Town of Colchester, Connecticut

127 Norwich Avenue, Colchester, Connecticut 06415

Board of Selectmen Agenda
Regular Meeting
Thursday, November 16, 2017
Colchester Town Hall @ 7PM

1. Call to Order
2. Additions to the Agenda
3. Citizen's Comments
4. Consent Agenda
   1. Approve Minutes of the November 2, 2017 Regular Board of Selectmen Meeting
   2. Agriculture Commission – Christopher Bourque reappointment for a three-year term to expire on 11/30/2020
   3. Planning & Zoning
      a. Resignation of John Rosenthal
      b. Beverly Sealy moved from alternate member to regular member to expire 12/31/2019
      c. Karen Godbout moved from alternate member to regular member to expire 12/1/2019
   4. Conservation Commission
      a. Resignation of Morris Epstein
      b. Rebecca Meyer moved from alternate member to regular member to expire 10/1/2018
5. Presentation of Proclamation to the Charter Revision Commission
6. Boards and Commissions – Interviews and/or Possible Appointments
   a. Commission on Aging– Roberta Avery possible appointment to expire 12/1/2020
7. Discussion and Possible Action on Park Place Subdivision Old Hebron Rd and Old Hartford Rd
8. Discussion and Possible Action on Incord C-Tip Applications
9. Discussion and Possible Action on Anthem Blue Cross and Blue Shield Provider Agreement for Ground Ambulance Network
10. Citizen's Comments
11. First Selectman's Report
12. Liaison Reports
13. Adjourn

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Town of Colchester, Connecticut

127 Norwich Avenue, Colchester, Connecticut 06415

Board of Selectmen Minutes
Regular Meeting Minutes
Thursday, November 2, 2017
Colchester Town Hall @ 7pm

MEMBERS PRESENT: First Selectman Art Shilosky, Selectman Stan Soby, Selectman Rosemary Coyle, Selectman Denise Mizla and Selectman John Jones

MEMBERS ABSENT: none

OTHERS PRESENT: BOF Chair R Tarlov, Registrars D Mrowka and L Grzeika, one citizen, two students and Clerk T Dean.

1. **Call to Order**
   A Shilosky called the meeting to order at 7:00 pm.

2. **Additions to the Agenda**
   A Shilosky asked to add #5b Water & Sewer Commission – Kenneth Fargnoli to be interviewed and possible appointment, remove #6 Discussion and Possible Action on Incord C-Tip Applications, move agenda time #4.1 to regular agenda item #6, and renumber remaining items accordingly.

   R Coyle moved to remove/add items as presented, seconded by S Soby. Unanimously approved. MOTION CARRIED.

3. **Citizen's Comments** – none

4. **Consent Agenda**
   1. Approve Minutes of the October 19, 2017 Commission Chair Meeting
   2. Tax Refund and Rebates

   J Jones moved to approve the consent agenda, seconded by R Coyle. Unanimously approved. MOTION CARRIED

5. **Boards and Commissions – Interviews and/or Possible Appointments**
   a. Commission on Aging – Roberta Avery to be interviewed for a member position ending 12/1/2020 – was interviewed
   b. Water & Sewer Commission – Kenneth Fargnoli to be interviewed and possible appointment - was interviewed
   R Coyle moved to appoint Kenneth Fargnoli to the Sewer & Water Commission for a term to expire 6/1/2020, seconded by D Mizla. Unanimously approved. MOTION CARRIED.

6. **Approve Minutes of the October 19, 2017 Regular Board of Selectmen Meeting**
   R Coyle asked to correct #12 Liaison Report, certified drone "operator" in place. "Amount" in GM contingency has not "changed", "project is" under budget. S Soby asked to correct #12 Liaison report, agriculture commission to be replaced with "Planning and Zoning" commission.

   R Coyle moved to approve the minutes of the October 19, 2017 Regular Board of Selectmen meeting, as amended, seconded by J Jones. Unanimously approved. MOTION CARRIED.

7. **Citizen's Comments** - none

8. **First Selectman's Report**
   A Shilosky reported on the previous discussion regarding town return check policy. Investigated options internally and feel the current letter in place is sufficient and will not change. WJJMS change orders have been signed for credits up to about $100,000, adds were $24,000. The house next to Norton Mill owner has been contacted and informed that at this time the town is not in the position to entertain purchasing the property. Renters Rebate Program is going to be taken out of the state budget. Investigating to see how this will impact the town.

9. **Liaison Reports**
   R Coyle reported on the Building Committee – all glass will be in by mid-November. Discussing ladders for two levels at the roof. Global lock down discussion. Landscaping should be almost complete. Project is ahead of schedule and under budget. The committee has been amazing.

S Soby reported on Planning & Zoning Commission – held a public hearing on zoning regulation change. No language currently on locating duplexes in residential zones. Passed regulation change, in effect on 12/4. Sets the size parameter of lots regarding acreage, frontage and set back.
Economic Development Commission – gave the current CTIP application a thorough look and investigation. Have not completed the approval process as of yet.

D Mizla reported on Youth Advisory Board – discussion on fund raising. Discussion on improving the last event Junk in the Trunk. 5K resolution run will be Jan 1st, need volunteers. Bake sale will be held on Election Day.

13. Adjourn

J Jones moved to adjourn at 7:25 p.m., seconded by R Coyle. Unanimously approved. MOTION CARRIED.

Respectfully submitted,

Tricia Dean, Clerk

FW: P&Z

Mathieu, Joseph B (Office of the Chief UW Officer) <Joseph.Mathieu@thehartford.com>

Tue 11/7/2017 11:44 AM

To: Randall Benson <planning@colchesterct.gov>;

Randy,

Here is the note from John notifiying us of his resignation from the Board.

From: John Rosenthal [mailto:rosenthal.john7@gmail.com]
Sent: Thursday, November 02, 2017 8:11 AM
To: Mathieu, Joseph B (Office of the Chief UW Officer) <Joseph.Mathieu@thehartford.com>
Subject: P&Z

Joe,
Good morning.
It's time for me to resign from the Colchester Planning & Zoning Commission. I've really enjoyed the last 10 years. It's been an absolute pleasure working with you, I really admire the way you treat the residents of Colchester.
Thanks
John

RE: John R

Mathieu, Joseph B (Office of the Chief UW Officer) <Joseph.Mathieu@thehartford.com>

Tue 11/7/2017 11:22 AM

To Randall Benson <planning@colchesterct.gov>;

Hi Randy,

I forwarded the resignation separately. I do recommend that both alternates be moved to full members (for some reason I thought one of them was already a full member). As an aside, I bumped into Art this morning and mentioned this to him.

Thanks

Joe

Beverly Seely - exp 12/31/19
Karen Godbout - exp 12/1/2019

November 6, 2017

Colchester Board of Selectmen
127 Norwich Avenue, Colchester, CT

RE: Resignation from Conservation Commission

Colchester Selectmen Members,

As I regrettably indicated at the October 11, 2017 Conservation Commission meeting, my time has come to resign from the Colchester Conservation Commission. This correspondence shall serve as my official resignation notice and shall be effective immediately.

It is difficult for me to express just how much I have truly enjoyed my nearly 40 years of service on the commission. During my tenure, I have seen the Town go through so many changes, and I have been rewarded in knowing I have done my best to help protect & enhance the town's environment and natural resources throughout these changes.

I am extremely thankful to have been given the opportunity to continually serve for so many great years and I take great pride in my contributions to positively impact the town's wonderful attributes.

I wish you, the Conservation Commission and the town, nothing but the best for the years ahead.

Sincerely,

Morris Epstein

CC: **Jay Gigliotti, Conservation Commission Staff**
Colchester Conservation Commission
Gayle Furman, Colchester Town Clerk

Town of Colchester, Connecticut

127 Norwich Avenue, Colchester, Connecticut 06415
www.colchesterct.gov

November 9, 2017

Colchester Board of Selectmen
127 Norwich Avenue
Colchester, CT 06415

RE: Appointment of Existing Alternate Conservation Commission Member to Full-Time Member Status

Colchester Selectmen,

During the October 11, 2017 regular meeting of the conservation commission, long time regular member Mr. Morris Epstein, indicated that he would be resigning from the conservation commission, citing his long tenure and feeling that it was time to go.

On November 6, 2017, Colchester Conservation Commission staff, Jay Gigliotti, officially received Mr. Epstein's resignation letter (see attached).

The Conservation Commission would like to move Alternate member Rebecca Meyer, into Mr. Epstein's Full-time position with the commission.

Mrs. Meyer has been a contributing member during her tenure with the commission, has never had an attendance issue and she is currently enrolled in an environmental workshop sponsored by the CT association of Inland wetland & Conservation Commissions.

We believe that Mrs. Meyer has continued to make positive contributions during commission deliberations and that her appointment to a Full-Time member would only benefit the commission as a whole.

Please let me know if you have any questions.

Sincerely,

Arthur Falk von Plachecki
Chairman, Colchester Conservation Commission

Attachments:

-Morris Epstein Resignation letter dated 11/6/17
-Rebecca Ann Meyer commission ember application

Town of Colchester, Connecticut

127 Norwich Avenue, Colchester, Connecticut 06415

November 8, 2017

To: Colchester Board of Selectmen,

From: Salvatore A. Tassone P.E. – Town Engineer

Re: Park Place Subdivision Old Hebron Road and Old Hartford Road, Colchester, Connecticut, prepared for Park Place Holdings, LLC, by CLA Engineers, Inc., sheets 1 through 19 of 19, dated June 2015, latest date 9/25/15 shown on sheet 13.

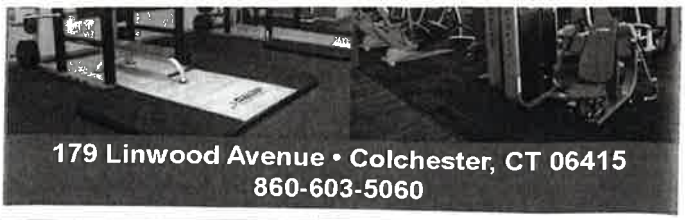
The Owner of the referenced Park Place Subdivision, Bob Gagnon of Park Place Holdings LLC., has requested the acceptance of the subdivision road, "Nature Avenue" as a Town Road.

As shown on the attached sketch, the subject Nature Avenue Cul-de-sac roadway is approximately 1,800 feet long and is located off of Old Hebron Road.

