Attachment C.18.d-1. Proposed Contract Templates for Individual Practitioners and Facilities

Pursuant to the guidance provided in the updated RFP and Q&A document on page 91 related to Sections 60.5.A.1-2, we are providing Attachment C.18.d-1 electronically, on thumb/flash drives in place of a hardcopy of these documents. The files are in a PDF format and do not include embedded documents, hyperlinks or hyperlinks to videos. As requested, we are providing a table of contents to clearly identify what information is included on the thumb/flash drive.

Attachment C.18.d-1 includes the following:

- Attachment C.18.d-1a. Provider Network — Proposed Individual Practitioner Contract Template
- Attachment C.18.d-1b. Provider Network — Proposed Facility Contract Template

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ANTHEM BLUE CROSS AND BLUE SHIELD PROVIDER AGREEMENT

WITH

Provider Name

ANTHEM BLUE CROSS AND BLUE SHIELD
PROVIDER AGREEMENT

This Provider Agreement (hereinafter "Agreement") is made and entered into by and between Anthem Health Plans of Kentucky, Inc. doing business as Anthem Blue Cross and Blue Shield (hereinafter "Anthem") and _____(hereinafter "Provider"), effective as of the date set forth immediately above Anthem's signature (the "Effective Date"). In consideration of the mutual promises and covenants herein contained, the sufficiency of which is acknowledged by the parties, the parties agree as follows:

ARTICLE I
DEFINITIONS

"Affiliate" means any entity that is: (i) owned or controlled, either directly or through a parent or subsidiary entity, by Anthem, or is under common control with Anthem, and (ii) that is identified as an Affiliate on Anthem's designated web site as referenced in the provider manual(s). Unless otherwise set forth in the Participation Attachment(s), an Affiliate may access the rates, terms and conditions of this Agreement.

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

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

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

"Claim" means either the uniform bill claim form or electronic claim form in the format prescribed by Plan submitted by a provider for payment by a Plan for Health Services rendered to a Member.

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

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

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

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

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

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

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

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

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

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

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

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

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

"Plan" means Anthem, an Affiliate, and/or an Other Payor. For purposes of this Agreement, when the term "Plan" applies to an entity other than Anthem, "Plan" shall be construed to only mean such entity (i.e., the financially responsible Affiliate or Other Payor under the Member's Health Benefit Plan).

"Plan Compensation Schedule" ("PCS") means the document(s) attached hereto and incorporated herein by reference, and which sets forth the Anthem Rate(s) and compensation related terms for the Network(s) in which Provider participates. The PCS may include additional Provider obligations and specific Anthem compensation related terms and requirements.

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

ARTICLE II
SERVICES/OBLIGATIONS

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

2.2 Provider Non-discrimination. Provider shall provide Health Services to Members in a manner similar to and within the same time availability in which Provider provides Health Services to any other individual. Provider will not differentiate, or discriminate against any Member as a result of his/her enrollment in a Health Benefit Plan, or because of race, color, creed, national origin, ancestry, religion, sex, marital status, age, disability,

payment source, state of health, need for Health Services, status as a litigant, status as a Medicare or Medicaid beneficiary, sexual orientation, gender identity, or any other basis prohibited by law. Provider shall not be required to provide any type, or kind of Health Service to Members that he/she/it does not customarily provide to others. Additional requirements may be set forth in the applicable Participation Attachment(s).

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

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

2.5 Submission and Adjudication of Claims. Provider shall submit, and Plan shall adjudicate, Claims in accordance with the applicable Participation Attachment(s), the PCS, the provider manual(s) and Regulatory Requirements. If Provider submits Claims prior to receiving notice of Anthem's approval pursuant to section 2.13, and/or approval of any requested change of status pursuant to section 9.3, then such Claims shall be processed as out of network and Anthem shall not make retroactive adjustments with respect to such Claims.

2.6 Payment in Full and Hold Harmless.

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

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

2.6.2.1 Cost Shares, if applicable;

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

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

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

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

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

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

2.7 Recoupment/Offset/Adjustment for Overpayments. Anthem shall be entitled to offset and recoup an amount equal to any overpayments or improper payments made by Anthem to Provider against any payments due and payable by Anthem to Provider with respect to any Health Benefit Plan under this Agreement. Provider shall voluntarily refund all duplicate or erroneous Claim payments regardless of the cause, with or without request from Plan, including, but not limited to, payments for Claims where the Claim was miscoded, non-compliant with industry standards, or otherwise billed in error, whether or not the billing error was fraudulent, abusive or wasteful. Upon determination by Anthem that any recoupment, improper payment, or overpayment is due from Provider, and Provider has not already voluntarily refunded the amount, Provider must refund the amount to Anthem within thirty (30) days of when Anthem notifies Provider. If such reimbursement is not received by Anthem within the thirty (30) days following the date of such notice, then Plan may offset future Claim payments in accordance with and within the time frames established by KRS 304.17A-714, or other applicable Regulatory Requirements. For Claims that are not subject to KRS 304.17A-714 or other applicable Regulatory Requirements, Plan may offset future Claim payments in lieu of a refund, except to the extent as may be set forth in a Participation Attachment(s). In such event, Provider agrees that all future Claim payments applied to satisfy Provider's repayment obligation shall be deemed to have been paid in full for all purposes, including section 2.6.1. Should Provider disagree with any determination by Plan that Provider has received an overpayment, Provider shall have the right to appeal such determination under Anthem's procedures set forth in the provider manual, and such appeal shall not suspend Anthem's right to recoup the overpayment amount during the appeal process. Anthem reserves the right to employ a third party collection agency in the event of non-payment.

2.8 Use of Subcontractors. Provider and Plan may fulfill some of their duties under this Agreement through subcontractors. For purposes of this provision, subcontractors shall include, but are not limited to, vendors and non-Participating Providers that provide supplies, equipment, staffing, and other services to Members at the request of, under the supervision of, and/or at the place of business of Provider. Unless otherwise set forth in a Participation Attachment(s), Provider shall provide Anthem with thirty (30) days prior notice of any Health Services subcontractors with which Provider may contract to perform Provider's duties and obligations under this Agreement, and Provider shall remain responsible to Plan for the compliance of his/her/its subcontractors with the terms and conditions of this Agreement as applicable, including, but not limited to, the Payment in Full and Hold Harmless provisions herein.

2.9 Compliance with Provider Manual(s) and Policies, Programs and Procedures. Provider agrees to cooperate and comply with, Anthem provider manual(s), and all other policies, programs and procedures (collectively "Policies") established and implemented by Plan applicable to the Network(s) in which Provider participates. Anthem or its designees may modify the provider manual(s) and its Policies by making a good faith effort to provide notice to Provider at least ninety (90) days in advance of the effective date of material modifications for business subject to Kentucky state law, and at least thirty (30) days in advance of the effective date of material modifications for all other lines of business thereto.

2.10 Referral Incentives/Kickbacks. Provider represents and warrants that Provider does not give, provide, condone or receive any incentives or kickbacks, monetary or otherwise, in exchange for the referral of a Member, and if a Claim for payment is attributable to an instance in which Provider provided or received an incentive or kickback in exchange for the referral, such Claim shall not be payable and, if paid in error, shall be refunded to Anthem.

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

In addition to and separate from Networks that support some or all of Plan's products and/or programs (e.g., HMO, PPO and Indemnity products), Provider further acknowledges that certain Health Services, including by way of example only, laboratory services, may be provided exclusively by designated Participating Providers (a "Health Services Designated Network"), as determined by Plan. Provider agrees to refer Members to such designated Participating Providers in a Health Services Designated Network for the provision of certain Health Services, even if Provider performs such services. Notwithstanding any other provision in this Agreement, if Provider provides a Health Service to a Member for which Provider is not a designated Participating Provider in a Health Services Designated Network, then Provider agrees that he/she/it shall not be reimbursed for such services by Anthem, Plan or the Member, unless Provider was authorized to provide such Health Service by Plan.

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

2.12.1 Any legal, governmental, or other action or investigation involving Provider which could affect Provider's credentialing status with Plan, or materially impair the ability of Provider to carry out his/her/its duties and obligations under this Agreement, except for temporary emergency diversion situations; or

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

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

2.14 Adjustment Requests. If Provider believes a Claim has been improperly adjudicated for Covered Service for which Provider timely submitted a Clean Claim to Plan, Provider must submit a request for an adjustment to Plan per the requirements set forth in the provider manual(s) or applicable Participation Attachment(s). Adjustment requests submitted that do not comply with such requirements may be denied for payment, and Provider shall not be permitted to bill Anthem, Plan, or the Member for those Covered Services for which payment was denied.

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

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

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

2.18 Request for Fees. Upon request by Provider, Plan shall provide Provider with the payment or fee schedules or other information sufficient to enable Provider to determine the amount and manner of payments under the

Agreement for Provider's services. This does not prohibit Plan from making any part of the information requested available electronically or via a web site.

ARTICLE III
CONFIDENTIALITY/RECORDS

3.1 Proprietary and Confidential Information. Except as otherwise provided herein, all information and material provided by either party in contemplation of or in connection with this Agreement remains proprietary and confidential to the disclosing party. This Agreement, including but not limited to the Anthem Rates, is Anthem's proprietary and confidential information. Neither party shall disclose any information proprietary or confidential to the other, or use such information or material except: (1) as otherwise set forth in this Agreement; (2) as may be required to perform obligations hereunder; (3) as required to deliver Health Services or administer a Health Benefit Plan; (4) to Plan or its designees; (5) upon the express written consent of the parties; or (6) as required by Regulatory Requirements. Notwithstanding the foregoing, either party may disclose such information to its legal advisors, lenders and business advisors, provided that such legal advisors, lenders and business advisors agree to maintain confidentiality of such information. Provider and Anthem shall each have a system in place that meets all applicable Regulatory Requirements to protect all records and all other documents relating to this Agreement which are deemed confidential by law. Any disclosure or transfer of proprietary or confidential information by Provider or Anthem will be in accordance with applicable Regulatory Requirements. Provider shall immediately notify Anthem if Provider is required to disclose any proprietary or confidential information at the request of an Agency or pursuant to any federal or state freedom of information act request.

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

3.3 Network Provider/Patient Discussions. Notwithstanding any other provision in this Agreement and regardless of any benefit or coverage exclusions or limitations associated with a Health Benefit Plan, Provider shall not be prohibited from discussing fully with a Member any issues related to the Member's health including recommended treatments, treatment alternatives, treatment risks and the consequences of any benefit coverage or payment decisions made by Plan or any other party. In addition, nothing in this Agreement shall be construed to, create any financial incentive for Provider to withhold Covered Services, or prohibit Provider from disclosing to the Member the general methodology by which Provider is compensated under this Agreement, such as for example, whether Provider is paid on a fee for service, capitation or Percentage Rate basis. Plan shall not refuse to allow or to continue the participation of any otherwise eligible provider, or refuse to compensate Provider in connection with services rendered, solely because Provider has in good faith communicated with one or more of his/her/its current, former or prospective patients regarding the provisions, terms or requirements of a Health Benefit Plan as they relate to the health needs of such patient. Nothing in this section shall be construed to permit Provider to disclose Anthem Rates or specific terms of the compensation arrangement under this Agreement.

3.4 Plan Access to and Requests for Provider Records. Provider and its designees shall comply with all applicable state and federal record keeping and retention requirements, and, as set forth in the provider manual(s) and/or Participation Attachment(s), shall permit Plan or its designees to have, with appropriate working space and without charge, on-site access to and the right to perform an Audit, examine, copy, excerpt and transcribe any books, documents, papers, and records related to Member's medical and billing information within the possession of Provider and inspect Provider's operations, which involve transactions relating to Members and as may be reasonably required by Plan in carrying out its responsibilities and programs including, but not limited to, assessing quality of care, complying with quality initiatives/measures, Medical Necessity, concurrent review, appropriateness of care, accuracy of payment, risk adjustment assessment as described in the provider manual(s), including but not limited to completion of the Encounter Facilitation Form (also called the "SOAP" note), compliance with this Agreement, and for research. In lieu of on-site access, at Plan's request, Provider or its designees shall submit records to Plan, or its designees via photocopy or electronic transmittal,

within thirty (30) days, at no charge to Plan from either Provider or its designee. Provider shall make such records available to the state and federal authorities involved in assessing quality of care or investigating Member grievances or complaints in compliance with Regulatory Requirements. Any examination or Audit of Provider records shall be performed using generally accepted, statistically valid or industry standard methodology. Provider acknowledges that failure to submit records to Plan in accordance with this provision and/or the provider manual(s), and/or Participation Attachment(s) may result in a denial of a Claim under review, whether on pre-payment or post-payment review, or a payment retraction on a paid Claim, and Provider is prohibited from balance billing the Member in any of the foregoing circumstances.

3.5 Transfer of Medical Records. Following a request, Provider shall transfer a Member's medical records in a timely manner, or within such other time period required under applicable Regulatory Requirements, to other health care providers treating a Member at no cost to Anthem, Plan, the Member, or other treating health care providers.

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

ARTICLE IV
INSURANCE

4.1 Anthem Insurance. Anthem shall self-insure or maintain insurance as required under applicable Regulatory Requirements to insure Anthem and its employees, acting within the scope of their duties.

4.2 Provider Insurance. Provider shall self-insure or maintain insurance acceptable to Anthem as set forth in the provider manual(s), Participation Attachment(s), PCS, or as required under applicable Regulatory Requirements.

ARTICLE V
RELATIONSHIP OF THE PARTIES

5.1 Relationship of the Parties. For purposes of this Agreement, Anthem and Provider are and will act at all times as independent contractors. Nothing in this Agreement shall be construed, or be deemed to create, a relationship of employer or employee or principal and agent, partnership, joint venture, or any relationship other than that of independent entities contracting with each other for the purposes of effectuating this Agreement.

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

ARTICLE VI
INDEMNIFICATION AND LIMITATION OF LIABILITY

6.1 Indemnification. Anthem and Provider shall each indemnify, defend and hold harmless the other party, and his/her/its directors, officers, employees, agents, Affiliates and subsidiaries ("Representatives"), from and

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

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

ARTICLE VII
DISPUTE RESOLUTION AND ARBITRATION

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

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

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

from disclosing any such details regarding the arbitration to its accountants, auditors, brokers, insurers, reinsurers or retrocessionaires.

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

7.2.2 Selection and Replacement of Arbitrator(s). If the total amount in dispute is less than four million dollars ($4,000,000), exclusive of interest, costs, and attorneys' fees, the dispute shall be decided by a single arbitrator selected, and replaced when required, in the manner described in the JAMS Comprehensive Arbitration Rules and Procedures. If the total amount in dispute is four million dollars ($4,000,000) or more, exclusive of interest, costs, and attorneys' fees, the dispute shall be decided by an arbitration panel consisting of three (3) arbitrators, unless the parties agree in writing that the dispute shall be decided by a single arbitrator.

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

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

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

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

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

ARTICLE VIII
TERM AND TERMINATION

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

8.2 This provision intentionally left blank.

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

8.4 Immediate Termination.

8.4.1 This Agreement or any Participation Attachment(s) may be terminated immediately by Anthem if:

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

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

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

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

8.4.1.5 Provider fails to maintain compliance with Plan's applicable credentialing requirements, accreditation requirements or standards of participation; or

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

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

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

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

8.4.1.10 Anthem discontinues the Network(s) in which Provider participates, discontinues operations in Provider's geographic area, or discontinues contracting with Provider's specialty type.

8.4.2 This Agreement may be terminated immediately by Provider if:

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

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

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

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

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

8.7 Continuation of Care Upon Termination. If this Agreement or any Participation Attachment terminates for any reasons other than one of the grounds set forth in the "Immediate Termination" section, then Provider shall at Anthem's discretion, continue to provide Covered Services to Members under this Agreement or any terminating Participation Attachment as applicable, in accordance with Regulatory Requirements. During such continuation period, Provider agrees to: (i) accept reimbursement from Anthem for all Covered Services furnished hereunder in accordance with this Agreement and at the rates set forth in the PCS attached hereto; and (ii) adhere to Anthem's Policies, including but not limited to, Policies regarding quality assurance requirements, referrals, pre-authorization and treatment planning.

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

8.8.1 Publication and Use of Provider Information;

8.8.2 Payment in Full and Hold Harmless;

8.8.3 Recoupment/Offset/Adjustment for Overpayments;

8.8.4 Confidentiality/Records;

8.8.5 Indemnification and Limitation of Liability;

8.8.6 Dispute Resolution and Arbitration;

8.8.7 Continuation of Care Upon Termination; and

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

ARTICLE IX
GENERAL PROVISIONS

9.1 Amendment. Except as otherwise provided for in this Agreement, Anthem retains the right to amend this Agreement, the Anthem Rate, any attachments or addenda by making a good faith effort to provide notice to Provider at least thirty (30) days in advance of the effective date of the amendment. Except to the extent that Anthem determines an amendment is necessary to effectuate Regulatory Requirements, if Provider objects to the amendment, prior to its effective date, then Provider has the right to terminate this Agreement, and such termination shall take effect on the later of the amendment effective date identified by Anthem or one hundred eighty (180) days from the date Provider has provided notice of his/her/its intention to terminate the Agreement pursuant to this section. Failure of Provider to provide such notice to Anthem within the time frames described herein will constitute acceptance of the amendment by Provider.

9.1.1 Except as otherwise provided for in this Agreement, for Networks, products and/or programs that are subject to state law, Anthem retains the right to amend this Agreement, the provider manual, any attachments or addenda. If such an amendment results in a material change as that term is defined under KRS 304.17A-235, Anthem shall provide notice of such amendment at least ninety (90) days

before the proposed effective date of the amendment. If the Provider objects to the amendment, the Provider must provide written notice of the objection within thirty (30) days of receipt of the notice of the Amendment. If the parties cannot reach an agreement, the Provider may terminate this Agreement pursuant to its original terms within thirty (30) days prior to the proposed effective date of the Amendment. If the Provider fails to timely object to the proposed Amendment, the Amendment shall become effective as to that Provider. If the Amendment relates to the Provider's inclusion in any new or modified insurance product or proposes changes to the Provider's network membership, the amendment shall only take effect upon the Provider's acceptance as evidenced by the Provider's signature.

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

9.3 Scope/Change in Status.

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

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

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

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

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

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

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

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

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

9.3.3.2 A change in mailing address.

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

9.3.5 Within forty-five (45) days of receipt of the written notice from Provider, Anthem shall notify Provider in writing whether it consents to the Change(s) (e.g., add a new location or acquired entity to this Agreement); and that new location/entity meets criteria for participation and has been added to the Agreement. New location/entity should not begin seeing Members until notified of acceptance into Networks.

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

9.5 Entire Agreement. This Agreement, exhibits, attachments, appendices, and amendments hereto, together with any items incorporated herein by reference, constitute the entire understanding between the parties and supersedes all prior oral or written agreements between them with respect to the matters provided for herein. If there is an inconsistency between any of the provisions of this Agreement and the provider manual(s) or Policies, then this Agreement shall govern. In addition, if there is an inconsistency between the terms of this Agreement and the terms provided in any attachment to this Agreement, then the terms provided in that attachment shall govern.

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

9.7 Compliance with Regulatory Requirements. Anthem and Provider agree to comply with all applicable Regulatory Requirements, as amended from time to time, relating to their obligations under this Agreement, and maintain in effect all permits, licenses and governmental and board authorizations and approvals as necessary for business operations. Provider warrants that as of the Effective Date, he/she/it is and shall remain licensed and certified for the term of this Agreement in accordance with all Regulatory Requirements (including those applicable to utilization review and Claims payment) relating to the provision of Health Services to Members. Provider shall supply evidence of such licensure, compliance and certifications to Anthem upon request. If there is a conflict between this section and any other provision in this Agreement, then this section shall control.

9.7.1 In addition to the foregoing, Provider warrants and represents that at the time of entering into this Agreement, neither he/she/it nor any of his/her/its employees, contractors, subcontractors, principals or agents are ineligible, excluded, suspended, terminated or debarred from participating in a Government Program ("Ineligible Person"). Provider shall remain continuously responsible for ensuring that his/her/its employees, contractors, subcontractors, principals or agents are not Ineligible Persons. If Provider or any employees, subcontractors, principals or agents thereof becomes an Ineligible Person after entering into this Agreement or otherwise fails to disclose his/her/its Ineligible Person status, Provider shall have an obligation to (1) immediately notify Anthem of such Ineligible Person status and (2) within ten (10) days of such notice, remove such individual from responsibility for, or involvement with, Provider's business operations related to this Agreement.

9.8 Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the state where Anthem has its primary place of business, unless such state laws are otherwise preempted by federal law. However, coverage issues specific to a Health Benefit Plan are governed by the state laws where the Health Benefit Plan is issued, unless such state laws are otherwise preempted by federal law.

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

except to the extent specified in the Payment in Full and Hold Harmless section of this Agreement, or in a Participation Attachment(s).

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

9.11 Notice. Any notice required to be given pursuant to the terms and provisions of this Agreement shall be in writing and shall be delivered by hand, facsimile, electronic mail, or mail. Notice shall be deemed to be effective: (a) when delivered by hand, (b) upon transmittal when transmitted by facsimile transmission or by electronic mail, (c) upon receipt by registered or certified mail, postage prepaid, (d) on the next business day if transmitted by national overnight courier, or (e) if sent by regular mail, five (5) days from the date set forth on the correspondence. Unless specified otherwise in writing by a party, Anthem shall send Provider notice to an address that Anthem has on file for Provider, and Provider shall send Anthem notice to Anthem's address as set forth on the signature page. Notwithstanding the foregoing, and unless otherwise required by Regulatory Requirements, Anthem may post updates to its provider manual(s) and Policies on its web site.

9.12 Severability. In case any one or more of the provisions of this Agreement shall be invalid, illegal, or unenforceable in any respect, the remaining provisions shall be construed liberally in order to effectuate the purposes hereof, and the validity, legality and enforceability of the remaining provisions shall not in any way be affected or impaired thereby. If one or more provisions of the Agreement are invalid, illegal or unenforceable and an amendment to the Agreement is necessary to maintain its integrity, the parties shall make commercially reasonable efforts to negotiate an amendment to this Agreement and any attachments or addenda to this Agreement which could reasonably be construed not to contravene such statute, regulation, or interpretation. In addition, if such invalid, unenforceable or materially affected provision(s) may be severed from this Agreement and/or attachments or addenda to this Agreement without materially affecting the parties' intent when this Agreement was executed, then such provision(s) shall be severed rather than terminating the Agreement or any attachments or addenda to this Agreement.

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

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

9.15 Counterparts and Electronic Signatures.

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

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

ARTICLE X
BCBSA REQUIREMENTS

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

shall not create any additional obligations whatsoever on the part of Plan other than those obligations created under other provisions of this Agreement.

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

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

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

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

PROVIDER LEGAL NAME: _____

By: _____ _____
Signature, Authorized Representative of Provider(s) | Date

Printed: _____ _____
Name | Title

Address _____ _____
Street | City | State | Zip

Tax Identification Number (TIN): _____

Anthem Health Plans of Kentucky, Inc.
doing business as Anthem Blue Cross and Blue Shield

ANTHEM INTERNAL USE ONLY

THE EFFECTIVE DATE OF THIS AGREEMENT IS: _____

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

Printed: Mike Lorch | Regional Vice President, Provider Solutions
Name | Title

Address 13550 Triton Park Blvd | Louisville | KY | 40223
Street | City | State | Zip

PROVIDER NETWORKS ATTACHMENT

Provider shall be designated as a Participating Provider in the Networks set forth below on the later of: (1) the Effective Date of this Agreement or; (2) the date Provider has met applicable credentialing requirements, standards of participation and accreditation requirements:

Government Programs::

Health Benefit Plans issued pursuant to an agreement between Plan and Agency in which Members have access to a network of providers and receive an enhanced level of benefits when they obtain Covered Services from Participating Providers regardless of product licensure status. Such Health Benefit Plans include:

☑ Kentucky Medicaid

Exceptions

Notwithstanding the foregoing:

Provider is not a Participating Provider in the following Networks and/or products:

- HMO and POS
- PPO
- Indemnity/Traditional/Standard
- Pathway PPO
- Pathway HMO
- IN Exchange
- OH Exchange
- Blue Access - OH I - Tier 1
- Blue Access - OH I - Tier 2
- Blue Access - OH II - Tier 1
- Blue Access - OH II - Tier 2
- Medicare Advantage HMO
- Medicare Advantage PPO
- Indiana Medicaid
- Healthy Indiana Plan
- Enhanced Personal Health Care Program
- Enhanced Personal Health Care Essentials
- Freestanding Patient Centered Care Organization (FPCC)
- KY WC
- IN WC

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

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

RECITALS

Anthem Kentucky Managed Care Plan, Inc. d/b/a Anthem Blue Cross and Blue Shield Medicaid, an Affiliate of Anthem Health Plans of Kentucky, Inc. doing business as Anthem Blue Cross and Blue Shield, is contracted with the Kentucky Cabinet for Health and Family Services Department of Medicaid Services to serve as a Medicaid managed care organization.

