PARTICIPATING PROVIDER AGREEMENT

This Participating Provider Agreement (together with all Attachments and amendments, this "***Agreement***") is made and entered by and between Centria Healthcare, LLC ("***Provider***") and Peach State Health Plan, Inc. ("***Health Plan***") (each a "***Party***" and collectively the "***Parties***"). This Agreement is effective as of the date designated by Health Plan on the signature page of this Agreement ("***Effective Date***").

WHEREAS, Provider desires to provide certain health care services to individuals in products offered by or available from or through a Company or Payor (as hereafter defined), and Provider desires to participate in such products as a Participating Provider (as defined herein), all as hereinafter set forth.

WHEREAS, Health Plan desires for Provider to provide such health care services to individuals in such products, and Health Plan desires to have Provider participate in certain of such products as a Participating Provider, all as hereinafter set forth.

NOW, THEREFORE, in consideration of the recitals and mutual promises herein stated, the Parties hereby agree to the provisions set forth below.

ARTICLE I - DEFINITIONS

When appearing with initial capital letters in this Agreement (including an Attachment(s)), the following quoted and underlined terms (and the plural thereof, when appropriate) have the meanings set forth below.

1.1. "Affiliate" means a person or entity directly or indirectly controlling, controlled by, or under common control with Health Plan.

1.2. "Attachment" means any document, including an addendum, schedule or exhibit, attached to this Agreement as of the Effective Date or that becomes attached pursuant to Section 2.2 or Section 8.7, all of which are incorporated herein by reference and may be amended from time to time as provided in this Agreement.

1.3. "Clean Claim" has, as to each particular Product, the meaning set forth in the applicable Product Attachment or, if no such definition exists, the Provider Manual.

1.4. "Company" means (collectively or individually, as appropriate in the context) Health Plan and/or one or more of its Affiliates, except those specifically excluded by Health Plan.

1.5. "Compensation Schedule" means at any given time the then effective schedule(s) of maximum rates applicable to a particular Product under which Provider and Contracted Providers will be compensated for the provision of Covered Services to Covered Persons. Such Compensation Schedule(s) will be set forth or described in one or more Attachments to this Agreement, and may be included within a Product Attachment.

1.6. "Contracted Provider" means a physician, hospital, health care professional or any other provider of items or services that is employed by or has a contractual relationship with Provider and that provides Covered Services. The term "Contracted Provider" includes Provider for those Covered Services provided by Provider.

1.7. "Coverage Agreement" means any agreement, program or certificate entered into, issued or agreed to by Company or Payor, under which Company or Payor furnishes administrative services or other services in support of a health care program for an individual or group of individuals, and which may include access to one or more of Company's provider networks or vendor arrangements, except those excluded by Health Plan.

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

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

1.10. "Medically Necessary" or "Medical Necessity" shall have the meaning defined in the applicable Coverage Agreement or applicable Regulatory Requirements.

1.11. "Participating Provider" means, with respect to a particular Product, any physician, hospital, ancillary, or other health care provider that has contracted, directly or indirectly, with Health Plan to provide Covered Services to Covered Persons, that has been approved for participation by Company, and that is designated by Company as a "participating provider" in such Product.

1.12. "Payor" means the entity (including Company where applicable) that bears direct financial responsibility for paying from its own funds, without reimbursement from another entity, the cost of Covered Services rendered to Covered Persons under a Coverage Agreement and, if such entity is not Company, such entity contracts, directly or indirectly, with Company for the provision of certain administrative or other services with respect to such Coverage Agreement.

1.13. "Payor Contract" means the contract with a Payor, pursuant to which Company furnishes administrative services or other services in support of the Coverage Agreements entered into, issued or agreed to by a Payor, which services may include access to one or more of Company's provider networks or vendor arrangements, except those excluded by Health Plan. The term "Payor Contract" includes Company's or other Payor's contract with a governmental authority (also referred to herein as a "Governmental Contract") under which Company or Payor arranges for the provision of Covered Services to Covered Persons.

1.14. "Product" means any program or health benefit arrangement designated as a "product" by Health Plan (e.g., Health Plan Product, Medicaid Product, PPO Product, Payor-specific Product, etc.) that is now or hereafter offered by or available from or through Company (and includes the Coverage Agreements that access, or are issued or entered into in connection with such product, except those excluded by Health Plan).

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

1.16. "Provider Manual" means the provider manual and any billing manuals, adopted by Company or Payor which include, without limitation, requirements relating to utilization management, quality management, grievances and appeals, and Product-specific, Payor-specific and State-specific requirements, as may be amended from time to time by Company or Payor.

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

1.18. "State" is defined as the state identified in the applicable Attachment.

ARTICLE II - PRODUCTS AND SERVICES

2.1. Contracted Providers. Provider shall, and shall cause each Contracted Provider, to comply with and abide by the agreements, representations, warranties, acknowledgements, certifications, terms and conditions of this Agreement (including the provisions of Schedule A that are applicable to Provider, a Contracted Provider, or their services, and any other Attachments), and the Provider Manual, and fulfill all of the duties, responsibilities and

obligations imposed on Provider and Contracted Providers under this Agreement (including each Attachment), and the Provider Manual.

2.2. Participation in Products. Subject to the other provisions of this Agreement, each Contracted Provider may be identified as a Participating Provider in each Product identified in a Product Attachment designated on Schedule B of this Agreement or added to this Agreement in accordance with Section 2.2 hereof.

2.2.1. Provider shall, at all times during the term of this Agreement, require each of its Contracted Providers to, subject to Company's approval, participate as Participating Providers in each Product identified in a Product Attachment that is designated on Schedule B to this Agreement or added to this Agreement in accordance with Section 2.2 hereof.

2.2.2. A Contracted Provider may only identify itself as a Participating Provider for those Products in which the Contracted Provider actually participates as provided in this Agreement. Provider acknowledges that Company or Payor may have, develop or contract to develop various Products or provider networks that have a variety of provider panels, program components and other requirements. No Company or Payor warrants or guarantees that any Contracted Provider: (i) will participate in all or a minimum number of provider panels, (ii) will be utilized by a minimum number of Covered Persons, or (iii) will indefinitely remain a Participating Provider or member of the provider panel for a particular network or Product.

2.2.3. Provider shall provide Health Plan with the information listed on Schedule C entitled "Information for Contracted Providers" for itself and the Contracted Providers as of the Effective Date. Provider shall provide Health Plan, from time to time or on a periodic basis as requested by Health Plan, with a complete and accurate list of Information for Contracted Providers and such other information as mutually agreed upon by the Parties, and shall provide Health Plan with a list of modifications to such list at least 30 days prior to the effective date of such changes, when possible. Provider shall provide such lists in a manner and format mutually acceptable to the Parties.

2.2.4. Provider may add new providers to this Agreement as Contracted Providers. In such case, Provider shall provide written notice to Health Plan of the prospective addition(s), and shall use best efforts to provide such notice at least 60 days in advance of such addition. Provider shall maintain written agreements with each of its Contracted Providers (other than Provider) that require the Contracted Providers to comply with the terms and conditions of this Agreement and that address and comply with the Regulatory Requirements.

2.2.5. If Company desires to add one or more Contracted Providers to an additional Product, Company or Payor, as applicable, will provide advance written notice (electronic or paper) thereof to Provider, along with the applicable Product Attachment and the new Compensation Schedule, if any. The applicable Contracted Providers will not be designated as Participating Providers in such additional Product if Provider opts out of such additional Product by giving Company or Payor, as applicable, written notice of its decision to opt-out within 30 days of Company's or Payor's, as applicable, giving of written notice. If Provider timely provides such opt-out notice, the applicable Contracted Providers will not be considered Participating Providers in such Product. If Provider does not timely provide such opt-out notice, then each applicable Contracted Provider shall be a Participating Provider in such additional Product on the terms and conditions set forth in this Agreement and the applicable Product Attachment.

2.3. Covered Services. Each Contracted Provider shall provide Covered Services described or referenced in the applicable Product Attachment(s) to Covered Persons in those Products in which the Contracted Provider is a Participating Provider, in accordance with this Agreement. Each Contracted Provider shall provide Covered Services to Covered Persons with the same degree of care and skill as customarily provided to patients who are not Covered Persons, within the scope of the Contracted Provider's license and in accordance with generally accepted standards of the Contracted Provider's practice and business and in accordance with the provisions of this Agreement, the Provider Manual, and Regulatory Requirements.

2.4. Provider Manual; Policies and Procedures. Provider and Contracted Providers shall at all times cooperate and comply with the requirements, policies, programs and procedures ("Policies") of Company and Payor,

which may be described in the Provider Manual and include, but are not limited to, the following: credentialing criteria and requirements; notification requirements; medical management programs; claims and billing, quality assessment and improvement, utilization review and management, disease management, case management, on-site reviews, referral and prior authorization, and grievance and appeal procedures; coordination of benefits and third party liability policies; carve-out and third party vendor programs; and data reporting requirements. The failure to comply with such Policies could result in a denial or reduction of payment to the Provider or Contracted Provider or a denial or reduction of the Covered Person's benefits. Such Policies do not in any way affect or remove the obligation of Contracted Providers to render care. Health Plan shall make the Provider Manual available to Provider and Contracted Providers via one or more designated websites or alternative means. Upon Provider's reasonable request, Health Plan shall provide Provider with a copy of the Provider Manual. In the event of a material change to the Provider Manual, Health Plan will use reasonable efforts to notify Provider in advance of such change. Such notice may be given by Health Plan through a periodic provider newsletter, an update to the on-line Provider Manual, or any other written method (electronic or paper).

2.5. Credentialing Criteria. Provider and each Contracted Provider shall complete Company's and/or Payor's credentialing and/or recredentialing process as required by Company's and/or Payor's credentialing Policies, and shall at all times during the term of this Agreement meet all of Company's and/or Payor's credentialing criteria. Provider and each Contracted Provider represents, warrants and agrees: (a) that it is currently, and for the duration of this Agreement shall remain: (i) in compliance with all applicable Regulatory Requirements, including licensing laws; (ii) if applicable, accredited by The Joint Commission or the American Osteopathic Association; and (iii) a Medicare certified provider under the federal Medicare program and a Medicaid participating provider under applicable federal and State laws; and (b) that all Contracted Providers and all employees and contractors thereof will perform their duties in accordance with all Regulatory Requirements, as well as applicable national, State and local standards of professional ethics and practice. No Contracted Provider shall provide Covered Services to Covered Persons or identify itself as a Participating Provider unless and until the Contracted Provider has been notified, in writing, by Company that such Contracted Provider has successfully completed Company's credentialing process.

2.6. Eligibility Determinations. Provider or Contracted Provider shall timely verify whether an individual seeking Covered Services is a Covered Person. Company or Payor, as applicable, will make available to Provider and Contracted Providers a method, whereby Provider and Contracted Providers can obtain, in a timely manner, general information about eligibility and coverage. Company or Payor, as applicable, does not guarantee that persons identified as Covered Persons are eligible for benefits or that all services or supplies are Covered Services. If Company, Payor or its delegate determines that an individual was not a Covered Person at the time services were rendered, such services shall not be eligible for payment under this Agreement. In addition, Company will use reasonable efforts to include or contractually require Payors to clearly display Company's name, logo or mailing address (or other identifier(s) designated from time to time by Company) on each membership card.

2.7. Referral and Preauthorization Procedures. Provider and Contracted Providers shall comply with referral and preauthorization procedures adopted by Company and or Payor, as applicable, prior to referring a Covered Person to any individual, institutional or ancillary health care provider. Unless otherwise expressly authorized in writing by Company or Payor, Provider and Contracted Providers shall refer Covered Persons only to Participating Providers to provide the Covered Service for which the Covered Person is referred. Except as required by applicable law, failure of Provider and Contracted Providers to follow such procedures may result in denial of payment for unauthorized treatment.

2.8. Treatment Decisions. No Company or Payor is liable for, nor will it exercise control over, the manner or method by which a Contracted Provider provides items or services under this Agreement. Provider and Contracted Providers understand that determinations of Company or Payor that certain items or services are not Covered Services or have not been provided or billed in accordance with the requirements of this Agreement or the Provider Manual are administrative decisions only. Such decisions do not absolve the Contracted Provider of its responsibility to exercise independent judgment in treatment decisions relating to Covered Persons. Nothing in this Agreement (i) is intended to interfere with Contracted Provider's relationship with Covered Persons, or (ii) prohibits or restricts a Contracted Provider from disclosing to any Covered Person any information that the Contracted Provider deems appropriate regarding health care quality, medical treatment decisions or alternatives.

2.9. Carve-Out Vendors. Provider acknowledges that Company may, during the term of this Agreement, carve-out certain Covered Services from its general provider contracts, including this Agreement, for one or more Products as Company deems necessary or appropriate. Provider and Contracted Providers shall cooperate with and, when medically appropriate, utilize all third party vendors designated by Company for those Covered Services identified by Company from time to time for a particular Product.

2.10. Disparagement Prohibition. Provider, each Contracted Provider and the officers of Company shall not disparage the other during the term of this Agreement or in connection with any expiration, termination or non-renewal of this Agreement. Neither Provider nor Contracted Provider shall interfere with Company's direct or indirect contractual relationships including, but not limited to, those with Covered Persons or other Participating Providers. Nothing in this Agreement should be construed as limiting the ability of either Health Plan, Company, Provider or a Contracted Provider to inform Covered Persons that this Agreement has been terminated or otherwise expired or, with respect to Provider, to promote Provider to the general public or to post information regarding other health plans consistent with Provider's usual procedures, provided that no such promotion or advertisement is specifically directed at one or more Covered Persons. In addition, nothing in this provision should be construed as limiting Company's ability to use and disclose information and data obtained from or about Provider or Contracted Provider, including this Agreement, to the extent determined reasonably necessary or appropriate by Company in connection with its efforts to comply with Regulatory Requirements and to communicate with regulatory authorities.