As of November 8, 2017, all of the proposed public improvements associated with the Park Place Subdivision have been completed and are in good condition. The necessary legal documents and road as-built plan have been submitted and the required Road Maintenance bond is in place. It is therefore recommended that the town of Colchester accept Nature Avenue as a town road.

RECOMMENDED MOTION:

Motion that the Town of Colchester accept Nature Avenue as a Town Road as recommended by the Town Engineer.



179 Linwood Avenue • Colchester, CT 06415
860-603-5060

NATURE AVE

Exit 16
Exit 17
Exit 18
Exit 19
Exit 20
Exit 6

North Westchester
P.O.
Parking
Knob Hill
Transfer Station
Amston Lake
Lake Haywood
State Boat Launching Area
DAM
HEBRON
AMSTON
LEBANON
LINWOOD
LETOWN
SOUTH MAIN ST
NEW LONDON
Airline Trail

A. North Court
B. Northern Boulevard
C. Center Court
D. Alpine Drive
E. Granite Court
F. East Court
G. Freedom Way
H. Autumn Ridge Road

MEMORANDUM

TO: Art Shilosky, First Selectman

November 8, 2017

FROM: Jean Walsh, Chair of Economic Development Commission

RE: CTIP Applications – 181 Upton Rd LLC (INCORD)

CC: Board of Selectmen, Economic Commission Members

The Colchester Economic Development Commission has reviewed the Application for Property Tax Incentive from 181 Upton Rd LLC (INCORD Corp of 226 Upton Road), of Colchester, dated October 16 2017, as presented at the Commissions' special meeting of November 1, 2017, for the construction of three new buildings:

1.) The construction of a new building with associated land improvements at 181 Upton Road.
2.) The construction of two new buildings with associated land improvements at 151 Upton Road

The Commission recommends the following Property Tax Incentive to be applied to this application/development as follows:

Starting for the first complete tax year, after the applicant receives the Certificate of Occupancy for each of the newly constructed buildings and for the next 4 consecutive years (total of 5 years), it is recommended the building (specifically the newly constructed building and land improvements) receive a variable tax abatement of the realized assessed increase in building value as determined by the Town Assessor.

The recommended abatement is for each newly constructed building upon their individual completion. The variable tax abatement formula shall follow the following schedule:

1. *Year one, 100% property tax abatement of the realized assessed increase in building value as determined by the Town Accessor*
2. *Year two, 90% property tax abatement of the realized assessed increase in building value as determined by the Town Accessor*
3. *Year 3, 80% property tax abatement of the realized assessed increase in building value as determined by the Town Accessor*
4. *Year 4, 70% property tax abatement of the realized assessed increase in building value as determined by the Town Accessor*
5. *Year 5, 50% property tax abatement of the realized assessed increase in building value as determined by the Town Accessor*

The Colchester Economic Development Commission has determined an incentive is appropriate and is recommending the tax incentive as described be presented to the Board of Selectman to initiate a Town meeting for the incentive approval.

Overview : The Colchester property tax incentive program was developed to encourage businesses and commercial interests to develop by offering partial relief from local property tax burdens.

The applicant (Incord Corp) has proposed constructing three new buildings to house their operation of fabricating and warehousing safety netting. The applicant has had their operations in Colchester for the past 11 years. INCORD has donated products and services to the Parks & Recreation Department, netting to our schools, and has participated in other community events. Incord is currently working on an intern program for Bacon Academy students going into a trade. They have continually been a "good neighbor".

Criteria *This abatement would be permitted, and meets the requirements, under Connecticut State Statute, Chapter 203, Section 12-65(b):*

The need for the incentive: Incord has demonstrated development costs on the proposed Colchester site are higher than competing parcels due to the topography of the existing site, including substantial fill to bring the site into building code compliance. The incentive will also offset initial startup costs of creating the additional manufacturing and warehouse space, as the operation ramps up. The incentive will put Colchester at a competitive advantage over other development choices Incord has.

Potential new job creation: The added operational space is projected to create 10 new full time jobs. INCORD currently has 135 employees, 90 of which in Colchester. The 181 and 151 Upton Road expansion will allow for the consolidation of warehouse services, inventory, and staff from Norwich. Incord is projecting adding on a second shift beginning in January 2018.

Appropriateness of the business to its proposed location: The applicant's proposed location is in an area already zoned for their use. INCORD also has their headquarters at 226 Upton Road. They have demonstrated a commitment to Colchester. The expansion plan includes a national "testing" site for their industry.

Possibility for the business to spawn other new business: The expansion of a nationally recognized business in the industrial park will demonstrate the viability of the location, and stimulate the perception of a growing community with tremendous future possibilities for the town.

Planned use by the business of other Colchester venders: INCORD has indicated the use of a local developer for their site construction, along with many service vendors to support their operations. Many construction job openings will be filled by Colchester residents.

Compatibility of the project with the environment and town resources: There will be minimal impact on the environment or town resources as the site plan proposed has met regulatory requirements .There will be a reduction in truck traffic from multiple deliveries from out of town locations, as well as the lesser emissions in our community. Their site plan shows no infringement on wetlands.

Contribution to the Town's infrastructure, including roads and utilities: Although the location of the proposed expansion and new build, is in an established business park, INCORD would be responsible for all water and sewer connection fees along with building and permitting fees.

An abatement of a portion of the taxes would be offset by the residual economic boost to our community through an increased use of local services, and businesses. The approval of this CTIP application will also serve as an example of how the Economic Development Commission and the Town of Colchester are willing to work with businesses, to be an equal partner in growth, and our goal to stimulate our economy. This is an ideal marketing opportunity to attract other businesses.

PROPOSED MOTION: It is hereby moved to accept the recommendation of the Economic Development Commission to grant a variable property Tax Incentive Abatement to 181 Upton Rd LLC (INCORD) as proposed in the amounts of 100 % in year one, 90% in year two, 80% in year three, 70% in year four, and 50% in year 5, of the increase in the building assessment for the new construction proposed at 181 and 151 Upton Road. Granting of the property tax incentives are contingent on the Certificate of Occupancy for the new construction issued by the Town of Colchester Building Official. The tax relief will be applied to the first full year after the Certificate of Occupancy by the Town of Colchester for each building.

CTIP APPLICATION 2017 - 2				181 Upton Rd LLC (INCORD)					edc dtip upton rd			
Est. New Construction Costs			181 Upton	$600,000								
	12,000 sq ft		addition		builds expected timeline			Dec 2017 or Jan 2018			when abatement ends	
				Yr 1	Yr 2	Yr 3	Yr 4	Yr 5		TOTAL 5 yr	Yr 6	
Est. Tax on new construction				$40,000	$40,000	$40,000	$40,000	$40,000		$200,000	$40,000	
Recommended Abatement %				100	90	80	70	50				
Abatement $ on new construction				$40,000	$36,000	$32,000	$28,000	$20,000		$156,000	not yielded until 1st complete year	
Taxes to be collected on new construction				0	$4,000	$8,000	$12,000	$20,000		$44,000	after C.O. (6/2018 est effective date	
REVENUE Est Equipment												
32.37	Equipment	120,000	$3,884	$3,884	$3,884	$3,884	$3,884	$3,884		$19,420	$3,884	
REVENUE - current												
Current taxes/ yr		36578		$36,578	$36,578	$36,578	$36,578	$36,578		$182,890	$36,578	current
								total current		$182,890		
							est w/ new bld			$63,420		
		TOTAL Revenue w/ new bld		$40,462	$44,462	$48,462	$52,462	$60,462		$246,310	$80,462	new
											per year	
	inventory	2,500,000	from Norwich warehouse						although land and equipmt value will also go up			
Est. Water & Sewer hookup			one time fee	$5,000								
Permit Fees - est			one time fee	$12,000								
Fire Service Fee		annually	pd qtrly	$500	$500	$500	$500	$500				
			ADDTL REV	**$17,500**	**$500**	**$500**	**$500**	**$500**				

Est. New Construction Costs			151 Upton	2,500,000								
	42,000 sq ft		new site	est build expected timeline			June 2018				when abatement ends	
				Yr 1	Yr 2	Yr 3	Yr 4	Yr 5		TOTAL 5 yr	Yr 6	
Est. Tax on new construction				$90,000	$90,000	$90,000	$90,000	$90,000		$450,000	$90,000	
Recommended Abatement %				100	90	80	70	50				
Abatement $ on new construction				$90,000	$81,000	$72,000	$63,000	$45,000		$351,000	not yielded until 1st complete year	
Taxes to be collected on new construction				0	$8,000	$18,000	$27,000	$45,000		$98,000	after C.O (6/2018 est effective date	
REVENUE Est Equipment												
32.37	Equipment	450,000	$14,566	$14,566	$14,566	$14,566	$14,566	$14,566		$72,830	$14,566	
REVENUE - current		land only										
Current taxes/ yr			$4,389	$4,389	$4,389	$4,389	$4,389	$4,389		$21,945	$4,389	current
								total current		$21,945		
		TOTAL Revenue w/ new bld		$18,955	$26,955	$36,955	$45,955	$63,955		$192,775	$108,955	new
											per year	
									although land and equipmt value will also go up			
Est. Water & Sewer hookup			one time fee	$30,000								
Permit Fees - est			one time fee	$50,000								
Fire Service Fee		annually		$1,200	$1,200	$1,200	$1,200	$1,200				
			ADDTL REV	**$81,200**	**$1,200**	**$1,200**	**$1,200**	**$1,200**				
	upon completion of 181 Upton			not yielded until 1st complete year after C.O (6/2018 est effective date)								

RECAP											1 yr	5 yr
		current taxes without development									$40,967	$204,835
		est taxes w/ development								avg	$189,417	$439,085
		ADDTL REV	$98,700	$1,700	$1,700	$1,700	$1,700		$142,000	$28,400	$142,000
										$217,817	$581,085
		ADDTL REV	$98,700	$1,700	$1,700	$1,700	$1,700		$142,000		
		TOTAL Revenue Est w/ bld	$59,417	$71,417	$85,417	$98,417	$124,417		$439,085		
		TOTAL Abatement	$130,000	$126,000	$113,000	$100,000	$83,000		$507,000		
NOTE: Other Revenue from 181 Upton Rd LLC												
		226 Upton Rd - r.e. tax	11719									
		- pers prop	66									
			11785									
Tax % from Town Assessor												
S & W estimate from DPW S&W												
Permit Fees from Town Planner - based on 2017 like contruction / similar business & size												
Est. land value after new builds used like property / size / use												

Town of Colchester – Tax Incentive Application

Revised June 6, 2017

The Colchester Tax Incentive Program (C-TIP) is designed to provide tax incentives for new businesses or the expansion of existing businesses to promote commercial growth in Colchester.

