CARESOURCE KENTUCKY CO.
GROUP PRACTICE 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 Kentucky Co., a Kentucky not-for-profit corporation ("Plan"), and the undersigned provider group ("Group Practice"). 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, or which owns or controls, or that is under common ownership or control with such Party.

1.02 Agreement. This CareSource Group Practice Agreement between Group Practice and Plan, including all of the Attachments, Addenda, and Exhibits attached hereto.

1.03 Centers for Medicare and Medicaid Services or CMS. The Centers for Medicare and Medicaid Services.

1.04 Claim. Either the uniform bill claim form or electronic claim form in the format prescribed by Plan submitted by Group Practice for payment by Plan 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.

1.05 Clean Claim or Complete Claim. Unless otherwise defined by any applicable state law, rule or regulation (which definition then shall be controlling), a Claim timely 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 considered a Clean Claim or Complete Claim.

1.06 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.

1.07 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 Plan’s Health Benefit Plans and who is eligible to receive Covered Services.

1.08 Covered Services. Medically Necessary Health Services, as determined by Plan, that are within the normal scope of services and registration or licensure of Group Practice and for which a Covered Person is entitled to receive coverage under the terms and conditions of a Health Benefit Plan.
1.09 **Credentialing/Recredentialing or Credentialed/Recredentialed.** Plan’s process of gathering, verifying and evaluating information for the purpose of determining whether applicable health care practitioners and facilities comply with Plan’s Network participation standards.

1.10 **Customary Charge.** The fee for Health Services charged by Group Practice that does not exceed the fee Group Practice would ordinarily charge another person regardless of whether the person is a Covered Person.

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 admission required to evaluate, treat, and stabilize an Emergency Medical Condition.

1.13 **Emergency Medical Condition.** A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson would reasonably have cause to believe constitutes a condition that the absence of immediate medical attention could reasonably be expected to result in: (a) 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; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. With respect to a pregnant woman who is having contractions, an emergency medical condition also includes: (a) a situation in which there is inadequate time to effect a safe transfer to another hospital before delivery; or (b) a situation in which 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 the Plan 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 the Plan.

1.16 **Group Practice Provider.** A provider employed by, contracting with, or associated with Group Practice who has agreed to provide Covered Services according to the terms and conditions of this Agreement and who has been credentialed pursuant to Plan’s Credentialing criteria to provide such services. Unless otherwise indicated herein, the term “Group Practice” shall include Group Practice Providers.

1.17 **Health Benefit Plan.** Document(s), 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, under which a Payor is obligated to provide coverage of Covered Services to a Covered Person.
1.18 **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.

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

1.20 **Medical Director.** A duly licensed physician or designee who has been designated by Plan to monitor the provision of Covered Services to Covered Persons.

1.21 **Medically Necessary/Medical Necessity.** For purposes of determining coverage under the Health Benefit Plan, Health Services that are necessary for the diagnosis or treatment of disease, illness, or injury without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ, or sufficient pain and discomfort; are determined to be medically appropriate in accordance with the Plan's medical policies and nationally recognized guidelines; are not Experimental or Investigational Services; are necessary to meet the basic health needs of the Covered Person; are rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Covered Service; are consistent in type, frequency, and duration of treatment with scientifically-based guidelines of national medical, research, or health care coverage organizations or governmental agencies that are accepted by Plan; are consistent with the diagnosis of the condition; are required for reasons other than the convenience of the Covered Person or his/her physician; and are demonstrated through prevailing peer-reviewed medical literature to be either: (a) safe and effective for treating or diagnosing the condition or sickness for which the use of such Health Services are proposed or (b) safe with promising efficacy for treating a life-threatening sickness or condition in a clinically controlled research setting using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health. For purposes of this definition, the term "life threatening" is used to describe sickness or conditions that are more likely than not to cause death within one (1) year of the date of the request for treatment. The fact that a physician has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for an injury, sickness, or mental sickness, or the fact that the physician has determined that a particular Health Service is medically appropriate or necessary does not mean that the procedure or treatment is a Covered Service under the Plan. The definitions of Medically Necessary and Medical Necessity used in this Agreement relate only to benefits provided by Plan and may differ from the way in which a physician engaged in the practice of medicine may define Medically Necessary or Medical Necessity. 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.

1.22 **Network.** A group of providers that support, through a direct or indirect contractual relationship with Plan, some or all of the product(s) and/or other program(s) in which Covered Persons are enrolled.

