CARESOURCE PROVIDER AGREEMENT
SIGNATURE PAGE

In consideration of the promises and representations stated, the Parties agree as set forth in this Agreement, the Authorized Representative acknowledges, warrants, and represents that the Authorized Representative has the authority and authorization to act on behalf of its Party. The Authorized Representative further acknowledges and represents that he/she received and reviewed this Agreement in its entirety.

The Authorized Representative of Provider acknowledges the Provider Manual was available for review prior to entering into this Agreement and agrees that Provider will comply with the provisions set forth under the Provider Manual section and other applicable provisions related to the Provider Manual in the Agreement.

The Authorized Representative for each Party executes this Agreement with the intent to bind the parties in accordance with this Agreement.

IN WITNESS WHEREOF, the Parties have executed and delivered this Agreement as of the last dated signature below ("Effective Date").

PROVIDER

on behalf of itself and its subsidiary
Federal Tax Identification Numbers:

Signature:_____

Name
(Printed):_____

Title
(Printed):_____

Date:_____

_____
Mailing Address – Official Correspondence

_____

CARESOURCE NETWORK PARTNERS, LLC,

on behalf of itself and its Affiliates

Signature:_____

Name
(Printed):_____

Title
(Printed):_____

Date:_____

_____
Mailing Address – Official Correspondence

_____

THIS AGREEMENT is made and entered into by and between CareSource Network Partners LLC, an Ohio limited liability company, on behalf of itself and its Affiliates ("**CareSource**"), and _____("**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, Appendices, Attachments and Addenda, shall have the meanings set forth below:

1.01 **"Affiliate"** means with respect to CareSource any subsidiary, joint venture, or partner of CareSource, as well as any entity identified by CareSource as an Affiliate, which is owned by CareSource, or under common control of CareSource, directly or indirectly, or any entity which is under common ownership, directly or indirectly, in whole or in part, with CareSource. With respect to Provider, "Affiliate" means any corporation, partnership or other legal entity directly owned or controlled by, which owns or controls, or that is under common ownership or control of Provider.

1.02 **"Agreement**" means this agreement including all Exhibits, Appendices, Attachments, and Addenda, attached hereto.

1.03 **"Claim"** means an electronic claim form submitted by Provider to CareSource unless another means of submission is expressly agreed to in writing by CareSource or permitted by Law. Other requirements for submitting a Claim are contained in CareSource's Policies and Procedures.

1.04 **"Clean Claim"** means, unless otherwise defined by Law, a Claim for services provided to a Covered Person that is submitted pursuant to this Agreement, can be processed and determined without obtaining additional information from the Provider or from a third party, does not involve coordination of benefits, third party liability or subrogation, is not under review for Medical Necessity, under investigation for fraud, waste, or abuse, or contains any material defect or error that prevents timely adjudication.

1.05 **"Cost Share**" means 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.

1.06 **"Covered Person**" means any individual, or eligible dependent of such individual, who is enrolled in a Health Benefit Plan and eligible to receive Covered Services.

1.07 **"Covered Services**" means Medically Necessary Health Services as determined by CareSource in accordance with applicable Law and described in the applicable Health Benefit Plan.

1.08 **"Credentialing/Recredentialing or Credentialed/Recredentialed**" means CareSource's or its delegate's process of gathering, verifying, and evaluating information to determine whether applicable practitioners and facilities comply with CareSource's Network participation standards and/or NCQA standards.

1.09 **"Government Authority**" means any state, federal, local, territorial, regulatory, and/or other government entity that governs any of the services performed by either Party to this Agreement.

1.10 **"Health Benefit Plan(s)**" means any product or government program now or hereafter established, marketed, administered, sold or sponsored by CareSource under which CareSource is obligated to provide coverage of Covered Services to Covered Persons, as defined in CareSource 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

means the document(s) that set forth Covered Services, rules, exclusions, terms and conditions of coverage. Such document(s) may include but are not limited to a Member handbook, a health certificate of coverage, or evidence of coverage.

1.11 **"Health Services**" means those services or supplies that a health care provider is licensed, equipped, or otherwise approved to provide and which such provider provides to or arranges for individuals. Provisions regarding Provider's specific Health Services are outlined in Appendix B.

