EFFECTIVE

OCT 0 1 2019

FOR MODA HEALTH USE ONLY
CONTRACT EFFECTIVE DATE:

MODA HEALTH PLAN, INC.
PARTICIPATING PROVIDER AGREEMENT
FOR COMMERCIAL BENEFIT PLANS

This Participating Provider Agreement ("Agreement") is entered into between Moda Health Plan, Inc. (hereinafter called "Moda Health") and **Centria Healthcare, LLC** (hereinafter called "Provider"). This Agreement shall be effective as of the date countersigned by Moda Health ("Effective Date"). Notwithstanding the Effective Date, Provider shall not provide services to Members under this Agreement unless and until all licensure verification and credentialing processes (if applicable) have been completed and approved by Moda Health.

RECITALS

A. Moda Health is an Oregon corporation engaged in the business of providing health insurance and administering or providing Health Benefit Plans.

B. Moda Health and Provider desire to enter into this Participating Provider Agreement under which Provider will provide medical services within the scope of its licensure or accreditation with respect to the Health Benefit Plans offered by Moda Health.

C. Moda Health and Provider recognize that while the Health Benefit Plans under which a Member may seek medical services may or may not cover and/or pay for the medical services requested, the final decision to provide or receive medical services is to be made by the Member and Provider. Provider will consider the Member's input into the proposed treatment plan, including the opportunity for the Member to refuse treatment and express preferences for future treatment and decisions.

NOW, THEREFORE, the parties agree as follows:

I. DEFINITIONS

1.1 **"Administrative Services Only"** or **"ASO"** means an arrangement whereby an employer or other entity has retained Moda Health to perform certain administrative tasks, such as claims handling and claims payment, for its employees. In an ASO arrangement, the employer acts in a self-insured role which means that they are financially responsible for any claim payments on behalf of their employees and Moda Health fulfills the role of a third party administrator.

1.2 **"Billed Charge"** is the fee for health care services typically charged by Provider for a particular service. The Billed Charge shall be the same regardless of whether or not an individual has insurance.

1.3 **"Clean Claim"** means a claim that has no defect, impropriety, lack of any required substantiating documentation or particular circumstance requiring special treatment that prevents timely payment in accordance with this Agreement.

1.4 **Coinsurance"** means a cost-sharing obligation that requires the Member to pay a percentage of the cost of specified Covered Services.

1.5 **"Continuity of Care"** means the feature of a health benefit plan under which a Member who is receiving care from an individual provider is entitled to continue with the individual provider for a limited period of time after the medical services contract terminates.

1.6 **"Co-payment"** means the amount that a Member is responsible to pay under a Health Benefit Plan at the time of service.

1.7 **"Covered Services"** means those medically necessary health care services covered under a Health Benefits Plan, as determined under the terms and conditions of the applicable Health Benefits Plan.

1.8 **"Deductible"** means the amount a Member must pay for Covered Services each calendar or contract year before a payer commences payment for Covered Services as defined under the applicable Health Benefit Plan.

1.9 **"Emergency Medical Condition"** means a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of a person, or a fetus in the case of a pregnant woman, in serious jeopardy.

1.10 **"Fully Insured Plan"** means an employer group health plan under which the employer pays a monthly premium to Moda Health for health coverage for the employer's employee and dependents of such employees and under which Moda Health administers the plan and assumes the risk. Fully Insured Plan also includes an individual plan for which the individual pays a premium to Moda Health for health coverage for the individual and/or the individual's dependents under which Moda Health administers the plan and assumes the risk.

1.11 **"Health Benefits Plan"** means a group health benefits plan, including individual or group health insurance policies, offering the services of approved health care providers participating in the Moda Health Benefit Plans, funded, underwritten or administered by Moda Health and which describe the Covered Services, applicable co-payments, co-insurance, and deductibles (if any), and other information pertinent to the provision of services.

1.12 **"Hospital"** means a fully licensed medical hospital.

1.13 **"Medical Case Management"** means the evaluation of a medical condition, developing and implementing a plan of care, coordinating medical resources, communicating health care needs to the Member and the Member's health care provider, and monitoring the Member's progress to facilitate quality care.

1.14 **"Medically Necessary"** means a service or supply that is required for the diagnosis or treatment of an illness or injury and which, in the opinion of Moda Health, is (i) appropriate to the treatment setting and level of care in terms of the amount, duration and frequency and consistent with the symptoms, diagnosis and treatment of the Member's condition; (ii) received in the least costly medically appropriate treatment setting; (iii) appropriate with regard to the accepted standards of medical practice as determined by Moda Health; (iv) and not primarily for the convenience of the Member, the Provider, or the Member's treating health care provider.

1.15 **"Mental Health"** refers to benefits, facilities, programs, levels of care and services related to the assessment and treatment of mental illness. For purposes of this Agreement "mental health" and "medical" are used interchangeably.

1.16 **"Mental Illness"** means any mental disorder covered by diagnostic categories listed in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV-TR, Fourth Edition (DSM-IV) or the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5).

1.17 **"Member"** means an individual who has enrolled in a Health Benefits Plan offered or administered by Moda Health.

1.18 **"Never Events"** means errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, and that indicate a real problem in the safety and credibility of a health care provider. Examples of such include surgery on the wrong body part; foreign body left in a patient after surgery; mismatched blood transfusion; major medication error; severe "pressure ulcer" acquired at Provider's facility; and preventable post-operative deaths.

1.19 **"Participating Provider Manual"** means the manual available on the Moda Health website which contains information and instructions for facilities and physicians, and which is prepared and provided by Moda Health, as revised by Moda Health from time-to-time.

1.20 **"Participating Provider"** means any individual health care professional, clinic or facility who: (i) is fully licensed or certified within their scope of practice to provide medical services to Members including but not limited to individuals who practice medicine or osteopathy who may be a sole practitioner or is an owner, member, shareholder, partner, or employee of a partnership or professional corporation; and (ii) has entered into an agreement with Moda Health to render health care services to Members.

1.21 **"Payer"** means an insurance company, employer health plan, Taft-Hartley Fund, or other self-funded entities for which Moda Health administers a plan or contract that is responsible to pay or arrange to pay for the provision of health care services to Members.

