CARESOURCE
PROVIDER AGREEMENT

THIS AGREEMENT is made and entered into as of the date set forth on the signature page of this Agreement ("Effective Date"), by and between CareSource Network Partners LLC, an Ohio limited liability company, on behalf of itself and its Affiliates ("CareSource"), and the undersigned health care provider ("Provider"). In consideration of the promises and mutual covenants set forth herein, the sufficiency of which is acknowledged by the Parties, the Parties agree as follows:

ARTICLE I. DEFINITIONS

The following terms, as used throughout the Agreement, its Exhibits, Attachments and Addenda, shall have the meanings set forth below:

1.01 **Affiliate**. With respect to a Party, any corporation, partnership, or other legal entity directly or indirectly owned or controlled by, which owns or controls, or that is under common ownership or control with, such Party.

1.02 **Agreement**. This CareSource Provider Agreement between Provider and CareSource, including all of the Attachments, Addenda, and Exhibits attached hereto.

1.03 **Base Agreement or Base Contract**. With respect to this Agreement, all of those terms and conditions in this Agreement aside from those in the State-Specific Attachments.

1.04 **CMS**. The Centers for Medicare and Medicaid Services.

1.05 **Claim.** Either the uniform bill claim form or electronic claim form in the format prescribed by CareSource submitted by a provider for payment by Payor for Health Services rendered to a Covered Person. A Claim can mean (a) a bill for Health Services rendered to a Covered Person; or (b) a line item of Health Services rendered to a Covered Person.

1.06 **Clean Claim or Complete Claim**. Unless otherwise defined by any applicable state law, rule or regulation (which definition then shall be controlling), a Claim submitted by a provider pursuant to this Agreement that can be processed and determined without obtaining additional information from the provider or from a third party and which does not involve coordination of benefits, third party liability or subrogation or any material defect or error that prevents timely adjudication. Neither a Claim from a provider who is under investigation for fraud or abuse nor a Claim under review for medical necessity is a Clean Claim or Complete Claim.

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

1.08 **Covered Person**. Any individual, or eligible dependent of such individual, whether referred to as "Insured," "Subscriber," "Member," "Participant," "Enrollee," "Dependent" or otherwise who is enrolled in one of CareSource's Health Benefit Plans and who is eligible to receive Covered Services.

1.09 **Covered Services**. Medically Necessary Health Services, as determined by CareSource, that are within the normal scope of services and registration or licensure of Provider and for which a Covered Person is entitled to receive coverage under the terms and conditions of a Health Benefit Plan.

1.10 **Credentialing/Recredentialing or Credentialed/Recredentialed**. CareSource's or its delegate's, as the case may be, process of gathering, verifying and evaluating information for the purpose of determining whether applicable health care practitioners and facilities comply with CareSource's Network participation standards or NCQA standards.

1.11 **Dispute**. Any dispute or controversy arising under, out of or in connection with or in relation to this Agreement or the breach of this Agreement.

1.12 **Emergency Admission**. An inpatient admission required to evaluate, treat, and stabilize an Emergency Medical Condition.

1.13 **Emergency Medical Condition.** As set forth in 42 U.S.C. §1395dd(e)(1), a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part; or with respect to a pregnant woman who is having contractions (i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or (ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.

1.14 **Emergency Services**. Inpatient services, outpatient services or medical transportation services furnished by a qualified provider and which are needed to evaluate, treat or stabilize an Emergency Medical Condition.

1.15 **Experimental or Investigational Services or Experimental or Investigational**. Medical, surgical, diagnostic, psychiatric, substance use disorders treatment or other Health Services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time CareSource makes a determination regarding coverage in a particular case, are determined to be any of the following: not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use; subject to review and approval by any institutional review board for the proposed use; the subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight (this includes diagnostic testing for purposes of possible inclusion in a clinical trial); or any Health Service billed with a temporary procedure code that is not designated as a Covered Service by CareSource.

1.16 **Health Benefit Plan**. The plan under which a Payor is obligated to provide coverage of Covered Services to Covered Persons, as defined in a plan's governing documents, including but not limited to a certificate of coverage, evidence of coverage, summary plan description, contract, or policy, whether in paper, electronic or other form.

1.17 **Health Services**. Those services or supplies that a health care provider is licensed, equipped, and staffed to provide and which such provider customarily provides to or arranges for individuals.

1.18 **Hospital.** An institution that provides to inpatients diagnostic, medical, surgical, obstetrical, psychiatric, or rehabilitation care for a continuous period longer than twenty-four hours and which is

classified as a "hospital" under applicable Laws.

1.19 Laws or Law. All applicable federal, state and local laws, statutes, regulations, decrees, and ordinances.

1.20 Medically Necessary/Medical Necessity. Health Services that a provider, 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 (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; (c) 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; and (d) are not Experimental or Investigational Services. For these purposes, "generally accepted standards of medical practice" means those standards utilized by CareSource 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. The above definition of Medically Necessary/Medical Necessity shall be inapplicable to the extent that a different definition is required by a Service Agreement or where a Law requires a different definition.

1.21 Network. A group of providers that supports, through a direct or indirect contractual relationship with CareSource, some or all of the Plan Programs and Health Benefit Plans in which Covered Persons are enrolled.

1.22 Network Notifications. The official means of communication regarding non-material changes related to Claims and/or reimbursement such as new coding edits, documentation requirements, accepted modifiers and other billing issues. Network Notifications are published a minimum of thirty (30) days in advance of the change and are located on the Provider website under the "Provider Materials" link. For purpose of this definition, "non-material changes" are those changes related to Claims and/or reimbursements that will not decrease Provider's payment or compensation or will not change the administrative procedures in a way that may reasonably be expected to significantly increase Provider's administrative expense.

1.23 Never Event. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients, as further defined by CMS at https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-Sheets/2006-Fact-Sheets-Items/2006-05-18.html or such other guidance issued by CMS.

1.24 Non-Covered Services. Health Services that are not Covered Services.

1.25 Overpayment. Any payment made by either Party for which the other Party had no entitlement or that portion of any payment made in excess of the amount due under this Agreement, including but not limited to amounts due under the applicable Attachments hereto.

1.26 Participating Provider. A health care professional or facility, including Provider, that has been Credentialed or approved by CareSource and entered into an agreement with CareSource to participate in the Network and to provide Covered Services to Covered Persons in accordance with CareSource requirements.

1.27 Participating Hospital. A Hospital which has entered into an agreement with CareSource and has been Credentialed with CareSource as a Hospital in which Participating Providers may provide

Covered Services to Covered Persons in accordance with CareSource requirements.

1.28 Party or Parties. Provider or CareSource, as the case may be, shall be individually referred to as a Party. Collectively, Provider and CareSource shall be referred to as the Parties.

1.29 Payor. An individual or entity obligated to a Covered Person to provide reimbursement for Covered Services under a Health Benefit Plan and authorized by CareSource to access Provider's services under this Agreement. With respect to Plan Programs and Health Benefit Plans offered by CareSource, the specific CareSource Affiliate that offers the applicable Plan Program or Health Benefit Plan shall be deemed the Payor for such Plan Program or Health Benefit Plan. Unless specifically set forth in this Agreement and mutually agreed upon by the Parties, CareSource shall be Payor under this Agreement.

1.30 Plan Compensation Schedule. The documents attached to and made part of this Agreement that set forth the rates, compensation and other related terms for the Network(s) in which Provider participates. The Plan Compensation Schedule may include additional Provider obligations and specific compensation related terms and requirements. If applicable, any value based reimbursement agreements agreed upon in writing by the Parties shall be included in the definition of Plan Compensation Schedule.

1.31 Plan Program. Any product or program now or hereafter established, marketed, administered, sold or sponsored by CareSource (and includes the Health Benefit Plans that access, or are issued, or entered into in connection with such program).

1.32 Policies and Protocols. Those policies, programs, protocols, and administrative procedures adopted by CareSource to be used by Provider in providing services and doing business with CareSource under this Agreement, including but not limited to CareSource's payment policies, Credentialing and Recredentialing processes, Utilization Management, Quality Improvement, peer review, fair hearing, Covered Person grievance process, or concurrent review.

1.33 Primary Care Provider or PCP. Primary Care Provider means (i) a physician with a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine who provides primary care services and who is a Participating Provider; (ii) a nurse practitioner, clinical nurse specialist, or physician assistant who provides primary care services; or (iii) any other individual or health care provider credentialed and contracted by CareSource, who contracts with CareSource to provide or arrange for the provision of all primary care Covered Services to Covered Persons, to initiate and manage referrals, and to maintain the continuity of Covered Persons' care, as required by the applicable Service Agreement. CareSource reserves the right to designate other specialties as PCPs when appropriate.

1.34 Provider Manual. A manual developed by CareSource and furnished to Participating Providers for the benefit of informing them of CareSource procedures, policies, requirements, rules and regulations which are amended or modified from time to time.

1.35 Provider Website. The online provider tool that providers should access through CareSource's website, as well as those other portions of CareSource's website containing resources, including but not limited to Network Notifications, for Participating Providers.

1.36 Quality Improvement. The processes established and operated by CareSource or its designee relating to the quality of Covered Services.