Anthem Health Plans of Kentucky, Inc. doing business as Anthem Blue Cross and Blue Shield is entering into this Medicaid Participation Attachment on behalf of its Affiliate Anthem Kentucky Managed Care Plan, Inc. d/b/a Anthem Blue Cross and Blue Shield Medicaid.

For purposes of this Attachment, Anthem Kentucky Managed Care Plan, Inc. d/b/a Anthem Blue Cross and Blue Shield Medicaid is referred to as ("Anthem").

ARTICLE I
DEFINITIONS

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

"Cabinet" means the Cabinet for Health and Family Services in which the Kentucky Department of Medicaid Services is located.

"Commonwealth" means the Commonwealth of Kentucky.

"Finance" means the Kentucky Cabinet for Finance and Administration.

"Clean Claim" means, for purposes of this Attachment, unless otherwise required by applicable state Regulatory Requirements, an accurate and timely filed Claim submitted pursuant to this Attachment, that has no defect or impropriety, for which all information necessary to process such Claim and make a benefit determination is included. This includes but is not limited to, the claim being submitted in a nationally accepted format in compliance with standard coding guidelines, and which requires, adjustment, or alteration by Provider of the services in order to be processed and paid.

"Medicaid Program(s)" means, for purposes of this Attachment, a medical assistance program provided under a Health Benefit Plan approved under Title XVI, Title XIX and/or Title XXI of the Social Security Act or any other federal or state funded program or product as designated by Anthem.

"Medicaid Covered Services" means, for purposes of this Attachment, only those Covered Services provided under Anthem's Medicaid Program(s).

"Medicaid Member" means, for purposes of this Attachment, a Member who is enrolled in Anthem's Medicaid Program(s).

"Medically Necessary/Medical Necessity" means, for purposes of this Attachment, Medicaid Covered Services which are medically necessary as defined under 907 KAR 3:130, meet national standards, if applicable, and provided in accordance with 42 CFR § 440.230, including children's services pursuant to 42 U.S.C. 1396d(r)).

"State Agency" means the Kentucky Department for Medicaid Services within the Cabinet for Health and Family Services, or other Commonwealth or local governing body responsible for the governance or administration Anthem's Medicaid Program(s).

ARTICLE II

SERVICES/OBLIGATIONS

2.1 Participation-Medicaid Network. As a participant in Anthem's Medicaid Network, Provider will render Medicaid Covered Services to Medicaid Members in accordance with the terms and conditions of the Agreement and this Attachment. Such Medicaid Covered Services provided shall be within the scope of Provider's licensure, expertise, and usual and customary range of services pursuant to the terms and conditions of the Agreement and this Attachment, and Provider shall be responsible to Anthem for his/her/its performance hereunder. Except as set forth in this Attachment or the Plan Compensation Schedule ("PCS"), all terms and conditions of the Agreement will apply to Provider's participation in Anthem's Medicaid Network. The terms and conditions set forth in this Attachment are limited to the provision of and payment for Health Services provided to Medicaid Members.

2.2 Provider's Duties and Obligations to Medicaid Members. All of Provider's duties and obligations to Members set forth in the Agreement shall also apply to Medicaid Members. Provider shall not discriminate in the acceptance of Medicaid Members for treatment, and shall provide to Medicaid Members the same access to services, including but not limited to, hours of operation, as Provider gives to all other patients. Provider shall furnish Anthem with at least ninety (90) days prior written notice if Provider plans to close its practice to new patients or ceases to continue in Provider's current practice.

2.2.1 To the extent mandated by Regulatory Requirements, Provider shall ensure that Medicaid Members have access to 24 hour-per-day, 7 day-per-week urgent and Emergency Services, as defined in the PCS.

2.2.2 Unless otherwise required under Regulatory Requirements, a PCP, as defined in the PCS, shall provide Medicaid Covered Services or make arrangements for the provision of Medicaid Covered Services to Medicaid Members on a twenty-four (24) hour-per-day, seven (7) day-per-week basis to assure availability, adequacy, and continuity of care to Medicaid Members. Provider shall arrange for after hours office phone coverage by an answering service that and can contact Provider or another designated medical practitioners. If Provider is unable to provide Medicaid Covered Services, Provider shall arrange for another Participating Provider to cover Provider's patients in accordance with Policies. Provider and any PCPs employed by or under contract with Provider may arrange for Medicaid Covered Services to Medicaid Members to be performed by a Specialist Physician only in accordance with Policies.

2.2.3 If Provider is furnishing Specialist Physician services under this Attachment, Provider and the Specialist Physician(s) employed by or under contract with Provider, shall accept as patients all Medicaid Members and may arrange for Medicaid Covered Services to Medicaid Members to be performed by Specialist Physician only in accordance with Policies.

2,2,4 Provider shall display notices of Medicaid Members' right to appeal adverse action affecting services in public areas of Provider's facility/office in accordance with the Cabinet' rules and regulations.

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

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

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

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

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

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

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

2.10 Coordinated and Managed Care. Provider shall participate in Anthem's quality assessment and performance improvement activities and utilization management and care management programs designed to facilitate the coordination of services as referenced in the applicable provider manual(s). Subject to medical judgment, patient care interests, and a patient's express instructions, and recognizing that the level of Medicaid Covered Services provided by Provider may be affected by the Provider's scope of services, Provider shall report all required clinical encounter data, and shall obtain all required Medicaid Member consents or authorizations necessary for Provider to report such clinical encounter data to Anthem. Prior authorization shall not be required for a physical Emergency Service or a behavioral health Emergency Service. In order to be covered, an Emergency Service shall be: (1) Medically Necessary; (2) Authorized after being provided if the service was not prior authorized; and (3) covered in accordance with 907 KAR 17:020.

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

2.12 Kentucky Health Information Exchange. Provider shall sign a Participation Agreement with the Kentucky Health Information Exchange (KHIE) within one (1) month of signing this Agreement. Provider will engage with

KHIE for the purpose of connecting its electronic health records (EHR) system to the health information exchange to share its patient electronic records in order to facilitate improved care coordination resulting in higher quality care and better outcomes.
If Provider does not have an EHR system, Provider must still sign a Participation Agreement with KHIE and sign up for Direct Secure Messaging services so that clinical information can be shared securely with other providers in Provider's community of care.

ARTICLE III
COMPENSATION AND AUDIT

3.1 Submission and Adjudication of Medicaid Claims. Unless otherwise instructed, or required by Regulatory Requirements, Provider shall submit Claims to Anthem, using appropriate and current Coded Service Identifier(s), within three hundred sixty five (365) days from the date the Health Services are rendered or Anthem may refuse payment. If Anthem is the secondary payor, the three hundred sixty five (365) day period will not begin until Provider receives notification of primary payor's responsibility.

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

3.1.2 Provider agrees to provide to Anthem, unless otherwise instructed, at no cost to Anthem, Anthem or the Medicaid Member, all information necessary for Anthem to determine its payment liability. Such information includes, without limitation, accurate and Clean Claims for Medicaid Covered Services. If Anthem or Anthem asks for additional information so that Anthem may process the Claim, Provider must provide that information within sixty (60) days, or before the expiration of the three hundred sixty five (365) day period referenced in section 3.1 above, whichever is longer.

3.1.3 Once Anthem determines Anthem has any payment liability, all Clean Claims will be adjudicated in accordance with the terms and conditions of a Medicaid Member's Health Benefit Plan, the PCS, the provider manual(s), and the Regulatory Requirements applicable to Anthem's Medicaid Program(s).

3.1.4 As payment in full for Medicaid Covered Services provided to Medicaid Members hereunder, Anthem shall pay to Provider the reimbursement specifically set forth in the PCS for all Clean Claims processed and paid in accordance with KRS 304.17A-726 and conforming to KRS 304.17A-700 to 304.17A-730 and KRS 205.593, 304.14-135 and 304.99-123, as may be amended. Payment shall be in compliance with the prompt pay timeframes set forth in KRS 304.17A-702.

3.1.5 Anthem shall compensate Provider for services provided hereunder in accordance with the Government Contract and its then current policies and procedures. If third party liability exists, Anthem shall pay claims in accordance with any applicable Government Contract requirements related to claims involving third party liability. Without limiting the foregoing, in the event that Anthem fails to adjudicate and pay Provider in accordance with this Attachment for Medicaid Covered Services within the prompt pay timeframes set forth in KRS 304.17A-702, Anthem shall be liable for the amount due and unpaid with interest on that amount at the rate forth in KRS 304.17A-730.

3.1.6 Provider agrees to accept payment from Anthem in accordance with this Attachment as payment in full for all Medicaid Covered Services performed pursuant to this Attachment, except for permitted co-payments or other cost sharing requirements. Provider shall not seek or request payment from Cabinet for any Medicaid Covered Services performed hereunder.

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

ARTICLE IV
COMPLIANCE WITH FEDERAL REGULATORY REQUIREMENTS

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

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

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

ARTICLE V
COMPLIANCE WITH STATE REGULATORY REQUIREMENTS

5.1 Indemnification of Cabinet and Commonwealth. In addition to the Indemnification provision of the Agreement, Provider shall indemnify and hold harmless the Commonwealth, its agencies, including the Cabinet, its officers, and employees from all claims, losses, or suits relating to activities undertaken by Provider pursuant to the Government Contract, including court costs, attorney's fees, and other expenses, brought because of injuries or damages received or sustained by any person, persons, or property that is caused by any act or omission of Provider.

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

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

5.4 Performance Within the U.S. Provider agrees that all services to be performed herein shall be performed in the United States of America. Breach, or anticipated breach, of the foregoing shall be a material breach of this Attachment and, without limitation of remedies, shall be cause for immediate termination of the Agreement and this Attachment.

5.5 No Payment Outside the United States. Provider agrees that Anthem shall not provide any payments for items or services provided under the Agreement to any financial institution or entity located outside the United States of America.

5.6 Behavioral Health Services.

5.6.1 If Provider is a Primary Care Provider, Provider shall have screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders, and shall provide to Medicaid Members access to 24 hours a day, 7 days per week primary health care services,

5.6.2 Members receiving inpatient behavioral health services will be scheduled for outpatient follow-up and/or continuing treatment prior to discharge. The outpatient treatment must occur within seven (7) days from the date of discharge. Behavioral Health Service Providers are required to contact Medicaid Members' who have missed an appointment within twenty-four (24) hours to reschedule appointments.

5.7 Additional Provider Requirements.

5.7.1 For services requiring a specific form (e.g., hospice, sterilization, hysterectomy, or abortion), the form shall be properly completed by Provider according to the appropriate Kentucky Administrative Regulation (KAR). Provider shall retain such form in the event of audit and a copy shall be submitted to the Department upon request.

5.8 Cultural Competency. Provider shall participate with the Commonwealth's efforts to promote the delivery of services in a culturally competent manner to all Medicaid Members, including those with limited English proficiency and diverse cultural ethnic backgrounds, disabilities and regardless of gender, sexual orientation or gender identity. To that end, Provider agrees to comply with all Anthem policies and procedures designed to ensure that culturally competent services are provided by Anthem both directly and through its health care providers and subcontractors.

5.9 Records Maintenance. Provider shall maintain medical, financial and administrative records concerning services provided to Medicaid Members in accordance with industry standards and Regulatory Requirements, including, without limitation and any applicable law regarding confidentiality of Medicaid Member information. Such records shall be retained by Provider for the period of time required under Regulatory Requirements, but in no event less than ten (10) years from the date the service is rendered, unless a federal statute or regulation requires a longer retention period. Provider shall allow authorized representatives of the Cabinet, or other Commonwealth and federal agencies, reasonable access to Provider’s premises, physical facilities, equipment and records for financial and medical audit purposes both during and after the term of this Agreement.

5.10 Record Transfer. Following a Medicaid Member's request for record transfer, Provider shall transfer such Medicaid Member's medical records in Provider's custody within ten (10) days following the request, or such other time period required under applicable Regulatory Requirements. Provider shall have the Medicaid Member sign a release of medical records prior to the transfer of such records. Provider shall also timely submit to Anthem any information, including reports and clinical information, necessary for Anthem to perform its obligations under the Government Contract.

5.11 Waiting Times for Appointments. Provider must provide services within the timeframes as set forth in the Government Contract and the provider manual.

5.12 Provider Performance. Provider understands and agrees that Anthem will monitor Provider’s performance and quality of services delivered under this Agreement on an ongoing basis and will subject Provider to formal periodic review. Provider shall also comply with corrective action plans as required by Anthem.

5.13 Program Integrity. As a condition of receiving any amount of payment under this Agreement, Provider agrees to comply with the Program Integrity requirements of the Government Contract, as applicable.

ARTICLE VI
TERMINATION

6.1 Termination of Government Contract. If a Government Contract between Agency and Anthem terminates or expires or ends for any reason or is modified to eliminate a Medicaid Program, or if directed by the Cabinet, this Attachment shall have no further or effect with respect to the applicable Medicaid Program.

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

ARTICLE VII
GENERAL PROVISIONS

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

7.2 Inconsistencies. In the event of an inconsistency between terms and conditions of this Attachment and the terms and conditions as set forth in the Agreement, the terms and conditions of this Attachment shall govern. In the event of an inconsistency between terms and conditions of this Agreement and this Attachment with the terms and conditions as set forth in the Government Contract, the terms and conditions of the Government Contract shall govern and the conflicting terms and conditions shall be null and void. Except as set otherwise forth herein, all other terms and conditions of the Agreement remain in full force and effect.

7.3 Subcontractor Requirements. In addition to the Provider Subcontractors provision in the Agreement, Provider certifies that neither it nor its principals nor any of its subcontractors are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from entering into this Attachment by any Federal agency or by any department, agency or political subdivision of the State. For purposes of this Attachment, "principal" means an officer, director, owner, partner, key employee, or other person with primary management or supervisory responsibilities, or a person who has a critical influence or substantive control over Provider's operations (42 CFR 438.610). Provider agrees to comply with requirements set forth in 42 CFR 455.100 through 455.106 regarding disclosure by providers of ownership and control information and disclosure of information on a provider's owners' and other persons' conviction of criminal offenses against Medicare, Medicaid, or Title XX services program ("Disclosures") and will agree to provide required Disclosures at the time of initial contract, upon contract renewal, and/or upon request by the Anthem. Provider further agrees to notify Anthem within fourteen (14) days of any changes to the Disclosures.

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

7.5 Not Third Party Beneficiary. Provider understands and agrees that Provider is not a third party beneficiary to the Government Contract and that Provider is performing services as agreed upon with Anthem as outlined in this Agreement.

7.6 Provider Insurance. Provider shall self-insure or maintain at its own expense professional and comprehensive general Liability and medical malpractice insurance acceptable to Anthem as set forth in the provider manual(s), Participation Attachment(s), PCS, or as required under applicable Regulatory Requirements through the terms of the Government Contract.

PLAN COMPENSATION SCHEDULE ("PCS")

I. DEFINITIONS

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

"Anthem Medicaid Fee Schedule(s)/Rate(s)/Methodologies" means the Anthem Rate(s) that is a proprietary rate that is based on the applicable state Medicaid Fee Schedule(s)/Rate(s)/Methodologies, which could be enhanced by additional Covered Services included in the Government Contract.

"Anthem Medicaid Rate(s)/Fee Schedule(s)/Methodologies" means the Anthem Rate for the applicable KY Medicaid Rate(s) /Fee Schedule(s)/ in effect on the date of service for the provider type(s)/service(s) identified herein for the applicable Medicaid Program(s).

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

"Anthem Proprietary Medicaid Fee Schedule(s)" means the Anthem Rate(s) which is based on the applicable proprietary Medicaid Fee Schedule(s), and which could be enhanced by additional Covered Services included in the Government Contract.

"Capitation" means the amount paid by Anthem to a provider or management services organization on a per member per month basis for either specific services or the total cost of care for Covered Services.

"Case Rate" means the all-inclusive Anthem Rate for an entire admission or one outpatient encounter for Covered Services. Individual services billed shall not be reimbursed separately.

"Coded Service Identifier(s)" means a listing of descriptive terms and identifying codes, updated from time to time by CMS or other industry source, for reporting Health Services on the CMS 1500 or CMS 1450/UB-04 claim form or its successor as applicable based on the services provided. The codes include but are not limited to, American Medical Association Current Procedural Terminology ("CPT®-4"), CMS Healthcare Common Procedure Coding System ("HCPCS"), International Classification of Diseases, 10th Revision ("ICD-10"), National Uniform Billing Committee ("Revenue Code") and National Drug Code ("NDC") or their successors.

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

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

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

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

"Emergency Condition" 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.

"Emergency Services" means those Covered Services provided in connection with an Emergency Condition.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

II. GENERAL PROVISIONS

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

Claim Submissions for Pharmaceuticals. Each Claim submitted for a pharmaceutical product must include standard Coded Service Identifier(s), a National Drug Code ("NDC") number of the covered medication, a description of the product, and dosage and units administered. Unless otherwise required under Regulatory

Requirements, Plan shall not reimburse for any pharmaceuticals that are not administered to the Member and/or deemed contaminated and/or considered waste.

Coding Updates. Coded Service Identifier(s) used to define specific rates are updated from time to time to reflect new, deleted or replacement codes. Anthem shall use commercially reasonable efforts to update all applicable Coded Service Identifiers within sixty (60) days of release by CMS or other applicable authority. When billing codes are updated, Provider is required to use appropriate replacement codes for Claims for Covered Services, regardless of whether this Agreement has been amended to reflect changes to standard billing codes. If Provider bills a revised code prior to the effective date of the revised code, the Claim will be rejected and Provider shall resubmit Claim with correct code. In addition, Claims with codes which have been deleted will be rejected.

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

Modifiers. All appropriate modifiers must be submitted in accordance with industry standard billing guidelines, if applicable.

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

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

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

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

Reimbursement for Anthem Rate Based on Eligible Charges. Notwithstanding any reimbursement amount set forth herein, Provider shall only be allowed to receive such reimbursement if such reimbursement is for an Eligible Charge. In addition, if Provider reimbursement is under one or more of the following methodologies:

Capitation, Case Rate, DRG Rate, Encounter Rate, Global Case Rate, Per Diem Rate, Per Relative Value Unit, Per Service Rate, and Per Visit Rate, then individual services billed shall not be reimbursed separately, unless otherwise specified in Article IV of this PCS.

Reimbursement for Subcontractors. Plan shall not be liable for any reimbursement in addition to the applicable Anthem Rate as a result of Provider's use of a subcontractor. Provider shall be solely responsible to pay subcontractors for any Health Services, and shall via written contract, contractually prohibit such subcontractors from billing, collecting or attempting to collect from Anthem, Plan or Members. Notwithstanding the foregoing, if Anthem has a direct contract with the subcontractor, the direct contract shall prevail over this Agreement and the subcontractor shall bill Anthem under the direct contract for any subcontracted services, with the exception of nursing services provided for Home Infusion Therapy, or unless otherwise agreed to by the parties.

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

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

III. PROVIDER TYPE

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

IV. SPECIFIC REIMBURSEMENT TERMS

KENTUCKY MEDICAID PROGRAM(S)

Anthem shall compensate Provider for Medicaid Covered Services provided to Medicaid Members, subject to all terms and conditions of this Agreement, benefit design, coordination of benefits (COB), applicable authorization requirements, applicable Cost Shares, program eligibility, and the provider manual, in an amount equal to the lesser of Eligible Charges or the amounts shown below.

Service Description	Billing Code	Anthem Rate	Method
All Covered Services	Applicable CPT/HCPCS Code	100% Anthem Medicaid Kentucky Fee Schedule	Per Service Rate

Payments specified as Anthem Medicaid Kentucky Fee Schedule refer to the Anthem Medicaid Kentucky Fee Schedule in effect as of the date of service for the market(s) and program(s) covered by the basic agreement at the time service is initiated to the Medicaid Member. The parties acknowledge and agree that the Anthem Medicaid Kentucky Fee Schedule is subject to modification by Anthem at any time during the term of this Agreement. This includes updating the Anthem Medicaid Kentucky Fee Schedule with new or replacement codes and fees as applicable.

Any services not specified in this PCS or in the specified Anthem Medicaid Kentucky Fee Schedule are not reimbursable.

DENTAQUEST OF KENTUCKY, LLC
DENTAL PROVIDER SERVICE AGREEMENT

THIS AGREEMENT, effective as of date executed by DentaQuest ("Effective Date"), is made between DENTAQUEST OF KENTUCKY, LLC (hereinafter referred to as "DentaQuest") and _____ (hereinafter referred to as "Provider").
(Business name as listed on W-9)

WHEREAS, DentaQuest arranges for the delivery of dental services to Members of prepaid healthcare plans and employer groups contracting with DentaQuest; and

WHEREAS, Provider, has an unrestricted license to practice dentistry in the Cabinet and Commonwealth of Kentucky and desires to provide dental services pursuant to the terms and conditions of this Agreement; and

NOW, THEREFORE, in consideration of the above and the promises hereinafter contained, the parties hereby agree as follows:

1. Definitions

(a) "Agreement" means this Agreement between DentaQuest and Provider, including all attachments hereto.

(b) "Cabinet": The Cabinet and Commonwealth of Kentucky

(c) "Covered Services" is a dental service or supply that satisfies all of the following criteria:
1. provided or arranged by a Participating Provider to a Member;
2. authorized by DentaQuest in accordance with the Plan Certificate; and
3. submitted to DentaQuest according to DentaQuest's filing requirements; and
4. limited to the most professionally recognized standards of dental practice within the service area and applicable polices and procedures.

(d) "Disclosure Form": The disclosure form required by the Cabinet and Commonwealth of Kentucky's Department for Medicaid Services (the "Department") as a condition of participation under this Agreement and attached hereto as Exhibit A.

(e) "Medically Necessary" is care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health, to diagnose a condition or prevent a medical condition from occurring.

(f) "Member" means any individual who is eligible to receive Covered Services pursuant to a contract and the eligible dependents of such individuals.

(g) "Participating Provider" is a dental professional or facility or other entity, including Provider, that has entered into a written agreement with DentaQuest, directly or through another entity, to provide dental services to selected groups of Members.

(h) "Plan" is an insurer, health maintenance organization or any other entity that is an organized system which combines the delivery and financing of health care and which provides basic health services to enrolled members.

(i) "Plan Certificate" means the document that outlines the benefits available to Members.

(j) "Provider" means the undersigned health professional or any other entity that has entered into a written agreement with DentaQuest to provide certain health services to Members. Each Provider shall have its own distinct tax identification number.

(k) "Provider Dentist" means a doctor of dentistry, duly licensed and qualified under the applicable laws, who practices as a shareholder, partner, or employee of Provider.

2. Obligations of DentaQuest

(a) Operations. DentaQuest shall conduct the day-to-day administrative operations of DentaQuest, including but not limited to: drafting and negotiating contracts and provider agreements with Providers, making benefit determinations; conducting actuarial analyses; setting, collecting and accounting for fixed periodic payments; processing claims; regulatory compliance and reporting; and marketing DentaQuest. Compensation to individuals that conduct UM activities is not structured to provide incentives to deny, limit or discontinue medically necessary services to a member.

(b) Directories. DentaQuest shall maintain a listing of Participating Providers and may include Provider's participation in Plan's network in provider directories and/or other publications intended for use of Members, subject to approval by Plan.

(c) Benefit Changes. DentaQuest shall notify Provider of changes in benefit provisions offered by the Plan.

(d) Quality Improvement. DentaQuest shall operate, at its own expense, quality assurance, utilization review and Member grievance programs.

(e) Payment Processing. DentaQuest shall transmit payments to Provider in accordance with the terms and conditions of this Agreement, or as may otherwise be agreed upon between the parties in writing. DentaQuest shall not incentivize, reduce, limit or withhold Medically necessary services.

(f) Regulatory Compliance. Provider and employees and agents must meet the minimum requirements for participation in the Medicaid program as required by State and Federal regulations. All services related to this Agreement must be performed in accordance with the Medicaid Contract.

(g) Access to Care. DentaQuest shall conduct its administrative operations in a manner that does not encourage Provider to jeopardize Member's access to care or the appropriate delivery of Covered Services to Members. DentaQuest shall not require providers to perform any treatment or procedure which is contrary to the provider's conscience, religious beliefs or ethical principles. DentaQuest prohibits discrimination of any provider acting within the scope of their license or those providers serving high risk populations or specializing in conditions requiring costly treatments.

3. Provider Obligations

(a) Provision of Services. Provider shall render to Members all Covered Services and continue to provide Covered Services to Members. After the date of termination from participation, upon the request of DentaQuest, Provider shall continue to provide Covered Services to Members for a period not to exceed ninety (90) days during which time period payment will be made pursuant to Attachment A for Covered Services provided.

(b) Submission of Claims. Provider shall submit claims for dental services to DentaQuest in a manner and format prescribed by DentaQuest. Provider understands that failure to submit claims or failure to submit requested documentation within 180 days will result in loss of reimbursement for services provided. Provider shall submit claims electronically to DentaQuest. If unable to submit claims electronically, paper claims must be submitted on a standard ADA claim form or a format that has been approved by DentaQuest in advance. Provider agrees to accept electronic payment and electronic remittance if/when available.

