVIDER
ATTACHMENT TO THE
ANTHEM BLUE CROSS AND BLUE SHIELD
PROFESSIONAL PROVIDER AGREEMENT

This is an Attachment to the Anthem Blue Cross and Blue Shield Professional Provider Agreement ("Agreement"), entered into by and between *ANTHEM* and *PROVIDER* and is incorporated into the Agreement.

1. *PROVIDER* is designated as a Specialty Care Provider ("SCP" or "Specialty Care Provider") for those Network(s) designated on the Participation Attachment(s).

2. Upon your notice of Termination Without Cause, paragraph 7.2, *PROVIDER* is required to notify Covered Individual(s) sixty (60) days prior to your effective date of termination with *ANTHEM.*

3. Except in case of an Emergency, or as otherwise set forth in the Covered Individual's Health Benefit Plan, or required by statute or regulation, prior to treating a Covered Individual, Specialty Care Provider agrees to obtain a referral, in accordance with Covered Individual's Health Benefit Plan, from a Primary Care Provider ("PCP") who is primarily responsible for providing or authorizing the professional services set forth in the Health Benefit Plan.

4. In the event of a conflict between the terms and conditions of this Attachment and the terms and conditions of the Agreement, the terms and conditions of this Attachment shall control. Except as set forth herein, all other terms and conditions of the Agreement remain in full force and effect.

ATTACHMENT IS EFFECTIVE: _____

EMPLOYED HEALTH PROFESSIONAL PRACTITIONER ATTACHMENT
TO THE
ANTHEM BLUE CROSS AND BLUE SHIELD
PROFESSIONAL PROVIDER AGREEMENT

This is an Attachment to the Anthem Blue Cross and Blue Shield Professional Provider Agreement ("Agreement"), entered into by and between *ANTHEM* and *PROVIDER* and is incorporated into the Agreement.

1. "Health Professional Practitioner" means any state or nationally licensed or certified health professional for which *ANTHEM* maintains a compensation schedule including but not limited to, Certified Nurse Practitioners, Certified Nurse Midwives, Certified Registered Nurse Anesthetists, Clinical Nurse Specialists, Physician Assistants.

2. "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 (HIPPA).

3. 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.

4. This provision intentionally left blank.

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

6. 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*" or "Provider" throughout the Agreement and all Attachments thereto shall be construed to include Health Professional Practitioners.

7. Health Professional Practitioners shall be included in those networks designated below. 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.

8. 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.

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

10. Plan shall reimburse and *PROVIDER* agrees to accept compensation in accordance with the Health Professional Practitioners Plan Fee Schedule that corresponds to the type of Health Professional Practitioner performing the Covered Service and which is in effect at the time the Covered Service is rendered. Such Health Professional Practitioner Plan Fee Schedule may be amended from time to time as provided for in the Agreement.

11. Following the effective date of this Attachment, all claims for services rendered by Health Professional Practitioners shall be submitted to *ANTHEM* solely under the Health Professional Practitioner NPI number. Claims submitted under an NPI other than that of the individual Health Professional Practitioner or physician personally rendering the service to a Covered Individual shall be considered invalid.

12. In the event of a conflict between the terms and conditions of this Attachment and the terms and conditions of the Agreement, the terms and conditions of this Attachment shall control. Except as set forth herein, all other terms and conditions of the Agreement remain in full force and effect.

CENTRAL REGION

[X] **Blue Traditional/Traditional**
[X] **Blue Access/Access**
[X] **Medicare Advantage HMO**
[X] **Blue Preferred Primary Plus/Preferred Primary Plus**
[X] **Blue Preferred Primary/Preferred Primary**
[X] **Medicare Advantage PPO**

THIS ATTACHMENT IS EFFECTIVE: _____

EXCHANGE AMENDMENT TO THE
ANTHEM BLUE CROSS AND BLUE SHIELD
PROFESSIONAL AGREEMENT

This is an Amendment ("Amendment") to the Anthem Blue Cross and Blue Shield PROFESSIONAL Agreement ("Agreement") between Anthem Insurance Companies, Inc. doing business as Anthem Blue Cross and Blue Shield (hereinafter "Anthem") and the undersigned health care provider (hereinafter "Provider") and is incorporated into the Agreement as follows:

WHEREAS, Anthem has developed two new HMO networks, currently called the Anthem Individual Exchange Network and the Anthem Individual Off Exchange Network, for use in the Individual market in Indiana in connection with the State Individual Exchange and the Individual Off Exchange Products, and

WHEREAS, Provider would like to participate in Anthem's two new HMO networks.

THEREFORE, Anthem and Provider agree as follows:

1. Provider agrees to participate as a Network/Participating Provider in both the Anthem Individual Exchange Network and the Anthem Individual Off Exchange Network,
2. Provider understands that the Anthem Individual Exchange Network supports Individual Products or Plan Programs offered by Anthem on state-based, regional or federal health insurance exchanges ("Exchanges") effective 2014 and established by the Patient Protection and Affordable Care Act. Provider acknowledges that the Anthem Individual Exchange Network and the products or Plan Programs it supports are subject to federal and state regulatory requirements, and Provider agrees to abide by all applicable rules, regulations and other requirements of the Exchanges as they exist and as they may be amended or changed from time to time.
3. Provider understands that the Anthem Individual Off Exchange Network is a network to be used with Individual Off Exchange Products as well as other products as determined by Anthem.
4. Provider agrees that participation in each of the two networks, the Anthem Individual Exchange Network and the Anthem Individual Off Exchange Network, is contingent upon participation in both networks. Provider may only participate in each network if it participates in both networks, and termination from one network will result in termination from both networks.
5. The Parties agree that the Anthem Rates for the Anthem Individual Exchange Network and the Anthem Individual Off Exchange Network are equivalent to the standard Anthem Indiana statewide Blue Access (PPO) Fee schedule and are added to the Plan Compensation Schedule ("PCS").

All other provisions of the Agreement shall remain in full force and effect. In the event of a conflict between the provision of this Amendment and the provisions of the Agreement, the provisions set forth in this Amendment shall control.

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

THE EFFECTIVE DATE OF THIS AMENDMENT IS: _____

PROVIDER LEGAL NAME: Centrality Behavior Support Training, LLC

By: _____ _____
Name Date

Printed: Meagan Daut Owner
Name Title

Address: 3725 E. Southport Rd Ste F Indianapolis, IN 46227
Street City State Zip

TAX IDENTIFICATION NUMBER (TIN): 46-4197524

Anthem Insurance Companies, Inc.
dba Anthem Blue Cross and Blue Shield

By: _____ _____
Name Date

Printed: David T. Lee, MD VP Provider Engagement & Contracting
Name Title

Address: P.O. Box 7171 Indianapolis IN 46207-7171
Street City State Zip

AMENDMENT TO THE
ANTHEM BLUE CROSS AND BLUE SHIELD
PROFESSIONAL PROVIDER AGREEMENT

This is an Amendment ("Amendment" to the Anthem Blue Cross and Blue Shield Professional Provider Agreement ("Agreement") between Anthem Insurance Companies, Inc. doing business as Anthem Blue Cross and Blue Shield (hereinafter *"ANTHEM"*) and Centrality Behavior Support Training, LLC (hereinafter *"PROVIDER"*) and is incorporated into the Agreement as follows:

Indiana Workers' Compensation Program Participation Attachment

PROVIDER agrees to participate as a Network *PROVIDER* in *ANTHEM*'s Workers' Compensation Program for Indiana Plan Covered Individuals. Accordingly, the parties agree to the Workers' Compensation Participation Attachment attached to this Amendment. The Workers' Compensation Participation Attachment is hereby incorporated into this Amendment by reference.

All other provisions of the Agreement shall remain in full force and effect. In the event of a conflict between the provision of this Amendment and the provisions of the Agreement, the provisions set forth in this Amendment shall control.