1.37 State-Specific Attachments. Those attachments included in this Agreement that address those certain terms and conditions that apply to the Plan Programs offered in a particular state. Each set of State-Specific Attachments includes the Plan Compensation Schedules applicable to the Plan Programs

offered in the corresponding state.

1.38 Underpayment. Any payment made by either party to the other party in an amount less than the amount due under this Agreement, including but not limited to amounts due under the applicable Attachments hereto.

1.39 Utilization Management. The processes to review and determine whether certain health care services provided or to be provided to Covered Persons are in accordance with CareSource policies and procedures.

ARTICLE II. PROVIDER OBLIGATIONS

2.01 Provision of Health Services. Provider shall make available to Covered Persons those usual and customary Covered Services that are offered within the scope of Provider's licensure and certification under applicable Laws and based on the qualifications determined by CareSource or its delegate. Provider shall provide Medically Necessary Covered Services to Covered Persons through the last day this Agreement is in effect or such other date as set forth in this Agreement or is required by Law, whichever is later. In providing Covered Services to Covered Persons, Provider agrees to be bound by and to abide by the terms of this Agreement, Exhibits, Attachments and Addenda hereto, and CareSource requirements as set forth in the CareSource Provider Manual. Provider is responsible to check for new or updated Network Notifications and comply with any changes outlined therein. With regard to the types of providers Credentialed by CareSource or its delegate as set forth in the CareSource Provider Manual, Provider will not allow non-Credentialed providers employed by Provider to serve Covered Persons unless they are Provider based providers that CareSource or its delegate does not Credential but who Provider has credentialed under in accordance with NCQA standards, or such other industry standards acceptable to CareSource or its delegate, applicable to the provider's specialty; in which case, Provider shall indemnify and hold CareSource or its delegate harmless should such a non-Credentialed provider serve a Covered Person. If applicable, Provider shall actively educate Covered Persons concerning appropriate follow-up and self-care.

2.02 Policies and Protocols. Provider agrees to comply with CareSource's Policies and Protocols and to cooperate with CareSource with respect to its payment, quality assurance, quality improvement, accreditation, risk management, utilization review, utilization management, clinical trial, Credentialing/Recredentialing processes and other administrative policies and procedures, if applicable, established and revised from time to time. CareSource shall communicate changes to CareSource requirements to Provider in a timely manner. Except as prohibited by Law, CareSource may conduct such communications by posting to its Provider Website. Provider is responsible for regularly monitoring CareSource's Provider Website which shall contain the Provider Manual, important updates, payment policies, and Policies and Protocols. Provider shall also be responsible for checking new or updated Network Notifications and comply with any changes outlined.

2.03 Covered Person Status. To determine whether an individual is a Covered Person entitled to receive Covered Services, Provider shall ask the individual to present his or her identification card and such other information necessary to validate Covered Person's identity. CareSource shall establish a verification system through which Provider may verify whether a person seeking Health Services is a Covered Person. Provider shall be responsible for verifying that an individual is a Covered Person. Provider acknowledges that such eligibility information is subject to change retroactively (1) if CareSource does not receive proper and timely notification regarding termination of a Covered Person's coverage; (2) as a result of a final decision about a Covered Person's continuation of coverage pursuant to Law; or (3) if eligibility information is later proven to be false. If CareSource subsequently determines

that the individual was not eligible for coverage for the Health Services rendered, those Health Services shall be considered Non-Covered Services not eligible for payment by CareSource. If Provider provides Health Services to an individual and it is later determined that the individual was not a Covered Person, then Provider may directly bill the individual for such Health Service. If CareSource determines that the individual was not eligible for coverage for the Health Services rendered after payment has already occurred, CareSource will follow the procedures set forth in Section 5.12.

2.04 Rights of Covered Persons. Neither Provider nor any assistant or employee of Provider shall discriminate in violation of any Law in the treatment of Covered Persons or in the quality, quantity, or type of Health Services delivered to Covered Persons on the basis of race, gender, age within the scope of Provider's care, marital status, disability, color, national origin, ancestry, religion, sex, health status, sexual preference, Vietnam-era veteran's status or presence of handicap, source of payment, or need for Health Services. Provider will observe, protect and promote the rights of Covered Persons as patients. Provider will comply with any Laws regarding the right of Covered Persons to make decisions regarding medical care. If CareSource, at any time, determines that a Covered Person's health or safety is in jeopardy by remaining with Provider, CareSource shall arrange for immediate transfer of the Covered Person to another Participating Provider or Participating Hospital, as the case may be. Provider acknowledges that (a) Covered Persons have a right to be treated with respect and recognition of their dignity and need for privacy; (b) Covered Persons have a right to participate in decision-making regarding their treatment planning; and (c) Covered Persons have a right to voice complaints or appeals about Provider or the care provided.

2.05 Provider Locations and Affiliates. Provider agrees to provide Covered Services only through those Affiliates listed on Exhibit A of this Agreement. The Parties agree that an Affiliate of Provider shall not be added to the definition of Provider under this Agreement unless and until the Parties agree in writing that such Affiliate is bound to the terms of this Agreement.

2.06 Compliance with Laws. Provider shall perform its duties, and shall cause its employees, agents, and independent contractors to perform their duties, in accordance with all applicable Laws, standards of professional ethics and practices, and contractual obligations of CareSource. If Provider is a laboratory testing site or provides laboratory services to Covered Persons, Provider must maintain a Clinical Laboratory Improvement Amendment ("CLIA") Certificate of Waiver, Certificate of Accreditation, or a Certificate of Registration along with a CLIA identification number.

2.07 Professional Credentials: Licensure. Provider and all health care professionals employed by or under contract or acting as independent contractors for or with Provider to render Covered Services hereunder on behalf of Provider shall:

(a) be duly licensed, certified, or registered to perform such services and in good standing under applicable state and federal statutes and regulations;

(b) to the extent applicable, comply with the requirements of and maintain continuous participation in the Medicaid program and the Medicare program;

(c) provide Covered Services with the same standard of care, skill, and diligence customarily used by similar providers in the community in which such services are rendered and in accordance with nationally accepted standards of care; and

(d) render Covered Services in the same manner in accordance with the same standards, and with the same availability as offered to individuals who are not Covered Persons.

At any time during the term of this Agreement, Provider shall, upon request of CareSource, provide CareSource with evidence that Provider meets the criteria described in this Agreement and by CareSource's Credentialing/Recredentialing policies and procedures. Credentialing/Recredentialing will be repeated on a periodic basis. Credentials will be collected by CareSource and evaluated by CareSource's designated credentials or quality improvement committee(s).

2.08 **Notice by Provider**. Provider shall give CareSource written notice of any of the following within five (5) business days after its occurrence:

(a) the suspension, revocation, condition, limitation, qualification or other restriction on Provider's license, registration, certification or permit ("License") required to perform Provider's duties under this Agreement by any state in which Provider is authorized to provide Health Services;

(b) the suspension, revocation, condition, limitation, qualification or other restriction on the License of a health professional employed or contracted by Provider to perform services on behalf of Provider pursuant to this Agreement by any state in which such individual is authorized to provide Health Services;

(c) any malpractice action in which Provider or any employee of Provider who provides Health Services pursuant to this Agreement has been named as a defendant and which results in an adverse decision;

(d) commission or omission of any act or any misconduct or allegation of misconduct for which Provider's license, certification, or accreditation may be subject to revocation or suspension whether or not actually revoked or suspended;

(e) Provider is otherwise disciplined by any licensing, regulatory, professional entity or any professional organization with jurisdiction over Provider;

(f) criminal indictment for any act or omission by Provider; or

(g) filing of voluntary or involuntary bankruptcy of Provider or Provider being placed in receivership; or exclusion from or loss of good standing in the Medicaid or Medicare program.

2.09 **In-Network Referrals and Transfers**. Provider shall use its best efforts when medically appropriate to refer Covered Persons to Participating Providers within the Network.

2.10 **Liability Coverage.** Throughout the term of this Agreement, Provider shall maintain and provide proof of professional liability and comprehensive general and/or umbrella liability insurance acceptable to CareSource, and other insurance as necessary to protect Provider and its agents, officers, directors, trustees, members and employees acting within the scope of their duties against any claim or claims. Provider shall notify CareSource not more than five (5) days after receipt of notice of any reduction, cancellation, or non-renewal of such coverage. Provider shall also give CareSource prompt written notice of all complaints involving Covered Persons that are filed with any court alleging misconduct or unlawful discrimination on the part of Provider and/or any health professional employed by, agent of or independent contractor of Provider and which result in an adverse decision. CareSource shall maintain insurance of the nature and in the amounts as may be required by Law. CareSource and Provider may satisfy this paragraph by self-insurance programs which are lawful in structure and amounts of retained limits.

2.11 **Grievance System**. CareSource shall maintain and administer a grievance system for Covered

Persons. Complaints received by CareSource concerning services rendered by Provider and/or its employees will be resolved in accordance with the grievance procedure. Provider agrees to cooperate with CareSource in the resolution of complaints made by Covered Persons and comply with all final determinations made by CareSource. A copy of the grievance procedure shall be made available to Provider by CareSource.