(c) Non-discrimination. Provider shall not discriminate in the treatment or quality of services provided to Members on the basis of race, color, religion, sex, sexual orientation, age, disability, national origin, Vietnam-era veteran's status, ancestry, health status or need for health services of such Members and without regard to source of payments made for health services rendered to such Members. Provider shall make their services accessible to Members during the same hours and with the same intensity as they do to non-Members.

Provider agrees to comply with all applicable federal and state laws relating to non-discrimination and equal employment opportunity, including the Civil Rights Act of 1964, regulations issued pursuant to that Act and provision of Executive Order 11246 dated September 26, 1965. Provider agrees to provide physical and program accessibility of dental services to persons with physical and sensory disabilities pursuant to Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. 794), all requirements imposed by any applicable DHFS regulations (45 C.F.R. Part 84) of CMS regulation (42 C.F.R. Parts 417 and 434) and all guidelines and interpretations issued pursuant thereto.

(d) Cultural Competencies. Provider shall comply with the DentaQuest's Cultural Competency Plan.

(e) Policies and Procedures. Provider agrees to comply with any and all policies, rules and regulations of DentaQuest as they may exist from time to time including, but not limited to, claims processing, credentialing, quality or cost containment standards established by DentaQuest and Plans. Provider agrees to refer patients that require covered specialty services (oral surgery, endodontics, prosthetics, and orthodontics) that Provider does not perform, only to dental specialists designated by DentaQuest.

(f) Records. Provider agrees to:

1. Maintain adequate dental/medical, financial and administrative records related to covered dental services rendered by Provider in accordance with federal and state law.
2. Safeguard all information about Members according to applicable state and federal laws and regulations. All material and information, in particular information relating to Members or potential Members, which is provided to or obtained by or through Provider's performance under this Agreement, whether verbal, written, tape, or otherwise, shall be reported as confidential information to the extent confidential treatment is provided under state and federal laws. Provider shall not use any information so obtained in any manner except as necessary for the proper discharge of his/her obligations and securement of his/her rights under this Agreement. Neither DentaQuest nor Provider shall share confidential information with a Member's employer absent the Member's consent for such disclosure. Provider agrees to comply with the requirements of the Health Insurance Portability and Accountability Act ("HIPAA") relating to the exchange of information and shall cooperate with DentaQuest in its efforts to ensure compliance with the privacy regulations promulgated under HIPAA and other related privacy laws. Provider and DentaQuest acknowledge that the activities conducted to perform the obligations undertaken in this Agreement are or may be subject to HIPAA as well as the regulations promulgated to implement HIPAA. Provider and DentaQuest agree to conduct their respective activities, as described herein, in accordance with the applicable provisions of HIPAA and such implementing regulations. Provider and DentaQuest further agree that, to the extent HIPAA or such implementing regulations require amendments(s) hereto, Provider and DentaQuest shall conduct good faith negotiations to amend this Agreement. Provider shall maintain adequate dental/medical, financial and administrative records related to covered dental services rendered by Provider in accordance with federal and state law.
3. To cooperate and provide Plan, DentaQuest, government agencies and any external review organizations ("Oversight Entities") with access to each Member's dental records for the purposes of quality assessment, service utilization and quality improvement, investigation of Member complaints or grievances or as otherwise is necessary or appropriate

4. To provide such information and data, including, but not limited to, encounter, utilization, referral and other data, that Oversight Entities may require.
5. To provide, at no cost to the Member or the Member's new or different dental provider, all Member's dental/medical records.
6. That any and all Member records will be maintained for a period not less than six (6) years, or minimum required by state, following the termination of this Agreement or, if such records are under review or audit, until such review or audit is complete.
7. That all records shall be made available for fiscal audit, medical audit, medical review, utilization review and other periodic monitoring upon request of Oversight Entities at no cost to the requesting entity.
8. Upon termination of this Agreement for any reason, to make available to any Oversight Entities, in a useable form, all records, whether dental/medical or financial, related to Provider's activities undertaken pursuant to the terms of this Agreement at no cost to the requesting entity.
9. That any Oversight Entities, including but not limited to DSS, the Attorney General of the Cabinet and Commonwealth of Kentucky, the state fraud agency, the United States Department of Health and Human Services ("HHS"), the Comptroller General of the United States, and/or their duly authorized representatives shall have access to any books, documents, papers and records which are related to this Agreement for the purpose of making audit, examination, excerpts and transcriptions; provided, however, that those records detailing health care status and/or treatment of specific Members eligible for coverage of health care/dental services under Title XVIII of the Social Security Act need not be made available to the Comptroller General of the United States.
10. That Provider shall allow duly authorized agents or representatives of Oversight Entities, during normal business hours, access to Provider's premises to inspect, audit, monitor or otherwise evaluate the performance of Provider's contractual activities and shall forthwith produce all records requested as part of such review or audit. In the event right of access is requested under this paragraph, Provider shall, upon request, provide and make available staff to assist in the audit or inspection effort, and provide adequate space on the premises to reasonably accommodate personnel conducting the audit or inspections effort. All inspections or audits shall be conducted in a manner as will not unduly interfere with the performance of Provider's activities. All information so obtained will be accorded confidential treatment as provided under applicable law. Oversight Entities and/or their duly authorized representatives shall be allowed access to evaluate through inspection or other means, the quality, appropriateness and timeliness of services performed under this Agreement.

(g) Pre-contract Communication. Provider agrees that all information communicated between the Health Plan and the Cabinet prior to the effective date of the Kentucky Contract shall be kept confidential subject to the Cabinet and Federal public information disclosures laws

(h) Authority of Provider. Provider represents and warrants that it has full authority to bind those providers listed as Provider Dentist to the terms and conditions of this Agreement.

(i) Insurance. Provider shall procure and maintain at their own cost, liability insurance with limits as otherwise required by law. Provider shall provide evidence of such coverage to DentaQuest upon the execution of this Agreement and thereafter as requested by DentaQuest.

(j) Clinical Laboratory Improvement Amendments. Provider shall refer all authorized laboratory tests and procedures to a laboratory that has been issued (A) either a certificate of registration under The Clinical Laboratory Improvement Amendments ("CLIA"), a certificate waiver under CLIA, or a certificate of accreditation under CLIA, and (B) a CLIA identification number. A laboratory that has been issued a certificate of waiver may only perform the tests and procedures permitted under its waiver.

(k) Appointment Status. Provider shall ensure Members are offered appointments according to Kentucky requirements; 21 days routine, 48 hours urgent, and 24 hours emergent.

4. Professional Requirements

(a) Licensure. Provider and employees or agents rendering services to Members shall be appropriately licensed to render such services as required by state or federal law or regulatory agencies, and such licenses shall be maintained in good standing. Provider shall provide DentaQuest a copy of said license(s) upon execution of this Agreement.

(b) Restriction of Licensure. Provider shall notify DentaQuest within two (2) business days of the loss or restriction of his/her DEA permit or dentistry license or any other action that limits or restricts Provider's ability to practice dentistry.

(c) Professional Training. Provider and all employees or agents rendering services to Members shall possess the education, skills, training, physical and mental health status, and other qualifications necessary to provide quality dental patient care.

(d) Professional Standards. Provider and employees or agents rendering services to Members shall provide dental care, which meets or exceeds the standard of care for dentists in the region and shall comply with all standards for dentists as established by any state or federal law or regulation.

(e) Continuing Education. Provider and employees or agents rendering services to Members shall comply with continuing education standards as required by state or federal law or regulatory agencies.

(f) Regulatory Compliance. Provider must meet the minimum requirements for participation in the Medicaid program as provided by the State.

(g) Medical Records. Provider agrees to allow DentaQuest access to Provider's personal medical records, to the extent permitted by state and federal law.

5. Payment Arrangement

(a) Compensation. Upon receipt of payment from Plan, DentaQuest shall pay Provider according to the Attachments to this Agreement.

(b) Hold Harmless. Provider agrees and warrants that in no event, including, but not limited to, nonpayment by DentaQuest, DentaQuest insolvency, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from or have any recourse against any Member or persons acting on their behalf for providing Covered Services. This provision does not prohibit Provider from seeking to collect co-insurance, co-payments or deductibles from Members or fees for non-covered services delivered on a fee-for-service basis to Members as well as services received by ineligible persons in accordance with the terms of the applicable Plan Certificate. Provider agrees that they shall hold the Members harmless and shall not bill the Member for non-covered services if the services are not covered as a result of any error or omission by Provider.

Provider also agrees that this hold harmless and warranty provision herein shall:

1. survive the termination of the Agreement regardless of the cause giving rise to termination, and
2. supersede any oral or written contract agreement heretofore entered into between Provider, DentaQuest, Plan and Members or designees.

Provider also agrees to hold the Cabinet and Commonwealth of Kentucky, Members and the state agencies financially harmless from unpaid claims for Covered Services and not seek payment

from the Cabinet and Commonwealth of Kentucky, Members or state agencies if DentaQuest will not pay for Covered Services performed by Provider under this Agreement.

(c) Co-payment Limits and Member Charges For Noncovered Services. No deductibles or co-payments are permitted for Medicaid covered services unless defined in their benefit coverage limitations. A provider shall be permitted to charge an eligible Member for goods or services which are not covered only if the Member knowingly elects to receive the goods or services and enters into an agreement in writing to pay for such goods or services prior to receiving them. For purposes of this section noncovered services are services not covered under the Medicaid state plan, services which are provided in the absence of appropriate authorization and services which are provided out-of-network unless otherwise specified in the contract, policy or regulation (e.g., family planning, mental health or emergency room services.

(d) Coordination of Benefits. Provider shall notify DentaQuest whenever he/she has reason to believe a Member may be entitled to coverage under any other health benefit plan and shall assist DentaQuest in obtaining information for the coordination of benefits when a Member holds other coverage. If a Member is also covered by another dental plan, and DentaQuest determines it is the primary carrier, the Provider agrees that DentaQuest's obligation to Provider will not exceed the compensation described in this Agreement for the Covered Services in question. If a Member is also covered by another health benefit plan and DentaQuest determines that it is the secondary carrier, the Provider agrees that DentaQuest's obligation shall not exceed the compensation described in the Agreement for the Covered Services in question and that Provider will refund (reduced by any payments the Member may have made to Provider) the aggregate compensation Provider received from the other health benefits plan for the Covered Services in question.

(e) Other Coverage. Provider agrees that payment defined in Attachment A shall be his/her sole compensation for rendering Covered Services to Members. All other monies received by him/her from any other worker's compensation and/or auto, health, property/casualty insurance company must be reported and turned over to the DentaQuest subrogation department.

(f) Missed Appointment. Provider shall not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from or have any recourse against a Member or persons acting on their behalf for missed appointments. Provider shall not be required to accept or continue treatment of a Member with whom Provider feels he/she cannot establish and/or maintain a professional relationship, or is beyond the scope of Provider's expertise or ability.

(g) Plan Reimbursement. Compensation of Provider by DentaQuest is subject to, and dependent upon, DentaQuest's receipt of proper claims payment from Plan. In the event of nonpayment by Plan, DentaQuest reserves the right to withhold or recover payment to Provider for all claims not paid by Plan. Once DentaQuest has received the outstanding amount for such claims from Plan, DentaQuest will reimburse Provider according to the terms of this Agreement.

(h) Continuation of Care. Provider agrees to complete any treatment in progress for continuation of care cases and cases in mid-treatment for a newly enrolled Member. DQV agrees to negotiate fees in good faith for partial cases/treatment.

6. Quality Management

(a) Cooperation with Quality Programs. Provider shall cooperate with and participate in the utilization review, quality assurance, credentialing, grievance, peer review, claims processing, and audit procedures of DentaQuest, and shall comply with all final determinations rendered by such procedures.

(b) Re-credentialing. Provider shall cooperate with the re-evaluation of their credentials at such intervals, as DentaQuest shall determine, but not more frequently than every two years. Such evaluation may take into account a review of Provider's past performance and practice patterns,

and a review of dental records and evaluations pertaining to Provider's participation in the delivery of dental care.

(c) Audit of Records. DentaQuest, Plan and all applicable state and federal agencies shall have access at reasonable times and upon demand, to inspect the books, records and papers of Provider for the purpose of auditing and evaluating and determining on a concurrent or retrospective basis the necessity or appropriateness of health services provided to Members. DentaQuest, Plan or state and federal agencies or their designees shall also have the right to inspect, upon demand and at reasonable times, Provider's facilities pursuant to quality management programs or peer review programs. Provider shall provide copies of medical records to DentaQuest, Plan or state and federal agencies or their designees upon request. Copying and delivery expenses associated with compliance with this Agreement shall be the responsibility of Provider.

(d) Plan and Regulatory Agency Oversight. The Provider acknowledges and agrees that nothing in the Agreement shall be construed to limit: (a) the authority of the Plan to ensure the Provider's participation in and compliance with Plan's quality assurance, utilization management, member grievance and other systems and procedures; (b) any applicable regulatory agency's authority to monitor the effectiveness of such systems and procedures; or (c) Plan's authority to sanction or terminate a Provider found to be providing inadequate or poor quality care or failing to comply with Plan's systems, standards or procedures.

The Provider acknowledges and agrees that any delegation under a contract of quality assurance, utilization management, credentialing, provider relations and other dental management programs, shall be subject to Plan's oversight and monitoring of DentaQuest's performance. The Provider further acknowledges and agrees that Plan, upon the failure of DentaQuest to properly implement and administer such systems or to take prompt corrective action after identifying quality, member satisfaction or other problems, may terminate the contract and that, as a result of such termination, the Provider's participation in Plan may also be terminated.

7. Independent Contractors

(a) Professional Relationship. Provider is an independent contractor and is responsible for maintaining a professional relationship with Members. Provider is responsible for his/her own acts or omissions in his/her professional practice of dentistry, as well as those acts or omissions of his/her employees and agents. No action by DentaQuest has or is intended to have the effect of infringing upon Provider's care and treatment of the Member, including without limitation all decisions with respect to administration, treatment or discharge of such Member.

(b) Appropriate Treatment. DentaQuest allows open Provider-Member communication regarding appropriate treatment alternatives. Provider will not be penalized for discussing medically necessary or appropriate patient care. A determination by DentaQuest that a particular course of treatment is not a Covered Service does not relieve Provider from providing or recommending such care to Members as he/she deems to be appropriate, and that determination may not be considered to be a medical determination made by DentaQuest.

8. Provider Dentist

(a) Provider Dentist Approval. Provider shall supply all information requested by DentaQuest for the purpose of credentialing Provider Dentist, and Provider Dentist must be approved for participation by DentaQuest in writing before rendering Covered Services to Members.

(b) Rights and Obligations. Provider Dentist shall have the rights and obligations provided in the Agreement, which are applicable to Provider, and understands that certain provisions of the Agreement shall also be individually binding on Provider Dentist, and that DentaQuest may require performance of all provisions by Provider Dentist. Provider Dentist also understands that

DentaQuest and Provider may amend the Agreement without right of review by or approval of Provider Dentist.

(c) Reimbursement by Provider. Provider Dentist agrees to look solely to Provider for reimbursement of Covered Services, where Provider is designated as payee pursuant to Agreement, as applicable.

9. Term and Termination

(a) Term. This Agreement shall begin on the Effective Date and shall end one (1) year from such date. Thereafter, this agreement shall automatically renew for successive one (1) year periods unless either party provides notice of its intent not to renew.

(b) Termination. This Agreement may be terminated as follows:

i. By DentaQuest upon 30 days prior written notice without cause.

ii. By Provider upon 60 days prior written notice without cause.

iii. By either party, in the event of a material breach of this Agreement by the other party, upon 60 days prior written notice to the other party.

iv. Upon the occurrence of any of the following events with respect to Provider or Provider Dentist, DentaQuest has the option to immediately terminate Provider or Provider Dentist's designation as a Participating Provider:

1. the death of Provider;
2. the loss or suspension of the dental license or Provider;
3. the loss or suspension of Provider's drug enforcement administration license, or the loss of Provider's unrestricted prescribing privileges;
4. the loss of Provider's liability insurance;
5. the Provider being restricted from receiving payments from Medicare or Medicaid;
6. the Provider is convicted of any felony;
7. the Provider is convicted of any offense involving DentaQuest or Plan;
8. the failure of the Provider to meet any quality assurance, credentialing, or grievance program requirements of DentaQuest, Plan or any state or federal regulatory agency or their designees;
9. the Provider intentionally and purposefully does not comply with the referral and notification requirements of DentaQuest, Plan or any state or federal regulatory agency or their designees;
10. the Provider fails to cooperate with DentaQuest in the provision of cost-effective, quality services to Members;
11. the Provider is found to be harming Members; or
12. any adverse regulatory finding with respect to Provider.

(c) Effect of Termination. In the event of termination of this Agreement, Provider agrees to complete any treatment in progress and/or assist in the orderly transfer of Members to another provider, as requested by DentaQuest. Plan will communicate such termination to members as required by and in accordance with laws and Program Requirements

10. Miscellaneous

(a) Non-exclusivity. This Agreement is not an exclusive contract and DentaQuest may contract with other providers of dental services. Provider may contract with other dental plans. This Agreement shall be regarded as confidential and its terms or contents shall not be disclosed to any other party unless agreed to in writing by DentaQuest; except, however, Provider may disclose the contents of this Agreement to the legal representative of Provider without the consent of DentaQuest.

(b) Amendment or Restated Agreement. DentaQuest may amend or restate this Agreement by sending a copy of the amendment or restated agreement to Provider at least 30 days prior to its effective date. If Provider does not object to such amendment or restated agreement in writing within such 30-day notice period, Provider shall be deemed to have accepted the proposed amendment or restated agreement as of the end of the 30-day notice period. In the event Provider objects within the 30-day notice period, by providing written notice to DentaQuest, the parties shall confer in good faith to reach agreement. If such agreement cannot be reached, DentaQuest may terminate this Agreement.

(c) Change in Status. Provider understands that any and all changes in the Provider's legal and contractual relationship to and with Provider's clinic partners, who are also party to this Agreement must be communicated in writing to DentaQuest, or DentaQuest may elect to immediately terminate this Agreement. Provider also agrees to provide DentaQuest with 30 days advance written notice of any closure of their practice to additional Members, or new location at which Provider anticipates seeing Members.

(d) Waiver of Breach. The waiver by either party of a breach of violation of any provision of the Agreement shall not operate as or be construed to be a waiver of any subsequent breach hereof.

(e) Governing Law. This Agreement shall be governed in all respects by the laws of the Cabinet and Commonwealth of Kentucky.

(f) Responsibility for Actions. Each party shall be responsible for any and all claims, liabilities, damages, or judgments that may arise as a result of its own negligence or intentional wrongdoing.

(g) Severability. The invalidity or unenforceability of any term of condition shall in no way affect the validity or enforceability of the remainder of this Agreement.

(h) Arbitration. If a dispute regarding payment arises between the parties involving a contention by one party that the other has failed to perform its obligations and responsibilities under this Agreement, then the party making such contention shall promptly give notice to the other. Such notice shall set forth in detail, the basis for the party's contention, and shall be sent by Certified Mail-Return Receipt Requested. The other party shall within thirty (30) calendar days of receipt of the notice provide a written response seeking to satisfy the party that gave notice regarding the matters as to which notice was given. Following such response, or the failure of the second party to respond to the compliant of the first party within thirty (30) calendar days, if the party that gave notice of dissatisfaction remains dissatisfied, then the party shall so notify the other party and the matter shall be promptly submitted to inexpensive and binding arbitration.

(i) Assignment. DentaQuest may assign this Agreement immediately upon written notice to Provider. Provider must obtain DentaQuest's prior written consent to assign this Agreement.

(j) Notice. Any notices required to be given pursuant to the terms and provision hereof shall be sent by mail, addressed to DentaQuest at:

DentaQuest of Kentucky, LLC
Attn: Provider Information
12121 N. Corporate Parkway
Mequon, WI 53092

and to the Provider at the address stated herein or as he/she may otherwise notify DentaQuest in writing.

(k) Form. All words used herein in the singular number shall extend to and include the plural. All words used in the plural numbers shall extend to and include the singular. All words used in any gender shall extend to and include all genders.

(l) Entire Agreement. This Agreement, together with all subordinate and other documents and exhibits incorporated herein, constitutes the final and entire expression of the Agreement between the parties with respect to the subject matter contained herein and expressly supercedes all prior and contemporaneous representations, statements, drafts, correspondence or similar understanding or documents.

(m) Delegated Activities. Any delegated activities including credentialing and reporting will be specified and monitored by DentaQuest on an ongoing basis and Audited at least annually.

(n) Errors. DentaQuest shall make every effort to maintain accurate information; however, DentaQuest shall not be held liable for any damages directly or indirectly due to typographical errors. The Provider agrees to immediately notify DentaQuest of any errors found on remittance statements.

(o) Hold Harmless. Provider will indemnify and hold harmless the Commonwealth, The Cabinet, The Department and every Member from all claims, demands, liabilities, suits, or damages including court costs and attorney fees arising out of or connected in any way to the Kentucky Contract. This shall survive the termination of the Agreement.

(p) Marketing. Provider agrees that all marketing activities directed to Members are subject to DentaQuest's approval prior to distribution to Members. Any marketing materials developed and distributed by Providers shall be submitted to DentaQuest for approval.

(q) Delegation of Provider Selection. As applicable, Provider understands that if selection of providers who render services to Members has been delegated to DentaQuest and/or Provider by Health Plan, either expressly or impliedly, then Health Plan retains the right to approve, suspend or terminate such downstream or subcontracted arrangements. [42 C.F.R. § 422.504(i)(5)]

(r) Confidential by the Cabinet and Commonwealth. Provider shall comply with the Privacy Act of 1974 and require its employees to keep confidential information concerning Member data, the business of the Commonwealth with its financial affairs as well as any other information which may be specifically classified as confidential by the Commonwealth. All Federal and State regulations and statutes related to confidentiality shall be applicable.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement on the date written below:

Provider/Clinic Name & Address **DENTAQUEST OF KENTUCKY, LLC**

Name_____

Address_____

_____

_____

Phone _____

Tax ID _____

Group NPI # _____

BY: _____ BY: _____
(Signature) Vice President

BY: _____
(Please Print or Type Name)

DATE: _____/_____/_____ DATE: _____/_____/_____

PROVIDER DENTISTS
(Please Type or Print)

Please list the name of all individual dentists providing services under the terms of this Agreement.

Dentist Name	Specialty	Medicaid Number
Dentist Name	Specialty	Medicaid Number
Dentist Name	Specialty	Medicaid Number
Dentist Name	Specialty	Medicaid Number
Dentist Name	Specialty	Medicaid Number
Dentist Name	Specialty	Medicaid Number
Dentist Name	Specialty	Medicaid Number

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Attachment C.18.d-1a. Provider Network – Proposed Individual Practitioners and Facilities

As noted, pages 43 contain Proprietary Data and are being submitted under separate sealed cover marked "Proprietary Data."

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Attachment C.18.d-1a. Provider Network – Proposed Individual Practitioners and Facilities

As noted, pages 45-48 contain Proprietary Data and are being submitted under separate sealed cover marked "Proprietary Data."

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ATTACHMENT B
KENTUCKY MEDICAID
DENTAL REIMBURSEMENT
ADULTS 21 & OVER

Provider Reimbursement

1.0 Provider shall be reimbursed the lesser of billed charges or 100% of current Medicaid Fee Schedule. See Attachment B-1 for the provision of Medically Necessary Covered Services rendered to eligible Medicaid Members.

1.01 Board certified Oral Surgeons shall be reimbursed the lesser of billed charges or 100% of current Medicaid Fee Schedule. See Attachment B-2 for the provision of Medically Necessary Covered Services rendered to eligible Medicaid Members.

2.0 DentaQuest shall pay Provider within thirty (30) calendar days of receipt of clean claims for dental services rendered to Members. Provider agrees to accept electronic payment and electronic remittances if/when available.

3.0 Provider reimbursement requires receipt of a clean claim. A claim shall be considered clean only if the claim requires no further information, documentation, adjustment or alteration by Provider to be adjudicated by DentaQuest. Any dispute regarding payment shall be deemed waived unless Provider submits written notification of the reasons for the dispute within sixty (60) days of receipt of the payment, statement of denial or adjustment. Provider agrees that DentaQuest can adjust future payments or request Provider refund an amount equal to any payment made to Provider in error by DentaQuest including but not limited to an overpayment, duplicate payment, an ineligible member or for any other reason for which payment should not have initially been made.

4.0 DentaQuest shall make every effort to maintain accurate information; however, DentaQuest shall not be held liable for any damages directly or indirectly due to typographical errors. The Provider agrees to immediately notify DentaQuest of any errors found on remittance statements.

190509 KY Medicaid

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Attachment C.18.d-1a. Provider Network – Proposed Individual Practitioners and Facilities

As noted, pages 52-55 contain Proprietary Data and are being submitted under separate sealed cover marked "Proprietary Data."

