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

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

ARTICLE I
DEFINITIONS

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

"Anthem Ohio Medicaid Fee Schedule" means the proprietary rate that may be based on, but is not limited to, the applicable Ohio Medicaid Fee Schedule(s)/ Rate(s)/ Methodologies, CMS and/or Medicare Fee Schedule(s)/ Rate(s)/ Methodologies, or the Fee Schedule(s)/ Rate(s)/ Methodologies developed by Anthem in accordance with industry standards.

"Clean Claim" means, 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 does not require adjustment, or alteration by Provider of the services in order to be processed and paid.

"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.

"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.

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

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

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

"Medically Necessary/Medical Necessity" means those services, based upon generally accepted medical practices in light of the Medicaid Covered Member's condition at the time of treatment, that are: (i) appropriate and consistent with the diagnosis of the treating provider and the omission of which could adversely affect the Medicaid Member's medical condition; (ii) compatible with the standards of acceptable medical practice in the community; (iii) provided in a safe, appropriate, and cost-effective setting given the nature of the diagnosis and the severity of the symptoms; (iv) not provided solely for the convenience of the Medicaid Member or the convenience of the provider or hospital; (v) not primarily custodial care unless custodial care is a Medicaid Covered Service; and (vi) there are no other effective and more conservative or substantially less costly treatment, service and setting available.

"Ohio Medicaid Fee Schedule(s)/ Rate(s)/ Methodologies " means the Ohio 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).

"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.

"State Agency" means the Ohio Department of Medicaid ("ODM") or any other duly authorized state agency.

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

2.2 Duties and Obligations to Medicaid Members. All of Provider's duties and obligations to Members set forth in the Agreement shall also apply to Medicaid Members. To the extent mandated by Regulatory Requirements, Provider shall ensure that Medicaid Members have access to twenty-four (24) hour-per-day, seven (7) day-per-week urgent and Emergency Services, as defined in the PCS. Provider shall not discriminate in the acceptance of Medicaid Members for treatment, and shall provide to Medicaid Members the same access to services, 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.

2.3 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 Plan Marketing/Information Requirements. Provider agrees to abide by Plan's marketing/information requirements. Provider shall forward to Plan for prior approval all flyers, brochures, letters and pamphlets Provider intends to distribute to Medicaid Members concerning its payor affiliations, or changes in affiliation or relating directly to the Medicaid population. Provider will not distribute any marketing or recipient informing materials without the consent of Plan or the applicable 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 Condition, as defined in the PCS, where such verification may not be possible. In the case of an Emergency Condition, Provider shall establish a Medicaid Member's eligibility as soon as reasonably practical. Plan shall provide a system for Providers to contact Plan to verify a Medicaid Member's eligibility twenty-four (24) hours a day, seven (7) days per week. Nothing contained in this Attachment or the Agreement shall, or shall be construed to, require advance notice, coverage verification, or pre-authorization for Emergency Services, as defined in the PCS, provided in accordance with the federal Emergency Medical Treatment and Active Labor Act ("EMTALA") prior to Provider's rendering such Emergency Services.

2.8 Hospital Affiliation and Privileges. To the extent required under Plan's credentialing requirements, Provider or any Network/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, Provider shall immediately notify Anthem in the event any such hospital privileges are revoked, limited, surrendered, or suspended by Facility.

2.9 Network/Participating Provider Requirements. Provider shall require that all Network/Participating Providers are employed by or under contract or subcontract with Provider, and 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 Network/Participating Providers all providers employed by or under contract or subcontract with Provider.

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

2.11 Representations and Warranties. Provider represents and warrants that all information provided to 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.

ARTICLE III
COMPENSATION AND AUDIT

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

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

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

3.1.3 If Anthem or Plan asks for additional information so that Plan may process the Claim, Provider must provide that information within sixty (60) days, or before the expiration of the three hundred and sixty five (365) day period referenced in section 3.1 above, whichever is longer.

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

3.2 Medicaid Affiliate Services. Provider acknowledges that Anthem is affiliated with health plans that offer similar benefits under similar programs as the programs covered hereunder ("Medicaid Affiliates"). The parties acknowledge that Provider is not a Network/Participating Provider in Medicaid Affiliate's Network for purposes

of rendering services to Medicaid Members. However, in the event Provider treats a Medicaid Member of a Medicaid Affiliate, subject to Regulatory Requirements, Provider shall accept as payment in full the rates established by the Medicaid Affiliate's state program governing care to Medicaid Members. Such services must be Medicaid Covered Services under the Medicaid Affiliate's state program, and shall require prior authorization, except for Emergency Services and services for which a Medicaid Member is entitled to self-refer. Upon request, Anthem shall coordinate and provide information as necessary between Provider and Medicaid Affiliate for services rendered to Medicaid Member.

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

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

5.2 Medicaid Hold Harmless. Provider agrees that Plan'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 State for any Health Services rendered pursuant to this Attachment, with the exception of Cost Shares, if any, or payment for non-Medicaid Covered Services otherwise requested by, and provided to, the Medicaid Member if the Medicaid Member agrees in writing to pay for the service prior to the service being rendered. The form of agreement must specifically state the admissions, services or procedures that are non-Medicaid Covered Services and the approximate amount of out of pocket expense to be incurred by the Medicaid Member. Provider agrees not to bill Medicaid Members for missed appointments while enrolled in the Medicaid Programs. This provision shall remain in effect even in the event Plan 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 Plan and the Agency, which applicable terms are incorporated herein by reference. Plan 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 Agreement and, without limitation of remedies, shall be cause for immediate termination of the Agreement and this Attachment.

5.5 ADT Data. If Provider is a hospital, Provider agrees to provide admission, discharge, and transfer (ADT) data to Health Information Exchanges.

ARTICLE VI
TERMINATION

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

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

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

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. Except as set otherwise forth herein, all other terms and conditions of the Agreement remain in full force and effect.

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

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 a Medicaid Member or persons acting on their behalf that relates to liability for payment for, or continuation of, Medicaid Covered Services provided under the terms and conditions of these provisions.

ARTICLE VIII
OHIO MEDICAID COMPENSATION

8.1 Intentionally left blank

ARTICLE IX
OHIO MEDICAID ADDENDUM

9.1 Required Provisions. The parties acknowledge and agree the provisions set forth in the Ohio Department of Medicaid Anthem Medicaid Addendum ("Medicaid Addendum") attached hereto, which includes Verbatim Language, as defined below, which is required to be included in any contract by and between Anthem and Anthem's Providers, and in all contracts, if any, between Anthem's Providers and a person or entity with which said Providers subcontract for the provision of Medicaid Covered Services ("Verbatim Language") which is attached hereto and incorporated herein.

9.2 Controlling Language. To the extent any provision contained within this Article and the Medicaid Addendum conflicts with any other provision set forth in the Agreement, or Attachment, addenda, exhibits or schedules hereto, the provisions set forth in this Article and Medicaid Addendum shall control.

9.3 Modifications or Amendments to the Verbatim Language. The parties acknowledge and agree that any and all modifications or amendments to the Verbatim Language in the Medicaid Addendum from time to time made by the State of Ohio or any of its applicable agencies shall be deemed included in this Article and Medicaid Addendum and each of the parties shall be bound thereby as if such modifications or amendments are contained herein. Furthermore, Provider acknowledges that no modifications may be made to the Medicaid Addendum except to add personalizing information such as Provider or Anthem's name per State Agency directive.

9.4 The Verbatim Language. The Provider/subcontractor agrees to serve enrollees in State Agency Medicaid Program and, in doing so, to comply with all the provisions of the Medicaid Addendum.