1.23 **Non-Covered Services.** Health Services that are not Covered Services.

1.24 **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.

1.25 **Participating Hospital.** A hospital which has entered into an agreement with Plan and has been Credentialed with Plan as a hospital in which Participating Providers may provide Covered Services to Covered Persons in accordance with Plan requirements.

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

1.27 **Party or Parties.** Group Practice or Plan, as the case may be, shall be individually referred to as a Party. Collectively, Group Practice and Plan shall be referred to as the Parties.

1.28 **Payor.** An individual or entity obligated to a Covered Person to provide reimbursement for Covered Services under a Health Benefit Plan and authorized by Plan to access Group Practice’s services under this Agreement. Plan is not a Payor under any Service Agreement pursuant to which Plan provides only administrative services.

1.29 **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 Group Practice participates. The Plan Compensation Schedule may include additional Group Practice obligations and specific Plan compensation related terms and requirements. Value based reimbursement agreements shall be included in the definition of Plan Compensation Schedule.

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

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

1.32 **Preventable Adverse Event.** Surgery performed on the wrong patient, surgery performed on the wrong body part, the wrong surgery performed on a patient, a Hospital Acquired Condition (as defined by CMS at [http://www.cms.gov/hospitalacqcond](http://www.cms.gov/hospitalacqcond)), or other events defined in the Provider Manual.

1.33 **Primary Care Provider.** An individual licensed physician (M.D. or D.O.), generally, in the specialty of internal medicine, pediatrics, family medicine or general practice, or any other individual credentialed by the Plan, including an advanced practice registered nurse, who contracts with the Plan 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. Plan reserves the right to designate other specialties as PCPs when appropriate.

1.34 **Provider Charges.** The regular, uniform rate or price Group Practice determines and submits to Plan and charges for Health Services provided by Group Practice to Covered Persons.

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

1.36 **Provider Portal.** The online provider tool that providers may access through Plan’s website, as well as those other portions of Plan’s website intended as a resource for providers.

1.37 **Quality Improvement.** The processes established and operated by Plan or its designee relating to the quality of Covered Services.
1.38 **Service Agreement.** Those agreements between Plan and an insurer, government agency or other organization or entity, or an individual, that specify services to be provided to, or arranged for or reimbursed to, or for the benefit of Covered Persons, and the terms and conditions under which those services are to be provided or reimbursed.

1.39 **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.

1.40 **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 Plan policies and procedures.

**ARTICLE II. GROUP PRACTICE OBLIGATIONS**

2.01 **Provision of Health Services.** Group Practice shall make available to Covered Persons all available medical services within the normal scope of and in accordance with Group Practice’s license and certifications and privileges and to provide certain services based on the qualifications as determined by Plan. Group Practice shall make available to Covered Persons certain usual and customary services in accordance with the provisions of this Agreement that are within the scope of Group Practice’s licensure and certification under applicable Laws. Group Practice shall provide Medically Necessary Covered Services to Covered Persons through the last day this Agreement is in effect. In providing Covered Services to Covered Persons, Group Practice agrees to: (a) be bound by and to abide by the terms of this Agreement, Exhibits, Attachments and Addenda hereto, and Plan requirements as set forth in the Plan Provider Manual; and (b) with regard to the types of providers Credentialled by Plan as set forth in the Plan Provider Manual, not allow non-Credentialled providers employed by Group Practice to serve Covered Persons and shall indemnify and hold Plan harmless should such a non-Credentialled provider serve a Covered Person. If applicable, Group Practice shall actively educate Covered Persons concerning appropriate follow-up and self-care.

2.02 **Policies and Protocols.** Group Practice agrees to comply with Plan’s Policies and Protocols and to cooperate with Plan with respect to its payment, quality assurance, quality improvement, accreditation, risk management, utilization review, utilization management, clinical trial and other administrative policies and procedures, if applicable, established and revised from time to time. Plan shall communicate changes to Plan requirements to Group Practice in a timely manner. Except as prohibited by Law, Plan may conduct such communications by posting to its Provider Portal. Group Practice is responsible for regularly monitoring Plan’s Provider Portal which shall contain the Provider Manual, important updates, payment policies, and Policies and Protocols.