1.12 **"Law(s)**" means all applicable federal, state and local laws, statutes, regulations, decrees, ordinances, licensing requirements, standards of professional ethics and practice, treaties, instructions, writs, decisions, judgements, the decisions of any Government Authority, and the terms and conditions of any contract between CareSource and any Governmental Authority. This includes, but is not limited to, any state or product specific regulatory language included in this Agreement.

1.13 **"Medically Necessary/Medical Necessity**" means the definition set forth in the Policies and Procedures and/or Product Specific Exhibit(s).

1.14 **"Network"** means a group of Participating Providers that support one or more Health Benefit Plan(s) in which Covered Persons are enrolled. Provider shall be eligible to participate in only those Networks designated in Product Specific Exhibit(s).

1.15 **"Network Notifications"** means 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.

1.16 **"Non-Covered Services**" means Health Services that are not Covered Services.

1.17 **"Overpayment"** means any funds that a Provider receives or retains of which the Provider is not entitled under the terms of this Agreement.

1.18 **"Participating Provider"** means a health care professional, facility, or other person or entity, including Provider, that has satisfied all applicable CareSource credentialing Policies or Procedures or has otherwise been approved by CareSource, and has entered into an agreement with CareSource to participate in designated Networks..

1.19 **"Party or Parties**" means Provider or CareSource, as the case may be, each of which shall be individually referred to as a Party. Collectively, Provider and CareSource shall be referred to as the Parties.

1.20 **"Policies and Procedures**" means the applicable provider manual and those policies, procedures, 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/Recredentialing processes, utilization management, quality improvement, peer review, grievance process, and concurrent review.

1.21 **"CareSource's Provider Website"** means the online provider tool, including the provider portal that providers should access through CareSource's website, as well as those other portions of CareSource's website containing resources for Participating Providers.

1.22 **"Product Specific Exhibit(s)"** means those Exhibit(s), in Appendix C of this Agreement, that provide the additional terms and conditions applicable to a specific Health Benefit Plan and a corresponding state.

ARTICLE II
SERVICES/OBLIGATIONS

2.01 **Provision of Health Services**. Provider shall provide all Covered Services, and cause all employees, agents and subcontractors to provide all Covered Services, in accordance with this Agreement, applicable licensure and/or certification requirements, Laws, generally accepted standards of medical practice, and Policies and Procedures. Provider shall provide 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 during the term of this Agreement or following termination of this Agreement, Provider agrees to be bound by and to abide by the terms of this Agreement, and CareSource requirements as set forth in Policies and Procedures. Provider is responsible to check for updates on CareSource's Provider Website including 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(s) as set forth in the Policies and Procedures, Provider will only allow Credentialed providers employed by Provider to serve Covered Persons.

2.02 **Licensure**. Provider represents that it and each of its employed providers or agents has a current, valid, and unrestricted license in the state in which it provides services to Covered Persons and that it, and they, are compliant with all applicable Laws. Provider also represents and warrants that it has the authority to conduct business in the state(s) in which it provides any services to Covered Persons.

2.03 **Government Programs Exclusion**. Provider represents that neither Provider nor any employee, agent or subcontractor of Provider is suspended and/or excluded from doing business with any Government Authority, state and/or federal government programs.

2.04 **Required Notices**. Provider shall make commercially reasonable effort to give notice to CareSource within five (5) business days of Provider's knowledge or when the Provider should have known, of any event that could be expected to impair the ability of Provider, or its agents providing services on its behalf, to comply with the obligations of this Agreement, including but not limited to any of the following: (a) an occurrence that causes any of the representations in this Agreement made by or on behalf of a Provider to be inaccurate, (b) Provider fails to maintain insurance as required by this Agreement, (c) Provider's license, certification or accreditation expires or is suspended, revoked, conditioned or otherwise restricted, (d) Provider is suspended, excluded, debarred, or sanctioned under a federal health care program, (e) a disciplinary action is initiated by a Governmental Authority against a Provider, (f) Provider's hospital privileges are suspended, limited, revoked or terminated, (g) Provider is under investigation for fraud or a felony, and/or (h) Provider entered into a settlement related to any of the foregoing.