Project Information

Applicant Name: 181 UPTON RD LLC (EDWARD RITZ)
Name of Business: INCORD
Property Address: 181 UPTON RD

Proposed Project Type *(Select all that apply)*:

- X Manufacturing
- __ High Technology
- __ New Retail Business
- __ Mixed Use/Other: _____
- __ Office/Commercial
- X Wholesale/Distribution *(1 job per 1000sqft)*
- __ Commercial Farming

Project Details

	Budget	Area
Acquisition	$ _____	____ Acres 112,000 Sqft of existing buildings
New construction	$ 600,000	12,000 Sqft of new buildings
Rehabilitation	$ _____	17,500 Sqft of existing buildings
Equipment	$ 120,000	
Personal Property	$ 2,500,000	
Total	$ 3,220,000	

Employment Details

	Present # of Employees	Future # of Employees
Officials & Managers	9	
Professionals		
Technicians	5	
Sales	18	
Office & Clerical	11	
Skilled (Craft) Laborers	70	
Unskilled Laborers		
Service Workers		
Total	115	

From this review by the Economic Development Commission, the application and recommended incentive package is sent to the Board of Selectmen. The Selectmen consider the recommendation and may adjust the package, as they deem appropriate. After Selectmen's review, the package is brought before the legislative body of the Town, (the Town Meeting), for approval. The Town Meeting is the sole decision-maker regarding the approval of the incentive package. The members of the Economic Development Commission and the Board of Selectmen simply develop recommendations for the package. Only those in attendance at the Town Meeting can actually award the incentives to the applicant.

D. Criteria for Incentive Recommendations

The Economic Development Commission will recommend tax incentives as allowed by state statue after considering the following criteria:

- Need for incentives
- Potential for new job creation
- Providing a product, need or service to the local community
- Appropriateness of the business to its proposed location
- Possibility for the business to spawn other new businesses
- Planed use by the business of other Colchester venders
- Compatibility of the project with the environment and town resources
- Contribution to the Town's infrastructure, including roads and utilities
- Net gain provided to the Town tax base
- Improvement or renovation to historic structures

These are not exclusive criteria, and the members of the Commission may consider other issues when appropriate to do so. Each application presents a unique set of circumstances, and should those circumstances require the consideration of additional factors, the applicant should make the Commission so aware.

E. Incentive for Developers of Commercial Real Estate

In the event a developer of commercial real estate applies to C-TIP, the members of the Commission may award tax incentives to the developer, providing the developer covenants to pass through to tenants, on a prorate basis, the benefit of the incentive award. The Commission may award tax incentives to developers prior to full occupancy. Applications from developers will be reviewed subject to the same criteria as in "C" above.

What type of tax abatements can be given?

5. Will your project require and improvements to, or extension of the Town of Colchester infrastructure and/or utility systems? If so, please describe.

6. To what extent do you plan to employ Colchester-based vendors I the planning, design, and construction of this project? If possible, please provide the Colchester-based contractors you intend to use and the estimated value of your contracts to them.

7. How many jobs, if any, do you expect to create as a result of this business?

8. What is the planned start-up and completion dates of this project? Are there multiple phases to this project?

9. What other locations besides Colchester are being considered for this project?

If you are applying as a lessor of commercial space:

10. Please provide the type of lessees you are targeting(types of business tenants)

11. Are these new tenants to Colchester or existing businesses?

12. If you have signed tenants and/or lessees in process, please share the percentage of open lease space you currently have

Signature of Applicant: _____ Title: PRESIDENT, INCORD Date: 10/16/17

Department Sign-off – To be completed by staff

Planning and Zoning Department

Completed Application Received: X Yes ___ No

Signature: Randall S Bowen Date: 10/16/17

Tax Assessor's Office

Appraised Value of Improvements*: $_____

Assessed Value of Improvements*:$_____

*Good-faith estimate based on representations from applicant

Signature: _____ Date: _____

Tax Collector's Office

InCord/151 Upton Road LLC
Town of Colchester – Tax Incentive Application

Note, separate Tax Incentive Applications are being submitted for two adjacent sites (151 and 181 Upton Rd).

1. **Background information on yourself, other key members of your management team and your company**
   181 Upton Rd LLC and InCord, Ltd are principally owned by Edward Ritz, who founded InCord in 1995 and moved the company to Colchester in 2006. Ed's children (Daniel, Robin & Meredith) who work in the business each own a small portion of InCord, and this ownership will increase over time according to a succession plan.

   181 Upton Rd was purchased to support InCord's growing capacity requirements in 2015. InCord has a 20-year lease on the current building on the property.

   InCord is the largest fabricator of custom safety nets in the US. InCord sells nationwide to more than eight distinct markets including Safety & Construction, Material Handling & Logistics, Play & Amusement (theme parks, water parks & playgrounds), Sports, and Theatre. InCord has been recognized among "Connecticut's Best Workplaces" for 7 consecutive years. InCord recruits from Colchester and is committed to retaining and developing its employees through long-term, full-time employment and generous benefits including health care, paid time off, and profit sharing.

2. **A brief project description and include those you feel the Town of Colchester and its residents would benefit from your business or project.**
   InCord is considering expanding its administrative and production space to support anticipated growth over the next several years.

   InCord is evaluating plans to develop 151 Upton Rd with 2 buildings: a 12,000 sf and a 30,000 sf production facility. The two buildings promote operational flexibility and simplify construction due to site characteristics. Once completed and fully operational, the two buildings would support at least 20 FT employees. The important benefits to the Town of Colchester include InCord's contributions to the town's tax base and job creation, which yield secondary benefits to the town's economic base through use of locally sourced goods and services. This construction is not expected to increase demand for town services.

3. **Attach your business plan for the project or business including any capital improvements, projected income and hiring plans, including what type of jobs, for the next five years.**
   Construction estimate: $2,500,000
   Equipment/Personal Property: $450,000

9. **What other locations besides Colchester are being considered for this project?**
   The project is dependent on approval and successful completion of the related project to build a warehouse on 181 Upton Rd. InCord's plans to further develop Upton Rd is most likely dependent on both 151 and 181 projects being approved.

   An alternative site in Oakdale has been identified. This site is located on a 5 acre parcel (with 100 acres adjacent on option) where a production facility that InCord leases from Colchester Construction.

Town of Colchester – Tax Incentive Application

Revised June 6, 2017

The Colchester Tax Incentive Program (C-TIP) is designed to provide tax incentives for new businesses or the expansion of existing businesses to promote commercial growth in Colchester.

Project Information

Applicant Name: 181 UPTON RD LLC (EDWARD RITZ)
Name of Business: INCORD
Property Address: 151 UPTON RD.

Proposed Project Type *(Select all that apply)*:

- [X] Manufacturing
- [ ] High Technology
- [ ] New Retail Business
- [ ] Mixed Use/Other:
- [X] Office/Commercial
- [X] Wholesale/Distribution *(1 job per 1000sqft)*
- [ ] Commercial Farming

Project Details

	Budget	Area
Acquisition	$	____ Acres _____Sqft of existing buildings
New construction	$ 2,500,000	42,000 Sqft of new buildings
Rehabilitation	$	_____Sqft of existing buildings
Equipment	$ 450,000	
Personal Property	$	
Total	$ 2,950,000	

Employment Details

	Present # of Employees	Future # of Employees
Officials & Managers	9	9
Professionals		
Technicians	5	5
Sales	18	18
Office & Clerical	11	11
Skilled (Craft) Laborers	70	90
Unskilled Laborers		
Service Workers		
Total	115	135

A. Purpose and Philosophy of the Tax Incentive Program

The Colchester Tax Incentive Program ("THE C-TIP) attracts new businesses and commercial interests to Colchester and encourages existing businesses and interests to expand by offering partial relief from local property tax burdens.

The C-TIP developed pursuant to a directive from the members of the Colchester Board of Selectmen, who have made economic development a priority for the Town. The Town has experienced s tremendous amount or residential growth over the past few years, and C-TIP is intended to foster the commercial development that is necessary when such growth occurs. With residential growth comes the need for jobs and many types of commercial development. Also needed is growth in the Town tax base, for as the community grows, so does the demand for Town services.

Specifically, the goals of the Colchester Tax Incentive Program are to:

- Encourage new job creation and expansion of existing businesses
- Attract forms of commercial development not currently offered
- Foster the development of start-up companies within the Town
- Grow the Town tax base and more equitably distribute tax burdens

B. Qualifying Applicants

Applications to C-TIP will be accepted from any individual, group or entity that pays or will pay real estate taxes in the Town, provided: (1) the applicant is not delinquent in the payment of any taxes or service charges to the Town; (2) the applicant plans to invest at least $25,000 for either the construction of a new facility or the expansion of a current operation; and (3) the applicant evidences a solid financial base and potential for growth. The C-TIP application is only available for new construction. The C-TIP application is not available for construction that has already been started or completed.

C. The Application and Approval Process

Qualified applicants for tax incentives are required to present their application to the Town's Economic Development Commission. The members of the Commission review each application and make a determination as to whether incentives are appropriate, based on certain criteria established annually by the Commission. If they determine that incentives are appropriate, Commission members will further determine the appropriate amount and duration for the incentive.

From this review by the Economic Development Commission, the application and recommended incentive package is sent to the Board of Selectmen. The Selectmen consider the recommendation and may adjust the package, as they deem appropriate. After Selectmen's review, the package is brought before the legislative body of the Town, (the Town Meeting), for approval. The Town Meeting is the sole decision-maker regarding the approval of the incentive package. The members of the Economic Development Commission and the Board of Selectmen simply develop recommendations for the package. Only those in attendance at the Town Meeting can actually award the incentives to the applicant.

D. Criteria for Incentive Recommendations

The Economic Development Commission will recommend tax incentives as allowed by state statue after considering the following criteria:

- Need for incentives
- Potential for new job creation
- Providing a product, need or service to the local community
- Appropriateness of the business to its proposed location
- Possibility for the business to spawn other new businesses
- Planed use by the business of other Colchester venders
- Compatibility of the project with the environment and town resources
- Contribution to the Town's infrastructure, including roads and utilities
- Net gain provided to the Town tax base
- Improvement or renovation to historic structures

These are not exclusive criteria, and the members of the Commission may consider other issues when appropriate to do so. Each application presents a unique set of circumstances, and should those circumstances require the consideration of additional factors, the applicant should make the Commission so aware.