2.03 **Covered Person Status.** To determine whether an individual is a Covered Person entitled to receive Covered Services, Group Practice shall ask the individual to present his or her identification card. Plan shall establish a verification system through which Group Practice may verify whether a person seeking Health Services is a Covered Person. Group Practice shall be responsible for verifying that an individual is a Covered Person. Group Practice acknowledges that such eligibility information is subject to change retroactively: (a) if Plan does not receive proper and timely notification regarding termination of a Covered Person’s coverage; (b) as a result of a final decision about a Covered Person’s continuation of coverage pursuant to Law; or (c) if eligibility information is later proven to be false. If Plan 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
Plan. If Group Practice provides Health Services to an individual and it is later determined that the individual was not a Covered Person, then Group Practice may directly bill the individual for such Health Service. If Plan determines that the individual was not eligible for coverage for the Health Services rendered after payment has already occurred, Plan may set-off such payment against future Claim payments to Group Practice by Plan to the extent permitted by applicable law.

2.04 Rights of Covered Persons. Group Practice shall accept referrals of Covered Persons on the same basis that Group Practice accepts other patients who are not Covered Persons. Neither Group Practice nor any assistant or employee of Group Practice shall discriminate in violation of any Law in the treatment of Covered Persons or in the quality, quantity, or type of Health Service delivered to Covered Persons on the basis of race, age within the scope of Group Practice'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. Group Practice will observe, protect and promote the rights of Covered Persons as patients. Group Practice will comply with any Laws regarding the right of patients to make decisions regarding medical care. If Plan at any time determines that a Covered Person’s health or safety is in jeopardy by remaining with Group Practice, Plan shall arrange for immediate transfer of the Covered Person to another Participating Provider. Group Practice acknowledges: (a) that Covered Persons have a right to be treated with respect and recognition of their dignity and need for privacy; (b) that Covered Persons have a right to participate in decision-making regarding their treatment planning; and (c) that Covered Persons have a right to voice complaints or appeals about Group Practice or the care provided.

2.05 Group Practice Locations and Affiliates. Group Practice agrees to provide Covered Services only at those locations identified in Exhibit A of this Agreement. Group Practice agrees to notify Plan regarding the addition or deletion of any locations at least thirty (30) days prior to the date that Group Practice intends to make such addition or deletion effective. Until Plan approves the addition of a Group Practice location in writing, Plan has no obligation to reimburse Group Practice for any Health Services provided at said location. The Parties agree that an Affiliate of Group Practice shall not be added to the definition of Group Practice 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. Group Practice 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 Plan. If Group Practice is a laboratory testing site or provides laboratory services to Covered Persons, Group Practice 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. Group Practice and all health care professionals employed by or under contract or acting as independent contractors for or with Group Practice to render Covered Services hereunder on behalf of Group Practice 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, Group Practice shall, upon request of Plan, provide Plan with evidence that Group Practice meets the criteria described in this Agreement and by Plan’s Credentialing/Recredentialing policies and procedures. Credentialing/Recredentialing will be repeated on a periodic basis. Credentials will be collected by Plan and evaluated by the Plan’s designated credentials or quality improvement committee(s).

2.08 **Notice by Group Practice.** Group Practice shall give Plan 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 Group Practice’s (including a Group Practice Provider’s) license, registration, certification or permit (“License”) required to perform Group Practice's duties under this Agreement by any state in which Group Practice 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 Group Practice (including a Group Practice Provider) to perform services on behalf of Group Practice pursuant to this Agreement by any state in which such individual is authorized to provide Health Services;

(c) any malpractice action in which Group Practice or any employee of Group Practice (including a Group Practice Provider) who provides Health Services pursuant to this Agreement has been named as a defendant;

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

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

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

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

2.09 **Referrals.** Group Practice and Group Practice Providers shall refer Covered Persons to Participating Providers except: (a) in the case of emergency; (b) as otherwise described in the Provider Manual; (c) as otherwise required by Law; or (d) as prior approved by the Plan.

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

2.11 **Grievance System.** Plan shall maintain and administer a grievance system for Covered Persons. Complaints received by Plan concerning services rendered by Group Practice and/or its employees will be resolved in accordance with the grievance procedure. Group Practice agrees to cooperate with Plan in the resolution of complaints made by Covered Persons and comply with all final determinations made by Plan. A copy of the grievance procedure shall be made available to Group Practice by Plan.