2.12 CareSource Access to Covered Persons. When a Covered Person's medical condition permits, Provider, to the extent applicable and allowed by Law, agrees to allow CareSource or its representatives access to the Covered Person or a person acting on behalf of the Covered Person to discuss CareSource benefits, discharge planning, follow up care and other pertinent CareSource processes or requirements.

2.13 Accessibility. Provider agrees to keep reasonable office hours or facility hours for Covered Persons for elective services and agrees to either be available for emergency needs or have a covering provider on call twenty-four (24) hours per day, seven (7) days per week. Provider agrees to provide Covered Persons with access to Covered Services without undue delay and as soon as necessary in light of the Covered Person's medical condition. Provider shall provide coverage arrangements with providers who are Participating Providers in accordance with CareSource policies and procedures unless otherwise approved in advance by CareSource.

2.14 Quality Improvement, Credentialing/Recredentialing, and Utilization Management. Provider agrees to cooperate with, participate in, and comply with the requirements of CareSource's Quality Improvement, Credentialing–Recredentialing, and Utilization Management programs. Provider agrees that CareSource may use Provider's performance data for CareSource's Quality Improvement activities. Upon reasonable notice and at reasonable hours, CareSource or its agents may inspect Provider's premises and operations to ensure that such premises and operations are appropriate to meet Covered Persons' needs and to comply with quality assurance guidelines. Provider shall notify CareSource immediately after the initiation of any complaint, inquiry, investigation, or review with or by any licensing or regulatory authority, peer review organization, Provider committee, or other committee, organization or body which reviews quality of medical care if such action involves or is related to a Covered Person. Further, Provider shall immediately notify CareSource after it has been determined that the basis for any such complaint, inquiry, investigation, or review is substantiated (an adverse outcome). Provider acknowledges that CareSource may delegate Credentialing/Recredentialing to another entity.

ARTICLE III. SPECIFIC PROVISIONS FOR WHEN PROVIDER IS A HOSPITAL

3.01 **Accreditation**. If Provider is a Hospital, then Provider shall, on the Effective Date and through the term of this Agreement, be accredited by The Joint Commission, the American Osteopathic Association, or another comparable accreditation organization approved in writing by CareSource. Upon written request, Provider agrees to share accreditation survey findings with CareSource and all documentation of correction of sustained contingencies.

3.02 **Chargemaster**. In the event that Provider is a Hospital, Provider shall provide CareSource with a minimum of sixty (60) days prior written notice of any proposed increases to Hospital's Chargemaster ("Increase Notice"). CareSource shall have thirty (30) days to respond to the Increase Notice and open negotiations with Hospital.

3.03 **Provider's Referrals and Transfers to Participating Hospitals**. In the event that Provider is a Hospital and a Covered Person requires Health Services that are not available at such Hospital, the Provider may transfer Covered Person to another Participating Hospital after obtaining a written transfer order by the attending physician and prior authorization by CareSource; provided, however, that such prior authorization shall not be required in the event that the services necessitating transfer require an Emergency Admission by the receiving Participating Hospital. Provider agrees to notify CareSource promptly, but in any event within twenty-four (24) hours or the next business day, whichever is sooner, of any such emergency transfer not pre-authorized by CareSource (or its designee), even if CareSource appears not to be the applicable payor.

3.04 **Pre-Admission Authorization**. In the event that Provider is a Hospital, then Provider must obtain prior authorization from CareSource before all inpatient admissions and services except Emergency Admissions and before furnishing any of the outpatient services specified in CareSource's Provider Manual or on the Provider Website as requiring prior authorization. If Provider fails to obtain prior authorization from CareSource prior to any non-emergency inpatient admission or services, or prior to rendering outpatient service for which prior authorization is required, then Provider shall not seek payment from CareSource or Covered Persons for such non-emergency admission or services, and neither CareSource nor any Covered Person will be required to pay for such non-emergency admission or services.

3.05 **Emergency Services**. In the event that Provider is a Hospital, then Provider shall provide Emergency Services to Covered Persons seven (7) days per week, twenty-four (24) hours per day, three hundred sixty-five (365) days per year. Provider agrees to provide a copy of an emergency visit medical record regarding a Covered Person to the Covered Person's PCP within two (2) weeks of discharge. The Provider shall provide medical screening exams consistent with the Emergency Medical Treatment and Active Labor Act (EMTALA) (42 U.S.C. §1395 dd(a)), and stabilize the Covered Person in all cases. Prior Authorization is not required prior to providing Emergency Services, for which the Provider will be paid according to the Attachments hereto. If the Covered Person requires non-Emergency Services that arise out of the screening assessment, Provider shall request and receive prior authorization for such non-Emergency Services prior to providing or arranging for the provision of such non-Emergency Services.

3.06 **Emergency Admissions**. In the event that Provider is a Hospital, then Provider agrees to notify CareSource promptly, but in any event within twenty-four (24) hours or the next business day, whichever is sooner, of any Emergency Admission and of any other admission not pre-authorized by CareSource (or its designee), even if CareSource appears not to be the applicable payor. In the event Provider fails, other than because of any act or omission of CareSource, to notify CareSource of an admission, neither CareSource nor any Covered Person will be required to pay for the Covered Services rendered prior to the time of CareSource's notification by Provider.

ARTICLE IV. CARESOURCE OBLIGATIONS

4.01 **Discussion with Covered Persons**. CareSource agrees not to prevent Provider and its employees from discussing all treatment options with Covered Persons, including options that may not reflect CareSource's position or options that may not be Covered Services.

4.02 **Description of Covered Services**. CareSource shall provide Provider with notice of those Covered Services covered by CareSource and for which Provider is responsible for providing to Covered Persons. Such descriptions shall be made available through the Provider Website, Provider portal, the Provider Manual, Policies and Protocols, and other methods of communication as deemed appropriate by CareSource. CareSource shall also provide Provider with a method for verifying whether a Health Service is a Covered Service and whether limitations and conditions apply to a Covered Service.

4.03 **Statutory Responsibility.** CareSource and its Affiliates have the statutory responsibility to monitor and oversee the offering of Covered Services to Covered Persons.

ARTICLE V. CLAIMS AND PAYMENTS

5.01 **Form and Content of Claims.** Provider shall submit Claims for Covered Services in a format and manner prescribed by CareSource. Unless otherwise directed by CareSource, Provider shall submit Claims in accordance with applicable CMS and HIPAA requirements. Provider will use best efforts to utilize electronic submission for all of its Claims under this Agreement for which CareSource accepts electronic submission.

5.02 **Time to File Claims**. With respect to all Covered Services provided to Covered Persons by Provider, Provider shall submit Complete Claims within the time frames set forth on the applicable State-Specific Attachment(s).

5.03 **Payment of Claims**. CareSource will pay Claims for Covered Services in accordance with the applicable Plan Compensation Schedule(s). Claims for Covered Services subject to coordination of benefits will be paid in accordance with the Provider Manual and those Policies and Protocols related to coordination of benefits.

5.04 **Timing of Payment of Claims.** CareSource shall adjudicate or arrange for adjudication and where appropriate make payment for Complete Claims within the time frames set forth on the applicable State-Specific Attachment and/or Exhibit B in the case of a Medicare Advantage Plan Program.

5.05 **Payment in Full and Cost Shares**. Provider agrees to accept as payment in full, in all circumstances, the compensation rates set forth in the Plan Compensation Schedule(s) whether such payment is in the form of a Cost Share, a payment by CareSource, or payment by another source, such as

through coordination of benefits or subrogation. Provider shall bill, collect, and accept as compensation the Cost Shares owed by Covered Persons. Provider agrees to make reasonable efforts to verify Cost Shares prior to billing for such Cost Shares. In no event shall CareSource be obligated to pay Provider or any person acting on behalf of Provider for Health Services that are not Covered Services, or any amounts in excess of the amounts set forth in the Plan Compensation Schedule(s) less Cost Shares or payment by another source, as set forth above. Notwithstanding the foregoing, Provider agrees to accept the compensation rates set forth in the Plan Compensation Schedule(s) as payment in full from CareSource even if the Covered Person has not yet satisfied his or her deductible.

5.06 Non-Covered Services. CareSource has no obligation under this Agreement to compensate Provider for Non-Covered Services or for Health Services rendered to individuals who are not Covered Persons. If Provider renders Health Services to an individual who, on the date of service, is not a Covered Person, Provider may bill that individual directly for those Non-Covered Services. Provider may bill Covered Persons for Non-Covered Services only in accordance with Section 5.08 of this Agreement. Any payments for Claims made with regard to such Non-Covered Services may be recovered by CareSource as overpayments under the process described herein to the extent permitted by law.

5.07 Coordination of Benefits. Provider agrees to cooperate with CareSource regarding subrogation and coordination of benefits, as set forth in the Provider Manual and the Policies and Protocols. Provider agrees to notify CareSource promptly after receipt of information regarding any Covered Person who may have a Claim involving subrogation or coordination of benefits.