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

THE EFFECTIVE DATE OF THIS AMENDMENT IS: _____

PROVIDER LEGAL NAME Centrality Behavior Support Training, LLC

By: _____ (Name) _____ (Date)

Printed: Meagan Dant (Name) Owner (Title)

Address: 3125 E. Southport Suite F (Street) Indianapolis, IN 46227 (City, State, Zip)

TAX IDENTIFICATION NUMBER (TIN): 46-4197524

Anthem Insurance Companies, Inc.
dba Anthem Blue Cross and Blue Shield

By: _____ (Name) _____ (Date)

Printed: David T. Lee, MD (Name) VP Provider Engagement & Contracting (Title)

Address: P.O. Box 7171 (Street) Indianapolis IN 46207-7171 (City, State, Zip)

WORKERS' COMPENSATION
PARTICIPATION ATTACHMENT TO THE
ANTHEM BLUE CROSS AND BLUE SHIELD
PROFESSIONAL PROVIDER AGREEMENT

This is an Attachment to the Anthem Blue Cross and Blue Shield Professional 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 Workers' Compensation Participation Attachment.

1.1 "Administrator" means an entity, either internal or external to an employer, authorized by a permissibly self-insured employer to administer its Injured Worker(s) claims.

1.2 "Anthem Workers' Compensation Network" means a network of healthcare providers (including *PROVIDER* herein) which includes Network Providers that have expertise in providing the treatment and documentation of work-related injuries in compliance with State of Indiana's workers' compensation laws and regulations.

1.3 "Carrier" means a workers' compensation insurance company duly authorized to do business in the State of Indiana.

1.4 "Compensable Medical Care" means medical care determined by the Carrier or Administrator to be covered under a Workers' Compensation Plan.

1.5 "Employer" means a business providing Workers' Compensation insurance to its employees on either an insured or permissibly self-insured basis.

1.6 "Injured Worker(s)" means an employee covered under a Workers' Compensation Plan, whose Employer, Administrator or Carrier has contracted for services under the Anthem Workers' Compensation Network.

1.7 "Other Payors" means persons or entities, utilizing the Network(s) pursuant to an agreement with *ANTHEM* or an Affiliate, including without limitation, other Blue Cross and/or Blue Shield Plans that are not Affiliates, and employers or insurers providing Health Benefit Plans pursuant to insured, self-administered or self-insured programs.

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

1.9 "Utilization Review" means a function performed by *ANTHEM*, an Affiliate or Other Payors to assess the frequency, duration, level and medical appropriateness of care and services to determine that they are, or were, reasonably required to cure or relieve the injury or illness in accordance with the State of Indiana's workers' compensation laws and regulations, and any applicable regulations, accepted for coverage under a Workers' Compensation Plan.

1.10 "Workers' Compensation Plan" means an Employer's obligation and undertaking to pay benefits as required under the State of Indiana's workers' compensation laws and regulations, and a Carrier's policies of workers' compensation insurance issued by Carrier.

ARTICLE II
SERVICES/OBLIGATIONS

2.1 Injured Worker(s) Compensable Medical Care. *PROVIDER* shall provide to Injured Worker(s) Compensable Medical Care which is Medically Necessary and which is in accordance with this Participation Attachment and the State of Indiana's workers' compensation laws and regulations. *PROVIDER* shall provide and maintain Injured Worker(s) continuity of care, including timely referral of Injured Worker(s) to specialists within the Anthem Workers' Compensation Network.

2.2 Utilization Review. *PROVIDER* agrees to comply with the Utilization Review guidelines as required by the State of Indiana's workers' compensation laws and regulations.

2.3 Non-Compensable Medical Care. *PROVIDER* agrees that if care rendered to an Injured Worker(s) is subsequently deemed not to be Compensable Medical Care by the Carrier or Administrator or by judicial order, no payment will be made unless treatment has been authorized by the Carrier and such care was Medically Necessary. Should there be a dispute by or among the Injured Worker(s), the Carrier, and or Administrator whether or not services are Compensable Medical Care, *PROVIDER* shall not make any attempt to collect for such care from the Injured Worker(s) until a final determination between the Carrier, Administrator and Injured Worker(s) that care is not Compensable Medical Care, except *PROVIDER* may take what steps are reasonably necessary to preserve any claim for benefits that may be available for the non-occupational medical care of the Injured Worker(s) under any insurance, health plan coverage or similar program.

2.4 Refund for non-Medically Necessary Care. *PROVIDER* agrees that if care is rendered to an Injured Worker(s) and is subsequently determined not to be Medically Necessary, after payment for such services by Affiliate or Other Payor, *PROVIDER* shall reimburse Affiliate or Other Payor the full amount paid *PROVIDER* for such non-Compensable Medical Care. If *ANTHEM* or Other Payor opts for reimbursement, full reimbursement shall be due within thirty (30) days of request for reimbursement.

2.5 Reports. *PROVIDER* shall provide to Administrators, Carriers, Workers' Compensation Plan, or their representatives, all reports and information as required under the State of Indiana's workers' compensation laws and regulations.

2.6 Injured Workers of Other Payors of Affiliates. When the Network Provider is utilized by an Other Payor, Affiliate or Other Carrier, *PROVIDER* agrees to provide Compensable Medical Care to Injured Worker(s) of the Other Payor in accordance with the terms of this Participation Attachment. All duties owed to *ANTHEM* by Network Provider shall be owed to such Affiliate or Other Payor.

2.7 Payment in Full. *PROVIDER* agrees to accept as payment in full for Medically Necessary Compensable Medical Care provided to Injured Worker(s) the lesser of (i) the Anthem Workers' Compensation Plan Fee Schedule Rate, ii) the State Office Medical Fee Schedule or Usual and Customary allowable for workers' compensation in effect on the date the services or expenses were incurred (whichever is applicable); or (iii) *PROVIDER's* billed charges. Such payment shall be for Medically Necessary Compensable Medical Care provided on or after the Effective Date of this Participation Attachment.

2.8 Injured Worker Liability. *PROVIDER* agrees that the only charges for which an Injured Worker(s) may be liable and be billed by *PROVIDER* shall be for medical services that are non-Compensable Medical Care.

2.9 Hold Harmless. *PROVIDER* shall not charge Injured Worker(s) for Compensable Medical Care denied by reason of not being Medically Necessary.

2.10 Medical Record Review. *PROVIDER* agrees to cooperate in Utilization Review programs for the purpose of avoiding unnecessary or unduly costly Covered Services while ensuring the delivery of quality health care for Injured Worker(s). *ANTHEM* may conduct medical record review of Claims submitted by Network Provider prior to payment. Neither *ANTHEM* nor the Injured Worker(s) shall be obligated to pay for any services that *ANTHEM* determines to be Medically un-Necessary, and Network Provider agrees not to bill Injured Worker(s) for such services.

2.11 Provider Treatment. *PROVIDER* agrees to treat Injured Worker(s) with new and existing work related injuries.

2.12 Other Payors. Access to the Anthem Workers' Compensation Network may be sold, leased, transferred or conveyed to Other Payors, which may include workers' compensation insurers, self insurer's security fund, a group of self-insured employers, a joint powers of authority, the state, third party administrators, or other covered employers as permitted under the State of Indiana's workers' compensation laws and regulations. *ANTHEM* will provide within thirty (30) days of receipt of a written request from *PROVIDER* a summary of all Other Payors currently eligible to pay the negotiated rates under this Attachment as a result of their arrangement with *ANTHEM*. *ANTHEM* requires such Other Payors to actively encourage Covered Individuals including those covered by workers' compensation carriers to use Network Providers when obtaining medical care through the use of one or more of the following: reduced Cost Share, premium discounts directly attributable to the use of a Network Provider, financial penalties directly attributable to the

non-use of a Network Provider, providing Covered Individuals with the names, addresses and phone numbers of Network Providers in advance of their selection of a health care provider through the use of provider directories, toll-free telephone numbers and internet web site addresses. In the event *ANTHEM* enters into an arrangement with an Other Payor that does not require such active encouragement of the use of the Anthem Workers' Compensation Network, *PROVIDER* shall be allowed to decline to provide services to such Other Payor.

PROVIDER agrees that when the Anthem Workers' Compensation Network is utilized by an Affiliate or Other Payor, *PROVIDER* agrees to provide services to Covered Individuals including those covered by workers' compensation carriers of that Affiliate or Other Payor in accordance with the terms of this Attachment. *ANTHEM* agrees to pre-qualify Other Payors with respect to determining their ability to pay Claims in accordance with the rates as set forth in this Attachment. In all events, however, *PROVIDER* shall look for payment only to the particular Affiliate or Other Payor that covers the particular services for which *PROVIDER* seeks to be compensated (except for applicable Cost Shares or other obligations of Covered Individuals). *ANTHEM* shall use its best efforts to assure Other Payors compensate *PROVIDER* in accordance with the rates as set forth in this Attachment. In the event any such Other Payor fails to make required payments, *PROVIDER* may seek payment from the Covered Individual (up to the rates specified herein) unless prohibited by applicable law. When an Other Payor utilizes the Anthem Workers' Compensation Network, *PROVIDER* shall follow such Other Payor's specified utilization review requirements.