2.05 **Policies and Procedures**. Provider acknowledges its obligation to comply with all Policies and Procedures applicable to Health Services provided to Covered Person. CareSource, in its sole discretion, may make changes to Policies and Procedures as it deems may be required to administer Health Benefit Plans consistent with applicable Laws and subject to required approval from a Government Authority Except as prohibited by Law, CareSource may communicate changes to Policies and Procedures by posting such changes on its CareSource's Provider Website. Provider is responsible for regularly monitoring CareSource's Provider Website to keep apprised of such changes. CareSource shall make commercially reasonable efforts to provide thirty (30) days prior written notice of changes to Policy and Procedures which are expected to have a material impact on Provider's payments or obligations under this Agreement, unless a different notice period is required by Law. Where the change to a Policy and Procedure is a result is the result of a change in Law, Provider shall comply with any such change(s) prior to the effective date.

2.06 **Accreditation Programs**. Provider acknowledges that CareSource and/or its Affiliates participate(s) in certain accreditation programs, such as the National Committee for Quality Assurance ("**NCQA**"), and Provider agrees to participate and assist CareSource in Audits, programs, reviews and any other activity required for same.

2.07 **Rights of Covered Persons**. Neither Provider nor any employees, agents or subcontractors 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, 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, as the case may be. Provider acknowledges that: (i) Covered Persons have a right to be treated with respect and recognition of their dignity and need for privacy; (ii) Covered Persons have a right to participate in decision-making regarding their treatment planning; and (iii) Covered Persons have a right to voice complaints or appeals about Provider or the care provided.

2.08 **Provider Locations and Affiliates**. Provider agrees to provide Covered Services only through those Affiliates, locations and providers listed on Appendix A of this Agreement, as updated via approved electronic notification. Provider shall immediately notify CareSource in the event any of the information listed in Appendix A changes. The Parties agree that an Affiliate of Provider, new location or individual provider shall not be added to the definition of Provider under this Agreement or to this Agreement unless and until the Parties agree in writing that such Affiliate is bound to the terms of this Agreement.

2.09 **Laboratory Certification**. 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.

2.10 **Credentialing/Recredentialing.** Provider must meet all applicable Credentialing/Recredentialing requirements prior to the effective date of this Agreement. In the event Provider has not been credentialed prior to the Effective Date of this Agreement, this Agreement shall not take effect until Provider is credentialed. Provider acknowledges that it has access to applicable Credentialing Policies and Procedures and agrees to comply with same. CareSource shall have no obligation to pay providers that are not fully Credentialed for any services rendered prior to the completion of the Credentialing requirements. Provider acknowledges that CareSource may delegate Credentialing/Recredentialing to another entity.

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

2.12 **Provider Insurance**. 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 as required by Credentialing requirements, along with 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(s). 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 before any court or arbitration organization (such as AHLA or JAMS) 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 and Provider may satisfy this paragraph by self-insurance programs which are lawful in structure and amounts of retained limits.

2.13 **CareSource Insurance.** CareSource shall maintain insurance of the nature and in the amounts as may be required by Law.

2.14 **Covered Person Identification**. CareSource shall ensure Covered Persons have a means of identifying themselves as a Covered Person by issuing a paper, plastic, electronic or other document to each Covered Person. The identification shall permit Provider to determine a Covered Person's participation in a Health Benefit Plan. The existence of such identification is not a guaranty of payment from CareSource, and the lack of identification does not mean the individual is not a Covered Person. Provider is required to confirm an individual's eligibility for Health Services prior to submitting a Claim to CareSource

2.15 **Grievance System**. CareSource shall maintain and administer a grievance system for Covered Persons. Provider agrees to cooperate with CareSource in the resolution of complaints made by Covered Persons and comply with all final determinations made by CareSource. Complaints received by CareSource concerning services rendered by Provider and/or its employees, agents, subcontractors will be resolved in accordance with the grievance procedure.

2.16 **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.

2.17 **Description of Covered Services**. CareSource shall make available a description of Covered Services through the CareSource's Provider Website, and/or other methods of communication as deemed appropriate by CareSource or as required by Law.