5.08 Covered Persons Held Harmless. Provider agrees that in no event, including but not limited to nonpayment by CareSource, insolvency of CareSource, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against a Covered Person or person acting on behalf of the Covered Person, if Covered Services were provided pursuant to this Agreement. This does not prohibit Provider from collecting Cost Shares for Covered Services if specifically required by the Health Benefit Plan or from collecting fees for Non-Covered Services delivered on a fee-for-service basis to Covered Persons referenced above, nor from any recourse against CareSource or its successor. Provider shall not deny services to any Covered Person due to said Covered Person's non-payment of a Cost Share. Provider agrees that, in order to seek payment from a Covered Person or person acting on behalf of the Covered Person for Non-Covered Services delivered on a fee-for-service basis to the Covered Person, Provider must, in advance of providing said Non-Covered Services, give the Covered Person written notice, and have the Covered Person acknowledge his or her receipt in writing, that the Health Services at issue are Non-Covered Services and that the Covered Person will be responsible for payment of such Non-Covered Services. Provider agrees that the hold harmless provisions, warranties and protections set forth in this paragraph shall (a) survive the termination of this Agreement regardless of the cause giving rise to the termination, and (b) supersede all oral and/or written contracts and agreement heretofore or hereafter entered into between Provider, CareSource and Covered Persons or persons acting on their behalf.

5.09 Determination of Payment. Provider agrees that referrals, notifications and authorizations are not determinations or representations that an individual is or will continue to be a Covered Person, that the services requested are Covered Services for which benefits will be payable, or that CareSource or Payor guarantees payment. An authorization is a determination of whether a Health Service is Medically Necessary only and is subject to re-determination if the information submitted to CareSource to obtain the authorization was materially incomplete or inaccurate at the time it was provided.

5.10 Claim Denial Appeals. Appeals of Claims denied by CareSource shall be submitted in writing by Provider to CareSource by the last of the following: (a) within three hundred and sixty five (365) days from the date of service, (b) within three hundred and sixty five (365) days from the date of discharge, or

(c) if CareSource is not the primary payer and Provider is pursing payment from the primary payer, within ninety (90) days from the date in which Provider receives an explanation of payment from the Covered Person's primary payer. An appeal in which Provider was denied authorization or reimbursement due to not obtaining a required prior authorization may be submitted, with or without the related Claim, by the last of the following: (a) within one hundred eighty (180) days from the date of service, (b) within one hundred and eighty (180) days from the date of discharge, or (c) if CareSource is not the primary payer and Provider is pursing payment from the primary payer, within ninety (90) days from the date in which Provider receives an explanation of payment from the Covered Person's primary payer. CareSource's Appeals Committee or its designee will render a decision in accordance with applicable regulatory requirements.

5.11 Reviews and Audits. The following provisions apply to reviews and audits conducted by CareSource.

(a) CareSource shall have the right to review Provider's Claims prior to payment for appropriateness in accordance with industry standard billing rules, applicable rules and regulations, and CareSource's payment policies. Such standard billing rules include, but are not limited to: CPT and HCPCS coding; UB manual and editor; CMS rules, including bundling/unbundling rules and multiple procedure billing rules; NCCI Edits; and FDA definitions and determinations of designated implantable devices, implantable orthopedic devices, and specialty pharmacy. Reviews may be conducted either on a line-by-line basis or other basis that CareSource deems appropriate. Based upon the standards described herein, CareSource shall have the right to exclude inappropriate line items, adjust payment and reimburse Provider at the revised level.

(b) CareSource shall have the right to conduct concurrent and retrospective reviews to determine Medical Necessity and to conduct post-payment billing audits. The purposes for which CareSource may conduct such audits and the issues and topics that may be addressed include, but are not limited to: the performance and discharge of any and all of CareSource's obligations with respect to program integrity or other CareSource contract requirements; performance and implementation of CareSource's compliance plan; the detection and prevention of fraud, waste, and abuse; implementation and evaluation of CareSource's False Claims Act Policy; Provider's coding and claims practices; the performance of Quality Improvement and Utilization Management; determination of the accuracy of facts that were necessary and relied upon by CareSource in determining whether services were Medically Necessary; performance and discharge of any and all of CareSource's legal obligations with respect to the collection and reporting of data including, but not limited to, HEDIS requirements; ensuring that Provider meets professionally recognized standards for health care and medical practice; the quantity, quality, appropriateness and timeliness of services performed and care provided to Covered Persons under this Agreement; reconciliation of benefit liabilities; determination of amounts payable for Covered Persons' care; coordination of benefits; and identifying Overpayments, Underpayments and errors in billing or payment.

(c) CareSource shall have the right to conduct utilization reviews to determine Medical Necessity and conduct post-payment billing audits. Such CareSource audits may include evaluating, inspecting, copying and/or obtaining extracts of any books, contracts, medical records, patient care documentation, Claims, payment and other financial data and records that pertain to any aspect of Health Services performed for Covered Persons. Such records shall be maintained and access shall be permitted for the period of at least ten (10) years following termination of this Agreement or from the date of completion of any audit conducted pursuant to this Section 5.11, whichever is later. CareSource shall use established industry claims adjudication and/or clinical

practices, state and federal guidelines, and/or CareSource's policies and data to determine the appropriateness of the billing, coding and payment. Provider shall cooperate with CareSource's audits of Claims and payments by providing access to requested Claims information, all supporting medical records, and other related data referenced above and requested by CareSource within thirty (30) days of the request.

(d) Each Party shall inform the other within sixty (60) days after discovery of any Overpayment or any Underpayment and both parties shall take prompt and effective measures to remedy such Overpayment or Underpayment. A Party may recover an Overpayment only if that Party demands repayment, recoupment or offset of the Overpayment within two (2) years after the other Party's receipt of the Overpayment in question. Either Party may recover funds necessary to correct an Underpayment only if that party demands payment of such funds within two (2) years after that Party's receipt of the payment that resulted in the Underpayment in question. CareSource reserves the right to withhold or off-set Overpayments against future Claim payments to Provider by CareSource to the extent permitted by law and as further defined in Section 5.12. This provision does not apply to late submission of Claims.

(e) Termination of this Agreement shall not terminate or otherwise limit either party's rights under this Section.

5.12 **Adjustments for Overpayments**. Unless prohibited by Law, Provider shall refund all duplicate or erroneous Claim payments regardless of the cause. If CareSource determines that an Overpayment has been made to Provider, CareSource will notify Provider of such Overpayment and the Provider may refund any due amounts by check within thirty (30) days. If Provider does not remit payment to CareSource within thirty (30) days, CareSource may off-set such payment against future Claim payments owed to Provider by CareSource to the extent permitted by applicable Law.

5.13 **Never Events**. Notwithstanding any provision in this Agreement to the contrary, when any Never Event occurs with respect to a Covered Person, the Provider shall neither bill, nor seek to collect from, nor accept any payment from CareSource or Covered Person for such events. If Provider receives any payment from CareSource or Covered Person for a Never Event, it shall refund such payment to the person or entity making the payment within ten (10) business days of becoming aware of such receipt. Further, Provider shall cooperate with CareSource, to the extent reasonable, in any CareSource initiative designed to help analyze or reduce such Never Events.

5.14 **False Claims**. Any falsification or concealment of material fact made by Provider when submitting Claims may be prosecuted under Law. Provider shall comply with all requirements of Section 6032 of the Deficit Reduction Act of 2005, as codified by Section 1902(a)(68) of the Social Security Act. Provider shall adopt CareSource's False Claims Act Policy, a copy of which is available on CareSource's Provider Portal.

ARTICLE VI. INFORMATION AND RECORDS

6.01 **Confidentiality**. Provider acknowledges and agrees that all information relating to CareSource's Quality Assurance, Utilization Management, risk management, Policies and Protocols, this Agreement, including rates of compensation payable under this Agreement and all other information related to CareSource's programs, policies, protocols and procedures, is proprietary information. Provider shall not disclose any such information to any person or entity without CareSource's express written consent.

6.02 **Records**. CareSource and Provider agree that clinical records of Covered Persons shall be regarded as confidential and both shall comply with all applicable Laws regarding such records. Provider shall be responsible for obtaining Covered Persons' consent for release of medical record information by Provider when such consent is required by Law. Provider shall:

(a) maintain and furnish such records and documents as may be required by regulators, CMS or their designees, or by Laws and CareSource requirements. Provider shall cooperate with CareSource to facilitate the information and record exchanges necessary for the Quality Improvement Program, Credentialing-Recredentialing, Utilization Management, peer review, transfer of records to new providers, and other programs required for CareSource operations;

(b) provide CareSource or its designee with access during regular business hours and upon reasonable notice to specified clinical and medical records of all Covered Persons maintained by Provider. CareSource shall have access to records for the period of at least ten (10) years following termination of this Agreement, from the date of completion of any audit or as long as required by Law, whichever is later;

(c) provide CareSource or its designee copies of such records at no cost as may be required by CareSource or as may be requested for purposes of any audit required by Law or accreditation organizations;

(d) place any and all advance directives in a prominent place within the Covered Person's medical record;

(e) provide Covered Persons with timely access to their own clinical records in accordance with Laws;

(f) share information about Covered Persons with other providers in a confidential manner, using adequate privacy and security mechanisms to send and receive Covered Persons' information and otherwise in accordance with Laws;

(g) in the event that a Covered Person is transferred to another provider, transmit copies of all records regarding such Covered Person to CareSource or the provider assuming the responsibility for care of the Covered Person, within ten (10) days of the request for records; and

(h) at all times, maintain records pertinent to the provision of Covered Services in an accurate and timely manner.