2.11. Nondiscrimination. Provider and each Contracted Provider will provide Covered Services to Covered Persons without discrimination on account of race, sex, sexual orientation, age, color, religion, national origin, place of residence, health status, type of Payor, source of payment (e.g., Medicaid generally or a State-specific health care program), physical or mental disability or veteran status, and will ensure that its facilities are accessible as required by Title III of the Americans With Disabilities Act of 1991. Provider and Contracted Providers recognize that, as a governmental contractor, Company or Payor may be subject to various federal laws, executive orders and regulations regarding equal opportunity and affirmative action, which also may be applicable to subcontractors, and Provider and each Contracted Provider agree to comply with such requirements as described in any applicable Attachment.

2.12. Notice of Certain Events. Provider shall give written notice to Health Plan of: (i) any event of which notice must be given to a licensing or accreditation agency or board; (ii) any change in the status of Provider's or a Contracted Provider's license; (iii) termination, suspension, exclusion or voluntary withdrawal of Provider or a Contracted Provider from any state or federal health care program, including but not limited to Medicaid; or (iv) any settlements or judgments in connection with a lawsuit or claim filed or asserted against Provider or a Contracted Provider alleging professional malpractice involving a Covered Person. In any instance described in subsection (i)-(iii) above, Provider must notify Health Plan or Payor in writing within 10 days, and in any instance described in subsection (iv) above, Provider must notify Health Plan or Payor in writing within 30 days, from the date it first obtains knowledge of the pending of the same.

2.13. Use of Name. Provider and each Contracted Provider hereby authorizes each Company or Payor to use their respective names, telephone numbers, addresses, specialties, certifications, hospital affiliations (if any), and other descriptive characteristics of their facilities, practices and services for the purpose of identifying the Contracted Providers as "Participating Providers" in the applicable Products. Provider and Contracted Providers may only use the name of the applicable Company or Payor for purposes of identifying the Products in which they participate, and may not use the registered trademark or service mark of Company or Payor without prior written consent.

2.14. Compliance with Regulatory Requirements. Provider, each Contracted Provider and Company agree to carry out their respective obligations under this Agreement and the Provider Manual in accordance with all applicable Regulatory Requirements, including, but not limited to, the requirements of the Health Insurance Portability and Accountability Act, as amended, and any regulations promulgated thereunder. If, due to Provider's or Contracted Provider's noncompliance with applicable Regulatory Requirements or this Agreement, sanctions or penalties are imposed on Company, Company may, in its sole discretion, offset such amounts against any amounts

due Provider or Contracted Providers from any Company or require Provider or the Contracted Provider to reimburse Company for such amounts.

2.15. Program Integrity Required Disclosures. Provider agrees to furnish to Health Plan complete and accurate information necessary to permit Health Plan to comply with the collection of disclosures requirements specified in 42 C.F.R. Part 455 Subpart B or any other applicable State or federal requirements, within such time period as is necessary to permit Health Plan to comply with such requirements. Such requirements include but are not limited to: (i) 42 C.F.R. §455.105, relating to (a) the ownership of any subcontractor with whom Provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request and (b) any significant business transaction between Provider and any wholly owned supplier or subcontractor during the five (5) year period ending on the date of the request; (ii) 42 C.F.R. §455.104, relating to individuals or entities with an ownership or controlling interest in Provider; and (iii) 42 C.F.R. §455.106, relating to individuals with an ownership or controlling interest in Provider, or who are managing employees of Provider, who have been convicted of a crime.

ARTICLE III - CLAIMS SUBMISSION, PROCESSING, AND COMPENSATION

3.1. Claims or Encounter Data Submission. As provided in the Provider Manual and/or Policies, Contracted Providers shall submit to Payor or its delegate claims for payment for Covered Services rendered to Covered Persons. Contracted Provider shall submit encounter data to Payor or its delegate in a timely fashion, which must contain statistical and descriptive medical and patient data and identifying information, if and as required in the Provider Manual. Payor or its delegate reserves the right to deny payment to the Contracted Provider if the Contracted Provider fails to submit claims for payment or encounter data in accordance with the Provider Manual and/or Policies.

3.2. Compensation. The compensation for Covered Services provided to a Covered Person ("Compensation Amount") will be the appropriate amount under the applicable Compensation Schedule in effect on the date of service for the Product in which the Covered Person participates. Subject to the terms of this Agreement and the Provider Manual, Provider and Contracted Providers shall accept the Compensation Amount as payment in full for the provision of Covered Services. Subject to the terms of this Agreement, Payor shall pay or arrange for payment of each Clean Claim received from a Contracted Provider for Covered Services provided to a Covered Person in accordance with the applicable Compensation Amount less any applicable copayments, cost-sharing or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement.

3.3. Financial Incentives. The Parties acknowledge and agree that nothing in this Agreement shall be construed to create any financial incentive for Provider or a Contracted Provider to withhold Covered Services.

3.4. Hold Harmless. Provider and each Contracted Provider agree that in no event, including but not limited to non-payment by a Payor, a Payor's insolvency, or breach of this Agreement, shall Provider or a Contracted Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Covered Person or person acting on the Covered Person's behalf, other than Payor, for Covered Services provided under this Agreement. This provision shall not prohibit collection of any applicable copayments, cost-sharing or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement. This provision survives termination or expiration of this Agreement for any reason, will be construed for the benefit of Covered Persons, and supersedes any oral or written agreement entered into between Provider or a Contracted Provider and a Covered Person.

3.5. Recovery Rights. Payor or its delegate shall have the right to immediately offset or recoup any and all amounts owed by Provider or a Contracted Provider to Payor or Company against amounts owed by the Payor or Company to the Provider or Contracted Provider. Provider and Contracted Providers agree that all recoupment and any offset rights under this Agreement will constitute rights of recoupment authorized under State or federal law and that such rights will not be subject to any requirement of prior or other approval from any court or other government authority that may now have or hereafter have jurisdiction over Provider or a Contracted Provider.

ARTICLE IV - RECORDS AND INSPECTIONS

4.1. Records. Each Contracted Provider shall maintain medical, financial and administrative records related to items or services provided to Covered Persons, including but not limited to a complete and accurate permanent medical record for each such Covered Person, in such form and detail as are required by applicable Regulatory Requirements and consistent with generally accepted medical standards.

4.2. Access. Provider and each Contracted Provider shall provide access to their respective books and records to each of the following, including any delegate or duly authorized agent thereof, subject to applicable Regulatory Requirements: (i) Company and Payor, during regular business hours and upon prior notice; (ii) appropriate State and federal authorities, to the extent such access is necessary to comply with Regulatory Requirements; and (iii) accreditation organizations. Provider and each Contracted Provider shall provide copies of such records at no expense to any of the foregoing that may make such request. Each Contracted Provider also shall obtain any authorization or consent that may be required from a Covered Person in order to release medical records and information to Company or Payor or any of their delegates. Provider and each Contracted Provider shall cooperate in and allow on-site inspections of its, his or her facilities and records by any Company, Payor, their delegates, any authorized government officials, and accreditation organizations. Provider and each Contracted Provider shall compile information necessary for the expeditious completion of such on-site inspection in a timely manner.

4.3. Record Transfer. Subject to applicable Regulatory Requirements, each Contracted Provider shall cooperate in the timely transfer of Covered Persons' medical records to any other health care provider, at no charge and when required.

ARTICLE V - INSURANCE AND INDEMNIFICATION

5.1. Insurance. During the term of this Agreement and for any applicable continuation period as set forth in Section 7.3 of this Agreement, Provider and/or each Contracted Provider shall maintain policies of general and professional liability insurance and other insurance necessary to insure Provider and such Contracted Provider, respectively; their respective employees; and any other person providing services hereunder on behalf of Provider or such Contracted Provider, as applicable, against any claim(s) of personal injuries or death alleged to have been caused or caused by their performance under this Agreement. Such insurance shall include, but not be limited to, any "tail" or prior acts coverage necessary to avoid any gap in coverage. Insurance shall be through a licensed carrier acceptable to Health Plan, and in a minimum amount of $1,000,000 per occurrence, and $3,000,000 in the aggregate unless a lesser amount is accepted by Health Plan or where State law mandates otherwise. Provider and/or each Contracted Provider will provide Health Plan with at least 10 days prior written notice of cancellation, non-renewal, lapse, or adverse material modification of such coverage. Upon Health Plan's request, Provider and each Contracted Provider will furnish Health Plan with evidence of such insurance.

5.2. Indemnification by Provider and Contracted Provider. Provider and each Contracted Provider shall indemnify and hold harmless (and at Health Plan's request defend) Company and Payor and all of their respective officers, directors, agents and employees from and against any and all third party claims for any loss, damages, liability, costs, or expenses (including reasonable attorney's fees) judgments or obligations arising from or relating to any negligence, wrongful act or omission, or breach of this Agreement by Provider, a Contracted Provider, or any of their respective officers, directors, agents or employees.

5.3. Indemnification by Health Plan. Health Plan agrees to indemnify and hold harmless (and at Provider's request defend) Provider, Contracted Providers, and their officers, directors, agents and employees from and against any and all third party claims for any loss, damages, liability, costs, or expenses (including reasonable attorney's fees), judgments, or obligations arising from or relating to any negligence, wrongful act or omission or breach of this Agreement by Company or its directors, officers, agents or employees.

ARTICLE VI - DISPUTE RESOLUTION

6.1. Informal Dispute Resolution. Any dispute between Provider and/or a Contracted Provider, as applicable (the "Provider Party"), and Health Plan and/or Company, as applicable (including any Company acting as Payor) (the "Administrator Party"), with respect to or involving the performance under, termination of, or interpretation of this Agreement, or any other claim or cause of action hereunder, whether sounding in tort, contract or under statute (a "Dispute") shall first be addressed by exhausting the applicable procedures in the Provider Manual pertaining to claims payment, credentialing, utilization management, or other programs. If, at the conclusion of these applicable procedures, the matter is not resolved to satisfaction of the Provider Party and the Administrator Party, or if there are no applicable procedures in the Provider Manual, then the Provider Party and the Administrator Party shall engage in a period of good faith negotiations between their designated representatives who have authority to settle the Dispute, which negotiations may be initiated by either the Provider Party or the Administrator Party upon written request to the other, provided such request takes place within one year of the date on which the requesting party first had, or reasonably should have had, knowledge of the event(s) giving rise to the Dispute. If the matter has not been resolved within 60 days of such request, either the Provider Party or the Administrator Party may, as its sole and exclusive forum for the litigation of the Dispute or any part thereof, initiate arbitration pursuant to Section 6.2 below by providing written notice to the other party.

6.2. Arbitration. If either the Provider Party or the Administrator Party wishes to pursue the Dispute as provided in Section 6.1, such party 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 1 year following, as applicable, the end of the 60 day negotiation period set forth in Section 6.1, or the date of notice of termination. Arbitration proceedings shall be conducted by an arbitrator chosen from the National Healthcare Panel at a mutually agreed upon location within the State. The arbitrator shall not award any punitive or exemplary damages of any kind, shall not vary or ignore the provisions of this Agreement, and shall be bound by controlling law. Any arbitration in which the total amount in controversy is less than $100,000 shall be conducted in a single hearing day. The Parties and the Contracted Providers, on behalf of themselves and those that they may now or hereafter represent, agree to and do hereby waive any right to pursue, on a class basis, any Dispute. Each of the Provider Party and the Administrator Party shall bear its own costs and attorneys' fees related to the arbitration except that the AAA's Administrative Fees, all Arbitrator Compensation and travel and other expenses, and all costs of any proof produced at the direct request of the arbitrator shall be borne equally by the applicable parties, and the arbitrator shall not have the authority to order otherwise. The existence of a Dispute or arbitration proceeding shall not in and of itself constitute cause for termination of this Agreement. Except as hereafter provided, during an arbitration proceeding, each of the Provider Party and the Administrator Party shall continue to perform its obligations under this Agreement pending the decision of the arbitrator. Nothing herein shall bar either the Provider Party or the Administrator Party from seeking emergency injunctive relief to preclude any actual or perceived breach of this Agreement, although such party shall be obligated to file and pursue arbitration at the earliest reasonable opportunity. Judgment on the award rendered may be entered in any court having jurisdiction thereof. Because of the confidential nature of this Agreement, the Provider and Administrator Parties further agree that in any action to compel arbitration or enforce any arbitration award, no party may file any part of this Agreement (including Attachments) in the court record, except this Section 6.2. Nothing contained in this Article VI shall limit a Party's right to terminate this Agreement with or without cause in accordance with Section 7.2.

ARTICLE VII - TERM AND TERMINATION

7.1. Term. This Agreement is effective as of the Health Plan Effective Date, and will remain in effect for an initial term ("Initial Term") of 3 year(s), after which it will automatically renew for successive terms of 1 year each (each a "Renewal Term"), unless this Agreement is sooner terminated as provided in this Agreement or either Party gives the other Party written notice of non-renewal of this Agreement not less than 180 days prior to the end of the then-current term. In addition, either Party may elect to not renew a Contracted Provider's participation as a Participating Provider in a particular Product for the next Renewal Term, by giving Provider written notice of such non-renewal not less than 180 days prior to the, as applicable, last day of the Initial Term or applicable Renewal Term; in such event, Provider shall immediately notify the affected Contracted Provider of such non-renewal. Termination of any Contracted Provider's participation in a particular Product will not have the effect of terminating

either this Agreement or the Contracted Provider's participation in any other Product in which the Contract Provider participates under this Agreement.