2.18 **Accessibility**. Provider agrees to keep reasonable office hours or facility hours for Covered Persons in accordance with CareSource Policies and Procedures or as required by Law. Provider agrees to provide Covered Persons with access to Covered Services without undue delay and as soon as necessary in consideration of the Covered Person's medical condition.

2.19 **Quality Improvement and Utilization Management**. Provider agrees to cooperate with, participate in, and comply with the requirements of CareSource's quality improvement 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 within five (5) days of 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 notify CareSource within five (5) days after it has been determined that the basis for any such complaint, inquiry, investigation, or review is substantiated (an adverse outcome).

Provider will assist CareSource in fulfilling CareSource's legal obligations with respect to the collection and reporting of data including, but not limited to, HEDIS and STARs requirements.

2.20 **Referral Incentives/Kickbacks.** Provider represents that Provider does not give, provide, condone, or receive any incentives or kickbacks, monetary or otherwise, in exchange for a referral of a Covered Person. Further, if a Claim is attributable to an incentive or kickback, such Claim shall not be paid, and if paid shall be considered an Overpayment due to CareSource.

ARTICLE III
CLAIMS AND PAYMENTS

3.01 **Claims and Encounters**. Provider shall submit Claims and accurate and complete encounter data to CareSource for all Covered Services in accordance with Policies and Procedures and applicable Law. Upon CareSource's request, Provider will, at no cost to CareSource, supply CareSource electronically an itemized bill and supporting medical records for Health Services rendered to Covered Persons.

3.02 **Time to File and Payment of Claims**. Provider shall submit Clean Claims within the time frames set forth on the applicable Policies and Procedures and Product Specific Exhibits, and CareSource will adjudicate and pay those Clean Claims for Covered Services within the times frames provided in Policies and Procedures and Product Specific Exhibit(s),

3.03 **Payment in Full.**

(a) Provider agrees to accept as payment in full, in all circumstances, for Covered Services, the payment set forth in the Product Specific Exhibit(s) whether such payment is in the form of a Cost Share, a payment by CareSource, or payment by another source. In no event shall CareSource be obligated to pay Provider any amounts in excess of the payment set forth in the Product Specific Exhibit(s) less any applicable Cost Shares or payments to Provider by another source including, but not limited to, payments received in connection with coordination of benefits. Provider agrees to accept the payment set forth in the Product Specific Exhibit(s) as payment in full from CareSource even if the Covered Person has not yet satisfied his or her Cost Shares.

(b) Provider shall bill and collect the Cost Shares owed by Covered Persons. Provider agrees to make reasonable efforts to verify Cost Shares prior to billing for such Cost Shares. Except as permitted by Law, Provider shall not bill or collect from Covered Persons payment of Covered Services in excess of Cost Share amounts provided in applicable Health Benefit Plan(s) including, but not limited to, in the event of insolvency of CareSource, breach of this Agreement, or denials or adjustments based on miscoding or other billing errors.

3.04 **Non-Covered Services**. CareSource has no obligation to compensate Provider for Non-Covered Health Services. Provider agrees that in order to seek payment from a Covered Person for Health Services that are not Medically Necessary or experimental/investigative, Provider must, in advance of providing such Health Services, give the Covered Person written notice and the Covered Person must acknowledge, in writing, receipt of such notice that the Health Services that are not Medically Necessary, nor experimental/investigative are Non-Covered Services, and that the Covered Person will be responsible for payment of such Non-Covered Service. Such advanced written notice shall also include an estimated amount of the cost of the Non-Covered Services and contain all other information that is required by Policies and Procedures and Law. Provider may bill Covered Persons for such Non-Covered Services only in accordance with the provisions of this Agreement. Any payments made by CareSource to Provider or representatives of Provider for Non-Covered Services may be recovered as Overpayments pursuant to the terms of this Agreement, Policies and Procedures, and Product Specific Exhibit(s), to the extent permitted by Law.

3.05 **Subrogation, Recovery, and Coordination of Benefits.** Provider agrees to cooperate with CareSource and promptly provide information regarding subrogation, recovery, and coordination of benefits, as set forth in the Policies and Procedures and Product Specific Exhibit(s).