6.03 **HIPAA**. Provider agrees to comply with the United States Department of Health and Human Services ("HHS") issued regulations on "Privacy Standards for Individually Identifiable Health Information" and "Security Standards for the Protection of Electronic Protected Health Information," implementing the Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. Parts 160 through 164 ("the Privacy and Security Standards") and all other provisions of the Health Insurance Portability and Accountability Act of 1996, as amended by the Health Information Technology for Economic and Clinical Health Act and its implementing regulations, and as thereafter amended.

6.04 **Access to Data**. Provider and CareSource represent that in conducting their operations, they shall each collect, share and review certain quality and clinical data. The Parties will work together in good faith to share such data with one another through health insurance exchanges (HIEs) (when applicable) in furtherance of quality of care. In the absence of an option to share clinical data via HIEs, direct electronic medical record system (or equivalent) will suffice. Within three (3) months of the Effective Date, the Parties shall use their best efforts to initiate and implement a process whereby Provider and CareSource will share clinical data through the methods described above, with such process developed in accordance with state and federal law.

6.05 **Use of the Name.** Provider agrees that Provider's name, office locations, office telephone numbers, addresses, specialties, board certifications, hospital affiliations, and other demographic information may be included on Payor's Website, in CareSource's provider directories or provider look-up tool, or such other written or electronic literature distributed to existing or potential Covered Persons, Participating Providers, and Payors. Provider's use of CareSource's name shall be upon prior written approval or as the Parties may agree; provided, however, that Provider may use CareSource's name to advise the public that Provider is a Participating Provider. Any use of Provider's name other than listed shall be upon prior written approval or as the Parties may agree.

6.06 **Release of Information**. Provider consents to the release of information from any person, institution, organization or entity which does or may maintain records of additional information and/or information which will validate responses on the CareSource Provider Application Form. Provider agrees to hold harmless any person or entity furnishing such information.

ARTICLE VII. RELATIONSHIP OF PARTIES

7.01 **Independent Contractor**. This Agreement is not intended to create nor shall it be construed to create any relationship between CareSource and Provider other than that of independent entities contracting for the purpose of effecting provisions of this Agreement. Neither Party nor any of their representatives shall be construed to be the agent, employer, employee, partner, member of joint venture, or representative of the other.

7.02 **Medical Independence**. Nothing in this Agreement, including Provider's participation in the Quality Improvement Program and Utilization Management process shall be construed to interfere with or in any way affect Provider's obligation to exercise independent medical judgment in rendering Health Services to Covered Persons. Provider understands and agrees that payments made directly or indirectly to Provider by CareSource under the terms of this Agreement are not, in any way, intended as an inducement to reduce or limit Provider's provision of Medically Necessary Services to any Covered Person and that Provider shall not reduce or limit its provision of Medically Necessary Services to any Covered Person.

7.03 **Physicians, Assistants, Employees, and Equipment.** At Provider's sole expense, Provider may

employ, subcontract, and use assistants and employees that are necessary to provide Covered Services to Covered Persons. Provider shall not employ or contract with any individuals who have been debarred or excluded by any State or Federal agency. CareSource may not control, direct, or supervise Provider's assistants or employees in the provision of Covered Services, but Provider shall ensure that all applicable individuals undergo rigorous Credentialing/Recredentialing and oversight under applicable standards, and services provided by them shall comport with CareSource's utilization review/quality management processes. Provider shall supply all necessary equipment and supplies required to provide Covered Services.

ARTICLE VIII. TERM AND TERMINATION

8.01 **Term of Agreement**. This Agreement shall begin on the Effective Date and shall continue from year to year on the anniversary of the Effective Date thereafter, unless terminated as set forth below.

8.02 **Termination for Material Breach**. Either Party to this Agreement may terminate this Agreement due to a material breach of the terms of this Agreement by the other Party, provided that such breaching Party fails to cure such breach within thirty (30) days of receipt of a written notice of breach from the non-breaching Party.

8.03 **Termination for Cause**. Either Party to this Agreement may terminate this Agreement immediately for cause. Such termination shall be effective as of the date on which the terminating Party provides a termination notice to the non-terminating Party in accordance with the notice provisions set forth in Section 11.09 herein. For purposes of this Section 8.03, "for cause" shall mean:

(a) habitual neglect or continued failure by either Party to perform its duties under this Agreement which affects the quality of care being delivered to the Covered Person;

(b) any material misrepresentation or falsification of any information submitted by Provider to CareSource including but not limited to billing information or information set forth in CareSource's Credentialing or Recredentialing application;

(c) commission or omission of any act or any misconduct or allegation of misconduct for which Provider's license, certification, or accreditation may be subject to revocation or suspension whether or not actually revoked or suspended, or if Provider is otherwise disciplined by any licensing, regulatory, professional entity or any professional organization with jurisdiction over Provider;

(d) the occurrence of or criminal indictment for any act or omission by Provider that is determined by CareSource or Payor to be detrimental to the reputation, operation or activities of CareSource or Payor;

(e) failure of Provider or CareSource to maintain required liability coverage protection;

(f) commission or omission of any act or conduct by Provider or its employees which is deemed by CareSource or its designee to be detrimental to a Covered Person's health or safety; or that represents an imminent danger to a Covered Person or to the public health, safety, or welfare;

(g) the occurrence of any act or omission which involves fraud, dishonesty or moral turpitude whether or not in Provider or a Provider employee's professional capacity;

(h) if any court or governmental agency determines that one of the Parties is operating in violation of any law or regulation, or otherwise orders that the Party cease operation;

(g) applicable Laws require the deletion of any provision of the Agreement which, if deleted, would destroy the underlying purpose of the Agreement;

(i) the other Party loses or ceases to maintain any license, qualification, authorization, accreditation, regulatory approval or certification necessary to perform its obligations under this Agreement; or

(j) the other Party or any successor in interest declares bankruptcy, becomes insolvent, or makes an assignment for the benefit of its creditors.

8.04 Termination Without Cause. Either Party to this Agreement may terminate this Agreement without cause upon one hundred twenty (120) days prior written notice by the terminating Party to the other Party. In the event of such termination, Provider acknowledges that CareSource may determine that Provider is not necessarily entitled to the payment of any or all withheld monies maintained in reserve, if applicable.

8.05 Date of Agreement's Termination. Termination of this Agreement shall be actuated pursuant to the mandatory notice periods set forth in this Article.

8.06 Termination of Attachments and Amendments. Attachments and Amendments may be terminated individually by Amendment as provided in this Agreement. Termination of any individual Attachment or Amendment will not have the effect of terminating the entire Agreement and all remaining Attachments and Amendments of this Agreement will remain in full force.

8.07 Effect of Termination on Credentialed Status. Upon termination of this Agreement for any reason, Provider's Credentialed status with CareSource shall be revoked, effective as of the date of such termination.

8.08 Rights and Obligations Upon Termination. Upon termination of this Agreement for any reason, the rights of each Party hereunder shall terminate, except as provided in any Amendment to this Agreement. Any such termination, however, shall not release Provider or CareSource from obligations under this Agreement prior to the effective date of termination. Provider agrees to provide Covered Services to Covered Persons through the last day of this Agreement and accept payment from CareSource, pursuant to this Agreement, through the day of termination of this Agreement. Upon termination of this Agreement, unless terminated for reasons related to quality of care or fraud, the Provider shall continue to provide Covered Services pursuant to this Agreement to Covered Persons who are receiving care from the Provider at the time of such termination until the earlier of the following: (i) sixty (60) days following the termination of this Agreement; or (ii) in the event that Provider is a Hospital, the date that the Covered Person is released from inpatient status at the Hospital. CareSource shall, at its discretion or as required by State or Federal requirements, notify Covered Persons that Provider is no longer a Participating Provider. During this continuation of care period, the Provider shall agree to continue accepting the terms and conditions of this Agreement, together with applicable deductibles and copayments, as payment in full; and is prohibited from billing the Covered Person for any amounts in excess of the Covered Person's applicable deductible or copayment. Provider, upon termination of this Agreement, shall promptly supply all records necessary for the settlement of outstanding medical bills. Provider agrees to transfer copies of Covered Persons' medical records to the new Participating Provider within ten (10) days following notification being given to Provider of such new Participating Provider, if applicable. This section shall survive the termination of this Agreement.

8.09 **Continuance of Care-Insolvency**. In the event of CareSource's insolvency or other cessation of operations, Provider agrees to continue to provide Covered Services to Covered Persons as needed to complete Medically Necessary procedures commenced but unfinished at the time of CareSource's insolvency or other cessation of operations. The completion of a Medically Necessary procedure commenced but unfinished at the time of CareSource's insolvency or cessation of operations includes the rendition of all Covered Services that constitute Medically Necessary follow-up care for that procedure. If Provider is a Hospital and a Covered Person is receiving Medically Necessary inpatient care at such Hospital at the time of CareSource's insolvency or other cessation of operations, Provider agrees to continue to provide Covered Services to the Covered Person as needed to complete Medically Necessary care until the Covered Person is discharged from Hospital or until there is a determination by the Covered Person's attending physician that inpatient care is no longer medically indicated for the Covered Person. However, nothing in this provision precludes CareSource from engaging in utilization review as described in the Covered Person's Health Benefit Plan. Provider is not required to continue to provide any Covered Services after the occurrence of any of the following: (1) the end of the Covered Person's period of coverage for which the premium has been paid; (2) the end of the thirty (30) day period following the entry of a liquidation order under applicable law; (3) the Covered Person obtains equivalent coverage with another payor, or the Covered Person's employer obtains such coverage; (4) the Covered Person or the Covered Person's employer terminates coverage under the contract; and (5) a liquidator effects a transfer of CareSource's obligations under the contract under applicable law. This provision shall survive termination of this Agreement, regardless of the reason for termination, including insolvency of CareSource, and shall be for the benefit of Covered Persons.