7.2. Termination. This Agreement, or the participation of Provider or a Contracted Provider as a Participating Provider in one or more Products, may be terminated or suspended as set forth below.

7.2.1. Upon Notice. This Agreement may be terminated by either Party giving the other Party at least 180 days prior written notice of such termination. The participation of any Contracted Provider as a Participating Provider in a Product may be terminated by either Party giving the other Party at least 180 days prior written notice of such termination; in such event, Provider shall immediately notify the affected Contracted Provider of such termination.

7.2.2. With Cause. This Agreement, or the participation of any Contracted Provider as a Participating Provider in one or more Products under this Agreement, may be terminated by either Party giving at least 90 days prior written notice of termination to the other Party if such other Party (or the applicable Contracted Provider) is in breach of any material term or condition of this Agreement and such other Party (or the Contracted Provider) fails to cure the breach within the 60 day period immediately following the giving of written notice of such breach. Any notice given pursuant to this Section 7.2.2 must describe the specific breach. In the case of a termination of a Contracted Provider, Provider shall immediately notify the affected Contracted Provider of such termination.

7.2.3. Suspension of Participation. Unless expressly prohibited by applicable Regulatory Requirements, Health Plan has the right to immediately suspend or terminate the participation of a Contracted Provider in any or all Products by giving written notice thereof to Provider when Health Plan determines that (i) based upon available information, the continued participation of the Contracted Provider appears to constitute an immediate threat or risk to the health, safety or welfare of Covered Persons, or (ii) the Contracted Provider's fraud, malfeasance or non-compliance with Regulatory Requirements is reasonably suspected. Provider shall immediately notify the affected Contracted Provider of such suspension. During such suspension, the Contracted Provider shall, as directed by Health Plan, discontinue the provision of all or a particular Covered Service to Covered Persons. During the term of any suspension, the Contracted Provider shall notify Covered Persons that his or her status as a Participating Provider has been suspended. Such suspension will continue until the Contracted Provider's participation is reinstated or terminated.

7.2.4. Insolvency. This Agreement may be terminated immediately by a Party giving written notice thereof to the other Party if the other Party is insolvent or has bankruptcy proceedings initiated against it.

7.2.5. Credentialing. The status of a Contracted Provider as a Participating Provider in one or more Products may be terminated immediately by Health Plan giving written notice thereof to Provider if the Contracted Provider fails to adhere to Health Plan's credentialing criteria, including, but not limited to, if the Contracted Provider (i) loses, relinquishes, or has materially affected its license to provide Covered Services in the State, (ii) fails to comply with the insurance requirements set forth in this Agreement; or (iii) is convicted of a criminal offense related to involvement in any state or federal health care program or has been terminated, suspended, barred, voluntarily withdrawn as part of a settlement agreement, or otherwise excluded from any state or federal health care program. Provider shall immediately notify the affected Contracted Provider of such termination.

7.3. Effect of Termination. After the effective date of termination of this Agreement or a Contracted Provider's participation in a Product, this Agreement shall remain in effect for purposes of those obligations and rights arising prior to the effective date of termination. Upon such a termination, each affected Contracted Provider (including Provider, if applicable) shall (i) continue to provide Covered Services to Covered Persons in the applicable Product(s) during the longer of the 90 day period following the date of such termination or such other period as may be required under any Regulatory Requirements, and, if requested by Company, each affected Contracted Provider (including Provider, if applicable) shall continue to provide, as a Participating Provider, Covered Services to Covered Persons until such Covered Persons are assigned or transferred to another Participating Provider in the applicable Product(s), and (ii) continue to comply with and abide by all of the applicable terms and conditions of this Agreement, including, but not limited to, Section 3.4 (Hold Harmless) hereof, in connection with the provision of such Covered

Services during such continuation period. During such continuation period, each affected Contracted Provider (including Provider, if applicable) will be compensated in accordance with this Agreement and shall accept such compensation as payment in full.

7.4. Survival of Obligations. All provisions hereof that by their nature are to be performed or complied with following the expiration or termination of this Agreement, including without limitation Sections 2.8, 2.10, 3.2, 3.4, 3.5, 4.2, 5.1, 5.2, 5.3, 6.2, 7.3, and 7.4 and Article VIII, survive the expiration or termination of this Agreement.

ARTICLE VIII - MISCELLANEOUS

8.1. Relationship of Parties. The relationship between or among Health Plan, Company, Provider, Payor and any Contracted Provider hereunder is that of independent contractors. None of the provisions of this Agreement will be construed as creating any agency, partnership, joint venture, employee-employer, or other relationship. References herein to the rights and obligations of any Company under this Agreement are references to the rights and obligations of each Company individually and not collectively. A Company is only responsible for performing its respective obligations hereunder with respect to a particular Product, Coverage Agreement, Payor Contract, Covered Service or Covered Person. A breach or default by an individual Company shall not constitute a breach or default by any other Company, including but not limited to Health Plan.

8.2. Conflicts Between Certain Documents. If there is any conflict between this Agreement and the Provider Manual, this Agreement will control. In the event of any conflict between this Agreement and any Product Attachment, the Product Attachment will control as to such Product.

8.3. Assignment. This Agreement is intended to secure the services of and be personal to Provider and may not be assigned, sublet, delegated, subcontracted or transferred by Provider without Health Plan's prior written consent. Health Plan shall have the right, exercisable in its sole discretion, to assign or transfer all or any portion of its rights or to delegate all or any portion of its interests under this Agreement or any Attachment to an Affiliate, successor of Health Plan, or purchaser of the assets or stock of Health Plan, or the line of business or business unit primarily responsible for carrying out Health Plan's obligations under this Agreement.

8.4. Headings. The headings of the sections of this Agreement are inserted merely for the purpose of convenience and do not limit, define, or extend the specific terms of the section so designated.

8.5. Governing Law. The interpretation of this Agreement and the rights and obligations of Health Plan, Company, Provider and any Contracted Providers hereunder will be governed by and construed in accordance with applicable federal and State laws.

8.6. Third Party Beneficiary. This Agreement is entered into by the Parties signing it for their benefit, as well as, in the case of Health Plan, the benefit of Company, and in the case of Provider, the benefit of each Contracted Provider. Except as specifically provided in Section 3.4 hereof, no Covered Person or third party, other than Company, will be considered a third party beneficiary of this Agreement.

8.7. Amendment. Except as otherwise provided in this Agreement, this Agreement may be amended only by written agreement of duly authorized representatives of the Parties.

8.7.1. Health Plan may amend this Agreement by giving Provider written notice of the amendment to the extent such amendment is deemed necessary or appropriate by Health Plan to comply with any Regulatory Requirements. Any such amendment will be deemed accepted by Provider upon the giving of such notice.

8.7.2. Health Plan may amend this Agreement by giving Provider written notice (electronic or paper) of the proposed amendment. Unless Provider notifies Health Plan in writing of its objection to such amendment during the 30 day period following the giving of such notice by Health Plan, Provider shall be deemed to have accepted the amendment. If Provider objects to any proposed amendment to either the base agreement or any

Attachment, Health Plan may exclude one or more of the Contracted Providers from being Participating Providers in the applicable Product (or any component program of, or Coverage Agreement in connection with, such Product).

8.8. Entire Agreement. All prior or concurrent agreements, promises, negotiations or representations either oral or written, between Health Plan and Provider relating to a subject matter of this Agreement, which are not expressly set forth in this Agreement, are of no force or effect.

8.9. Severability. The invalidity or unenforceability of any terms or provisions hereof will in no way affect the validity or enforceability of any other terms or provisions.

8.10. Waiver. The waiver by either Party of the violation of any provision or obligation of this Agreement will not constitute the waiver of any subsequent violation of the same or other provision or obligation.

8.11. Notices. Except as otherwise provided in this Agreement, any notice required or permitted to be given hereunder is deemed to have been given when such written notice has been personally delivered or deposited in the United States mail, postage paid, or delivered in hard copy or electronically by a service that provides written receipt or acknowledgment of delivery, addressed as follows:

To Health Plan at:	To Provider at:
Attn: President	Attn: Brian Bucher
Peach State Health Plan, Inc.	Centria Healthcare, LLC
1100 Circle 75 Parkway, Suite 1100	2000 Riveredge Pkwy NW, Suite 885
Atlanta, GA 30339	Atlanta, GA 30328
	Contracts@centriahealthcare.com

or to such other address as such Party may designate in writing. Notwithstanding the previous paragraph, Health Plan may provide notices by electronic mail, through its provider newsletter or on its provider website.

8.12. Force Majeure. Neither Party shall be liable or deemed to be in default for any delay or failure to perform any act under this Agreement resulting, directly or indirectly, from acts of God, civil or military authority, acts of public enemy, war, accidents, fires, explosions, earthquake, flood, strikes or other work stoppages by either Party's employees, or any other similar cause beyond the reasonable control of such Party.

8.13. Proprietary Information. Each Party is prohibited from, and shall prohibit its Affiliates and Contracted Providers from, disclosing to a third party the substance of this Agreement, or any information of a confidential nature acquired from the other Party (or Affiliate or Contracted Provider thereof) during the course of this Agreement, except to agents of such Party as necessary for such Party's performance under this Agreement, or as required by a Payor Contract or applicable Regulatory Requirements. Provider acknowledges and agrees that all information relating to Company's programs, policies, protocols and procedures is proprietary information and Provider shall not disclose such information to any person or entity without Health Plan's express written consent.

8.14. Authority. The individuals whose signatures are set forth below represent and warrant that they are duly empowered to execute this Agreement. Provider represents and warrants that it has all legal authority to contract on behalf of and to bind all Contracted Providers to the terms of the Agreement with Health Plan. Provider and each Contracted Provider acknowledges that references herein to the rights and obligations of any "Company" or a "Payor" under this Agreement are references to the rights and obligations of each Company and each Payor individually and not of the Companies or Payors collectively. Notwithstanding anything herein to the contrary, all such rights and obligations are individual and specific to each such Company and each such Payor and the reference to Company or Payor herein in no way imposes any cross-guarantees or joint responsibility or liability by, between or among such

individual Companies or Payors. A breach or default by an individual Company or Payor shall not constitute a breach or default by any other Company or Payor, including but not limited to Health Plan.

* * * * *

THIS AGREEMENT CONTAINS A BINDING ARBITRATION PROVISION THAT MAY BE ENFORCED BY THE PARTIES.

IN WITNESS WHEREOF, the Parties hereto have executed this Agreement, including all Product Attachments noted on Schedule B, effective as of the date set forth beneath their respective signatures.

HEALTH PLAN:	**PROVIDER:**
Peach State Health Plan, Inc.	Centria Healthcare, LLC (Legibly Print Name of Provider)
Authorized Signature: Urcel Fields Urcel Fields (May 27, 2022 11:28 EDT)	Authorized Signature: Brian Bucher Brian Bucher (May 26, 2022 16:02 EDT)
Print Name: Urcel Fields	Print Name: Brian Bucher
Title: Chief Operating Officer	Title: CFO
Signature Date: May 27, 2022	Signature Date: May 26, 2022
ICM #: ICMProviderAgreement_159350	Tax Identification Number: 27-1402749
To be completed by Health Plan only: Effective Date: May 1, 2022	National Provider Identifier: 1053641498 Medicare Number:

PARTICIPATING PROVIDER AGREEMENT

SCHEDULE A
CONTRACTED PROVIDER-SPECIFIC PROVISIONS

Provider and Contracted Providers shall comply with the applicable provisions of this Schedule A.

1. Hospitals. If Provider or a Contracted Provider is a hospital ("Hospital"), the following provisions apply.

1.1 24 Hour Coverage. Each Hospital shall be available to provide Covered Services to Covered Persons twenty-four (24) hours per day, seven (7) days per week.

1.2 Emergency Care. Each Hospital shall provide Emergency Care (as hereafter defined) in accordance with Regulatory Requirements. The Contracted Provider shall notify Company's medical management department of any emergency room admissions by electronic file sent within 24 hours or by the next business day of such admission. "Emergency Care" (or derivative thereof) has, as to each particular Product, the meaning set forth in the applicable Coverage Agreement or Product Attachment. If there is no definition in such documents, "Emergency Care" means inpatient and/or outpatient Covered Services furnished by a qualified provider that are needed to evaluate or stabilize an Emergency Medical Condition. "Emergency Medical Condition" means 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 the absence of immediate medical attention to result in the following: (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

1.3 Staff Privileges. Each Hospital shall assist in granting staff privileges or other appropriate access to Company's Participating Providers who are qualified medical or osteopathic physicians, provided they meet the reasonable standards of practice and credentialing standards established by the Hospital's medical staff and bylaws, rules, and regulations.

1.4 Discharge Planning. Each Hospital agrees to cooperate with Company's system for the coordinated discharge planning of Covered Persons, including the planning of any necessary continuing care.

1.5 Credentialing Criteria. Each Hospital shall: (a) currently, and for the duration of this Agreement, remain accredited by the Joint Commission or American Osteopathic Association, as applicable; and (b) ensure that all employees of Hospital perform their duties in accordance with all applicable local, State and federal licensing requirements and standards of professional ethics and practice.

1.6 National Committee for Quality Assurance ("NCQA") Accreditation of Health Plans Standards. Each Hospital agrees to: (i) cooperate with Quality Management and Improvement ("QI") activities; (ii) maintain the confidentiality of a Covered Persons information and records pursuant to the Agreement; and (iii) allow the Company to use Hospital's performance data.

