INDIVIDUAL PRODUCT ATTACHMENT

THIS INDIVIDUAL PRODUCT ATTACHMENT (referred to herein as this "***Attachment***") is made and entered into between Berkley Community Health Care ("HMO") and _____. ("***Provider***").

WHEREAS, HMO and Provider entered into that certain provider agreement, including all Attachments, as may have been amended and supplemented from time to time (the "Agreement"), pursuant to which Provider agrees to provide to covered persons those covered services described in the Agreement;

WHEREAS, HMO desires (i) to include Participating Providers (as hereafter defined) as participating providers in the "***Individual Product***," as defined and described in this Attachment, for the purposes of participating in health care reform programs on and off health care exchanges, and (ii) to add the Individual Product Attachment (as defined below) as a binding attachment to the Agreement;

NOW THEREFORE, in consideration of the foregoing, and for other good and valuable consideration, the Agreement is amended as set forth below.

1. Amendment.

1.1 Effective Date. This Attachment is effective as of _____, 20__ ("Effective Date").

1.2 Defined Terms. All capitalized terms not specifically defined in this Attachment will have the meanings given to such terms in the Agreement.

1.3 Modification to Defined Terms. For purposes of the Individual Product only, Article I of the Agreement is hereby amended by deleting the definitions in the Agreement for the following quoted terms and inserting in lieu thereof the definitions set forth below.

"***Covered Person***" means any individual entitled to receive Covered Services pursuant to the terms of a Coverage Agreement.

"***Covered Services***" means those services and items for which benefits are available and payable under the applicable Coverage Agreement and which are determined, if applicable, to be medically necessary under the applicable Coverage Agreement.

"***Emergency***" or "***Emergency Care***" has the meaning set forth in the Covered Person's Coverage Agreement.

"***Emergency Medical Condition***" has the meaning set forth in the Covered Person's Coverage Agreement.

"***Medically Necessary***" has the meaning set forth in the Covered Person's Coverage Agreement.

"***Participating Health Care Provider***" or "***Participating Provider***" means, with respect to a particular Product, any physician, hospital, ancillary, or other health care provider that has contracted, directly or indirectly, with HMO or Payor to provide Covered Services to Covered Persons, and that is designated by HMO or Payor as a "participating provider" in such Product.

"***Payor***" means the entity that bears direct financial responsibility for paying from its own funds, without reimbursement from another entity, the cost of Covered Services rendered to Covered Persons under a Coverage Agreement.

"***Payor Contract***" means the contract with a Payor, pursuant to which HMO or an Affiliate furnishes administrative services or other services in support of the Coverage Agreements entered into, issued or agreed to by a Payor, which services may include access to one or more of provider networks or vendor arrangements of HMO or an Affiliate. The term "Payor Contract" includes a contract with a governmental authority (also referred to herein as a "Governmental Contract") under which HMO, an Affiliate or Payor arranges for the provision of Covered Services to eligible individuals.

"***Provider Manual***" means the manuals, requirements, policies and procedures adopted by the HMO, an Affiliate, Payor, or its delegate to be followed by Participating Providers, including, without limitation, those relating to utilization management, quality management, grievances and appeals, and Product-specific, Payor-specific and State-specific requirements, as the same may be amended from time to time by the HMO, an Affiliate, Payor or its delegate.

1.4 New Definitions. For purposes of the Individual Product only, Article I of the Agreement is hereby amended by adding the new defined terms and definitions set forth below to the end of that Article; such quoted terms, when appearing with initial capital letters in this Amendment and Attachment or the Agreement, will have the meanings set forth below.

"***Compensation Schedule***" means at any given time the then effective schedule(s) of maximum rates applicable to the Individual Product under which Provider and Participating Providers will be compensated for the provision of Covered Services to Covered Persons. Such Compensation Schedule(s) will be set forth or described in an exhibit to the Individual Product Attachment.

"***Individual Product***" means those programs and health benefit arrangements offered by or available from or through HMO or a Payor that provide incentives to Covered Persons to utilize the services of certain contracted providers. The Individual Product includes those Coverage Agreements entered into, issued or agreed to by a Payor under which HMO , an Affiliate, or its delegate furnishes administrative services or other services in support of a health care program for an individual or group of individuals,

which may include access to one or more of the HMO 's or Payor's provider networks or vendor arrangements. The Individual Product does not apply to any Coverage Agreements that are specifically covered by another Product Attachment to the Agreement.

"***Coverage Agreement***" means any agreement, program or certificate entered into, issued or agreed to by a Payor, under which the Payor arranges for the delivery of health care services to Covered Persons through one or more network(s) of providers or other vendor arrangements.