2.12 **Pre-Health Service Authorization.** Group Practice must obtain prior authorization from Plan before rendering those Health Services to Covered Persons that require Plan’s prior authorization as set forth in Plan’s Policies and Protocols, Provider Manual, and Provider Portal. If Group Practice fails to obtain prior authorization from Plan prior to rendering any such Health Services for which prior authorization is required, then Group Practice shall not seek payment from Plan or Covered Persons for such unauthorized Health Services, and neither Plan nor any Covered Person will be required to pay for such unauthorized Health Services.

2.13 **Notification to Plan.** Group Practice agrees to notify Plan of any Covered Person’s Emergency Admission or other inpatient admission within twenty-four (24) hours of such admission.

2.14 **Quality Improvement, Credentialing and Utilization Management.** Group Practice agrees to cooperate with, participate in, and comply with the requirements of Plan’s Quality Improvement, Credentialing–Recredentialing, and Utilization Management programs. Upon reasonable notice and at reasonable hours, Plan or its agents may inspect Group Practice’s premises and operations to insure that such premises and operations are appropriate to meet Covered Persons’ needs and to comply with Quality Assurance guidelines. Group Practice shall notify Plan immediately after the initiation of any complaint, inquiry, investigation, or review with or by any licensing or regulatory authority, peer review organization, Group Practice 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, Group Practice shall immediately notify Plan after it has been determined that the basis for any such complaint, inquiry, investigation, or review is substantiated (an adverse outcome).

2.15 **Plan Access to Covered Persons.** When a Covered Person’s medical condition permits, Group Practice agrees to allow Plan or its representatives access to the Covered Person or a person acting on behalf of the Covered Person to discuss Plan benefits, discharge planning, follow up care and other pertinent Plan processes or requirements.

2.16 **Accessibility.** Group Practice 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. Group Practice 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. Group Practice shall provide coverage arrangements with providers who are Participating Providers in accordance with Plan policies and procedures unless otherwise approved in advance by Plan.

2.17 **Hospital Admissions.** Each Group Practice Provider, if a physician, shall designate one or more Participating Hospital(s) where Group Practice will admit Covered Persons under Group Practice’s care. Group Practice shall admit Covered Persons only to Participating Hospitals except: (a) in the case of an emergency; (b) as otherwise provided in the Provider Manual; (c) as otherwise required by Law; or (d) as prior approved by the Plan.
ARTICLE III. PLAN OBLIGATIONS

3.01 Discussions with Covered Persons. Plan agrees not to prevent Group Practice from discussing all treatment options with Covered Persons, including options that may not reflect Plan’s position or options that may not be Covered Services.

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

3.03 Statutory Responsibility. Plan has statutory responsibility to monitor and oversee the offering of Covered Services to Covered Persons.

3.04 Any Willing Provider. Plan agrees to allow any provider who meets Plan’s terms and conditions for participation to become a participating provider of Plan. Plan will not discriminate against any provider who is located within Plan’s geographic service area and who is willing to meet Plan’s terms and conditions for participation. Terms and conditions that Plan requires a provider to satisfy for participation in Plan will be filed by Plan with the Kentucky Department of Insurance for review.

3.05 Applications for Provider Participation. Plan agrees to allow all providers who desire to apply for participation in Plan the opportunity to apply for such participation at any time during the year and to make criteria for provider participation in Plan available to all applicants.

ARTICLE IV. CLAIMS AND PAYMENTS

4.01 Form and Content of Claims. Group Practice shall submit Claims for Covered Services in a format and manner prescribed by Kentucky Revised Statute 304.14-135, which requires the uniform health insurance claim form for a health care provider to consist of the HCFA 1500 data set or its successor as adopted by the National Uniform Claims Committee. Unless otherwise directed by Plan, Group Practice shall submit Claims in accordance with applicable CMS and HIPAA requirements. Group Practice will use electronic submission for all of its Claims under this Agreement.

4.02 Time to File Claims. With respect to all Covered Services provided to Covered Persons by Group Practice, Group Practice shall submit Clean Claims to Plan 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 Plan is not the primary payer and Group Practice is pursuing payment from the primary payer, within ninety (90) days from the date in which Group Practice receives an explanation of payment from the Covered Person’s primary payer. In no event, regardless of the cause or circumstance, shall Plan or Covered Person be responsible or liable for any Claim submitted by Group Practice to Plan after the expiration of the filing deadlines set forth in this Section.