1.22 **"Primary Care Provider" or "PCP"** means a health care professional who is a family physician, pediatrician, nurse practitioner or internist, and whose billings for primary care services are at least fifty percent (50%) of the physician's total billings. With respect to women patients, "Primary Care Provider" may include a women's health care provider, defined as an obstetrician, gynecologist or physician assistant specializing in women's health, advanced registered nurse practitioner specialist in women's health or certified nurse midwife, practicing within the applicable lawful scope of practice under applicable state law.

1.23 **"Prior Authorization"** or **"Service Authorization"** means a determination by Moda Health, prior to the provision of services, that the Member is eligible for coverage and/or determinations by Moda Health relating to benefit coverage and medical necessity.

II. GENERAL REQUIREMENTS OF MODA HEALTH

2.1 Enrollment of Members. Moda Health shall use best efforts to contract with individuals or employers to provide Health Benefit Plans and to enroll Members in the Health Benefit Plans.

2.2 Changes to Member Contracts. Moda Health may change, revise, modify or alter the form and/or content of Health Benefit Plans without prior approval of or notice to Provider.

2.3 Member Identification and Eligibility. Each Member shall be provided with an identification card which is to be presented by Member upon visits to Provider.

2.4 Publication. Moda Health will promote use of Participating Providers by including their names and telephone numbers in its Participating Provider directory, and by so designing its Health Benefit Plans as to offer financial incentives to Members to use Participating Providers' services and facilities. Any incorrect or incomplete information involving Provider published by Moda Health shall be corrected and disseminated by Moda Health in a timely manner.

2.5 Agreements with Payers. During the term of this Agreement, Moda Health will make reasonable efforts to maintain its existing agreements with its ASO groups and other Payers. Moda Health shall also evaluate the ability of ASO groups and Payers to meet claims payments obligations and to terminate or bring into compliance an ASO group or Payer that has defaulted.

III. GENERAL REQUIREMENTS OF PROVIDER

3.1 Licenses and Certifications. Provider shall possess and will maintain in good standing, all licenses, registrations, certifications, and accreditations required by law to render health care in the State in which Provider is located, and will comply with any applicable local, state and/or federal laws or regulations related to the delivery of health care services.

3.2 Notice of Adverse Action. Provider shall promptly notify Moda Health in writing, but within not more than thirty (30) days, of any formal action against any licenses or, if applicable, against any certifications by any certifying boards or organizations, as well as any changes in Provider's practice ownership, Tax ID number, or business address, along with any other problem or situation that may or will impair the ability of Provider to carry out the duties and obligations of this Agreement. Provider staff shall not have confessed to, been convicted or found guilty of any offense or act that is a violation of any applicable regulations or statutes governing professional conduct of health care professionals. A conviction shall include a plea or verdict of guilty or a conviction following a plea of *nolo contendere*.

3.3 Review Committees. Provider shall participate in, accept and abide by the results of, and comply with the requirements and result of the Credentialing, Peer Review, Utilization Review and Quality Assurance Programs as set forth in the Participating Provider Manual, which is incorporated herein by this reference. These shall include but are not limited to, medical records review, investigation of complaints, outcomes studies and data collection from monitoring and evaluation of health care service and delivery for Members. Provider shall share outcomes studies and data with Moda Health to the same extent it shares such information with any other health plan or Payer.

3.4 Provider Competency. Any individual employed by Provider and providing health care services hereunder shall be competent and have the training necessary to perform the services as set forth in this Agreement.

3.5 Compliance with Laws. Provider will cooperate with Moda Health so that Moda Health may meet any requirements imposed on Moda Health, or imposed on the Health Benefit Plans subject to this Agreement, by state and federal law, as amended, and all regulations issued pursuant thereto. To the extent that the terms of this Agreement conflict with applicable state and federal law, this Agreement will be deemed amended to comply with the applicable state and federal law and all regulations issued pursuant thereto. To the extent that any services are provided to patients related to any health plan related to the Affordable Care Act, Provider agrees that it will comply with all applicable laws and regulations relating to the standards specified in CFR § 156.340(a).

3.6 Reporting Obligations. Moda Health and Provider recognize that federal and state law may impose certain reporting requirements on Moda Health. By way of example, but not limitation, such reporting requirements may involve reports concerning utilization review and quality assurance or

quality assessment, including preventative health care. Provider agrees to cooperate with Moda Health to provide data within Provider's control in order to assist Moda Health to respond to such reporting requirements imposed upon Moda Health.

3.7 Provider Manual. Provider shall comply with the Participating Provider Manual, as may be modified by Moda Health from time to time. Moda Health shall provide Provider sixty (60) days prior notice of any material changes.

3.8 Directory Listing and Provider Demographic Information. Provider shall permit Moda Health to use Provider's name, address, telephone number, applicable specialty designation, and other information concerning Provider in directories provided to Members and other participants in Health Benefit Plans. Any incorrect or incomplete information involving Provider published by Moda Health shall be corrected and disseminated by Moda Health in a timely manner. It is Provider's obligation to inform Moda Health, as soon as possible, but no later than two (2) business days of any change to Provider demographic information that affects Member's access or availability of care, including name, practice location address, phone number, Tax ID number, or ability to accept new patients.

3.9 Participating Providers. Provider shall ensure that all of its employed or contracted providers are Participating Providers with Moda Health.

3.10 Cost Effectiveness. Provider agrees to practice in a cost-effective manner while ensuring quality patient care for Members and to the extent feasible, Provider agrees that it shall make best efforts to:

(a) Avoid referring Members to an emergency department when other treatment would be equally medically appropriate and more cost-effective.

(b) Utilize outpatient services whenever medically feasible in lieu of in-patient services.

(c) Cooperate fully with the Moda Health pre-authorization program and particularly to obtain prior approval for all but emergency Hospital admissions.

(d) Participate in Moda Health's utilization review planning for appropriate discharge of hospitalized patients.

(e) If there is a medical emergency requiring emergency admission to a Hospital, to comply with the provisions of Section 4.6 of this Agreement.