2. Practitioners. If Provider or Contracted Provider is a physician or other health care practitioner (including physician extenders) ("Practitioner"), the following provisions apply.

2.1 Contracted Professional Qualifications. At all times during the term of this Agreement, Practitioner shall, as applicable, maintain medical staff membership and admitting privileges with at least one hospital that is a Participating Provider ("Participating Hospital") with respect to each Product in which the Practitioner participates. Upon Company's request, Practitioner shall furnish evidence of the foregoing to Company. If Practitioner does not have such admitting privileges, Provider or the Practitioner shall provide Company with a written statement from another Participating Provider who has such admitting privileges, in good standing, certifying

that such individual agrees to assume responsibility for providing inpatient Covered Services to Covered Persons who are patients of the applicable Practitioner.

2.2 Acceptance of New Patients. To the extent that Practitioner is accepting new patients, such Practitioner must also accept new patients who are Covered Persons with respect to the Products in which such Practitioner participates. Practitioner shall notify Company in writing 45 days prior to such Practitioner's decision to no longer accept Covered Persons with respect to a particular Product. In no event will an established patient of any Practitioner be considered a new patient.

2.3 Preferred Drug List/Drug Formulary. If applicable to the Covered Person's coverage, Practitioners shall use commercially reasonable efforts, when medically appropriate under the circumstances, to comply with formulary or preferred drug list when prescribing medications for Covered Persons.

2.4 National Committee for Quality Assurance ("NCQA") Accreditation of Health Plans Standards. Each Practitioner agrees to: (i) cooperate with Quality Management and Improvement ("QI") activities; (ii) maintain the confidentiality of a Covered Persons information and records pursuant to the Agreement; and (iii) allow the Company to use Practitioner's performance data.

3. Ancillary Providers. If Provider or Contracted Provider is an ancillary provider (including but not limited to a home health agency, durable medical equipment provider, sleep center, pharmacy, ambulatory surgery center, nursing facility, laboratory or urgent care center)("Ancillary Provider"), the following provisions apply.

3.1 Acceptance of New Patients. To the extent that Ancillary Provider is accepting new patients, such Ancillary Provider must also accept new patients who are Covered Persons with respect to the Products in which such Ancillary Provider participates. Ancillary Provider shall notify Company in writing 45 days prior to such Ancillary Provider's decision to no longer accept Covered Persons with respect to a particular Product. In no event will an established patient of any Ancillary Provider be considered a new patient.

3.2 National Committee for Quality Assurance ("NCQA") Accreditation of Health Plans Standards. Each ancillary provider agrees to: (i) cooperate with Quality Management and Improvement ("QI") activities; (ii) maintain the confidentiality of a Covered Persons information and records pursuant to the Agreement; and (iii) allow the Company to use ancillary provider's performance data.

4. FQHC. If Provider or a Contracted Provider is a federally qualified health center ("FQHC"), the following provision applies.

4.1 FQHC Insurance. To the extent FQHC's employees are deemed to be federal employees qualified for protection under the Federal Tort Claims Act ("FTCA") and Health Plan has been provided with documentation of such status issued by the U.S. Department of Health and Human Services (such status to be referred to as "FTCA Coverage"), Section 5.1 of this Agreement will not apply to those Contracted Providers with FTCA Coverage. FQHC shall provide evidence of such FTCA Coverage to Health Plan at any time upon request. FQHC shall promptly notify Health Plan if, any time during the term of this Agreement, any Contracted Provider is no longer eligible for, or if FQHC becomes aware of any fact or circumstance that would jeopardize, FTCA Coverage. Section 5.1 of this Agreement will apply to a Contracted Provider immediately upon such Contracted Provider's loss of FTCA Coverage for any reason.

5. Facility Providers. If Provider or a Contracted Provider is a facility (including but not limited to Clinic, FQHC, LTAC, Nursing Home, Rehab, Rural Health Clinic, Skilled Nursing) ("Facility Provider") the following provision applies.

5.1 National Committee for Quality Assurance ("NCQA") Accreditation of Health Plans Standards. Each facility agrees to: (i) cooperate with Quality Management and Improvement ("QI") activities; (ii) maintain the confidentiality of a Covered Persons information and records pursuant to the Agreement; and (iii) allow the Company to use facility's performance data.

6. Long Term Services and Supports ("LTSS") and Home and Community-Based Services ("HCBS") Providers. If Provider or a Contracted Provider is a provider of LTSS and/or HCBS services, the following provisions apply.

6.1 Definition. LTSS generally includes assistance with daily self-care activities (e.g., walking, toileting, bathing, and dressing) and activities that support an independent lifestyle (e.g., food preparation, transportation, and managing medications). The broad category of LTSS also includes care and service coordination for people who live in their own home, a residential setting, a nursing facility, or other institutional setting. Home and community-based services ("HCBS") are a subset of LTSS that functions outside of institutional care to maximize independence in the community.

6.2 Acknowledgement. Health Plan acknowledges that Provider is a provider of LTSS and is not necessarily a provider of medical or health care services. Nothing in this Agreement is intended to require Provider to provide medical or health care services that Provider does not routinely provide, but would not prohibit providers from offering these services, as appropriate.

6.3 Notification Requirements. Provider or the applicable Contracted Provider shall provide the following notifications to Health Plan, via written notice or via telephone contact at a number to be provided by Health Plan, within the following time frames:

6.3.1 Provider or the applicable Contracted Provider shall notify Health Plan of a Covered Person's visit to urgent care or the emergency department of any hospital, or of a Covered Person's hospitalization, within 24 hours of becoming aware of such visit or hospitalization.

6.3.2 Provider or the applicable Contracted Provider shall notify Health Plan of any change to the designated/assigned services being provided under a Covered Person's plan of care and/or service plan, within 24 hours of becoming aware of such change.

6.3.3 Provider or the applicable Contracted Provider shall notify Health Plan if a Covered Person misses an appointment with Provider, within 24 hours of becoming aware of such missed appointment.

6.3.4 Provider or the applicable Contracted Provider shall notify Health Plan of any change in a Covered Person's medical or behavioral health condition, within 24 hours of becoming aware of such change. (Examples of changes in condition are set forth in the Provider Manual.)

6.3.5 Provider or the applicable Contracted Provider shall notify Health Plan of any safety issue identified by Provider or Contracted Provider or its agent or subcontractor, within 24 hours of the identification of such safety issue. (Examples of safety issues are set forth in the Provider Manual.)

6.3.6 Provider or the applicable Contracted Provider shall notify Health Plan of any change in Provider's or Contracted Provider's key personnel, within 24 hours of such change.

6.4 Minimum Data Set. If Contracted Provider is a nursing facility, Provider or such Contracted Provider shall submit to Health Plan or its designee the Minimum Data Set as defined by CMS and required under federal law and Health Plan policy as it relates to all Covered Persons who are residents in Contracted Provider's facility. Such submission shall be via electronic mail, facsimile transmission, or other manner and format reasonably requested by Health Plan.

6.5 Quality Improvement Plan. Each Contracted Provider shall participate in Health Plan's LTSS quality improvement plan. Each Contracted Provider shall permit Health Plan to access such Contracted Providers' assessment and quality data upon reasonable advance notice, which may be given by electronic mail.

6.6 Electronic Visit Verification. If Contracted Provider provides in-home services, Contracted Provider shall comply with 21st Century Cures Act and Health Plan's electronic visit verification system requirements where applicable and accessible.

6.7 Criminal Background Checks. Provider shall conduct a criminal background check on each Contracted Provider prior to the commencement of services under this Agreement and as requested by Health Plan thereafter. Provider shall provide the results of such background checks to Health Plan and member, if self-directed, upon request. Provider agrees to immediately notify Health Plan of any criminal convictions of any Contracted or sub-contracted Provider. Provider shall pay any costs associated with such criminal background checks.

7. Person-Centered Planning, Care/Service Plan, and Services ("PCSP"). Provider shall comply with all state and federal regulatory requirements related to person-centered planning, care/service plans, and services including, but not limited to:

7.1 Covered Persons shall lead the person-centered planning process and can elect to include, and/or consult with, any of their LTSS providers in the care/service plan development process.

7.2 The care/service plan must be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation through the mechanism required by state and federal requirements. Non-medical service providers (such as meals or assistive technology) can signify their agreement through this contract or written agreement in lieu of directly in the plan, if permitted by the Covered Persons.

7.3 LTSS Provider shall be aware of, respect, and adhere to a Covered Person's preferences for the delivery of services and supports.

7.4 LTSS Provider shall ensure services and supports are culturally appropriate, provided in plain language (where applicable), and accessible to Covered Persons and the person(s) supporting them who have disabilities and/or are limited English proficient.

7.5 Health Plan agrees to complete the care/service plan in a timely manner (within at least one hundred twenty (120) days of enrollment or annually, or less if state requirements differ) and provide a copy to LTSS Provider(s) responsible for implementation.

8. Mid-level Behavioral Health Practitioner. If Provider or Contracted Provider is a licensed professional counselor, licensed marriage family therapist, licensed clinical social worker or other health care practitioner (including physician extenders) ("Practitioner"), the following provisions apply.

8.1 Acceptance of New Patients. To the extent that Practitioner is accepting new patients, such Practitioner must also accept new patients who are Covered Persons with respect to the Products in which such Practitioner participates. Practitioner shall notify Company in writing forty-five (45) days prior to such Practitioner's decision to no longer accept Covered Persons with respect to a particular Product. In no event will an established patient of any Practitioner be considered a new patient.

8.2 Preferred Drug List/Drug Formulary. If applicable to the Covered Person's coverage, Practitioners shall use commercially reasonable efforts, when medically appropriate under the circumstances, to comply with formulary or preferred drug list when prescribing medications for Covered Persons.

8.3 Covered Services. Provider or Contracted Provider shall provide Covered Services to Covered Persons in accordance with the terms of this Agreement, the applicable Attachments, the Provider Manual and in accordance with generally accepted standards of clinical practice in the Provider's community, and the scope of Provider's or Contracted Provider's license. Provider or Contracted Provider shall make necessary and appropriate arrangement to assure the availability of Cover Services to Covered Persons on a twenty-four (24) hour per day, seven (7) day per week basis, including arrangements to assure coverage of Covered Person after-hours or when Provider

or Contracted Provider is absent. Provider or Contracted Provider further agrees that such coverage is with a Participating Provider.

8.4 Reporting to Primary Care Physician. Provider or Contracted Provider shall report Covered Services provider to Covered Person's primary care physician ("PCP"), as may be required by State and federal law and this Agreement.

PARTICIPATING PROVIDER AGREEMENT

SCHEDULE B
PRODUCT PARTICIPATION

Provider will be designated as a "Participating Provider" in the Product Attachments listed below as of the date of successful completion of credentialing in accordance with this Agreement.

List of Product Attachments:
Attachment A: Medicaid
Attachment B: [Reserved]
Attachment C: Commercial-Exchange
Attachment D: [Reserved]
Attachment E: [Reserved]

PARTICIPATING PROVIDER AGREEMENT

SCHEDULE C
INFORMATION FOR CONTRACTED PROVIDERS

Provider shall provide Health Plan with the information set forth below with respect to: (i) Provider; (ii) each Contracted Provider; and (iii) if applicable, each Contracted Provider's locations and/or professionals. To the extent Provider provides the name of any Contracted Provider to Health Plan hereunder, such entity and/or individual will be considered a Contracted Provider under this Agreement regardless of whether the complete list of information set forth below relating to such Contracted Provider is provided by Provider.

1. Name
2. Address
3. E-mail address
4. Telephone and facsimile numbers
5. Professional license numbers
6. Medicare/Medicaid ID numbers
7. Federal tax ID numbers
8. Completed W-9 form
9. National Provider Identifier (NPI) numbers
10. Provider Taxonomy Codes
11. Area of medical specialty
12. Age restrictions (if any)
13. Area hospitals with admitting privileges (where applicable)
14. Whether Providers are employed or subcontracted with Contracted Provider using the designation "E" for employed or "C" for subcontracted.
15. For a subcontracted Provider, whether its Providers are employed or contracted with the subcontracted Provider using the designation "E" for employed or "C" for contracted.
16. Office contact person
17. Office hours
18. Billing office
19. Billing office address
20. Billing office telephone and facsimile numbers
21. Billing office e-mail address
22. Billing office contact person
23. Ownership Disclosure Form, as required to comply with Regulatory Requirements and Governmental Contract

NOTE: For a complete listing of the information and additional documentation required, please refer to the enrollment application.

Attachment A: Medicaid

PRODUCT ATTACHMENT AND STATE-MANDATED PROVISIONS

This Attachment A is incorporated into this Agreement between the parties. This Attachment shall be effective on the Effective Date of the Agreement.

I. RECITALS.

A. Health Plan has contracted to be a State Medicaid Care Management Organization to provide health care services to Covered Persons of Georgia Families, the State's Medicaid program, and PeachCare for Kids®, Georgia's State Children's Health Insurance Program, and such other programs (hereafter referred to as "Medicaid") as may be awarded to Health Plan by the Department of Community Health ("DCH").

B. Provider has entered into the Agreement with Health Plan. This Attachment is intended to supplement the Agreement by setting forth the parties' rights and responsibilities related to the provision of Covered Services to Medicaid Covered Persons.

C. Notwithstanding any provisions set forth in this Attachment, to the extent applicable, Provider shall comply with all duties and obligations under the Medicaid Contract that Health Plan has delegated to Provider. Provider agrees and understands that Covered Services shall be provided in accordance with the Medicaid Contract, the Participating Health Care Provider Manual, any applicable State Medicaid Agency Manuals, and all applicable State and federal laws and regulations. To the extent Provider is unclear about Provider's duties and obligations, Provider shall ask Health Plan for guidance.