4.03 Payment of Claims. Plan 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.

4.04 Timing of Payment of Claims. Except for Claims involving organ transplants, Plan shall
reimburse Group Practice for a Clean Claim or send written or electronic notice denying or contesting the Claim within thirty (30) calendar days from the date that Plan or Plan’s designee receives the Claim. Clean Claims involving organ transplants shall be paid, denied, or contested within sixty (60) calendar days from the date that the Plan or Plan’s designee receives the Claim. Within these applicable time frames, Plan agrees to pay the total amount of the Clean Claim in accordance with the fee schedule provisions set forth in this Agreement; pay any portion of the Claim that is not in dispute and notify Group Practice, in writing or electronically, of the reasons the remaining portion of the Claim will not be paid; or notify Group Practice, in writing or electronically, of the reasons that no part of the Claim will be paid.

4.05  **Payment in Full and Cost Shares.** Group Practice 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 Plan, or payment by another source, such as through coordination of benefits or subrogation. Group Practice shall bill, collect, and accept as compensation the Cost Shares owed by Covered Persons. Group Practice agrees to make reasonable efforts to verify Cost Shares prior to billing for such Cost Shares. In no event shall Plan be obligated to pay Group Practice or any person acting on behalf of Group Practice 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, Group Practice agrees to accept the compensation rates set forth in the Plan Compensation Schedule(s) as payment in full from the Plan even if the Covered Person has not yet satisfied his or her deductible.

4.06  **Non-Covered Services.** Plan has no obligation under this Agreement to compensate Group Practice for Non-Covered Services or for Health Services rendered to individuals who are not Covered Persons. If Group Practice renders Health Services to an individual who, on the date of service, is not a Covered Person, Group Practice may bill that individual directly for those Non-Covered Services. Group Practice may bill Covered Persons for Non-Covered Services only in accordance with Section 4.08 of this Agreement. Any payments for Claims made with regard to such Non-Covered Services may be recovered by Plan as overpayments under the process described herein to the extent permitted by law.

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

4.08  **Covered Persons Held Harmless.** Group Practice agrees that in no event, including but not limited to nonpayment by Plan, insolvency of Plan, or breach of this Agreement, shall Group Practice 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, for Covered Services provided pursuant to this Agreement. This does not prohibit Group Practice 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 persons referenced above, nor from any recourse against Plan or its successor. Group Practice shall not deny services to any Covered Person due to said Covered Person’s non-payment of a Cost Share. Group Practice 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, Group Practice 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. Group Practice 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 Group Practice, Plan and Covered Persons or persons acting on their behalf.

4.09 Determination of Payment. Group Practice 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 Plan 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 Plan to obtain the authorization was materially incomplete or inaccurate at the time it was provided.

4.10 Payment Disputes. Appeals of Claims denied by Plan shall be submitted in writing by Group Practice to Plan 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 Plan is not the primary payer and Group Practice is pursing payment from the primary payer, within ninety (90) days from the date in which Group Practice receives an explanation of payment from the Covered Person’s primary payer. An appeal in which Group Practice 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 Plan is not the primary payer and Group Practice is pursing payment from the primary payer, within ninety (90) days from the date in which Group Practice receives an explanation of payment from the Covered Person’s primary payer. Plan’s Appeals Committee or its or designee will render a decision within thirty (30) days after receipt of the appeal notice. Group Practice may also file an appeal with Plan on behalf of a Covered Person for denial of a Claim or payment for a Health Service, if Group Practice is authorized by a Covered Person in accordance with KRS 304.17A-600 et seq.

4.11 Reviews and Audits.

(a) Plan shall have the right to review Group Practice’s Claims prior to payment for appropriateness in accordance with industry standard billing rules. 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 Plan deems appropriate. Plan shall have the right to exclude inappropriate line items, adjust payment and reimburse Group Practice at the revised level.

(b) Plan 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 Plan may conducted 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 Plan’s obligations with respect to program integrity or other Plan contract requirements; performance and implementation of Plan’s compliance plan; the detection and prevention of fraud, waste, and abuse; implementation and evaluation of Plan’s False Claims Act Policy; Group Practice’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 Plan in determining whether services were Medically Necessary; performance and discharge of any and all of Plan’s legal obligations with respect to the collection and reporting of data including, but not limited to, HEDIS requirements; ensuring that Group Practice 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) Plan shall have the right to conduct utilization reviews to determine Medical Necessity and conduct post-payment billing audits. Such Plan 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 4.11, whichever is later. Plan shall use established industry claims adjudication and/or clinical practices, state and federal guidelines, and/or Plan’s policies and data to determine the appropriateness of the billing, coding and payment. Group Practice shall cooperate with Plan’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 Plan 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 twenty-four (24) months of the date in which the Party made the Overpayment in question. A Party may recover funds necessary to correct an Underpayment only if that Party demands payment of such funds within twenty-four (24) months after that Party’s receipt of the payment that resulted in the Underpayment in question. Plan reserves the right to withhold or set-off Overpayments against future Claim payments to Group Practice by Plan to the extent permitted by law. 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.