3.06 **Covered Person Held Harmless**. Provider agrees to hold all Covered Persons harmless in accordance with the Product Specific Exhibit(s) or as required by applicable Law.

3.07 **Pre-Determination of Coverage**. CareSource shall provide a method for verifying whether a Health Service is a Covered Service pursuant to the terms of a Health Benefit Plan. Provider agrees to comply with any applicable precertification and/or prior-authorization requirements in the Policies and Procedures. Provider agrees that determinations or representations that an individual is a Covered Person that the services requested are Covered Services, or a determination of whether a Health Service is Medically Necessary is not a final determination of Claim payment, unless otherwise provided by Law. Payment of the Claim is subject to all the terms and conditions of the applicable Health Benefit Plan.

3.08 **Claim Denial Appeals**. Appeals of Claims denied by CareSource will be processed in accordance with the time frame and requirements of the applicable the Policies and Procedures and Product Specific Exhibit.

3.09 **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 Policies and Procedures. Such standard billing rules include, but are not limited to: (a) CPT and HCPCS coding; (b) UB manual and editor; (c) CMS rules, including

bundling/unbundling rules and multiple procedure billing rules; (d) NCCI Edits; and (e) FDA definitions and determinations of designated implantable devices, implantable orthopedic devices, and specialty pharmacy and drugs. Such reviews are not considered audits.

(b) CareSource shall have access to any of Provider's books, contracts, medical records, patient care documentation, payment and other financial data and records that pertain to any aspect of Health Services provided to Covered Persons for inspection and audit as may be reasonably required by CareSource to satisfy the terms of this Agreement, Policies and Procedures, Health Benefit Plans or as required by Law. In lieu of on-site access and at CareSource's request, Provider shall submit requested records to CareSource, within thirty (30) days at no cost to CareSource. In addition, Provider shall make records available, at no cost, to CareSource and/or state and federal authorities in connection with Covered Persons grievances, complaints, and appeals. Provider acknowledges that failure to submit records to CareSource in connection with the review of a Claim may result in a denial of that Claim under review.

(c) Termination of this Agreement shall not terminate or otherwise limit CareSource's rights under this Section.

3.10 **Claim Adjustments**. 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 or underpayment in accordance with this Agreement, Policies and Procedures and Law.

If CareSource determines that an Overpayment has been made to Provider, CareSource will notify Provider of such Overpayment and the Provider shall refund any amounts due 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. If Provider disagrees with any determination by CareSource that Provider has received an Overpayment, Provider shall have the right to appeal such determination as provided in Policies and Procedures; however, such appeal shall not suspend CareSource's right to recover the Overpayment during the appeals process, unless otherwise prohibited by Law.

3.11 **Never Event(s)**. "Never Event" means errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, as further defined by CMS or such other guidance issued by CMS. 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 or CareSource may offset amounts owed from future payments in accordance with Law. Further, Provider shall cooperate with CareSource, to the extent reasonable, in any CareSource initiative designed to help analyze and/or reduce Never Events.

3.12 **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.

3.13 **Survival**. This entire Article shall survive even after termination of this Agreement.

ARTICLE IV
INFORMATION AND RECORDS

4.01 **Confidentiality**. Provider acknowledges and agrees that all information relating to CareSource's quality assurance, utilization management, risk management, Policies and Procedures, this Agreement, including rates of compensation payable under this Agreement and all other information related to CareSource's programs, Policies and Procedures, is confidential and proprietary information. Provider shall not disclose any such information to any person or entity without

CareSource's express written consent or as required by Law. Notwithstanding the terms of this provision, Provider may disclose such information to its legal or business advisors as long as such legal or business advisors agree to keep such information confidential according to the terms of this Agreement. Provider shall immediately notify CareSource in the event that Provider is required to disclose CareSource's confidential and proprietary information to a third party other than its legal or business advisors including, but not limited to, disclosure to a Government Authority or pursuant to a court order.

4.02 **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 payment of Claims, quality improvement program, Credentialing/Recredentialing, utilization management, peer review, transfer of records to providers, and other programs required for CareSource administration of this Agreement;

(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, at no cost, to CareSource or its designee copies of such records as may be requested by CareSource 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 in accordance with applicable 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 subject to obtaining necessary authorization for release of medical records as required by Law.