"***Product***" means any program or health benefit arrangement designated as a "product" by HMO or a Payor (e.g., HMO Product, Medicaid Product, Individual Product, Payor-specific Product, etc.) that is now or hereafter offered by or available from or through HMO, an Affiliate or a Payor that provides Covered Persons in such product with incentives or access to Participating Providers in such product. For purposes of the Individual Product Attachment, "Product" means the Individual Product.

"***Product Attachment***" means an Attachment setting forth certain requirements, terms and conditions specific to one or more Products, including certain provisions that must be included in a provider agreement under the laws of the State, which may be alternatives to, or in addition to, the requirements, terms and conditions set forth in the Agreement or the Provider Manual.

"***Regulatory Requirements***" means all applicable statutes, regulations, regulatory guidance, judicial or administrative rulings, requirements of Governmental Contracts and standards and requirements of any accrediting or certifying organization, including, but not limited to, the requirements set forth in a Product Attachment.

"***State***" means the State of Ohio, unless otherwise defined in an Attachment for purposes of that Attachment.

2. Individual Product Attachment.

2.1 Product Attachment. This Section 2 constitutes the "Individual Product Attachment" ("***Product Attachment***") and is incorporated into the Agreement between Provider and HMO. It supplements the Agreement by setting forth specific terms and conditions that apply to the Individual Product with respect to which a Participating Provider has agreed to participate, and with which a Participating Provider must comply in order to maintain such participation.

2.2 Participation.

(a) Unless otherwise specified in this Product Attachment and as limited by Section 2.2(b) below, all Participating Providers under the Agreement will participate in the Individual Product as "Participating Providers," and will provide to Covered Persons enrolled in or covered by a Individual Product, upon the same terms and conditions contained in the

Agreement, as supplemented or modified by this Product Attachment, those Covered Services that are provided by Participating Providers pursuant to the Agreement. In providing such services, Provider shall, and shall cause Participating Providers, to comply with and abide by the provisions of the Agreement, including this Product Attachment and the Provider Manual.

(b) Provider and Participating Providers may only identify themselves as a Participating Provider for those Individual Products in which the Participating Provider actually participates as provided in the Agreement and this Product Attachment. Provider acknowledges that HMO, an Affiliate or a Payor may have, develop or contract to develop various Individual Products or provider networks that have a variety of provider panels, program components and other requirements, and that all or certain of HMO's duties with respect to the Individual Product may be delegated to an Affiliate, a Payor or their delegates. Neither HMO nor any Payor warrants or guarantees that any Participating Provider: (i) will participate in all or a minimum number of provider panels, (ii) will be utilized by a minimum number of Covered Persons, or (iii) will indefinitely remain a Participating Provider or member of the provider panel for a particular network or Individual Product.

2.3 Attachment. This Product Attachment includes at Exhibit 1 the Regulatory Requirements with which Participating Providers are required to comply in connection with their participation in the Individual Product. Any additional Regulatory Requirements that may apply to Participating Providers are or will be set forth in the Provider Manual or another Attachment and are incorporated herein by this reference. This Product Attachment also includes a Compensation Schedule at Exhibit 2.

2.4 Term. The term of the Participating Providers' participation in the Individual Product will commence as of the Effective Date and, thereafter, will be coterminous with the term of the Agreement unless terminated pursuant to the Agreement or this Product Attachment. The participation of any Participating Provider as a "Participating Provider" in an Individual Product may be terminated by either party giving the other party at least ninety (90) days' prior written notice of such termination; in such event, Provider shall immediately notify the affected Participating Provider of such termination.

2.5 Conflict and Construction. This Amendment and Attachment modifies, supplements and forms a part of the Agreement. Except as otherwise provided in this Amendment and Attachment, the terms and conditions of the Agreement will remain unchanged and in full force and effect. In the event of any conflict or inconsistency between the provisions of the Agreement (or any other Attachment) and the provisions of this Product Attachment, the terms and conditions of this Product Attachment will govern with respect to health care services, supplies or accommodations (including Covered Services) rendered to Covered Persons enrolled in or covered by the Individual Product. To the extent Provider or any Participating Provider is unclear about its, his or her respective duties and obligations, Provider or the applicable Participating Provider shall request clarification from HMO.

IN WITNESS WHEREOF, the Parties hereto have executed and delivered this Amendment as of the date first set forth above.