4.12 **Adjustments for Overpayments.** Unless prohibited by Law, Group Practice shall refund all duplicate or erroneous Claim payments regardless of the cause. Plan may offset future Claim payments in lieu of a refund.

4.13 **Preventable Adverse Events.** Notwithstanding any provision in this Agreement to the contrary, when any Preventable Adverse Event occurs with respect to a Covered Person, the Group Practice shall neither bill, nor seek to collect from, nor accept any payment from Plan or Covered Person for such events. If Group Practice receives any payment from Plan or Covered Person for a Preventable Adverse Events, 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, Group Practice shall cooperate with Plan, to the extent reasonable, in any Plan initiative designed to help analyze or reduce such preventable adverse events.

4.14 **False Claims.** Any falsification or concealment of material fact made by Group Practice when submitting Claims may be prosecuted under Law. Group Practice 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. Group Practice shall adopt Plan’s False Claims Act Policy, a copy of which is available on Plan’s Provider Portal.
ARTICLE V. INFORMATION AND RECORDS

5.01 Confidentiality. Group Practice acknowledges and agrees that all information relating to Plan’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 Plan’s programs, policies, protocols and procedures, is proprietary information. Group Practice shall not disclose any such information to any person or entity without Plan’s express written consent.

5.02 Records. Plan and Group Practice agree that clinical records of Covered Persons shall be regarded as confidential and both shall comply with all applicable Laws regarding such records. Group Practice shall be responsible for obtaining Covered Persons’ consent for release of medical record information by Group Practice when such consent is required by Law. Group Practice shall:

(a) maintain and furnish such records and documents as may be required by regulators, CMS or their designees, or by Laws and Plan requirements. Group Practice shall cooperate with Plan 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 Plan operations;

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

(c) provide Plan or its designee copies of such records at no cost as may be required by Plan 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 Plan 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.
5.03 **HIPAA.** Group Practice 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.

5.04 **Access to Data.** Group Practice and Plan represent that in conducting their operations, they each collect and review certain quality and clinical data. The Parties will work together in good faith to share such data with one another in furtherance of quality of care. Within twelve (12) months of the Effective Date, the Parties shall use their best efforts to develop a process whereby Group Practice and Plan will share clinical data through their electronic medical record systems, with such process developed in accordance with state and federal law.

5.05 **Use of the Name.** Group Practice agrees that Group Practice’s name, office locations, office telephone numbers, addresses, specialties, board certifications and Group Practice affiliations may be included in literature distributed to existing or potential Covered Persons, Participating Providers, and Payors. Group Practice’s use of Plan’s name shall be upon prior written approval or as the Parties may agree; provided, however, that Group Practice may use Plan’s name to advise the public that Group Practice is a Participating Provider. Any use of Group Practice’s name other than listed shall be upon prior written approval or as the Parties may agree.

5.06 **Release of Information.** Group Practice 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 Plan Provider Application Form. Group Practice agrees to hold harmless any person or entity furnishing such information.

**ARTICLE VI. RELATIONSHIP OF PARTIES**

6.01 **Independent Contractor.** This Agreement is not intended to create nor shall it be construed to create any relationship between Plan and Group Practice 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.

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

6.03 **Group Practice’s Physicians, Assistants, Employees, and Equipment.** At Group Practice's sole expense, Group Practice may employ, subcontract, and use assistants and employees that are necessary to provide Covered Services to Covered Persons. Group Practice shall not employ or contract with any individuals who have been debarred or excluded by any State or Federal agency. Plan may not control, direct, or supervise Group Practice's assistants or employees in the provision of Covered
Services, but Group Practice shall ensure that all applicable individuals undergo rigorous credentialing and oversight under applicable standards, and services provided by them shall comport with Plan’s utilization review/quality management processes. Group Practice shall supply all necessary equipment and supplies required to provide Covered Services. In addition, Group Practice understands that if Group Practice intends to enter into any subcontract agreement with another provider to provide their licensed health care services to a Covered Person, where the subcontracted provider will bill Plan or Covered Persons directly for the subcontracted services, Group Practice must notify Plan of same in advance of any such subcontract relationship in order for Plan to ensure that such subcontract agreement meets all of the requirements of Kentucky Revised Statute Chapter 304 Subtitle 17A applicable to provider agreements and so that Plan may file such subcontract agreement with the Kentucky Department of Insurance in accordance with KRS 304.17A-527.

