PROVIDER GROUP AGREEMENT

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PROVIDER GROUP AGREEMENT

This Provider Group Agreement ("Agreement") is made and entered into as of October 1, 2014 ("Effective Date") by and between Aetna Health Inc., a Pennsylvania corporation, on behalf of itself and its Affiliates (hereinafter "Company"), and Centrality Behavior Support Training LLC (hereinafter "Group"). The Regulatory Compliance Addendum attached to this Agreement as Exhibit A, is expressly incorporated into this Agreement and is binding upon the parties to this Agreement. In the event of any inconsistent or contrary language between the Regulatory Compliance Addendum and any other part of this Agreement, including but not limited to exhibits, attachments or amendments, the parties agree that the provisions of the Regulatory Compliance Addendum shall prevail, but, if applicable, only with respect to a particular line of business (e.g., fully-insured HMO) and/or product.

WHEREAS, Company contracts with certain health care providers and facilities to provide health care services to Members and in return for the provision of health care services by providers and facilities, Company will pay or arrange for the payment of claims for Covered Services under the terms of this Agreement.

NOW, THEREFORE, in consideration of the foregoing and of the mutual covenants, promises and undertakings in this Agreement, the sufficiency of which is hereby acknowledged, and intending to be legally bound, the parties agree as follows:

1.0 DEFINITIONS

When used in this Agreement, all capitalized terms shall have the following meanings:

1.1 Affiliate. Any corporation, partnership or other legal entity directly or indirectly owned or controlled by, or which owns or controls, or which is under common ownership or control with Company.

1.2 Clean Claim. Unless otherwise required by law or regulation, a claim which (a) is submitted within the proper timeframe as set forth in this Agreement and (b) has (i) detailed and descriptive medical and patient data, (ii) a corresponding referral (whether in paper or electronic format), if required for the applicable claim, (iii) whether submitted via an electronic transaction using permitted standard code sets (e.g., CPT-4, ICD-10 or its successor standard, HCPCS) as required by the applicable Federal or state regulatory authority (e.g., U.S. Dept. of Health & Human Services, U.S. Dept. of Labor, state law or regulation) or otherwise, all the data elements of the UB-04 or CMS-1500 (or successor standard) forms (including but not limited to Member identification number, national provider identifier ("NPI"), date(s) of service, complete and accurate breakdown of services), and (c) does not involve coordination of benefits, and (d) has no defect or error (including any new procedures with no CPT code, experimental procedures or other circumstances not contemplated at the time of execution of this Agreement) that prevents timely adjudication.

1.3 Coinsurance. The percentage of the lesser of: (a) the rates established under this Agreement; or (b) Participating Group Provider's usual, customary and reasonable billed charges, which a Member is required to pay for Covered Services under a Plan.

1.4 Confidential Information. Any information that identifies a Member and is related to the Member's participation in a Plan, the Member's physical or mental health or condition, the provision of health care to the Member or payment for the provision of health care to the Member. Confidential Information includes, without limitation, "individually identifiable health information," as defined in 45 C.F.R. § 160.103 and "non-public personal information" as defined in laws or regulations promulgated under the Gramm-Leach-Bliley Act of 1999.

1.5 Copayment. A charge required under a Plan that must be paid by a Member at the time of the provision of Covered Services, or at such other time as determined by Participating Group Provider.

1.6 Covered Services. Those health care services for which a Member is entitled to receive coverage under the terms and conditions of a Plan.

1.7 Covering Provider. A Participating Provider designated by a Participating Group Provider to provide Covered Services to Members when a Participating Group Provider is unavailable (e.g. out of the office or on vacation).

1.8 Deductible. An amount that a Member must pay for Covered Services during a specified coverage period in accordance with the Member's Plan before benefits will be paid.

1.9 Emergency Services. Those services necessary to treat a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (a) placing the health of the individual (or, with respect to a pregnant woman, her pregnancy or health or the health of her fetus) in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part; or such other definition as may be required by applicable law.