3.11 Provider may collect any applicable Co-payments at the time of service. Provider shall not require advance payment of Deductible and Co-insurance amounts.

IV. PROVISION OF SERVICES

4.1 Availability of Services. Provider agrees to provide medical services to Members in accordance with this Agreement and shall make best efforts to render services in a manner that assures availability, adequacy and Continuity of Care to Members.

4.2 Services to Members. Services to Members shall be in accordance with appropriate professional standards of care. The quality and availability of Covered Services provided to Members shall be no less than the quality and availability provided to other patients. This Agreement shall not be

construed so as to alter Provider's relationship with Provider's patients, or to interfere with Provider's ability to provide services acceptable under current medical standards.

The final decision to provide or receive services is to be made by the Member and Provider, regardless of whether Moda Health or its designated agent has determined such services are medically necessary or Covered Services. Provider will consider the Member's input into the proposed treatment plan including the opportunity for the Member to refuse treatment and express preferences for future treatment and decisions. Moda Health and Provider recognize that while the Health Benefit Plans under which a Member may seek medical services may or may not cover and/or pay for the medical services requested, the final decision to provide or receive medical services is to be made by the Member and Provider

4.3 Coverage During Absence. Provider agrees to maintain appropriate coverage arrangements among Participating health care professionals so that Covered Services remain available and accessible to Members, including access to Provider's emergency medical services on a 24-hour, 7-day-a-week basis. The parties acknowledge that with respect to certain Participating Providers, an after-hours telephone service may satisfy this coverage requirement, provided Members are directed to an on-call provider or area facility offering urgent and emergent care.

4.4 Referrals. Provider agrees, in the treatment and care of Members, to the extent feasible, to use only Participating Providers and facilities. Provider agrees to make best efforts to obtain prior approval of Moda Health pursuant to procedures set forth in the Participating Provider Manual before obtaining the services of a non-Participating Provider or agency, in the event Provider believes that such health care professional or agency possesses unique skills or services necessary to give adequate care to any Member; provided, however, that consistent with Section 4.2 of this Agreement, this limitation on referrals is not intended to cause the Provider to deny referral of a Member to a non-Participating Provider for the provision of such care, if the Member is informed that the Member will be responsible for the payment of such non-covered, experimental or referral care and the Member nonetheless desires to obtain such care or referral.

4.5 Prior Authorizations. Provider understands that prior authorization by Moda Health is necessary with respect to certain services to be provided by Provider to a Member and in such cases, Provider shall make best efforts to obtain prior authorization of Moda Health pursuant to procedures set forth in the Participating Provider Manual before authorizing or providing such services. If Provider fails to obtain a prior authorization where one is required, Moda Health may deny the services and Provider may not balance bill the Member.

4.6 Emergency Admission. In the event of a medical emergency admission in circumstances where prior authorization is not possible, not feasible, or might involve delays jeopardizing the Member's care, Provider shall proceed with its best medical judgment and shall make best efforts to notify Moda Health within two (2) business days of patient's admission.

In such event, Moda Health shall pay for all Covered Services (pursuant to coverage limitations and payment provisions in the applicable Health Benefits Plan) rendered up to the time of such notification and the Moda Health approval or disapproval of the continuation of any such service. In the event that the notice required by this section is not given as required, Moda Health reserves the right to suspend, refuse or terminate payment for Covered Services rendered between the time such notice should have been given to Moda Health and the time notice was actually given to Moda Health.

4.7 Withdrawal. Subject to Provider's professional responsibilities, Provider may withdraw from the care of a Member when, in the professional judgment of Provider, it is in the best interest of the Member to do so.

4.8 Advocacy. Provider may advocate a decision, policy or practice to Moda Health, on behalf of a Member that is a patient of Provider without being subject to termination or penalty for the sole reason of such advocacy.

4.9 Member Identification and Eligibility. Provider shall use best efforts to verify a Moda Health Member's eligibility for service before treatment commences or as soon thereafter as reasonably possible.

4.10 Laboratory Certification. Provider shall take all reasonable measures to ensure that all laboratory testing sites providing services under this Agreement have either a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver or a certificate of registration along with a CLIA Identification number. Those laboratories with certificates of waiver will provide only the types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

4.11 Moral or Religious Objections of Provider. The parties acknowledge that Provider shall not be obligated to provide health care services that are judged morally wrong by any religious teachings or authority under which Provider operates, except to the extent that such services are required by applicable State or Federal law.

V. RELATIONSHIP OF PARTIES

5.1 Provider - Moda Health. It is expressly understood that Provider renders services to Members as an independent medical service. Neither party acts as the agent, principal, joint venturer or partner of the other. It is the sole responsibility of Provider to care for Members and to determine with the Member what services are medically appropriate for any Member.

5.2 Liability for Obligations. Notwithstanding any other section or provision of this Agreement, nothing contained herein shall cause either party to be liable or responsible for any debt, liability, or obligation of the other party, any third party, or Payer unless such liability or responsibility is expressly assumed by the party sought to be charged therewith. With the exception of those items subject to Section 5.3 of this Agreement, each party shall be solely responsible for the payment of debts and obligations which may be sought by a third party that may be due as a result of that party's actions and exercise of its obligations hereunder.

5.3 Indemnification and Contribution.

These provisions relate to third party claims made by persons or entities, including Members, other than Provider and Moda Health.

5.3.1 Medical Treatment. In the event of alleged improper medical treatment of a Member by Provider, Provider agrees to indemnify and hold Moda Health harmless from and against any and all liabilities, costs, damages and expenses, including attorney's fees, to the extent resulting from or attributable to the negligence or intentionally wrongful acts of Provider or Provider's employees.

5.3.2 Mutual Indemnification. With respect to claims other than those described in Section 5.3.1, as between Provider and Moda Health and within the limits of their respective policies of

professional and general liability insurance, and to the extent to not be otherwise inconsistent with the laws of the applicable jurisdiction, each party shall indemnify and hold harmless the other, its appointed board members, officers, and employees, , individually and collectively, from all fines, claims, demands, suits or actions of any kind or nature to the extent caused by the indemnifying party's negligent acts or omissions or intentionally wrongful acts in the course of its performance of its obligations under this Agreement. Nothing in this Agreement or in its performance will be construed to result in any person being deemed the officer, servant, agent or employee of the other party when such person, absent this Agreement and its performance, would not in law have held such status.

