NOTICE OF AMENDMENT - PHYSICIAN AGREEMENT

Pursuant to the executed Participating Provider Agreement between Physician and Commonwealth Health Corporation, d/b/a Center Care ("Network"), this NOTICE contains the Amendment to the Physician Agreement between Physician and Network ("Agreement") setting forth the terms of Physician’s participation in the Medicaid Managed Care Product ("Medicaid Product") of Kentucky Spirit Health Plan, Inc. ("MCO"). Now, therefore, the parties agree to amend the Agreement as follows:

1. **Product Attachment and Reimbursement Schedule.** The “Product Attachment” attached hereto as Appendix 1 and “Reimbursement Schedule” attached hereto as Appendix 2 shall govern Physician’s participation in the Medicaid Product and are incorporated as part of the Agreement.

2. **Cooperation with MCO Carve-Out Vendors.** Physician acknowledges that MCO may, during the term of the Agreement, carve-out certain Covered Services from its general provider contracts, including the Agreement, as MCO deems necessary to promote the quality and cost-effectiveness of services provided to Covered Persons. Physician shall cooperate with any and all third party vendors that have contracted with MCO or an Affiliate of MCO to provide services to Covered Persons.

3. **MCO Indemnification.** Physician agrees to indemnify and hold harmless (and at MCO’s request defend) MCO, its Affiliates, officers, employees and agents from and against any and all claims, loss, damages, liability, costs, expenses (including reasonable attorney’s fees), judgments, or obligations arising from or in connection with third party claims alleging any negligence or otherwise wrongful act or omissions of Physician, its agents or employees in the performance of Physician’s obligations under the Agreement.

4. **Informal Dispute Resolution.** Any disputes between the parties arising with respect to the performance or interpretation of the Agreement ("Dispute") shall first be resolved by exhausting the processes available in the MCO Provider Manual, then through good faith negotiations between designated representatives of the parties that have authority to settle the Dispute. If the matter has not been resolved within sixty (60) days of the request for negotiation, either party may initiate arbitration in accordance with the Arbitration section of the Agreement by providing written notice to the other party.

5. **Arbitration.** If a Dispute is not resolved in accordance with the Informal Dispute Resolution section of the Agreement, either party wishing to pursue the Dispute shall submit it to binding arbitration conducted in accordance with the Commercial Arbitration Rules of the American Arbitration Association ("AAA"). In no event may any arbitration be initiated more than one (1) year following the end of the sixty (60) day negotiation period of the Informal Dispute Resolution section of the Agreement. Arbitration proceedings shall be conducted at a mutually agreed upon location within the Commonwealth of Kentucky. The arbitrators shall have no right to award any punitive or exemplary damages or to vary or ignore the terms of the Agreement and shall be bound by controlling law. Each party shall bear its own costs related to the arbitration except that the costs imposed by the AAA shall be shared equally. The existence of a Dispute or arbitration proceeding shall not in and of itself constitute cause for termination of the Agreement. During an arbitration proceeding, each party shall continue to perform its obligations under the Agreement pending the decision of the arbitrator. **THIS AGREEMENT CONTAINS A BINDING ARBITRATION PROVISION THAT MAY BE ENFORCED BY THE PARTIES.**

6. **Provider Manual and Recoupment.** Physician agrees to comply with MCO’s Provider Manual and recoupment policies.

7. **Conflict.** In the event of a conflict between the Agreement as amended and the Product Attachment, the Product Attachment shall govern.

This Amendment is hereby agreed to by:

____________________________________  ______________________________________
Physician       Center Care

Print Name: __________________________
APPENDIX 1

COMMONWEALTH OF KENTUCKY MEDICAID MANAGED CARE PROGRAM
PRODUCT AND STATE MANDATED ATTACHMENT

ARTICLE I
RECITALS

1.1 MCO has contracted with the Kentucky Cabinet for Health and Family Services, Department for Medicaid Services (the “Department for Medicaid Services”) to arrange for the provision of medical services to Covered Persons under the Kentucky Medicaid Managed Care Program (“Kentucky Medicaid Program”).