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Attachment C.18.d-1a. Provider Network – Proposed Individual Practitioners and Facilities

As noted, pages 57-58 contain Proprietary Data and are being submitted under separate sealed cover marked "Proprietary Data."

10. the Provider fails to cooperate with DentaQuest in the provision of cost-effective, quality services to Members;

11. the Provider is found to be harming Members; or

12. any adverse regulatory finding with respect to Provider.

In the event of termination of this Amendment, Provider agrees to complete any treatment in progress and/or assist in the orderly transfer of Members to another provider, as requested by DentaQuest. Plan will communicate such termination to members as required by and in accordance with laws and Program Requirements

190509 KY DQ Commercial Exchange Marketplace

Attachment C.18.d-1a. Provider Network – Proposed Individual Practitioners and Facilities

As noted, pages 60-64 contain Proprietary Data and are being submitted under separate sealed cover marked "Proprietary Data."

AUTHORIZATION TO HONOR DIRECT AUTOMATED CLEARING HOUSE (ACH) CREDITS DISBURSED BY DENTAQUEST, LLC

INSTRUCTIONS

1. Complete all parts of this form.
2. Execute all signatures where indicated. If account requires counter signatures, both signatures must appear on this form.
3. **IMPORTANT:** Attach voided check from checking account.

MAINTENANCE TYPE:

_____ Add
_____ Change (Existing Set Up)
_____ Delete (Existing Set Up)

ACCOUNT HOLDER INFORMATION:

Account Number: _____

Account Type: _____ Checking

_____ Personal _____ Business (choose one)

Bank Routing Number: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Bank Name: _____

Account Holder Name: _____

Effective Start Date: _____

As a convenience to me, for payment of services or goods due me, I hereby request and authorize **DentaQuest, LLC** to credit my bank account via Direct Deposit for the (agreed upon dollar amounts and dates.) I also agree to accept my remittance statements online and understand paper remittance statements will no longer be processed.

This authorization will remain in effect until revoked by me in writing. I agree you shall be fully protected in honoring any such credit entry.

I understand in endorsing or depositing this check that payment will be from Federal and State funds and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws.

I agree that your treatment of each such credit entry, and your rights in respect to it, shall be the same as if it were signed by me. I fully agree that if any such credit entry be dishonored, whether with or without cause, you shall be under no liability whatsoever.

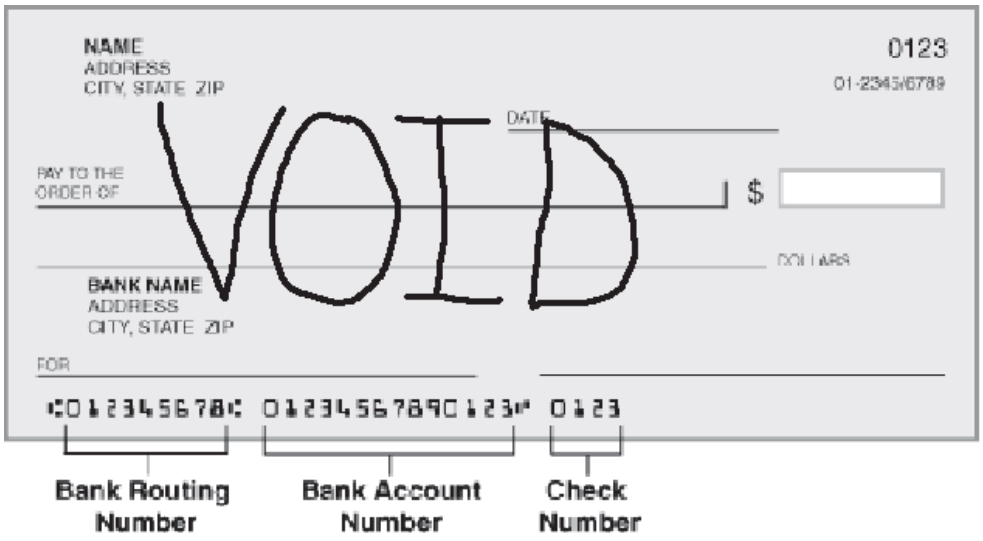
_____ _____
Date Print Name

_____ _____
Phone Number Signature of Depositor (s) (As shown on Bank records for the account, which this authorization applicable.)

_____
Legal Business/Entity Name (As appears on W-9 submitted to DentaQuest)

_____
Tax Id (As appears on W-9 submitted to DentaQuest)

Please attach your VOIDED check here



Legal Business/Entity Name: _____

Tax ID Number_____

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Attachment C.18.d-1a. Provider Network – Proposed Individual Practitioners and Facilities

As noted, pages 68 contain Proprietary Data and are being submitted under separate sealed cover marked "Proprietary Data."

3.0 Provider Performance. Provider understands and agrees that DentaQuest/eyeQuest will monitor Provider's performance and quality of services delivered under this Agreement on an ongoing basis and will subject Provider to formal periodic review. Provider shall also comply with corrective action plans as required by Anthem.

4.0 Program Integrity. As a condition of receiving any amount of payment under this Agreement, Providers agree to comply with the Program Integrity requirements of the Government Contract, as applicable.

5.0 Controlling Agreement. In the event of an inconsistency between terms and conditions of this Agreement and this Attachment with the terms and conditions as set forth in the Government Contract, the terms and conditions of the Government Contract shall govern and the conflicting terms and conditions shall be null and void.

6.0 No Third Party Beneficiary. Provider understands and agrees that Provider is not a third party beneficiary to the Government Contract and that Provider is performing services as agreed upon with Anthem as outlined in this Agreement.

7.0 Insurance. Provider shall self-insure or maintain at its own expense professional and comprehensive general Liability and medical malpractice insurance acceptable to Anthem as set forth in the provider manual(s), Participation Attachment(s), PCS, or as required under applicable Regulatory Requirements through the terms of the Government Contract.

8.0 Submission of Claims. Provider shall submit claims for dental services to DentaQuest in a manner and format prescribed by DentaQuest. Provider understands that failure to submit claims or failure to submit requested documentation within 365 days will result in loss of reimbursement for services provided. Provider shall submit claims electronically to DentaQuest. If unable to submit claims electronically, paper claims must be submitted on a standard ADA claim form or a format that has been approved by DentaQuest in advance. Provider agrees to accept electronic payment and electronic remittance if/when available.

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ATTACHMENT F
ANTHEM MEDICAID
DENTAL REIMBURSEMENT
ADULTS 21 AND OLDER

Provider Reimbursement

1.0 Provider shall be reimbursed the lesser of billed charges or 100% of current Medicaid Fee Schedule. See Attachment B-1 for the provision of Medically Necessary Covered Services rendered to eligible Medicaid Members.

1.01 Board certified Oral Surgeons shall be reimbursed the lesser of billed charges or 100% of current Medicaid Fee Schedule. See Attachment B-2 for the provision of Medically Necessary Covered Services rendered to eligible Medicaid Members.

2.0 DentaQuest shall pay Provider within thirty (30) calendar days of receipt of clean claims for dental services rendered to Members. Provider agrees to accept electronic payment and electronic remittances if/when available.

3.0 Provider reimbursement requires receipt of a clean claim. A claim shall be considered clean only if the claim requires no further information, documentation, adjustment or alteration by Provider to be adjudicated by DentaQuest. Any dispute regarding payment shall be deemed waived unless Provider submits written notification of the reasons for the dispute within sixty (60) days of receipt of the payment, statement of denial or adjustment. Provider agrees that DentaQuest can adjust future payments or request Provider refund an amount equal to any payment made to Provider in error by DentaQuest including but not limited to an overpayment, duplicate payment, an ineligible member or for any other reason for which payment should not have initially been made.

4.0 DentaQuest shall make every effort to maintain accurate information; however, DentaQuest shall not be held liable for any damages directly or indirectly due to typographical errors. The Provider agrees to immediately notify DentaQuest of any errors found on remittance statements.

Additional Terms

9.0 Appointment Availability. Provider must provide services within the timeframes as set forth in the Government Contract and the provider manual.

10.0 Appeal Rights. Provider shall display notices of Medicaid Members' right to appeal adverse action affecting services in public areas of Provider's facility/office in accordance with the Cabinet's rules and regulations.

11.0 Provider Performance. Provider understands and agrees that DentaQuest/eyeQuest will monitor Provider's performance and quality of services delivered under this Agreement on an ongoing basis and will subject Provider to formal periodic review. Provider shall also comply with corrective action plans as required by Anthem.

12.0 Program Integrity. As a condition of receiving any amount of payment under this Agreement, Providers agree to comply with the Program Integrity requirements of the Government Contract, as applicable.

13.0 Controlling Agreement. In the event of an inconsistency between terms and conditions of this Agreement and this Attachment with the terms and conditions as set forth in the Government Contract, the terms and conditions of the Government Contract shall govern and the conflicting terms and conditions shall be null and void.

14.0 No Third Party Beneficiary. Provider understands and agrees that Provider is not a third party beneficiary to the Government Contract and that Provider is performing services as agreed upon with Anthem as outlined in this Agreement.

15.0 Insurance. Provider shall self-insure or maintain at its own expense professional and comprehensive general Liability and medical malpractice insurance acceptable to Anthem as set forth in the provider manual(s), Participation Attachment(s), PCS, or as required under applicable Regulatory Requirements through the terms of the Government Contract.

16.0 Submission of Claims. Provider shall submit claims for dental services to DentaQuest in a manner and format prescribed by DentaQuest. Provider understands that failure to submit claims or failure to submit requested documentation within 365 days will result in loss of reimbursement for services provided. Provider shall submit claims electronically to DentaQuest. If unable to submit claims electronically, paper claims must be submitted on a standard ADA claim form or a format that has been approved by DentaQuest in advance. Provider agrees to accept electronic payment and electronic remittance if/when available.

DENTAQUEST
VISION PARTICIPATING PRACTICE SERVICE AGREEMENT

THIS VISION PARTICIPATING PRACTICE SERVICE AGREEMENT (this "***Agreement***"), effective as of the date executed by the Company ("***Effective Date***"), is made between DENTAQUEST OF KENTUCKY, LLC (hereinafter referred to as the "***Company***") and the undersigned legal entity identified by Business Name and Tax ID on the Signature Page (hereinafter referred to as the "***Participating Practice***" and together with the Company and each employee, individual Provider and agent of the Participating Practice who becomes party to this Agreement, the "***Partie***s" and each, a "***Party***").

The Participating Practice shall provide services in relation to the product types marked with an "x" below:

☐ Medicare Advantage - Addendum A (see also Addendum C, and, as applicable, Addenda B and/or D)
☒ Medicaid - Addendum B (see also Addendum C, and, as applicable, Addenda A and/or D)
☐ Commercial Business - Addendum C (see also, as applicable, Addenda A, B and/or D)
☐ Exchange Business - Addendum C (see also, Addendum D, and, as applicable, Addenda A and/or B)
☐ Other - Addendum D (see also, Addendum C, and, as applicable, Addenda A and/or B)

The terms and conditions of this Agreement are set forth herein and in the referenced Addenda. Each provision set forth in the Addenda, to the extent not addressed in this Agreement, is intended to supplement the provisions in this Agreement and, to the extent addressed in this Agreement, is intended to override the corresponding provision in this Agreement. For each product type, please refer to the Addenda indicated above.

WHEREAS, the Company is a company that through itself and/or its affiliates arranges for the delivery of vision and eye care services to eligible Members of employer groups, other groups, individual insurance programs, state and private exchanges, prepaid healthcare plans and/or government programs; and

WHEREAS, each Provider has an unrestricted license to practice optometry, medicine or provide optical services in the State and desires to provide vision and/or eye care services pursuant to the terms and conditions of this Agreement;

NOW, THEREFORE, in consideration of the above and the promises hereinafter contained, the Parties hereby agree as follows:

1. Definitions

(a) "***Agency***" means the applicable state or any of its agencies or the federal government or any of its agencies including, but not limited to, the Centers for Medicare and Medicaid Services ("***CMS***") and the United States Department of Health and Human Services ("***DHHS***").

(b) "***Agreement***" means this Agreement between the Company and Participating Practice, including all attachments hereto.

(c) "***Commercial, Exchange, or Marketplace***" means a group or individual plan not offered through the Medicare Advantage or Medicaid Programs, for which the Company is administering vision or eye care benefits.

(d) "***Covered Services***" shall have the meaning of covered services set forth (1) in the vision office reference manual for the applicable Member ("***ORM***"), or (2) in the event that there is no such ORM, in the benefits summary for the applicable Commercial, Exchange, or Marketplace Member ("***Summary***"); provided, however, that in the event of a conflict between the provisions of a Commercial, Exchange, or Marketplace Member's Summary and the provisions of such Commercial, Exchange, or Marketplace Member's Plan Certificate, the provisions of the Plan Certificate shall govern.

(e) "***Emergency Care***" shall have the meaning set forth in the applicable state law, or, in the absence of such applicable state law, by the Centers for Medicare and Medicaid Services in the Emergency Medical Treatment and Labor Act (42 U.S.C. § 1395d).

(f) "***Fee Schedule***" is the schedule which indicates the amount used to calculate the amount that the Company shall compensate the Participating Practice for services rendered. Each product type, as defined below, shall have a corresponding Fee Schedule.

(g) "***Medically Necessary***" shall have the meaning as set forth in the Plan(s) Certificate(s) or in Addendum C.

(h) "***Medicaid***" means medical assistance provided under a state plan approved under Title XIX of the Social Security Act. Such term includes medical assistance when delivered through a Medicaid managed care organization pursuant to a contract under section 1903(m) of the Social Security Act or through a primary care case manager as defined in section 1905(t)(2) of the Social Security Act.

(i) "***Medicare Advantage***" means Medicare benefits provided under a Medicare Part C plan, approved under Title XVIII of the Social Security Act, whereby a private insurer receives compensation from the Centers for Medicare and Medicaid Services to administer the plan.

(j) "***Member***" means any individual, including the eligible dependents of such individual, who is eligible to receive benefits from or administered by the Company for Covered Services pursuant to an agreement between the Company and the Member or a third party.

(k) "***Oversight Entities***" include, but are not limited to, the Company, the Plans, government entities and agencies, and any external review organizations that have or may have oversight responsibilities related to this Agreement.

(l) "***Plan***" is an insurer, health maintenance organization, Employee Retirement Income Security Act ("***ERISA***") plan, employer or any other entity that is organized or has arranged to fund, in whole or in part, vision or eye care-related services to its enrolled members for which the Company is providing insurance, administrative, or other vision or eye care related services. Such term may include Medicaid managed care plans (under section 1903(m) of the Social Security Act) and Medicare Advantage plans (as defined in 42 C.F.R. § 422.2). References to Plan shall include the Company in circumstances where the Company is the insurer and has ultimate responsibility for claims payment.

(m) "***Plan Certificate***" means the contractual document that sets forth the vision benefits available to Members.

(n) "***Provider***" means a doctor of optometry or medicine, or an individual who is otherwise licensed to provide optical services, duly licensed and qualified under the applicable laws, who practices as a shareholder, partner, contractor or employee of Participating Practice, and utilizes Provider's tax identification number ("TIN") in connection therewith (see Exhibit 1).

(o) "***State***" as used in this agreement, refers to the State in which Provider is providing Covered Services to Members under this Agreement.

2. Vision Services

(a) Services. Participating Practice agrees to provide Covered Services for Members pursuant to the provisions of this Agreement, all Addenda to this Agreement, the Company's policies or procedure manuals, and Plan Certificates, as amended from time to time.

(b) Oversight. The Company acknowledges its responsibility to monitor and oversee the provision of Covered Services to its Members in accordance with the laws of the State (see Addendum C).

(c) Operations. The Company shall conduct the day-to-day administrative operations of the Company required for the program.

(d) Credentialing. The Company shall credential all Providers in accordance with the National Committee for Quality Assurance ("***NCQA***") standards.

3. Participating Practice Obligations

(a) Services. Participating Practice shall provide Covered Services to Members. Participating Practice shall continue to provide Covered Services to Members in the event of the Company's insolvency or discontinuance of operations, as needed to complete any Medically Necessary procedures commenced but unfinished at the time of the Company's insolvency or discontinuance of operations.

(b) Office of Inspector General Exclusion List. Participating Practice represents and warrants that neither the Participating Practice nor any Providers included herein are included on the Office of Inspector General Exclusion List, which identifies individuals and entities excluded from participation in federal healthcare programs. Participating Practice must immediately notify the Company if the Participating Practice or any Provider included herein becomes included on the Office of Inspector General Exclusions List.

(c) Submission of Claims. Participating Practice shall submit claims for Covered Services rendered to Members to the Company in a manner and format prescribed by the Company. Participating Practice understands that failure to submit claims or failure to submit requested documentation within the required timeframe as required in the appropriate addendum may result in loss of reimbursement for services provided. To the extent that the timeframe is not provided in the appropriate Addendum, Participating Practice must submit all claims within ninety (90) days of the performance of services. Participating Practice shall submit claims electronically to the Company in a format approved by the Company. If the Company does not approve the electronic format proposed by Participating Practice or Participating Practice is unable to submit claims electronically, paper claims must be submitted in a format that has been approved by the Company in advance. Participating Practice agrees to accept electronic payment and electronic remittance/explanation of benefits. The Participating Practice shall use HIPAA compliant billing and diagnosis codes when billing or submitting encounter data. This applies to both electronic and paper claims and encounter submissions. When billing codes are updated, the Participating Practice shall use appropriate replacement codes for submitted claims and encounter data for Covered Services. An amendment to the Agreement shall not be required to replace such billing codes. The Company shall not pay any claims submitted using non-compliant billing codes.

(d) Non-discrimination. Participating Practice shall not discriminate in the delivery, treatment or quality of services based on the Member's race, color, religion, sex, sexual orientation, age, disability, national origin, veteran's status, ancestry, health status, need for health services, or source of payments made for such services. Participating Practice shall make its services accessible to Members during the same hours and in the same manner as the Participating Practice would treat non-Members.

Participating Practice agrees to comply with all applicable federal and State laws relating to non-discrimination and equal employment opportunity, including, but not limited to: the Civil Rights Act of 1964, regulations issued pursuant to that Act and provision of Executive Order 11246 dated September 26, 1965. Participating Practice agrees to provide physical and program accessibility of vision and eye care services to persons with physical and sensory disabilities pursuant to Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), all requirements imposed by any applicable DHHS regulations (45 C.F.R. Part 84) of CMS regulation (42 C.F.R. Parts 417, 422, and 434) and all guidelines and interpretations issued pursuant thereto. Participating Practice agrees not to identify the addressee of a communication as a Medicaid consumer on the outside of the envelope when contacting members who are Medicaid consumers by mail.

(e) Policies and Procedures. Participating Practice agrees to comply with any and all policies, rules and regulations of the Company and Plans as they may exist from time to time including, but not limited to, claims processing, credentialing, quality or cost containment standards established by the Company and Plans. Participating Practice agrees to refer patients who require specialty services that are Covered Services and that Participating Practice does not perform, to Company or Plan for placement. Participating Practice agrees to provide services as listed in the appropriate Addenda (within Participating Practice's scope of practice).

(f) Records. Participating Practice hereby acknowledges and agrees to:

1. Maintain adequate medical, financial and administrative records related to Covered Services rendered by Participating Practice and all Providers in accordance with federal and state law and any regulatory policies.

2. Safeguard all information about Members according to applicable state and federal laws and regulations. All material and information which is provided to or obtained by or through Participating Practice or Provider's performance under this Agreement, whether verbal, written, tape, or otherwise, shall be regarded as confidential information to the extent confidential treatment of such material and information is provided for under state and federal laws. Neither Participating Practice nor Provider shall use any information so obtained in any manner except as necessary for the proper discharge of his/her obligations and securement of his/her rights under this Agreement. Participating Practice and all Providers agree to comply with the requirements of the Health Insurance Portability and Accountability Act ("***HIPAA***") relating to the exchange of information and shall cooperate with the Company and Plan in efforts to ensure compliance with the privacy regulations promulgated under HIPAA and other related privacy laws. Participating Practice, Providers and the Company acknowledge that the activities conducted to perform the obligations undertaken in this Agreement are or may be subject to HIPAA, as well as the regulations promulgated to implement HIPAA. Participating Practice, Providers and the Company agree to conduct their respective activities, as described herein, in accordance with the applicable provisions of HIPAA and such implementing regulations. Participating Practice, Providers and the Company further agree that, to the extent HIPAA, the regulations promulgated thereunder, or the regulations governing the Medicare Advantage programs (42 C.F.R. §§ 422.1, *et seq.*) require amendments(s) hereto, Participating Practice, Providers, and the Company shall conduct good faith negotiations to amend this Agreement. Provider shall maintain adequate medical, financial and administrative records related to Covered Services rendered by Participating Practice or Providers in accordance with federal and state law.

3. Cooperate and provide Oversight Entities with access to each Member's patient records for the purposes of quality assessment, service utilization and quality improvement, investigation of Member complaints or grievances or as otherwise is necessary or appropriate subject to HIPAA and any and all pertinent laws.

4. Provide information and data, including, but not limited to, encounter, utilization, referral and other data, that Oversight Entities may request.

5. Provide, at no cost to the Member or the Member's new or different vision or eye care services provider, a copy of all Members' patient records. Upon written consent by a Member, Participating Practice agrees to transfer the information in such Member's health care records to the person specified by the Member at no charge.

6. That any and all Member records will be maintained for a period not less than the minimum required by the State or ten (10) years, whichever is longer, and shall allow access to said records for review or audit upon request.

7. Provide Oversight Entities, including but not limited to any state department of social services, the Attorney General of the United States or a state in which Participating Practice operates, any fraud agency, DHHS, CMS (or its designees), the Comptroller General of the United States (or its designees), and/or their duly authorized representatives with access to any books, documents, papers and records which are related to this Agreement for the purpose of any audit, investigation, or examination; provided, however, all laws relating to a members privacy shall be followed regarding such disclosures.

8. Allow duly authorized agents or representatives of Oversight Entities, during normal business hours and other reasonable times, access to Participating Practice's premises to inspect, audit, monitor or otherwise evaluate the performance of Participating Practice under this Agreement, including auditing claims submissions, evaluating and determining on a concurrent or retrospective basis the necessity or appropriateness of services provided to Members, evaluating through inspection or other means, the quality, appropriateness and timeliness of services provided under this Agreement, and pursuant to quality management programs or peer review programs. Participating Practice shall produce all records, including copies of medical records, requested as part of such review or audit without charge. In the event right of access is requested under this paragraph, Participating Practice shall, upon request, provide and make available staff to assist in the audit or inspection effort, and provide adequate space on the premises to reasonably accommodate personnel conducting the audit or inspections effort. All inspections or audits shall be conducted in a manner as will not unduly interfere with the performance of Participating Practice's activities. Oversight entities shall comply with applicable laws and regulations, including those pertaining to privacy and confidentiality, with respect to such information.

(g) Authority of Participating Practice. Participating Practice represents and warrants that it has full authority to bind Providers listed on Exhibit 1 of this Agreement.

(h) Additional Providers. Subject to paragraph 3(b) above, if the Participating Practice wishes to add Providers, then Participating Practice shall inform the Company of the request in writing by providing to Company a revised Exhibit 1. A Provider may not provide services under this Agreement until Provider has been credentialed and approved for participating in writing by the Company. To be approved by the Company, a Provider must complete all credentialing requirements, including but not limited to, meeting all licensure requirements. Once a provider is credentialed and approved for participation by the Company, Provider will automatically become a signatory hereto, and the revised Exhibit 1 shall be included as an exhibit to the Agreement. All Providers included in Exhibit 1 shall be responsible for complying with all terms of the Agreement pursuant to paragraph 3(g).

(i) Compensation of Provider. Participating Practice shall require all Providers to agree to look solely to Participating Practice for payment for Covered Services under this Agreement.

(j) Insurance. Participating Practice shall procure and maintain liability insurance with limits as required by law, or in accordance with customary practices, at their own cost. Participating Practice shall provide evidence of such coverage to the Company upon participation in the credentialing process and thereafter as requested by the Company.

(k) Quality of Services. Participating Practice on behalf of Providers is solely responsible for the quality of services provided hereunder and for all acts or omissions relating to the evaluation and treatment of Members.

(l) Indemnification. Participating Practice shall protect, defend, indemnify and hold harmless the Company and each of its agents, officers, administrators, directors and employees (the "***Indemnitee***") from and against any and all claims, demands, actions, damages, liabilities, costs and expenses incurred by Indemnitee for damages, including, without limitation, bodily injury, personal injury, death, property damage, punitive damage, or other claim brought by any person arising out of or in connection with the performance of vision and/or eye care services by Participating Practice

and Providers. Participating Practice's indemnity obligations shall not be limited to the insurance provisions of this Agreement, as the Parties intend and agree that Participating Practice shall be fully responsible for liabilities assumed, regardless of the presence or absence of insurance.