4.03 **Destruction of Information.** Should Provider receive from CareSource misrouted information about an individual that Provider is not currently treating, Provider shall immediately destroy any misrouted information, safeguard the information for as long as it is retained, or immediately contact CareSource to report receipt of such misrouted information.

4.04 **Access to Data**. Provider and CareSource represent that in conducting their operations, they shall each collect, share, and review certain quality and clinical data as permitted by Law. Where available, the Parties will work together in good faith to share such data with one another through health information exchanges ("HIEs") (when applicable) in furtherance of treatment purposes, payment purposes, or health care operations as defined in HIPAA (45 CFR 164.501) or as revised. 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 Law.

4.05 **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 CareSource's Provider Website in CareSource's provider directories or such other written or electronic literature distributed to existing or potential Covered Persons or Participating Providers. Provider's use of CareSource's name shall only be used 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.

ARTICLE V
RELATIONSHIP OF PARTIES

5.01 **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.

5.02 **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 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 Health Services to any Covered Person. CareSource agrees not to prevent Provider and its employees and agents from discussing all treatment options with Covered Persons.

5.03 **Physicians, Agents, Employees, and Equipment**. At Provider's sole expense, Provider may employ, subcontract, and use agents 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 employees, agents and subcontractors in the provision of Covered Services, but Provider shall ensure that all applicable individuals undergo Credentialing/Recredentialing and oversight under applicable standards, and services provided by them shall comport with CareSource's Policies and Procedures.

ARTICLE VI
TERM AND TERMINATION

6.01 **Term of the Agreement.** This Agreement shall begin on the Effective Date and continue for one (1) year and thereafter will automatically renew for successive one (1) year terms unless written notice of termination is provided by a Party in accordance with this section.

6.02 **Termination.** Unless otherwise set forth in a Product Specific Exhibit, this Agreement may be terminated as follows:

6.03 **Termination Without Cause**. Either Party may terminate this Agreement or any Appendix or Exhibit hereto within at least one hundred and eighty (180) days' written notice to the other party, unless a longer notice period is otherwise required by the terms of a Product Specific Exhibit or Law.

6.04 **Termination for Breach of Agreement - Option to Cure Breach.** In the event a Party fails to comply with any material term of this Agreement, the other party may notify the breaching party of its breach in writing detailing the nature of the issue(s) giving rise to the breach. The breaching party shall have thirty (30) days to cure the breach. If the breach is not cured to the reasonable satisfaction of the non-breaching party within the cure period, the non-breaching party may terminate this agreement, which termination shall be no earlier than ninety (90) days from the date of the end of the cure period.

6.05 **Termination for Breach of Agreement - No Option to Cure Breach.** This Agreement and all Appendix(es) and Exhibit(s) shall terminate immediately up the reasonable determination by CareSource that any of the following have occurred:

(a) Provider is convicted of a felony;

(b) Provider has filed a petition for bankruptcy or liquidation or otherwise becomes insolvent;

(c) Provider's loss or suspension of license or is otherwise restricted from providing Covered Services;

(d) Provider's insurance coverage as required under the terms of this Agreement has lapsed;

(e) Provider has committed a fraud or material misstatement in materials submitted to CareSource or government agency;

(f) Provider has placed the health of a Covered Person in jeopardy;

(g) Provider fails to maintain compliance with CareSource's applicable Credentialing/Recredentialing requirements or other CareSource requirements for participation in a Network;

(h) Provider is ineligible or excluded from participating in a government sponsored Health Benefit Plan; or in the case of an employee or contractor of Provider, Provider fails to remove such individual from responsibilities related to this Agreement.

CareSource may terminate an individual health care provider from providing Covered Services under this Agreement as specified by this Section.

6.06 **Continuation of Care.** Provider shall provide continuation of care health services requirements required by Policies and Procedures, Appendix(es), Product Specific Exhibit(s) or Law.

ARTICLE VII
INDEMNIFICATION AND LIMITATION OF LIABILITY

7.01 **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 (1) the indemnifying Party's violation of any Law or standard of care or (2) the indemnifying Party's performance or non-performance of any obligations under 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 with the indemnifying Party in connection with such defense and settlement.