1.2 Provider has entered into the Agreement with MCO. This Product Attachment is intended to supplement the Agreement by setting forth the parties’ rights and responsibilities related to the provision of Covered Services to Covered Persons as it pertains to the Kentucky Medicaid Program. In the event of a conflict between the terms and conditions of the Agreement and the terms and conditions of this Product Attachment, this Product Attachment shall govern.

1.3 Notwithstanding any provisions set forth in this Product Attachment, to the extent applicable, Provider shall comply with all duties and obligations under the Agreement, the Provider Manual and this Product Attachment. Provider agrees and understands that Covered Services shall be provided in accordance with the contract between the Department for Medicaid Services and MCO (“Managed Care Contract”), the Provider Manual, any applicable State handbooks or policy and procedure guides, and all applicable State and federal laws and regulations. To the extent Provider is unclear about Provider’s duties and obligations, Provider shall request clarification from MCO.

ARTICLE II
DEFINITIONS

The definitions listed below will supersede any meanings contained in the Agreement.

2.1 Covered Persons or Member means a person eligible for and enrolled in MCO or an affiliate to received Covered Services.

2.2 Department means the Department for Medicaid Services (DMS) within Finance, or its designee.

2.3 Emergency Medical Condition means the following, as defined in 42 USC 1395dd(e) and 42 CFR 438.114:

A. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention to result in:
(1) 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,
(2) serious impairment of bodily functions, or
(3) serious dysfunction of any bodily organ or part; or

B. With respect to a pregnant woman having contractions:
(1) that there is an inadequate time to effect a safe transfer to another hospital before delivery, or
(2) that transfer may pose a threat to the health or safety of the woman or the unborn child.
Emergency Medical Services or Emergency Care means care for a condition as defined in 42 USC 1395dd and 42 CFR 438.114.

Finance means the Commonwealth of Kentucky Finance and Administration Cabinet.

Medically Necessary or Medical Necessity means Covered Services which are medically necessary as defined under 907 KAR 3:130, and provided in accordance with 42 CFR § 440.230, including children’s services pursuant to 42 U.S.C. 1396d(r).

Primary Care Provider or PCP means a licensed or certified health care including a doctor of medicine, doctor of osteopathy, advance registered nurse, physician assistant, or health clinic including a FQHC, primary care center and rural health clinic that functions within the scope of licensure or certification, has admitting privileges at a hospital or formal referral agreement with a provider possessing admitting privileges, and agrees to provide twenty-four (24) hours per day, seven (7) days a week primary health care services to individuals and for a Member who has a gynecological or obstetrical health care needs, disability or chronic illness, is a specialist who agrees to provide and arrange for all appropriate primary and preventive care. The PCP is the patient’s initial and most important contact with the MCO.

State or Commonwealth means the Commonwealth of Kentucky, as represented through any agency, department, board, or commission.

Urgent Care means care for a condition not likely to cause death or lasting harm but for which treatment should not wait for a normally scheduled appointment.

ARTICLE III
PRODUCT REQUIREMENTS

Compliance with Managed Care Contract. Provider shall comply with all applicable federal, State and local laws and regulations, and all amendments thereto. Provider understands and agrees that this Product Attachment and/or the Agreement shall be deemed automatically amended as necessary to comply with any applicable State or federal or regulation, or any applicable provision of the Managed Care Contract.

Emergency and Urgent Care. Emergency Care provided by Provider shall be available to Covered Persons twenty-four (24) hours, seven (7) days a week. Urgent care services shall be provided within forty-eight (48) hours of receipt of the request for Urgent Care services.

Encounter Records. Provider shall comply with MCO’s electronic health encounter records submission in a format to be provided by MCO to Provider and as required by the Department for Medicaid Services. Such encounter records shall be submitted in a timely fashion as directed by MCO. Provider shall submit encounter records in the format specified by DMS so that the MCO can meet DMS’s specifications required by the State Contract.