(m) Clinical Laboratory Improvement Amendments. If applicable, Participating Practice shall refer all authorized laboratory tests and procedures to a laboratory that has been issued (A) either a certificate of registration under The Clinical Laboratory Improvement Amendments ("***CLIA***"), a certificate waiver under CLIA, or a certificate of accreditation under CLIA, and (B) a CLIA identification number. A laboratory that has been issued a certificate of waiver may only perform the tests and procedures permitted under its waiver.

4. Professional Requirements

(a) Licensure. Participating Practice, Providers, and Participating Practices' employees or agents rendering services to Members shall be appropriately licensed to render such services as required by state or federal law or regulatory agencies, and such licenses shall be maintained in good standing. Participating Practice shall provide the Company with a copy of said license(s) upon request.

(b) Restriction of Licensure. Participating Practice shall notify the Company within two (2) business days of the loss or restriction of Participating Practice's or any Provider's DEA permit or optometry or medical license or any other action that limits or restricts such Provider's ability to practice optometry or ophthalmology or otherwise provide vision or eye care services.

(c) Professional Training. Participating Practice, Providers, and all Participating Practice's employees or agents rendering services to Members shall possess the education, skills, training, physical and mental health status, and other qualifications necessary to provide professional patient care.

(d) Professional Standards. Participating Practice, Providers, and Participating Practice's employees or agents rendering services to Members shall provide vision and eye care services which meets or exceeds the standard of care for vision and/or eye care services, as applicable, in the region and shall comply with all standards for optometrists, ophthalmologists and any other eye care service providers as established by any state or federal law or regulation. Participating Practice shall practice cost effective, quality vision and eye care.

(e) Continuing Education. Participating Practice and Participating Practice's employees, Providers or agents rendering services to Members shall comply with continuing education standards as required by state or federal law or regulatory agencies.

(f) Regulatory Compliance. Providers must meet the minimum requirements for participation in the program(s) as provided by the State and/or Plan.

(g) National Provider Identification. Providers rendering services to Members must have a National Provider Identifier (NPI).

5. Compensation

(a) Fee Schedule. Participating Practice shall be compensated in accordance with the applicable attached Fee Schedule(s) corresponding to product types.

(b) Hold Harmless. Participating Practice hereby agrees that in no event, including, but not limited to, nonpayment by the Company or Plan, the Company or Plan insolvency, or breach of this Agreement, shall the Participating Practice bill, charge, collect a deposit from; seek compensation, remuneration or reimbursement from; or have any recourse against any Member or persons acting on his or her behalf for providing Covered Services. Except where otherwise provided by law, this provision shall not prohibit collection of any applicable co-insurance, co-payments or deductibles from Members or fees for non-covered services delivered on a fee-for-service basis to Members under

the terms of the Plan, Plan Certificates, or other similar documents issued by the Company or the Plan. Participating Practice agrees that it shall hold the Members harmless and shall not bill a Member for non-covered services if the services are not covered as a result of any error or omission by Provider.

Participating Practice further agrees that (i) this provision shall survive the termination of this Agreement regardless of the cause giving rise to such termination and shall be construed to be for the benefit of Members, and (ii) this provision supersedes any oral or written agreement to the contrary now existing or hereafter entered into between Participating Practice and the Member or persons acting on the Member's behalf.

(c) Non-Covered Services. Pursuant to section 5(d), Participating Practice may bill and collect from Members, fees for non-covered services delivered on a fee-for-service basis under the terms of the Plan if:

1. Participating Practice notified the Member prior to services being performed that such service is a non-covered service; and

2. The Member has provided written consent and acknowledgement that this service is non-covered and the Member will be billed separately for such service.

(d) Coordination of Benefits. Participating Practice shall notify the Company whenever Participating Practice has reason to believe a Member may be entitled to coverage under any other health benefit plan and shall assist the Company in obtaining information for the coordination of benefits when a Member holds other coverage. If a Member is also covered by another vision or eye care plan, and the Company determines the Company is the primary carrier, the Participating Practice agrees that the Company's obligation to the Participating Practice will not exceed the compensation described in this Agreement for the Covered Services in question. If a Member is also covered by another health benefit plan and the Company determines that the Company is the secondary carrier, the Participating Practice agrees that the Company's obligation shall not exceed the difference between compensation described in the Agreement for the Covered Services and the amount paid by the other carrier. If applicable, in accordance with this Section 5(d), Participating Practice will refund (reduced by any payments the Member may have made to Provider) the aggregate compensation Participating Practice received from the other health benefits plan for the Covered Services in question.

(e) Missed Appointment. Participating Practice shall not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from or have any recourse against a Member or persons acting on their behalf for missed appointments. Participating Practice shall not be required to accept or continue treatment of a Member with whom Participating Practice feels he/she cannot establish and/or maintain a professional relationship, or is beyond the scope of Participating Practice's expertise or ability.

(f) Plan Reimbursement. Compensation of Participating Practice by the Company is subject to, and dependent upon, the Company's receipt of proper claims payment from Plan. In the event of nonpayment by Plan, the Company reserves the right to withhold or recover payment to Participating Practice for all claims not paid by Plan. If and when the Company has received the outstanding amount for such claims from Plan, the Company will reimburse Participating Practice according to the terms of this Agreement.

(g) Continuation of Care. Participating Practice agrees to complete any treatment in progress for continuation of care cases and cases in mid-treatment for a newly enrolled Member. The Company agrees to negotiate fees in good faith for partial cases/treatment.

6. Quality Management

(a) Cooperation with Quality Programs. Participating Practice shall cooperate with and participate in the quality improvement activities of the Company to improve the quality of care and services and the members' experience, including in the collection and evaluation of data and participation in the Company's quality improvement activities. This includes the use of practitioner performance data for quality improvement activities.

(b) Re-credentialing. Participating Practice and Providers shall cooperate with the re-evaluation of their credentials at such intervals, as the Company shall determine, but not more frequently than every two years. Such evaluation may take into account a review of Participating Practice's past performance and practice patterns, and a review of patient records and evaluations pertaining to Participating Practice's participation in the delivery of vision and/or eye care, as the case may be.

(c) Plan and Regulatory Agency Oversight. Participating Practice acknowledges and agrees that nothing in this Agreement shall be construed to limit: (a) the authority of the Company to ensure Participating Practice's participation in and compliance with Plan's quality assurance, utilization management, member grievance and other systems and procedures; (b) any applicable regulatory Agency's authority to monitor the effectiveness of such systems and procedures; or (c) Plan's authority to sanction or terminate Participating Practice if Participating Practice is found to be providing inadequate or poor quality care or failing to comply with Plan's systems, standards or procedures.

The Participating Practice acknowledges and agrees that any delegation by a Plan to the Company under a contract of quality assurance, utilization management, credentialing, provider relations and other vision management programs, shall be subject to Plan's oversight and monitoring of the Company's performance. The Participating Practice further acknowledges and agrees that Plan, upon the failure of the Company to properly implement and administer such systems or to take prompt corrective action after identifying quality, Member satisfaction or other problems, may terminate the contract and that, as a result of such termination, the Participating Practice's participation in Plan may also be terminated.

7. Additional Requirements. The Company and Participating Practice agree to abide by the requirements of this Agreement, including all Addenda attached hereto, that are applicable to the products in which Participating Practice is participating in, specifically including Addendum A (Medicare Requirements), Addendum B (Medicaid Requirements), Addendum C (State Requirements), and Addendum D (Other), as applicable. To the extent the terms of the Agreement and an Addendum are in conflict, the Addendum shall control.

8. Independent Contractors

(a) Professional Relationship. Participating Practice and all Providers are independent contractors and are responsible for maintaining a professional relationship with Members. Participating Practice is responsible for Providers' own acts or omissions in the Provider's professional practice of optometry, ophthalmology or other vision or eye care related services, as well as those acts or omissions of the Participating Practice's employees and agents including, but not limited to, all employed Providers, such as optometrists and ophthalmologists. No action by the Company has or is intended to have the effect of infringing upon Provider's care and treatment of the Member, including without limitation all decisions with respect to administration, treatment or discharge of such Member.

(b) Appropriate Treatment. Providers may freely communicate with patients regarding their treatment and applicable treatment alternatives, regardless of benefit coverage limitations. Neither Participating Practice nor any Provider will be penalized for discussing Medically Necessary or appropriate patient care with Members. A determination by the Company that a particular course of treatment is not a Covered Service does not relieve Participating Practice from providing or recommending such care to Members as the Provider deems to be appropriate and that determination may not be considered to be a medical determination made by the Company.

(c) Interpretation. Notwithstanding anything in this Agreement, any Exhibit or Addendum, none of the terms of this Agreement, Exhibits or Addenda shall be construed:

1. As an inducement to the Participating Practice to reduce or limit Medically Necessary health care services to a Member;
2. As a penalty to Provider that assists an enrollee to seek a reconsideration of the Company's decision to deny or limit benefits to the Member;
3. As a limit or other restriction on Provider's ethical and legal responsibility to fully advise Members about their medical condition and about medically appropriate treatment options;
4. As a penalty to the Provider for principally advocating for Medically Necessary vision and/or eye care services;
5. As a penalty to the Provider for providing information or testimony to a legislative or regulatory body or Agency. This shall not be construed to prohibit the Company from penalizing a Participating Practice or Provider that provides information or testimony that is libelous or slanderous or that discloses trade secrets that Participating Practice or Provider has no privilege or permission to disclose, or that is otherwise not in accordance with law.
6. Nothing in this Section shall be construed to prohibit the Company from doing either of the following:
    a. Making a determination not to reimburse or pay for a particular treatment or other service;
    b. Enforcing reasonable peer review, utilization review or anti-fraud protocols, or determining whether a provider has complied with these protocols.

9. Term and Termination

(a) Term. This Agreement shall begin on the Effective Date and shall end one (1) year from such date. Thereafter, this Agreement shall automatically renew for successive one (1) year periods unless either Party provides notice of its intent not to renew at least thirty (30) days prior to the last day of the applicable one (1) year period.

(b) Termination. To the extent permitted by applicable State and federal law, this Agreement may be terminated as follows:

i. By the Company upon at least thirty (30) days' prior written notice without cause.

ii. By Provider upon at least sixty (60) days' prior written notice without cause, with an effective date of the last day of the month after the sixtieth (60^{th}) day.

iii. By either Party, in the event of a material breach of this Agreement by the other Party, upon thirty (30) days' prior written notice to the other Party.

iv. Upon the occurrence of any of the following events with respect to Participating Practice or Provider, the Company has the option to immediately terminate Participating Practice or Provider's designation as a Participating Practice or Provider:

1. the death of Provider;
2. the loss or suspension of the Provider's license to practice optometry, ophthalmology or to provide optical services;
3. the loss or suspension of Provider's drug enforcement administration license, or the loss of Provider's unrestricted prescribing privileges;
4. the loss of Participating Practice or Provider's liability insurance;
5. Participating Practice or Provider being restricted or excluded from receiving payments from Medicare or Medicaid;
6. Provider is convicted of any felony;

7. Provider is convicted of any offense involving the Company or Plan;
8. the failure of Participating Practice or Provider to meet any quality assurance, credentialing, or grievance program requirements of the Company, Plan or any Agency or their designees;
9. Participating Practice or the Provider intentionally and purposefully does not comply with the referral and notification requirements of the Company, Plan or Agency or their designees;
10. Participating Practice or Provider fails to cooperate with the Company in the provision of cost-effective, quality services to Members, or any audits, peer review matter or other investigation;
11. Participating Practice or Provider is found to be harming Members or to present a risk of imminent harm to Members;
12. fraud or malfeasance of Participating Practice or Provider; or
13. any adverse regulatory or legal finding with respect to the Participating Practice or Provider.

(c) Effect of Termination. In the event of termination of this Agreement, Participating Practice agrees to complete any treatment in progress and/or assist in the orderly transfer of Members to another provider, as requested by the Company. When applicable, Participating Practice must continue to provide services through the term of the period for which premiums have been paid. Participating Practice shall notify Members with written notification of the termination of a Participating Practice in accordance with applicable law.

(d) Survival. The following provisions shall survive the termination of this Agreement: Sections 3(a), 3(c), 3(d), 3(f), 5(b), 5(c), 5(d), 5(f), 5(g), 8, 10(b), 10(g), 10(h), 10(i), 10(j), and 10(m).

10. Miscellaneous

(a) Non-Exclusivity. This Agreement is not an exclusive contract and the Company may contract with other providers of vision and/or eye care services. Provider may contract with other vision and/or eye care plans.

(b) Confidentiality. This Agreement shall be regarded as confidential and its terms or contents shall not be disclosed to any other party unless agreed to in writing by the Company; except, however, Participating Practice may disclose the contents of this Agreement to the legal representative of Participating Practice, during a legal process or regulatory request.

(c) Amendment or Restated Agreement. The Company may amend or restate this Agreement by sending a copy of Amendment or Restated Agreement to the Participating Practice at least thirty (30) days prior to its effective date ("Notification Period"), unless shorter notice is required due to a regulatory change. Unless Participating Practice objects in writing within such notice period, Practice shall be deemed to have accepted such Amendment or Restated agreement as of the end of the notice period. In the event Participating Practice objects in writing within the thirty (30) day notice period, the parties shall work in good faith to come to an Agreement; however, if an Agreement cannot be reached during the Notification Period, the Agreement shall automatically terminate.

(d) Change in Status. Participating Practice understands that Participating Practice must inform the Company of any and all changes including address, telephone number, group affiliations and changes in the Participating Practice's legal and contractual relationship to and with the Participating Practice's Providers, employees and agents who are also Party to this Agreement must be communicated in writing to the Company, or the Company may elect to immediately terminate this Agreement. Participating Practice also agrees to provide the Company with thirty (30) days' advance written notice of any closure of their practice to additional Members, or new or closed locations at which Participating Practice or a Provider anticipates seeing Members.

(e) Waiver of Breach. The waiver by either Party of a breach of violation of any provision of the Agreement shall not operate as or be construed to be a waiver of any subsequent breach hereof.

(f) Governing Law. This Agreement shall be governed in all respects by the laws of the State.

(g) Responsibility for Actions. Each Party shall be responsible for any and all claims, liabilities, damages, or judgments that may arise as a result of its own negligence or intentional wrongdoing.

(h) Severability. The invalidity or unenforceability of any term or condition shall in no way affect the validity or enforceability of the remainder of this Agreement.

(i) Assignment and Delegation. The Company may assign this Agreement immediately upon written notice to Participating Practice. Participating Practice must obtain the Company's prior written consent to assign this Agreement. The Company may delegate or assign any of its rights or obligations to any of affiliates without notice, subject to any applicable laws.

(j) Notice. Any notices required to be given pursuant to the terms and provisions hereof shall be sent by mail, addressed to:

the Company at:

Attn: Provider Information (Vision)
DentaQuest of Kentucky, LLC
PO BOX 2906
Milwaukee WI 53201-2906

and to the Participating Practice at the correspondence address provided on the signature page below.

(k) Form. All words used herein in the singular number shall extend to and include the plural. All words used in the plural numbers shall extend to and include the singular. All words used in any gender shall extend to and include all genders.

(l) Entire Agreement. This Agreement together with all Addenda, subordinate and other documents and exhibits incorporated herein, constitutes the final and entire expression of the agreement between the Parties with respect to the subject matter contained herein and expressly supersedes all prior and contemporaneous representations, statements, drafts, correspondence or similar understanding or documents, including, without limitation all prior provider service agreements between the Parties.

(m) Errors. The Company shall make every effort to maintain accurate information; however, the Company shall not be held liable for any damages directly or indirectly due to typographical errors. The Participating Practice agrees to immediately notify the Company of any errors.

SIGNATURE PAGE

IN WITNESS WHEREOF, the parties hereto have executed this Agreement on the date written below:

PARTICIPATING PRACTICE INFORMATION:

Business Name (as it appears on W9 & tax returns): _____

Tax ID #_____

Group NPI #:_____

Mailing Address: _____

City:_____State:_____ Zip:_____

PARTICIPATING PRACTICE AUTHORIZATION:

BY: _____
(Signature)

NAME (Please print): _____

TITLE: _____

DATE: _____/_____/_____

Pursuant to the terms of this Agreement, our group will participate in the delivery of the following Covered Services when applicable to a Plan:

____Routine Exams
____Optical Services (dispensary on premises)
____Medical and/or Surgical Care

Do not write below this line – Company use only

COMPANY AUTHORIZATION:

BY: _____
(Signature)

NAME: _____

TITLE: _____

DATE: _____/_____/_____

ADDENDUM B
MEDICAID
KENTUCKY

This Kentucky Medicaid Addendum (this "Addendum") is part of the Vision Participating Practice Service Agreement between Company and the Participating Practice (the "Agreement"). Capitalized terms not otherwise defined herein shall have the meanings ascribed to them in the Agreement. Except as specifically amended hereby, the terms and conditions of the Agreement remain the same. In the event of a conflict between the Agreement and this Addendum, this Addendum shall control.

1. Application of Addendum. This Addendum shall apply to all services provided by the Participating Practice to Members enrolled in the Kentucky Medicaid Program and the Kentucky Children's Health Insurance Program ("CHIP" or "KCHIP") (collectively the "Medicaid Members").

2. Compliance with DMS Agreement and Federal Law. Company and Participating Practice understand and agree that they will be subject to all relevant duties and obligations imposed by the Kentucky Cabinet for Health and Family Services, Department for Medicaid Services ("DMS") pursuant to the Contract between Plan and DMS (the "Medicaid Contract") and with all applicable requirements of 42 CFR Part 438, as may be amended from time to time.

3. Routine, Emergency and Urgent Care. Participating Practice shall ensure that a general vision appointment wait time shall not exceed: 1. Three (3) weeks for a regular appointment; or Forty-eight (48) hours for urgent care 907 KAR 17:015(2)(b).

4. Medical Records. Participating Practice shall keep Medicaid Member medical records in paper or in an electronic format. Medicaid Member Medical Records shall be maintained timely, legible, current, detailed, and organized to permit effective and confidential patient care and quality review. Complete medical records include, but are not limited to, medical charts, prescription files, hospital records, provider specialist reports, consultant and other health care professionals' findings, appointment records, and other documentation sufficient to disclose the quantity, quality, appropriateness, and timeliness of services provided under the Agreement. The medical record shall be signed by the provider of service. Such medical records shall generally be preserved and maintained for a minimum of five (5) years unless federal requirements mandate a longer retention period. 907KAR 17:015(12)

5. Appeals and Grievances. Participating Practice shall have the right to file a grievance with Company or an appeal with Company regarding (a) a payment issue of a contractual issue. Any such grievance of appeal shall be resolved within thirty (30) calendar days. If not resolved within thirty (30) days, Company shall request a fourteen (14) day extension from Participating Practice. The Participating Practice shall approve the extension request from Company. If the Participating Practice requests an extension, the Company shall approve the extension. 907 KAR 17:015 (11).

Attachment C.18.d-1a. Provider Network – Proposed Individual Practitioners and Facilities

As noted, pages 86 contain Proprietary Data and are being submitted under separate sealed cover marked "Proprietary Data."

ADDENDUM C
STATE
KENTUCKY

This Kentucky State Addendum (this "Addendum") is part of the Vision Participating Practice Service Agreement between Company and Participating Practice (the "Agreement"). Capitalized terms not otherwise defined herein shall have the meanings ascribed to them in the Agreement. Except as specifically amended hereby, the terms and conditions of the Agreement remain the same. In the event of a conflict between the Agreement and this Addendum, this Addendum will control.

1. Application of Addendum. This Addendum shall apply to all services provided by the Participating Practice to individuals ("Members") enrolled in a group or individual Plan for which Company is administering the vision benefits in the Cabinet and Commonwealth of Kentucky, except to the extent a provision conflicts with another Addendum attached hereto, in which case the provision in the other Addendum shall control.

2. Prompt Payment. Company shall reimburse Participating Practice for a clean claim, as defined in KRS 304-17A-700, or send a written or an electronic notice denying or contesting the claim within thirty (30) calendar days from the date that the claim is received by the Company. KRS 304.17A-702.

3. Interest. In the event the Plan fails to pay, deny, or settle a clean claim, it shall pay interest according to the following schedule on the amount of the claim that remains unpaid:

   (a) For claims that are paid between one (1) and thirty (30) days from the date that payment was due under KRS 304.17A-702, interest at a rate of twelve percent (12%) per annum shall accrue from the date payment was due;

   (b) For claims that are paid between thirty-tone (31) and sixty (60) days from the date that payment was due under KRS 304.17A-702 interest at a rate of eighteen percent (18%) per annum shall accrue from the date payment was due; and

   (c) For claims that are paid between more than sixty (60) days from the date that payment was due under KRS 304.17A-702, interest at a rate of twenty-one percent (21%) per annum shall accrue from the date payment was due.

   The interest obligation otherwise imposed by this section shall not apply if the failure to pay, deny or settle a claim is due to, or results from, in whole or in part, acts or events beyond the control of the insurer, including but not limited to acts of God, natural disasters, epidemics, strikes or other labor disruptions, war, civil disturbance, riot, or complete or partial disruption of facilities. KRS 304.17A-730.

4. Material Change.

   If Company makes any material change, as defined in KRS 304-17A-235, to the Agreement or any attachments and exhibits thereto, Company will provide at least ninety (90) days' written notice to Participating Practice of the material change which such notice shall include an opportunity for the Participating Practice to meet with the Company using real-time communication to discuss the proposed changes if requested by the Participating Practice. For purposes of this paragraph, "real-time communication" means any mode of telecommunications in which all users can exchange information instantly or with negligible latency and includes the use of traditional telephone, mobile telephone, teleconferencing, and videoconferencing. If requested by the Participating Practice, the opportunity to communicate to discuss the proposed changes may occur via electronic mail instead of real-time communication. The notice of any such material change shall be transmitted in a form required by KRS 304.17A-235. The Participating Practice has the option to either accept or reject the proposed material change in accordance with this section and KRS 304-17A.235. In the event Participating Practice objects to any such material change to the Agreement, Participating Practice shall send written notice to Company within thirty (30) days of the Participating Practice's receipt of notice of the proposed material change material change. If Company makes changes to changes an existing prior authorization, precertification, notification, or referral program, or changes an edit program or specific edits, Company will provide Participating Practice with fifteen (15) days prior notice to such change.

5. Non-Discrimination. Company shall not discriminate against any provider who is located within the geographic coverage area of the Plan and who is willing to meet the terms and conditions for participation established by the health insurer, including the Kentucky state Medicaid program and Medicaid partnerships. KRS 304-17C-050(2)

6. Provider Subcontracts. In the event Participating Practice enters into any subcontract agreement with another provider to provide Covered Services to Covered Persons, such agreement shall meet all requirements of the Agreement and shall be filed with the Kentucky Department of Insurance. KRS 304.17C-060(1)(c)

7. Termination. If Participating Practice's participation will be terminated or withdrawn prior to the date of the termination of the Agreement as a result of a professional review action, the Company and Participating Practice shall comply with the standards in 42 U.S.C. sec. 11112. If the Company finds that Participating Practice represents an imminent danger to an individual patient or to the public health, safety, or welfare, the medical director shall promptly notify the appropriate professional state licensing board. KRS304-17C-050(3)

ADDENDUM D

ANTHEM MEDICAID

VISION REIMBURSEMENT

CHILDREN UNDER AGE 21

Additional Terms

1. Appointment Availability. Provider must provide services within the timeframes as set forth in the Government Contract and the provider manual.

2. Appeal Rights. Provider shall display notices of Medicaid Members' right to appeal adverse action affecting services in public areas of Provider's facility/office in accordance with the Cabinet's rules and regulations.

3. Provider Performance. Provider understands and agrees that DentaQuest/eyeQuest will monitor Provider's performance and quality of services delivered under this Agreement on an ongoing basis and will subject Provider to formal periodic review. Provider shall also comply with corrective action plans as required by Anthem.

4. Program Integrity. As a condition of receiving any amount of payment under this Agreement, Providers agree to comply with the Program Integrity requirements of the Government Contract, as applicable.

5. Controlling Agreement. In the event of an inconsistency between terms and conditions of this Agreement and this Attachment with the terms and conditions as set forth in the Government Contract, the terms and conditions of the Government Contract shall govern and the conflicting terms and conditions shall be null and void.

6. No Third Party Beneficiary. Provider understands and agrees that Provider is not a third party beneficiary to the Government Contract and that Provider is performing services as agreed upon with Anthem as outlined in this Agreement.

7. Insurance. Provider shall self-insure or maintain at its own expense professional and comprehensive general Liability and medical malpractice insurance acceptable to Anthem as set forth in the provider manual(s), Participation Attachment(s), PCS, or as required under applicable Regulatory Requirements through the terms of the Government Contract.

8. Submission of Claims. Provider shall submit claims for vision services to DentaQuest in a manner and format prescribed by DentaQuest. Provider understands that failure to submit claims or failure to submit requested documentation within 365 days will result in loss of reimbursement for services provided. Provider shall submit claims electronically to DentaQuest. If unable to submit claims electronically, paper claims must be submitted on a standard ADA claim form or a format that has been approved by DentaQuest in advance. Provider agrees to accept electronic payment and electronic remittance if/when available.