8.10 **Summary Suspension**. In accordance with CareSource's Fair Hearing Plan, the President and Chief Executive Officer of CareSource, in consultation with CareSource's Chief Medical Officer, shall have the power to enter a summary suspension of a Participating Provider or Participating Hospital, effective immediately. In the event of a summary suspension, the Provider shall have the rights afforded it under the Fair Hearing Plan.

ARTICLE IX. INDEMNIFICATION AND LIMITATION OF LIABILITY

9.01 **Indemnification.** CareSource and Provider shall each indemnify, defend, and hold harmless the other Party and 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 violation of any Law, order, standard of care, rule or regulation or from the indemnifying Party's performance or non-performance of this Agreement. 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 fault or imposes any restrictions or obligations on an indemnified Party without that indemnified Party's prior written consent which shall not be unreasonably withheld, and cooperating fully with the indemnifying Party in connection with such defense and settlement.

9.02 **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, exemplary, 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 (collectively referred to as "Consequential Damages"). Further, in no event shall CareSource be liable to Provider for any extra contractual damages relating to any claim or cause of action assigned to Provider by any person or entity.

9.03 Period of Limitations. Unless otherwise provided for in this Agreement, neither Party shall commence any arbitration, proceeding, or special proceeding against the other to recover on any claim arising out of this Agreement more than two (2) years after the event(s) which gave rise to such claim, unless compliance with this section would compel a Party to violate the terms of the Health Benefit Plan. The deadline for initiating an action shall not be tolled by the appeal process or any other administrative process.

ARTICLE X. DISPUTE RESOLUTION AND GOVERNING LAW

10.01 Good Faith. The Parties shall work together in good faith to resolve any Dispute in a timely manner. As applicable, CareSource agrees to post to its Provider Website, the Provider Manual, which contains information regarding the internal dispute resolution mechanisms applicable to this Agreement.

10.02 First-Level Dispute Resolution. Upon a written notice of a Dispute setting forth the issues and the reasons to support such Dispute from the disputing Party to the other Party ("Dispute Notice"), the Parties shall meet in good faith to resolve such dispute. Unless otherwise agreed upon by the Parties, such meeting shall take place within thirty (30) days of the date of the Dispute Notice.

10.03 Second-Level Dispute Resolution. If the Dispute is not resolved or settled within sixty (60) days of the date of the Dispute Notice, each Party shall select a vice president and two other individuals to represent each Party, and such representatives shall meet in good faith to settle the Dispute. If the Dispute is not satisfactorily resolved within ninety (90) days of the Dispute Notice, then either Party can refer the matter to binding arbitration as described below. In no event may arbitration be initiated by a Party more than one (1) year following the date of the Dispute Notice.

10.04 Binding Arbitration. Any Dispute not resolved after the Parties have exhausted the First-Level and Second-Level Dispute Resolution process described above shall be (a) conducted in accordance with the American Arbitration Association Alternative Commercial Arbitration Rules and Mediation Procedures (the "AAA Rules"); and (b) determined and settled by a panel of three (3) arbitrators selected in accordance with the AAA Rules. Venue shall be determined in accordance with paragraph 10.05 of this Agreement. The arbitrators may construe or interpret, but shall not vary or ignore, the terms of this Agreement. The arbitrators shall have no authority to award any Consequential Damages, as defined in Article IX of this Agreement. Any award rendered by the arbitration shall be final and binding upon each of the Parties, and judgment thereof may be entered in any court having jurisdiction thereof. The costs of the arbitration shall be borne equally by both Parties, provided that each Party shall bear the fees and costs of attorneys or other persons representing the interests of such Party. During the pendency of any such arbitration proceeding and until final judgment hereon has been entered, this Agreement shall remain in full force and effect unless otherwise terminated as provided hereunder. The Parties agree that if the Dispute pertains to a matter which is generally administered by certain Policies or Protocols (including but not limited to the Fair Hearing Plan, quality improvement plans, and billing audits), the procedures set forth in such Policies or Protocols must be fully exhausted by a Party before such Party may invoke its right to arbitration under this section.

10.05 Exceptions: Notwithstanding the foregoing, either Party may seek equitable remedies in any court of competent jurisdiction to protect its intellectual property or confidential information. The Parties further agree to exclude the following matters from the operation of this arbitration clause: any

counterclaim, cross-claim or third-party claim for indemnity or contribution between CareSource and Provider in any Covered Person's suit against CareSource or Provider, unless a court requires the Parties to submit the Covered Person's entire claim to arbitration.

10.06 Governing Law and Venue. The Parties agree to the governing law and venue provisions set forth in the State-Specific Attachments. The Parties agree that the State-Specific Attachment applicable to a Dispute shall be determined by the state in which the Plan Program at issue is offered. In the event that more than one State-Specific Attachment applies, the Parties shall mutually decide upon the governing law and venue; provided, however, that if the Parties cannot agree upon such, governing law shall default to the State of Ohio as governing law and venue shall default to Montgomery County, Ohio as the sole, proper venue of any arbitration, proceeding or special proceeding between the Parties that arises out of or is in connection with any right, duty or obligation under this Agreement.

ARTICLE XI. MISCELLANEOUS TERMS

11.01 Contracting Authority. Provider represents and warrants that it has full legal authority to bind its employed physicians, practitioners and the Affiliates listed on Exhibit A to the terms of this Agreement. CareSource Network Partners LLC represents that CareSource Network Partners LLC has full legal authority to bind its Affiliates to the terms of this Agreement.

11.02 Change in Law. Any change, including any addition and/or deletion, to any provision(s) of this Agreement, that is required by duly enacted law shall be deemed to be part of this Agreement effective immediately without further action required to be taken by either Party to amend this Agreement to effect such change or changes, for as long as such law is in effect and applicable to the operation of this Agreement. However, in the case of a change in Law or guidance by CMS, CareSource shall deem the Agreement to be amended with such new or revised language or requirements.

11.03 Compliance with Regulatory Requirements. Provider acknowledges, understands, and agrees that this Agreement may be subject to review and approval by state and federal agencies with regulatory authority subject matter to which this Agreement may be subject. Any modifications of this Agreement requested by such agencies or required by Law shall be incorporated herein as provided in Section 11.12.

11.04 Assignment. This Agreement shall be binding upon and inure to the benefit of the respective legal successors and assignees of the Parties. However, neither this Agreement, nor any rights or obligations hereunder may be assigned by operation of law or otherwise, delegated, transferred in whole or part, without the prior written consent of the other Party, except that CareSource retains the right to assign, by operation of law or otherwise, delegate or transfer in whole or part, this Agreement to an Affiliate. The term "assign" shall include any assignment to any successor in interest from a merger, acquisition, reorganization, or sale of all or substantially all of a Party's stock, corporate membership interests or assets. Any attempted assignment in violation of this paragraph shall be void.

11.05 Non-Exclusivity. The Parties enter into this Agreement on a nonexclusive basis.

11.06 Entire Agreement. This Agreement, Attachments, Exhibits, and Amendments hereto contain all the terms and conditions agreed upon by the Parties and supersedes all other agreements, express or implied, regarding the subject matter hereof. Any amendments hereto and the terms contained therein shall supersede those of other parts of this Agreement in the event of a conflict.

11.07 Enforceability and Waiver. The invalidity and non-enforceability of any term or provision of

this Agreement shall in no way affect the validity of enforceability of any other term or provision. The waiver by either Party of a breach of any provision of this Agreement shall not operate as or be construed as a waiver of any subsequent breach thereof.

11.08 Regulatory Approval. In the event that CareSource has not received any applicable regulatory approval for use of this Agreement prior to the execution of this Agreement, this Agreement shall be deemed to be a binding letter of intent. In such event, the Agreement shall become effective on the date that such regulatory approval is obtained. If CareSource is unable to obtain such approval after due diligence, CareSource shall notify Provider and both Parties shall be released from any liability under this Agreement; provided however, that if such approval is obtained upon the condition of CareSource's amendment of this Agreement, then this Agreement shall continue and CareSource shall amend pursuant to this Agreement.

11.09 Notice. All notices and other communications permitted to be given under this Agreement shall be in writing and either (i) deposited in first class United States mail, certified, with postage prepaid, (ii) delivered by personal messenger, (iii) sent by a nationally recognized overnight courier, or (iv) sent by a fully completed confirmed facsimile transmission (with a written confirmation simultaneously sent in first class United States mail) to the addressees set forth on the signature page of this Agreement; provided, however, that Provider shall also provide a copy of any notice sent pursuant to this Agreement to CareSource's Office of General Counsel, P.O. Box 8738, Dayton, OH 45401-8738. Notices sent pursuant to this section shall be deemed given on the date received by the recipient. If a recipient rejects or refuses to accept notice given pursuant to this section, or if notice is not deliverable due to a changed address or fax number of which no notice was given, such notice shall be deemed received two (2) days after such notice was mailed. The foregoing shall not preclude the effectiveness of actual written notice given to any Party at any address or by any other means.