VI. PAYMENT AND BILLING

6.1 Billings. Provider shall make best efforts to submit written claims and detailed billings to Moda Health within ninety (90) days of the date services were provided and, in any event, shall submit claims no later than twelve (12) months from the date that the Member received the services. Except for claims for which Moda Health is the secondary insurer, claims not submitted within twelve (12) months of the date of services shall be disallowed and Provider shall not bill the Member nor Moda Health for services or supplies associated with such claims. No claims may be submitted before the date of service. Provider shall not bill Moda Health for amounts in excess of Provider's Billed Charge for such services, nor shall Provider bill services provided to Members at a rate higher than Provider bills for services provided to individuals without health care coverage.

6.2 Never Events. Provider agrees that should a Never Event occur that Provider waives the right to bill and collect any reimbursement from either Moda Health or the Member for any and all services (medical or otherwise) that are related to the Never Event and for any medical services provided thereafter as a result of the Never Event occurring.

In the event that Moda Health has made any payment(s) for services that are defined after payment as Never Events, Provider agrees to promptly refund all monies paid related to the Never Event services, including any amounts paid to Provider by Member as co-payments, deductibles, and co-insurance. Provider will refund such monies promptly upon its own discovery of the occurrence of a Never Event or upon learning of a Never Event from Moda Health, the Member or any other third party.

6.3 Moda Health as the Secondary Insurer. Provider shall make best efforts to submit claims for which Moda Health is the secondary insurer within thirty (30) days of the primary carrier's payment or denial but in no case more than one (1) year from the date of the primary carrier's payment or denial. Should a Member fail to provide Provider with information regarding Member's coverage through Moda Health prior to expiration of the twelve (12) month claim limitation period, Member shall be responsible for payment.

6.4 Claim Forms and Content. Provider is expected to submit claims for services rendered using valid codes from HIPAA-approved code sets. 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). Claims will be submitted on the CMS UB 04 and/or CMS 1500 or other recognized forms (including any future editions), for health care services to Members. Such billings shall include a full itemization for charges, use of modifiers or extenders, if any, and summary information on diagnosis, scope of treatment and patient identity.

6.5 Claim Payment. For Covered Services provided to Members, Moda Health shall pay a Clean Claim or deny the claim not later than thirty (30) days after the date on which Moda Health receives the

claim. If Moda Health requires additional information before payment of a claim, not later than thirty (30) days after the date on which Moda Health receives the claim, Moda Health shall notify the Member and Provider in writing of the delay and provide an explanation of the additional information needed to process the claim. Moda Health shall pay a Clean Claim or deny the claim not later than thirty (30) days after the date on which Moda Health receives the additional information. Moda Health shall make payment to Provider within the timeframes required by applicable state and federal law. Such payment shall be based on maximum fees payable by Moda Health as described in Exhibit B. If Moda Health fails to pay a Clean Claim within the time frames specified herein, Provider shall be entitled to interest payments as provided in ORS 743.913.

6.6 Limitation of Member Liability. Provider shall not bill or collect payment from the Member, or seek to impose a lien, for the difference between the amount allowed under this Agreement and Provider's Billed Charges, or for any amount denied or otherwise not paid under this Agreement for any reason, including but not limited to the following:

(a) Provider's failure to timely file claims;
(b) Lack of medical necessity as determined by Payer or failure to obtain prior authorization;
(c) Inaccurate or incorrect claim processing;
(d) Insolvency or other failure by Payer to fund claim payments if Payer is an entity required by law to ensure that its Members not be billed in such circumstances.

Nothing in this provision is intended to prevent Provider and Member from contracting for the payment by a Member for services that are not Covered Services under the Member's applicable Health Benefits Plan. In addition, Member and Provider may enter into a payment agreement regarding the provision of Covered Services where the Member requests to obtain such services outside the scope of the Health Benefits Plan. In such instances, Moda Health shall not be billed for such Covered Services and Provider may collect payment for such services directly from the Member.

6.7 Overpayment/Underpayment/Erroneous Payment. As required under applicable state law, Moda Health shall have the right to make, and Provider shall have the right to request, corrective adjustments to a previously submitted claim. Any request for a corrective adjustment must specify the reason as to why the requesting entity believes it is entitled to an adjustment. Moda Health shall have no obligation to pay additional amounts and Provider shall have no obligation to refund any amounts unless the request for corrective adjustment is made within eighteen (18) months from the date the claim was originally paid or denied. In addition, for claims involving coordination of benefits, the request for corrective action must be made within thirty (30) months from the date that the claim was originally paid or denied, and any such request must specify the reason the party believes it is owed the refund or additional payment, and include the name and mailing address of the entity that has primary responsibility for payment of the claim or who has disclaimed responsibility for payment of the claim. Moda Health shall have the right to request a refund at any time on claims involving fraud or instances where a third party is found responsible for satisfaction of the claim as a consequence of liability imposed by law and where Moda Health is unable to recover directly from the third party because the third party has either already paid or will pay Provider for the health services covered by the claim.

If Provider fails to contest a refund request in writing to Moda Health within thirty (30) days of its receipt, the request is deemed accepted and the refund must be paid. If Provider contests the refund request, the dispute will be processed in accordance with the appeal procedure set forth in Section 8.1. If Moda Health does not receive payment or a request for appeal within thirty (30) days of Provider's receipt of the written request, then the amount owed may be deducted from the amounts due Provider on the next claim(s) processed for Provider until the debt is settled. Neither party

may request that a contested corrective adjustment be made any sooner than six months after receipt of the request. This 30 day period may be waived upon mutual agreement of the parties. Nothing in this section prohibits Provider from choosing at any time to refund to Moda Health any payment previously made to satisfy a claim.