ARTICLE VII. TERM AND TERMINATION

7.01 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.

7.02 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 notice of breach from the non-breaching Party.

7.03 Termination for Cause. Either Party to this Agreement may terminate this Agreement immediately for cause. Such termination shall be effective as of the date in which the terminating Party provides a termination notice to the non-terminating Party in accordance with the notice provisions set forth in Section 10.08 herein. For purposes of this Section 7.03, “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 Group Practice to Plan including but not limited to billing information or information set forth in Group Practice's Credentialing or Recredentialing application;

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

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

(e) failure of Group Practice or Plan to maintain required liability coverage protection;

(f) commission or omission of any act or conduct by Group Practice or its employees which is deemed by the Plan Medical Director 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;
the occurrence of any act or omission which involves fraud or dishonesty whether or not in Group Practice’s professional capacity;

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;

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

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

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

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

7.05 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.

7.06 Effect of Termination on Credentialed Status. Upon termination of this Agreement for any reason, Group Practice’s Credentialed status with Plan shall be revoked, effective as of the date of such termination.

7.07 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 Group Practice or Plan from obligation under this Agreement prior to the effective date of termination. Group Practice agrees to provide Covered Services to Covered Persons through the last day of this Agreement and accept payment from Plan, pursuant to this Agreement, through the day of termination of this Agreement. Upon termination of this Agreement for any reason, Plan shall, at its discretion or as required by State or Federal requirements, notify Covered Persons that Group Practice is no longer a Participating Provider. Plan shall pay for Covered Services rendered to a Covered Person by a PCP or Group Practice between the date of termination and five (5) days after notification of termination is mailed to the Covered Person at the Covered Person’s last known address. Group Practice, upon termination of this Agreement, shall promptly supply all records necessary for the settlement of outstanding medical bills. Group Practice agrees to transfer copies of Covered Persons’ medical records to the new Participating Provider within ten (10) days following notification being given to Group Practice of new Participating Provider, if applicable. This section shall survive the termination of this Agreement.

7.08 Continuance of Care. Upon termination of this Agreement for any reason other than a quality of care issue or fraud, Group Practice agrees to continue to provide Medically Necessary Covered Services and Plan agrees to continue to compensate Group Practice for the provision of Medically Necessary Covered Services as follows, but only in accordance with the terms of this Agreement and the Covered Person’s Health Benefit Plan:

(a) until the applicable Covered Person is discharged from an inpatient facility or the active course of treatment is completed, whichever time is greater, and
(b) until the end of the post-partum period in the case of a Covered Person who is a pregnant woman and who is in her fourth or later month of pregnancy at the time this Agreement is terminated.

This Continuance of Care provision shall survive the termination of this Agreement for any reason.

7.09 Summary Suspension. The President and Chief Executive Officer of Plan, in consultation with the Plan’s Chief Medical Officer, shall have the absolute power to summarily suspend Group Practice or any Group Practice Provider if it appears that same is engaged in behavior or is practicing in a manner that appears to pose a significant risk to the health, welfare or safety of a Covered Person or Covered Persons. In the event of a summary suspension, Group Practice or Group Practice Provider, as the case may be, shall have the rights afforded to providers under Plan’s “Fair Hearing Plan,” which is available at www.caresource.com.

ARTICLE VIII. INDEMNIFICATION AND LIMITATION OF LIABILITY

8.01 Indemnification. Plan and Group Practice 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 or care, rule or regulation. The obligation to provide indemnification under this Agreement shall be contingent upon the Party seeking indemnification providing the indemnifying Party with prompt written notice of any claim for which indemnification is sought, allowing the indemnifying party to control the defense and settlement of such claim, provided, however, that the indemnifying Party agrees not to enter into any settlement or compromise of any claim or action in a manner that admits fault or imposes 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.

8.02 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 Plan be liable to Group Practice for any extra contractual damages relating to any claim or cause of action assigned to Group Practice by any person or entity.