E. Incentive for Developers of Commercial Real Estate

In the event a developer of commercial real estate applies to C-TIP, the members of the Commission may award tax incentives to the developer, providing the developer covenants to pass through to tenants, on a prorate basis, the benefit of the incentive award. The Commission may award tax incentives to developers prior to full occupancy. Applications from developers will be reviewed subject to the same criteria as in "C" above.

What type of tax abatements can be given?

Under the State of Connecticut General Statutes Section 12-65b a municipality can approve a tax abatement if the project meets the requirements previously list in this application. To determine what amount of tax abatement you may qualify for is determined by three provisions listed in the State of Connecticut General Statute 12-65b. The three provisions are listed as follows:

1. Tax abatement for a period of not more than 7 years, provided the cost of such improvements to be constructed is not less than three million dollars.

2. Tax abatement for a period of not more than two years, provided the cost of such improvements to be constructed is not less than five hundred thousand dollars.

3. Tax abatement to the extent of not more than fifty percent of such increased assessment, for a period of not more than three years, provided the cost of such improvements is not less than ten thousand dollars.

All tax abatements will be based on the increase in the assessed value as determined by the Town of Colchester Tax Assessor. The tax abatement is based on the increase in assessment of real property only. The Tax abatement period will not begin until the first tax billing after the Certificate of Occupancy for new construction or the Certificate of Approval for expansion of existing developments issued by the Town of Colchester Building Official.

Business Project Information

Please provide the following information. Use additional pages to provide more detail and attach any relevant documents as needed.

1. Background information on yourself, other key members of your management team and your company.

2. A brief project description and include hose you feel the Town of Colchester and its residents would benefit from your business or project.

3. Attach your business plan for the project or business including any capital improvements, projected income and hiring plans, including what type of jobs, for the next five years.

4. The estimated costs of the proposed real property to be constructed/renovated for the business.

5. Will your project require and improvements to, or extension of the Town of Colchester infrastructure and/or utility systems? If so, please describe.

6. To what extent do you plan to employ Colchester-based vendors I the planning, design, and construction of this project? If possible, please provide the Colchester-based contractors you intend to use and the estimated value of your contracts to them.

7. How many jobs, if any, do you expect to create as a result of this business?

8. What is the planned start-up and completion dates of this project? Are there multiple phases to this project?

9. What other locations besides Colchester are being considered for this project?

If you are applying as a lessor of commercial space:

10. Please provide the type of lessees you are targeting(types of business tenants)

11. Are these new tenants to Colchester or existing businesses?

12. If you have signed tenants and/or lessees in process, please share the percentage of open lease space you currently have.

Signature of Applicant: _____ Title: PRESIDENT, NCORD Date: 10/16/17

Department Sign-off – To be completed by staff

Planning and Zoning Department

Completed Application Received: ___Yes ___No

Signature: _____ Date: _____

Tax Assessor's Office

Appraised Value of Improvements*: $_____

Assessed Value of Improvements*:$_____

*Good-faith estimate based on representations from applicant

Signature: _____ Date: _____

Tax Collectors Office

All Parties Current on Owed Taxes: ___Yes ___No

Signature: _____ Date: _____

InCord/181 Upton Road LLC
Town of Colchester – Tax Incentive Application

1. **Background information on yourself, other key members of your management team and your company**
   181 Upton Rd LLC and InCord, Ltd are principally owned by Edward Ritz, who founded InCord in 1995 and moved the company to Colchester in 2006. Ed's children (Daniel, Robin & Meredith) who work in the business each own a small portion of InCord, and this ownership will increase over time according to a succession plan.

   181 Upton Rd was purchased to support InCord's growing capacity requirements in 2015. InCord has a 20-year lease on the current building on the property.

   InCord is the largest fabricator of custom safety nets in the US. InCord sells nationwide to more than eight distinct markets including Safety & Construction, Material Handling & Logistics, Play & Amusement (theme parks, water parks & playgrounds), Sports, and Theatre. InCord has been recognized among "Connecticut's Best Workplaces" for 7 consecutive years. InCord recruits from Colchester and is committed to retaining and developing its employees through long-term, full-time employment and generous benefits including health care, paid time off, and profit sharing.

2. **A brief project description and include those you feel the Town of Colchester and its residents would benefit from your business or project.**
   InCord is considering expanding its facilities to eliminate the need for out-of-town warehousing and production. Initially the proposed space would be used to store raw materials which are currently warehoused in Taftville. Building additional warehouse or production space on Upton Rd reduce truck traffic to bring in raw materials from outside warehouse.

   Over the longer term, InCord will also look to develop 151 Upton Rd with a larger warehouse (20 – 30,000 sf) which would enable the proposed building to be converted to production space. Production space of this size would support approximately 10 FT employees.

3. **Attach your business plan for the project or business including any capital improvements, projected income and hiring plans, including what type of jobs, for the next five years.**
   Construction estimate: $600,000
   Equipment: $120,000
   Personal property: $2,500,000 (inventory)

   The project does not increase employees immediately due to the use of space. Over the longer term (3-5 years) it is expected that this space will be converted to production space, which will lead to the creation of approximately 10 FT manufacturing and administrative jobs.

4. **The estimated costs of the proposed real property to be constructed/renovated for the business.**
   Initial cost estimates for construction of a 12,000 sf building are $50/sf ($600,000 total) for construction plus ancillary costs of engineering and site preparation.

   That the cost of building in Colchester is considerably higher than other possible sites due site characteristics and other factors. The request for Tax Abatement serves to offset the higher cost of developing in Colchester.

5. **Will your project require any improvements to, or extension of the Town of Colchester infrastructure and/or utility systems? If so, please describe.**
   No

6. **To what extent do you plan to employ Colchester-based vendors in the planning, design, and construction of this project. If possible, please provide the Colchester-based contractors you intend to use and the estimated value of your contracts to them.**
   The project is still in a design phase and has not been put out to competitive bid. InCord's preferred partner for construction in the area is Colchester Construction, who we have a long history of successful projects.

   Richie Baldi has performed initial site preparation and excavation work.

7. **How many jobs, if any, do you expect to create as a result of this business.**
   The initial planned use of the new building is to relocate an existing warehouse to Colchester. Subsequent phases of InCord's capacity plans in Colchester are expected to generate an estimated 10 FT positions.

8. **What is the planned start-up and completion dates of this project? Are there multiple phases to this project?**
   Permitting: Nov, 2017
   Construction: Jan – Apr, 2018 (weather permitting)
   Build out: May – Jun, 2018
   Occupancy: July 2018

9. **What other locations besides Colchester are being considered for this project?**
   The project will relocate an existing warehouse in Taftville. InCord has a 5-year lease (3.5 years remaining) which can be extended to 15 years for this location.

   An alternative site in Oakdale has also been identified. This site is located on a parcel where a production facility that InCord leases from Colchester Real Estate.

MEMORANDUM

TO: Art Shilosky, First Selectman October 25, 2017

FROM: Walter Cox, Chief – Fire /EMS

RE: Anthem Blue Cross and Blue Shield Provider Agreement

CC: Board of Selectmen

The attached is a Provider Agreement with the Anthem Blue Cross and Town of Colchester. They are requesting a signature to continue to participate in Anthem's reimbursement network, which is currently 90% of the State of CT Allowable Rate. The rate for 2018 has not been determined by the State of CT Dept. of Public Health yet. It is expected before 1/1/18. Therefore the referenced "attached rate schedule" is expected to accompany the executed copy of the agreement.

The term of the agreement is 1 year, and shall continue automatically for consecutive 1 yr terms unless otherwise terminated.

Signing this agreement will ensure payment of all claims come directly to the Town of Colchester.

Note: no prior agreement is on file with the Colchester Fire Dept, or Shared Response, the Town of Colchester's designated billing agency.

As such, it is my recommendation that the Board of Selectmen authorize Art Shilosky, the First Selectman, as the Authorized Representative to sign the agreement on page 17.

PROPOSED MOTION: THE BOARD OF SELECTMEN HEREBY AUTHORIZE THE FIRST SELECTMAN TO SIGN THE ANTHEM BLUE CROSS PROVIDER AGREEMENT AND PLAN COMPENSATION SCHEDULE, DATED OCTOBER 11, 2017 FOR THE PARTICIPATION IN THE GROUND AMBULANCE NETWORK.

Sincerely Submitted by : Walter Cox, Chief of the Fire / EMS department.

ANTHEM BLUE CROSS AND BLUE SHIELD PROVIDER AGREEMENT

WITH

TOWN OF COLCHESTER

ANTHEM BLUE CROSS AND BLUE SHIELD
PROVIDER AGREEMENT

This Provider Agreement (hereinafter "Agreement") is made and entered into by and between Anthem Health Plans, Inc. doing business as Anthem Blue Cross and Blue Shield (hereinafter "Anthem") and TOWN OF COLCHESTER (hereinafter "Provider"), effective as of the date set forth immediately below 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. Covered Services do not include the preventable adverse events as set forth in the provider manual(s).

"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 Title XVIII, Title XIX or Title XXI of the Social Security Act, and any other federal or state funded program or product as designated by Anthem. 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 or standards of participation 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, as applicable.

"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, and performance data.

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.

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. 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 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.

2.6.2.4 Provider acknowledges, that pursuant to section 20-7f, it is an unfair trade practice in

violation of chapter 735a for any health care provider to request payment from a subscriber or an enrollee, other than a coinsurance, copayment, deductible or other out-of-pocket expense, for covered medical or emergency services or facility fees, as defined in section 19a-508c, or surprise bills; or to report to a credit reporting agency an enrollee's failure to pay a bill for such services when a health care center has primary responsibility for payment of such services, fees or bills.

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 under this Agreement. Provider shall voluntarily refund all duplicate or erroneous Claim payments regardless of the cause, including, but not limited to, payments for Claims where the Claim was miscoded, non-compliant with industry standards, or otherwise billed in error, whether or not the billing error was fraudulent, abusive or wasteful. Upon determination by Anthem that any recoupment, improper payment, or overpayment is due from Provider, Provider must refund the amount to Anthem within thirty (30) days of when Anthem notifies Provider. If such reimbursement is not received by Anthem within the thirty (30) days following the date of such notice, Anthem shall be entitled to offset such overpayment against other amounts due and payable by Anthem to Provider in accordance with Regulatory Requirements. Anthem reserves the right to employ a third party collection agency in the event of non-payment.