6.8 Coordination of Benefits. Coordination of Benefits ("COB") refers to the determination of which of two or more health benefit plans, including Medicare, or Medicaid, will pay, as either primary or secondary payer, for medical services provided to a Member. The determination of liability for payment of medical services, subject to COB, will be in accordance with applicable state and federal laws and regulations and applicable language in the Health Benefit Plans issued or administered by Moda Health. Provider agrees to cooperate with Moda Health in presenting claims for payment to other payers, or pursuing claims against other payers, for appropriate application of COB as set forth in this section. To the extent permitted by applicable state law, a secondary payer may adjust COB payments within two (2) years from the date of the initial estimated payment, should the primary carrier provide actual benefit information.

6.9 Services Not Medically Necessary and Services Considered Experimental/Investigational. If Moda Health determines that a service or supply rendered to a Member was not Medically Necessary or was experimental or investigational, Provider will not charge either Payer or Member for such service or supply unless Provider can demonstrate that the Member was notified prior to receiving such service or supply that Payer considered the service or supply experimental, investigational or not Medically Necessary, and that the Member had agreed in writing, in advance, to pay for such service or supply.

6.10 Audits of Provider by Moda Health. Moda Health or its designee may conduct audits of Provider's facility and Members' records at Provider's office during Provider's regular business hours. Moda Health shall provide Provider not less than thirty (30) calendar days advance notice of such audit, except when Moda Health, in its discretion, determines there is a significant quality of care issue or risk that Provider's documents may be altered, created or destroyed. In such case, Provider shall provide Moda Health access to facility or records upon twenty-four (24) hours' notice. For Member record audits, Moda Health's notice shall apprise Provider of the period of the audit. Provider agrees to have all Member records for that period available at the time of the audit. Such records shall include dates of service, name of Member, diagnosis, description of services provided, any supporting documentation, medical and billing records and identity of practitioner providing the services. Records not produced at the time of the audit will be deemed non-existent. Moda Health shall be responsible for the cost of copying any records photocopied during an on-site audit. Audits shall be conducted in a manner that, to the greatest extent possible, avoids disruption of Provider's business affairs and minimizes the burden on Provider. Audits will comply with all laws, statutes and regulations pertaining to the confidentiality of Member records. Failure by Provider to cooperate with the audit will be a breach of this Agreement. These rights shall survive termination of this Agreement.

Moda Health's remedies for Provider's failure to cooperate with the auditors, for overutilization or lack of documentation, or for Provider's inappropriate billing, whether fraudulent, undocumented, or for medically unnecessary services, shall include, but not be limited to: application of payment of current claims to reduce the amount that Moda Health determines Provider owes for past inappropriate billing; one-hundred percent (100%) review of Provider's current and future claims and their supporting documentation; recovery of payments made to Provider for past inappropriately billed claims; denial of future inappropriately billed claims and immediate termination of Provider's agreements with Moda Health. If Moda Health denies claims for inappropriate billing, Provider shall not bill the Member.

To the extent that any records relate to patients who are covered under a health plan related to the Affordable Care Act, Provider agrees that it will permit access to the Secretary of HHS and the

United States Office of Inspector General or their designees in connection with their right to evaluate through audit, inspection, or other means, to Provider's books, contracts, computers, or other electronic systems, including medical records and documentation, relating to Moda Health Plan, Inc.'s obligations in accordance with Federal standards under CFR § 156.340(a) until 10 years from the final date of the agreement period.

6.11 Special Investigations Unit. The Moda Health Special Investigations Unit (SIU) may conduct audits of Provider during Provider's regular business hours. The SIU shall provide Provider ten (10) business days (or lesser notice if mutually agreed upon) advance notice of such audit. However, if Moda Health reasonably determines there is a significant quality of care issue or risk that Provider's documents may be altered, created or destroyed, Provider shall provide Moda Health access to facility or records upon twenty-four (24) hours' notice, except as shall not be allowed by applicable law. Except as otherwise restricted by applicable law, all medical records provided to Moda Health shall include dates of service, name of Member, diagnosis, description of services provided, any supporting documentation, medical and billing records and identity of practitioner providing the services.

Unless otherwise specified, Moda Health follows Centers for Medicare and Medicaid Services Guidelines and MCG Care Guidelines (formerly Milliman) (collectively, the "Guidelines") for the purposes of determining the appropriateness of the services and/or accuracy of the claim. Records not produced at the time of the audit will be deemed non-existent if not produced by Provider to Moda Health within thirty (30) days after the submission of the final audit report by Moda Health fully describing the audit findings. Provider shall be responsible for the cost of copying any records photocopied during an on-site audit. Audits shall be conducted in a manner that, to the greatest extent possible, avoids disruption of Provider's business affairs and minimizes the burden on Provider. Audits (including access to Provider's records) will be limited to and comply with all laws, statutes and regulations pertaining to the confidentiality of Member records. Failure by Provider to cooperate with the audit will be a breach of this Agreement. Moda Health's rights to audit shall survive termination of this Agreement.

Provider may appeal audit findings in accordance with the SIU appeal rights set forth in the Participating Provider Manual.

6.12 Audits of Moda Health by Provider. Provider shall have the right to audit Moda Health's records related to adjudication of Provider's claims. The audit may be performed either by Provider or by an independent auditor selected by Provider. Such audits shall be conducted during Moda Health's regular business hours at Moda Health's office and shall be limited to records necessary to perform the audit. Provider shall give Moda Health no less than thirty (30) calendar days advance notice of such claims audit and shall inform Moda Health of the claim records to be audited. Moda Health shall have the records for that time period available for the auditors at the time of the audit. Such audits shall be conducted in a manner that, to the greatest extent possible, avoids disruption of Moda Health's business affairs and minimizes the burden on Moda Health. Audits will comply with all laws, statutes and regulations pertaining to the confidentiality of Member records. Failure by Moda Health to cooperate with the audit will be a breach of this Agreement. These rights shall survive termination of this Agreement.

VII. TERM AND TERMINATION

7.1 Effective Date; Term. This Agreement will become effective on the Effective Date and will continue in effect for a period of twelve (12) months. Unless otherwise terminated as provided in this Agreement, on each anniversary of the Effective Date this Agreement will automatically extend and continue in effect for successive renewal terms of twelve (12) months each on the same terms and conditions then in effect.