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ADDENDUM E

ANTHEM MEDICAID

VISION REIMBURSEMENT

ADULTS 21 AND OLDER

Additional Terms

1. Appointment Availability. Provider must provide services within the timeframes as set forth in the Government Contract and the provider manual.

2. Appeal Rights. Provider shall display notices of Medicaid Members' right to appeal adverse action affecting services in public areas of Provider's facility/office in accordance with the Cabinet's rules and regulations.

3. Provider Performance. Provider understands and agrees that DentaQuest/eyeQuest will monitor Provider's performance and quality of services delivered under this Agreement on an ongoing basis and will subject Provider to formal periodic review. Provider shall also comply with corrective action plans as required by Anthem.

4. Program Integrity. As a condition of receiving any amount of payment under this Agreement, Providers agree to comply with the Program Integrity requirements of the Government Contract, as applicable.

5. Controlling Agreement. In the event of an inconsistency between terms and conditions of this Agreement and this Attachment with the terms and conditions as set forth in the Government Contract, the terms and conditions of the Government Contract shall govern and the conflicting terms and conditions shall be null and void.

6. No Third Party Beneficiary. Provider understands and agrees that Provider is not a third party beneficiary to the Government Contract and that Provider is performing services as agreed upon with Anthem as outlined in this Agreement.

7. Insurance. Provider shall self-insure or maintain at its own expense professional and comprehensive general Liability and medical malpractice insurance acceptable to Anthem as set forth in the provider manual(s), Participation Attachment(s), PCS, or as required under applicable Regulatory Requirements through the terms of the Government Contract.

8. Submission of Claims. Provider shall submit claims for vision services to DentaQuest in a manner and format prescribed by DentaQuest. Provider understands that failure to submit claims or failure to submit requested documentation within 365 days will result in loss of reimbursement for services provided. Provider shall submit claims electronically to DentaQuest. If unable to submit claims electronically, paper claims must be submitted on a standard ADA claim form or a format that has been approved by DentaQuest in advance. Provider agrees to accept electronic payment and electronic remittance if/when available.

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ANTHEM BLUE CROSS AND BLUE SHIELD MEDICAID FACILITY AGREEMENT

WITH

ANTHEM BLUE CROSS AND BLUE SHIELD MEDICAID
FACILITY AGREEMENT

This Facility Agreement (hereinafter "Agreement") is made and entered into by and between Anthem Kentucky Managed Care Plan, Inc. doing business as Anthem Blue Cross and Blue Shield Medicaid (hereinafter "Anthem") and (hereinafter "Facility") and is solely applicable to Anthem's Kentucky Medicaid business. The parties agree that the following terms and conditions shall control the relationship as it pertains solely to Anthem's managed Medicaid business and services provided by Facility to Kentucky Medicaid eligible members enrolled in Anthem programs. All terms and conditions hereinafter shall be construed to pertain solely to managed care Medicaid business and shall not alter or affect any other agreements for other Plans, programs or Networks governed by separate agreements currently or hereinafter in affect between the parties. In consideration of the mutual promises and covenants herein contained, the sufficiency of which is acknowledged by the parties, the parties agree as follows:

ARTICLE I
DEFINITIONS

"Affiliate" means any entity owned or controlled, either directly or through a parent or subsidiary entity, by Anthem, or any entity which is under common control with Anthem and that accesses the rates, terms or conditions of this Agreement. Anthem will have a current listing of such Affiliates available through a commonly available web site or upon request.

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

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

"Chargemaster" or "Charges" means Facility's listing of Facility charges for products, services and supplies.

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

"Coded Service Identifier(s)" means a listing of descriptive terms and identifying codes, updated from time to time by the Centers for Medicare and Medicaid Services ("CMS") or other industry source, for reporting Health Services on the UB-04 claim form or its successor. The codes include but are not limited to, American Medical Association Current Procedural Terminology ("CPT®-4"), CMS Healthcare Common Procedure Coding System ("HCPCS"), International Classification of Diseases, 9th Revision, Clinical Modification ("ICD-9-CM"), National Drug Code ("NDC"), and Revenue Codes or their successors.

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

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

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

"DRG" means Diagnosis Related Group or its successor as established by CMS or other grouper as set forth in the PCS.

"DRG Rate" means the all inclusive dollar amount applied to the appropriate DRG Weight which results in the Anthem Rate, if the reimbursement methodology as set forth in the PCS is on a DRG basis.

"DRG Weight" means the CMS cost weights for each DRG as published in the Federal Register to be effective on October 1st each year, or other cost weights used by Anthem, as set forth in the PCS.

"Emergency Condition" 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. "Emergency Services" means those Covered Services provided in connection with an Emergency Condition.

"Fee Schedule Rate" means the Anthem Rate payable to Facility based on a specific Coded Service Identifier(s), as set forth in the applicable fee schedule(s).

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

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

"Inlier Rate" means the Anthem Rate of payment which is not subject to Outlier Rate reimbursement as set forth in the PCS.

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

"Medically Necessary" or "Medical Necessity" means, unless otherwise set forth by statute, regulation, or the Covered Individual's Health Benefit Plan, 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; and (4) the most appropriate supply or level of service which can be safely provided to the Covered Individual. 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.

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

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

"Observation" means the services furnished by a Network/Participating Provider on the Facility's premises, regardless of the length of stay, including use of a bed and periodic monitoring by nursing or other staff, which are Medically Necessary to evaluate an outpatient condition and determine the need for a possible admission to the Facility as an inpatient.

"Other Payors" means persons or entities, utilizing the Network(s)/Plan Program(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.

"Other Services Rate" means the Anthem Rate as set forth in the PCS to be used when there is not a specifically negotiated rate for the particular service.

"Outlier Rate" means the Anthem Rate of payment applied to an admission which exceeds the outlier threshold as set forth in the PCS.

"Outpatient Services" means Covered Services other than Inpatient Services which are provided to a Covered Individual by Facility.

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

"Patient Day" means each approved calendar day of care that a Covered Individual receives in the Facility, to the extent such day of care is a Covered Service under the terms of the Covered Individual's Health Benefit Plan, but excluding the day of discharge.

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

"Per Diem Rate" means the Anthem Rate that is expressed as the all inclusive fixed payment for each Patient Day of admission or one outpatient encounter.

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

"Per Visit Rate" means the Anthem Rate that is expressed as the all inclusive fixed payment rate for the service type designated under Outpatient Services.

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

"Plan Compensation Schedule ("PCS")" means the document(s) attached to, or made a part of this Agreement which sets forth the Anthem Rate(s) and compensation related terms for the Network(s) in which Facility participates.

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

ARTICLE II
SERVICES/OBLIGATIONS

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

2.2 Facility Non-discrimination. Facility shall provide Health Services to Covered Individuals in a manner similar to and within the same time availability in which Facility provides Health Services to any other individual. Facility 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. Facility shall not be required to provide any type, or kind of Health Service to Covered Individuals that it does not customarily provide to others.

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

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

2.5 Submission and Payment of Claims. Unless otherwise instructed, or required by state, or federal law, Facility shall submit Claims to Plan, using appropriate and current Coded Service Identifier(s), within three hundred sixty five (365) days from the date the Health Services are rendered or Plan will refuse payment. If Plan is the secondary payor, the three hundred sixty five (365) day period will not begin until Facility receives notification of primary payor's responsibility.

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

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

2.5.3 If Anthem or Plan asks for additional information so that Plan may process the Claim, Facility must provide that information within sixty (60) days, or before the expiration of the three hundred sixty five (365) day period referenced above, whichever is longer.

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

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

2.6 Plan Payment Time Frames. Unless otherwise set forth by statute, regulation, or the Covered Individual's Health Benefit Plan, 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 Facility in accordance and within the time frames established by KRS 304.17A-702 or other applicable state or federal statute or regulation. For Claims that are neither subject to KRS 304.17A-702 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 Facility within ninety (90) days, exclusive of Claims that have been suspended due to the need to determine Medical Necessity, or the extent of Plan's payment liability, if any, because of issues such as coordination of benefits, subrogation or verification of coverage.

2.7 Payment in Full and Hold Harmless.

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

2.7.2 Facility agrees that in no event, including but not limited to, nonpayment by applicable Plan, insolvency of applicable Plan, or breach of this Agreement, or Claim payment denials or adjustment requests or recoupments based on miscoding or other billing errors of any type, whether or not fraudulent or abusive, shall Facility, or any person acting on behalf of Facility, bill, charge, collect a deposit from, seek compensation from, or have any other recourse against a Covered Individual, or a person legally acting on the Covered Individual's behalf, for Covered Services provided pursuant to this Agreement. This section does not prohibit Facility from collecting reimbursement for the following from the Covered Individual:

2.7.2.1 Cost Shares, if applicable;

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

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

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

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

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

2.7.2.3 Any reduction in or denial of payment as a result of the Covered Individual's failure to comply with his/her utilization management program pursuant to his/her Health Benefit Plan, except when Facility has been designated by Anthem to comply with utilization management for the Health Service provided by Facility to the Covered Individual;

2.7.2.4 Health Services which are not payable in the Covered Individual's Health Benefit Plan because Facility does not participate in the applicable Plan Program.

2.8 Adjustments for Incorrect Payments. Facility shall refund to Plan all duplicate or erroneous Claim payments regardless of the cause, including but not limited to, payments for Claims where the Claim was miscoded or otherwise billed in error, whether or not the billing error was fraudulent or abusive, 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.

2.9 Facility Subcontractors. Facility shall provide Anthem with at least ninety (90) days prior notice of any Health Services subcontractors with which Facility may contract to perform Facility's duties and obligations under this Agreement. Facility shall provide Anthem with a sample contract of any agreement between Facility and such subcontractors at least ninety (90) days prior to the commencement of such subcontractor(s)' services, for the purpose of Anthem's filing such agreement with the Kentucky Department of Insurance, as required by KRS 304.17A-527(1)(e). Facility shall require such subcontractors to abide by the terms and conditions of this Agreement, including but not limited to, the Payment in Full and Hold Harmless provisions of section 2.7 hereof, and including the provisions of KRS 304.17A. Facility agrees that Anthem may contract directly with any Health Services providers rather than relying on the subcontracting arrangements entered by Facility.

2.10 Compliance with Provider Manual(s) and Policies, Programs and Procedures. Facility agrees to abide by, and comply with, Anthem's provider manual(s), and all other policies, programs and procedures (collectively "Policies") established and implemented by Plan. Anthem or its designees may modify the provider manual(s) and Policies by making a good faith effort to provide notice to Facility at least ninety (90) days in advance of the effective date of material modifications thereto.

2.11 In Network Referrals and Transfers. Facility shall when medically appropriate refer and transfer Covered Individuals to Network/Participating Providers.

2.12 Programs and Provider Panels. Facility acknowledges that Plan may have, develop, or contract to develop, various networks or programs that have a variety of provider panels, program components and other requirements, and that Plan may discontinue, or modify such networks or programs. Anthem shall offer the Facility the opportunity to meet any such selection criteria in the same manner as any other Network/Participating Provider, including the opportunity to participate in various other networks or programs. If Facility does not meet the selection criteria, or declines the opportunity, Facility understands and agrees that it will cooperate in the transfer of the Covered Individual to a provider within the other network. If Facility renders Health Services that should have been rendered by a Network/Participating Provider in a separate network, then Facility agrees that it will be deemed not to be a Network/Participating Provider under the Covered Individual's Health Benefit Plan, for the rendition of said Health Services; Facility agrees not to bill Anthem, or Covered Individual for any such services. Anthem will give Facility at least ninety (90) days advance notice of the implementation of a separate network.

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

2.13 Facility's Inability to Carry Out Duties. Facility shall promptly send written notice, in accordance with the Notice section of this Agreement, to Anthem of:

2.13.1 Any change in Facility's business address;

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

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

2.14 Facility Staff Privileges. Facility agrees to facilitate Anthem's recruitment of Facility's medical staff, and to expeditiously grant admitting privileges to Network physicians who meet Facility's credentialing standards.

2.15 Facility-Based Providers. Facility agrees to require its contracted Facility-based providers or those with exclusive privileges at Facility to obtain and maintain Network/Participating Provider status with Anthem. Until such time as Facility-based providers enter into agreements with Anthem, Facility agrees to fully cooperate with Anthem to prevent Covered Individuals from being billed amounts in excess of the applicable Anthem non-participating reimbursement for such Covered Services. Facility-based providers may include, but are not limited to, anesthesiologists, radiologists, pathologists, neonatologists, hospitalists and emergency room physicians.

2.16 Facility Accreditation. Facility agrees to meet any applicable accreditation requirements which Anthem may apply to participating facilities as set forth in the provider manual(s).

2.17 Adjustment Requests. If Facility believes a Claim has been improperly adjudicated for a Covered Service, for which Facility timely submitted a Claim to Plan, Facility must submit a request for an adjustment to Plan within two (2) years from the date of Plan's payment or explanation of payment, unless otherwise set forth in the provider manual. The request must be submitted in accordance with Plan's payment inquiry process. Requests for adjustments submitted after this date may be denied for payment, and Facility will not be permitted to bill Anthem, Plan, or the Covered Individual for those services for which payment was denied.

2.18 Blue Cross Blue Shield Out of Area Program. Facility agrees to provide Covered Services to any person who is covered under another BCBSA out of area or reciprocal programs and to submit Claims for payment in accordance with current BCBSA Claims filing guidelines. Facility agrees to accept payment by Plan at the Anthem Rate for the equivalent Network as payment in full except Facility may bill, collect and accept compensation for Cost Shares. The provisions of this Agreement shall apply to Charges for Covered

Services under the out of area or reciprocal programs. Facility further agrees to comply with other similar programs of the BCBSA. For Covered Individuals who are enrolled under BCBSA out of area or reciprocal programs, Facility shall comply with the applicable Plan's utilization management policies.

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

2.20 Cost Effective Care. Facility shall provide Covered Services in the most cost effective, clinically appropriate setting and manner.

2.21 Request for Fees. Upon request by Facility, Plan shall provide Facility with the payment or fee schedules or other information sufficient to enable Facility to determine the amount and manner of payments under the Agreement for Facility's services.

ARTICLE III
CONFIDENTIALITY/RECORDS

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

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

3.3 Plan Access to and Requests for Facility Records. Facility shall comply with all applicable state and federal record keeping requirements, and as set forth in the provider manual(s), shall permit Plan or its designees to have, with appropriate working space and without charge, on-site access to and the right to examine, audit, copy, excerpt and transcribe any books, documents, papers, and records related to Covered Individual's medical and billing information within the possession of Facility and inspect Facility'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, accuracy of payment, compliance with this Agreement, and for research. In lieu of on-site access, at Plan's request, Facility shall submit records to Plan, the Covered Individual or their respective designees via photocopy or electronic transmittal, at no charge. Facility shall make such records available to the state and federal authorities involved in assessing quality of care or investigating Covered Individual grievances or complaints. Plan shall use best efforts to conduct routine audits, including but not limited to credit balance assessments, DRG validations and periodic Claims sampling, no more frequently than on a quarterly basis. Non-routine audits related to Plan analytics or Facility-specific issues may be conducted at any time. Provider shall maintain medical, financial and administrative records concerning services provided to Medicaid Members in accordance with industry standards and Regulatory Requirements, including, without limitation and any applicable law regarding confidentiality of Covered Individual information. Such records shall be retained by Provider for the period of time required under Regulatory Requirements, but in no event less than ten (10) years from the date the service is rendered, unless a federal statute or regulation requires a longer retention period. Provider shall allow authorized representatives of the Cabinet, or other Commonwealth and federal agencies, reasonable access to Provider’s premises, physical facilities, equipment and records for financial and medical audit purposes both during and after the term of this Agreement.

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

ARTICLE IV
INSURANCE

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

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

ARTICLE V
RELATIONSHIP OF THE PARTIES

5.1 Relationship of the Parties. For purposes of this Agreement, Anthem and Facility are and will act at all times as independent contractors. Nothing in this Agreement shall be construed, or be deemed to create, a relationship of employer or employee or principal and agent, or any relationship other than that of independent entities contracting with each other for the purposes of effectuating this Agreement. In no way shall Anthem or Plan be construed to be providers of Health Services or responsible for the provision of such Health Services. Facility shall be solely responsible to the Covered Individual for treatment and medical care with respect to the provision of Health Services. Facility may freely communicate with Covered Individuals regarding the treatment options available to them, including medication treatment options, regardless of benefit coverage limitations.

5.2 Blue Cross Blue Shield Association (BCBSA). Facility hereby expressly acknowledges its understanding that this Agreement constitutes a contract between Facility and Anthem, that Anthem is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and/or Blue Shield Plans ("Association"), permitting Anthem to use the Blue Cross and/or Blue Shield Service Marks in the state (or portion of the state) where Anthem is located, and that Anthem is not contracting as the agent of the Association. Facility 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 Facility for any of Anthem's obligations to Facility created under this Agreement. Facility 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 Facility to use the Brands. Any references to the Brands made by Facility in its own materials are subject to review and approval by Anthem. This section shall not create any additional obligations whatsoever on the part of Plan other than those obligations created under other provisions of this Agreement.

ARTICLE VI
INDEMNIFICATION AND LIMITATION OF LIABILITY

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

6.2 Limitation of Liability. Regardless of whether there is a total and fundamental breach of this Agreement or whether any remedy provided in this Agreement fails of its essential purpose, in no event shall either of the parties hereto be liable for any amounts representing loss of revenues, loss of profits, loss of business, the multiple portion of any multiplied damage award, or incidental, indirect, consequential, special or punitive

damages, whether arising in contract, tort (including negligence), or otherwise regardless of whether the parties have been advised of the possibility of such damages, arising in any way out of or relating to this Agreement. Further, in no event shall Plan be liable to Facility for any extracontractual damages relating to any claim or cause of action assigned to Facility by any person or entity.

6.3 Period of Limitations. Unless otherwise provided for in this Agreement, the provider manual(s), or Policies, neither party shall commence any action at law or equity, including but not limited to, an arbitration demand, against the other to recover on any legal or equitable claim arising out of this Agreement more than two (2) years after the events which gave rise to such claim, unless compliance with this section would compel a party to violate the terms of the Health Benefit Plan. The deadline for initiating an action shall not be tolled by the appeal process, provider dispute resolution process or any other administrative process. To the extent a dispute is timely commenced, it will be administered in accordance with Article VII of this Agreement.

ARTICLE VII
DISPUTE RESOLUTION AND ARBITRATION

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

7.1.1 In order to invoke the dispute resolution procedures in this Agreement, a party first shall send to the other party a written demand letter that contains a detailed description of the dispute and all relevant underlying facts, a detailed description of the amount(s) in dispute and how they have been calculated and any other information that the Anthem provider manual(s) may require Facility to submit with respect to such dispute. If the total amount in dispute as set forth in the demand letter is less than two million dollars ($2,000,000), exclusive of interest, costs, and attorneys' fees, then within twenty (20) calendar days following the date on which the receiving party receives the demand letter, representatives of each party's choosing shall meet to discuss the dispute in person or telephonically in an effort to resolve the dispute. If the total amount in dispute as set forth in the demand letter is two million dollars ($2,000,000) or more, exclusive of interest, costs, and attorneys' fees, then within ninety (90) calendar days following the date of the demand letter, the parties shall engage in non-binding mediation in an effort to resolve the dispute unless both parties agree in writing to waive the mediation requirement. The parties shall mutually agree upon a mediator, and failing to do so, Judicial Arbitration and Mediation Services ("JAMS") shall be authorized to appoint a mediator.

7.2 Arbitration. Any dispute within the scope of subsection 7.1.1 that remains unresolved at the conclusion of the applicable process outlined in subsection 7.1.1 shall be resolved by binding arbitration in the manner as set forth below. Except to the extent as set forth below, the arbitration shall be conducted pursuant to the JAMS Comprehensive Arbitration Rules and Procedures, provided, however, that the parties may agree in writing to further modify the JAMS Comprehensive Arbitration Rules and Procedures. The parties agree to be bound by the findings of the arbitrator(s) with respect to such dispute, subject to the right of the parties to appeal such findings as set forth herein. No arbitration demand shall be filed until after the parties have completed the dispute resolution efforts described in section 7.1 above.

7.2.1 Selection and Replacement of Arbitrator(s). If the total amount in dispute as set forth in the demand letter is less than two million dollars ($2,000,000), exclusive of interest, costs, and attorneys' fees, the dispute shall be decided by a single arbitrator selected, and replaced when required, in the manner described in the JAMS Comprehensive Arbitration Rules and Procedures. If the total amount in dispute as set forth in the demand letter is two million dollars ($2,000,000) or more, exclusive of interest, costs, and attorneys' fees, the dispute shall be decided by an arbitration panel consisting of three (3) arbitrators, unless the parties agree in writing that the dispute shall be decided by a single arbitrator.

7.2.2 Appeal. If the total amount of the arbitration award is five million dollars ($5,000,000) or more, inclusive of interest, costs, and attorneys' fees, the parties shall have the right to appeal the decision of the arbitrator(s) pursuant to the JAMS Optional Arbitration Appeal Procedure. In reviewing a decision of the arbitrator(s), the appeal panel shall apply the same standard of review that a United States Court of Appeals would apply in reviewing a similar decision issued by a

United States District Court in the jurisdiction in which the arbitration hearing was held.

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

ARTICLE VIII
TERM AND TERMINATION

8.1 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 three (3) years ("Initial Term"). Thereafter this Agreement shall continue until such time as it is terminated as provided herein.

8.2 This provision intentionally left blank.

8.3 This provision intentionally left blank.

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

8.5 Termination With Cause.

8.5.1 This Agreement may be terminated immediately by Anthem if:

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

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

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

8.5.1.4 Facility's insurance coverage as required by this Agreement lapses for any reason; or

8.5.1.5 Facility fails to maintain compliance with Anthem's credentialing standards; or

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

8.5.1.7 Facility has been abusive to a Covered Individual; or

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

8.5.2 This Agreement may be terminated immediately by Facility if:

8.5.2.1 Anthem commits any act or conduct for which its license(s), permit(s), or any

governmental or board authorization(s) or approval(s) necessary for business operations are lost or voluntarily surrendered in whole or in part; or

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

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

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

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

8.7 Continuance of Care-Termination. Unless otherwise set forth by statute or regulation, or the Covered Individual's Health Benefit Plan Facility 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 from Facility, or the active course of treatment is completed, whichever time is greater, and in the case of a pregnant woman, Facility 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 purposes of this provision, "discharge" shall mean the Covered Individual's physical release from the Facility. Notwithstanding the foregoing, any ancillary services that are part of a global charge for the Health Services which caused an admission for such Health Services shall continue to be paid in accordance with the Agreement even though the Covered Individual has been physically released from Facility. In addition, Facility 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 was 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.

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

8.8.1 Publication and Use of Facility Information (Section 2.3) excluding transparency information;

8.8.2 Payment in Full and Hold Harmless (Section 2.7);

8.8.3 Adjustments for Incorrect Payments (Section 2.8);

8.8.4 Confidentiality/Records (Article III);

8.8.5 Indemnification and Limitation of Liability (Article VI);

8.8.6 Dispute Resolution and Arbitration (Article VII); and

8.8.7 Continuance of Care-Termination (Section 8.7).

ARTICLE IX
GENERAL PROVISIONS

9.1 Amendment. Except for the Anthem Rate, or as otherwise provided for in this Agreement, Anthem retains the right to amend this Agreement, any attachments or addenda by providing notice to Facility at least forty-five (45) days in advance of the effective date of the amendment. If Facility decides not to accept the amendment, Facility has the right to terminate this Agreement by providing written notice within thirty (30) days from receipt of such notice from Anthem. Facility's termination shall take effect one hundred eighty (180) days from the date Facility has provided notice of its intention to terminate pursuant to this section. Failure of Facility to provide such notice to Anthem within the time frames described herein will constitute acceptance of the amendment by Facility.

9.1.1 Material Change. Except as otherwise provided for in this Agreement, in the event Anthem makes a material change to this Agreement, the Anthem Rate, the provider manual, any attachments or

addenda, Anthem shall provide notice to Facility at least ninety (90) days in advance of the effective date of the material change. If Facility decides not to accept the material change, Facility has the right to terminate this Agreement by providing written notice to Anthem no later than forty-five (45) days prior to the effective date of the material change. Facility's termination shall take effect sixty (60) days from the date Facility has provided such notice of his/her/its intention to terminate pursuant to this provision. Failure of Facility to provide such notice to Anthem within the timeframes described herein will constitute acceptance of the material change by Facility. For purposes of this Agreement, a material change means a change to the Agreement, the occurrence and timing of which is not otherwise clearly identified in the contract, that decreases Facility's payment or compensation or changes the administrative procedures in a way that may reasonably be expected to significantly increase Facility's administrative expense.