11.10 Conflict Between Documents. If there is any conflict between this Agreement (including its Attachments) hereto and the Provider Manual, the Policies and Protocols, the Provider Portal, Provider Website, or other manuals or documents, then this Agreement shall control.

11.11 State-Specific Attachments. Provider understands that CareSource operates Plan Programs in various states and that each of those states has specific regulatory requirements that must be met as relate to Plan Programs offered in such state. Provider and CareSource shall include in this Agreement the State-Specific Attachments that apply to the Plan Programs and Health Benefit Plans to which this Agreement applies. Provider understands that the determination of which State-Specific Attachment applies is governed by the state in which the Health Benefit Plan at issue is offered.

11.12 Amendment. This Agreement and the Attachments hereto may be amended. CareSource reserves the right to amend this Agreement, the Plan Compensation Schedules, or any Attachments or Addenda by providing the Provider written notice of any amendment to the Agreement not less than forty-five (45) days before the proposed effective date of the amendment ("Amendment Notice"). The Provider, after receiving the Amendment Notice may choose not to approve of the proposed amendment and may terminate the Agreement without penalty by informing CareSource that the Provider chooses not to approve the proposed amendment. The Provider must give CareSource written notice of its decision not to approve the proposed amendment not later than fifteen (15) days after receiving the Amendment Notice. Termination is effective ninety (90) days after CareSource receives written notice of the Provider's decision not to approve the proposed amendment, or on an earlier date, if agreed to by CareSource and Provider.

SIGNATURE PAGE FOLLOWS

SIGNATURES

In WITNESS WHEREOF, the parties have executed and delivered this Agreement as of the Effective Date. This Agreement may be executed in multiple originals.

EFFECTIVE DATE: _____

CARESOURCE NETWORK PARTNERS LLC, on behalf of itself and its Affiliates

230 N Main St
Dayton, Ohio 45402

By: _____
Steve W Smitherman

Title: VP, Indiana Market

Date: _____

CENTRALITY BEHAVIOR SUPPORT TRAINING LLC
Legal Name of Provider

3711 E. Southport Road
Indianapolis, IN 46227
Address

By: _____
Meagan Dant

Title: MA, BCBA - Clinical Director

Date: _____

46-4197524
Federal Tax I.D. Number

.
Medicare Provider Number

.
Medicaid Provider Number

EXHIBIT A – AFFILIATIONS ATTACHMENT

LEGAL NAMES OF AFFILIATES AND FEDERAL EMPLOYER IDENTIFICATION NUMBERS

Group(s) under the Agreement cover and all of its entities, subsidiaries and affiliates and facilities billing for Covered Services and/or operating under the following federal tax identification numbers:

Federal Tax ID	Legal IRS Name
46-4197524	CENTRALITY BEHAVIOR SUPPORT TRAINING LLC

EXHIBIT B
PROVISIONS APPLICABLE TO
CARESOURCE MEDICARE ADVANTAGE PLANS

Provider understands that the following provisions apply to all Covered Services rendered by Provider to Covered Persons who are covered by CareSource under a CareSource Medicare Advantage Plan. In the event that the terms of this Exhibit B conflict with the Base Agreement, than the terms of this Exhibit B shall control.

For purposes of this Exhibit B, "CMS Rules" shall mean the laws, administrative rules and regulations, policies, instructions, and guidance set forth by CMS and the obligations set forth in the CareSource's Medicare Advantage agreement with CMS.

HHS Audit. Provider shall give the United States Department of Health and Human Services ("HHS") and the Comptroller General of the United States General Accounting Office ("GAO") and their authorized designees, the right to audit, evaluate, and inspect books, contracts, records, including medical records, of Provider relating to its participation in CareSource's Medicare Advantage Plan and to services furnished to Medicare Advantage Members, and any other relevant information that CMS may require during the term of this Agreement and for a period of ten (10) years following termination of this Agreement for any reason, or until completion of an audit, whichever is later pursuant to 42 C.F.R. § 422.504(e)(4). This provision shall survive termination of the Agreement.

Compliance with CMS Rules. Provider, its contractors and subcontractors shall comply with the CMS Rules.

Oversight. CareSource shall be accountable to CMS for the oversight of Covered Services. Nothing in this Agreement amends or changes the obligation of CareSource to adhere to and fully comply with the terms and conditions of its agreement with CMS. Any delegation herein of activities or functions from CareSource to Provider shall be conducted in a manner consistent with the requirements of CMS Rules. In the event that CareSource has delegated to Provider any of its activities or responsibilities under its contract with CMS as described in the CMS Rules, the Parties shall enter into an agreement or include additional language in this Agreement, to address such delegation as required by CMS Rules. In the event that the Parties have not entered into a delegation agreement as described above, then the absence of such agreement shall mean that CareSource has not delegated to Provider any of its activities or responsibilities. The performance of Provider will be monitored by CareSource on an ongoing basis.

Accessibility and Continuity of Care. In the event of CareSource's insolvency, CareSource's discontinuance of operations, or termination of CareSource's agreement with CMS, Provider shall continue to provide Covered Services to Covered Persons for the duration of the period that CareSource was paid a capitation payment by CMS on behalf of the Covered Persons. Provider shall continue to provide Covered Services to Covered Persons as needed to complete any medically necessary procedures, including all medically necessary follow-up care, commenced but unfinished at the time of CareSource's insolvency, CareSource's discontinuance of operations, or termination of CareSource's agreement with CMS. Provider's obligation to provide such services shall cease after the end of the thirty (30) day period following CareSource's liquidation, CareSource's discontinuance of operations, or termination of CareSource's agreement with CMS.

Treatment Plans. Provider shall establish procedures to identify, assess, and establish treatment plans for Covered Persons with complex medical conditions.

Covered Person Financial Protections. CareSource shall adopt and maintain arrangements satisfactory to CMS to protect Covered Persons from incurring liability for payment of any fees that are the legal obligation of CareSource. Provider shall not hold any Covered Person liable for payment of any such fee that is the legal obligation of CareSource. Covered Persons shall not be held liable for Medicare Part A and B cost sharing when the State or another payor is responsible for paying such amounts. Provider shall accept payment from CareSource as payment in full for Covered Services, or bill the appropriate responsible party, for any Medicare Part A and B cost sharing that is covered by Medicaid.

Prompt Payment. CareSource shall pay ninety-five percent (95%) of Clean Claims within thirty (30) days of receipt and shall comply with the provisions set forth in 42 C.F.R. § 422.520.

Sequestration. In the event that CMS implements a sequestration adjustment which is permitted by Law and which reduces the amount of compensation that CareSource receives from CMS in connection with CareSource's operation of its Medicare Advantage managed care plans ("Sequestration Reduction"), then CareSource shall apply the same Sequestration Reduction to the reimbursement rates set forth in any of the Medicare Advantage Plan Compensation Schedules of this Agreement.

EXHBIT C – INDIANA

STATE SPECIFC PROVISIONS

FOR INDIANA

The provisions set forth in this Attachment and in the Base Agreement shall be read and applied together to the maximum extent possible. In the event that the terms of the Base Agreement conflict with the State Specific Provisions for Indiana, then the State Specific Provisions for Indiana shall control with respect to all Plan Programs and Health Plans offered by CareSource in the State of Indiana.

Payment of Claims:

Time to File Claims and Billing Procedures. With respect to all Covered Services provided to Covered Persons by Provider, Provider shall submit Clean Claims to CareSource within three hundred sixty-five (365) days of the date Covered Services were rendered. If CareSource is not the primary payor, and Provider is pursuing payment from the primary payor, the three hundred sixty-five (365) day filing limit will begin on the date Provider receives the Claim response from such primary payor. In no event, regardless of the cause or circumstance, shall Covered Person be responsible or liable for any Claim submitted by Provider to CareSource after the expiration of the filing deadlines set forth in this Section.

Timing for Payment of Claims. For Claims Payment, CareSource shall adjudicate or arrange for adjudication and where appropriate make payment for Clean Claims for Covered Services submitted by Provider within thirty (30) days of receipt. CareSource shall request additional information necessary to process Claims that are not Clean Claims within thirty (30) days of Claim receipt and shall pay such Claims within thirty (30) days of receipt of additional information. If CareSource fails to pay or deny a Clean Claim within the timeframe listed above, but subsequently pays the Clean Claim, CareSource shall pay the Provider the interest on the lesser of the usual, customary, and reasonable charge for the Covered Services provided to the Covered Person, or the reimbursement rate agreed to by CareSource and the Provider. The interest paid shall accrue beginning on the thirty first (31st) day after receipt. The interest paid stops accruing on the date CareSource pays the Clean Claim. The parties agree that the terms and conditions set forth in **Indiana Code Section 27-13-36.2, et seq.** shall apply to this Agreement. Notwithstanding the foregoing, CareSource shall not pay Provider interest if CareSource timely pays a Claim but underpays the Claim.