ARTICLE III
GENERAL PROVISIONS

3.1 Timely Payment. Affiliate, Carrier, or Other Payor shall pay *PROVIDER* within thirty (30) working days of receipt of the accurate and complete doctor's first report and each subsequent required report thereafter as required under the State of Indiana's workers' compensation laws and regulations and billings which are accurate and complete.

3.2 Anthem as Intermediary. *ANTHEM*, under this Participation Attachment, acts as an intermediary of the Carriers, Other Payors, Administrators and Employers with which it contracts, and no financial obligations are assumed by *ANTHEM*. Money refunded or returned to *ANTHEM* by *PROVIDER* is received by *ANTHEM* on behalf of the Administrator, Carrier, Other Payor or Employer responsible for the original payment.

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

ARTICLE IV
TERM AND TERMINATION

4.1 Term of Participation Attachment. This Attachment shall become effective on the Effective Date and shall continue in effect unless otherwise terminated as provided for in this Attachment or in the Agreement.

4.2 Termination Without Cause. Either party may terminate this Participation Attachment without cause at any time by giving at least one hundred eighty (180) days prior written notice of termination to the other party.

MEDICARE ADVANTAGE
PARTICIPATION ATTACHMENT TO THE
ANTHEM BLUE CROSS AND BLUE SHIELD
PROFESSIONAL PROVIDER AGREEMENT

This Medicare Advantage Participation Attachment ("Attachment") to the Anthem Blue Cross and Blue Shield Professional 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 Medicare Advantage Participation Attachment:

1.1 "Clean Claim" means a Claim that has no defect or impropriety, including a lack of required substantiating documentation or particular circumstances requiring special treatment that prevents timely payment from being made on the Claim. A Claim is clean even though Plan refers it to a medical specialist within Plan for examination. If additional documentation (e.g., a medical record) involves a source outside Plan, then the Claim is not considered clean.

1.2 "Covered Individual" means, for purposes of this Attachment, a Medicare beneficiary covered under a Medicare agreement between CMS and Plan under Part C of Title XVIII of the Social Security Act ("Medicare Advantage Program").

1.3 "Emergency or Emergency Medical 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: (1) 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; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

1.4 "Emergency Services" means covered inpatient and outpatient Health Services that are: (1) furnished by a provider qualified to furnish emergency services; and (2) needed to evaluate or stabilize an Emergency Medical Condition.

1.5 "CMS" means the Centers for Medicare and Medicaid Services.

1.6 "Medicare" means the Health Insurance for the Aged Act, Title XVIII of the Social Security Act, as then constituted or later amended.

1.7 "Urgently Needed Care" means Covered Services provided when a Covered Individual is either:

1.7.1 Temporarily absent from Plan's Medicare Advantage service area and such Covered Services are Medically Necessary and immediately required: (1) as a result of an unforeseen illness, injury, or condition; and (2) it was not reasonable, given the circumstances, to obtain the services through Plan's Medicare Advantage Network; or

1.7.2 Under unusual and extraordinary circumstances, the Covered Individual is in the service area but Plan's provider Network is temporarily unavailable or inaccessible and such Covered Services are Medically Necessary and immediately required: (1) as a result of an unforeseen illness, injury, or condition; and (2) it was not reasonable, given the circumstances, to obtain the services through Plan's Medicare Advantage Network.

ARTICLE II
SERVICES/OBLIGATIONS

2.1 Participation-Medicare Advantage. As a participant in Plan's Medicare Advantage Program, *PROVIDER* will render Covered Services to Covered Individuals enrolled in Plan's Medicare Advantage Program in accordance with the terms and conditions of the Agreement and this Attachment. Except as set forth in this Attachment, or the Anthem Medicare Advantage Fee Schedule attached to the Agreement, if any, all terms and conditions of the Agreement will apply to *PROVIDER* 's participation in Plan's Medicare Advantage Program(s). This Agreement does not apply to any of the Plan's Medicare Advantage Private Fee for Service or Medical Savings Account Programs.

2.2 Participation-Out of Area Programs. Pursuant to the Blue Cross and Blue Shield Out of Area Program provision of the Agreement, *PROVIDER* hereby acknowledges and agrees that *PROVIDER* shall provide Covered Services to any person who is covered under another Blue Cross and Blue Shield Plan under the Blue Cross and Blue Shield Association Out of Area Program, including, but not limited to, a network sharing PPO developed to support Medicare Advantage Programs.

2.3 Participation-Medicare Advantage Program. By virtue of the fact that *PROVIDER* is a Medicare Advantage Network Provider, *PROVIDER* hereby acknowledges and agrees that *PROVIDER* shall provide services to any Medicare Advantage Covered Individual enrolled in a Plan insured product that utilizes the Medicare Advantage Provider Network.

2.4 Covered Individual/Covered Service-Defined. The parties agree that all references in the Agreement to Covered Individual(s) include Covered Individuals of Plan's Medicare Advantage Program and all references to Covered Services include services offered pursuant to Plan's Medicare Advantage Program.

2.5 Medical Necessity. Medical Necessity decisions regarding Covered Individuals will be made in compliance with CMS guidelines.

2.6 Accountability/Oversight. Plan delegates to *PROVIDER* its responsibility under its Medicare Advantage contract with CMS to provide the services as set forth in this Attachment to Covered Individuals. Plan may revoke this delegation, including, if applicable, the delegated responsibility to meet CMS reporting requirements, and thereby terminate the Attachment if CMS or Plan determine that *PROVIDER* has not performed satisfactorily. Such revocation shall be consistent with the termination provisions of this Attachment. Performance of the *PROVIDER* shall be monitored by Plan on an ongoing basis as provided for in this Attachment. *PROVIDER* further acknowledges that Plan is accountable to CMS for the functions and responsibilities described in the Medicare Advantage regulatory standards and ultimately responsible to CMS for the performance of all services. *PROVIDER* acknowledges that Plan shall oversee and is accountable to CMS for the functions and responsibilities described in the Medicare Advantage regulatory standards. Further, *PROVIDER* acknowledges that Plan may only delegate such functions and responsibilities in a manner consistent with the standards as set forth in 42 CFR § 422.504(i)(4).

2.7 Accountability/Credentialing. Both parties acknowledge that accountability shall be in a manner consistent with the requirements as set forth in 42 CFR § 422.504(i)(4). Therefore the following are acceptable for purposes of meeting these requirements:

2.7.1 The credentials of medical professionals affiliated with the Plan or the *PROVIDER* will be either reviewed by the Plan if applicable; or

2.7.2 The credentialing process will be reviewed and approved by the Plan and the Plan must audit the *PROVIDER's* credentialing process and/or delegate's credentialing process on an ongoing basis.

2.8 Medicare Provider. *PROVIDER* must have a provider and/or supplier agreement, whichever is applicable, with CMS that permits them to provide services under original Medicare.

ARTICLE III
ACCESS: RECORDS/FACILITIES

3.1 Inspection of Books/Records. *PROVIDER* acknowledges that Plan, Health and Human Services department (HHS), the Comptroller General, or their designees have the right to timely access to inspect, evaluate and audit any books, contracts, medical records, patient care documentation, and other records of *PROVIDER*, or his/her/its first tier, downstream and related entities, including but not limited to subcontractors or transferees involving transactions related to Plan's Medicare Advantage contract through ten (10) years from the final date of the contract period or from the date of the completion of any audit, or for such longer period provided for in 42 CFR § 422.504(e)(4) or other applicable law, whichever is later. For the purposes specified in this provision, *PROVIDER* agrees to make available *PROVIDER's* premises, physical facilities and equipment, records relating to Plan's Covered Individuals, including access to *PROVIDER* computer and electronic systems and any additional relevant information that CMS may require. *PROVIDER* acknowledges that failure to allow HHS, the Comptroller General or their designees the right to timely access under this section can subject *PROVIDER* to a fifteen thousand dollar ($15,000) penalty for each day of failure to comply.