2.8 Use of Subcontractors. Subject to the terms and conditions of section 9.2 of this Agreement, Provider and Plan may fulfill some of their duties under this Agreement through subcontractors. For purposes of this provision, subcontractors shall include, but are not limited to, vendors and non-Participating Providers that provide supplies, equipment, staffing, and other services to Members at the request of, under the supervision of, and/or at the place of business of Provider. Provider shall provide Anthem with thirty (30) days prior notice of any Health Services subcontractors with which Provider may contract to perform Provider's duties and obligations under this Agreement, and Provider shall remain responsible to Plan for the compliance of his/her/its subcontractors with the terms and conditions of this Agreement as applicable, including, but not limited to, the Payment in Full and Hold Harmless provisions herein.

2.9 Compliance with Provider Manual(s) and Policies, Programs and Procedures. Provider agrees to cooperate and comply with, Anthem's provider manual(s), which is incorporated herein by reference, and all other policies, programs and procedures (collectively "Policies") established and implemented by Plan, including but not limited to, credentialing, utilization management, quality improvement, grievances, peer review, coordination of benefits, third party liability and care management programs. Notwithstanding any other provision in this Agreement to the contrary, or as otherwise required by Regulatory Requirements, Anthem and Provider agree that Anthem shall have the right to modify the provider manual(s), and communicate Policies to Provider via electronic means, including e-mail and the Internet. Anthem shall provide no less than thirty (30) days' notice of a "Material Change" to the provider manual(s) and Policies. For purposes hereof, a "Material Change" shall be considered a change that alters the rights of a party hereunder or significantly alters a party's performance requirements or obligations hereunder.

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 acknowledges that as of the Effective Date, he/she/it participates only in those Networks designated on the Provider Networks Attachment of this Agreement. 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). 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, unless otherwise set forth in a Participation Attachment(s).

2.14 Adjustment Requests. If Provider believes a Claim has been improperly adjudicated for Covered Service for which Provider timely submitted a Claim to Plan, Provider must submit a request for an adjustment to Plan in accordance with the provider manual(s).

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

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

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

ARTICLE III
CONFIDENTIALITY/RECORDS

3.1 Proprietary and Confidential Information. Except as otherwise provided herein, all information and material provided by either party in contemplation of or in connection with this Agreement remains proprietary and confidential to the disclosing party. This Agreement, including but not limited to the Anthem Rates, is Anthem's proprietary and confidential information. Neither party shall disclose any information proprietary or confidential to the other, or use such information or material except: (1) as otherwise set forth in this Agreement; (2) as may be required to perform obligations hereunder; (3) as required to deliver Health Services or administer a Health Benefit Plan; (4) to Plan or its designees; (5) upon the express written consent of the parties; or (6) as required or allowed 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. 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. In addition, nothing in this Agreement shall be construed to create any financial incentive for Provider to withhold Covered Services.

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, 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.

ARTICLE IV
INSURANCE

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

4.2 Provider Insurance. Provider shall self-insure or maintain insurance in types and amounts 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, 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 failure to perform the indemnifying party's obligations under this Agreement, and/or the indemnifying party's or his/her/its agent'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. Notwithstanding the foregoing, if a claim is brought by a governmental entity against Plan, and Plan seeks indemnification from Provider pursuant to this section, then Provider shall not engage in any direct communication with such governmental entity regarding such claim without Plan's prior consent.

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. Notwithstanding the foregoing, if a claim is brought by an Agency against Plan, the foregoing limitations of liability shall not apply.**

6.3 Period of Limitations. Unless otherwise provided for in this Agreement, a Health Benefit Plan, the provider manual(s), Policies, or 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 more than two (2) years after the events which gave rise to such claim;

provided, however, this two (2) year limitation shall not apply to actions by Anthem against Provider related to fraud, waste or abuse. 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 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.

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.

8.1.1 Term of Agreement if Provider is licensed and located in the State of Rhode Island. This provision replaces section 8.1, if Provider is licensed and located in the State of Rhode Island. This Agreement shall commence on the Effective Date and shall remain in effect until December 31st of the year in which the Effective Date occurs ("Initial Term"), subject to the termination provisions as specified in this Agreement. Thereafter, this Agreement shall automatically renew for an additional twelve (12) consecutive month term, and shall renew from year to year thereafter each January 1st, subject to the termination provisions as specified in this Agreement, unless Anthem provides Provider with written notice of its intention not to extend the term of the Agreement at least ninety (90) days prior to the end of the Initial Term or any subsequent term.

8.2 Termination Without Cause. Either party may terminate this Agreement without cause at any time by giving at least one hundred twenty (120) days prior written notice of termination to the other party. Notwithstanding the foregoing, should a Participation Attachment contain a longer without cause termination period, the Agreement shall continue in effect only for such applicable Participation Attachment until the termination without cause notice period in the applicable Participation Attachment ends.

8.2.1 Termination Without Cause if Provider is licensed and located in the State of Rhode Island.

Notwithstanding anything in "Termination Without Cause" section 8.2 to the contrary, if Provider is licensed and located in the State of Rhode Island, Anthem may not terminate this Agreement without cause.

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 identified as ineligible, excluded, suspended or debarred from participating in a state or federal program according to the General Services Administration ("GSA"), HHS/OIG or other state or federal agency list or website, 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 program under Titles VXIII, XIX or XX of the Social Security Act as the result of a settlement agreement; or

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

8.4.2 This Agreement may be terminated immediately by Provider if:

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

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

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

8.5 Termination of Individual Providers. If applicable, Anthem reserves the right to terminate individual providers 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 terminates for any reasons other than the grounds set forth in the "Immediate Termination" section, then Provider shall continue to provide Covered Services to Members 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.

8.9 Rhode Island Licensed Clinicians Only. Provider may appeal any decision made by Anthem that results in the suspension or termination of this Agreement or of Provider's status as a Participating Provider, except any decision by Anthem not to renew this Agreement at the end of the Initial term or any subsequent term. Such appeal shall be in accordance with the appeal procedure attached hereto as Rhode Island Appendix 1 and shall be subject to the following:

a Anthem shall notify Provider in writing of Anthem's proposed action, or immediate action pursuant to paragraph (c) hereof, including the reason(s) for such action;

b the appeal, if requested, shall be completed prior to the implementation of any proposed action(s), and

c when Anthem has reason to suspect that there is immediate danger to a Member, Anthem shall notify the Rhode Island Director of Health immediately and shall take the appropriate action to protect Members, notwithstanding any provision herein to the contrary.

Provider may waive, in writing, the due process procedures as set forth herein, but Anthem shall not require Provider to waive his/her rights to due process as a condition of this Agreement.

ARTICLE IX
GENERAL PROVISIONS

9.1 Amendment. Except as otherwise provided for in this Agreement, Anthem may amend this Agreement and any attachments or addenda by providing notice to Provider at least thirty (30) days in advance of the effective date of the amendment. Provider may object in writing to any such proposed amendment within thirty (30) days following receipt of notice. Failure to object shall constitute Provider's acceptance thereof. If Provider objects to a proposed amendment, then the proposed amendment shall not go into effect with respect to Provider and Anthem and Provider may discuss the terms of the amendment to attempt to reach

a mutually acceptable resolution. If no mutually acceptable resolution can be reached, either party may terminate this Agreement by providing at least one hundred twenty (120) days' notice to the other party. Notwithstanding the foregoing, notice regarding fee schedule changes and rights to object thereto shall be in accordance with applicable Regulatory Requirements.

9.2 Assignment. The rights under this Agreement, nor the duties hereunder, may be assigned or delegated, in whole or in part, by either party without the prior written consent of the other party. Any assignment or delegation by a party without such prior consent shall be voidable at the sole discretion of the non-assigning/non-delegating party. Notwithstanding the foregoing, by executing this Agreement, Provider hereby expressly agrees that Anthem may assign its rights under this Agreement, or delegate its duties hereunder, in whole or in part, to an Affiliate or an entity that has the right to use the Blue Cross and/or Blue Shield service marks or trade names in connection with any service performed by such entity and, further, that Anthem may assign its rights under this Agreement or delegate any of its duties hereunder in the ordinary course of business. In the event of a partial assignment or delegation 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 delegate/assignee with respect to the part delegated or assigned, and such delegate/assignee is solely responsible to perform all obligations of Anthem's with respect to the part delegated or 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 A change in providers who are part of the group, if applicable. Any new providers must meet Plan's credentialing requirements or other applicable standards of participation prior to being designated as a Participating Provider; or

9.3.3.2 A change in mailing address.

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

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

9.5 Entire Agreement. This Agreement, exhibits, attachments 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 are any conflicts between any of the provisions of this Agreement and the provider manual(s) or Policies, 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 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 or agents are ineligible, excluded, suspended or debarred from participating in a state or federal program according to the General Services Administration ("GSA"), HHS/OIG or other state or federal agency list or website ("Ineligible Person"). Provider shall remain continuously responsible for ensuring that his/her/its employees, contractors, subcontractors or agents are not Ineligible Persons. If Provider or any employees, subcontractors 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.

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 LEGAL NAME: TOWN OF COLCHESTER

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

Printed: _____ _____
Name

Address _____ _____
Street | City | State | Zip

Tax Identification Number (TIN): 066001974

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

Group NPI Number: 1245228618

Anthem Health Plans, 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: L. Kathryn Norman | Vice President, Provider Solutions
Name | Title

Address 2221 Edward Holland Drive, Mail Drop VA4004-RR11 | Richmond | VA | 23230
Street | City | State | Zip

PROVIDER NETWORKS ATTACHMENT

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

- HMO (includes HMO and POS products such as: BlueCare Product or Programs; BlueCard POS Product or Programs; Off-Exchange Individual and Small Group HMO Product or Programs; and New England Health Plans Product or Programs)
- PPO (includes PPO, EPO and CDHP products such as: Century Preferred Products or Programs; State Preferred Products or Programs; PPO BlueCard PPO Products or Programs; Federal Employee Program Products or Programs; National Accounts Products or Programs; Off-Exchange Individual and Small Group PPO Products or Programs; and UniCare Life and Health Insurance Company PPO Products or Programs)
- Traditional/Standard (includes traditional & standard products);
- Medicare HMO (includes group HMO and POS products such as: MediBlue℠ HMO Products or Programs)
- Medicare PPO (includes PPO products such as: MediBlue℠ PPO Products or Programs)
- HMO/PPO Individual On-Exchange Products or Programs
- HMO/PPO SHOP On-Exchange Products or Programs
- All other Programs for which Provider is a Participating Provider

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

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

ARTICLE I
DEFINITIONS

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

"Clean Claim" means a bill for Covered Services or a line item of goods or services contained on one bill, which bill can be processed without obtaining additional information from the provider of service(s) or a third party and which bill otherwise meets Anthem's billing requirements. A Clean Claim does not include a Claim from a provider who is under investigation for fraud or abuse, or a Claim under review for Medical Necessity.