Medical Records. Provider shall keep Covered Persons medical records in paper and electronic format. Complete medical records include, but are not limited to, medical charts, prescription files, hospital records, provider specialist reports, consultant and other health care professionals’ findings, appointment records, and other documentation sufficient to disclose the quantity, quality, appropriateness, and timeliness of services provided under the agreement. Such records shall be retained by Provider for the period of time required by all applicable laws or regulations, but in no event less than the later of seven (7) years from the date the service was rendered or termination of the Agreement. Provider shall allow MCO, the Department for Medicaid Services and the Office of Inspector General, and other authorized Commonwealth and federal agents access to all medical records of Covered Persons for the purposes of auditing.
3.5 **PCP Requirements.** If a Provider is a PCP, Provider shall (i) discuss advance medical directives with all adult Covered Persons at the first medical appointment and chart such discussion in the Covered Person’s medical record; and (ii) have screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders.

3.6 **Kentucky Health Information Exchange.** If Provider is a PCP, Provider shall be required to connect to the Kentucky Health Information Exchange (“KHIE”) within one (1) year of the effective date of the Agreement or other schedule as determined by the Department for Medicaid Services. MCO encourages all non-primary care providers to establish connectivity with the KHIE.

3.7 **Cultural Consideration and Competency.** Provider shall deliver Covered Services in a culturally competent manner to all Covered Persons, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

3.8 **Qualifications and Credentialing Criteria.** Provider shall hold all necessary licenses, registrations and/or certifications required under State or federal law to provide the services contracted for hereunder and shall at all times meet, maintain and adhere to the policies and procedures of MCO and other requirements, including but not limited to (1) policies and procedures of MCO relating to certification to participate in any federal or State health care program including but not limited to the Medicare and Medicaid programs; (2) the Provider Manual; (3) requirements of the Department for Medicaid Services; and (4) policies and procedures relating to licensure, certification, accreditation, utilization management/quality assurance (including requirements for review of Provider’s services by MCO personnel and committees), complaints/appeals, and administrative policies such as those (by way of example but not limitation) relating to claims submission, coordination of benefits, and coverage verification. Provider will be subject to recredentialing by the MCO three (3) years from the Provider’s credentialing committee approval date. Participating Providers shall give immediate notice to MCO of any event that causes Participating Providers to be out of compliance with its ability to fulfill its obligations under this Agreement, or of any change in Participating Providers’ name, ownership, control, or taxpayer identification number.

3.9 **Provider Appeals.** In the event Provider disagrees with MCO determination with regard to an issue that is appealable under Section 8(1) of 907 KAR 1:671, the Participating Health Care Provider may request, pursuant to the procedures set forth at Section 8(2) of 907 KAR 1:671, a dispute resolution meeting with MCO, which shall be granted and administered by MCO pursuant to Section 8 of 907 KAR 1:671. MCO will not discriminate against Provider solely on the grounds that the Provider filed an appeal or is making an informal grievance.

3.10 **Nondiscrimination by MCO.** MCO shall not discriminate against Provider or any Participating Health Care Provider who services high-risk populations or who specializes in conditions that require costly treatment or based upon that Provider’s licensure or certification.

3.11 **Ethical Reasons for Non-Performance of Medical Treatment.** MCO shall not require Provider to perform any treatment or procedure which is contrary to the Provider’s conscience, religious beliefs, or ethical principles and shall meet the requirements of 42 C.F.R. 438.102. In such instances, Provider shall consult MCO when referring the Covered Person to another health care provider licensed, certified or accredited to provide care for the individual service or assigned to another PCP licensed to provide care appropriate to the Covered Person’s medical condition.

3.12 **Covered Person Communications.** Nothing in the Agreement shall be construed as limiting a Provider’s ability to communicate with Covered Person with regard to health status, medical care, or treatment, regardless of whether benefits for such care are provided under the Managed Care Contract.
3.13 **Inpatient Psychiatric Services.** Prior to discharging a Covered Person receiving inpatient psychiatric services, Participating Health Care Providers shall schedule outpatient follow-up and/or coordinating treatment. Outpatient treatment must occur within fourteen (14) days of discharge.