3.2 Confidentiality. Each party agrees to abide by all federal and state laws applicable to that party regarding

confidentiality and disclosure for mental health records, medical records, other health information, and enrollee information. *PROVIDER* agrees to maintain records and other information with respect to Covered Individuals in an accurate and timely manner; to ensure timely access by enrollees to the records and information that pertain to them; and to safeguard the privacy of any information that identifies a particular enrollee. Information from, or copies of, records may be released only to authorized individuals. *PROVIDER* must ensure that unauthorized individuals cannot gain access to or alter patient records. Original medical records must be released only in accordance with federal or state laws, court orders or subpoenas. Both parties acknowledge that Plan, HHS, the Comptroller General or its designee have the right, pursuant to section 3.1 above, to audit and/or inspect *PROVIDER* to monitor and ensure compliance with the CMS requirements for maintaining the privacy and security of protected health information (PHI) and other personally identifiable information of Covered Individuals.

ARTICLE IV
ACCESS: BENEFITS AND COVERAGE

4.1 Non-Discrimination. *PROVIDER* shall not deny, limit, or condition the furnishing of Health Services to Covered Individuals of Plan on the basis of any factor that is related to health status, including, but not limited to medical condition; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of acts of domestic violence; or disability.

4.2 This provision intentionally left blank.

4.3 Direct Access. *PROVIDER* acknowledges that Covered Individuals may obtain covered mammography screening services and influenza vaccinations from a participating provider without a referral and that Covered Individuals who are women may obtain women's routine and preventive Health Services from a participating women's health specialist without a referral.

4.4 No Cost Sharing. *PROVIDER* acknowledges that covered influenza vaccines and pneumococcal vaccines are not subject to Covered Individual Cost Share obligations.

4.5 Timely Access to Care. *PROVIDER* agrees to provide Covered Services consistent with Plan's: (1) standards for timely access to care and member services; (2) policies and procedures that allow for individual Medical Necessity determinations; and (3) policies and procedures for the *PROVIDER*'s consideration of Covered Individual input in the establishment of treatment plans.

4.6 Continuity of Care. A *PROVIDER* who is a Primary Care Provider, or a gynecologist or obstetrician, shall provide Health Services or make arrangements for the provision of Health Services to Covered Individuals on a twenty-four (24) hour per day, seven (7) day a week basis to assure availability, adequacy, continuity of care to Covered Individuals. In the event a *PROVIDER* is not one of the foregoing described Providers, then *PROVIDER* shall provide Health Services to Covered Individuals on a twenty-four (24) hour per day, seven (7) day a week basis or at such times as Health Services are typically provided by similar Providers to assure availability, adequacy, and continuity of care to Covered Individuals. If *PROVIDER* is unable to provide Health Services as described in the previous sentence, *PROVIDER* will arrange for another Network Provider to cover *PROVIDER's* patients in *PROVIDER's* absence.

ARTICLE V
BENEFICIARY PROTECTIONS

5.1 Cultural Competency. *PROVIDER* shall ensure that Covered Services rendered to Covered Individuals, both clinical and non-clinical, are accessible to all Covered Individuals, including those with limited English proficiency or reading skills, with diverse cultural and ethnic backgrounds, the homeless, and individuals with physical and mental disabilities. *PROVIDER* must provide information regarding treatment options in a cultural-competent manner, including the option of no treatment. *PROVIDER* must ensure that individuals with disabilities have effective communications with participants throughout the health system in making decisions regarding treatment options.

5.2 Health Assessment. *PROVIDER* acknowledges that Plan has procedures approved by CMS to conduct a health assessment of all new Covered Individuals within ninety (90) days of the effective date of their enrollment. *PROVIDER* agrees to cooperate with Plan as necessary in performing this initial health assessment.

5.3 Identifying Complex and Serious Medical Condition. *PROVIDER* acknowledges that Plan has procedures to identify Covered Individuals with complex or serious medical conditions for chronic care improvement

initiatives; and to assess those conditions, including medical procedures to diagnose and monitor them on an ongoing basis; and establish and implement a treatment plan appropriate to those conditions, with an adequate number of direct access visits to specialists to accommodate the treatment plan. To the extent applicable, *PROVIDER* agrees to assist in the development and implementation of the treatment plans and/or chronic care improvement initiatives.

5.4 Advance Directives. *PROVIDER* shall establish and maintain written policies and procedures to implement Covered Individuals' rights to make decisions concerning their health care, including the provision of written information to all adult Covered Individuals regarding their rights under state and federal law to make decisions regarding their right to accept or refuse medical treatment and the right to execute an advance medical directive. *PROVIDER* further agrees to document or oversee the documentation in the Covered Individuals' medical records whether or not the Covered Individual has an advance directive, that *PROVIDER* will follow state and federal requirements for advance directives and that *PROVIDER* will provide for education of his/her/its staff and the community on advance directives.

5.5 Standards of Care. *PROVIDER* agrees to provide Covered Services in a manner consistent with professionally recognized standards of health care.

5.6 Hold Harmless. *PROVIDER* agrees that in no event, including but not limited to non-payment by Plan, insolvency of Plan or breach of the Agreement, shall the *PROVIDER* bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Covered Individual or persons other than Plan acting on their behalf for Covered Services provided pursuant to the Agreement. This provision does not prohibit the collection of supplemental charges or Cost Shares on Plan's behalf made in accordance with the terms of the Covered Individual's Health Benefit Plan or amounts due for services that have been correctly identified in advance as a non-Covered Service, subject to medical coverage criteria, with appropriate disclosure to the Covered Individual of their financial obligation. This advance notice does not apply to services not covered due to a statutory exclusion from the Medicare Advantage Program.

5.6.1 *PROVIDER* further agrees that for Covered Individuals who are dual eligible enrollees for Medicare and Medicaid, that *PROVIDER* will ensure they will not bill the Covered Individual for Cost Sharing that is not the Covered Individual's responsibility and such Covered Individuals will not be held liable for Medicare Parts A and B Cost Sharing when the State is liable for the Cost Sharing. In addition, *PROVIDER* agrees to accept the Plan payment as payment in full or by billing the appropriate state source.

5.7 Continuation of Care-Insolvency. *PROVIDER* agrees that in the event of Plan's insolvency, termination of the CMS contract or other cessation of operations, Covered Services to Covered Individuals will continue through the period for which the premium has been paid to Plan, and services to Covered Individuals confined in an inpatient hospital on the date of termination of the CMS contract or on the date of insolvency or other cessation of operations will continue until their discharge.

5.7.1 Survival after Termination. To the extent the Agreement terminates before this Attachment, the parties agree that all necessary terms of the Agreement will survive to allow continuation of this Attachment until the effective date of the termination of the Attachment.

5.8 Survival of Attachment. *PROVIDER* further agrees that: (1) the hold harmless and continuation of care provisions shall survive the termination of the Covered Individual; (2) these provisions supersede any oral or written contrary agreement now existing or hereafter entered into between *PROVIDER* and a Covered Individual or persons acting on their behalf that relates to liability for payment for, or continuation of, Covered Services provided under the terms and conditions of these clauses; and (3) any modifications, addition or deletion to these provisions shall become effective on a date no earlier than fifteen (15) days after the Administrator of CMS has received written notice of such proposed changes.

ARTICLE VI
COMPENSATION AND FEDERAL FUNDS

6.1 Compensation-Medicare Advantage. For Covered Services provided to Covered Individuals, *PROVIDER* shall be compensated at the Anthem Rate which equals one-hundred percent (100%) of the current Medicare Advantage Plan Fee Schedule for the year in which services are provided. Such compensation may be amended from time to time as provided for in the Agreement.

Notwithstanding the foregoing, *ANTHEM* reserves the right to price Not Otherwise Classified (NOC) codes in accordance with its NOC reimbursement policies.

6.2 Prompt Payment. Plan agrees to make best efforts to pay a majority of Clean Claims for Covered Services submitted by or on behalf of Covered Individuals, within forty-five (45) days of receipt by Plan. Plan agrees to make best efforts to pay all remaining Clean Claims for Covered Services submitted by or on behalf of Covered Individuals, within sixty (60) days of receipt by Plan. Plan agrees to make best efforts to pay all non-Clean Claims for Covered Services submitted by or on behalf of Covered Individuals within sixty (60) days of receipt by Plan of the necessary documentation to adjudicate the Claim.