1.10 Final Contract Period. The final term of any contract between the Centers for Medicare and Medicaid Services ("CMS") and Company to offer one or more Medicare Plans.

1.11 Full Risk Plan. A Plan where Company is the underwriter, in full, of the Plan (i.e. fully-insured Plans.)

1.12 Group Provider. A duly licensed and qualified provider of health care services who is employed by, or who is a partner or shareholder, of Group.

1.13 Material Change. Any change in Policies that could reasonably be expected, in Company's determination, to have a material adverse impact on (i) Group's reimbursement for Provider Services or (ii) administration of Group's practice.

1.14 Medically Necessary or Medical Necessity. Health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and (c) not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with the standards set forth in (b) above.

1.15 Medicare Plan. A Medicare Advantage plan offered by Company to Medicare beneficiaries under a contract with CMS pursuant to Part C of Title XVIII of the Social Security Act.

1.16 Member. An individual covered by or enrolled in a Plan.

1.17 Participating Provider. Any physician, hospital, hospital-based physician, skilled nursing facility, mental health and/or substance abuse professional (which shall include psychiatrists, psychologists, social workers, psychiatric nurses, counselors, family or other therapists or other mental health/substance abuse professionals), or other individual or entity involved in the delivery of health care or ancillary services who or which has entered into and continues to have a current valid contract with Company to provide Covered Services to Members, and, where applicable, has been credentialed according to Company's policies by Company or its designee.

1.18 Participating Group Provider. A Group Provider who has been accepted as a Participating Provider by Company.

1.19 Party. Company or Group, as applicable.

1.20 Plan. A Member's health care benefits as set forth in the Member's Summary Plan Description, Certificate of Coverage or other applicable coverage document, including, but not limited to, a Medicare Plan.

1.21 Plan Sponsor. An employer, insurer, third party administrator, labor union, organization or other person or entity which has contracted with Company to offer, issue and/or administer a Plan that is not a Full Risk Plan and has agreed to be responsible for funding benefit payments for Covered Services provided to Members under the terms of a Plan.

1.22 Policies. The policies and procedures promulgated by Company which relate to this Agreement. Policies include, but are not limited to, those policies and procedures set forth in Company's manuals, Health Care Professional toolkit or their successors, Clinical Policy Bulletins and other policies and procedures (as modified from time to time) and made available via Company's internet website, letter, newsletter, electronic mail or other media.

1.23 Primary Care Physician. A Participating Physician whose area of practice and training is family practice, general medicine, internal medicine or pediatrics, or who is otherwise designated as a Primary Care Physician by Company, and who has agreed to provide primary care services and to coordinate and manage all Covered Services for Members who have selected or been assigned to such Participating Physician, if the applicable Plan provides for a Primary Care Physician. This term may also include a nurse practitioner and/or physician assistant practicing within the applicable scope of practice and provided such provider meets Company standards.

1.24 Proprietary Information. Any and all information, whether prepared by a Party, its advisors or otherwise, relating to such Party or the development, execution or performance of this Agreement or any future agreement between the Parties whether furnished prior to or after the Effective Date. Proprietary Information includes but is not limited to, with respect to Company, the development of a pricing structure, (whether written or oral) all financial information, rate schedules and financial terms which relate to Group and which are furnished or disclosed to Group by Company.

1.25 Specialty Program. A Company established program for a targeted group of Members with certain types of illnesses, conditions, cost or risk factors (e.g., organ transplants, women's health, other disease management programs, etc).

2.0 GROUP AND PARTICIPATING GROUP PROVIDER SERVICES AND OBLIGATIONS

2.1 Provision of Services.
Group shall provide to Members, through Participating Group Providers, those Covered Services which are within the scope of the respective Participating Group Provider's license and certification to practice ("Provider Services") and accepts the compensation for such Provider Services listed and set forth in the **Services and Compensation Schedule** attached hereto and made a part hereof. Company and Group may mutually agree in writing at any time, and from time to time, either to increase or decrease the Provider Services made available to Members under this Agreement. Participating Group Providers may not provide any Covered Services to Members unless and until Participating Group Providers have been fully credentialed and approved by the applicable peer review committee.

