ENCORE PPO
ENCIRCLE EPO
PROVIDER SERVICE AGREEMENT

Please select one of the following:

☐ **Group Agreement** (If you are practicing in a group and wish to sign the Provider Service Agreement as a group, only one Provider Service Agreement needs to be signed by the Director or Administrator of the group.

☐ **Solo Agreement**

☒ **Ancillary Agreement**

For: Centrality Behavior Support Training
Name of Group or Corporation

Tax ID: 46-4197524

- Please complete Provider sections on pages 18, 20 and Exhibit L.
- All providers must complete an application and go through the credentialing process unless delegated credentialing has been granted.

Providers will be notified of their effective date.

If you have questions, please call Tina Bilodeau 317-621-4269 or e-mail tbilodeau@encoreppo.com.

Please return two (2) copies to:

Encore Health Network
Attn: Tina Bilodeau
8520 Allison Pointe Blvd, #200
Indianapolis, IN 46250-4250

PROVIDER SERVICES AGREEMENT

BETWEEN

THE HEALTHCARE GROUP, LLC

ENCORE HEALTH NETWORK PPO

ENCIRCLE EXCLUSIVE PROVIDER ORGANIZATION

AND

_____Centrality Behavior Support Training_____

Date Signed: _____

Effective Date: 8/1/2014
(To be determined by Encore Health Network)

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TO
PROVIDER SERVICES AGREEMENT

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ENCORE PPO

ENCIRCLE EPO

PROVIDER SERVICES AGREEMENT

This Service Agreement ("Agreement"), by and between The HealthCare Group, LLC (**"THCG"**), registered in the state of Indiana, an Indiana non-profit company, Encore PPO (**"Encore"**) Encircle EPO (**"Encircle"**) and, Centrality Behavioral Support Training (**"Provider"**), entered into and effective as of the 1 **day of** August, **2014** (the "Effective Date"). This Agreement supersedes any oral or written agreements now existing.

WITNESSETH:

WHEREAS, Network has established a network of Providers which have a contractual arrangement with Network to provide quality, cost-effective and accessible health care services for members of contracted managed care companies and other Payors of Network pursuant to this Agreement;

WHEREAS, the Providers with which Network has contractual relations are duly licensed and certified to practice medicine according to applicable federal and state law and standards of the medical profession; and/or are duly licensed to provide hospital services; or duly licensed and authorized to provide other medical services.

WHEREAS, Provider wishes to become or remain a Participating Provider under such program on the terms and conditions set forth in this Agreement.

NOW, THEREFORE, in consideration of the mutual covenants herein contained, the parties agree as follows:

AGREEMENT

I. DEFINITIONS

CLEAN CLAIM means a claim submitted by a Provider for payment for health care services that has no defect, impropriety or particular circumstance requiring special treatment preventing payment. Such special treatment shall include, but is not limited to, Coordination of Benefit efforts, subrogation, and request for itemized billings. See Provider Handbook for requirements.

COINSURANCE means a charge that can be billed directly by Participating Provider or Participating Provider's designee to a Participant in accordance with the Participant's Contract with Payor and/or Employer.

CONTRACT means the group insurance policy or other written documents constituting an agreement between Payor and/or Employer and Participant which sets forth the health care benefits the Participant is entitled to receive, including co-payments and deductibles.

CONTRACT PARAMETERS means the scope of the Payor arrangements, within which Network is authorized to contract with Payors on behalf of Network and its Participating Providers, a copy of which is attached hereto and incorporated herein as **Exhibit "A"**, as it may be revised from time to time by Network under the notification process described in Section 2.4.

CO-PAYMENT means any flat amount a Payor or TPA requires a Participant to pay to the Participating Provider at the time the services are rendered pursuant to a Contract between Payor and Participant.

COVERED SERVICES means those Covered Services including Payor or employer medical liability programs such as workers compensation or supplies which Participating Provider is licensed and qualified to provide and routinely provides and for which the Payor is obligated to pay pursuant to a Contract between Payor and/or Employer and Participant and an Agreement between Network and Payor, and for which Network has contracted with the Provider to provide.

DEDUCTIBLE means an amount which the Participant must satisfy before benefits are payable by Payor.

EMERGENCY means a medical condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person who possesses an average knowledge of health and medicine to (1) place an individual's health in serious jeopardy; (2) result in serious impairment to the individual's bodily functions; or (3) result in serious dysfunction of a bodily organ or part of the individual. Emergency shall include a woman in active labor.

MEDICALLY NECESSARY or MEDICAL NECESSITY means services or supplies which under the terms and conditions of this Agreement; are Covered Services and are determined through Payor's Utilization Management program to be:

(a) Appropriate and necessary for the symptoms, diagnosis or treatment of the condition of Participants;

(b) Provided for the diagnosis or direct care and treatment of the condition of Participants;

(c) Within standards of professional practice within the Participating Provider's community;

(d) Not primarily for the convenience of the Participant, the Participant's physician or other provider; and

(e) The most appropriate supply or level of service or supplies, which can safely be provided from a clinical perspective.

NON-COVERED SERVICES means health care services provided to Participant but not included in the Contract between Payor and/or Employer and Participant as described herein.

PARTICIPANT means any eligible employee or group member and any eligible dependent entitled to health care services according to the terms and conditions of this Agreement and pursuant to an applicable Contract between Payor and/or Employer and Participant.

PARTICIPATING PROVIDER means a physician group, physician, allied professional, facility, hospital, hospital-based provider, or other licensed health care provider who has entered into a contractual agreement with Network to provide health care services to Participants or who has otherwise been designated by Network as a Participating Provider.

PAYOR means the party liable for the payment of Covered Services on behalf of medical coverage sponsors including, without limitation, an employer, insurance carriers, self-insured funded employer plans, prepaid plans, associations, trust funds, medical plans, multiple employer welfare arrangements, governmental plans, administrative service groups, and/or unions which sponsor a plan. For the purpose of this Agreement, Network is not a Payor.

PROVIDER HANDBOOK means the document distributed to each Participating Provider that sets forth several administrative policies. The Provider Handbook is incorporated in this Agreement by reference; however, where the Provider Handbook may contradict terms of this Agreement, this Agreement supersedes the Provider Handbook.