D. Where Company is not the Payor, the rights and responsibilities assigned under this Attachment to Company, Payor, or "Company or Payor" shall be understood to apply to either Company or Payor as applicable under the circumstances and as determined by the terms of the Payor Contract, Regulatory Requirements and/or Company policies and procedures. The phrase "Company or Payor" is not intended to nor shall result in the expansion of any rights on the part of Provider or Contracted Providers or any liabilities on the part of Company or Payor. Nothing in this Attachment shall be construed as conferring any financial or legal liabilities of Payor under any Regulatory Requirements or the Payor Contract to Company or Health Plan. Nothing in this Attachment shall be construed as altering the terms of the Payor Contractor, or in a manner that is inconsistent with Regulatory Requirements. The rights and responsibilities that arise under a Payor Contract (including a Governmental Contract) and that are assigned under this Attachment to Health Plan are understood to be assigned to Company (and references to "Health Plan" will be understood to be references to Company) where Company is a party to the Payor Contract.

II. DEFINITIONS APPLICABLE TO THIS PRODUCT. The following terms, and any terms defined in the Agreement, shall have the specified meanings when capitalized in this Attachment:

A. ***Advance Directives*** means a written instruction, such as a living will or durable power of attorney for Health Care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of Health Care when the individual is incapacitated.

B. ***After-Hours*** means a Provider's office/visitation hours that extend beyond the normal business hours of Monday-Friday 9-5:30 and also extend to Saturday hours.

C. ***Business Days*** means the traditional workdays, including Monday, Tuesday, Wednesday, Thursday, and Friday. State Holidays are excluded.

D. ***Calendar Days*** means all seven days of the Week.

E. ***Care Management Organization (CMO)*** means an entity (such as HMO) that is organized for the purpose of providing Health Care and has a Health Maintenance Organization Certificate of Authority or Consent Order issued by the Office of the Insurance and Safety Fire Commissioner, which contracts with Providers, and furnishes Health Care services on a capitated basis to Members.

F. ***Centers for Medicare & Medicaid Services or CMS*** means the Agency within the U.S. Department of Health and Human Services with responsibility for the Medicare, Medicaid and the State Children's Health Insurance Program.

G. ***Chronic Condition*** means any ongoing physical, behavioral, or cognitive disorder, including chronic illnesses, impairments and disabilities. There is an expected duration of at least twelve (12) months with resulting functional limitations, reliance on compensatory mechanisms (e.g., medications, special diet, assistive device, etc.) and service use or need beyond that which is normally considered routine.

H. ***Claim*** means a bill for services, a line item of services, or all services for one recipient within a bill.

I. ***Clean Claim*** means a claim received by Health Plan for adjudication, in a nationally accepted format in compliance with standard coding guidelines and which requires no further information, adjustment, or alteration by the Provider of the services in order to be processed and paid by Health Plan. The following exceptions apply to this definition: (a) a Claim for payment of expenses incurred during a period of time for which premiums are delinquent; (b) a Claim for which Fraud is suspected; and (c) a Claim for which a Third Party Resource should be responsible.

J. ***Condition*** means a disease, illness, injury, disorder, of biological, cognitive, or psychological basis for which evaluation, monitoring and/or treatment are indicated.

K. ***Co-payment*** means the part of the cost-sharing requirement for Medicaid Covered Persons in which a fixed monetary amount is paid for certain services/items received from the Health Plan's Providers.

L. ***Credentialing*** means the Health Plan's determination as to the qualifications and ascribed privileges of a specific Provider to render specific Health Care services.

M. ***Cultural Competency Plan*** means a plan created by Health Plan and approved by DCH which describes how the Providers, individuals and systems within the CMO plan will effectively provide services to people of all cultures, races, ethnic backgrounds and religions in a manner that recognizes, values, affirms and respects the worth of the individual Medicaid Covered Persons and protects and preserves the dignity of each.

N. ***Department of Insurance (DOI)*** means the Agency in the State of Georgia responsible for licensing, overseeing, regulating, and certifying insuring entities.

O. ***Emergency Care or Emergency Services*** means covered inpatient and outpatient services furnished by a qualified Provider that are needed to evaluate or stabilize an Emergency Medical Condition that is found to exist using the prudent layperson standard.

P. ***Emergency Medical Condition*** means 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 the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairments of bodily functions; (iii) serious dysfunction of any bodily organ or part; (iv) serious harm to self or others due to an alcohol or drug abuse emergency; (v) injury to self or bodily harm to others; or (vi) with respect to a pregnant woman having contractions: (a) that there is inadequate time to effect a safe transfer to another hospital before delivery, or (b) that transfer

may pose a threat to the health or safety of the woman or the unborn child. An Emergency Medical Condition shall not be defined on the basis of lists of diagnoses or symptoms.

Q. ***Encounter*** means, for the purposes of this Agreement, a Health Care encounter is defined as a distinct set of services provided to a Medicaid or PeachCare for Kids® member enrolled with a Health Plan on the dates that the services were delivered.

R. ***Encounter Data*** means Health Care Encounter Data that includes: (a) all data captured during the course of a single Health Care Encounter that specify the diagnoses, comorbidities, procedures (therapeutic, rehabilitative, maintenance, or palliative), pharmaceuticals, medical devices and equipment associated with the Medicaid Covered Persons receiving services during the Encounter; (b) the identification of the Medicaid Covered Persons receiving and the Provider(s) delivering the Health Care services during the single Encounter; and, (c) a unique, i.e. unduplicated, identifier for the single Encounter.

S. ***Fee-for-Service (FFS) Reimbursement*** means a method of reimbursement based on payment for specific services rendered to a Medicaid Covered Person.

T. ***Financial Relationship*** means a direct or indirect ownership or investment interest (including and option or nonvested interest) in any entity. This direct or indirect interest may be in the form of equity, debt, or other means and includes any indirect ownership or investment interest no matter how many levels removed from a direct interest, or a compensation arrangement with an entity.

U. ***Fraud*** means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit or financial gain to him/herself or some other person. It includes any act that constitutes Fraud under applicable federal or State law.

V. ***Georgia Families*** means the risk-based managed care delivery program for Medicaid and PeachCare for Kids® in which DCH contracts with CMOs to manage the care of eligible Members.

W. ***Health Care*** means care, services, or supplies related to the health of an individual. Health Care includes, but is not limited to, the following: (a) preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or procedure with respect to the physical or mental Condition, or functional status, of an individual or that affects the structure or function of the body; and (b) sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription.

X. ***Health Check*** means the State's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program pursuant to Title XIX of the Social Security Act.

Y. ***Medicaid*** means the joint federal/state program of medical assistance established by Title XIX of the Social Security Act, which in Georgia is administered by DCH.

Z. ***Medicaid Contract*** means the agreement then in effect between Health Plan and the State, as revised or replaced from time to time (including, but not limited to, the Medicaid Contract awarded to Health Plan pursuant to the State Medicaid managed care program as implemented by the State from time to time) pertaining to the provision of services by Health Plan to its Medicaid Covered Persons who are beneficiaries of the State Medicaid program and who enroll to receive care through Health Plan.

AA. ***Medicaid Covered Person(s)*** means an individual Medicaid beneficiary who is eligible and has enrolled to receive Covered Services from Health Plan pursuant to the terms of the Medicaid Contract.

BB. ***Medical Records*** means the complete, comprehensive records of a Medicaid Covered Persons including, but not limited to, x-rays, laboratory tests, results, examinations and notes, accessible at the site of the Medicaid Covered Person's participating Primary Care physician or Provider, that document all medical services received by the Medicaid Covered Persons, including inpatient, ambulatory, ancillary, and

Emergency Care, prepared in accordance with all applicable DCH rules and regulations, and signed by the medical professional rendering the services.

CC. ***Medically Necessary Services*** means services that, based upon generally accepted medical practices in light of Conditions at the time of treatment, are: (a) appropriate and consistent with the diagnosis of the treating Provider and the omission of which could adversely affect the eligible Medicaid Covered Person's medical Condition; (b) compatible with the standards of acceptable medical practice in the community; (c) provided in a safe, appropriate, and cost-effective setting given the nature of the diagnosis and the severity of the symptoms; (d) not provided solely for the convenience of the Medicaid Covered Person or the convenience of the Health Care Provider or hospital; and (e) not primarily custodial care unless custodial care is a covered service or benefit under the Medicaid Covered Persons evidence of coverage. There must be no other effective and more conservative or substantially less costly treatment, service and setting available. A determination that a service is Medically Necessary does not mean that a particular service is a Covered Service if the service is otherwise excluded under the Covered Person's Health Plan Coverage Plan.

DD. ***Primary Care*** means all Health Care services and laboratory services, including periodic examinations, preventive Health Care and counseling, immunizations, diagnosis and treatment of illness or injury, coordination of overall medical care, record maintenance, and initiation of Referrals to specialty Providers described in this Contract, and for maintaining continuity of patient care. These services are customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician, and may be furnished by a nurse practitioner to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them.

EE. ***Prior Authorization (also known as "pre-authorization" or "prior approval")*** means Authorization granted in advance of the rendering of a service after appropriate medical review.

FF. ***Referral*** means a request by a PCP for a Medicaid Covered Person to be evaluated and/or treated by a different physician, usually a specialist.

GG. ***Third Party Resource*** means any person, institution, corporation, insurance company, public, private or governmental entity who is or may be liable in contract, tort, or otherwise by law or equity to pay all or part of the medical cost of injury, disease or disability of an applicant for or recipient of medical assistance.

HH. ***Urgent Care*** means Medically Necessary treatment for an injury, illness, or another type of Condition (usually not life threatening) which should be treated within twenty-four (24) hours.

II. ***Utilization Management*** means a service performed by the Health Plan which seeks to assure that Covered Services provided to Medicaid Covered Persons are in accordance with, and appropriate under, the standards and requirements established by the Health Plan, or a similar program developed, established or administered by DCH.

JJ. ***Utilization Review*** means evaluation of the clinical necessity, appropriateness, efficacy, or efficiency of Health Care services, procedures or settings, and ambulatory review, prospective review, concurrent review, second opinions, care management, discharge planning, or retrospective review.

KK. ***Week*** means the traditional seven-day week, Sunday through Saturday.

III. COMPLIANCE WITH STATE MEDICAID AGENCY REQUIREMENTS.

A. With the exception of nominal Cost-Sharing pursuant to the State Medicaid Plan, the State Medicaid Policies and Procedures Manual, and the applicable Medicaid Contract, Provider shall look only to the applicable Payor and agree to hold Covered Persons harmless for compensation for all Covered Services provided to Covered Persons during the term of this Agreement. Under no circumstances, including, but not limited to, nonpayment by the State or Payor, Payor insolvency, or breach of this Agreement or

Attachment, shall Provider bill, charge, collect a deposit from, or seek compensation, remuneration, or reimbursement from, or have any recourse against, Medicare, Medicaid, Covered Persons or persons (other than Payor) acting on the Covered Person's behalf (including, but not limited to, the applicable participating employer group or Payor) for Covered Services provided pursuant to this Agreement. This provision shall not prohibit collection of Co-payments on Payor's behalf made in accordance with the terms of the applicable Health Plan Coverage Plan, nor does this provision affect the right of Provider and its Provider Physicians to collect fees for services provided to Covered Persons which do not constitute Covered Services (unless Payor denied payment on the basis of lack of Medical Necessity or Provider and its Provider Physician's failure to comply with the terms and conditions of this Agreement or any Attachment) or for which Covered Person has specifically otherwise assumed financial responsibility, in writing, prior to the time that services were rendered. Provider further agree that this section shall: (i) survive the termination of this Agreement or any Attachment, regardless of the reason for termination; (ii) supersede any oral or written agreement now existing or hereafter entered into between Provider and a Covered Person, persons acting on the Covered Person's behalf (other than Health Plan), and the participating employer, Payor, or group contract holder. Any modifications, additions, or deletions to this provision shall be effective no earlier than thirty (30) days after the State Medicaid Agency or the appropriate federal or State agency, has received written notice of such changes.

B. Provider shall provide Covered Services as set forth in Attachment A. Provider accepts such payments as described in the Exhibit 1 Compensation Schedule as payment in full for Covered Services provided to Medicaid Covered Persons, as deemed Medically Necessary and appropriate under Health Plan's quality improvement and Utilization Management program, less any applicable Medicaid Covered Person Cost-Sharing pursuant to the Medicaid Contract. When submitting Claims for payment for Covered Services, Provider shall follow all billing and coding guidelines as specified in the Participating Health Care Provider Manual.

C. In the event that this Agreement terminates as provided above, Provider shall provide, to any such Covered Person who is suffering from and receiving active Health Care services for a Chronic Condition or terminal illness or who is an inpatient shall have the right to continue to receive Health Care services from Provider and its Provider Physicians for a period of up to 60 days from the date of the termination. Any Covered Person who is pregnant and receiving treatment in connection with that pregnancy at the time of the termination, Covered Person shall have the right to continue receiving Health Care services from Provider throughout the remainder of the pregnancy, including six Weeks' post-delivery care. During such continuation of coverage period, the Provider shall continue providing such Covered Services in accordance with the terms of this Agreement at the time of the termination, and Health Plan shall continue to meet all obligations of this Agreement. The Covered Person shall not have the right to the continuation provisions provided in this section, if the Agreement was terminated because of the suspension or revocation of Provider(s)' license(s) or if Health Plan determines that Provider poses a threat to the health, safety or welfare of Covered Persons or for reasons related to the quality of Health Care services rendered.