2.2 Non-Discrimination.

2.2.1 Equitable Treatment of Members. Group and Participating Group Providers agree to provide Provider Services to Members with the same degree of care and skill as customarily provided to Participating

Group Providers' patients who are not Members, according to generally accepted standards of Provider practice. Group, Participating Group Providers and Company agree that Members and non-Members should be treated equitably. Group and Participating Group Providers agree not to discriminate against Members on the basis of race, ethnicity, gender, creed, ancestry, lawful occupation, age, religion, marital status, sexual orientation, mental or physical disability, medical history, color, national origin, place of residence, health status, claims experience, evidence of insurability (including conditions arising out of acts of domestic violence), genetic information, source of payment for services, cost or extent of Provider Services required, or any other grounds prohibited by law or this Agreement.

2.2.2 Affirmative Action. Company is a Federal contractor and an Equal Opportunity Employer which maintains an Affirmative Action Program. To the extent applicable to Group and Participating Group Providers, Group and Participating Group Providers, on behalf of themselves and any subcontractors, agree to comply with the following, as amended from time to time: Executive Order 11246, the Vietnam Era Veterans Readjustment Act of 1974, the Drug Free Workplace Act of 1988, Section 503 of the Rehabilitation Act of 1973, Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") administrative simplification rules at 45 CFR parts 160, 162, and 164, the Americans with Disabilities Act of 1990, Federal laws, rules and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of Federal criminal law, the False Claims Act (31 U.S.C. 3729 et. seq.), and the anti-kickback statute (Section 1128B(b) of the Social Security Act), and any similar laws, regulations or other legal mandates applicable to recipients of federal funds and/or transactions under or otherwise subject to any government contract of Company.

2.3 Group and Participating Group Provider Representations.

2.3.1 General Representations. Group represents and covenants, as applicable, that: (a) it and Participating Group Providers have, and shall maintain throughout the term of this Agreement all appropriate license(s) and certification(s) mandated by governmental regulatory agencies, which for each Participating Group Provider shall include, without limitation, an unrestricted DEA certification (unless such certification is not a criterion of participation for Participating Group Provider under the **Participation Criteria Schedule**) and license to practice medicine in the state(s) in which such Participating Group Provider maintains offices and provides Provider Services to Members; (b) it has established an ongoing quality assurance/assessment program which includes, but is not limited to, credentialing of employees and subcontractors and shall supply to Company the relevant documentation, including, but not limited to, internal quality assurance/assessment protocols, state licenses and certifications, Federal agency certifications and/or registrations upon request; (c) all health care personnel employed by, associated or contracted with Provider who treat Members: (i) are and will remain throughout the term of this Agreement appropriately licensed and/or certified (when and as required by state law) and supervised, and qualified by education, training and experience to perform their professional duties; and (ii) will act within the scope of their licensure or certification, as the case may be; (d) its credentialing, privileging, and re-appointment procedures are in accordance with its medical staffs by-laws, regulations, and policies, comply with The Joint Commission ("TJC") standards, meet the querying and reporting requirements of the National Practitioner Data Bank ("NPDB") and Healthcare Integrity and Protection Data Bank ("HIPDB"), and fulfill all applicable state and Federal standards; (e) that neither Group nor Participating Group Providers nor any Provider Related Parties (as defined in Section 2.3.3) has (i) been excluded from participation in any federal or state-funded health program; or (ii) been listed in the National Practitioner Data Bank, the Healthcare Integrity and Protection Data Bank, or the Exclusion Lists (as defined in Section 2.3.3.1 (d)) (each a "Data Source"); (f) it and Participating Group Providers are, and will remain throughout the term of this Agreement, in compliance with all applicable Federal and state laws and regulations related to this Agreement and the services to be provided under this Agreement; (g) each Participating Group Provider has and shall maintain throughout the term of this Agreement unrestricted hospital privileges at a Participating Hospital (unless the maintenance of such privileges is not a criterion of participation for Participating Group Provider under the **Participation Criteria Schedule**); (h) it is legally

authorized to negotiate on behalf of Participating Group Providers and to bind those Participating Group Providers to abide by the terms of this Agreement, as amended from time to time; and (i) this Agreement has been executed by its duly authorized representative.