PROVIDER LISTING means the document provided by Network to a Payor which lists contracted Participating Providers. Network shall amend this list from time to time.

PRODUCT means Encore Preferred Provider Organization and Encircle Exclusive Provider Organization, each owned by The HealthCare Group, LLC and both products are combined in this Agreement. Encircle is a smaller network of Participating Providers and is made up of THCG owners, their affiliates and strategic facilities based on employer design.

REPRICER means either the Payor or an entity contracted by Network or Payor who receives Provider claims, indicates negotiated discount, and if subcontracted entity forwards repriced claims to Payor for payment.

THIRD PARTY ADMINISTRATOR OR "TPA" means an organization or entity responsible pursuant to a written agreement, in the case of some Payors, who provides administrative services for certain employers and other entities who provide self-insured plans and the processing and payment of claims for Covered Services provided to Participants and may also contract with Provider Networks for the provision of Covered Services to Participants.

UTILIZATION MANAGEMENT means a system for prospective, concurrent, or retrospective review of the Medical Necessity and appropriateness of Covered Services provided, or proposed to be provided, to a Participant.

II. RELATIONSHIP BETWEEN NETWORK AND PROVIDER

2.1 Independent Contractor. Network and Provider are independent entities. Nothing in this Agreement shall be construed or be deemed to create a relationship of employer and employee, principal and agent, joint venture, partnership, or any other relationship other than that of independent entities contracting with each other solely for the purpose of carrying out the terms and conditions of this Agreement.

2.2 Obligations. Neither party shall have any express or implied right or authority to assume or create any obligations or responsibility on behalf of or in the name of the other party, except as set forth herein.

2.3 Provider-Patient Relationship. Nothing in this Agreement shall be construed to affect the manner in which Participating Providers conduct their independent medical practice or provide Covered Services. Network and Payors agree that they will not intervene in any manner in the method or means by which Participating Provider renders Covered Services. Nothing herein shall be construed to require Network or Participating Provider to take any action inconsistent with professional judgment concerning the medical care and treatment to be rendered to Participants.

2.4 Contract Parameters. THCG shall only enter into Payor arrangements on behalf of Encore or Encircle and Participating Providers that fall within the scope of the Encore or Encircle Contract Parameters established between THCG and Payor, Contract parameters for each Product are described in **Exhibit "A" (Encore)** and **Exhibit "E" (Encircle)**. In the event the Contract Parameters are amended from time to time, then Provider shall be notified and given up to sixty (60) days to accept or reject such amended provision. Rejection of amended Contract Parameters may initiate termination procedures according to the terms of this Agreement as described herein.

Should THCG desires to enter into a Payor arrangement on behalf of Provider which does not fall within the Contract Parameters, and which does not constitute an amendment to the standard Contract Parameters (**Exhibit "A" or "E"**), then Provider shall be provided with forty-five (45) days prior written notice as **Exhibit "A-1" or Exhibit "E-1"** (and consecutive numbers) describing the proposed unique Payor arrangement. Provider must then notify THCG within fifteen (15) days of the effective date of the notice by signing applicable exception notice indicating acceptance or rejection, or Provider will be deemed to have accepted the Payor arrangement. A sample of such written notice is included in the Provider Handbook.

2.5 Preserving Integrated System by Providers. Provider will use best efforts to refer Participants to other Providers of health care services that are Participating Providers unless such referral is not consistent with sound medical practice in accordance with accepted community professional standards for rendering quality medical care. In the event Provider

refers a Participant to another health care Provider that the Provider knows is not a Participating Provider, Provider shall inform the Participant prior to said referral.

2.6 Scope of Network Services as Consultant. Network does not determine benefits, eligibility, or benefit availability for persons covered by a Contract. The parties agree that Network specifically does not exercise any discretion or control as to Payor's benefit plan assets or with respect to benefit plan policy, payment, coverage decisions, interpretation, practices or procedures.

III. PROVIDER'S DUTIES, SERVICES, AND RESPONSIBILITIES

3.1 Scope of Service. Participating Providers shall provide Covered Services that are Medically Necessary to Participants in accordance with generally accepted medical, ethical and professional practices and standards prevailing in the Participating Provider's community at the time of treatment and that are within the Participating Provider's qualifications and credentials. Covered Services that are reasonably determined to be not Medically Necessary, pursuant to a Payor's Utilization Management program (including any applicable appeal processes), are not eligible for payment by Payor under this Agreement. However, Participating Providers may seek payment from Participants for health care services provided to Participants that are Non-Covered Services. The Participating Provider, prior to performing the service, agrees to implement internal policies to obtain consent in writing that the Participant, and not the Payor, has sole financial responsibility for Non-Covered and/or not Medically Necessary Covered Services.

3.2 Professional Requirements. Participating Physician Providers shall maintain medical licenses which allow the Participating Providers to practice medicine in the state in which they practice; maintain a current narcotics number except Providers defined in Network credentialing criteria who do not normally write prescriptions and, if applicable; hold appropriate privileges required for medical staff membership at a Participating Provider hospital. All other Participating Providers shall maintain appropriate licensure and certification. Evidence of compliance with these requirements shall be submitted to Network upon reasonable written request. Network shall enter into agreements with Participating Providers under which the Participating Providers shall be required to comply with the administrative policies, rules and procedures set forth in the Provider Handbook which may be amended by Network from time to time with reasonable prior notice to Provider. Participating Providers shall also be required to comply with policies, rules and procedures regarding professional conduct, including Network credentialing policies, procedures and criteria. A Participating Provider shall endeavor to immediately notify Network in writing, should the Participating Provider experience (i) a loss or suspension of license, narcotics number or any hospital privileges, (ii) any sanction/disciplinary action by any professional organization, hospital, or regulatory agency, (iii) a criminal indictment of any nature, and/or (iv) a criminal conviction, and (v) loss of malpractice coverage required under Article VIII. Participating Providers shall cooperate with Network's periodic evaluation of professional qualifications.