3.14 **Representation and Warranty.** Provider represents and warrants that neither Provider nor any individual who has a direct or indirect ownership or controlling interest of 5% or more of the Provider, nor any officer, director, agent or managing employee (i.e., general manager, business manager, administrator, director or like individual who exercises operational or managerial control over Provider or who directly or indirectly conducts the day-to-day operation of Provider) is an entity or individual (1) who has been convicted of any offense under Section 1128(a) of the Social Security Act (42 U.S.C. §1320a-7(a)) or of any offense related to fraud or obstruction of an investigation or a controlled substance described in Section 1128(b)(1)-(3) of the Social Security Act (42 U.S.C. §1320a-7(b)(1)-(3)); or (2) against whom a civil monetary penalty has been assessed under Section 1128A or 1129 of the Social Security Act (42 U.S.C. §1320a-7a; 42 U.S.C. §1320a-8); or (3) who has been excluded from participation in a program under Title XVIII, 1902(a)(39) and (41) of the Social Security Act, Section 4724 of the BBA or under a Commonwealth health care program.

3.15 **Compliance with Laws.** Provider shall comply with the following laws, among others:

A) Title VI of the Civil Rights Act of 1964 (Public Law 88-352);

B) Rules and regulations prescribed by the United States Department of Labor in accordance with 41 C.F.R. Parts 60-741;

C) Regulations of the United States Department of Labor recited in 20 C.F.R. Part 741, and Section 504 of the Federal Rehabilitation Act of 1973 (Public Law 93-112);


3.16 **Access to Premises.** Provider shall allow duly authorized agents or representatives of the Commonwealth or federal government or the independent external quality review organization required by Section 1902 (a)(30)(c) of the Social Security Act, 42 U.S. Code Section 1396a(a)(30), access to their premises during normal business hours, and shall cause similar access or availability to their premises to inspect, audit, investigate, monitor or otherwise evaluate the performance of Provider, as applicable. Provider shall forthwith produce all records, documents, or other data requested as part of such review, investigation, or audit.

In the event right of access is requested under this Section, Provider shall provide and make available staff to assist in the audit or inspection effort, and provide adequate space on the premises to reasonably accommodate the Commonwealth, federal, or external quality review personnel conducting the audit, investigation, or inspection effort. All inspections or audits shall be conducted in a manner as will not unduly interfere with the performance of Provider's activities. All information obtained will be accorded confidential treatment as provided under applicable laws, rules and regulations.

3.17 **Provider Indemnity.** Except as otherwise provided in the State Contract, Provider shall indemnify, defend and hold harmless the Commonwealth, its officers, agents, and employees, and each and every Covered Person from any liability whatsoever arising in connection with the State Contract for the payment of any debt of or the fulfillment of any obligation of Provider. Provider further covenants and agrees that in the event of a breach of this Agreement by the MCO, termination of this Agreement, or insolvency of the MCO, Provider shall provide all services and fulfill all of its obligations pursuant to the Agreement for the remainder of any month for which DMS has made payments to the MCO, and shall fulfill all of its obligations respecting the transfer of Covered Persons to other providers, including record maintenance, access and reporting.
requirements, all such covenants, agreements, and obligations of which shall survive the
termination of the State Contract and this Agreement.

3.18 **Commonwealth as Third Party Beneficiary.** Provider acknowledges and agrees that the
Commonwealth is the intended third-party beneficiary of this Agreement and, as such, the
Commonwealth is entitled to all remedies entitled to third-party beneficiaries under law.

3.19 **Incorporation of State Contract.** All provisions of the State Contract are incorporated herein to
the fullest extent applicable to the service or activity delegated pursuant to this Agreement,
including without limitation, the obligation to comply with all applicable federal and
Commonwealth law and regulations, including but not limited to, KRS 205.8451-8483, all rules,
policies and procedures of Finance and DMS, and all standards governing the provision of Covered
Services and information to Covered Persons, all QAPI requirements, all record keeping and
reporting requirements, all obligations to maintain the confidentiality of information, all rights of
Finance, DMS, the Office of the Inspector General, the Attorney General, Auditor of Public
Accounts and other authorized federal and Commonwealth agents to inspect, investigate, monitor
and audit operations, all indemnification and insurance requirements, and all obligations upon
termination.