6.3 Federal Funds. *PROVIDER* acknowledges that payments *PROVIDER* receives from Plan to provide Covered Services to Covered Individuals 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 is 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 and any other regulations applicable to recipients of Federal Funds.

ARTICLE VII
REPORTING AND DISCLOSURE REQUIREMENTS

7.1 Risk Adjustment Data Validation Audits. Plan and *PROVIDER* are required in accordance with 42 CFR §422.310(e) to submit a sample of medical records for Covered Individuals for the purpose of validation of risk adjustment data. Accordingly, Plan, or their designee, shall have the right, as set forth in section 3.1 to obtain copies of such documentation on at least an annual basis. *PROVIDER* agrees to provide the requested medical records to Plan, or their designee, within fourteen (14) calendar days from Plan's, or their designee's, written request. Such records shall be provided to Plan, or their designee, at no additional cost.

7.2 Data Reporting Submissions. *PROVIDER* agrees to provide to Plan all information necessary for Plan to meet its data reporting and submission obligations to CMS, including but not limited to, data necessary to characterize the context and purpose of each encounter between a Covered Individual and the *PROVIDER* ("Risk Adjustment Data"), and data necessary for Plan to meet its reporting obligations under 42 CFR §§ 422.516 and 422.310. In accordance with the CMS requirements, the Plan reserves the right to assess *PROVIDER* for any penalties resulting from *PROVIDER'S* submission of false data.

7.3 Risk Adjustment Data. *PROVIDER's* Risk Adjustment Data shall include all information necessary for Plan to submit such data to CMS as set forth in 42 CFR § 422.310 or any subsequent or additional regulatory provisions. If *PROVIDER* fails to submit his/her/its Risk Adjustment Data accurately, completely and truthfully, in the format described in the 42 CFR § 422.310 or any subsequent or additional regulatory provisions, then this will result in denials and/or delays in payment of *PROVIDER's* Claims.

7.4 Accuracy of Risk Adjustment Data. *PROVIDER* further agrees to certify the accuracy, completeness, and truthfulness of *PROVIDER* generated Risk Adjustment Data that Plan is obligated to submit to CMS. Within thirty (30) days after the beginning of every Fiscal Year or as required by CMS while the Medicare Advantage Participation Attachment is in effect, *PROVIDER* agrees to give Plan a certification in writing, in a format that Plan specifies, that certifies to the accuracy, completeness, and truthfulness of *PROVIDER's* Risk Adjustment Data submitted to Plan during the specified period.

ARTICLE VIII
QUALITY ASSURANCE/QUALITY IMPROVEMENT REQUIREMENTS

8.1 Independent Quality Review Organization. *PROVIDER* agrees to comply and cooperate with an independent quality review and improvement organization's activities pertaining to the provision of Covered Services for Covered Individuals.

8.2 Compliance with Plan Medical Management Programs. *PROVIDER* agrees to comply with Plan's medical policies, quality improvement and performance improvement programs, and medical management programs to the extent provided to or otherwise made available to *PROVIDER* in advance.

8.3 Consulting with Network Providers. Plan agrees to consult with Network Providers regarding its medical policies, quality improvement program and medical management programs and ensure that practice guidelines and utilization management guidelines: (1) are based on reasonable medical evidence or a consensus of health care professionals in the particular field; (2) consider the needs of the enrolled population; (3) are developed in consultation with participating physicians; (4) are reviewed and updated

periodically; and (5) are communicated to Providers and, as appropriate, to Covered Individuals. Plan also agrees to ensure that decisions with respect to utilization management, Covered Individual education, coverage of Health Services, and other areas in which the guidelines apply are consistent with the guidelines.

ARTICLE IX
COMPLIANCE

9.1 Compliance: Medicare Laws/Regulations. *PROVIDER* agrees to comply, and to require any of his/her/its subcontractors to comply, with all applicable Medicare laws, regulations, and CMS instructions. Further, *PROVIDER* agrees that any Covered Services provided by the *PROVIDER* or his/her/its subcontractors to Plan's Covered Individuals will be consistent with and will comply with Plan's Medicare Advantage contractual obligations.

9.2 Compliance: Exclusion from Federal Health Care Program. *PROVIDER* may not employ, or subcontract with an individual, or have persons with ownership or control interests, who have been convicted of criminal offenses related to their involvement in Medicaid, Medicare, or social services programs under Title XX of the Social Security Act, and thus have been excluded from participation in any Federal health care program under §§ 1128 or 1128A of the Act (or with an entity that employs or contracts with such an individual) for the provision of any of the following:

9.2.1 healthcare;
9.2.2 utilization review;
9.2.3 medical social work; or
9.2.4 administrative services.

9.3 Compliance: Appeals/Grievances. *PROVIDER* agrees to comply with Plan's policies and procedures in performing his/her/its responsibilities under the Agreement. *PROVIDER* specifically agrees to comply with Medicare requirements regarding Covered Individual appeals and grievances and to cooperate with Plan in meeting its obligations regarding Covered Individual appeals, grievances and expedited appeals, including the gathering and forwarding of information in a timely manner and compliance with appeals decisions.

9.4 Compliance: Policy and Procedures. *PROVIDER* agrees to comply with Plan's policy and procedures in performing his/her/its responsibilities under the Agreement and this Attachment including any supplementary documents that pertain to Plan's Medicare Advantage Program such as the Product Guide.

9.5 Illegal Remunerations. Both parties specifically represents and warrants that activities to be performed under this Agreement are not considered illegal remunerations (including kickbacks, bribes or rebates) as defined in 42 USCA § 1320(a)-7b.

9.6 Compliance: Training, Education and Communications. In accordance with, but not limited to 42 C.F.R. §§422.503(b)(4)(vi)(C)&(D) and 423.504(b)(4)(vi)(C)&(D), *PROVIDER* agrees and certifies that it, as well as its employees, subcontractors, downstream entities, related entities and agents who provide services, to or for Plan's Medicare Advantage and/or Part D Covered Individuals or to or for the Plan itself, shall participate in applicable compliance training, education and/or communications as reasonably requested by the Plan or its designee annually or as otherwise required by applicable law, and must be made a part of the orientation for a new employee, new first tier, downstream or related entity and for all new appointments of a chief executive, manager, or governing body member. Both parties agree that the Plan or its designee may make such compliance training, education and lines of communication available to *PROVIDER* in either electronic, paper or other reasonable medium. To the extent Plan does not indicate that it will be documenting attendance and completion of the compliance training, education and/or lines of communication, *PROVIDER* shall be responsible for documenting applicable employee's, subcontractor's, downstream entity's, related entity's and/or agent's attendance and completion of such training. Upon notice, *PROVIDER* shall provide such documentation to Plan, unless otherwise not required by CMS regulation. In addition, the training requirement set forth herein is not required for providers or suppliers who have met the fraud, waste and abuse certification requirements through enrollment into the Medicare program, as those providers and/or suppliers are deemed to have met that portion of the fraud waste and abuse training required by CMS.

ARTICLE X
MARKETING

10.1 Approval of Materials. Both parties agree to comply, and to require any of his/her/its subcontractors to

comply, with all applicable federal and state laws, regulations, CMS instructions, and marketing activities under this Agreement, including but not limited to, the National Marketing Guide and any requirements for CMS prior approval of materials. Any printed materials, including but not limited to letters to Plan Covered Individuals, brochures, advertisements, telemarketing scripts, packaging prepared or produced by *PROVIDER* or any of his/her/its subcontractors pursuant to this Agreement must be submitted to Plan for review and approval at each planning stage (*i.e.,* creative, copy, mechanicals, blue lines, etc.) to assure compliance with federal, state, and Blue Cross/Blue Shield Association guidelines. Plan agrees its approval will not be unreasonably withheld or delayed.

ARTICLE XI
TERM AND TERMINATION

11.1 Notice Upon Termination. If Plan decides to terminate this Attachment, Plan shall give *PROVIDER* written notice, to the extent required under CMS regulations, of the reasons for the action, including, if relevant, the standards and the profiling data the organization used to evaluate *PROVIDER* and the numbers and mix of Network Providers Plan needs. Such written notice shall also set forth *PROVIDER*'s right to appeal the action and the process and timing for requesting a hearing.