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

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

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

"Medically Necessary" or "Medical Necessity" means health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are (1) in accordance with generally accepted standards of medical practice; (2) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and (3) not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with the standards set forth in policy issues involving clinical judgment.

ARTICLE II
SERVICES/OBLIGATIONS

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

2.1.1 Federal Employees Health Benefits Program ("FEHBP"). Provider acknowledges and understands that Anthem participates in the Federal Employees Health Benefits Program ("FEHBP") - the health insurance plan for federal employees. Provider 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. Provider 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. Provider further agrees that in

the event of a conflict between the Agreement, this Attachment and/or the provider manual(s), and the rules/regulations/other requirements of the FEHBP, the terms of the rules/regulations/other requirements of the FEHBP shall control.

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

2.2 Transparency Initiatives. Provider agrees that Anthem, Plans or its designees may use, publish, disclose, and display, either directly or through a third party, Anthem Rates, and any other information related to Provider for transparency initiatives.

2.3 Submission and Adjudication of Commercial Business Claims. Unless otherwise instructed, or required by Regulatory Requirements, Provider shall submit Claims to Plan, using appropriate and current Coded Service Identifier(s), within one hundred twenty (120) days from the date the Health Services are rendered or Plan will refuse payment. If Plan is the secondary payor, the one hundred twenty (120) day period will not begin until Provider receives notification of primary payor's responsibility.

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

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

2.3.3 If Anthem or Plan asks for additional information so that Plan may process the Claim, Provider must provide that information within sixty (60) days, or before the expiration of the one hundred twenty (120) day period referenced in section 2.3 above, whichever is longer.

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

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

2.4 Plan Payment Time Frames. Except as otherwise required by applicable law, Anthem shall require Plans or their designees to use best efforts to make payment or arrange for payment for all Clean Claims for Commercial Business Covered Services submitted by Provider within ninety (90) days exclusive of Claims that have been suspended due to the need to determine Medical Necessity, or the extent of Plan's payment liability, if any, because of issues such as coordination or non duplication of benefits, subrogation, verification of coverage or eligibility for coverage. Interest, if any, shall be paid in accordance with applicable law.

2.4.1 Provider may not bill Commercial Business Member for Commercial Business Covered Services, except for Cost Shares, where Plan denies payment because Provider has failed to comply with the terms or conditions of the Agreement or this Attachment.

2.4.2 Provider acknowledges, that pursuant to section 20-7f, it is an unfair trade practice in violation of

chapter 735a for any health care provider to request payment from a subscriber or an enrollee, other than a coinsurance, copayment, deductible or other out-of-pocket expense, for covered medical or emergency services or facility fees, as defined in section 19a-508c, or surprise bills; or to report to a credit reporting agency an enrollee's failure to pay a bill for such services when a health care center has primary responsibility for payment of such services, fees or bills.

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

2.6 Pass-Through Charges. Provider agrees not to pass through to Plan or the Commercial Business Member any charges which Provider incurs as a result of providing supplies or making referrals to another provider or entity. Examples include, but are not limited to, pass-through charges associated with laboratory services, pathology services, radiology services and durable medical equipment. If Anthem has a direct contract with the subcontractor, the direct contract shall prevail over the Agreement.

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

2.8 Connecticut HMO Compliance. The following provisions (the "State of Connecticut HMO Compliance Provisions") shall apply to Anthem HMO Programs. For purposes of these State of Connecticut HMO Compliance Provisions, the term "Anthem HMO Program" shall mean and be inclusive of but not limited to, BlueCare Health Plan programs and products, State BlueCare, Exchange HMO programs and products and off-Exchange HMO programs and products. For purposes of this section, the term Commercial Business Member shall be deemed to include an enrollee in an Anthem HMO Program. In the event of a conflict between provisions of the Agreement and these State of Connecticut HMO Compliance Provisions, these State of Connecticut HMO Compliance Provisions shall control with respect to Anthem HMO Programs.

2.8.1 Provider hereby agrees that in no event, including but not limited to, nonpayment by Plan, Plan's insolvency, or breach of the Agreement shall Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against a Commercial Business Member or person acting on behalf of such Commercial Business Member, other than Plan, for Commercial Business Covered Services provided pursuant to the Agreement. This provision shall not prohibit collection of Cost Shares, or costs for Commercial Business non-Covered Services, which have not otherwise been paid by a primary or secondary carrier in accordance with Regulatory Requirements for coordination of benefits, from Commercial Business Member in accordance with the terms of the Commercial Business Member's Health Benefit Plan.

2.8.2 Provider agrees that in the event of Plan's insolvency or dissolution occurring when a Commercial Business Member is an inpatient on or after the date of such insolvency or dissolution, Provider shall continue to provide Covered Services to such Commercial Business Member through the last to occur of: i) the date for which premiums or other payments by or on behalf of the Commercial Business Member have been made; or ii) the date the Commercial Business Member is released from the facility in which the Commercial Business Member is an inpatient. Provider further agrees that in the event of Plan's insolvency or dissolution occurring when a Commercial Business Member is not an inpatient on or after the date of such insolvency or dissolution, Provider shall continue to provide Covered Services to such Commercial Business Member until the Commercial Business Member becomes covered under another health plan or until the date for which premiums or other payments by or on behalf of the Commercial Business Member have been made, whichever occurs first. In either case, prior to the date Covered Services are no longer required to be provided as set forth in this provision, the Commercial Business Member shall only be required to pay those amounts required to be paid by the Commercial Business Member under his/her Health Benefit Plan on an in-network basis.

2.8.3 Provider further agrees: (i) that the provisions of paragraphs 2.8.1 and 2.8.2 of these State of Connecticut HMO Compliance provisions shall survive termination of the this Attachment regardless of the cause giving rise to termination and shall be construed to be for the benefit of Commercial Business Member, and (ii) that this provision supersedes any oral or written contrary

agreement now existing or hereafter entered into between Plan and Commercial Business Member or persons acting on their behalf.

2.8.4 If Provider contracts with other providers or facilities who agree to provide Commercial Business Covered Services to Commercial Business Members with the expectation of receiving payment directly or indirectly from Plan, such providers or facilities shall agree to abide by the provisions of paragraphs 2.8.1 and 2.8.2 and 2.8.3 of these State of Connecticut HMO Compliance provisions.

2.8.5 Anthem hereby informs Provider, as required by applicable Connecticut law, that pursuant to Connecticut General Statutes Section 20-7f, it is an unfair trade practice in violation of Chapter 735a for any health care provider to request payment from a Commercial Business Member, other than Cost Shares, for Commercial Business Covered Services, or to report to a credit reporting agency an Commercial Business Member's failure to pay a bill for Commercial Business Covered Services when Plan has primary responsibility for payment of such services.

2.9 No Modification of Member's Health Benefit Plan. Notwithstanding any other provision in the Agreement or this Attachment, nothing in the Agreement or this Attachment shall be construed to modify the rights and benefits contained in the Commercial Business Member's Health Benefit Plan.

2.10 Management of High Risk Commercial Business Members. Plan may notify Provider about Commercial Business Members who have selected Provider as a Primary Care Physician ("PCP"), if applicable, or who have received services from Provider in the past. These Commercial Business Members may include individuals with chronic conditions that may benefit from preventive care measures and/or enhanced care management interventions. In connection with these Commercial Business Members, Plan may make one or more of the following requests of Provider ("Requests"): 1) phone calls to applicable Commercial Business Members to discuss their care needs and options; 2) the scheduling of visits for diagnosis and assessment; and 3) engagement with applicable Commercial Business Members to refer them to Plan or other providers for appropriate interventions or care management. Provider shall comply with Requests within thirty (30) days of their receipt by Provider.

ARTICLE III
TERMINATION

3.1 Termination-Commercial Business Attachment and/or Network(s). At any time either party may terminate, without cause, Provider's participation in one or more Commercial Network(s) designated on the Provider Networks Attachment, or this Attachment by giving at least ninety (90) days prior written notice of termination to the other party. Following any termination as described herein, the remainder of the Agreement shall remain in full force and effect, if applicable.

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

3.2.1 Any provisions required in order to comply with Regulatory Requirements; and

3.2.2 Connecticut HMO Compliance.

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

ARTICLE IV
GENERAL PROVISIONS

4.1 This provision intentionally left blank.

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

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

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

ARTICLE I
DEFINITIONS

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

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

"CMS" is defined as set forth in Article I of the Agreement.

"Downstream Entity(ies)" means any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the Medicare Advantage benefit, below the level of the arrangement between Anthem and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

"Emergency Condition" is defined as set forth in the PCS.

"Emergency Services" is defined as set forth in the PCS.

"First Tier Entity(ies)" means any party that enters into a written agreement, acceptable to CMS, with Anthem to provide administrative services or health care services for a Medicare eligible Member under the Medicare Advantage Program.

"Medically Necessary" or "Medical Necessity" means care for which CMS determines is reasonable and necessary under Medicare for services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of MA Member's medical condition and meet accepted standards of medical practice.

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

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

"Medicare Advantage Member ("MA Member")" means, for purposes of this Attachment, a Member who is covered under a Medicare agreement between CMS and Plan under Part C of Title XVIII of the Social Security Act ("Medicare Advantage Program") and for Plan's DSNP Medicare Program, the beneficiary is also entitled to Medicaid under Title XIX of the Social Security Act, see 42 USC §1396 et seq..

"Medicare Advantage Network" means Network of Providers that provides MA Covered Services to MA Members.