3.20 **Suspected Fraud and Abuse.** Provider shall immediately report all suspected fraud and abuse to
MCO.

3.21 **Invocation of Remedy by Finance.** Provider acknowledges and agrees that Finance shall have the
right to invoke against Provider any remedy set forth in the State Contract, including the right to
require the termination of this Agreement or the right to terminate the State Contract, for each and
every reason for which it may invoke such a remedy against the MCO.

3.22 **Coordination of Benefits.** Provider must report all COB information to MCO. Provider shall not
pursue collection of any COB payment from any Covered Person.

3.23 **Accreditation.** Provider shall provide MCO with a copy of its current certificate of accreditation
from NCQA/URAC or other national accreditation body, if and as applicable, together with a copy
of any survey report in connection therewith, subject to the applicable restrictions of such
accrediting body.

3.24 **Non-Discrimination by Provider.** At all times during the performance of this Agreement, the
Provider agrees as follows:

**A)** Provider shall not discriminate against any employee or applicant for employment because
of race, color, religion, sex, or national origin. Provider will take affirmative action to
ensure that applicants are employed, and that employees are treated during employment,
without regard to their race, color, religion, sex or national origin. Such action shall
include, but not be limited to the following: employment, upgrading, demotion, or transfer;
recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of
compensation; and selection for training, including apprenticeship. Provider agrees to post
in conspicuous places, available to employees and applicants for employment, notices to be
provided by the contracting officer setting forth the provisions of this nondiscrimination
clause.

**B)** Provider will, in all solicitations or advertisements for employees placed by or on behalf of
Provider, state that all qualified applicants will receive consideration for employment
without regard to race, color, religion, sex or national origin.

**C)** Provider will send to each labor union or representative of workers with which he has a
collective bargaining agreement or other contract or understanding, a notice, to be provided
by the agency contracting officer, advising the labor union or workers' representative of
Provider's commitments under Section 202 of Executive Order No. 11246 of September 24, 1965, and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

D) Provider will comply with all provisions of Executive Order No. 11246 of Sept. 24, 1965, and of the rules, regulations, and relevant orders of the Secretary of Labor.

E) Provider will furnish all information and reports required by Executive Order No. 11246 of September 24, 1965, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to his books, records, and accounts by the contracting agency and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

F) In the event of Provider’s noncompliance with the nondiscrimination clauses of this contract or with any of such rules, regulations, or orders, this contract may be cancelled, terminated or suspended in whole or in part and Provider may be declared ineligible for further Government contracts in accordance with procedures authorized in Executive Order No. 11246 of Sept. 24, 1965, and such other sanctions may be imposed and remedies invoked as provided in Executive Order No. 11246 of September 24, 1965, or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

G) Provider will include the provisions of paragraphs (A) through (G) in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor issued pursuant to Section 204 of Executive Order No. 11246 of September 24, 1965, so that such provisions will be binding upon each subcontractor or vendor. The contractor will take such action with respect to any subcontract or purchase order as may be directed by the Secretary of Labor as a means of enforcing such provisions including sanctions for noncompliance: Provided, however, that in the event Provider becomes involved in, or is threatened with, litigation with a subcontractor or vendor as a result of such direction, Provider may request the United States to enter into such litigation to protect the interests of the United States.

ARTICLE IV
STATE MANDATED REQUIREMENTS

4.1 Any Willing Provider. MCO shall not discriminate against any provider who is located within the geographic coverage area of the MCO and is willing to meet the terms and conditions for participation established by the MCO.

4.2 Enrollment Period. Provider acknowledges that all providers who wish to apply to participate in the MCO Medicaid managed care plans shall do so at any time.

4.3 Participation in Other MCO Benefit Plans. MCO shall not require Provider, as a condition of participation under the Agreement, to participate in any of MCO’s other health benefit plans.