D. In addition to any other provision in the Agreement between Health Plan and Provider, and notwithstanding any other provision of the Medicaid Contract, the State Medicaid Agency may request Provider's termination of Provider immediately, or the Health Plan may immediately terminate Provider's participation under the Agreement if Provider fails to abide by the terms and conditions of the Agreement, as determined by the State Medicaid Agency, or, in the sole discretion of the State Medicaid Agency, fails to come into compliance within fifteen (15) Calendar Days after a receipt of notice from Health Plan specifying such failure and requesting Provider to abide by the terms and conditions hereof.

E. If the Agreement between Health Plan and Provider is terminated for any reason, Provider may utilize the applicable appeals procedures outlined in the Participating Health Care Provider Manual. No additional or separate right of appeal to the State Medicaid Agency or Health Plan shall be created as a result of the Health Plan's act of terminating or decision to terminate any Provider. Notwithstanding the termination of the Agreement with respect to Provider, the Medicaid Contract and this Agreement shall remain in full force and effect with respect to all other Participating Health Care Providers.

F. Provider shall cooperate with the Health Plan's quality improvement and Utilization Review and Utilization Management activities. Provider shall comply with the State's Health Check requirements.

G. Health Plan may immediately transfer a Medicaid Covered Person to a new PCP or CMO should the Medicaid Covered Person's health or safety be in jeopardy.

H. Nothing in this Agreement shall be construed to limit Provider from discussing treatment or non-treatment options with Medicaid Covered Persons that may not reflect the Health Plan's position or may not be covered by the Health Plan.

I. Nothing in this Agreement shall be construed to limit Provider from acting within the lawful scope of practice, from advising or advocating on behalf of a Medicaid Covered Person for the Medicaid Covered Person's health status, medical care, or treatment or non-treatment options, including any alternative treatments that might be self-administered.

J. Health Plan shall not prohibit Provider from advocating on behalf of the Medicaid Covered Person in any appeal system, Utilization Review process, or individual authorization process to obtain necessary Health Care or Covered Services.

K. Provider shall provide for continuity of treatment in the event Provider's participation terminates during the course of a Medicaid Covered Person's treatment by Provider.

L. Health Plan shall not discriminate with respect to participation, reimbursement, or indemnification of Provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of such license or certification. This provision should not be construed as an any willing Provider law, as it does not prohibit Health Plan from limiting Provider's participation to the extent necessary to meet the needs of the Medicaid Covered Persons. This provision also does not interfere with measures established by the Health Plan that are designed to maintain quality and control costs.

M. Health Plan shall not discriminate against Provider for serving high-risk populations or providing health care to Medicaid Covered Persons with conditions requiring costly treatments.

N. Center for Medicaid and Medicare Services and State Medicaid Agency, and Health Plan will have the right to inspect, evaluate, and audit any pertinent books, financial records, documents, papers, and records of Provider involving financial transactions related to the Medicaid Contract.

O. Health Plan shall ensure timely payment to Provider for Covered Services provided to Medicaid Covered Persons pursuant to the State Prompt Payment Requirements. Timely payment for Clean Claims is defined by the State as fifteen (15) Business Days.

P. Provider must comply with the Health Plan's Cultural Competency Plan.

Q. All marketing materials developed for or distributed to Medicaid Covered Persons by Provider must be submitted to the Health Plan and submitted to the State Medicaid Agency for approval. Provider shall not distribute any marketing materials to Medicaid Covered Persons without prior written approval of the Health Plan and the State Medicaid Agency.

R. In the case of newborns, the Health Plan shall be responsible for any payment owed to Provider for services rendered prior to the newborn's Enrollment with the Health Plan. The Provider shall be responsible for notifying Health Plan or its agent of any Medicaid Covered Persons who are expectant mothers at least ninety (90) Calendar Days prior to the expected date of delivery. In the event a woman does not enroll in the HMO plan until she is already within ninety (90) Calendar Days of her expectant due date, the Provider shall notify Health Plan or its agent immediately.

i. Within twenty-four (24) hours of the birth, the Provider shall ensure the submission of a newborn notification form to Health Plan or its agent.

ii. If the mother has made a PCP selection, this information shall be included in the newborn notification form. If the mother has not made a PCP selection, Provider shall notify Health Plan regarding the same.

S. Except as required under the "72-hour" verification process set forth in the Participating Health Care Provider Manual, Health Plan shall not be responsible for any payments owed to Provider for Covered Services rendered prior to a Medicaid Covered Person's enrollment with the Health Plan, even if the Covered Services fell within the established period of retroactive eligibility.

T. Provider shall comply with 42 CFR 434 and 42 CFR 438.6.

U. Provider shall obtain and maintain a unique physician identifier number (UPIN) for the Initial Term and Renewal Term(s) of this Agreement. Effective May 23, 2007, in accordance with 45 CFR 160.103, Provider shall obtain and maintain a national Provider identifier ("NPI").

V. Providers shall collect Medicaid Covered Person's Copayments as specified in the Medicaid Contract.

W. Providers shall not employ or subcontract with individuals on the State or Federal Exclusions list.

X. Providers shall not make Referrals for designated health services to health care entities with which Provider or a member of the Provider's family has a Financial Relationship.

Y. Provider shall cooperate in all respects with other health care Providers and health plans in transitioning Covered Medicaid Persons to assure maximum health outcomes for Covered Medicaid Persons.

Z. The Provider PCP is responsible for supervising, coordinating, and providing all Primary Care to each assigned Medicaid Covered Person. In addition, the PCP is responsible for coordinating and/or initiating Referrals for specialty care (both in and out of network), maintaining continuity of each Medicaid Covered Person's Health Care and maintaining the Medicaid Covered Person's Medical Record, which includes documentation of all services provided by the PCP as well as any specialty services.

AA. Provider shall not discriminate in the rendering of Covered Services under this agreement against individuals on the basis of race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, health status, income status, or physical or mental disability, type of Health Plan Coverage Plan or Payor, or need for Health Care services, and will not use any policy or practice that has the effect of discriminating on the basis of race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, health status, income status, or physical or mental disability, type of Health Plan Coverage Plan or Payor, or need for Health Care services. Provider and Provider Physicians will observe, protect and promote the rights of Covered Persons as patients as is done for all Provider patients.

BB. Provider shall not intentionally segregate Medicaid Covered Persons in any way from other persons receiving services.

CC. Provider agrees that Health Plan may use each Provider's names, locations, office hours, telephone numbers, closed panel status and non-English languages spoken, in Health Plan marketing, advertisement, and Medicaid Covered Person information materials, including both electronic and non-electronic Provider directories. Provider will immediately notify Health Plan of any changes to Provider's names, locations, office hours, telephone numbers, closed panel status and non-English languages spoken.

DD. In compliance with 42 CFR 438.6 (i)(1)-(2) and 42 CFR 422.128, Health Plan shall maintain written policies and procedures for advance directives, including mental health Advance Directives. Provider shall include such Advance Directives shall be included in each Medicaid Covered Person's Medical Record. Health Plan shall provide these policies to all Medicaid Covered Persons eighteen (18) years of age and older and shall advise Medicaid Covered Persons (i) their rights under the law of the State of Georgia, including the right to accept or refuse medical or surgical treatment and the right to formulate Advance Directives and (ii) Health Plan's written policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of Advance Directives as a matter of conscience.

EE. Provider shall offer hours of operation for Medicaid Covered Persons that are no less than the hours of operation offered to commercial and Fee-For-Service patients. Provider is encouraged to offer After-Hours office care in the evenings and on weekends.

FF. Appointment Requirements. Provider shall meet and maintain compliance with the State's waiting times for appointments with Medicaid Covered Persons as set forth herein, or as otherwise amended by the State. The appointment waiting times are set forth below:

PCPs (routine visits)	14 Calendar Days
PCPs (adult sick visit)	24 hours
PCPs (pediatric sick visit)	24 hours
Maternity Care	First Trimester – Not to exceed 14 Calendar Days Second Trimester – Not to exceed seven (7) Calendar Days Third Trimester – Not to exceed three (3) Business Days
Specialists	30 Calendar Days
Therapy: Physical Therapists, Occupational Therapists, Speech Therapists, Aquatic Therapists	Not to exceed thirty (30) Calendar Days
Vision Providers	Not to exceed thirty (30) Calendar Days
Dental Providers (Routine Visits)	21 Calendar Days
Dental Provider (Urgent Care)	48 hours
Non-Emergency Hospital Stays	30 Calendar Days
Mental Health Providers	14 Calendar Days
Urgent Care Providers	24 hours
Emergency Providers	Immediately (24 hours a day, 7 days a Week) and without prior authorization

GG. Moreover, Provider shall provide adequate capacity for initial visits for pregnant women within fourteen (14) Calendar Days and visits for Health Check eligible children within ninety (90) Calendar Days of Medicaid Covered Person's enrollment in Health Plan. The Provider shall take corrective action and notify Health Plan within three (3) days if there is a failure to comply with these waiting times. Health Plan shall also take whatever corrective action is necessary to ensure compliance with the State's waiting time and capacity requirements. Health Plan shall notify Provider in writing of any changes to the State's appointment requirements and Provider shall comply in accordance with the Medicaid Contract.

HH. CMS and DCH will have the right, during mutually agreed upon normal business hours, to inspect, evaluate, audit, and copy any pertinent books, financial records, documents, papers, and records of any Provider involving financial transactions related to this Agreement.

II. Provider shall maintain, throughout the terms of the Agreement, at its own expense, professional and comprehensive general liability, and medical malpractice, insurance. Such comprehensive general liability policy of insurance shall provide coverage in an amount established by the Health Plan. Such professional liability policy of insurance shall provide a minimum coverage in the amount of one million dollars

($1,000,000) per occurrence, and three million dollars ($3,000,000) annual aggregate. At Health Plan's discretion, Providers may be allowed to self-insure if the Provider establishes an appropriate actuarially determined reserve. DCH reserves the right to waive this requirement if necessary for business need. If applicable, allied mental health professionals shall maintain, throughout the terms of the Agreement, professional and comprehensive general liability, and medical malpractice, insurance. Such allied mental health comprehensive general liability policy of insurance shall provide coverage in an amount established by the Health Plan pursuant to its written Agreement with Provider. Such professional liability policy of insurance shall provide a minimum coverage in the amount of one million dollars ($1,000,000) per occurrence, and one million dollars ($1,000,000) annual aggregate. In the event any such insurance is proposed to be reduced, terminated or canceled for any reason, the Provider shall provide to Health Plan at least forty-five (45) Calendar Days prior written notice of such reduction, termination or cancellation. Prior to the reduction, expiration and/or cancellation of any insurance policy required hereunder, the Provider shall secure replacement coverage upon the same terms and provisions so as to ensure no lapse in coverage, and shall furnish Health Plan, DCH, and DOI with a Certificate of Insurance indicating the receipt of the required coverage at the request of Health Plan, DCH, or DOI. Providers shall maintain insurance coverage (including, if necessary, extended coverage or tail insurance) sufficient to insure against claims arising at any time during the term of this Agreement or the Medicaid Contract, even though asserted after the termination of the this Agreement or the Medicaid Contract. DCH or DOI, at its discretion, may request that the Health Plan immediately terminate the Provider from participation in the program upon the Provider's failure to abide by these provisions. The provisions of this Section shall survive the expiration or termination of this Agreement or the Medicaid Contract for any reason.

JJ. Upon Health Plan's receipt of notice from DCH that DCH is due funds from Provider, the Health Plan shall reduce payment to the Provider for all Claims submitted by Provider by one hundred (100) percent, or such other amount as DCH may elect, until such time as the amount owed to DCH is recovered, and shall promptly remit any such funds recovered to DCH in the manner specified by DCH. Health Plan shall recoup all payments from Provider under this Agreement in accordance with applicable law.

KK. Health Plan shall adjust its Negotiated Payments and scope of Covered Services with Provider to reflect budgetary changes to the State program, as directed by the Commissioner of DCH, to the extent such adjustments can be made within funds appropriated to DCH and available for payment to Health Plan.

LL. Nothing in this Agreement shall be construed to require Prior Authorization or Pre-Certification for Emergency Services, Post-Stabilization Services, or Urgent Care Services as described in the Medicaid Contract.

MM. Provider will submit complete and timely Encounter Data pursuant to the Medicaid Contract.

NN. As applicable, Provider shall notify Health Plan at least sixty (60) Calendar Days prior to the effective date of the termination or withdrawal of a Provider from participation in the Health Plan's network.

OO. Health Plan and Provider acknowledge and agree that Health Plan has not, as a condition of contracting with Provider, required Provider to participate in or accept other HMO plans or products that are unrelated to providing Covered Services to Covered Persons under this Agreement.

PP. Health Plan and Provider acknowledge and agree that Provider has not, as a condition of contracting with Health Plan, required Health Plan to contract with or not contract with another health care provider.

QQ. This Agreement is non-exclusive.

RR. If Provider has exhausted the applicable appeals procedures, outlined in the Participating Health Care Provider Manual, for disputes related to a denied or underpaid claim(s), Provider shall have the option either to pursue administrative review in accordance with Georgia Code Section 49-4-153, or to select binding arbitration, by a private arbitrator who is certified by a nationally recognized association.

Arbitration(s) under this Section shall be conducted in accordance with the terms and conditions of this Agreement and applicable law.

SS. Health Plan shall not deny or inappropriately reduce payment to Provider for administering any evaluation, diagnostic testing or treatment to a Covered Person receiving Emergency Services. Health Plan shall not make payment for Emergency Services contingent upon Covered Person or Provider providing notice to Health Plan, either before or after receiving or rendering emergency care.