11.2 Termination for Medicare Exclusion. *PROVIDER* acknowledges that this Attachment shall be terminated if *PROVIDER*, or a person or entity with ownership or control interest in *PROVIDER* is excluded from participation in Medicare under § 1128A of the Social Security Act or from participation in any other Federal health care program.

11.3 Termination Without Cause. Either party may terminate *PROVIDER's* participation in Plan's Medicare Advantage Network without cause by giving at least one hundred eighty (180) days prior written notice of termination to the other party. Upon your notice of Termination Without Cause, *PROVIDER* is required to notify Covered Individual(s) sixty (60) days prior to your effective date of termination with *ANTHEM.*

11.4 Term/Termination. This Attachment shall be effective on the effective date set forth below, and shall continue in effect for a term of one year, automatically renewing for consecutive one year terms unless otherwise terminated as provided for in this Attachment or in the Agreement.

ARTICLE XII
GENERAL PROVISIONS

12.1 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.

12.2 Interpret According to Medicare Laws. *PROVIDER* and Plan intend that the terms of the Agreement and this Attachment as they relate to the provision of Covered Services under the Medicare Advantage Program shall be interpreted in a manner consistent with applicable requirements under Medicare law.

12.3 Subcontractors. *PROVIDER* agrees that if *PROVIDER* enters into subcontracts to perform services under the terms of this Attachment, *PROVIDER*'s subcontracts shall include: (1) an agreement by the subcontractor to comply with all of the *PROVIDER*'s obligations in the Agreement and this Attachment; (2) a prompt payment provision as negotiated by the *PROVIDER* and the subcontractor; (3) a provision setting forth the term of the subcontract (preferably one (1) year or longer); and (4) dated signatures of all the parties to the subcontract.

12.4 Delegated Activities. If Plan has delegated activities to *PROVIDER*, then the Plan will provide the following information to *PROVIDER* and *PROVIDER* shall provide such information to any of its subcontracted entities:

12.4.1 A list of delegated activities and reporting responsibilities;

12.4.2 Arrangements for the revocation of delegated activities;
12.4.3 Notification that the performance of the contracted and subcontracted entities will be monitored by the Plan;
12.4.4 Notification that the credentialing process must be approved and monitored by the Plan; and
12.4.5 Notification that all contracted and subcontracted entities must comply with all applicable Medicare laws, regulations and CMS instructions.

12.5 Delegation of Provider Selection. In addition to the responsibilities as set forth in section 12.4 above, to the extent that Plan has delegated selection of the providers, contractors, or subcontractor to *PROVIDER*, the Plan retains the right to approve, suspend, or terminate any such arrangement.

INDIANA

☐ **Medicare Advantage HMO** ☐ **Medicare Advantage PPO**

THIS ATTACHMENT IS EFFECTIVE: _____

ANTHEM BLUE CROSS AND BLUE SHIELD
PROFESSIONAL PROVIDER AGREEMENT
PROVIDER MANUAL

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ANTHEM BLUE CROSS AND BLUE SHIELD
PROFESSIONAL PROVIDER AGREEMENT
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SECTION I.

INTRODUCTION

This Provider Manual is a part of and incorporated into the Anthem Blue Cross and Blue Shield Professional Provider Agreement ("Agreement"). This Provider Manual may be updated from time to time in accordance with the terms and conditions of the Agreement.

PROVIDER and *ANTHEM* understand and agree that any information regarding the other's business activities which is not otherwise available to the general public is privileged and confidential. *ANTHEM* shall provide reports from time to time to Covered Individuals, reinsurers, accounts, potential accounts and/or their representatives regarding *ANTHEM's* compensation to health care providers. In certain circumstances, *ANTHEM* may require the recipient of the information to execute a confidentiality agreement.

SECTION II.

QUALITY IMPROVEMENT PROGRAM

ANTHEM conducts an ongoing Provider Quality Improvement Program ("QI Program") designed to promote the delivery of health care to *ANTHEM* Covered Individuals. *PROVIDER's* participating in certain Networks as designated by *ANTHEM* are expected to implement and maintain quality improvement programs in accordance with *ANTHEM's* QI Program requirements and performance targets, including, but not limited to:

On-site Office Review

All Providers have agreed to comply with on-site office review procedures under the terms and conditions of their Professional Provider Agreement.

Physician office reviews are conducted prior to contracting and biannually thereafter for all Primary Care Providers ("PCP", or "PCPs"), obstetrician/gynecologists, and high volume specialty care physicians. *ANTHEM's* Network Management staff conducts the initial on-site review. A PCP's medical records are reviewed by the regional QI staff to determine if: (1) they meet eighty percent (80%) of the medical record review criteria; and (2) the combined on-site and medical record reviews meet the eighty percent (80%) target. Ob/Gyns and high volume specialists are required to have on-site reviews conducted without review of medical records. Following the review, the *PROVIDER* will receive, at a minimum, a letter that includes the percentage of criteria met and the findings of the review, whether they are positive or require follow-up action.

If the standards are not met, regional QI staff will develop a corrective action plan and present it to *PROVIDER*. Action could include further auditing of medical care at specified intervals, education regarding practices, dissemination of comparative data or standards of care, a meeting with *PROVIDER*, probation or termination of Network participation.

In addition to the general review, medical records with the following diagnoses and procedures are reviewed to determine compliance with minimum disease management and health practice guidelines. The review is conducted according to disease management and preventive health indicators developed by expert resources and clinical staff.

- Well baby care (newborns to one (1) year)
- Well child care (fifteen (15) to twenty-four (24) months)
- Recurrent otitis media
- Asthma
- Diabetes mellitus
- Normal pregnancy
- Mammography
- Pap Smears
- Cardiovascular Disease

Medical Records

Medical record documentation is essential to the delivery of excellent medical care. Plan strongly encourages *PROVIDER* to comply with the preferred medical record elements (listed below).

PROVIDER's medical records should provide continuity and coordination of care over time, even if several providers are involved. Medical records are evaluated during or after on-site office reviews. The following elements should be documented or considered to ensure a complete medical record:

- Patient identification on each page
- Biographical and personal data
- Dated entries
- Identifies the physician or office staff who made the entries
- Writing is legible
- Complete problem list
- Complete medication list

SECTION II.

QUALITY IMPROVEMENT PROGRAM
continued

- Allergies/adverse reactions to medications prominently noted
- Complete history and physical
- Use of alcohol, drug, and/or tobacco
- Appropriate ordering of lab tests and studies
- Verified review by physician of all lab tests, studies, consults, and other medical reports
- Diagnosis consistent with findings
- Treatment plan consistent with diagnosis
- Follow-up for each plan
- Follow through on problems from previous visits
- Appropriate use of consultants
- Continuity and coordination of care between PCPs and specialty physicians
- Appropriate medical care
- Preventive services completed, such as immunizations, mammograms, and Pap smears
- Appropriate confidentiality of records maintained

Note: Continuity and coordination of care are assessed by evaluating the extent to which referrals are noted in the primary care chart, specialty referral reports, etc.

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SECTION III.

PROVIDER CREDENTIALING STANDARDS

Introduction

The following section applies to those Provider types required to be credentialed for participation in *ANTHEM's* managed care networks.

Initial Selection

Providers must complete a standard application for the credentialing process when applying to participate in *ANTHEM's* managed care networks.

Credentialing Criteria

Providers initially applying to participate in *ANTHEM's* managed care networks must satisfy criteria for participation.

Each application is reviewed by a credentialing specialist or outsourced to a Credentialing Verification Organization (CVO). The credentialing specialist or CVO reviews the application for completeness and if necessary requests additional information from the provider. After the primary source verification is completed, the credentialing specialist or CVO verifies whether the provider appears to meet the minimum criteria or thresholds, such as education and training requirements, sufficient liability insurance, satisfactory medical malpractice history, etc. If the provider does not meet the established minimum standard, the deficiency or area of concern is noted for review by *ANTHEM's* credentialing committee. Provider's application status is considered incomplete until all appropriate verifications have been satisfactorily completed.

Criteria Verified from Primary Source

In the initial credentialing process of Providers, *ANTHEM*, or CVO obtains and reviews verifications of the following credentials from primary sources:

- License(s) in the state(s) in which the provider practices
- Primary hospital privileges
- DEA/CSR certification
- Board certification or highest level training/education
- Malpractice insurance
- Professional liability claims history
- Work history is reviewed but not verified with primary sources.