7.2 Discretionary Termination. Either party may terminate this Agreement at any time by giving at least one hundred twenty (120) calendar days' prior written notice to the other party specifying that termination is being made under the provisions of this clause and specifying the effective date of termination.

7.3 Termination for Cause. Either party may terminate this Agreement at any time for cause by providing thirty (30) calendar days' written notice to the other party. Cause shall mean any material violation or breach of this Agreement. The notice must specify the basis for the termination and provide the other party thirty (30) calendar days to cure the breach to avoid termination under this section.

7.4 Immediate Termination. This Agreement shall terminate immediately upon written notice upon: (i) the institution by or against either party of insolvency, receivership, or bankruptcy proceedings or any other proceedings for the settlement of either party's debts; (ii) either party making an assignment for the benefit of creditors; (iii) either party's dissolution or ceasing to operate in the ordinary course of business; or (iv) Provider's failure to maintain credentialing or re-credentialing per Moda's processes and standards.

7.5 Information to Members. The parties agree to cooperate with each other in good faith and without disparagement in connection with information supplied by either party to Members in connection with any termination or non-renewal of this Agreement. If Members seek services from Provider after the date of termination, Provider shall inform such Members that Provider no longer has an agreement with Moda to render Covered Services and shall direct them to Moda's customer service department. Provider shall not otherwise initiate communications with Members, verbally, or in writing concerning the termination, unless the parties have agreed in writing to the content of such communications in the context of a mutually agreed communication plan. Nothing in this provision is intended, nor shall it be construed, to prohibit or restrict Provider from disclosing to any Member information regarding treatments available, the risk, benefits and alternatives thereto. The terms of this Section 7.5 shall survive termination of this Agreement.

7.6 Effect of Termination. If this Agreement is terminated for any reason other than for quality of care concerns or Provider's failure to maintain licenses or certifications as described herein, the terms of this Agreement shall continue to be in effect as follows:

(a) Until the day following the date on which an active course of treatment entitling the Member to Continuity of Care is completed or the 120th day after date of notification by Moda Health to the Member of the termination of the contractual relationship with Provider, whichever is first; or

(b) For those Members undergoing care by Provider for pregnancy and who become entitled to Continuity of Care after commencement of the second trimester of the pregnancy, such Members shall receive the care until the later of the following dates:

(i) The 45th day after the birth; or

(ii) As long as the Member continues under an active course of treatment, but not later than the 120th day after the date of notification by Moda Health to the Member of the termination of the contractual relationship with Provider.

During this continuation period, Provider shall be paid at the rates and terms in effect as of the date of termination. Moda Health will make a good faith effort to direct Members to other participating providers.

7.7 Survival of Rights Upon Termination. The parties' confidentiality (Section 9.14) and indemnification (Section 5.3) obligations under this Agreement shall continue after termination.

7.8 NPDB Reporting Obligation. In the event that any Provider is given notice that their participation in this Agreement is being terminated for any cause relating to credentialing, re-credentialing, and quality of care or for any reason reportable to the National Practitioner Data Bank ("NPDB"), Provider shall have the appeal rights as specified in the Participating Provider Manual.

7.9 ACA Revocation Right. To the extent that any services involve Members covered under a health plan related to the Affordable Care Act, all delegated activities may be revoked at any time if the United States Health and Human Services (HHS) or Moda Health Plan, Inc. determines that Provider has not performed the delegated activities satisfactorily.

VIII. APPEALS AND DISPUTE RESOLUTION

8.1 Appeal Procedure. Provider shall have the right to appeal compensation disputes to Moda Health including disputes regarding adjustments pursuant to Section 6.7. Such appeal shall result in review by the Moda Health Director with oversight of Claims and the Moda Health Medical Director or their designees. If such appeal remains unresolved to the satisfaction of Provider, a final appeal may be made in writing to an appeals committee comprised of the senior director, vice president or senior vice president of Claims, and director or vice president of Professional Relations, and a hearing will be held unless waived by the parties.

8.2 Member Appeal. On behalf of a Member and with the Member's consent, Provider may appeal a pre-service denial to Moda Health pursuant to the appeal grievance procedures set forth in the Health Benefits Plan providing coverage to the Member. If a Member consents to a Provider's appeal of a pre-service denial, as provided herein, such consent must be in writing and provide that the Member agrees to be bound by the decisions rendered in the appeal process to the same extent as if the Member were prosecuting the appeal.

8.3 Dispute Resolution. Any claims, disputes, or controversies between the parties arising out of or relating to this Agreement that cannot be resolved informally shall be submitted to binding arbitration in the City of Portland, Oregon and in accordance with the rules of the Portland Arbitration Service. Any judgment arising from the arbitration may be entered by either party in any court having jurisdiction. The costs of arbitration will be shared equally by Provider and Moda Health, except that each party will be responsible for its own attorney's fees.

IX. MISCELLANEOUS

9.1 Professional Liability Insurance. During the term of this Agreement, Provider shall maintain professional liability insurance in an amount not less than **$1,000,000 per claim/$3,000,000** aggregate. This coverage is to be primary, and insure against claims for damages arising by reason of personal injury, including bodily injury or death, directly or indirectly, in connection with the acts or omissions of Provider and/or its agents or employees, with the exception of general liability. Such coverage may be provided via a self-insured program. Provider will not make material changes to its coverage without giving thirty (30) days prior written notice to Moda Health. Upon request by Moda Health, Provider will produce evidence of such insurance.

9.2 General Liability Insurance. As applicable, during the term of this Agreement, Provider shall maintain general liability insurance in an amount not less than **$1,000,000 per claim/$3,000,000** aggregate. This coverage is to be primary, and insure against claims for damages arising by reason of personal injury, including bodily injury or death, directly or indirectly, in connection with the acts or omissions of Provider and/or its agents or employees, with the exception of professional liability. Such coverage may be provided via a self-insured program. Provider will not make material changes to its coverage without giving thirty (30) days prior written notice to Moda Health. Upon request by Moda Health, Provider will produce evidence of such insurance.