TT. If Provider is a hospital and/or birthing center, Provider shall ensure that a newborn receives an EPSDT initial newborn preventive visit in the hospital/birthing center. The newborn preventive visit should be completed within twenty-four (24) hours after birth and prior to discharge of the infant. For the purposes of this provision, EPSDT shall mean "early and periodic screening, diagnostic, and treatment services" as defined in Section 1905 of the Social Security Act.

UU. Provider shall not require a pre-service consultation prior to providing care.

VV. Provider shall participate in all DCH and CMO driven quality improvement, performance measurement activities and program integrity operations.

IV. ADDITIONAL REQUIREMENTS FOR HEALTH PLAN AND NETWORK.

A. Geographic Access Requirements. Network shall ensure that its Provider panel conforms to the State's geographic access requirements as set forth herein, or as otherwise amended by the State. The geographic access requirements are set forth below:

Provider Type	Urban	Rural
PCPs	Two (2) within eight (8) miles	Two (2) within fifteen (15) miles
Pediatricians	Two (2) within eight (8) miles	Two (2) within fifteen (15) miles
Obstetric Providers	Two (2) within thirty (30) minutes or (30) miles	Two (2) within forty-five (45) minutes or forty-five (45) miles
Specialists	One (1) within thirty (30) minutes or thirty (30) miles	One (1) within forty-five (45) minutes or forty-five (45) miles
General Dental Providers	One (1) within thirty (30) minutes or thirty (30) miles	One (1) within forty-five (45) minutes or forty-five (45) miles
Dental Subspecialty Providers	One (1) within thirty (30) minutes or thirty (30) miles	One (1) within forty-five (45) minutes or forty-five (45) miles
Hospitals	One (1) within thirty (30) minutes or thirty (30) miles	One (1) within forty-five (45) minutes or forty-five (45) miles
Mental Health Providers	One (1) within thirty (30) minutes or thirty (30) miles	One (1) within forty-five (45) minutes or forty-five (45) miles
Pharmacies	One (1) twenty-four (24) hours a day, seven (7) days a week within fifteen (15) minutes or fifteen (15) miles	One (1) twenty-four (24) hours a day (or has an afterhours emergency phone number and pharmacist on call), seven (7) days a week within thirty (30) minutes or thirty (30) miles
Therapy: (Physical Therapists, Occupational Therapists and Speech Therapists)	One (1) within thirty (30) minutes or thirty (30) miles	One (1) within forty-five (45) minutes or forty-five (45) miles
Vision Providers	One (1) within thirty (30) minutes or thirty (30) miles	One (1) within forty-five (45) minutes or forty-five (45) miles

V. NO OTHER CHANGES.

A. Other than as set forth above, this Attachment shall not alter any of the terms or conditions of the Agreement, all of which shall remain in full force and effect.

In the event of any questions from Provider regarding the existence or performance of Covered Services, Health Plan shall assist Provider with proper citations and references to the contract between the State Medicaid Agency and Health Plan, and applicable statutes and regulations.

Attachment A: Medicaid

PRODUCT ATTACHMENT AND CMS REGULATORY REQUIREMENTS

Provider and Contracted Providers shall comply with the applicable provisions of this CMS Regulatory Requirements Product Attachment.

1. Person-Centered Planning, Care/Service Plan, and Services. Provider shall comply with all State and federal regulatory requirements related to person-centered planning, care/service plans, and services including, but not limited to:

A. Covered Persons shall lead the person-centered planning process and can elect to include, and/or consult with, any of their LTSS providers in the care/service plan development process.

B. The care/service plan must be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation through the mechanism required by State and federal requirements. Non-medical service providers (such as meals or assistive technology) can signify their agreement through this contract or written agreement in lieu of directly in the plan, if permitted by the Covered Person.

C. LTSS Provider shall be aware of, respect, and adhere to a Covered Person's preferences for the delivery of services and supports.

D. LTSS Provider shall ensure services and supports are culturally appropriate, provided in plain language (where applicable), and accessible to Covered Persons and the person(s) supporting them who have disabilities and/or are limited English proficient.

Health Plan agrees to complete the care/service plan in a timely manner (within at least 120 days of enrollment or annually, or less if State requirements differ) and provide a copy to LTSS Provider(s) responsible for implementation.

[SIGNATURE BLOCK FOLLOWS]

IN WITNESS WHEREOF, the Parties hereto have executed this Product Attachment to the Agreement, including all Schedules, effective as of the date set forth beneath their respective signatures.

HEALTH PLAN:	**PROVIDER:**
Peach State Health Plan, Inc.	Centria Healthcare, LLC (Legibly Print Name of Provider)
Authorized Signature: Urcel Fields Urcel Fields (May 27, 2022 11:28 EDT)	Authorized Signature: Brian Bucher Brian Bucher (May 26, 2022 16:02 EDT)
Print Name: Urcel Fields	Print Name: Brian Bucher
Title: Chief Operating Officer	Title: CFO
Signature Date: May 27, 2022	Signature Date: May 26, 2022
ICM #: ICMProviderAgreement_159350	Tax Identification Number: 27-1402749
To be completed by Health Plan only: Effective Date: May 1, 2022	National Provider Identifier: 1053641498 Medicare Number:

Attachment A: Medicaid

EXHIBIT 1
COMPENSATION SCHEDULE
PRACTITIONER SERVICES
BEHAVIORAL HEALTH

Centria Healthcare, LLC

This compensation schedule ("Compensation Schedule") sets forth the maximum reimbursement amounts for behavioral health Covered Services provided by Contracted Providers to Covered Persons enrolled in a Medicaid Product. Where the Contracted Provider's tax identification number ("TIN") has been designated by the Payor as subject to this Compensation Schedule, Payor shall pay or arrange for payment of a Clean Claim for Covered Services rendered by the Contracted Provider according to the terms of, and subject to the requirements set forth in, the Agreement and this Compensation Schedule. Payment under this Compensation Schedule shall consist of the Allowed Amount as set forth herein less all applicable Cost-Sharing Amounts. All capitalized terms used in this Compensation Schedule shall have the meanings set forth in the Agreement, the applicable Product Attachment, or the Definitions section set forth at the end of this Compensation Schedule.

The maximum compensation for practitioner Covered Services rendered to a Covered Person shall be the "Allowed Amount." Except as otherwise provided in this Compensation Schedule, the Allowed Amount for practitioner Covered Services is the lesser of: (i) Allowable Charges; or (ii) 90% of the Payor's Medicaid fee schedule. As applicable, the Allowed Amount may be reduced based on the Contracted Provider's specialty, provider type, licensing/certifications or education.

If there is no established payment amount on the Payor's Medicaid fee schedule for a Covered Service provided to a Covered Person, Payor may establish a payment amount to apply in determining the Allowed Amount. Until such time as Payor establishes such a payment amount, the maximum compensation shall be 25% of Allowable Charges.

Additional Provisions:

1. Code Change Updates. Payor utilizes nationally recognized coding structures (including, without limitation, revenue codes, CPT codes, HCPCS codes, ICD codes, national drug codes, ASA relative values, etc., or their successors) for basic coding and descriptions of the services rendered. Updates to billing-related codes shall become effective on the date ("Code Change Effective Date") that is the later of: (i) the first day of the month following sixty (60) days after publication by the governmental agency having authority over the applicable Product of such governmental agency's acceptance of such code updates, (ii) the effective date of such code updates as determined by such governmental agency or (iii) if a date is not established by such governmental agency or the applicable Product is not regulated by such governmental agency, the date that changes are made to nationally recognized codes. Such updates may include changes to service groupings. Claims processed prior to the Code Change Effective Date shall not be reprocessed to reflect any such code updates.

2. Fee Change Updates. Updates to the fee schedule shall become effective on the effective date of such fee schedule updates, as determined by the Payor ("Fee Change Effective Date"). The date of implementation of any fee schedule updates, i.e. the date on which such fee change is first used for reimbursement ("Fee Change Implementation Date"), shall be the later of: (i) the first date on which Payor is reasonably able to implement the update in the claims payment system; or (ii) the Fee Change Effective Date. Claims processed prior to the Fee Change Implementation Date shall be reprocessed to reflect any updates to such fee schedule.

3. Claim Form - Professional. Contracted Provider when submitting outpatient or professional claims (billed on a CMS-1500 claim form, or its successor) spanning multiple dates of service: (i) is required to identify each date of service; and (ii) must contain modifiers as identified in the Provider Manual. Applicable modifiers should be placed in the first modifier field for claims payment.

4. Primary Contact Billing. If Covered Person sees more than one health care professional during an encounter, the NPI billed on the CMS-1500 claim form, or its successor form, should indicate the primary contact. The primary contact is defined as the health care professional who spends the greatest amount of time with the client during services.

5. Provider Type. Services must be provided by the appropriate provider type or specialty as defined in the Provider Manual. The Allowed Amount may be reduced based on the Contracted Provider's specialty, provider type, licensing/certifications or education as set forth in the Provider Manual.

6. Modifiers. Unless specifically indicated otherwise, fee amounts listed in the fee schedule represent global fees and may be subject to reductions based on appropriate Modifier (for example, professional and technical modifiers). As used in the previous sentence, "global fees" refers to services billed without a Modifier, for which the fee amount includes both the professional component and the technical component. Modifiers must be used as appropriate and be specific to primary contact, as applicable.

7. Place of Service Pricing Rules. This fee schedule follows CMS guidelines for determining when services are priced at the facility or non-facility fee schedule.

8. Provider Documentation. Provider is required to maintain treatment plans, progress notes, and other similar documentation as identified in the Provider Manual.

9. Authorizations. Authorization requirements are as defined in this Agreement or in the Provider Manual. Service limits, unless specified in this Compensation Schedule, are as defined by the Provider Manual.

10. Level of Care. All reimbursement under this Compensation Schedule shall correspond to the level of care authorized by Payor.

11. Payment under this Compensation Schedule. Claims should be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative (CCI) Policy Manual, CCI table edits and other CMS guidelines). All payments under this Compensation Schedule are subject to the terms and conditions set forth in the Agreement, the Provider Manual, and any applicable billing manual and in accordance with Medicare and Health Plan or Payor's claims processing policies.

Definitions:

1. **Allowable Charges** means a Contracted Provider's billed charges for services that qualify as Covered Services.

2. **Allowed Amount** means the amount designated as the maximum amount payable to a Contracted Provider for any particular Covered Service provided to any particular Covered Person, pursuant to this Agreement or its Attachments for Covered Services. As applicable, the Allowed Amount may be reduced based on the Contracted Provider's specialty, provider type, licensing/certifications or education.

3. **Contracted Provider** means a physician, hospital, health care professional or any other provider of items or services that is employed by or has a contractual relationship with Provider, also known in the Agreement as "Group", "Practitioner" or "Facility". The term "Contracted Provider" includes Provider for those Covered Services provided by Provider.

4. **Cost-Sharing Amounts** means any amounts payable by a Covered Person, such as copayments, cost-sharing, coinsurance, deductibles or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement, if applicable.

Attachment C: Commercial-Exchange

PRODUCT ATTACHMENT
(INCLUDING REGULATORY REQUIREMENTS AND COMPENSATION SCHEDULE)

THIS PRODUCT ATTACHMENT (this "***Product Attachment***") is made and entered between Peach State Health Plan, Inc. ("Health Plan") and Provider.

WHEREAS, Health Plan and Provider entered into that certain Participating Provider Agreement, as the same may have been amended and supplemented from time to time (the "***Agreement***"), pursuant to which Provider and its Contracted Providers or other Downstream Entities participate in certain Products offered by or available from or through a Company; and

WHEREAS, pursuant to the provisions of the Agreement, this Product Attachment is identified on Schedule B of the Agreement and, as such, the Contracted Providers identified herein will be designated and participate as Participating Providers in the commercial and exchange Products described in this Product Attachment, and will be considered to be and will be governed under this Product Attachment as Downstream Entities as defined in this Product Attachment; and

WHEREAS, the Agreement is modified or supplemented as hereafter provided.

NOW THEREFORE, in consideration of the recitals, the mutual promises herein stated, the parties hereby agree to the provisions set forth below.

1. Defined Terms. For purposes of the Commercial Exchange Product, the following terms have the meanings set forth below. All capitalized terms not specifically defined in this Product Attachment will have the meanings given to such terms in the Agreement.

1.1 "***Commercial-Exchange Product***" refers to those programs and health benefit arrangements offered by a Company that provide incentives to Covered Persons to utilize the services of certain contracted providers. The Commercial-Exchange Product includes those Coverage Agreements entered into, issued or agreed to by a Payor under which a Company furnishes administrative services or other services in support of a health care program for an individual or group of individuals, which may include access to one or more of the Company's provider networks or vendor arrangements, and which may be provided in connection with a state or governmental-sponsored, employer-sponsored or other private health insurance exchange, except those excluded by Health Plan. The Commercial-Exchange Product does not apply to any Coverage Agreements that are specifically covered by another Product Attachment to the Agreement.

1.2 "***Delegated Entity***" means any party, including an agent or broker, that enters into an agreement with Health Plan to provide administrative services or health care services to qualified individuals, qualified employers or qualified employees and their dependents (as such terms are defined in 45 C.F.R. §156.20).

1.3 "***Downstream Entity***" means any party, including an agent or broker, that enters into an agreement with a Delegated Entity or with another Downstream Entity for purposes of providing administrative or health care services related to the agreement between the Delegated Entity and Health Plan. The term "Downstream Entity" is intended to reach the entity that directly provides administrative services or health care services to qualified individuals, qualified employers, or qualified employees and their dependents (as such terms are defined in 45 C.F.R. §156.20).