Office Reviews

In addition to the above criteria, PCPs and Ob/Gyns applying for participation as care-managers must successfully pass an office review.

Review by the Credentialing Committee

ANTHEM's Quality Improvement Committee designates a Medical Director to oversee *ANTHEM's* credentialing program.

Each state or health service area designates a credentialing committee to review the providers applying for participation in *ANTHEM's* managed care networks and makes recommendations to the Medical Director. After the recommendations are reviewed by the Medical Director the provider is notified in writing of his/her acceptance or denial for participation in the Network(s).

Recredentialing

Providers in *ANTHEM's* managed care networks are recredentialed at least every three (3) years in order to ensure that Providers continue to meet established credentialing criteria.

SECTION III.

PROVIDER CREDENTIALING STANDARDS
continued

The recredentialing process is very similar to the credentialing process. All PCPs and Ob/Gyns must successfully pass another office review. Also, those specialists who have been identified as high volume must also complete an office review.

All credentials, with the exception of education and training, are once again primary source verified. All appropriate external monitoring agencies are also queried. Information related to customer complaints, clinical reviews, utilization and drug formulary compliance are also incorporated into the review process.

Providers who do not meet the minimum criteria or who are above threshold are identified for special review by the credentialing committee. The credentialing committee makes recommendations on the acceptability of Providers to the Medical Director.

The Medical Director reviews the recommendations and notifies the appropriate network management staff of the acceptance or denial of the Providers.

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SECTION IV.

UTILIZATION MANAGEMENT PROGRAM

PROVIDER agrees to abide by the following Utilization Management Program ("UM Program") requirements in accordance with the terms of the Agreement and the Covered Individual's Health Benefit Plan. *PROVIDER* agrees to adhere to the following provisions and provide the information as outlined below, including, but not limited to:

Referrals

As part of the Professional Provider Agreement, *PROVIDER* agrees to refer Covered Individuals to other Network Providers, including specialists and admit to Network hospitals and facilities except:

- in the case of an Emergency and no Network Providers are available
- when required services are not geographically available
- when the Covered Individual refuses to accept your recommendation of referral to another Network Provider.

To obtain the most current listing of Network Providers, please access Anthem's web site at www.anthem.com, or its successor.

Medical Management Authorizations

Any PCP in one of Plan's HMO or Health Insuring Corporation ("HIC") Programs is responsible for initiating the referral process for their Covered Individuals who have illnesses or injuries which require the services of a Specialty Care Physician (SCP).

PCPs should refer Covered Individuals to participating SCPs (or facilities) when they are unable to provide the required services and when consistent with sound medical judgment. It is the PCP's responsibility to obtain authorization from the utilization management unit PRIOR to making the referral to ensure the Covered Individual's benefits include coverage for the service. It is the SCP's responsibility to ensure that authorization has been obtained by the PCP prior to rendering services.

Please call the appropriate utilization management unit to authorize services so that the Covered Individual will not be responsible for payment of all or part of the charges for the service.

Unless otherwise stated in the Covered Individual's Health Benefit Plan, *PROVIDER* should not authorize Covered Individual self-referrals to specialists or facilities. Covered Individuals participating in a HMO/HIC program are responsible for ALL charges incurred for services which are not authorized by the PCP.

The utilization management authorization is limited to the specific SCP, facility, condition, dates of service, length of time and number of visits stated in the written authorization notification that is mailed to the PCP, SCP and/or Covered Individual.

Changes regarding authorized services or rescheduled SCP/facility appointments should be processed with the utilization management staff which may avoid inappropriately denied claims to the Covered Individual.

Referrals to Specialty Care Physicians

As the gatekeeper for the Covered Individual's health care needs, the PCP has agreed to refer Covered Individuals to participating SCPs when medically indicated. If the Network does not have the necessary specialist in-network, the utilization management unit may authorize services to a non-network provider. In situations such as this, the Covered Individual will receive maximum benefits. Out-of-network authorizations can only be approved by the appropriate utilization management unit.

SECTION IV.

UTILIZATION MANAGEMENT PROGRAM
continued

Please note: Covered Individuals may decide to utilize an out-of-network physician when a Network Provider is available and receive the alternate (lower) level of benefits. For each condition, the PCP may elect to use one of two referral options:

- Consult only
- Consult and treat with Plan approval

The intent of these programs is to pre-certify Medical Necessity of all inpatient admissions based on nationally recognized criteria. Then, once the admission is pre-certified, an approved length of stay is established based on the admitting diagnosis, the Covered Individual's condition, signs and symptoms, and the plan of treatment.

The admission will not be certified (under the terms of the Covered Individual's Health Benefit Plan) if *ANTHEM* determines that the admission is not Medically Necessary. However, the Covered Individual may elect to be admitted without receiving certification. Then, coverage for the care will be subject to reduced benefits associated with the program, and the Covered Individual will be responsible for the appropriate hospital bill balances.

Please remember that there are some pre-certification programs in which the *PROVIDER* is responsible for this procedure; others allow the Covered Individual to initiate the process.

In either case, if you have or accept the responsibility for obtaining pre-certification, please follow-up since some programs impose a penalty upon the Covered Individual or *PROVIDER* for failure to complete the process.

On-Site Case Management

The hospital's Utilization Review (UR) staff is responsible for monitoring the stay and treatment, helping to ensure the efficient use of services and resources; and evaluating alternative, available outpatient treatment options.

Re-certification and extending the stay are also based on Medical Necessity.

If more inpatient care is needed beyond the initial days certified, the UR staff should contact the *ANTHEM* utilization management staff to give discharge information or information to extend the stay.

Utilization Statistics Information

On occasion, *ANTHEM* may request utilization statistics for disease management purposes by either diagnosis or CPT code. This may include:

- Patient name
- Patient identification number
- Date of service or date specimen collected
- Physician name and /or identification number
- Value of test requested or any other pertinent information *ANTHEM* deems necessary.

This information will be provided by *PROVIDER* to Plan at no charge to *ANTHEM.*

Failure to Comply With Utilization Management Program

PROVIDER acknowledges that Plan may apply monetary penalties as a result of *PROVIDER*'s failure to provide notice of admission as required under this Agreement, or for *PROVIDER*'s failure to fully comply with and participate in any cost management procedures and/or utilization management activities.

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SECTION V.

REIMBURSEMENT & ADMINISTRATIVE POLICY

Submission of Claims and Encounter Data

PROVIDER agrees to submit Claims to Plan for payment within one hundred eighty (180) days from the date the Health Services are rendered on a CMS 1500 form, or its successor, and/or in a manner consistent with industry standards. *ANTHEM* agrees to make a good faith effort to pay all complete and accurate Claims for Covered Services submitted by *PROVIDER* in accordance with state statute, exclusive of Claims that have been suspended due to the need to determine Medical Necessity, or the extent of *ANTHEM's* payment liability, if any, because of issues such as coordination of benefits, subrogation or verification of coverage. *ANTHEM* agrees to make such determinations in a reasonable period of time and to cooperate with *PROVIDER*, upon request, in good faith and within reason, in creating and maintaining methods and procedures to allow *ANTHEM* to efficiently identify Covered Services.

Not Otherwise Classified Codes

PROVIDER agrees to submit current, standardized, specific current procedural terminology ("CPT") or health care financing administration common procedure coding system ("HCPC") codes for Covered Services. In the event there is no proper CPT or HCPC code for the Covered Services rendered by *PROVIDER*, *PROVIDER* agrees to utilize the code that most closely matches the actual Covered Service rendered. *PROVIDER* further agrees to use unlisted, not otherwise classified, unspecified codes, commonly known as NOC codes, only when there is no specific CPT or HCPC code for the Covered Service rendered. When utilizing a NOC code, *PROVIDER* agrees to provide, along with the Claim, documentation, including, but not limited to, an operative report, equipment or supply invoice, equipment make and model number, or a detailed description of the Covered Service to assist *ANTHEM* in determining proper reimbursement. In the event *PROVIDER* fails to submit appropriate documentation with the Claim when utilizing a NOC code, *PROVIDER* acknowledges that *ANTHEM* may deny the Claim and return it to *PROVIDER*.