2.3.2 Qualified Personnel. Group also represents that Group and Participating Group Providers have established an ongoing quality assurance/assessment program which includes, but is not limited to, credentialing of employees and subcontractors. Group shall supply to Company the relevant documentation, including, but not limited to, internal quality assurance/assessment protocols, state licenses and certifications, Federal agency certifications and/or registrations upon request. Group further represents that all personnel employed by, associated or contracted with Group and Participating Group Providers who treat Members: (a) are and shall remain throughout the term of this Agreement appropriately licensed and/or certified and supervised (when and as required by state law), and qualified by education, training and experience to perform their professional duties; and (b) shall act within the scope of their licensure or certification, as the case may be. Company may audit Group and Participating Group Providers compliance with this Section upon prior written notice.

Group is prohibited from using any individual or entity ("Offshore Entity") (including, but not limited to, any employee, contractor, subcontractor, agent, representative or other individual or entity) to perform any services for Plans if the individual or entity is physically located outside of one of the fifty United States or one of the United States Territories (i.e., American Samoa, Guam, Northern Marianas, Puerto Rico, and Virgin Islands), unless Company, in its sole discretion and judgment, agrees in advance and in writing to the use of such Offshore Entity. Group further agrees that Company has the right to audit any Offshore Entity prior to the provision of services for Plans.

2.3.3 Government Program Representations. Company has or may seek a contract to serve Medicare beneficiaries ("Government Programs"). To the extent Company participates in such Government Programs, Group and Participating Group Providers agree, on behalf of themselves and any subcontractors of Group or Participating Group Providers, to be bound by all rules and regulations of, and all requirements applicable to, such Government Programs. Group and Participating Group Providers acknowledge and agree that all provisions of this Agreement shall apply equally to any permanent and temporary employees and Downstream Entities, as defined in 42 C.F.R. § 422.2 (collectively, "Provider Related Parties") of Group and Participating Group Providers who provide or may provide Covered Services to Members of Government Programs, and Group and Participating Group Providers represents and warrants that Group and Participating Group Providers shall take all steps necessary to cause Provider Related Parties to comply with the Agreement and all applicable laws, rules and regulations and perform all requirements applicable to Government Programs. In the event Group, Participating Group Providers or any Provider Related Parties are listed in a Data Source after the Effective Date of this Agreement, Company shall have the right, in its sole discretion and judgment, to terminate any schedule or attachment to the Agreement relating to the performance of Provider Services for Medicare Plans by Group and Participating Group Providers in accordance with the applicable provisions of the Agreement or to disqualify the listed person(s) from providing any part of the Provider Services.

Group and Participating Group Providers agree that all services and other activities performed by Group and Participating Group Providers under this Agreement will be consistent and comply with Company's obligations under its contract(s) with CMS, and any applicable state regulatory agency, to offer Medicare Plans. Group and Participating Group Providers further agree to allow CMS, any applicable state regulatory agency, and Company to monitor Group and Participating Group Providers' performance under this Agreement on an ongoing basis in accordance with Medicare laws, rules and regulations. Upon request, Group and/or Participating Group Provider shall immediately provide to Company any information that is required by Company to meet its reporting obligations to CMS, including without limitation, physician incentive plan information, if applicable. To the extent that Group and/or Participating Group Providers generates and/or compiles and provides any data to Company that Company, in turn, submits to CMS, Group and/or Participating Group Providers certify,

to the best of their knowledge and belief, that such data is accurate, complete and truthful. Group and Participating Group Providers acknowledge and agree that Company may only delegate its activities and responsibilities under its contract(s) with CMS and any applicable regulatory agency, to offer Medicare Plans in a manner consistent with Medicare laws, rules and regulations, and that if any such activity or responsibility is delegated by Company to Group and Participating Group Providers, the activity or responsibility may be revoked if CMS or Company determine that Group and Participating Group Providers have not performed satisfactorily.