3.3 Compliance With Medicare and Medicaid. Network does not require Providers to participate in Medicare and Medicaid Programs, however for Network's credentialing and recredentialing requirements, Providers are required to report any past or present Medicare

and/or Medicaid suspensions, limitations, restrictions or exclusions from participating in the Medicare and/or Medicaid reimbursement programs.

3.4 Compliance With Law. Network and Provider shall comply with relevant federal, state and local laws, statutes, ordinances, orders and regulations that are applicable to the terms and conditions of this Agreement.

3.5 Availability of Services. Provider shall provide Covered Services to those Participants who select Provider or are referred to Provider in the same manner and in accordance with the same availability as afforded to Provider's other patients. In the event that Provider cannot provide health care services to Participant, either individually or through coverage, Provider shall notify Network.

3.6 Non-Discrimination. Provider shall comply with federal and state laws applicable to this Agreement, including those that prohibit Participating Providers from discriminating against Participants because of race, sex, color, marital status, sexual orientation, age, disability, religion or national origin or health status.

3.7 Verification of Eligibility. Provider shall comply with such method of verifying eligibility of enrollment and authorization of services as defined in Provider Handbook.

3.8 Quality and Utilization. Provider shall cooperate with Payor's Quality and Utilization Management Programs, (see **Exhibit "K"** for minimum requirements). All hospital admissions and continued stays, including ancillary services, outpatient services and any other care, treatment or supplies furnished to the Participant can be subject to Payor's Utilization Management and Quality Assurance Programs. Utilization Management services are for the sole purpose of assuring that all professional services provided by Participating Providers are Medically Necessary under the circumstances and the utilization management firm shall continuously review: (a) the cost effective provision of medical care provided by Participating Providers; (b) compliance by Participating Providers with the terms and conditions of their respective Agreement with Network; and (c) such other matters as may be specified in the Payor's Utilization Management Plan. The decision of the UM firm in no way removes, affects, or increases any obligation of Participating Providers to render care. Nothing herein shall be construed to preclude Participating Providers from providing services on such terms as a Participating Provider and a Participant may previously agree regarding Participant's health care. If required by the Contract between Payor and/or Employer and Participant, Participant has the responsibility to pre-certify and/or authorize Covered Services.

3.9 Coordination of Benefits. To the extent permitted by law, Provider shall reasonably cooperate with Payor's or TPA's coordination of benefits efforts. Participating Providers shall agree to file secondary Payor claims for Network's Participants when Network's Payor is secondary. Payments made to Provider by Payors and/or Participants pursuant to this Agreement shall be based upon the payment process described in the Contract Parameters, regardless of whether such Payor is the Primary Payor for a Participant, provided, however, with respect to contracts subject to state regulation. Network shall ensure that such Contract shall comply with applicable federal and state laws.

3.10 Availability of Coverage. Provider, as appropriate, shall have twenty-four (24) hour answering services. Provider shall be available to provide, or have in place formal arrangements with other appropriate health care professionals to provide, at all times, Medically Necessary services or referrals of Participants pursuant to the terms of this Agreement.

3.11 Release. Provider shall release from liability Network, its affiliates, board, committees, officers, employees or agents, and agrees to waive legal claims which Provider may now or hereafter have against such individuals or entities, related solely to any and all reasonable and appropriate actions taken in good faith, in connection with evaluating the Provider's professional qualifications. Provider shall further release from liability any individual or entity who may have information bearing on Provider's professional qualifications who discloses in good faith such information in connection with evaluation by the above entities and individuals of Provider's professional qualifications as part of peer review activity in connection with this Agreement.

3.12 Complaint/Grievance Procedure. Provider agrees to participate in Network's or Payor's (which ever is applicable) grievance hearing and resolution procedures, as amended from time to time, a summary of which is described in **Exhibit "I"**. All parties shall make efforts to resolve oral or written complaints at Level I – Complaints (the informal discussion), Level II – Appeals (consultation), or Level III – Grievances (Network conference).

3.13 Provision of Clinical Service. No provision contained in this Article III or elsewhere in this Agreement shall make Network responsible for or in any way liable by reason of the provision of clinical services by Provider.

3.14 Claims Submission. Provider agrees to submit claims as directed by information on Participant's identification card and according to the terms of Section 5.1 herein.

IV. NETWORK RESPONSIBILITES

4.1 Compliance and Law. Network shall comply with all relevant local, state (in the state where services are provided) and federal laws and regulations that are applicable to the terms and conditions of this Agreement.

4.2 Administrative Responsibilities. Network shall perform or arrange for the performance of all administrative responsibilities necessitated under this Agreement for the provision of Covered Services to Participants except as otherwise specified herein, and will act as a liaison with Payors to facilitate the performance of Payors under this Agreement or under Network's agreement with Payor. Network shall monitor Payors for compliance with the terms of the Payor Agreement between Payor and Network and, as necessary, corrective action shall be instituted as described in the Provider Handbook.

4.3 Participant Eligibility. Payors shall be solely responsible for providing current, updated information concerning the identity and eligibility of Participants and an appropriate system for the verification of Participant eligibility. Provider shall, except in the case of an emergency and/or a patient in active labor, make best efforts, consistent with the verification

requirements set forth in this Agreement and the Provider Handbook, to verify a patient's coverage with the applicable Payor(s) prior to providing Medically Necessary Covered Services to any patient who presents himself/herself as a Participant. In the event a patient is later determined to be ineligible for health care services under this Agreement, the Provider may directly bill that patient.

4.4 Marketing. Network shall market or arrange for the marketing of the services of Provider to Payor-sponsored benefit plans, and to the Participants of such plans, by providing Payors and Participants with current Participating Provider Directory and contracting with such Payors. Network agrees that contracts with Payors will contain a statement prohibiting the sales, marketing and use of Network as a blind or silent PPO. Network further agrees to implement and pursue corrective action immediately upon notification of such breach of contract.

4.5 Consent. Neither Network nor Provider shall use the other party's name, symbols, trademarks or service marks in advertising or promotional materials or otherwise without the written consent of that party, which consent shall not be unreasonably withheld or delayed, and shall cease any such usage immediately upon written notice to the party or upon termination of this Agreement whichever is sooner. Notwithstanding this limitation, Network may include Providers name, specialty, address, and phone number in a listing distributed by Network to Participants or potential Participants, and Provider may disclose its status as a contracted provider in Network's provider network.