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

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

1.6 "***State***" means the State of Georgia, or such other state to the extent that a Coverage Agreement or Covered Person is subject to such other state's law.

2. Commercial-Exchange Product. This Product Attachment constitutes the "Commercial-Exchange Product Attachment" and is incorporated into the Agreement between Provider and Health Plan. It supplements the Agreement by setting forth specific terms and conditions that apply to the Commercial-Exchange Product with respect to which a Participating Provider has agreed to participate, and with which a Participating Provider must comply in order to maintain such participation. This Product Attachment applies with respect to the provision of health care services, supplies or accommodations (including Covered Services) to Covered Persons enrolled in or covered by a Commercial-Exchange Product.

3. Participation. Except as otherwise provided in this Product Attachment or the Agreement, all Contracted Providers under the Agreement will participate as Participating Providers in this Commercial-Exchange Product, and will provide to Covered Persons enrolled in or covered by a Commercial-Exchange Product, upon the same terms and conditions contained in the Agreement, as supplemented or modified by this Product Attachment, those Covered Services that are provided by Contracted Providers pursuant to the Agreement. In providing such services, Provider shall, and shall cause Contracted Providers, to comply with and abide by the provisions of this Product Attachment and the Agreement (including the Provider Manual).

4. Attachments. This Product Attachment includes, at Schedule A, the Regulatory Requirements with which Participating Providers are required to comply based on State laws governing the applicable Coverage Agreement or Covered Person and at Exhibit 1, the Compensation Schedule for the Commercial-Exchange Product, each of which are incorporated herein by reference.

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

6. Term. This Product Attachment will become effective as of the Effective Date, and will be coterminous with the Agreement unless a Party terminates the participation of the Contracted Provider in this Commercial-Exchange Product in accordance with the applicable provisions of the Agreement or this Product Attachment.

7. Federal Requirements. The following requirements apply to Delegated and Downstream Entities under this Commercial Exchange Product Attachment, which includes but is not limited to Provider and all Contracted Providers.

7.1 Provider's delegated activities and reporting responsibilities, if any, are specified in the Agreement or applicable attachment to the Agreement (e.g., Delegated Credentialing Agreement, Delegated Services Agreement, Statement or Work, or other scope of services attachment) attached to this Agreement. If such attachment is not executed, no administrative functions shall be deemed as delegated.

7.2 CMS, Health Plan and Payor reserve the right to revoke the delegation activities and reporting requirements or to specify other remedies in instances where CMS, Health Plan or the Payor determine that Provider or any Downstream Entity has not performed satisfactorily.

7.3 Provider and all Downstream Entities must comply with all applicable laws and regulations relating to the standards specified under 45 CFR §156.340(a);

7.4 Provider and all Downstream Entities must permit access by the Secretary and OIG or their designees in connection with their right to evaluate through audit, inspection or other means, to the Provider's or Downstream Entities' books, contracts, computers, or any other electronic systems including medical records and documentation, relating to Health Plan's obligations in accordance with federal standards under 45 CFR §156.340(a) until ten (10) years from the termination date of this Product Attachment.

8. Other Terms and Conditions. Except as modified or supplemented by this Product Attachment, the compensation hereunder for the provision of Covered Services by Contracted Providers to Covered Persons enrolled in or covered by the Commercial-Exchange Product is subject to all of the other provisions in the Agreement (including the Provider Manual) that affect or relate to compensation for Covered Services provided to Covered Persons.

Attachment C: Commercial-Exchange

SCHEDULE A
REGULATORY REQUIREMENTS

This Schedule sets forth the provisions that are required by State or federal law to be included in the Agreement with respect to this Commercial-Exchange Product. Any additional Regulatory Requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product may be set forth in the Provider Manual or another Attachment. To the extent that a Coverage Agreement, or a Covered Person, is subject to the law cited in the parenthetical at the end of a provision on this Schedule A, such provision will apply to the rendering of Covered Services to a Covered Person with such Coverage Agreement, or to such Covered Person, as applicable.

GA-1 Physician Specific Provisions. If a Participating Provider is a physician, the following apply.

GA-1.1 If the Agreement or a Participating Provider's participation is terminated by Health Plan thereby affecting any Covered Person's opportunity to continue receiving health care services from the Participating Provider under the Coverage Agreement, any such Covered Person who is suffering from and receiving active health care services for a chronic or terminal illness or who is an inpatient shall have the right to continue to receive health care services from the Participating Provider for a period of up to sixty (60) days from the date of the termination of the Agreement. Any Covered Person who is pregnant and receiving treatment in connection with that pregnancy at the time of the termination of that Covered Person's Participating Provider's Agreement shall have the right to continue receiving health care services from the Participating Provider throughout the remainder of that pregnancy, including six (6) weeks' post-delivery care. During such continuation of coverage period, the Participating Provider shall continue providing such services in accordance with the terms of the Agreement applicable at the time of the termination, and Health Plan or Payor, as applicable, shall continue to meet all obligations of such Participating Provider's Agreement. The Covered Person shall not have the right to the continuation provisions provided in this Section if the Participating Provider's Agreement is terminated because of the suspension or revocation of the Participating Provider's license or if Health Plan determines that the Participating Provider poses a threat to the health, safety, or welfare of Covered Persons. (GA. CODE ANN. § 33-20A-61(a))

GA-1.2 Notwithstanding the foregoing, if a Participating Provider terminates his or her Agreement thereby affecting any Covered Person's opportunity to continue receiving health care services from that Participating Provider under the Coverage Agreement, any such Covered Person who is suffering from and receiving active health care services for a chronic or terminal illness or who is an inpatient shall have the right to receive health care services from that Participating Provider for a period of up to sixty (60) days from the date of the termination of the Participating Provider's Agreement. Any Covered Person who is pregnant and receiving health care services in connection with that pregnancy at the time of the termination of that Covered Person's Participating Provider's Agreement shall have the right to continue receiving health care services from that Participating Provider throughout the remainder of that pregnancy, including six (6) weeks' post-delivery care. During such continuation of coverage period, the Participating Provider shall continue providing such services in accordance with the terms of the Agreement applicable at the time of the termination, and Health Plan and Payor, as applicable, shall continue to meet all obligations of such Participating Provider's Agreement. The Covered Person shall not have the right to the continuation provisions provided in this Section if the Participating Provider terminates his or her Agreement because of the suspension or revocation of the Participating Provider's license or for reasons related to the quality of health care services rendered or issues related to the health, safety, or welfare of Covered Persons. (GA. CODE ANN. § 33-20A-61(b))

IN WITNESS WHEREOF, the Parties hereto have executed this Product Attachment to the Agreement, including all Schedules, effective as of the date set forth beneath their respective signatures.

HEALTH PLAN:	**PROVIDER:**
Peach State Health Plan, Inc.	Centria Healthcare, LLC (Legibly Print Name of Provider)
Authorized Signature: Urcel Fields Urcel Fields (May 27, 2022 11:28 EDT)	Authorized Signature: Brian Bucher Brian Bucher (May 26, 2022 16:02 EDT)
Print Name: Urcel Fields	Print Name: Brian Bucher
Title: Chief Operating Officer	Title: CFO
Signature Date: May 27, 2022	Signature Date: May 26, 2022
ICM #: ICMProviderAgreement_159350	Tax Identification Number: 27-1402749
To be completed by Health Plan only: Effective Date: May 1, 2022	National Provider Identifier: 1053641498 Medicare Number:

Attachment C: Commercial-Exchange

EXHIBIT 1
COMPENSATION SCHEDULE
PRACTITIONER SERVICES
BEHAVIORAL HEALTH

Centria Healthcare, LLC

This compensation schedule ("Compensation Schedule") sets forth the maximum reimbursement amounts for behavioral health Covered Services provided by Contracted Providers to Covered Persons enrolled in a Commercial-Exchange Product. Where the Contracted Provider's tax identification number ("TIN") has been designated by the Payor as subject to this Compensation Schedule, Payor shall pay or arrange for payment of a Clean Claim for Covered Services rendered by the Contracted Provider according to the terms of, and subject to the requirements set forth in, the Agreement and this Compensation Schedule. Payment under this Compensation Schedule shall consist of the Allowed Amount as set forth herein less all applicable Cost-Sharing Amounts. All capitalized terms used in this Compensation Schedule shall have the meanings set forth in the Agreement, the applicable Product Attachment, or the Definitions section set forth at the end of this Compensation Schedule.

The maximum compensation for behavioral health practitioner Covered Services rendered to a Covered Person shall be the "Allowed Amount " Except as otherwise provided in this Compensation Schedule, the Allowed Amount for behavioral health practitioner Covered Services is the lesser of: (i) Allowable Charges; or (ii) 80% of the Payor's fee schedule. As applicable, the Allowed Amount may be reduced based on the Contracted Provider's specialty, provider type, licensing/certifications or education.

Reimbursement for Drugs and Biologicals. The reimbursement for Drugs and Biologicals shall be 100% of the Average Sales Price (ASP) plus 6%. In the event the item is not listed on the ASP fee schedule, then the reimbursement shall be 100% of the Average Wholesale Cost (AWP) less twenty percent (20%).

Additional Provisions:

1. Code Change Updates. Payor utilizes nationally recognized coding structures (including, without limitation, revenue codes, CPT codes, HCPCS codes, ICD codes, national drug codes, ASA relative values, etc., or their successors) for basic coding and descriptions of the services rendered. Updates to billing-related codes shall become effective on the date ("Code Change Effective Date") that is the later of: (i) the first day of the month following sixty (60) days after publication by the governmental agency having authority over the applicable Product of such governmental agency's acceptance of such code updates, (ii) the effective date of such code updates as determined by such governmental agency or (iii) if a date is not established by such governmental agency or the applicable Product is not regulated by such governmental agency, the date that changes are made to nationally recognized codes. Such updates may include changes to service groupings. Claims processed prior to the Code Change Effective Date shall not be reprocessed to reflect any such code updates.

2. Fee Change Updates. Updates to the fee schedule shall become effective on the effective date of such fee schedule updates, as determined by the Payor ("Fee Change Effective Date"). The date of implementation of any fee schedule updates, i.e. the date on which such fee change is first used for reimbursement ("Fee Change Implementation Date"), shall be the later of: (i) the first date on which Payor is reasonably able to implement the update in the claims payment system; or (ii) the Fee Change Effective Date. Claims processed prior to the Fee Change Implementation Date shall not be reprocessed to reflect any updates to such fee schedule, even if service was provided after the Fee Change Effective Date.

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

CMS fee amount for that code and no longer use the Alternate Fee Source Amount. If CMS has no published fee amount or a gap fill fee source is not available for a Covered Service provided to a Covered Person, Payor may establish a payment amount to apply in determining the Allowed Amount. Until such time as Payor establishes such a payment amount, the maximum compensation shall be thirty percent (30%) of Allowable Charges.

4. Claim Form – Professional. Contracted Provider when submitting outpatient or professional claims (billed on a CMS-1500 claim form, or its successor) spanning multiple dates of service: (i) is required to identify each date of service; and (ii) must contain modifiers as identified in the Provider Manual. Applicable modifiers should be placed in the first modifier field for claims payment.

5. Primary Contact Billing. If Covered Person sees more than one health care professional during an encounter, the NPI billed on the CMS-1500 claim form, or its successor form, should indicate the primary contact. The primary contact is defined as the health care professional who spends the greatest amount of time with the client during services.

6. Provider Type. Services must be provided by the appropriate provider type or specialty as defined in the Provider Manual. The Allowed Amount may be reduced based on the Contracted Provider's specialty, provider type, licensing/certifications or education as set forth in the Provider Manual.

7. Modifiers. Unless specifically indicated otherwise, fee amounts listed in the fee schedule represent global fees and may be subject to reductions based on appropriate Modifier (for example, professional and technical modifiers). As used in the previous sentence, "global fees" refers to services billed without a Modifier, for which the fee amount includes both the professional component and the technical component. Modifiers must be used as appropriate and be specific to primary contact, as applicable.

8. Place of Service Pricing Rules. This fee schedule follows CMS guidelines for determining when services are priced at the facility or non-facility fee schedule.

9. Provider Documentation. Provider is required to maintain treatment plans, progress notes, and other similar documentation as identified in the Provider Manual.

10. Authorizations. Authorization requirements are as defined in this Agreement or in the Provider Manual. Service limits, unless specified in this Compensation Schedule, are as defined by the Provider Manual.

11. Level of Care. All reimbursement under this Compensation Schedule shall correspond to the level of care authorized by Payor.

12. Payment under this Compensation Schedule. Claims should be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative (CCI) Policy Manual, CCI table edits and other CMS guidelines). All payments under this Compensation Schedule are subject to the terms and conditions set forth in the Agreement, the Provider Manual, and any applicable billing manual and claims processing policies.

Definitions:

1. **Allowable Charges** means a Contracted Provider's billed charges for services that qualify as Covered Services.

2. **Allowed Amount** means the amount designated as the maximum amount payable to a Contracted Provider for any particular Covered Service provided to any particular Covered Person, pursuant to this Agreement or its Attachments for Covered Services. As applicable, the Allowed Amount may be reduced based on the Contracted Provider's specialty, provider type, licensing/certifications or education.

3. **Contracted Provider** means a physician, hospital, health care professional or any other provider of items or services that is employed by or has a contractual relationship with Provider, also known in the Agreement as "Group", "Practitioner" or "Facility". The term "Contracted Provider" includes Provider for those Covered Services provided by Provider.

4. **Cost-Sharing Amounts** means any amounts payable by a Covered Person, such as copayments, cost-sharing, coinsurance, deductibles or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement, if applicable.