"Related Entity(ies)" means any entity that is related to Anthem by common ownership or control and (1) performs some of Anthem's management functions under contract or delegation; (2) furnishes services to MA Member under an oral or written agreement; or (3) leases real property or sells materials to Anthem at a cost of more than twenty-five hundred dollars ($2,500) during a contract period.

"Urgently Needed Care" means MA Covered Services provided when a MA Member is either: (1) temporarily absent from Plan's Medicare Advantage service area and such MA Covered Services are Medically Necessary and immediately required: (a) as a result of an unforeseen illness, injury, or condition;

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

ARTICLE II
SERVICES/OBLIGATIONS

2.1 Participation-Medicare Advantage. As a participant in Plan's Medicare Advantage Network, Provider will render MA Covered Services to MA Members enrolled in Plan's Medicare Advantage Program in accordance with the terms and conditions of the Agreement and this Attachment. Except as set forth in this Attachment, or in the PCS, all terms and conditions of the Agreement will apply to Provider's participation in Plan's Medicare Advantage Program(s). The terms and conditions set forth in this Attachment are limited to the provision of and payment for Health Services provided to MA Members. This Agreement does not apply to any of Plan's Medicare Advantage Private Fee for Service or Medical Savings Account Programs.

2.1.1 New Programs. Provider acknowledges that Plan has or may develop Medicare Advantage Networks that support certain products, programs or plans with specific participation criteria that may include but are not limited to, quality and/or cost of care metrics. Pursuant to this Agreement, Provider shall be a Participating Provider in any such Network unless Anthem notifies Provider in writing to the contrary. Plan shall notify Provider sixty (60) days in advance of any specific Network participation criteria. Any notice of non-inclusion in any of Plan's Medicare Advantage Network(s) shall be provided in writing sixty (60) days in advance.

2.2 Participation-Out of Area Programs. Pursuant to the Blue Cross and Blue Shield Out of Area Program section of the Agreement, Provider hereby acknowledges and agrees that Provider shall provide MA Covered Services to any person who is covered under another Blue Cross and Blue Shield Plan under the Blue Cross and Blue Shield Association Out of Area Program, a network sharing program developed to support Medicare Advantage Programs.

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

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

2.4.1 The credentials of medical professionals affiliated with Plan or Provider will be either reviewed by Plan, if applicable; or

2.4.2 The credentialing process will be reviewed and approved by Plan and Plan must audit Provider's credentialing process and/or delegate's credentialing process on an ongoing basis.

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

ARTICLE III
ACCESS: RECORDS/FACILITIES

3.1 Inspection of Books/Records. Provider acknowledges that Plan, Health and Human Services Department ("HHS"), the Comptroller General, or their designees have the right to timely access to inspect, evaluate and

audit any books, contracts, medical records, patient care documentation, and other records of Provider, or his/her/its First Tier, Downstream and Related Entities, including but not limited to subcontractors or transferees involving transactions related to Plan's Medicare Advantage contract through ten (10) years from the final date of the contract period or from the date of the completion of any audit, or for such longer period provided for in 42 CFR § 422.504(e)(4) or other Regulatory Requirements, whichever is later. For the purposes specified in this section, Provider agrees to make available Provider's premises, physical facilities and equipment, records relating to Plan's MA Member, including access to Provider's computer and electronic systems and any additional relevant information that CMS may require. Provider acknowledges that failure to allow HHS, the Comptroller General or their designees the right to timely access under this section can subject Provider to a fifteen thousand dollar ($15,000) penalty for each day of failure to comply.

3.2 Confidentiality. In addition to the confidentiality requirements under the Agreement, each party agrees to abide by all Regulatory Requirements applicable to that party regarding confidentiality and disclosure for mental health records, medical records, other health information, and MA Member information. Provider agrees to maintain records and other information with respect to MA Member in an accurate and timely manner; to ensure timely access by MA Member to the records and information that pertain to him/her; and to safeguard the privacy of any information that identifies a particular MA Member. Information from, or copies of, records may be released only to authorized individual. Provider must ensure that unauthorized individuals cannot gain access to or alter patient records. Original medical records must be released only in accordance with Regulatory Requirements, court orders or subpoenas. Both parties acknowledge that Plan, HHS, the Comptroller General or its designee have the right, pursuant to section 3.1 above, to audit and/or inspect Provider's premises to monitor and ensure compliance with the CMS requirements for maintaining the privacy and security of protected health information ("PHI") and other personally identifiable information ("PII") of MA Member.

ARTICLE IV
ACCESS: BENEFITS AND COVERAGE

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

4.2 Direct Access. Provider acknowledges that MA Member may obtain covered mammography screening services and influenza vaccinations from a participating provider without a referral and that MA Member who are women may obtain women's routine and preventive Health Services from a participating women's health specialist without a referral.

4.3 No Cost Sharing. Provider acknowledges that covered influenza vaccines and pneumococcal vaccines are not subject to MA Member Cost Share obligations.

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

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

ARTICLE V
BENEFICIARY PROTECTIONS

5.1 Cultural Competency. Provider shall ensure that MA Covered Services rendered to MA Members, both clinical and non-clinical, are accessible to all MA Members, including those with limited English proficiency or reading skills, with diverse cultural and ethnic backgrounds, the homeless, and MA Members with

physical and mental disabilities. Provider must provide information regarding treatment options in a cultural-competent manner, including the option of no treatment. Provider must ensure that MA Members with disabilities have effective communications with participants throughout the health system in making decisions regarding treatment options.

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

5.3 Identifying Complex and Serious Medical Condition. Provider acknowledges that Plan has procedures to identify MA Members with complex or serious medical conditions for chronic care improvement initiatives; and to assess those conditions, including medical procedures to diagnose and monitor them on an ongoing basis; and establish and implement a treatment plan appropriate to those conditions, with an adequate number of direct access visits to specialists to accommodate the treatment plan. To the extent applicable, Provider agrees to assist in the development and implementation of the treatment plans and/or chronic care improvement initiatives.

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

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

5.6 Hold Harmless. In addition to the hold harmless provision in the Agreement, Provider agrees that in no event, including but not limited to non-payment by Plan, insolvency of Plan or breach of the Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a MA Member or persons other than Plan acting on their behalf for MA Covered Services provided pursuant to this Attachment. This section does not prohibit the collection of supplemental charges or Cost Shares on Plan's behalf made in accordance with the terms of the MA Member's Health Benefit Plan or amounts due for services that have been correctly identified in advance as a non-MA Covered Service, subject to medical coverage criteria, with appropriate disclosure to the MA Member of their financial obligation. This advance notice must be provided in accordance with the CMS regulations for Medicare Advantage organizations. CMS regulations require that a coverage determination be made with a standard denial notice (Notice of Denial of Medical Coverage (or Payment)/CMS-10003) for a non-Covered Service when such Health Service is typically not covered, but could be covered under specific conditions. If prior to rendering the non-Covered Service, Provider obtains, or instructs the MA Member to obtain, a coverage determination of a non-Covered Service(s), the MA Member can be held financially responsible for non-Covered Services. However, if a service or item is never covered by the Plan, such as a statutory exclusion, and the MA Member's Evidence of Coverage ("EOC") clearly specifies that the service or item is never covered, the Provider does not have to seek a coverage determination from Anthem in order to hold the MA Member responsible for the full cost of the service or item. Additional information, related requirements and the process to request a coverage determination can be found in the Provider Guidebook. Both Parties agree that failure to follow the CMS regulations can result in Provider's financial liability.

5.6.1 Dual Eligibles. Provider further agrees that for MA Members who are dual eligible beneficiaries for Medicare and Medicaid, that Provider will ensure he/she/it will not bill the MA Member for Cost Sharing that is not the MA Member's responsibility and such MA Members will not be held liable for Medicare Parts A and B Cost Sharing when the State is liable for the Cost Sharing. In addition, Provider agrees to accept Plan payment as payment in full or Provider should bill the appropriate state source.

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

5.8 Out of Network Referrals and Transfers. In addition to the Cost Effective Care provision in the Agreement, Provider shall seek authorization from Plan prior to referring or transferring an MA Member to a non-Participating Provider. For Plan's HMO Medicare Advantage Network, if a Participating Provider is not accessible or available for a referral or transfer, then Provider shall call Plan for an authorization. If, however, a Participating Provider is accessible and available for a referral or transfer, then Provider shall transfer or refer the MA Member to such Participating Provider. For Plan's PPO MA Members, Provider shall advise the MA Member that an out of network referral is being made, and shall ensure that the MA Member understands and agrees to be financially responsible for any additional costs related to such out of network service.

ARTICLE VI
COMPENSATION AND AUDIT

6.1 Submission and Adjudication of Medicare Advantage 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 will refuse payment. If Plan is the secondary payor, the three hundred and sixty-five (365) day period will not begin until Provider receives notification of primary payor's responsibility.

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

6.1.2 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").

6.1.3 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 6.1 above, whichever is longer.

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

6.3 Audit for Compliance with CMS Guidelines. Notwithstanding any other terms and conditions of the Agreement, Plan has the same rights as CMS, to review and/or Audit and, to the extent necessary recover payments on any claim for MA Covered Services rendered pursuant to this Agreement to insure compliance with CMS Regulatory Requirements.

ARTICLE VII
REPORTING AND DISCLOSURE REQUIREMENTS

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

7.2 Data Reporting Submissions. Provider agrees to provide to Plan all information necessary for Plan to meet its data reporting and submission obligations to CMS, including but not limited to, data necessary to characterize the context and purpose of each encounter between a MA Member and Provider ("Risk Adjustment Data"), and data necessary for Plan to meet its reporting obligations under 42 CFR §§ 422.516

and 422.310. In accordance with the CMS Regulatory Requirements, Plan reserves the right to assess Provider for any penalties resulting from Provider's submission of false data.

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

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

ARTICLE VIII
QUALITY ASSURANCE/QUALITY IMPROVEMENT REQUIREMENTS

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

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

8.3 Consulting with Participating Providers. Plan agrees to consult with Participating Providers regarding its medical policies, quality improvement program and medical management programs and ensure that practice guidelines and utilization management guidelines: (1) are based on reasonable medical evidence or a consensus of health care professionals in the particular field; (2) consider the needs of the enrolled population; (3) are developed in consultation with participating physicians; (4) are reviewed and updated periodically; and (5) are communicated to providers and, as appropriate, to MA Member. Plan also agrees to ensure that decisions with respect to utilization management, MA Member education, coverage of Health Services, and other areas in which the guidelines apply are consistent with the guidelines.