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

9.3 Scope/Change in Status. Anthem and Facility agree that this Agreement applies to Health Services rendered at the locations as set forth on the Facility Locations/Networks Attachment of this Agreement. Anthem may limit this Agreement to Facility's locations, operations or business or corporate form, status or structure in existence on the Effective Date of this Agreement and prior to the occurrence of any of the following events:

9.3.1 Facility changes its locations, business or operations, or business or corporate form or status; or

9.3.2 Facility is acquired or controlled by any other entity through any manner, including but not limited to purchase, merger, consolidation, alliance, joint venture, partnership, association, or expansion; or

9.3.3 Facility acquires or controls any other medical facility, service or beds through any manner, including but not limited to asset only purchase, merger, consolidation, alliance, joint venture, partnership, association, or expansion; or

9.3.4 Facility (a) sells, transfers or conveys its business or any substantial portion of its business assets to another entity through any manner including but not limited to a stock, real estate or asset transaction or other type of transfer; or (b) enters into a management contract with another entity.

9.3.5 If Anthem consents in writing not to limit the Agreement to the original corporate entity, then Facility warrants and covenants that this Agreement will be assumed by the new entity unless the new entity already has an agreement with Anthem, in which case Anthem will determine which Agreement will prevail. Facility shall provide Anthem one hundred twenty (120) days prior written notice of any change in this section 9.3.

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

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

9.6 Force Majeure. Neither party shall be deemed to be in violation of this Agreement if such party is prevented from performing any of 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.

9.7 Compliance with Federal and State Laws. Anthem and Facility agree to comply with all requirements of the law relating to their obligations under this Agreement, and maintain in effect all permits, licenses and governmental and board authorizations and approvals as necessary for business operations, and as to Facility, its agents and employees, they shall be and remain licensed and certified (including Medicare certification in unqualified, unrestricted status) in accordance with all state and federal laws and regulations

(including those applicable to utilization review and Claims payment) relating to the provision of Facility services to Covered Individuals. Facility shall supply evidence of such licensure, compliance and certifications to Anthem upon request. From time to time legislative bodies, boards, departments or agencies may enact, issue or amend laws, rules, or regulations pertinent to this Agreement. Both parties agree to immediately abide by all said laws, rules, or regulations to the extent applicable, and to cooperate with the other to carry out any responsibilities placed upon the other by said laws, rules, or regulations, subject to the other's right to terminate as set forth under this Agreement. In the event of a conflict between this section and any other provision in this Agreement, this section shall control.

9.7.1 In addition to the foregoing, Facility warrants and represents that at the time of entering into this Agreement, neither it nor any of 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.epls.gov/ or its successor) and the HHS/OIG List of Excluded Individuals/Entities (available through the internet at http://www.oig.hhs.gov/fraud/exclusions.asp or its successor), or as otherwise designated by the Federal government. If Facility or any employees, subcontractors or agents thereof becomes an ineligible person after entering into this Agreement or otherwise fails to disclose its ineligible person status, Facility 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 Facility's business operations related to this Agreement.

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

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

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

9.11 Notice. Any notice required to be given pursuant to the terms and provisions of this Agreement shall be in writing and shall be delivered by electronic mail, by facsimile, by hand, or sent by mail. Unless specified otherwise in writing by a party, Anthem shall send Facility notice to an address that Anthem has on file for Facility, and notice initiated by Facility shall be sent to Anthem's address as set forth on the signature page. Notice shall be effective upon the marked date associated with the corresponding delivery method noted above. Notwithstanding the foregoing, Anthem may post updates to its provider manual(s) and Policies on its web site.

9.12 Severability. In case any one or more of the provisions of this Agreement shall be invalid, illegal, or unenforceable in any respect, the remaining provisions shall be construed liberally in order to effectuate the purposes hereof, and the validity, legality and enforceability of the remaining provisions shall not in any way be affected or impaired thereby. If one or more provisions of the Agreement are invalid, illegal or unenforceable and an amendment to the Agreement is necessary to maintain its integrity, the parties shall make commercially reasonable efforts to negotiate an amendment to this Agreement and any attachments or addenda to this Agreement which could reasonably be construed not to contravene such statute, regulation, or interpretation. In addition, if such invalid, unenforceable or materially affected provision(s) may be severed from this Agreement and/or attachments or addenda to this Agreement without materially affecting the parties' intent when this Agreement was executed, then such provision(s) shall be severed rather than terminating the Agreement or any attachments or addenda to this Agreement.

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

Agreement, shall thereafter be construed as a waiver of any subsequent breach of any of the provisions of this Agreement.

9.14 Exchanges. Unless specifically set forth on the Facility Locations/Networks Attachment and/or in the PCS or as otherwise designated by Anthem, the Anthem Rate shall not apply to any products or Plan Programs which Anthem may offer on state-based, regional or federal health insurance exchanges ("Exchanges") established by the Patient Protection and Affordable Care Act.

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

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

THE EFFECTIVE DATE OF THIS AGREEMENT IS: _____

FACILITY LEGAL NAME:

By: _____ _____
Signature, Authorized Representative of Facility(s) Date

Printed: _____ _____
Name Title

Address _____ _____
Street City State Zip

Tax Identification Number (TIN): _____

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

License Number: _____

Medicare Number: _____

Medicaid Number: _____

NPI Number: _____

Group NPI Number: _____

Facsimile Number: _____

Phone Number: _____

Email Address: _____

Web Site: _____

Facility's Fiscal Year Is: _____

Anthem Kentucky Managed Care Plan, Inc. doing business as Anthem Blue Cross and Blue Shield Medicaid

By: _____ _____
Signature, Authorized Representative of Anthem Date

Printed: _____ _____
Name Title

Address _____ _____
Street City State Zip

FACILITY LOCATIONS/NETWORKS ATTACHMENT

Name	Street Address	City	State	Zip

As of the Effective Date of this Agreement, Facility will be designated as Network/Participating Provider in the following:

Governmental lines of business:

Health Benefit Plans issued pursuant to an agreement between Plan and the federal or state government and in which Covered Individuals have access to a network of providers and receive an enhanced level of benefits when they obtain Covered Services from Network/Participating Providers regardless of product licensure status. Such Health Benefit Plans include but are not limited to:

- Medicaid

KENTUCKY MEDICAID
PARTICIPATION ATTACHMENT TO THE
ANTHEM BLUE CROSS AND BLUE SHIELD
FACILITY AGREEMENT

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

As a participant in Anthem's Kentucky Managed Care Plan, Inc. d/b/a Anthem Blue Cross and Blue Shield Medicaid ("Anthem") Medicaid Program, Facility will render Covered Services to Covered Individuals that are enrolled in Anthem's Medicaid Program in accordance with the terms and conditions of the Agreement, this Attachment and the Provider Manual. Except as set forth in this Attachment or the Provider Manual all terms and conditions of the Agreement will apply to Facility's participation in Anthem's Kentucky Medicaid Program(s).

ARTICLE I
DEFINITIONS

The following terms shall have the meanings set forth below with respect to services furnished under the Medicaid Program.

1.1 Agency. "Agency" means a federal, Commonwealth or local agency, administration, board or other governing body responsible for the governance or administration of a Program. With respect to the operation of the Programs, Agency means, without limitation, the Kentucky Department of Medicaid Services within the Cabinet for Health and Family Services and CMS.

1.2 Cabinet. "Cabinet" means the Cabinet for Health and Family Services in which the Kentucky Department of Medicaid Services is located.

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

1.4 Commonwealth. "Commonwealth" means the Commonwealth of Kentucky.

1.5 Covered Individual. "Covered Individual" means a person who is an eligible Program beneficiary and who is enrolled as an Anthem member in accordance with applicable Program enrollment requirements.

1.6 Covered Services. "Covered Services" means those health care services (including Behavioral Health Care Services) that a Covered Individual is entitled to receive through Anthem pursuant to Regulatory Requirements, and for which a Medicaid Compensation Schedule Attachment is attached hereto setting forth the Providers' reimbursement under the Program.

1.7 Finance. "Finance" means the Kentucky Cabinet for Finance and Administration.

1.8 Medically Necessary. "Medically Necessary" means Covered Services which are medically necessary as defined under 907 KAR 3:130, and provided in accordance with 42 CFR § 440.230, including children's services pursuant to 42 U.S.C. 1396d(r).

1.9 Program. "Program" means the terms of coverage under an applicable benefit contract for which an Attachment A is incorporated into this Agreement setting forth the Providers' reimbursement under the Cabinet Medicaid managed care program ("Medicaid").

1.10 Program Contract. "Program Contract" means the Cabinet Medicaid managed care program contract between Anthem and Cabinet which governs the delivery of managed health care services to Program beneficiaries.

1.11 Provider. "Provider" shall be Facility for purposes of this Attachment.

1.12 Regulatory Requirements. "Regulatory Requirements" means any requirements imposed by applicable federal, Commonwealth or local laws, rules, regulations, a Program Contract, or otherwise imposed by an Agency in connection with the operation of a Program or the performance required by either party under this Agreement.

ARTICLE II
REGULATORY REQUIREMENTS

2.1 Provider Services.

a. Provider shall provide to Covered Individuals those Covered Services within the scope of Provider's licensure, expertise, and usual and customary range of services pursuant to the terms and conditions of this Agreement, and shall be responsible to Anthem for its performance hereunder. If provider is a Primary Care Provider, these services shall include screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health problems or disorders. Provider shall provide to Covered Individuals access to twenty-four (24) hours a day, seven (7) days per week urgent and Emergency Services as required by Regulatory Requirements.

b. Covered Services may be accessed by Covered Individuals under this Agreement as referenced in the Provider Manual.

c. Covered Individuals receiving inpatient psychiatric services will be scheduled for outpatient follow-up and/or continuing treatment prior to discharge. Outpatient treatment must occur within fourteen (14) days from the date of discharge. Behavioral Health Service Providers are required to contact Covered Individuals' who have missed an appointment within twenty-four (24) hours to reschedule appointments.

d. A Provider who offers services through the Department of Public Health shall provide services for preventive health pursuant to KAR 907.1-360 and Anthem will reimburse Provider at rates commensurate with those provided under Medicare.

e. For services requiring a specific form (e.g., hospice, sterilization, hysterectomy, or abortion), the form shall be properly completed by Provider according to the appropriate Kentucky Administrative Regulation ("KAR"). Provider shall retain such form in the event of audit and a copy shall be submitted to the Department upon request.

f. Provider shall display notices of Covered Individuals' right to appeal adverse action affecting services in public areas of Provider's facility/office in accordance with the Cabinet' rules and regulations.

g. Unless otherwise required under Regulatory Requirements, a PCP, as defined in the PCS, shall provide Medicaid Covered Services or make arrangements for the provision of Medicaid Covered Services to Covered Individuals on a twenty-four (24) hour-per-day, seven (7) day-per-week basis to assure availability, adequacy, and continuity of care to Covered Individuals. Provider shall arrange for after hours office phone coverage by an answering service that and can contact Provider or another designated medical practitioners. If Provider is unable to provide Medicaid Covered Services, Provider shall arrange for another Participating Provider to cover Provider's patients in accordance with Policies. Provider and any PCPs employed by or under contract with Provider may arrange for Medicaid Covered Services to Covered Individuals to be performed by a Specialist Physician only in accordance with Policies.

h. Provider must provide services, including, but not limited to, waiting time standards for appointments, within the timeframes as set forth in the Program Contract and the provider manual.

i. Provider agrees to accept payment from Anthem in accordance with this Attachment as payment in full for all Medicaid Covered Services performed pursuant to this Attachment, except for permitted co-payments or other cost sharing requirements. Provider shall not seek or request payment from Cabinet for any Medicaid Covered Services performed hereunder.

2.2 Licensure and Accreditation. At all times during the term of this Agreement, Provider shall (a) maintain in good standing all applicable licenses, certifications and registrations required for Provider to furnish services hereunder; (b) be a certified Medicaid Provider; (c) obtain and maintain accreditation from the appropriate nationally recognized accrediting body for such provider, as and to the extent required by Anthem credentialing policies, and (d) maintain a National Provider Identification Number ("NPI") if required for Provider by applicable law. Provider shall ensure that each of Provider's employees is duly licensed, certified or registered as required under a Program and applicable standards of professional ethics and

practice. Provider shall have a process in place to screen Provider's employees on a monthly basis to ensure that such employees are not excluded from participation in Medicaid programs. Provider shall notify Anthem within three (3) business days following Provider's receipt of any notice of any restrictions upon, including, but not limited to, any suspension or loss of, any such licensure, certification, registration, or accreditation, or of learning that Provider or Provider's employee has been excluded from the Medicaid program. Provider shall submit to Anthem evidence of Provider's satisfaction of the requirements set forth in this section upon Anthem's request.

2.3 Provider Responsibility.

a. Anthem shall not be liable for, nor will it exercise control or direction over, the manner or method by which Provider provides services to Covered Individuals. Provider shall be solely responsible for all medical advice and services provided by Provider to Covered Individuals. Provider acknowledges and agrees that Anthem may deny payment for provider services rendered to a Covered Individual which it determines are not Medically Necessary, are not Covered Services pursuant to an applicable Program Contract, or are not otherwise provided in accordance with this Agreement. Neither such a denial nor any action taken by Anthem pursuant to a utilization review, referral, or discharge planning program shall operate to modify Provider's obligation to provide appropriate services to a Covered Individual under applicable law and any code of professional responsibility. Nothing in this Agreement shall be construed as prohibiting any Participating Provider from discussing treatment or non-treatment options with Covered Individuals irrespective of whether such treatment options are Covered Services.

b. If contracting with a Commonwealth operated or Commonwealth contracted psychiatric facility, provider is required to assure continuity of care for successful transition back into the community with based supports and shall provide appropriate follow-up to occur to ensure the community supports are meeting the needs of the Covered Individual.

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

2.5 Compliance with Credentialing, Utilization Management, Quality Assurance, Grievance, Coordination of Benefits, Third Party Liability and other Rules, Regulations, Policies and Procedures. Provider shall comply and cooperate with all Anthem, Program Contract and Agency requirements related to credentialing, utilization management, quality assurance, grievances, coordination of benefits and third party liability, and may be subject to performance review on a periodic basis. Provider shall comply with the terms of the Provider Manual for the Medicaid Network.

2.6 Monitoring. Anthem may monitor the quality of services delivered by Provider hereunder and may initiate corrective action when necessary to improve quality of care, in accordance with that level of medical or behavioral health care which is recognized as acceptable professional practice in the respective community in which Provider practices and/or the standards established by the Commonwealth. Provider shall comply with corrective action plans initiated by Anthem. Provider acknowledges that Anthem has the right to monitor Covered Services furnished by Provider to Covered Individuals in accordance with Anthem policies and procedures, and that such monitoring may be announced or unannounced. Provider shall comply with all applicable quality requirements to which Anthem must comply as required by the Commonwealth. Provider understands and agrees that Anthem will monitor Provider's performance and quality of services delivered under this Agreement on an ongoing basis and will subject Provider to formal periodic review. Provider shall also comply with corrective action plans as required by Anthem.

2.7 Insurance Coverage.

a. Coverage Requirements. At all times during the term of this Agreement, Provider shall maintain professional liability insurance, including maintaining such tail or prior acts coverage necessary to avoid any gap in coverage for claims arising from incidents occurring during the term of this Agreement. Such insurance shall (i) be obtained from a carrier authorized to issue coverage in the jurisdiction in which Provider operates, except for permitted self-insurance; and (ii) maintain minimum policy limits equal to five million ($5,000,000) dollars per occurrence and ten million ($10,000,000) dollars in the aggregate for acute care hospitals and one million ($1,000,000) dollars

per occurrence and three million ($3,000,000) dollars in the aggregate for other providers, or such other coverage amounts as prescribed by applicable Regulatory Requirements. Provider shall maintain at its own expense professional and comprehensive general liability insurance covering Provider's premises, insuring Provider against any claim of loss, liability, or damage caused by or arising out of the condition or alleged condition of said premises, or the furniture, fixtures, appliances, or equipment located therein, and if Provider operates motor vehicles in connection with Provider's services, with liability protection against any loss, liability or damage resulting from the operation of such motor vehicles by Provider, Provider's employees or agents. Such general liability insurance shall contain commercially reasonable coverage limits, or such limits as prescribed by Regulatory Requirements for a Program. To the extent required by Regulatory Requirements, Provider shall maintain medical malpractice insurance and workers' compensation insurance for Provider's employees.

b. Evidence of Insurance. Provider shall provide Anthem with evidence of Provider's compliance with the foregoing insurance requirements annually, or as otherwise reasonably requested by Anthem. Provider shall provide Anthem with at least thirty (30) days prior written notice of any cancellation or non-renewal of any required coverage or any reduction in the amount of Provider's coverage, and shall secure replacement coverage as needed to meet the requirements above so as to ensure no lapse in coverage. Provider shall furnish Anthem with a certificate of insurance evidencing such replacement coverage. Provider shall also furnish a certificate of insurance to a requesting Agency upon request. Provider may maintain professional liability coverage hereunder through a self-funded insurance plan, provided that Provider maintains actuarially sound reserves related to such self-funded plan and provides Anthem with an opinion letter from an independent actuarial firm or other proof reasonably acceptable to Anthem attesting to the financial adequacy of such reserves. At a minimum, Provider must furnish adequate proof of such reserves at the time of entering into this Agreement and upon Anthem's request.

2.8 Contracted Provider Requirements. Unless otherwise approved by Anthem, Provider and its employees shall perform all the services required hereunder directly and not pursuant to any subcontract between Provider and any other person or entity (a "Contracted Provider"). In the event that any portion of the services that Provider is responsible for hereunder are performed for or on behalf of Provider by a Contracted Provider, Provider shall be responsible for ensuring that such Contracted Provider furnishes such services in compliance with all of Provider's obligations under this Agreement including, without limitation, maintaining required insurance, holding Covered Individuals harmless for the cost of any services or supplies provided by Contracted Providers to such Covered Individuals and complying with the following:

Title VI of the Civil Rights Act of 1964 (Public Law 88-352);

Rules and regulations prescribed by the United States Department of Labor in accordance with 41 C.F.R. Parts 60-741; and

Regulations of the United States Department of Labor recited in 20 C.F.R. Part 741, and Section 504 of the Federal Rehabilitation Act of 1973 (Public Law 93-112).

2.9 Proprietary Information; Confidentiality.

a. The parties acknowledge and agree that all the following information is proprietary: Anthem's quality assurance, utilization management, risk management and peer review programs; Anthem's credentialing procedures; this Agreement, including the rates of reimbursement payable under this Agreement; Anthem's Provider Manual; information related to Anthem programs, policies, protocols and procedures, and all information otherwise furnished to Provider by Anthem as a result of this Agreement. The parties agree not to use such proprietary information except for the purpose of carrying out their obligations under this Agreement. Neither party shall disclose any proprietary information to any person or entity without the other party's express written consent except pursuant to Regulatory Requirements or to the extent such information is available in the public domain or was acquired by such party from a third party not bound to preserve the confidentiality of such information.

b. Provider and Anthem shall each treat all information which is obtained through its respective performance under the Agreement as confidential information to the extent that confidential treatment is required under applicable law and regulations, including without limitation 42 C.F.R.

§422.118 and 45 C.F.R. Parts 160 and 164, as may be amended from time to time, and shall not use any information so obtained in any manner except as necessary to the proper discharge of its obligations and securing of its rights hereunder. Provider and Anthem shall each have a system in effect to protect all records and all other documents deemed confidential by law which are maintained in connection with the respective activities of Provider or Anthem and performed in connection with this Agreement. Any disclosure or transfer of confidential information by Provider or Anthem will be in accordance with applicable law.

2.10 Representations and Warranties.

a. Provider Status. Provider hereby represents and warrants that Provider: (i) has the power and authority to enter into this Agreement; (ii) is legally organized and operated to provide the services contemplated hereunder; (iii) is not in violation of any licensure or accreditation requirement applicable to Provider under law, Program Contract or Agency rules; (iv) is in good standing with Commonwealth and federal agencies; (v) has not been convicted of bribery or attempted bribery of any official or employee of the jurisdiction in which Provider operates, nor made an admission of guilt of such conduct which is a matter of record; (vi) has not been convicted of any offense under Section 1128(a) of the Social Security Act (42 U.S.C. §1320a-7; (vii) has not been convicted of any offense related to fraud or obstruction of an investigation or a controlled substance described in Section 1128(b)(1)-(3) of the Social Security Act (42 U.S.C. §1320a-7(b)(1); (viii) has not been subject to a civil monetary penalty assessed under Section 1128A or 1129 of the Social Security Act (42 U.S.C. §1320a-7a; 42 U.S.C. §1320a-8); (ix) has not been excluded from participation in a program under Title XVIII, 1902(a)(39) and (41) of the Social Security Act, Section 4724 of the BBA or under a Commonwealth health care program; (x) is capable of providing all data related to the services provided hereunder in a timely manner as reasonably required by Anthem to satisfy Regulatory Requirements, including, without limitation, data required under the Health Employer Data and Information Set, and consistent with the Utilization Review Accreditation Commission and the National Committee for Quality Assurance requirements; and (xi) qualifies as a participating provider in all Programs for which an Attachment A is attached hereto in accordance with the applicable Regulatory Requirements.

2.11 Reporting Fraud and Abuse. Provider shall cooperate with Anthem's anti-fraud compliance program. If Provider identifies any actual or suspected fraud, abuse or misconduct in connection with the services rendered hereunder, in violation of Commonwealth or federal law, Provider immediately shall report such activity directly to the Compliance Officer of Anthem in accordance with the Provider Manual.

2.12 Provision of Non-Covered Services. Except in the case of an Emergency Medical Condition, prior to the provision of any services to a Covered Individual that are not Covered Services, Provider (a) shall advise the Covered Individual, in writing, (i) of the nature of the service; (ii) that the service is not a Covered Service for which compensation is payable hereunder; and (iii) that the Covered Individual will be responsible for paying for the service; and (b) shall otherwise comply with all Regulatory Requirements related to the provision of non-covered services to Covered Individuals. Nothing contained in this Attachment or the Agreement shall, or shall be construed to, require advance notice, coverage verification, or pre-authorization for Emergency Services, provided in accordance with the federal Emergency Medical Treatment and Active Labor Act ("EMTALA") prior to Provider's rendering such Emergency Services.

2.13 Claims Submission.

a. Except to the extent Provider is compensated on a capitation basis under this Agreement, Provider shall submit Claims on either a current CMS-1500 claim form for professional Claims or a CMS-1450 (UB-04)claim form for institutional Claims (or successor forms), or the electronic equivalent in the manner and to the location described in the Provider Manual. Provider is encouraged to submit Claims information through electronic data interchange ("EDI") that allows for automated processing and adjudication of Claims. As Anthem continues to develop electronic interface systems for registration, eligibility and benefit verification and claims processing, Provider will use such electronic interface systems. Provider must use HIPAA compliant billing codes when billing or submitting encounter data. This applies to both electronic and paper Claims. When billing codes are updated, Provider is required to use appropriate replacement codes for submitted Claims for Covered Services. In its discretion, Anthem may amend the Agreement as it deems necessary to clarify changes to standard billing codes. Regardless of whether Anthem so amends the Agreement, Anthem shall not pay any Claims submitted using non-compliant billing codes.

b. Claims must be submitted within three hundred sixty five (365) days following the date service is rendered. Claims not received by Anthem from Provider within such period may be denied payment. Anthem will not deny clean Claims for payment solely due to these claims being received after three hundred sixty five (365) days from the date services were rendered in the event that Provider was unable to determine that the patient was an Anthem Covered Individual, and where Provider timely filed such claim with another payor. In such event, Provider shall have ninety (90) days to resubmit such claim to Anthem from the date Provider receives a denial from the payor to which Provider originally submitted the claim. Such submission shall include proof of timely filing, and denial by, such other payor.

c. Kentucky Health Information Exchange. Provider shall sign a Participation Agreement with the Kentucky Health Information Exchange (KHIE) within one (1) month of signing this Agreement. Provider will engage with KHIE for the purpose of connecting its electronic health records (EHR) system to the health information exchange to share its patient electronic records in order to facilitate improved care coordination resulting in higher quality care and better outcomes. Provider will be required to also submit ADTs (Admission, Discharge, Transfer messages) to KHIE.
If Provider does not have an EHR system, Provider must still sign a Participation Agreement with KHIE and sign up for Direct Secure Messaging services so that clinical information can be shared securely with other providers in Provider's community of care.