4.6 Data Provision. Subsequent to execution of this Agreement, Network shall provide Payor with a list of Participating Providers. Provider shall also be supplied with the telephone numbers for eligibility and level of benefits verification, claims repricer and the utilization management service for each Payor with which Network contracts and Network shall supplement such information as reasonably necessary while the Agreement is in effect.

4.7 Credentialing. Network shall be responsible for credentialing and recredentialing its Participating Providers in accordance with its credentialing and recredentialing policies and procedures.

4.8 Network Not The Indemnifier or Insurer. Network shall not be liable for the payment of any claims by Payors or Payor's Participant relating to services provided by Participating Providers to Participants under this Agreement. Network is neither implicitly nor explicitly the insurer, guarantor, indemnifier, or underwriter of Payors' liability to pay for Covered Services to its Participants. Payors have sole responsibility and liability for payment of claims in accordance with this Agreement.

V. COMPENSATION AND BILLING

5.1 Billing for Network Services. Provider shall submit all bills; charges or demands for payment for Medically Necessary Covered Services provided to Participants within one hundred twenty (120) days after such services are rendered. Network and Participating Provider agree that the Payor may not be obligated to pay for Covered Services unless a claim for such services is submitted to the appropriate party within one hundred twenty (120) days after the services are rendered unless there is a question of primary coverage or Coordination of

Benefits. All claims shall be submitted in accordance with the requirements as described in the Provider Handbook supplied by Network. A Payor's appeal process shall be made available to a Participating Provider upon a Participating Provider's request to a Payor.

5.2 Payment Schedule. Network shall arrange for timely payment by its Payors or TPAs to Provider, in accordance with this Agreement, at the rates listed in attached reimbursement exhibits, less any applicable Co-payment, Co-insurance or Deductible, for Covered Services provided to Participants for which Provider has submitted a properly completed claim in accordance with Section 5.1 of this Agreement. Such compensation shall constitute payment in full from Payor for Covered Services provided to Participants except for applicable Co-payment, Co-insurance, Non-covered services, or Deductible payments, which are the responsibility of Participants. Network will require Payors to provide an explanation of payments made to Participating Providers. Network shall give Providers forty-five (45) days prior written notice of any change in the Physician Reimbursement Schedule. Provider shall have fifteen (15) days from the receipt of Network's written notice to accept or reject the Reimbursement Schedule as revised. Rejection may initiate reimbursement negotiations or termination procedures according to the terms of this Agreement. If the Provider chooses to initiate termination procedures, according to the terms of this Agreement and based upon a rejection of the Reimbursement Schedule, such proposed change in the Reimbursement Schedule shall not be effective as to the Provider during the time period involved in the termination process as stated herein.

5.3 Source of Payment. Network's arrangements with its Payors shall require Payors to make and remain responsible for payment to Participating Providers or Participants, as appropriate, in accordance with the terms of this Agreement. Network shall not be liable for the payment from its own funds of any claims by Participating Providers. All final claims decisions are the responsibility of the Payors. Provider agrees that the first course of action to resolve claims issues is to contact the Payor directly. Should Participating Provider and Payor be unable to satisfactorily resolve any claims payment disputes regarding inaccurate payment, non-payment or untimely payments, Network's corrective action process may be implemented as described in the Provider Handbook.

5.4 Time for Payment. Network's arrangements with its TPAs and Payors shall obligate TPA or Payor, as applicable, to provide payment to Participating Providers or Participants, as appropriate, for Covered Services provided to Participants, as described in the Contract Parameters in accordance with state law or, where the law does not apply, within thirty (30) days if submitted electronically, or forty-five (45) days, or sooner if required by law, of receiving a Clean Claim by paper submission from the Provider or if applicable from the Repricer. The parties agree that, for the purposes of this provision, receipt of paper claims for Clean Claim purposes shall be determined by the Provider's original mailing date plus three (3) days. Failure of a TPA or Payor to provide payment for Clean Claims within the time period described herein shall constitute a waiver of right to negotiated discount and such TPA or Payor will be liable to pay any penalty as described in state law in addition to Provider's full billed charges for all such claims. Provider shall contact Payor directly to request adjusted reimbursement due to untimely payment.

5.5 Payments by Participant. Providers shall not seek payment from the Participants for (a) the provision of Medically Necessary Covered Services, b) the difference between Participating Provider's billed charges and the compensation provided for in applicable reimbursement exhibit(s) and c) penalties imposed on Participating Providers by Payors for any reduction of fees as a result of Participating Provider's failure to comply with Network's and/or Payor's procedures of Utilization Management, after all final appeals have been exhausted.

Notwithstanding foregoing, Participating Providers may seek payment from Participants for (a) all Co-insurance amounts as reported on explanation of benefits (based on the applicable percentage of the reimbursement to Providers), Co-payments, and Deductibles as reported on explanation of benefits, (b) penalties imposed on Participants by Payor for Participants' failure to comply with Utilization Management processes, (c) those services which are determined not to be Medically Necessary, (d) Non-Covered Services, and (e) services for which the Payor has failed to pay Participating Providers within the time for payment as described herein.

5.6 Refund and Requests for Overpayment. Network shall make best efforts to include language in its Payor Agreements that requires Payors to notify Participating Providers of overpayment and allow Participating Provider thirty (30) days to reimburse Payor prior to any offset being taken on future claims and that Payors must request a refund of overpayment within one hundred and twenty (120) days of payment of claim or Provider may not be required to refund the amount requested beyond that time frame. Participating Provider agrees that all payment will be considered final unless Participating Provider requests adjustments in writing within one hundred and twenty (120) days after receipt by Participating Provider of payment explanation from Payor.

VI. PARTICIPANTS' RIGHTS

6.1 No Notice Due. Network and Provider reserve the right to amend or terminate this Agreement upon their mutual agreement without the consent of any Participant or Payor.

6.2 Third Party Beneficiary. This Agreement is not a third party beneficiary contract and shall not in any respect whatsoever increase the rights of Participants or any other third party with respect to Network or Participating Provider or the duties of Network or Participating Provider to Participants or create any rights or remedies on behalf of Participants against Network or Participating Provider.