ARTICLE IX
COMPLIANCE

9.1 Compliance: Medicare Laws/Regulations. Provider agrees to comply, and to require any of his/her/its subcontractors to comply, with all applicable Medicare Regulatory Requirements and CMS instructions. Further, Provider agrees that any MA Covered Services provided by Provider or his/her/its subcontractors to or on the behalf of Plan's MA Member will be consistent with and will comply with Plan's Medicare Advantage contractual obligations.

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

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

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

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

9.6 Compliance: Training, Education and Communications. In accordance with, but not limited to 42 CFR §§ 422.503(b)(4)(vi)(C)&(D) and 423.504(b)(4)(vi)(C)&(D), Provider agrees and certifies that it, as well as its employees, subcontractors, Downstream Entities, Related Entities and agents who provide services, to or for Plan's Medicare Advantage and/or Part D MA Members or to or for Plan itself, shall participate in CMS required fraud waste and abuse training and general compliance training, education and/or communications annually or as otherwise required by Regulatory Requirements, and must be made a part of the orientation for a new employee, new First Tier, Downstream or Related Entity and for all new appointments of a chief executive, manager, or governing body member. Provider or its subcontractors or Downstream Entities can complete the CMS training module located on the CMS MLN or incorporate the exact content of the CMS training into Providers existing compliance training and/or systems. If necessary and upon request, Plan or its designee can make such compliance training, education and lines of communication available to Provider in either electronic, paper or other reasonable medium. Provider shall be responsible for documenting applicable employee's, subcontractor's, Downstream Entity's, Related Entity's and/or agent's attendance and completion of such training. Upon notice, Provider shall provide such documentation to Plan, unless otherwise not required by Regulatory Requirements or CMS regulation. In addition, the training requirement set forth herein is not required for providers or suppliers who have met the fraud, waste and abuse certification requirements through enrollment into the Medicare program, as those providers and/or suppliers are deemed to have met that portion of the fraud waste and abuse training required by CMS.

9.7 Federal Funds. Provider acknowledges that payments Provider receives from Plan to provide MA Covered Services to MA Members are, in whole or part, from federal funds. Therefore, Provider and any of his/her/its subcontractors are subject to certain Regulatory Requirements that are applicable to Members and entities receiving federal funds, which may include but is not limited to, Title VI of the Civil Rights Act of 1964 as implemented by 45 CFR Part 84; the Age Discrimination Act of 1975 as implemented by 45 CFR Part 91; the Americans with Disabilities Act; the Rehabilitation Act of 1973, lobbying restrictions as implemented by 45 CFR Part 93 and 31 USC 1352 and any other regulations applicable to recipients of federal funds.

ARTICLE X
MARKETING

10.1 Approval of Materials. Both parties agree to comply, and to require any of his/her/its subcontractors to comply, with all applicable Regulatory Requirements, CMS instructions, and marketing activities under this Agreement, including but not limited to, the Medicare Marketing Guidelines for Medicare Managed Care Plans and any requirements for CMS prior approval of materials. Any printed materials, including but not limited to letters to Plan MA Members, brochures, advertisements, telemarketing scripts, packaging prepared or produced by Provider or any of his/her/its subcontractors pursuant to this Agreement must be submitted to Plan for review and approval at each planning stage (i.e., creative, copy, mechanicals, blue lines, etc.) to assure compliance with Regulatory Requirements, and Blue Cross/Blue Shield Association guidelines. Plan agrees its approval will not be unreasonably withheld or delayed.

ARTICLE XI
TERMINATION

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

11.2 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 Medicare Advantage Program are hereby terminated in full and shall have no further force and effect.

11.3 Termination Without Cause. Either party may terminate this Attachment without cause by giving at least one hundred twenty (120) days prior written notice of termination to the other party.

ARTICLE XII
GENERAL PROVISIONS

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

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

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

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

12.4.1 A list of delegated activities and reporting responsibilities;

12.4.2 Arrangements for the revocation of delegated activities;

12.4.3 Notification that the performance of the contracted and subcontracted entities will be monitored by Plan;

12.4.4 Notification that the credentialing process must be approved and monitored by Plan; and

12.4.5 Notification that all contracted and subcontracted entities must comply with all applicable Medicare Regulatory Requirements and CMS instructions.

12.5 Delegation of Provider Selection. In addition to the responsibilities for delegated activities as set forth herein, to the extent that Plan has delegated selection of providers, contractors, or subcontractor to Provider, Plan retains the right to approve, suspend, or terminate any such arrangement.

12.6 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 MA Member; and (2) these provisions supersede any oral or written contrary agreement now existing or hereafter entered into between Provider and an MA Member or persons acting on their behalf that relates to liability for payment for, or continuation of, MA Covered Services provided under the terms and conditions of these clauses.

12.7 Attachment Amendment. Notwithstanding the Amendment provision in the Agreement, this Attachment shall be automatically modified to conform to required changes to Regulatory Requirements related to Medicare Advantage Programs without the necessity of executing written amendments. For amendments not required by Regulatory Requirements related to Medicare Advantage Programs, Anthem shall make a good faith effort to provide notice to Provider at least thirty (30) days in advance of the effective date of the amendment.

PLAN COMPENSATION SCHEDULE ("PCS")

I. DEFINITIONS

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

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

"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.

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

"Emergency" or "Emergency Services" means the onset of a serious illness or injury which requires Emergency medical treatment; or the onset of symptoms of sufficient severity that a prudent layperson, acting reasonably, believes that Emergency medical treatment is needed.

"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.

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

"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.

"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. If an update is delayed beyond the sixty (60) days, Anthem shall notify Provider. When billing codes are updated, Provider is required to use appropriate replacement codes for Claims for Covered Services, regardless of whether this Agreement has been amended to reflect changes to standard billing codes. If Provider bills a new, replacement or revised code prior to the effective date of such code, the Claim will be rejected and the 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 Change in Scope and Status provision 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.

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

Reimbursement for Subcontractors. 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

"Ambulance Provider (Ground AMB)" means local ground transportation by a vehicle designed, equipped, and used only to transport the sick and injured for the purpose of, or related to, medical treatment and operated according to Regulatory Requirements which control the issuance of valid licenses or permits or be licensed when required by Regulatory Requirements.

Except in case of an emergency, or as otherwise set forth in the Member's Health Benefit Plan, or required by Regulatory Requirements, all scheduled ground ambulance transports require authorization prior to transporting a Member. When expedited services are needed, authorization must be requested by the next business day. While this Agreement is in effect, Provider must meet all licensing and other Regulatory Requirements to render Covered Services to Members and to maintain such license and Regulatory Requirements to practice in unqualified status throughout the term of this Agreement. Provider must also meet and comply with the following requirements:

Provider shall participate with Medicare in unqualified and unrestricted status.

Provider must maintain appropriate (as recognized by industry standard) professional liability insurance and comprehensive general liability insurance in amounts not less than one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) in aggregate. Provider shall provide memorandum copies of such insurance coverage to Anthem upon request. If Provider self-insures for medical malpractice insurance, then, at Anthem's request, Provider must provide evidence of its established policy and adequacy of its funding arrangement and any reinsurance provisions.

Provider must submit to Anthem copies or proof of valid licensing and certification of professional automobile liability insurance. Provider must report, in writing, any changes in licensure, certification or insurance coverage or status to Anthem within thirty (30) days of such change.

Reimbursement for ambulance services is a global payment and is limited to payment of the base rate plus

mileage charges only. Therefore, separate reimbursement is not available for additional services and supplies including but not limited to CPR, suction, telemetry, nursing services, waiting time, disposable supplies, medical supplies, defibrillation, IV drug therapy, esophageal intubation and oxygen. Any services other than those listed on the PCS Attachment will not be reimbursed and will be denied as provider liability.

IV. SPECIFIC REIMBURSEMENT TERMS

COMMERCIAL BUSINESS

For Covered Services provided by or on behalf of Provider to a Member who is enrolled in a product and/or program that is supported by a Network designated in this Agreement, Provider agrees to accept the lesser of Provider Charges or the compensation as set forth in the PCS Attachment, attached hereto and made part hereof.

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

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

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

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

MEDICARE ADVANTAGE

For Covered Services provided by or on behalf of Provider to a Medicare Advantage Member, Provider agrees to accept the lesser of Provider Charges or the amount(s) set forth on Anthem's Medicare Advantage Fee Schedule(s).

When determining the Anthem Medicare Advantage Rate, Anthem shall utilize a proprietary fee schedule which shall be provided to Provider upon request. If, however, any future reimbursement terms under this Agreement are based, in whole or in part, on Medicare rates, pricing, fee schedules, or payment methodologies published or established by CMS, shall refer to the per claim payment amounts that CMS and a Medicare beneficiary would directly pay to Provider for the same items or services under fee-for-service Medicare Part A or Part B. The Anthem Medicare Advantage Rate shall not include any bonus payment, or settlement amount paid to Provider by CMS outside of the Medicare per claim payment process, unless otherwise set forth in the Medicare Advantage reimbursement terms of this Agreement. Unless Anthem notifies Provider otherwise, in the event CMS changes payment to Provider due to a CMS directive, Act of Congress, Executive Order, or Regulatory Requirement, the amount payable to Provider hereunder will automatically be changed as soon as reasonably practicable, as described herein, in the amount specified by CMS as a result of such directive or change in law, or in the absence of such specification, in the same percentage amount as payment is changed by CMS to Provider.

"PCS" ATTACHMENT

RATE SHEET

Provider will be reimbursed for Covered Services provided to Covered Persons in accordance with the terms of the attached rate schedule.

Reimbursement for HMO, POS, PPO, Indemnity/Traditional/Standard and Exchange Plan Programs:

The rate shall be the lower of one hundred percent (100%) of the Maximum Allowable Amount (described below) or Ancillary Provider charges, subject to the Covered Person/Member's maximum benefit. Such compensation shall be reduced by any applicable Covered Person/Member payment responsibility. Payor agrees to pay the balance up to the compensation amount.

The Maximum Allowable Amount shall be ninety percent (90%) of the rates listed in Transportation Service Rates Section of the Maximum Schedule of Rates, as established for Ambulance Service by the State of Connecticut Department of Emergency Services, for the calendar year

Medicare Advantage HMO/ Medicare Advantage PPO Plans:

Designated Compensation shall be the lesser of Ancillary Provider's charges or 100% of the payment associated with Medicare Advantage.