2.14 Reimbursement. As payment in full for Covered Services provided to Covered Individuals hereunder, Anthem shall pay to Provider the reimbursement specifically set forth in the Medicaid Compensation Schedule Attachment for all Claims processed and paid in accordance with KRS 304.17A-726 and conforming to KRS 304.17A-700 to 304.17A-730 and KRS 205.593, 304.14-135 and 304.99-123.

a. Anthem shall compensate Provider for services provided hereunder in accordance with Program Contract and its then current policies and procedures. If third party liability exists, Anthem shall pay claims in accordance with any applicable Program Contract requirements related to claims involving third party liability. Without limiting the foregoing, in the event that Anthem fails to adjudicate and pay Provider in accordance with this Agreement for Medicaid Covered Services within forty-five (45) days after a paper clean Claim has been received by Anthem, or thirty (30) days after a clean Claim has been received electronically by Anthem, Anthem shall be liable for the amount due and unpaid with interest on that amount at the rate of one and one half percent (1 ½%) per month. Interest payments shall accrue and begin on the thirty-first (31st)day for electronic submissions and the forty-sixth (46th) day for hard copy.

b. Provider shall provide encounter data for Covered Services rendered to Covered Individuals. Such data shall be provided in the manner that Anthem and Cabinet prescribes, but no later than thirty (30) days following Provider's rendering of the services in question. This information includes, but is not limited to, statistical and descriptive medical, diagnostic and patient data for Covered Services rendered to Covered Individuals, and reporting requirements included in applicable Program Contracts.

c. Provider agrees to accept payment from Anthem in accordance with this Agreement as payment in full for all Covered Services performed pursuant to this Agreement, except for permitted co-payments. Provider shall not seek or request payment from Cabinet for any Covered Services performed hereunder.

d. Anthem reserves the right to conduct chart review upon reasonable notice to Provider at Provider's normal place of business during normal business hours in order to determine the appropriateness of services and/or charges on a specific claim. Anthem reserves the right to use a code-editing software to determine which services are considered part of, incidental to, or inclusive of the primary procedure.

e. Anthem shall not request or require a provider to pursue any other course of action regarding the payment of health care claims outside of the provisions set forth in KRS 304.17A-700 to 304.17A-730 and KRS 205.593, 304.14-135, and 304.99-123.

2.15 Financial Incentives. No provision in this Agreement shall, or shall be construed to, create any financial incentive for Provider to withhold Medically Necessary services.

2.16 Hold Harmless.

a. Provider agrees that in no event, including but not limited to nonpayment by Anthem, insolvency of Anthem, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against, a subscriber, enrollee, person to whom Health Services have been provided, or person acting on behalf of the covered enrollee, for Health Services provided pursuant to this Agreement. This does not prohibit Provider from collecting co-insurance, deductibles, or copayments as specifically provided in the evidence of coverage, or fees for uncovered Health Services delivered on a fee-for-service basis to persons referenced above, nor from any recourse against the health insuring corporation or its successor.

b. Provider further agrees that this provision shall survive the termination of this Agreement regardless of the cause giving rise to such termination and shall be construed to be for the benefit of Anthem Covered Individuals.

c. Provider agrees to hold harmless Cabinet and Covered Individuals in the event of Anthem denials or other failures to pay for services performed by the Provider under this Agreement.

2.17 This provision intentionally left blank.

2.18 Nondiscrimination.

a. The Provider will not discriminate against any employee or applicant for employment because of race, creed, color, or national origin. The Provider will take affirmative action to ensure that applicants are employed, and that employees are treated during employment, without regard to their race, creed, color, or national origin. Such action shall include, but not be limited to the following: employment, upgrading, demotion, or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. The Provider agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the contracting officer setting forth the provisions of this nondiscrimination clause.

b. The Provider will, in all solicitations or advertisements for employees placed by or on behalf of the Provider, state that all qualified applicants will receive consideration for employment without regard to race, creed, color, or national origin.

c. The Provider will send to each labor union or representative of workers with which Provider has a collective bargaining agreement or other contract or understanding, a notice, to be provided by the agency contracting officer, advising the labor union or workers' representative of the Provider's commitments under Section 202 of Executive Order No. 11246 of September 24, 1965, and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

d. The Provider will comply with all provisions of Executive Order No. 11246 of Sept. 24, 1965, and of the rules, regulations, and relevant orders of the Secretary of Labor.

e. The Provider will furnish all information and reports required by Executive Order No. 11246 of September 24, 1965, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to Provider's books, records, and accounts by the contracting agency and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

f. In the event of the Provider's noncompliance with the nondiscrimination clauses of this Agreement or with any of such rules, regulations, or orders, this Agreement may be cancelled, terminated or suspended in whole or in part and the Provider may be declared ineligible for further Government contracts in accordance with procedures authorized in Executive Order No. 11246 of Sept 24, 1965, and such other sanctions may be imposed and remedies invoked as provided in Executive Order No. 11246 of September 24, 1965, or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

g. The Provider will include the provisions of Paragraphs (a) through (f) of this section 6.5 in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor issued pursuant to Section 204 of Executive Order No. 11246 of Sept. 24, 1965, so that such

provisions will be binding upon each subcontractor or vendor. The Provider will take such action with respect to any subcontract or purchase order as Anthem may direct as a means of enforcing such provisions including sanctions for noncompliance: "Provided, however, that in the event the Provider becomes involved in, or is threatened with, litigation with a subcontractor or vendor as a result of such direction by Anthem, the Provider may request the United States to enter into such litigation to protect the interests of the United States."

h. Americans with Disabilities Act Compliance. Provider shall comply with all applicable requirements of the Americans with Disabilities Act ("ADA"), all applicable regulations promulgated thereunder and all amendments and successor statutes and regulations thereto. Provider shall not discriminate against any qualified disabled individual covered by the ADA.

2.19 Cultural Competency. Provider shall participate with the Commonwealth's efforts to promote the delivery of services in a culturally competent manner to all Covered Individuals, including those with limited English proficiency and diverse cultural ethnic backgrounds. To that end, Provider agrees to comply with all Anthem policies and procedures designed to ensure that culturally competent services are provided by Anthem both directly and through its health care providers and subcontractors.

2.20 Lobbying. Provider certifies, to the best of their knowledge and belief, that:

a. No Federal appropriated funds have been paid or shall be paid, by or on behalf of Provider, to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, or an employee of a member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

b. If any funds other than Federal appropriated funds have been paid or shall be paid to any person for influencing or attempting to influence an officer or employee of any agency, member of Congress, an officer or employee of Congress or an employee of a member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, Provider shall complete and submit Standard Form-LLL "Disclosure Form to Report Lobbying", in accordance with its instructions.

2.21 Laboratory Compliance. Provider shall comply with all requirements of the Clinical Laboratory Improvement Act ("CLIA"), regulations promulgated thereunder and any amendments and successor statutes and regulations thereto. Upon execution of this Agreement, Provider shall furnish written verification to Anthem that Provider's laboratory facilities, if any, and those with which it conducts business related to Covered Individuals, have appropriate CLIA certification of registration or waiver and a CLIA identification number. Provider shall notify Anthem in writing of any changes in Provider's CLIA certification status or the certification status of any laboratory facilities with which Provider conducts business related to Covered Individuals within five (5) business days of any such changes.

2.22 Performance within the U.S. Provider agrees that all services to be performed herein shall be performed in the United States of America. Breach, or anticipated breach, of the foregoing shall be a material breach of this Agreement and, without limitation of remedies, shall be cause for immediate termination of this Agreement.

2.23 No Payment outside the U.S. Provider agrees that Anthem shall not provide any payments for items or services provided under the Agreement to any financial institution or entity located outside the United States of America.

2.24 Third Party Beneficiary. The Commonwealth is the intended third party beneficiary of contracts between the Cabinet and Anthem and any subcontracts or provider agreements entered into by Anthem with subcontracting providers, and, as such, the Commonwealth is entitled to the remedies accorded to third party beneficiaries under the law. Provider understands and agrees that Provider is not a third party beneficiary to the Program Contract and that Provider is performing services as agreed upon with Anthem as outlined in this Agreement.

2.25 Records. Provider shall maintain medical, financial and administrative records concerning services provided to Covered Individuals in accordance with industry standards and Regulatory Requirements, including, without limitation and any applicable law regarding confidentiality of Covered Individual information. Such

records shall be retained by Provider for the period of time required under Regulatory Requirements, but in no event less than five (5) years from the date the service is rendered, unless a federal statute or regulation requires a longer retention period. Provider shall provide state and federal agencies access to review records related to the audit of services provided hereunder in accordance with Regulatory Requirements. Provider shall have available medical records for each clinical encounter. Provider shall permit Anthem or its designated agent to review records directly related to services provided to Covered Individuals, either by providing such records to Anthem for off-site review, or on-site at Provider's facility, upon reasonable notice from Anthem and during regular business hours. Provider shall obtain all necessary releases, consents and authorizations from Covered Individuals with respect to their medical records to permit Anthem access to such records. Provider shall supply the records described above in a timely manner at no charge upon request. The rights and obligations of the parties under this section shall survive the termination of this Agreement.

2.26 Record Transfer. Following a Covered Individual's request for record transfer, Provider shall transfer such Covered Individual's medical records in Provider's custody within ten (10) days following the request, or such other time period required under applicable Regulatory Requirements. Provider shall have the Covered Individual sign a release of medical records prior to the transfer of such records.

2.27 Availability of Records.

a. Finance representatives and authorized federal and Commonwealth personnel including, but not limited to, the Cabinet, the Office of the Inspector General (OIG), the Medicaid Fraud Control Unit (MFCU), the Department of Health and Human Services, Office of Inspector General (DHHS OIG) and the Department of Justice (DOJ), and any other duly authorized Commonwealth or federal agency, shall have immediate and complete access to all records pertaining to services provided to enrollees.

b. Provider shall make all records (including, but not limited to, financial and medical records) available at Provider's expense for administrative, civil and/or criminal review, audit, evaluation, inspection, investigation and/or prosecution by authorized federal and Commonwealth personnel, including representatives from the OIG, the MFCU, DOJ and the DHHS OIG, the Cabinet, Finance or any duly authorized Commonwealth or federal agency. Access will be either through on-site review of records or through the mail at the Agency's discretion and during normal business hours, unless there are exigent circumstances, in which case access will be at any time or through the mail at the Agency's discretion. Provider shall send all records to be sent by mail to the Cabinet within twenty (20) business days of request unless otherwise specified by the Cabinet or Regulatory Requirements. Requested records shall be provided at no expense to the Cabinet, authorized federal and Commonwealth personnel, including representatives from the OIG, the MFCU, DOJ and the DHHS OIG, or any duly authorized Commonwealth or federal agency.

c. Provider shall make all records, including, but not limited to, financial, administrative and medical records available to any duly authorized government agency, including, but not limited to, Finance, the Cabinet, OIG, MFCU, DHHS OIG and DOJ, upon any authorized government agency's request. The Cabinet, Finance, DHHS OIG, MFCU, and DOJ, as well as any authorized Commonwealth or federal agency or entity shall have the right to evaluate through inspection, evaluation, review or request, whether announced or unannounced, or other means, any record pertinent to this Agreement, including but not limited to medical records, billing records, financial records, and/or any records related to services rendered, quality, appropriateness and timeliness of services and/or any records relevant to an administrative, civil and/or criminal investigation and/or prosecution, and such evaluation, inspection, review or request, when performed or requested, shall be performed with the immediate cooperation of the Provider. Upon request, the Provider shall assist in such reviews, and provide complete copies of medical records. Any authorized government agency, including but not limited to, OIG, MFCU, DHHS OIG and DOJ, may use these records to carry out their authorized duties, reviews, audits, administrative, civil and/or criminal investigations and/or prosecutions.

d. Provider acknowledges that HIPAA Regulations do not bar disclosure of protected health information (PHI) to health oversight agencies, including, but not limited to, OIG, MFCU, DHHS OIG and DOJ.

2.28 Medicaid Initial Term and Renewal. Subject to the terms and conditions otherwise set forth in the Agreement, this Attachment shall have a Medicaid initial term of two (2) years, commencing as of the

Effective Date, and shall renew automatically in accordance with Article VIII of the Agreement.

2.28.1 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.

2.29 Termination Without Cause. Notwithstanding any other provision included in this Agreement, Provider and Anthem shall each be entitled to terminate this Agreement at any time, after the Medicaid initial term, in accordance with Article VIII of the Agreement.

2.30 Termination by Either Party for Cause. Either party may terminate this Agreement for cause, defined as a material breach of this Agreement by the other party hereto, upon ninety (90) days prior written notice to the other party. The notice shall set forth the reasons for termination and provide the breaching party ninety (90) days to cure such material breach or the termination becomes effective. Without in any way limiting the foregoing, Anthem shall be entitled to terminate this Agreement for cause in the event that Anthem reasonably determines that Provider is in violation of any applicable Commonwealth or federal requirements.

2.31 Termination of Government Contract. If a Program Contract between the Cabinet and Anthem terminates or expires or ends for any reason or is modified to eliminate a Medicaid Program, or at the direction of the Cabinet, this Attachment shall have no further or effect with respect to the applicable Medicaid Program.

2.31 Immediate Termination; Automatic Termination.

a. Immediate Termination. Anthem shall be entitled to terminate this Agreement immediately upon Anthem's determination made in good faith and with reasonable belief that (A) a Covered Individual's health is subject to imminent danger or a physician's ability to practice medicine is effectively impaired by an action of the Board of Medicine or other governmental agency or (B) Provider continues a practice or pattern of (1) substantial disregard for the rules and regulations of Anthem with respect to patient care, or (2) material deviation from the practice and quality assurance standards adopted by Anthem, or (C) Provider's continued participation could adversely affect the care of Covered Individuals. In addition, Anthem may immediately terminate this Agreement upon the filing of a petition in bankruptcy for liquidation or reorganization by or against Provider, if Provider becomes insolvent, or if a receiver is appointed for Provider or its property. In the case of termination under this subsection, the effective date of such termination shall be the date set forth in Anthem's written notice to Provider notifying Provider of such termination.

b. Automatic Termination. This Agreement shall automatically and immediately terminate upon the expiration, surrender, revocation, restriction or suspension of any professional license required for Provider to perform the services contemplated hereunder or Provider's participation in any applicable Program. In addition, if Provider is terminated, barred, suspended or otherwise excluded from participation in, or has voluntarily withdrawn as the result of a settlement agreement related to, any program under Titles XVIII, XIX or XX of the Social Security Act, this Agreement shall automatically and immediately terminate.

2.32 Post-termination Obligations. In the event of the termination of this Agreement for any reason except termination of this Agreement for cause by Anthem, Provider shall agree to furnish Covered Services to Covered Individuals as required by Regulatory Requirements. Except as otherwise set forth below, or in Regulatory Requirements, Provider shall continue to furnish such services for a time that is sufficient to permit coordinated transition planning consistent with the Covered Individual's condition and needs relating to continuity of care, and, in any event, shall not be less than thirty (30) days. If the Covered Individual has entered the third (3rd) trimester of pregnancy at the time of Provider's termination, the transitional period shall include the provision of post-partum care directly related to the delivery. Anthem shall be permitted to refuse to permit continued care by Provider if the Provider's termination was for reasons related to medical competence or professional behavior. During any such continuation period, Provider agrees to: (i) accept reimbursement from Anthem for all Covered Services furnished hereunder in accordance with this Agreement and at the rates set forth in the Medicaid Compensation Schedule Attachment hereto; (ii) adhere to Anthem's quality assurance requirements and provide to Anthem necessary medical information related to such care; and (iii) otherwise adhere to Anthem's policies and procedures, including but not limited to procedures regarding referrals, pre-authorization and treatment planning.

2.33 Amendment.

a. Notwithstanding any other Amendment process, limitation or requirement set forth in the Agreement: This Agreement including any attachments, amendments, exhibits or other addenda thereto may be amended by the mutual agreement of the parties as evidenced in a writing signed by the parties.

b. In addition, Anthem shall be entitled to amend this Agreement including any attachments, amendments, exhibits or other addenda thereto without the written agreement of Provider upon forty-five (45) days prior written notice to Provider:

Provider shall be entitled to object to the amendment, by written notice provided to Anthem within thirty (30) days following Provider's receipt of such amendment. If a timely objection is received by Anthem, then the amendment shall take effect until the parties mutually agree on a resolution to the objection or this Agreement is terminated in accordance with the terms hereof.

c. Regulatory Compliance. This Attachment shall be automatically amended to conform to applicable changes to state or federal laws, rules, regulations or ordinances related to Medicaid Covered Individuals or the Kentucky Medicaid program without the necessity of executing written amendments.

d. Material Change. For purposes of this Attachment, section 9.1.1 of the Agreement is hereby deleted in its entirety.

2.34 Assignment.

a. This Agreement may not be assigned by Provider without the prior written consent of Anthem or the Cabinet.

b. In the event of a partial assignment of this Agreement by Anthem, the obligations of the Provider shall be performed for Anthem with respect to the part retained and shall be performed for Anthem assignee with respect to the part assigned, and such assignee shall be solely responsible to perform all obligations of Anthem with respect to the part assigned.

c. The rights and obligations of the parties hereunder shall inure to the benefit of, and shall be binding upon, any permitted successors and assigns of the parties hereto.

2.35 Indemnification.

a. Provider agrees to indemnify, defend, and hold harmless Anthem and its officers, employees and agents from and against any and all liability, loss, claim, damage or expense, including defense costs and legal fees, incurred in connection with (i) Provider's breach of any representation and warranty made by Provider in this Agreement, and (ii) claims for damages of any nature whatsoever, including, but not limited to, bodily injury, death, personal injury or property damage arising from Provider's delivery of Health Services or Provider's performance or failure to perform Provider's obligations hereunder.

b. Anthem agrees to indemnify, defend, and hold harmless Provider and, if Provider is an entity, its officers, employees and agents from and against any and all liability, loss, claim, damage or expense, including defense costs and legal fees, incurred in connection with (i) Anthem's breach of any representation and warranty made by Anthem in this Agreement, and (ii) claims for damages of any nature whatsoever, arising from Anthem's performance or failure to perform its obligations hereunder.

c. Notwithstanding the foregoing subsections (a) and (b), this section shall be null and void to the extent that it is interpreted to reduce insurance coverage to which either party is otherwise entitled, by way of any exclusion for contractually assumed liability or otherwise.

d. In addition to the Indemnification provisions of the Agreement, Provider shall indemnify and hold harmless the Commonwealth, its agencies, including the Cabinet, its officers, and employees from all claims, losses, orand suits relating to activities undertaken by Provider pursuant to the Program Contract, including court costs, attorney's fees, and other expenses, brought because of injuries or damages received or sustained by any person, persons, or property that is caused by any act or omission of Provider.

2.36 Order of Precedence. All other provisions of the Agreement shall remain in full force and effect. In the event of a) a conflict between the provisions of this Attachment and the Agreement or b) any inconsistency or ambiguity in this Attachment, such conflict, inconsistency or ambiguity shall be resolved by giving precedence in the following order: i) state or federal law, rule, regulation or ordinance; ii) this Attachment; and iii) the Agreement. In the event of an inconsistency between terms and conditions of this Agreement and this Attachment with the terms and conditions as set forth in the Program Contract, the terms and conditions of the Program Contract shall govern, and the conflicting terms and conditions shall be null and void.

2.37 Program Integrity. As a condition of receiving any amount of payment under this Agreement, Provider agrees to comply with the Program Integrity requirements of the Program Contract, as applicable.

KENTUCKY MEDICAID COMPENSATION SCHEDULE
ATTACHMENT TO THE
ANTHEM BLUE CROSS AND BLUE SHIELD
FACILITY AGREEMENT

Acute Facility Services

Anthem shall compensate Facility for Covered Services provided to Covered Persons, subject to all terms and conditions of this Agreement, benefit design, coordination of benefits (COB), applicable authorization requirements, applicable coinsurance, program eligibility, and the Medicaid Provider Manual, in an amount equal to the lesser of Eligible Charges or the amounts shown below.

Section I: Definitions

Billing Code(s): Facility must use HIPAA compliant billing codes when billing or submitting encounter data. This applies to both electronic and paper claims. When billing codes are updated, Facility is required to use appropriate replacement codes for submitted claims for Covered Services. In its discretion, Anthem may amend the Agreement as it deems necessary to clarify changes to standard billing codes. Regardless of whether Anthem so amends the Agreement, Anthem shall not pay any claims submitted using non-compliant billing codes.

Eligible Charges: Charges billed by the Facility subject to conditions and requirements which make the service eligible for reimbursement. Eligibility for reimbursement of the service is dependent upon application of the following conditions and requirements including but not limited to: Covered Person program eligibility, provider program eligibility, benefit coverage, authorization requirements, Provider Manual guidelines, Anthem administrative, clinical and reimbursement policies, and code editing logic. The allowed amount reimbursed for the eligible charge is based on the applicable fee schedule or contracted/negotiated rate after application of coinsurance, co-payments, deductibles, and coordination of benefits. Anthem will not reimburse Facility for items the Facility receives free of charge and items the Facility provides to Covered Person free of charge.

Section II: Inpatient Services

Service Description	Billing Code	Methodology
Inpatient Services	Applicable Revenue Codes	100% of Kentucky Medicaid

• Unless otherwise set forth, rates are based on the lesser of Facility's billed charges or one hundred percent (100%) of the State of Kentucky Medicaid Reimbursement in effect on the date of service on file with Anthem, which shall represent payment in full to Facility for Covered Services rendered less any amount for which the Member is responsible and less payment by another source such as coordination of benefits.

• For Covered Services that are reimbursed based upon a DRG, services to be billed by DRG must have the DRG posted on the UB-04 (or its successor) form, or corresponding electronic format. Anthem reserves the right to validate the accuracy of the DRG code submitted by Facility by utilizing DRG grouper software, and to base payment on result of such validation.

• Anthem will update any applicable changes to Kentucky Medicaid reimbursement no more than sixty (60) days from the date of receipt of notice of final changes from Facility or Department of Medicaid Services, or on the effective date of such changes, whichever is later. Such changes shall be applied on a prospective basis.

• For a Covered Service code that does not have a published dollar amount in the then current Kentucky Medicaid Fee Schedule, has a zero dollar amount or requires manual pricing, such code shall be reimbursed at a rate established by Anthem for Covered Services.

• Adjustments Based on Changes in Facility's Charge Master. Within thirty (30) days prior to any adjustment to the charge amounts set forth in the Facility's Charge Master for a Covered Service set forth above for which Facility's reimbursement hereunder is based on percentage of Eligible Charges, Facility shall give notice to Anthem in writing regarding such increase. Anthem shall be entitled to reduce, as of the date of such Charge Master increase, the percentage set forth above applicable to such Covered Service by an offsetting amount such that the amount payable by Anthem to Facility for such Covered Service on and after such date shall equal the amount payable to Anthem to Facility for the Covered Service prior to the date of the Charge Master increase.

Section III: Outpatient Facility Services

Eligible Outpatient Facility Services shall be paid as follows:

Service Description	Anthem Rate
Laboratory Services	100% of Anthem Kentucky Reference Laboratory Fee Schedule
All Other Outpatient Services	100% of Kentucky Medicaid

1. Unless otherwise set forth, rates are based on the lesser of Facility's billed charges or one hundred percent (100%) of the State of Kentucky Medicaid Reimbursement in effect on the date of service on file with Anthem, which shall represent payment in full to Facility for Covered Services rendered less any amount for which the Member is responsible and less payment by another source such as coordination of benefits. Except for outpatient laboratory services, outpatient services that are reimbursed using a cost-to-charge ratio (Interim Rate), the Anthem Rate shall be the facility specific Interim Rate in effect on the date of service. With the exception of outpatient laboratory services, Anthem shall reconcile claims paid using an Interim Rate and the parties shall settle final reimbursement for eligible Covered Services consistent with the State of Kentucky Medicaid.

2. Anthem will update any applicable changes to Kentucky Medicaid reimbursement no more than sixty (60) days from the date of receipt of notice of final changes from Facility or Department of Medicaid Services, or on the effective date of such changes, whichever is later. Such changes shall be applied on a prospective basis.

3. For a Covered Service code that does not have a published dollar amount in the then current Kentucky Medicaid Fee Schedule, has a zero dollar amount or requires manual pricing, such code shall be reimbursed at a rate established by Anthem for Covered Services.

4. Adjustments Based on Changes in Facility's Charge Master. Within thirty (30) days prior to any adjustment to the charge amounts set forth in the Facility's Charge Master for a Covered Service set forth above for which Facility's reimbursement hereunder is based on percentage of Eligible Charges, Facility shall give notice to Anthem in writing regarding such increase. Anthem shall be entitled to reduce, as of the date of such Charge Master increase, the percentage set forth above applicable to such Covered Service by an offsetting amount such that the amount payable by Anthem to Facility for such Covered Service on and after such date shall equal the amount payable to Anthem to Facility for the Covered Service prior to the date of the Charge Master increase.

Section IV: Additional Notes

1. All services billed by Facility will be submitted on UB-04 or CMS 1450 (or its successor) forms or corresponding electronic format.

2. All appropriate modifiers must be used in accordance with standard billing guidelines, if applicable.

3. Anthem reserves the right to conduct chart review upon reasonable notice to Facility at Facility's normal place of business during normal business hours in order to determine the appropriateness of services and/or charges on a specific claim.

4. Anthem reserves the right to use a code editing software to determine which services are considered part of, incidental to, or inclusive of the primary procedure.

Section V: Exclusions

1. Any services not specified in this rate sheet or in the specified Fee Schedules are not reimbursable.

2. Payments are for inpatient and outpatient facility services only; professional services are excluded.

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