VII. RECORD MAINTENANCE, AVAILABILITY, INSPECTION AND AUDIT

7.1 Maintenance of Records. Provider shall prepare and maintain medical, financial and other records or data with respect to Participants that Participating Providers typically prepare and maintain on behalf of Participating Provider's patients. Such records shall be maintained in accordance with prudent record-keeping procedures as required by applicable federal and state law. In the event Network cannot obtain an appropriate authorization to release applicable and appropriate patient records to Network and Payor for purposes of utilization management, quality assurance and/or claims payment determination, then Provider agrees to

cooperate with Network in reasonable efforts to obtain such release, provided, however, that neither Network nor any Payor shall sanction Provider or any Participating Provider in the event a Participant refuses to consent to the disclosure of any confidential records or information not otherwise permitted to be disclosed under applicable state or federal law.

7.2 Review of Medical Records. Provider shall make medical records maintained on Participants' behalf in Participating Providers' offices or locations available for review (subject to Section 7.6) by Network or Payor pursuant to written authorization of Participants or to the extent permitted by applicable state and federal law.

7.3 Billing and Payment Records. To the extent permitted by applicable state and federal laws and regulations, and pursuant to Participant's prior authorization, Provider shall permit Network and Payors to review the billing and payment records related to the provision of Covered Services to Participants. Network agrees that its Payor Agreements will require Payors to comply with Provider's policies and procedures regarding auditing of billing and payment records and that auditing entity shall be duly licensed in the state of Indiana. Subject to Section 7.4, Network and Payors shall also be entitled to obtain copies of such records.

7.4 Copying of Records. Provider may collect reasonable costs related to the respective requests of Payors for copying of any records, with the exception of records copied solely for the purposes of claims payment determination. Reasonable costs for the purposes of this section shall be defined as outlined in applicable federal or state laws.

7.5 Retention of Records. Provider shall retain the financial and medical records of Participants in a manner and for the period of time that patient records are typically retained.

7.6 Access to Premises. Upon reasonable written notice, Provider shall provide reasonable access to Payor and/or Network representatives during normal business hours to inspect the premises and equipment used in the delivery of Covered Services to Participants, subject to any applicable federal or state law. Access to premises is subject to a five (5) business day advance written notice; however, access to premises for individual medical record review for Quality Assurance, Utilization Management or claims administration research is subject to 24-hour minimum advance written notice. Network shall make best efforts to require Payor and/or Network representatives comply with Provider's policies and procedures regarding access to premises.

7.7 HIPAA Compliance. Upon the respective applicable compliance effective dates, each party agrees that it will comply in all material respects with all federal and state mandated regulations, rules or orders applicable to privacy, security and electronic transactions, including without limitation, regulations promulgated under Title II Subtitle F of the Health Insurance Portability and Accountability Act (Public Law 104-191) ("HIPAA"). Each party further agrees to, in good faith, execute any and all documents and agreements reasonably necessary for either party to comply with HIPAA relevant to the terms and conditions of this Agreement.

VIII. LIABILITY PROTECTION

8.1 Participating Provider Coverage. During the term of this Agreement, Participating Provider shall carry and maintain, at Provider's own expense a professional liability insurance (malpractice) as described in **Exhibit "J"** in amounts required by state law in the state in which the provider practices. All Indiana Providers shall comply with the Indiana Medical Malpractice Act, as amended from time to time, and shall qualify as "providers" under said Act. Upon reasonable request, Participating Provider shall deliver reasonable evidence of such coverage to Network. Provider shall immediately notify Network in writing should a Provider's professional or general comprehensive liability insurance be cancelled or otherwise fail to meet the criteria as described above.

8.2 Network Coverage. During the term of this Agreement, Network shall carry and maintain, at its own expense, commercial or self-insurance for professional and general comprehensive liability in reasonable limits. Upon request, Network shall deliver reasonable evidence of such coverage to Provider.

IX. TERM AND TERMINATION

9.1 Termination of Agreement. This Agreement shall be in effect from the effective date for a period of twelve (12) months unless terminated as set forth below. This Agreement shall be automatically renewed on the anniversary date thereafter for successive twelve (12) month periods unless sooner terminated pursuant to this Article.

9.2 Termination for Breach. This Agreement may be terminated if there is a material breach in the performance of the terms and conditions of this Agreement which breach has not been cured within thirty (30) days following written notice from the non-breaching party to the breaching party of such material breach. Nothing in this Agreement shall be construed to limit either party's lawful remedies in the event of a material breach of this Agreement.

9.3 Termination Without Cause. Either party may terminate this Agreement without cause by giving at least ninety (90) days prior written notice to the other party. Notwithstanding the foregoing, nothing shall prevent termination of this Agreement at any time upon the mutual agreement of the parties.

9.4 Immediate Termination. If either party loses an applicable license or certification, loses its insurance coverage, or files or has filed against it a petition of bankruptcy, and/or insolvency, the other party may immediately terminate this Agreement. The parties agree that Providers who fail to meet Network's professional requirements as set forth in Section 3.2 shall be immediately terminated, including but not limited to, failure to meet Network's credentialing and recredentialing standards and sanctions by the federal Medicare/Medicaid program and being included on the Office of Inspector General (OIG) List of Excluded Individuals/Entities (Debarred Providers).

9.5 Obligations After Termination. Upon the termination or expiration of this Agreement, the rights of the parties hereunder shall terminate; provided, however, that such action shall not relieve Provider of obligations with respect to Participants currently being treated

by Provider. Unless there is a quality of care issue, Provider shall continue to provide Covered Services to Participants who require active treatment as of the date of termination of this Agreement, in accordance with prevailing standards of the medical profession in effect in the applicable community at the time of treatment for the shorter of: (1) expiration of the Participants' coverage, (2) the effective date of discharge from the hospital or transfer by Payor to another Participating Provider or (3) a period of sixty (60) days.