7.02 **Limitation of Liability**. In no event shall either Party be liable to the other Party 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.

7.03 **Period of Limitations**. Unless otherwise provided for in this Agreement or required by Law, neither Party shall commence any arbitration against the other to recover on any claim arising out of this Agreement or action in law or equity 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 a Health Benefit Plan. Where Provider believes that CareSource underpaid a Claim, the event giving rise is the date when CareSource first denies the Claim or first pays less than the amount expected by Provider. Where CareSource believes that it overpaid Provider, the event giving rise is the date when CareSource provides notice to Provider of the Overpayment. The deadline for initiating an action shall not be tolled by the appeal process or any other administrative process. This two (2) year limitation does not apply to any claim related to fraud, waste, or abuse.

ARTICLE VIII
DISPUTE RESOLUTION AND GOVERNING LAW

8.01 **Dispute Resolution**. The Parties will use good faith efforts to resolve any issue, dispute or controversy arising out of or relating to this Agreement. Prior to electing the dispute resolution process contained in this Agreement, Provider must exhaust the applicable internal and external review or appeal process provided in Policies and Procedures, Product Specific Exhibit(s) and Law. Provider will provide CareSource with written notice of a dispute and within thirty (30) days of receipt of such notice, the representatives of both Parties will have a conference call or shall meet to exchange relevant information to attempt to resolve the dispute. The notice of the dispute must contain a detailed description of the amounts in dispute, and how those amounts have been calculated, and other information relevant to the dispute. If either Party intends to have an attorney attend a meeting or participate in a conference call, it will notify the other Party at least two (2) business days before the meeting to enable the other Party to also be accompanied by an attorney. All negotiations pursuant to this provision will be treated as compromise and settlement negotiations for purposes of evidentiary rules. If the Parties are not able to resolve the matter within sixty (60) days of the initial notice, each Party is free to pursue binding arbitration. The Parties, however, may agree to extend any deadline within this paragraph.

8.02 **Binding Arbitration**. Any dispute not resolved after the Parties have exhausted the dispute resolution process described above shall be: (a) conducted in accordance with the American Arbitration American Health Lawyers Association Arbitration Rules and Mediation Procedures (the "**AHLA Rules**"); and (b) determined by an arbitrator if the amount in dispute is over $1,000,000 and settled by a panel of three (3) arbitrators for disputes in excess of $1,000,000. All arbitrators will be selected in accordance with the AHLA Rules. The arbitrators shall have no authority to award any consequential damages. 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. Each Party waves the right to join or consolidte claims in arbitration by or against other individuals or entities or to pursue, on a class basis, any dispute.

The Parties agree that they shall maintain the confidential nature of the arbitration, including without limitation, the existence of the arbitration, information exchanged during the arbitration, and the award of the arbitrator(s). Nothing in this provision, however, shall preclude either party from disclosing any such details regarding the arbitration to its accountants, auditors, brokers, insurers, reinsurers or retrocessionaires.

The costs of the arbitration shall be borne equally by the 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.

8.03 **Exception to Arbitration**. Notwithstanding the foregoing, either Party may seek equitable remedies in any court of competent jurisdiction to protect its intellectual property or confidential information.

8.04 **Governing Law and Venue**. The Parties agree to the governing law and venue provisions set forth in the Product Specific Exhibit(s). The Parties agree that the Product Specific Exhibit(s) applicable to a Dispute shall be determined by the state in which the Health Benefit Plan at issue is offered, unless otherwise preempted by Law. In the event that more than one Product Specific Appendix 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 or other proceeding between the Parties that arises out of or is in connection with any right, duty or obligation under this Agreement.

ARTICLE IX
MISCELLANEOUS TERMS

9.01 **Contracting Authority**. Provider represents and warrants that it has full legal authority to bind its employed physicians, practitioners and the Affiliates listed on Appendix A to the terms of this Agreement. CareSource represents that it has full legal authority to bind its Affiliates to the terms of this Agreement.