9.3 Records.

9.3.1 Records. As applicable, Provider and Moda Health shall maintain reasonable and necessary financial, medical, and other records pertinent to this Agreement. All financial records pertinent to this Agreement shall be maintained pursuant to generally accepted accounting principles, and other records shall be maintained to the extent necessary to clearly reflect actions taken. All medical records shall conform to professional standards, permit encounter claim review and allow for an adequate system for follow-up treatment. All records shall be retained by the parties for at least ten (10) years or such other longer period required by applicable law.

9.3.2 Confidentiality of Personal Health Information. Provider and Moda Health recognize each Member's right to confidentiality of personal health information. Moda Health and Provider agree to abide by applicable state and federal laws and regulations concerning confidentiality of patient medical records and personal health information, including financial information. The parties will cooperate in the exchange of information sufficient to permit Moda Health and Provider to perform its functions under this Agreement and its Health Benefit Plans. Moda Health agrees not to disclose any personal health information or privileged information to third parties, except, to the extent permitted by law, in its performance of Peer Review, Utilization Review and Quality Assurance Review programs, or in compliance with applicable state or federal law.

9.3.3 Request for Records. Subject to any legal restrictions and upon request by Moda Health, Provider will promptly provide copies of the medical and billing records to Moda Health, at no charge, for those purposes which Moda Health deems reasonably necessary, including without limitation, claims adjudication, quality assurance, medical audit, credentialing or re-credentialing.

9.4 Notices and Communication. The following provisions will apply to communications between the parties to this Agreement:

9.4.1 Certain Notices Required Under This Agreement. The following notices must be sent via overnight delivery with delivery confirmation or certified mail, return receipt requested:

a. all notices for termination of this Agreement and/or termination of any addendum, exhibit or attachment to this Agreement;
b. all requests for mediation; and
c. all requests for arbitration.

Mailed notices must be addressed to the parties at the following addresses:

To Moda Health:	To Provider:
Moda Health Plan, Inc. **601 SW Second Avenue** **Portland, OR 97204-3156** Attn: Medical Provider Contracting	**Centria Healthcare, LLC** **27777 Inkster Rd. Ste 100** **Farmington Hills, MI 48334**

Either party may change its address for notice by written notice given in accordance with this paragraph. Notice sent to the last known address of a party will be deemed sufficient notice. Notices will be deemed given as of the date of actual receipt for personal delivery and email and three days after mailing for First Class mail delivery.

9.4.2 All Other Notices and Communications. All other notices and communications between the parties which are necessary for the proper administration of this Agreement (including notices required within this Agreement which are not included in Section 9.4.1 above) may be communicated via regular U.S. mail, confirmed facsimile, or electronic mail.

In addition, Moda Health may notify Provider of policy changes, Participating Provider Manual changes, and other general communications by electronic mail or through a conspicuous posting on its Provider Web Site. Notice in this manner shall constitute notice under the Agreement. Moda Health shall provide Provider sixty (60) days prior notice of any such changes.

9.5 Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the state of Oregon.

9.6 Medical Decisions. A licensed doctor of medicine or osteopathy shall be retained by Moda Health and shall be responsible for all final medical and Mental Health decisions relating to coverage or payment made pursuant to this Agreement.

9.7 Force Majeure. Neither party shall be liable in damages or have the right to terminate this Agreement for any delay or default in performing hereunder if such delay or default is caused by conditions beyond its reasonable control, and occurring without its fault or negligence, including but not limited to acts of nature, government restrictions, wars, strikes, and insurrections. As a condition to the claim of non-liability, the party experiencing the delay shall give the other party prompt written notice of the reason for its non-performance and the date by which it believes performance can be resumed.

9.8 Entire Agreement. This Agreement supersedes any and all agreements, either written or oral, between the parties hereto with respect to the subject matter contained herein. In the event of a conflict or inconsistency between this Agreement and any exhibit, attachment, plan program, policy, manual or any other document affecting this Agreement, the provisions of this Agreement shall control.

9.9 Authority. Provider has the unqualified authority to and hereby binds itself and any health care professionals employed or contracted by Provider to provide services covered by this Agreement, to the terms and conditions of this Agreement, including any addenda, appendices, attachments and exhibits, extensions and renewals, as applicable. In the event Provider does not possess the right to legally bind any of its employed or contracted providers to this Agreement, Provider shall ensure that each such provider executes a statement in substantially the form provided by Moda Health in which each such provider agrees to be bound by the terms and conditions of this Agreement,

including any addenda, appendices, attachments and exhibits, extensions and renewals, as applicable.

9.10 Severability and Right to Terminate. If any provision of this Agreement is held by a court of competent jurisdiction or applicable state or federal law to be invalid, void or unenforceable, the remaining provisions will nevertheless continue in full force and effect; provided, however, that in such event, either party shall have the right to terminate this Agreement on ninety (90) calendar days written notice to the other that this Agreement is being terminated pursuant to this section.

9.11 Amendment. This Agreement may be amended by Moda Health in any one of three formats (1) Moda Health may at any time Amend this agreement by written notification to provider with sixty (60) days' notice. If Provider objects to the amendment, Provider must so advise Moda Health in writing within thirty days after receipt of the amendment. If Moda Health accepts Provider's rejection of the amendment, the amendment will be withdrawn. If the amendment is not withdrawn, Moda Health shall notify Provider that the amendment has not been withdrawn and the amendment shall become effective as written. If Provider does not withdraw the objection, Provider may terminate the agreement as provided in Section 7.2. (2) Moda Health may at any time without advance notice send Amendments to the Agreement to comply with CMS regulatory requirements as required by law. (3) Moda Health may amend this Agreement at any time by written agreement of both parties.

9.12 Assignment. Neither party may assign this Agreement without the written consent of the other party.

9.13 Waiver. Any waiver of compliance with any provision or waiver of the breach of any provision of this Agreement must be in writing and signed by the waiving party. Any such waiver shall not operate as, or be deemed to be, a waiver of any prior or future breach of such provision or of any other provision.

9.14 Confidentiality. The terms of this Agreement are confidential and proprietary information. Each of the parties agrees to use its best efforts to maintain the confidentiality of such information and to safeguard such information against loss, theft, or other inadvertent disclosure. To the extent consistent with applicable state law, neither party will disclose this or any other proprietary information or trade secret without the express written approval of the other party.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement.