9.6 Payment for Services After Termination. Upon such expiration or termination and in accordance with Section 9.5, Provider shall reasonably cooperate with Payors and Network in arranging for the transfer of care for Participants affected by such expiration or termination. Provider will be paid for such services in accordance with the applicable fee schedule specified herein. If a Participant has not been transferred within sixty (60) days of the termination of the Agreement, Provider will be paid its full, billed charges for all Medically Necessary Covered Services provided after the sixty (60) day period.

X. ARBITRATION

Network and Provider agree to submit to binding arbitration any dispute or claim arising out of the interpretation of or performance under this Agreement which cannot be settled by informal means. If a matter cannot be settled informally, then the matter shall be submitted, upon the motion of either party, to arbitration by a single arbitrator under the appropriate rules of the American Health Lawyers Association ("AHLA"). All such arbitration proceedings shall be administered by the AHLA; however, the arbitrator shall be bound by applicable state and federal law, and shall issue a written opinion setting forth findings of fact and conclusions of law. The parties agree that the decision of the arbitrator shall be final and binding as to each of them. No one shall serve as an arbitrator who is in any way interested, financially or otherwise, in this Agreement or in the affairs of either party. The parties agree that the arbitrator's award may be enforced in any court having jurisdiction thereof by the filing of a petition to enforce said award. Costs of filing may be recovered by the prevailing party.

Both parties agree that the arbitrator shall not be permitted to order resumption of the contractual relationship, punitive damages and/or injunctive relief. The arbitrator shall also not be permitted to rewrite this Agreement, except where a revision is necessary to comply with state or federal law and the parties are unable to agree to new language. Network and Provider understand and agree that this arbitration clause results in both parties giving up the right to a trial in a court of law including the right to a jury trial.

In all cases submitted to AHLA, the costs of arbitration shall be borne equally by the parties. Each party shall be responsible for its own attorney's fees. Claims or disputes involving medical malpractice shall not be subject to arbitration, it being the intent of the parties that allegations of all claims of alleged medical malpractice involving Indiana Participating Providers shall be resolved pursuant to the Indiana Medical Malpractice Act.

XI. CONFIDENTIALITY

The policies, procedures, manuals, materials, fee schedules, programs, advertising, marketing, and other promotional materials of either party ("Proprietary Information") are information proprietary to the particular party and shall be maintained by the other party in strictest confidence. This confidentiality clause shall continue after termination of this Agreement.

Unless otherwise required by law, neither Participating Provider nor Network will disclose information relating to the operation of Provider or Network, the facilities used under this Agreement or the programs operated to persons other than state licensing agencies, attorneys, accountants, and business consultants without obtaining the prior written consent of Provider or Network. Neither Provider nor Network will disclose information relating to the operation of Network or the facilities used under this Agreement to third party reimbursement agencies unless disclosure is required for purposes of providing information to the U.S. Comptroller, Medicare and/or Medicaid.

XII. MISCELLANEOUS PROVISIONS

12.1 Assignment. This Agreement may not be assigned, delegated or transferred by either party without the express written consent of the other or such transfer or assignment shall be void.

12.2 Waiver of Breach. Waiver of breach of any term or provisions of this Agreement shall not be deemed a waiver of any other breach of the same or different provision. In addition, waiver of any provision, obligation or duty as provided in this Agreement shall not constitute a waiver of a future breach or the relinquishments of any rights.

12.3 Business Interruption. In the event that the operations of Network or Provider are substantially interrupted by acts of war, fire, labor strikes, riots, earthquakes or other acts of nature or any cause that is not the fault of either party or is beyond the reasonable control of either party, such party shall be relieved of its obligations under this Agreement.

12.4 Notices. All notices, requests, demands, waivers and other communications required to be given hereunder shall be in writing and shall be deemed to have been duly given if served personally, transmitted by facsimile, delivered by an overnight courier service or mailed, registered or certified mail, postage prepaid and properly addressed as follows:

If to Network:
The HealthCare Group, LLC
8520 Allison Pointe Blvd, #200
Indianapolis, Indiana 46250-4250
Attention: Bruce Smiley, President

If to Provider:
Centrality Behavior Support Training
3725 E. Southport Road Suite F
Indianapolis, IN. 46237
Attention: Meagan Dant

In the event of service by mail, service shall be deemed to be complete on the date of actual delivery as shown by the addressee's registered or certified mail receipt. In the event of service by facsimile or personal delivery, notice shall be deemed given on the date of transmittal. In the event of service by an overnight courier service, notice shall be deemed given on the day after transmittal. Any party may change its address for notices by giving written notice of such change to another party in accordance with this Section.

12.5 Severability. In the event any term or provision of this Agreement is rendered invalid or unenforceable by any valid Act of Congress or the Indiana General Assembly, or by any regulation duly promulgated by officers of the United States or the state acting in accordance with law, or declared null and void by any court of competent jurisdiction, the remainder of the provisions of this Agreement shall remain in full force and effect.

12.6 Entire Agreement. This entire Agreement, together with the attached exhibits, all of which are incorporated herein by reference, contains the entire Agreement between Network and Participating Provider relating to the rights granted and the obligations assumed by the parties concerning the provision of health care services to Participants. Any prior agreements, promises, negotiations or representations, either oral or written, relating to the subject matter of this Agreement, not expressly set forth herein, are of no force or effect.

12.7 Amendment. This Agreement may only be amended or modified by a written agreement executed by the parties hereto.

12.8 Headings. The headings of articles and sections contained in this Agreement are for reference purposes only and shall not affect in any way the meaning or interpretation of this Agreement.

12.9 Non-Exclusive Agreement. Network and Participating Provider shall not be precluded from entering into agreements similar to this Agreement with any other persons. This Agreement is not exclusive and does not limit Provider Network in its ability to select, negotiate, or enter into agreements for any type of managed care arrangement.

12.10 Governing Law. This Agreement shall be construed and enforced in accordance with the laws of the State of Indiana.

12.11 Third Party Rights. This Agreement is entered into by and between the parties hereto and for their benefit. There is no intent by either party to create or establish a third party beneficiary or status or rights in a Participant, Payor, subcontractor or other third party to this Agreement, except as such rights are expressly created and as set forth in this Agreement, and no such third party shall have the rights created herein. Network will use its best efforts to name Providers as third party beneficiaries in its Payor Agreements.