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

9.03 **Compliance with Laws/Regulatory Requirements**. Provider shall perform its duties, and shall cause its employees, agents, and subcontractors to perform their duties, in compliance with all applicable Laws, rules, regulations, standards of professional ethics and practices, government directives, and contractual obligations of CareSource. Provider acknowledges, understands, and agrees that this Agreement and any subsequent amendments 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 required by such agencies or required by Law shall be incorporated herein as provided in the Amendment section.

9.04 **Assignment and Delegation**.

9.04.01 **By Provider**. Provider may not assign or transfer this Agreement to any person or entity without CareSource's prior written consent. Any attempted assignment, novation, or transfer without same shall be considered null and void. For the purposes of this provision, a change in control from a merger, stock transfer, consolidation, change in majority ownership or sale or transfer of a majority of stock ownership shall be considered an assignment, novation or transfer, even if it occurs through operation of law. Any attempted assignment in violation of this paragraph shall be void.

Provider may not delegate or subcontract its provider services or other contractual obligations under this Agreement without CareSource's prior written consent. Provider agrees that CareSource or any applicable governmental authority shall have the right to suspend or terminate any delegation or subcontract where, in its sole discretion, it is determined that provider or the delegate or subcontractor has performed unsatisfactorily. Any subcontract or delegation must be in writing and oblige the subcontractor to abide by the terms of this Agreement and applicable Laws.

9.04.02 **By CareSource**. CareSource may not assign by operation of law or otherwise, delegate, transfer in whole or part, without the prior written consent of Provider, 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.

9.05 **Non-Exclusivity**. The Parties enter into this Agreement on a nonexclusive basis. CareSource reserves the right to establish other networks or subnetworks for certain or all Health Services for one or more Health Benefit Plans, based on quality, cost, effectiveness or other criteria, which may involve differential Cost Shares or other Covered Person incentives. In such event, CareSource agrees to provide Provider with written notice at least sixty (60) days in advance of implementation of such network or subnetwork.

9.06 **New Health Benefit Plan(s)**. Unless prohibited by Law, CareSource reserves the right to determine, in compliance with applicable Laws, which new Health Benefit Plan(s) Provider shall participate in and does not guarantee Provider's participation in new Health Benefit Plan(s) that CareSource may introduce. Notwithstanding, CareSource represents that Provider shall have the ability to participate in new products, provided Provider meets all criteria and standards established and evaluated by CareSource.

9.07 **Entire Agreement**. This Agreement 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.

9.08 **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.

9.09 **Regulatory Approval**. Where regulatory approval is needed for the Agreement, and CareSource has not received same, the Agreement is not effective until the Parties receive the required approval. In the event regulatory approval is not obtained, the Agreement is null and void.

9.10 **Notice**. All notices and other communications required to be given under this Agreement shall be in writing and either: (i) sent via e-mail with proof of receipt; (ii) via CareSource's provider portal; or (iii) deposited in first class United States mail, certified, with postage prepaid 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, such notice shall be deemed received two (2) days after such notice was sent.

9.11 **Conflict Between Documents**. If there is any conflict between this Agreement and the Policies and Procedures, CareSource's Provider Website, or other manuals or documents, then this Agreement shall control.

9.12 **Amendment**.

9.12.01 **Non-Regulatory Amendments.** The Parties may amend this Agreement and/or any Product Specific Exhibit, or other attachment, at any time by mutual written amendment or as otherwise specified in a Product Specific Exhibit.

9.12.02 **Regulatory Amendments.** CareSource may amend this Agreement and/or any Product Specific Appendix, or other attachment, unilaterally at any time, upon written notice to Provider where such amendment is required by Law. Any such amendment shall be effective on the date specified in the amendment or the date required by the applicable Law, whichever is earlier.

9.13 **Days.** Unless otherwise specified in a provision all date ranges in the Agreement are counted as calendar days.

9.14 **Counterparts.** This Agreement may be executed in counterparts and transmitted by mail, e-mail, or facsimile, and a scanned, electronic, or facsimile signature shall have the same force and effect as an original.

APPENDIX A – PROVIDER DIRECTORY APPENDIX

See attached

APPENDIX B – PROVIDER SPECIFIC HEALTH SERVICE PROVISIONS

See attached

APPENDIX C - PRODUCT SPECIFIC EXHIBIT(S)

See attached