HMO:	**Provider:**
Berkley Care **Community Health**	.
Authorized Signature	Authorized Signature
Printed Name: John Snow	Printed Name:
Title: Vice President, Network Management	Title:
Date:	Date:
	Tax ID Number:
	State Medicaid Number:

EXHIBIT 1 TO THE INDIVIDUAL PRODUCT ATTACHMENT

REGULATORY REQUIREMENTS

This Exhibit sets forth the provisions that are required by State or federal law to be included in the Agreement with respect to the Individual Product. To the extent that a Payor, Coverage Agreement, or Covered Person is subject to the law cited in the parenthetical at the end of a provision on this Exhibit, such provision will apply to the rendering of Covered Services to a Covered Person of such Payor, to a Covered Person with such Coverage Agreement, or to such Covered Person, as applicable.

OH-1 Services. The Provider Manual describes (a) the specific health care services for which each Participating Provider is responsible, including limitations or conditions on such services (if any); (b) the rights and responsibilities of HMO and a Payor, and of the Participating Providers, with respect to administrative policies and programs, including, but not limited to, payments systems, utilization review, quality assurance, assessment, and improvement programs, credentialing, confidentiality requirements, and any applicable federal or state programs; and (c) the specifics of any obligation on a Participating Provider that is a primary care provider to provide, or to arrange for the provision of, Covered Services twenty-four (24) hours per day, seven (7) days per week. The procedures for the resolution of disputes arising out of the Agreement are sent forth in the Agreement or Provider Manual. (OHIO REV. CODE §§ 1751.13(C)(1); 1751.13(C)(4); 1751.13(C)(10); 1751.13(C)(11))

OH-2 Covered Person Hold Harmless. Each Participating Provider agrees that in no event, including but not limited to nonpayment by HMO or the Payor, insolvency of HMO or the Payor, or breach of the Agreement, shall the Participating Provider bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against, a Covered Person or person to whom health care services have been provided, or person acting on behalf of the Covered Person, for Covered Services provided pursuant to the Agreement. This does not prohibit the Participating Provider from collecting co-insurance, deductibles, or copayments as specifically provided in the evidence of coverage, or fees for uncovered health care services delivered on a fee-for-service basis to persons referenced above, nor from any recourse against HMO, the Payor or their respective successors. This Section shall survive the termination of the Agreement with respect to Covered Services provided under the Agreement during the time the Agreement was in effect, regardless of the reason for the termination, including the insolvency of the Payor. (OHIO REV. CODE §§ 1751.13(C)(2); 1751.13(C)(12); 1751.60(C))

OH-3 Continuity of Care. Each Participating Provider shall continue to provide Covered Services to patients that were Covered Persons under the Agreement in the event of HMO's or the Payor's insolvency or discontinuance of operations. Each Participating Provider shall continue to provide Covered Services to patients that were Covered Persons under the Agreement as needed to complete any Medically Necessary procedures commenced but unfinished at the time of HMO's or the Payor's insolvency or discontinuance of operations. The completion of a Medically Necessary procedure shall include the rendering of all Covered Services that constitute Medically Necessary follow-up care for that procedure. The foregoing

does not require the Participating Provider to continue to provide any Covered Service after the occurrence of any of the following: (a) the end of the thirty-day period following the entry of a liquidation order under Chapter 3903 of the Ohio Revised Code; (b) the end of the Covered Person's period of coverage for a contractual prepayment or premium; (c) the Covered Person obtains equivalent coverage with another health insuring corporation or insurer, or the Covered Person's employer obtains such coverage for the Covered Person; (d) the Covered Person or the Covered Person's employer terminates coverage under the Coverage Agreement or Payor Contract; (e) a liquidator effects a transfer of HMO's or the Payor's obligations under the contract under Section 3903.21(A)(8) of the Ohio Revised Code. (OHIO REV. CODE § 1751.13(C)(3))

OH-4 Records. Each Participating Provider shall keep confidential and make available those health records maintained by the Participating Provider to monitor and evaluate the quality of care, to conduct evaluations and audits, and to determine on a concurrent or retrospective basis the necessity of and appropriateness of health care services provided to Covered Persons. Each Participating Provider shall make these health records available to appropriate State and federal authorities involved in assessing the quality of care or in investigating the grievances or complaints of Covered Persons. Each Participating Provider shall comply with applicable State and federal laws related to the confidentiality of medical or health records. (OHIO REV. CODE § 1751.13(C)(5))

OH-5 Assignment. The contractual rights and responsibilities under the Agreement may not be assigned or delegated by the Participating Provider without the prior written consent of HMO. (OHIO REV. CODE § 1751.13(C)(6))