Amount of Payment

The dollar amount *ANTHEM* is obligated to pay for Covered Services shall be the applicable Anthem Rate less the dollar amount of any applicable Cost Share. The dollar amount of any applicable Cost Share shall be calculated based on the applicable Anthem Rate for Covered Services unless otherwise provided in a Covered Individual's Health Benefit Plan.

After Hours Coverage

Those providers contractually obligated to provide After Hours coverage for members shall not bill members for such coverage. Providers may only bill members for applicable Cost Share.

Electronic Billing

In the event *PROVIDER* submits claims electronically to *ANTHEM*, *PROVIDER* shall comply with the following:

a. *PROVIDER* shall utilize sufficient procedures and/or processes to ensure that all electronic submissions concerning Covered Individual patient-specific data are secure and protected from improper access and use.

b. *PROVIDER* shall retain and produce, upon request, all source documents and medical records pertaining to all electronic submissions transmitted by *PROVIDER* as required by federal or state law.

c. *PROVIDER* agrees that *ANTHEM* and/or its designee(s) may audit *PROVIDER*'s claims documentation to confirm information electronically submitted by *PROVIDER*, including the Covered Individual's authorization and signature.

d. *PROVIDER* warrants that all electronic transactions submitted to Plan and/or its designee(s) are accurate, complete, and truthful.

e. *PROVIDER* agrees to affix his/her *PROVIDER* number or group's *PROVIDER* number on each electronic transaction submitted to Plan and/or its contractor(s).

f. *PROVIDER* agrees that his/her provider number constitutes *PROVIDER*'s proper legal electronic signature.

g. *PROVIDER* agrees to maintain the equipment, software, services, and testing capabilities necessary to effectively and reliably exchange electronic transactions.

SECTION VI.

PROFESSIONAL PROVIDER APPEALS PROCESS

ANTHEM encourages providers to seek resolution of issues by using the provider complaint and appeal process outlined in detail in this Provider Manual. The provider complaint and appeal process is designed to provide appropriate and timely review when providers disagree with a decision made by *ANTHEM*. The procedures also meet requirements of state laws and accreditation agencies.

The building blocks of *ANTHEM's* provider complaint and appeal process are the 'complaint' and the 'appeal'. A complaint is any expression of dissatisfaction to *ANTHEM* by a provider. Initial requests for *ANTHEM* to change a previous decision other than an adverse utilization management decision will be handled exclusively as complaints. For some issues, the complaint is the only level of review available. An appeal is a form request for *ANTHEM* to change a decision upheld by *ANTHEM* through the complaint process or, in the case of an adverse utilization management decision, a request by a provider for *ANTHEM* to change that decision.

How Operational Issues are Handled

Operational complaints and appeals can be submitted to *ANTHEM's* Provider Inquiry Department. Examples of operational issues include Claim processing, benefit interpretation and reimbursement. For most issues involving reimbursement, the complaint is the only level of review. For other operational issues, a standard appeal (single level of review) is offered if the provider is not satisfied with the response to the complaint.

How Clinical Issues are Handled

Clinical appeals are change decisions based on whether services or supplies are Medically Necessary or experimental/ investigative. Utilization Management Program clinical appeals involve certification decisions, claims or predetermination decisions evaluated on these bases. For clinical issues, there are two (2) types of review; standard and expedited. *ANTHEM* offers an expedited appeal for decisions involving urgently needed care. Both standard and expedited appeals are reviewed by a person who did not make the initial decision.

When a physician or provider expresses dissatisfaction about an adverse Utilization Management Program decision involving a clinical issue, the case is automatically handled as an appeal or a reconsideration rather than as a complaint. A reconsideration is when *ANTHEM*, upon request by a treating physician, reevaluates the initial determination. Reconsiderations are handled outside of the appeals process and in accordance with *ANTHEM* Utilization Management policies. A standard appeal is available following the reconsideration, or initially if a reconsideration is not requested in a timely manner. An expedited appeal is available for urgently needed care.

A standard appeal is available following an expedited appeal is available for urgently needed care. A standard appeal is available following an expedited appeal, except for appeals involving Kentucky members.

Timeframes for Submitting Complaints and Appeals

Providers have one hundred eighty (180) calendar days to file an appeal from the date they receive notice of *ANTHEM's* initial decision.

All standard clinical appeals (pre-service and post-service) will be resolved within a reasonable period of time appropriate to the medical circumstances, but not later than thirty (30) calendar days from the receipt of the grievance request by *ANTHEM*.

For Indiana, administrative grievances will be resolved within twenty (20) business days from the receipt of the grievance request by *ANTHEM*.

For Ohio, *ANTHEM* typically completes the standard review process within thirty (30) business days from the receipt of the appeal by *ANTHEM*. If additional information is needed to complete processing of the provider's appeal *ANTHEM* may extend response time up to ten (10) business days.

For Kentucky, all standard appeals, both clinical and operational, must be completed and the responses must be sent out within thirty (30) calendar days of the appeal requests.

How Special Complaints and Appeals are Handled

Certain types of complaints or appeals are handled by specific *ANTHEM* departments and may follow different policies and procedures. The following is a brief summary of some of the special complaint and appeal procedures.

Member Complaints and Appeals

ANTHEM members may designate a representative to exercise their complaint and appeal rights. When a physician and provider is acting on behalf of a member as the designated representative, the complaint or appeal may be submitted to the Provider Inquiry Department. These types of issues are reviewed according to *ANTHEM's* Member Complaint and Appeal Procedures, **for each applicable state.**

Network Participation Appeals

Physicians and providers who are terminated or rejected from *ANTHEM's* network(s) for failure to satisfy *ANTHEM's* participation requirement, may appeal *ANTHEM's* decision. *ANTHEM* will send a letter of explanation that outlines how to initiate an appeal. In general, the physician or provider has thirty (30) days from receipt of this notice to request that *ANTHEM* reconsider its decision. The appeal process will vary depending upon the type of provider (physician, hospital, ancillary), the *ANTHEM* network in question, the state in which the provider is located, and the reason for the termination. For more information on appeals process for network participation issues, contact your provider relations/network management representative.

Most *ANTHEM* plans follow this process. Certain plans including the Federal Employee Service Benefit PPO plans and self-funded plans may have different processes.

For More Information

Questions concerning the complaint and appeals process can be directed to the Provider Inquiry Department at (800) 282-1016 or your provider relations/network management representative.

Anthem Insurance Companies, Inc. d/b/a
Anthem Blue Cross and Blue Shield

PROVIDER OWNERSHIP / EMPLOYMENT CERTIFICATION

Anthem Blue Cross and Blue Shield (*"ANTHEM"*) has received a request from Centrality Behavior Support Training, LLC (*"PROVIDER"*) to add practitioner(s) to its *ANTHEM* Professional Provider Agreement ("Agreement"). The Agreement in place includes practitioners who are employed (i.e., W-2) by *PROVIDER* or are owner physicians (i.e., K-1) of *PROVIDER*. The Agreement does not include those practitioners that provide contracted call coverage for staffing for *PROVIDER* and/or for those practitioners with which *PROVIDER* has established a contract for services (i.e., 1099). *ANTHEM's* direct contract with any such practitioners also contracted with *PROVIDER* will prevail, and such contracted practitioners are not eligible for inclusion in the Agreement. Such practitioners must file claims under their own direct tax ID and direct agreement with *ANTHEM* if they are not one hundred percent (100%) owned or employed by *PROVIDER*.

As a duly authorized and empowered representative of *PROVIDER*, I certify that *PROVIDER* employs the practitioners or the practitioners are owner physicians of *PROVIDER*. Exhibit A lists the employed and ownership physicians and is attached hereto.

PROVIDER agrees to notify *ANTHEM* immediately in the event the employment or ownership status of any these practitioners change.

PROVIDER LEGAL NAME Centrality Behavior Support Training, LLC
(Must match Provider Name on front page of Agreement)

By: _____ _____
Signature Date

Printed: Meagan Dant Owner
Name Title

Address: 3125 E. Southport Rd Ste F Indianapolis, IN 46227
Street City State Zip

EXHIBIT A

List of all owned/employed or owner physician Professional Practitioners:

Name of Practitioner	Individual NPI	Tax ID	W-2/K-1 Status
Meagan Dant	1053652776	46-4197524	