Moda Health Plan, Inc.
601 SW Second Avenue
Portland, OR 97204-3156

(Signature)

DR WILLIAM JOHNSON

William E. Johnson, MD, MBA
(Print Name)

President, Moda Health
Sr. Vice President, Moda, Inc.
(Title)

10/1/2019
(Date)

Centria Healthcare, LLC
27777 Inkster Rd. Ste 100
Farmington Hills, MI 48334

(Signature)

Paul McDonald
(Print Name)

CFO
(Title)

8/15/19
(Date)

27-1402749
(Tax ID Number)

Prepared by: C. Bender 7/30/19

EXHIBIT A
PROVIDER INFORMATION

Tax ID#: 27-1402749

Location(s)

Physical Address (Primary): 1800 NW 167th Place Suite 115		
City: Beaverton	**State:** OR	**Zip:** 97006-4846
Phone #: 503-302-8869	**Fax #:** 503-206-7938	
NPI: 1053641498		

Physical Address 2 (if applicable):		
City:	**State:**	**Zip:**
Phone #:	**Fax #:**	
NPI:		

(Attach any additional locations on a separate sheet)

Claims Remittance / Billing Location

Remittance / Billing Address*: 27777 Inkster Road, Suite 100		
City: Farmington Hills	**State:** MI	**Zip:** 48334
Phone #: 248-436-4400	**Fax #:** 248-598-4966	
Office Contact: Lauren Breland		
Contract Administrator email address (if applicable): contracts@centriahealthcare.com		

Payments will be made to Group/Clinic unless otherwise requested

**Remittance address listed must match information provided in box 33 on CMS 1500 or equivalent form, or box 2 on a UB-04 or equivalent form.*

EXHIBIT A
PROVIDER ROSTER

Please see attached roster.

EXHIBIT B
PARTICIPATING PROVIDER AGREEMENT
ABA SERVICES REIMBURSMENT
RATE EXHIBIT
CONNEXUS, BEACON, AFFINITY, CORNERSTONE, OHSU/TUALITY, SYNERGY, SUMMIT, CCN, OHSU PPO, OHSU TUALITY HEALTH & ASSOC. NETWORKS

1. All payments are subject to Moda coding guidelines. Nothing herein shall be construed as preventing Moda Health from denying and/or reducing payment for claims that are coded in a manner that is contrary to nationally-accepted coding guidelines.

2. Contracted reimbursement will be accepted by Provider for services rendered to members. Member will be held harmless for amounts billed over contracted reimbursement levels.

3. Except for any applicable co-payments, co-insurance and deductibles or as otherwise expressly permitted herein, Provider agrees to look solely to Moda Health for compensation for Covered Services provided to Members and to accept such compensation as payment in full, as further described in this Agreement.

4. Nothing in this contract shall prohibit Provider and a Member from entering into an agreement for payment by a Member for medical services that are not covered by the applicable Health Benefits Plan. In addition, Member and Provider may enter into a payment agreement regarding the provision of Covered Services where the Member requests to obtain such services outside the scope of the Health Benefits Plan. In such instance, Moda Health shall not be billed for such Covered Services and the Provider may collect payment for such services directly from the Member.

5. Maximum Fees
   Moda Health shall compensate Provider for all Covered Services rendered by Provider to Members. Provider understands and agrees that the maximum plan allowable shall be the lesser of Provider's Billed Charges or the fee schedule set forth below.

6. Medically Necessary supplies or unlisted procedures will be allowed at the Moda Fee Schedule when approved in advance by Moda Health Behavioral Health.

EXHIBIT B
PARTICIPATING PROVIDER AGREEMENT
ABA SERVICES REIMBURSMENT
RATE EXHIBIT
CONNEXUS, BEACON, AFFINITY, CORNERSTONE, OHSU/TUALITY, SYNERGY, SUMMIT, CCN, OHSU PPO NETWORKS

Fee Schedule ABA Services:

Code	Description	Per	Provider Type	Rate
97151	Behavior identification assessment, administered by a physician or other qualified health care professional, each 15 minutes of the physician's or other qualified health care professional's time face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan	15 min face to face and non-face to face	BCBA/BCaBA	$20.00
97152	Behavior identification-supporting assessment, administered by one technician under the direction of a physician or other qualified health care professional, face-to-face with the patient, each 15 minutes	15 min face to face	BCBA, BCaBA or Interventionist	$20.00
0362T	Behavior identification supporting assessment, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administration by the physician or other qualified health care professional who is on site; with the assistance of two or more technicians; for a patient who exhibits destructive behavior; completion in an environment that is customized to the patient's behavior.	15 minutes face to face	BCBA/BCaBA and Interventionists	$20.00
97153	Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with one patient, each 15 minutes	15 min face to face	Interventionist	$12.50

EXHIBIT B
PARTICIPATING PROVIDER AGREEMENT
ABA SERVICES REIMBURSMENT
RATE EXHIBIT
CONNEXUS, BEACON, AFFINITY, CORNERSTONE, OHSU/TUALITY, SYNERGY, SUMMIT, CCN, OHSU PPO NETWORKS

97154	Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with two or more patients, each 15 minutes	15 min face to face	Interventionist	$6.25
97155	Adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes	15 min face to face	BCBA/BCaBA with or without Interventionist	$35.00
97156	Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s), each 15 minutes	15 min face to face	BCBA/BCaBA	$22.50
97157	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers, each 15 minutes	15 min face to face	BCBA/BCaBA	$12.50
97158	Group adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, face-to-face with multiple patients, each 15 minutes	15 min face to face	BCBA/BCaBA	$12.50
0373T	Adaptive behavior treatment with protocol modification, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administration by the physician or other qualified health care professional who is on site; with the assistance of two or more technicians; for a patient who exhibits destructive behavior; completion in an environment that is customized to the patient's behavior.	15 min face to face	Two interventionists with BCBA/BCaBA onsite	$22.50

**If the physician or other qualified health care professional personally performs the technician activities, his or her time engaged in these activities may be included as part of the required technician time to meet the elements of the code.*