4.4 Provider’s Disclosure to Covered Persons. MCO shall not limit, penalize or terminate the Agreement due to Provider’s disclosure to a Covered Person who is Provider’s patient for discussing (i) all treatment options with the Covered Person; (ii) any information that the Provider determines to be in the best interest of the Covered Person; and (iii) financial incentives and financial arrangements between the Provider and MCO.

4.5 Continuation of Care. Provider shall, upon termination of the Agreement for reasons other than a quality of care issue or fraud, continue to provide and be compensated for Covered Services to Covered Persons under the terms and conditions of the Agreement until the earlier of such time that: (1) such Covered Person has completed his/her course of treatment; or (2) reasonable and medically appropriate arrangements have been made for a Participating Health Care Provider to
render health care services to the Covered Person. In the case of a pregnant woman, Provider shall continue to provide services through the end of the post-partum period if the pregnant woman is in her fourth or later month of pregnancy. If Provider is a facility, Provider shall continue to provide and be paid for Covered Services to Covered Persons under the same terms and conditions of the Agreement until such Covered Person is discharged from the facility. For purposes of this provision, “discharge” shall mean the Covered Person’s physical release from the facility. This provision shall survive the termination of the Agreement.

4.6 **Claims Payment.** In accordance with the Balanced Budget Act (BBA) Section 4708, MCO shall ensure that all Provider claims for which no further written information or substantiation is required in order to make payment, are paid or denied within thirty (30) days of the date of receipt of such claims and that all claims are processed within ninety (90) days of the date of receipt of such claims. In addition, MCO will comply with the Prompt-Pay statute, codified within KRS 304.17A-700-730, as may be amended, and KRS 205.593, and KRS 304.14-135 and 99-123, as may be amended.

4.7 **Changes to Compensation and Fee Schedules.** If MCO decides to make any changes to the Participating Health Care Provider’s fee schedule or payment for Covered Services, MCO shall provide Provider at least ninety (90) days notice prior to the effective date of the change.

4.8 **Material Changes.** If MCO makes any material changes to the Agreement or any attachments and exhibits thereto, MCO will provide written notice to Provider within ninety (90) days of the material change. Notwithstanding the foregoing, MCO shall make any material changes to this Agreement or any attachments and exhibits as a result of any applicable State or federal law or regulation and applicable provision of the Medicaid Managed Care Contract. In the event Participating Health Care Provider wishes to opt out of any material change to the Agreement, Provider shall send written notice to MCO no later than forty-five (45) days prior to the effective date of the material change. If MCO makes changes to prior authorization, precertification, notification or referral programs, MCO will provide Provider fifteen (15) days prior notice to such change.

4.9 **Provider Subcontracts.** In the event Provider enters into any subcontract agreement with another provider to provide Covered Services to Covered Persons, such agreement shall meet all requirements of the Agreement.

4.10 **Termination by MCO.** In addition to the termination provisions provided in Article X of the Agreement, MCO shall not have the right to terminate the Agreement without cause.
APPENDIX 2
PHYSICIAN REIMBURSEMENT SCHEDULE - MEDICAID

For Covered Services provided to Covered Persons, Payor shall pay Physician the lesser of: (i) the Physician’s Allowable Charges; or (ii) 100% of the State’s Medicaid fee schedule in effect on the date of service and specific to the services rendered.

For Covered Services for which there is no established fee amount, Payor shall pay Physician forty-five percent (45%) of the Allowable Charges until such time as Payor establishes a rate.

Additional Provisions:

1. **Code Change Updates.** Updates to billing-related codes (e.g., CPT, HCPCS, ICD-9, DRG, and revenue codes) shall become effective on the date (“Code Change Effective Date”) that is the later of: (i) the first day of the month following thirty (30) days after publication by the governmental agency having authority over the applicable product of such governmental agency’s acceptance of such code updates; or (ii) the effective date of such code updates, as determined by such governmental agency. Claim processed prior to the Code Change Effective Date shall not be reprocessed to reflect any code updates.

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

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

Definitions:

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