OH-6 Insurance. Each Participating Provider shall maintain adequate professional liability and malpractice insurance, and shall notify HMO not more than ten (10) days after the Participating Provider's receipt of notice of any reduction or cancellation of such coverage. (OHIO REV. CODE § 1751.13(C)(7))

OH-7 Covered Person Rights. Each Participating Provider shall observe, protect, and promote the rights of Covered Persons as patients. Each Participating Provider shall provide health care services without discrimination on the basis of a patient's participation in the health care plan, age, sex, ethnicity, religion, sexual preference, health status, or disability, and without regard to the source of payments made for health care services rendered to a patient. This requirement shall not apply to circumstances when the Participating Provider appropriately does not render services due to limitations arising from the Participating Provider's lack of training experience, or skill, or due to licensing restrictions. (OHIO REV. CODE §§ 1751.13(C)(8); 1751.13(C)(9))

OH-8 Definitions. The terms used in the Agreement and defined by Chapter 1751 of the Ohio Revised Code are to be construed when used in the Agreement in a manner consistent with those statutory definitions (OHIO REV. CODE § 1751.13(C)(13))

OH-9 Payor's Role. Each Participating Provider acknowledges that the Payor is a third-party beneficiary to the Agreement, and that each Payor retains the right to approve or

disapprove the participation of the Participating Provider with respect to any provider panel or network available for a particular Coverage Agreement. (OHIO REV. CODE § 1751.13(F))

OH-10 Oversight. Each Participating Provider acknowledges HMO's statutory responsibility to monitor and oversee the offering of Covered Services to Covered Persons. (OHIO REV. CODE § 1751.13(G))

OH-11 Third Party Access. The Agreement applies to network rental arrangements. One purpose of the Agreement is selling, renting or giving HMO rights to the services of the Participating Provider, including other preferred provider organizations, and the third party accessing the Participating Provider's services is any of the following: (i) a Payor or a third-party administrator or other entity responsible for administering claims on behalf of the Payor; (ii) a preferred provider organization or preferred provider network that receives access to the Participating Provider's services pursuant to an arrangement with the preferred provider organization or preferred provider network in a contract with the Participating Provider that is in compliance with Ohio Rev. Code § 3963.02(A)(1)(c), and is required to comply with all of the terms, conditions, and affirmative obligations to which the originally contracted primary participating provider network is bound under its contract with the Participating Provider, including, but not limited to, obligations concerning patient steerage and the timeliness and manner of reimbursement; (iii) an entity that is engaged in the business of providing electronic claims transport between HMO and the Payor or third-party administrator and complies with all of the applicable terms, conditions, and affirmative obligations of HMO's contract with the Participating Provider including, but not limited to, obligations concerning patient steerage and the timeliness and manner of reimbursement; (iv) an employer or other entity providing coverage for health care services to its employees or members, and that employer or entity has a contract with HMO or its Affiliate for the administration or processing of claims for payment for services provided pursuant to the Agreement with the Participating Provider; or (v) an entity that is an Affiliate or subsidiary of HMO or is providing administrative services to, or receiving administrative services from, HMO or an Affiliate or subsidiary of HMO. (OHIO REV. CODE § 3963.02)

OH-12 Summary Disclosure Form. The summary disclosure form, attached hereto as Exhibit 1-A, is incorporated herein by this reference. (OHIO REV. CODE § 3963.03)

EXHIBIT 1-A TO THE INDIVIDUAL PRODUCT ATTACHMENT
REGULATORY REQUIREMENTS
SUMMARY DISCLOSURE FORM

(1) Compensation terms
  (a) Manner of payment
    [X] Fee for service
    [ ] Capitation
    [ ] Risk
    [ ] Other _____ See _____
  (b) Fee schedule available at http://www.cms.gov/CenterProvider-Type/All-Fee-For-Service-Providers
  (c) Fee calculation schedule available at Exhibit 2 of the Individual Product Attachment
  (d) Identity of internal processing edits available at www.BCHPohio.com
  (e) Information in (c) and (d) is not required if information in (b) is provided

(2) List of products or networks covered by this contract
  [x] _CFC Medicaid_____
  [x] _ABD Medicaid_____
  [x] _Medicare Advantage_____
  [x] _Individual Product_____

(3) Term of this contract 3 years with automatic renewal

(4) Contracting entity or payer responsible for processing payment available at www.company.com

(5) Internal mechanism for resolving disputes regarding contract terms available at www.company.com

(6) Addenda to contract Title Subject
  (a) State of Ohio Medicaid Addendum
  (b) Medicare Advantage Addendum
  (c) Individual Product Attachment

(7) Telephone number to access a readily available mechanism, such as a specific web site address, to allow a participating provider to receive the information in (1) through (6) from the payer. 1-866-296-8371