IN WITNESS WHEREOF, Network and Provider have duly executed this Agreement on the day and year first written above.

THE HEALTHCARE GROUP, LLC

By: _____ Signature

Printed: Bruce Smiley

Title: President

Address: 8520 Allison Pointe Blvd, #200

Indianapolis, Indiana 46250-4250

Date: 7/30/2014

(PROVIDER)

By: Meagan Dant Signature

Printed: Meagan Dant

Title: Owner

Address: 3725 E. Southport Rd. Ste F

Indianapolis, IN. 46227

Date: 7/7/2014

Tax ID: 46-4197524

ENCORE PPO EXHIBIT "A"

CONTRACT PARAMETERS

Contracts with Payors will incorporate financial benefit incentives that direct Payor's members to Participating Providers. Network shall make best efforts to include a benefit differential of at least 20% in its contracts with Payors.

Payors will incorporate at least the following information for Participating Providers to identify participants in the Network programs.

The Identification Card will contain:

- Identifying logo or name of Payor
- Identifying logo or name of THCG PPO network (Encore)
- Claims address and telephone numbers for claims information
- Benefit, Customer Service and Utilization Management telephone number(s), if applicable

Payors will reimburse Participating Providers or Participants, as appropriate, for Covered Services provided to Participants in accordance with state law. Where the law does not apply, the Payor shall pay Clean Claims within thirty (30) calendar days of receipt of confirmation if submitted electronically, or forty-five (45) calendar days, or sooner if required by law, of receiving a Clean Claim from the Provider, or if applicable from the Repricer. The parties agree that, for the purposes of this provision, receipt of paper claims, for Clean Claims purposes, shall be determined by the Provider's original mailing date plus three (3) days. Failure of a TPA or Payor to comply with any of the requirements in this Exhibit A (unless an executed Exhibit "A-1" is in place and accepted by Participating Provider in writing) shall constitute a waiver of right to negotiated discount and such TPA or Payor will be liable to pay any penalty as described in state law in addition to Provider's billed charges for all such claims. Participating Provider shall contact Payor directly to request adjustment of reimbursement due to untimely payment.

Payors will identify the name of the THCG PPO Network (Encore) on the explanation of benefits (EOB).

EXHIBIT "B"

ENCORE PPO PARTICIPATING PHYSICIANS REIMBURSEMENT

NOT APPLICABLE

EXHIBIT "C"

ENCORE PPO HOSPITAL REIMBURSEMENT

NOT APPLICABLE

EXHIBIT "D"

ENCORE PPO ANCILLARY REIMBURSEMENT

Provider agrees to accept in full, the **Encore Fee Schedule** or billed charges, whichever is less, minus any applicable Co-Payment, Coinsurance or Deductible for Medically Necessary Covered Services provided to Network Patients for which the Provider has submitted a properly completed claim. The Encore Fee Schedule may be adjusted annually using current year Medicare adjustments. (See section 5.2 for notice provision.)

EXHIBIT "E"

ENCIRCLE EPO CONTRACT PARAMETERS

An EPO is an Exclusive Provider Organization that by contract requires steerage of patients to the Providers and includes financial incentives for patients to choose to receive Medically Necessary Covered Services from these exclusive Providers. EPO Providers agree to deeper discounts as described on the attached **Exhibit F,** if applicable. Payors agree to minimally incorporate the following information on Participant's **Identification Card** in order for Participating Providers to identify Participants of Encircle:

- Identifying logo or name of Payor
- Identifying logo or name of Encircle EPO network
- Claims address and telephone numbers for claims information
- Benefit, Customer Service and Utilization Management telephone(s), if applicable

The **Explanation of Benefit (EOB)** will contain identifying logo or name of THCG's Encircle EPO network.

Payors' Agreements will require Payors to:

- establish financial incentives of at least 30% differential for in- and out-of-network benefits.

- offer Encircle EPO Network as a dual choice to an employer groups on an Exclusive THCG basis. An Exclusive offering means the Employer has chosen to only offer Encircle EPO to employees as their benefit plan or along side another THCG product (i.e., Encircle *and* Encore or M-Plan). Should a dual choice network offering exist between Encircle and Encore the member's benefit plan will contain a minimum of a $600 difference to encourage financial steerage to Encircle EPO.

- language that the Payor and/or Employer agree that the Encircle EPO program may **not** be offered with any other non-THCG sponsored carve-out program (i.e., a Non-THCG sponsored cardiac care or laboratory service carve-out program will not be permitted to participate in the Encircle EPO program).

- Payors will reimburse Participating Providers or Participants, as appropriate, for Covered Services provided to Participants n accordance with state law, or where the law does not apply, within thirty (30) days if submitted electronically, or forty-five (45) days of receiving a Clean Claim by paper submission from the Provider, or if applicable from the Repricer. The parties agree that, for the purposes of this provision, receipt of paper claims for Clean Claim purposes shall be determined by the Provider's original mailing date plus three (3) days. Failure of a TPA or Payor to provide payment for a Clean Claim within the time period described herein shall constitute a waiver of right to negotiated discount and Payor will be liable to pay any penalty as described in state law in addition to and Provider's billed charges for all such claims.

EXHIBIT "F"

ENCIRCLE EPO PHYSICIAN REIMBURSEMENT

NOT APPLICABLE

EXHIBIT "G"

ENCIRCLE EPO HOSPITAL REIMBURSEMENT

NOT APPLICABLE

EXHIBIT "H"

ENCIRCLE EPO ANCILLARY REIMBURSEMENT

Provider agrees to accept, as payment in full, the current **Encircle Fee Schedule** or billed charges, whichever is less, minus any applicable Co-Payment, Coinsurance or Deductible for Medically Necessary Covered Services provided to Encircle Participants for which the Provider has submitted a properly completed claim. The Encircle Fee Schedule may be adjusted annually using current year Medicare adjustments. (See section 5.2 for notice provision.)

EXHIBIT "I"

THCG COMPLAINT OR GRIEVANCE PROCESS

A Provider has the right to file a Complaint or Grievance at any time for any reason. See Provider Handbook for information to file a Complaint or Grievance regarding a claim dispute.