Governing Law and Venue. The validity, enforceability and interpretation of this Agreement shall be governed by any applicable Laws. Hamilton County, Indiana shall be the sole, proper venue of any arbitration, proceeding or special proceeding between the Parties that arises out of or is in connection with any right, duty or obligation under this Agreement, and each Party agrees to submit to the jurisdiction of any court of Hamilton County, Indiana in order to enforce any arbitration decision issued by the American Arbitration Association and waives any objections based on forum non-conveniens or to enforce any equitable remedies to protect a Party's intellectual property or confidential information.

CareSource Indiana, Inc.

Medicaid Plan Addendum

This Addendum is limited to the terms and conditions governing the provision of and payment for Health Services provided to Covered Persons under the CareSource Indiana, Inc. Medicaid Plan(s) and only applies to Provider if the Provider participates in the Plan's Medicaid Network. If applicable, this Medicaid Addendum supplements the Agreement between the Plan and Provider and shall run concurrently with the terms of the Agreement. Plan and Provider agree to abide by all applicable provisions of the Plan's Medicaid contract(s) with the Indiana Family and Social Services Administration (the "Medicaid Contract"). Provider's compliance with the Medicaid Contract specifically includes but is not limited to the following requirements:

1. Provider shall maintain a current Indiana Health Coverage Programs (IHCP) provider agreement and be duly licensed in accordance with the appropriate state licensing board and remain in good standing with said board.

2. Provider shall submit all claims that do not involve a third party payer for Covered Services rendered to Covered Persons ninety (90) calendar days or less from the date of service. CareSource shall waive the timely filing requirement in the case of claims for Covered Persons with retroactive coverage.

3. Provider shall utilize the Indiana Health Coverage Program Prior Authorization Request Form available on the Indiana Medicaid website for submission of prior authorization requests to CareSource.

4. CareSource shall terminate its contractual relationship with Provider as soon as CareSource has knowledge that the Provider's license or IHCP provider agreement has terminated for purposes of Provider providing services pursuant to the Medicaid Contract.

5. CareSource shall terminate Provider's agreement to serve the Contractor's HIP and Hoosier Healthwise members at the end of CareSource's Contract with the State (i.e., the Medicaid Contract).

6. CareSource shall monitor Provider and apply corrective actions for those who are out of compliance with FSSA's or CareSource's standards.

7. Provider agrees that in the event this Agreement is terminated, Provider shall submit all encounter claims for services rendered to Covered Persons while serving as a Participating Provider and provide or reference CareSource's technical specifications for the submission of such encounter data.

8. For purposes of clarify, CareSource shall not obligate Provider to participate under exclusivity agreements that prohibit Provider from contracting with other state contractors.

9. If Provider is a Primary Medical Provider (PMP), then the PMP shall have the option to terminate the Agreement without cause with advance notice to CareSource of ninety (90) calendar days.

10. Provider shall, upon the reasonable request by a Covered Person, provide a copy of the Covered Person's medical record at no charge, and facilitate the transfer of the Covered Person's medical record to another provider at the Covered Person's request.

11. Provider agrees that it shall not seek payment from the State for any service rendered to a Covered Person under the Agreement.

12. For behavioral health providers, Covered Persons receiving inpatient psychiatric services must be scheduled for outpatient follow-up and/or continuing treatment prior to discharge. This treatment must be provided within seven (7) calendar days from the date of Covered Person's discharge.

13. Provider agrees to use best commercial efforts to collect required copayments for services rendered to HIP Basic and HIP State Plan Basic members.

14. Provider agrees to comply with all applicable Federal and State Laws and regulations including Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; the Americans with Disabilities Act of 1990 as amended; and section 1557 of the Patient Protection and Affordable Care Act.

15. Provider agrees to comply with the conflict of interest safeguards described in 42 C.F.R. §438.58 and with the prohibitions described in section 1902(a)(4)(C) of the Social Security Act applicable to contracting officers, employees, or independent contractors.

SIGNATURE PAGE FOLLOWS

CARESOURCE:

CARESOURCE NETWORK PARTNERS LLC, on behalf of itself and its Affiliates
230 N. Main Street
Dayton, Ohio 45402

By: Steve W Smitherman

Print Name: _____

Title: VP, Indiana Market

Date: _____

PROVIDER:

Provider Legal Name: CENTRALITY BEHAVIOR SUPPORT TRAINING LLC

Address: _____

_____

By: Meagan Dant

Print Name: _____

Title: MA, BCBA - Clinical Director

Date: _____

Provider Tax ID: 46-4197524

EXHIBIT C-INDIANA

PLAN COMPENSATION SCHEDULES

SEE ATTACHED

Revision 20160801
Contract Code: 86UHaYmWIIfg3KhVIf7uhQ

EXHIBIT C- INDIANA

PLAN COMPENSATION SCHEDULES

CARESOURCE INDIANA JUST4ME

PROVIDER/GROUP/ANCILLARY

For Medically Necessary Covered Services rendered to Covered Persons by Provider, in accordance with the terms of this Agreement, Provider shall accept as payment in full the lesser of:

(i) Provider's billed charges; or

(ii) The percentage, listed below, of the Medicare allowed amount applicable to Provider as published annually in the Federal Register and based on valid codes recognized by the Centers for Medicare and Medicaid Services (CMS) in effect on the date of service (the "Medicare Allowed Amount"). Any Cost Share shall be offset against the Medicare Allowed Amount for Covered Services, without regard to whether the Provider has collected such amounts.

- Professional Services Reimbursement Rate: 100% of the Medicare Allowed Amount

Injectable medications will generally be paid at 100%, according to the Medicare Fee Schedule in effect as of the date the services are rendered, except for those drugs that may be available through a specialty pharmacy benefits manager.

CareSource reserves the right to amend reimbursement policies with advanced notice.

Fee Schedule

To determine unit prices for any specific code or service, please refer to the Medicare link below:
Medicare: http://www.cms.gov/apps/physician-fee-schedule/overview.aspx

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By: Steve W Smitherman

Print Name: _____

Title: VP, Indiana Market

Date: _____

PROVIDER:

Provider Legal Name: CENTRALITY BEHAVIOR SUPPORT TRAINING LLC

Address: _____

_____

By: Meagan Dant

Print Name: _____

Title: MA, BCBA - Clinical Director

Date: _____

Provider Tax ID: 46-4197524

EXHIBIT C- INDIANA

PLAN COMPENSATION SCHEDULES

CARESOURCE INDIANA HEALTHY INDIANA PLAN

PROVIDER/GROUP/ANCILLARY

For Medically Necessary Covered Services rendered to Covered Persons by Provider, in accordance with the terms of this Agreement, Provider shall accept as payment in full the lesser of:

(i) Provider's billed charges; or

(ii) The percentage, listed below, of the Medicare allowed amount applicable to Provider as published annually in the Federal Register and based on valid codes recognized by the Centers for Medicare and Medicaid Services (CMS) in effect on the date of service (the "Medicare Allowed Amount"). Any Cost Share shall be offset against the Medicare Allowed Amount for Covered Services, without regard to whether the Provider has collected such amounts.

- Professional Services Reimbursement Rate: 100% of the Medicare Allowed Amount

Injectable medications will generally be paid at 100%, according to the Medicare Fee Schedule in effect as of the date the services are rendered, except for those drugs that may be available through a specialty pharmacy benefits manager.

CareSource reserves the right to amend reimbursement policies with advanced notice.

Fee Schedule

To determine unit prices for any specific code or service, please refer to the Medicare link below:
Medicare: http://www.cms.gov/apps/physician-fee-schedule/overview.aspx

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Print Name: _____

Title: VP, Indiana Market

Date: _____

PROVIDER:

Provider Legal Name: CENTRALITY BEHAVIOR SUPPORT TRAINING LLC

Address: _____

_____

By: Meagan Dant

Print Name: _____

Title: MA, BCBA - Clinical Director

Date: _____

Provider Tax ID: 46-4197524

EXHIBIT C - INDIANA

PLAN COMPENSATION SCHEDULES

CARESOURCE INDIANA HOOSIER HEALTHWISE

PHYSICIAN/PROVIDER/GROUP

For Medically Necessary Covered Services rendered to Covered Persons by Provider, in accordance with the terms of this Agreement, Provider shall accept as payment in full the lesser of:

(i) Provider's billed charges, or

(ii) CareSource's fee schedule for such services, which currently is the equivalent of 100% of the prevailing Indiana Medicaid fee schedule for physician Covered Services, and 100% of the current Indiana Medicaid fee schedule for non-physician Covered Services.

Injectable medications will generally be paid at 100%, according to the prevailing Indiana Medicaid Fee Schedule in effect as of the date the services are rendered, except for those drugs that may be available through a specialty pharmacy benefits manager.

Anesthesia will be reimbursed per Indiana Medicaid Fee Schedule.

CareSource reserves the right to amend reimbursement policies with advanced notice.

Fee Schedule:

To determine unit prices for any specific code or service, please refer to the listed links for details:

Indiana Medicaid Fee Schedule:
http://www.indianamedicaid.com/ihcp/Publications/MaxFee/fee_schedule.asp

Visit CareSource website for additional information:
https://www.caresource.com/providers/

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