IMPORTANT INFORMATION -- PLEASE READ CAREFULLY

The information provided in this Summary Disclosure Form is a guide to the attached Health Care Contract as defined in section 3963.01(G) of the Ohio Revised Code. The terms and conditions of the attached Health Care Contract constitute the contract rights of the parties. Reading this Summary Disclosure Form is not a substitute for reading the entire Health Care

Contract. When you sign the Health Care Contract, you will be bound by its terms and conditions. These terms and conditions may be amended over time pursuant to *section 3963.04 of the Ohio Revised Code*. You are encouraged to read any proposed amendments that are sent to you after execution of the Health Care Contract. Nothing in this Summary Disclosure Form creates any additional rights or causes of action in favor of either party.

EXHIBIT 2 of the INDIVIDUAL PRODUCT ATTACHMENT

PROVIDER COMPENSATION SCHEDULE

COMMERCIAL-EXCHANGE PRODUCT
PROFESSIONAL SERVICES

For Covered Services provided to Covered Persons, Payor shall pay Provider the lesser of: (i) the Provider's Allowable Charges; or (ii) one hundred percent (100%) of the Payor Medicare fee schedule in effect on the date of service and specific to the services rendered, less any applicable coinsurance or deductible. This fee schedule is based on the CMS/Medicare RBRVS relative values and for certain codes alternative fee sources may be used.

Additional Provisions:

Code Change Updates. Updates to existing billing-related codes shall become effective on the date ("Code Change Effective Date") that is the later of: (i) the first day of the month following thirty (30) days after publication by the governmental agency having authority over the applicable product of such governmental agency's acceptance of such code updates; or (ii) the effective date of such code updates, as determined by such governmental agency. Claim processed prior to the Code Change Effective Date shall not be reprocessed to reflect any code updates.

Modifier. Unless specifically indicated otherwise, Fee Amounts listed in the fee schedule represent global fees and may be subject to reductions based on appropriate Modifier (for example, professional and technical modifiers). As used in the previous sentence, "global fees" refers to services billed without a Modifier, for which the Fee Amount includes both the professional component and the technical component. Any co-payment, deductible or coinsurance that the customer is responsible to pay under the customer's benefit contract will be subtracted from the listed Fee Amount in determining the amount to be paid by the payer. The actual payment amount is also subject to matters described in this agreement, such as the Payment Policies.

Fee Sources. In the event CMS contains no published fee amount, alternate (or "gap fill") Fee Sources may be used to supply the Fee Basis amount for deriving the Fee Amount. At such time in the future as CMS publishes its own RBRVS value for that CPT/HCPCS code, Payor will use the CMS fee amount for that code and no longer use the alternate Fee Source.

Anesthesia Modifier Pricing Rules. The dollar amount that will be used in the calculation of time-based and non-time based Anesthesia Management fees in accordance with the Anesthesia Payment Policy. Unless specifically stated otherwise, the Anesthesia Conversion Factor indicated is fixed and will not change. The Anesthesia Conversion Factor is based on an anesthesia time unit value of 15 minutes.

Multiple Procedure Pricing Rules. Multiple procedures performed during the same day will be reimbursed at 100% for the primary procedure, 50% for the second procedure, and 50% for the third procedure, subsequent procedures shall not be eligible for reimbursement.

Place of Service Pricing Rules. This fee schedule follows CMS guidelines for determining when services are priced at the facility or non-facility fee schedule (with the exception of services performed at Ambulatory Surgery Centers, POS 24, which will be priced at the facility fee schedule).

Fee Change Updates. Updates to such fee schedule shall become effective on the date ("Fee Change Effective Date") that is the later of: (i) the first day of the month following thirty (30) days after publication by the governmental agency having authority over the applicable product of such governmental agency's acceptance of such fee schedule updates; or (ii) the effective date of such fee schedule updates, as determined by such governmental agency. Claims processed prior to the Fee Change Effective Date shall not be reprocessed to reflect any updates to such fee schedule.

Payment under this Exhibit. All payments under this Exhibit are subject to the terms and conditions set forth in the Agreement, the Provider Manual and the Billing Manual.

Definitions:

1. **Allowable Charges** mean those Provider billed charges for services that qualify as Covered Services

Note:

1. Except as modified or supplemented by this Attachment, the compensation set forth in this Exhibit for the provision of Covered Services to Covered Persons enrolled in or covered by the Commercial-Exchange Product is subject to all of the other provisions in the Agreement (including the Provider Manual) that affect or relate to compensation for Covered Services provided to Covered Persons.