Level I Complaint

Definition:

A Complaint is the first level of notification by a Provider that there is a disagreement regarding any service offered by THCG. The notification may be in person, by telephone, or in writing.

1. Complaints will be directed to the Customer Services Department for review and referrals to the appropriate designee. Inquiries will be responded to within fifteen (15) business days of the receipt of the Complaint.

2. When a Provider has a Complaint, every effort will be made to resolve the issue informally. In the event the issues cannot be resolved informally, the Provider may request that it be handled according to the Level II - Appeals Process.

Level II Appeals

Definition:

An Appeal is the second level of notification when a Provider is dissatisfied with the Complaint resolution.

1. A Provider who is not satisfied with a decision made in Level I may file a written Appeal and request a review of the Appeal by The HealthCare Group Vice President. The time for filing an Appeal shall be limited to a period of not more than six (6) months from the date of occurrence or thirty (30) business days following the issuance of a Complaint resolution decision under Level I, whichever is less.

2. The Vice President will issue a written decision within thirty (30) business days from the date of Appeal to include, a statement indicating the decision is binding unless the Provider files a Level III Grievance with the Grievance Committee.

Level III Grievance Committee

1. The Grievance Committee shall act as the final level of review of any Grievance. The Grievance Committee shall be composed of members who do not have a conflict of interest with party filing the Grievance.

2. The Provider may request a review by the Grievance Committee if he or she is not satisfied with the Vice President's decision. This request must be in writing to The HealthCare Group, accompanied by the notification received from the Vice President. The HealthCare Group must receive the appeal within fifteen (15) business days of the date of the Vice President's decision. The Provider may submit written materials in support of the appeal and may request the right to present oral argument to the Committee.

3. The Grievance Committee will review the decision of the Vice President, any written materials submitted by Provider in support of the request for review, and any oral arguments, before issuing a decision.

4. The Grievance Committee shall issue a decision within thirty (30) business days of receiving a request for review. The decision of the Grievance Committee shall be final unless Participating Provider demands Arbitration as described in Section X of this Agreement.

EXHIBIT "J"

LIABILITY INSURANCE SCHEDULE

A. Provider Professional Liability Insurance – Network shall require that each Physician maintain professional liability (malpractice) insurance in amounts required by state law in the state in which the provider practices.

EXHIBIT "K"

OVERVIEW OF MINIMUM UTILIZATION MANAGEMENT AND QUALITY ASSURANCE GUIDELINES

I. Utilization Management Programs

A. Programs offered: The Programs offered by THCG and its Payors may include, but are not limited to the following:

1. Pre-Certification
2. Pre-Admission Planning and Authorization
3. Ambulatory Surgery
4. Same Day Surgical Admission
5. Concurrent Review
   a. Admission Review
   b. Continued Stay Review
   c. Discharge Planning
6. Medically Unnecessary Inpatient Days – Deterrent Program
7. Alternatives to Inpatient Services
8. Second/Third Surgical Opinion Program
9. Patient/Employee Information and Education
10. Quality Assurance
11. Patient/Client Satisfaction Services
12. Home Health Services
13. Behavioral Health Services
14. Skilled Nursing Facility Services

B. Utilization Review Criteria: Utilization Management Programs are administered using nationally accepted criteria.

C. Contacts: Information regarding who to contact to pre-certify services will appear on member identification cards.

II. Quality Management Program

A. Description: The Quality Assurance Program is an ongoing process of evaluating the care being rendered. The source of the data collected for analysis is obtained through retrospective review of the medical records and claims data.

B. Goal of the Quality Assurance Program: To assure delivery of health care at an optimal level of quality in a safe, cost effective manner. It provides an effective mechanism for focused problems identification and assessment of health care.

EXHIBIT "L"

PHYSICIAN ROSTER

(Please include specialty and office location)

Behavior Analyst Certification Board, Inc.®

This Certificate Verifies That

Meagan Dant

Certificant # 1-13-13270

BACB® Certification Number

Has met the educational, experiential, and examination requirements of the Behavior Analyst Certification Board, Inc.® for certification as a

Board Certified Behavior Analyst®

BCBA®

Date First BACB Certified:
01/31/2013

Date of Issue:
01/31/2013

Recertification Date:
01/31/2016*

President, Board of Directors

Chief Executive Officer

***This Certificate must be renewed on an annual basis prior to the anniversary of the Date of Issue.**

TRAVELERS

One Tower Square, Hartford, Connecticut 06183

BUSINESSOWNERS COVERAGE PART DECLARATIONS

OFFICE PAC

POLICY NO.: 680-1E265223-14-42
ISSUE DATE: 03/10/2014

INSURING COMPANY:
TRAVELERS CASUALTY INSURANCE COMPANY OF AMERICA

POLICY PERIOD:
From 03-10-14 to 03-10-15 12:01 A.M. Standard Time at your mailing address

FORM OF BUSINESS: LIMITED LIAB CORP

COVERAGES AND LIMITS OF INSURANCE: Insurance applies only to an item for which a "limit" or the word "included" is shown.

COMMERCIAL GENERAL LIABILITY COVERAGE

OCCURRENCE FORM	LIMITS OF INSURANCE
General Aggregate (except Products-Completed Operations Limit)	$ 2,000,000
Products-completed Operations Aggregate Limit	$ 2,000,000
Personal and Advertising Injury Limit	$ 1,000,000
Each Occurrence Limit	$ 1,000,000
Damage to Premises Rented to You	$ 300,000
Medical Payments Limit (any one person)	$ 5,000

BUSINESSOWNERS PROPERTY COVERAGE

DEDUCTIBLE AMOUNT: Businessowners Property Coverage: $ 1,000 per occurrence.
Building Glass: $ 1,000 per occurrence.

BUSINESS INCOME/EXTRA EXPENSE LIMIT: Actual loss for 12 consecutive months

Period of Restoration-Time Period: Immediately

ADDITIONAL COVERAGE:
Fine Arts: $ 25,000

Other additional coverages apply and may be changed by an endorsement. Please read the policy.

SPECIAL PROVISIONS:

COMMERCIAL GENERAL LIABILITY COVERAGE
IS SUBJECT TO A GENERAL AGGREGATE LIMIT

006158