8.03 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 IX. DISPUTE RESOLUTION AND GOVERNING LAW

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

9.02 **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.

9.03 **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) 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.

9.04 **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 Health Lawyers Association Alternative Dispute Resolution Services Rules of Procedure for Arbitration (the “AHLA Rules”); and (b) determined and settled by a panel of three (3) arbitrators selected in accordance with the AHLA Rules. Franklin County, Kentucky shall be the sole, proper venue of any arbitration. 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 VIII 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.

9.05 **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 Plan and Group Practice in any Covered Person’s suit against Plan or Group Practice, unless a court requires the Parties to submit the Covered Person’s entire claim to arbitration.
9.06 **Governing Law and Venue.** The validity, enforceability and interpretation of this Agreement shall be governed by any applicable Laws. Franklin County, Kentucky 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 Franklin County, Kentucky, in order to enforce any arbitration decision issued by the American Health Lawyers 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.

**ARTICLE X. MISCELLANEOUS TERMS**

10.01 **Contracting Authority.** Group Practice represents and warrants that it has full legal authority to bind its employed physicians and practitioners to the terms of this Agreement.

10.02 **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, Plan shall deem the Agreement to be amended with such new or revised language or requirements.

10.03 **Compliance with Regulatory Requirements.** Group Practice 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 10.10.

10.04 **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 the Plan 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 assets. Any attempted assignment in violation of this paragraph shall be void.

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

10.06 **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.

10.07 **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.

10.08 **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 Group Practice shall also provide a copy of any notice sent pursuant to this Agreement to the Plan’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.

10.09 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 or other manuals or documents, then this Agreement shall control.

10.10 Amendment. Plan reserves the right to unilaterally amend this Agreement, the Plan Compensation Schedules, or any Attachments or Addenda. If Plan’s amendment will make a Material Change to the Agreement, the Plan Compensation Schedules, or any Attachments or Addenda, Plan will provide Group Practice at least ninety (90) days’ prior written notice of the Material Change. Such written notice will include a description of the Material Change and a statement that Group Practice has the option to withdraw from the Agreement as set forth in subpart (b), below, prior to the Material Change becoming effective. If Group Practice does not withdraw from the Agreement as set forth in subpart (b) below, then Plan’s amendment shall become effective ninety (90) days from the date of the written notice of Material Change.

(a) Material Changed Defined. For purposes of this provision, a Material Change means a change to the Agreement, Plan Compensation Schedules, Attachments or Addenda, the occurrence and timing of which is not otherwise clearly identified in the Agreement, that decreases Group Practice’s payment or compensation or changes the administrative procedures in a way that may reasonably be expected to significantly increase Group Practice’s administrative expense.

(b) Option to Withdraw. For Group Practice to effectively withdraw from the Agreement following receipt of Plan’s notice of Material Change, Group Practice must send written notice of withdrawal to the Plan no later than forty-five (45) days prior to the effective date of the Material Change.

Any Plan amendment to this Agreement, the Plan Compensation Schedules, or any Attachments or Addenda that does not include a Material Change will be provided in writing to Group Practice at least thirty (30) days prior to the date in which such amendment will take effect. This includes any amendment to this Agreement that changes an existing prior authorization, precertification, notification, or referral program, or changes an edit program or specific edits, unless such an amendment could constitute a Material Change.

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: _________________________________

PLAN:

CareSource Kentucky Co.
10200 Forest Green Blvd., Suite 400
Louisville, KY 40223

By: _________________________________
Title: _______________________________
Date: _______________________________

GROUP PRACTICE:

[insert legal name of Group Practice]

Address: _________________________________

By: _________________________________
Title: _______________________________
Date: _______________________________
Group Practice Tax ID: ____________________________
**Plan Compensation Schedule**

This Plan Compensation Schedule is applicable to Plan’s individual market health maintenance organization policies sold to residents of the Commonwealth of Kentucky.

Plan agrees to provide or make available to Group Practice, upon Group Practice’s request, the payment or fee schedule information sufficient to enable Group Practice to determine the manner and amount of payments under this Agreement for Group Practice’s services prior to the final execution of this Agreement and any renewal thereto. Plan further agrees that any change to payment or fee schedules set forth herein shall be made available and provided to Group Practice at least ninety (90) days prior to the effective date of the change, except for changes to standard codes and guidelines developed by the American Medical Association or a similar organization.