2.3.3.1 Medicare Compliance Program Requirements.

(a) Group agrees to comply with all applicable requirements set forth in the CMS Compliance Program Guidelines ("Compliance Program Guidelines") that apply to "first tier entities" and/or "downstream entities," as those terms are defined by CMS. In accordance with the Compliance Program Guidelines, Company will provide to Group general compliance information through distribution of Company's standards of conduct and/or compliance policies and procedures ("Company Standards of Conduct").

(b) Consistent with the Compliance Program Guidelines, Group agrees to either: (1) distribute Company Standards of Conduct to Provider Related Parties, or (2) adopt standards of conduct and prepare compliance policies and procedures that are detailed and specific and describe the operation of Group's compliance program ("Provider Standards of Conduct"), and distribute such Provider Standards of Conduct to Provider Related Parties.

Group agrees that distribution of Company or Provider Standards of Conduct shall occur within ninety (90) days of hire or contracting, when there are updates to such Standards of Conduct, and annually thereafter. Further, Group must maintain documentation necessary to demonstrate to Company and CMS that Company or Provider Standards of Conduct was distributed to Provider Related Parties as required in the Compliance Program Guidelines ("Standard of Conduct Documentation"). Group agrees that Standard of Conduct Documentation is "Information and Records," as defined in Section 5.3.2 of this Agreement, and will maintain and provide access to all Standard of Conduct Documentation as described in Section 5.3.2 of this Agreement.

(c) In accordance with the Compliance Program Guidelines, Group shall ensure that all of Provider's Related Parties complete a Medicare fraud, waste and abuse training course ("Medicare Compliance Training"). Provider Related Parties may complete Medicare Compliance Training by completing: (1) the CMS "Medicare Parts C&D Fraud, Waste and Abuse" course ("CMS Module"), which is available on CMS' website, or (2) a course provided by Provider. Provider Related Parties meeting the CMS Medicare Compliance Training requirements through enrollment in the fee-for-service Medicare program or accreditation as a durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) provider are deemed by CMS rules to have met the Medicare Compliance Training requirement in this Section. Group agrees that new Provider Related Parties will complete Medicare Compliance Training within ninety (90) days of initial hire or the effective date of contracting with Group, and at least annually thereafter.

If Group chooses to provide its own Medicare Compliance Training rather than use the CMS Module, Group shall ensure that Medicare Compliance Training complies with all laws, rules and regulations that apply to Medicare Compliance Training, including, without limitation, the requirements set forth in the Medicare Compliance Guidelines. In addition, Group shall: (i) maintain and provide to Company, upon request, a copy of the Medicare Compliance Training provided to Provider Related Parties and all information

and documentation demonstrating that Provider Related Parties completed Medicare Compliance Training on an annual basis (collectively, "FWA Documentation"), including proof of training (i.e., copies of sign-in sheets, Provider Related Parties attestations, and/or electronic certifications) from Provider Related Parties completing the Medicare Compliance Training, and (ii) agree to sign and submit to Company on an annual basis a written attestation (in a form and manner determined by Company), attesting to Group's and each Provider Related Party's completion of Medicare Compliance Training. Group agrees that FWA Documentation is "Information and Records", as defined in Section 5.3.2 of this Agreement, and will maintain and provide access to all FWA Documentation as described in Section 5.3.2 of this Agreement.

(d) In accordance with applicable laws, rules and regulations and the Compliance Program Guidelines, Group agrees to review the Department of Health and Human Services ("HHS") Office of Inspector General List of Excluded Individuals and Entities and the General Service Administrative Excluded Parties Lists System (collectively, "Exclusion Lists") to ensure that Provider Related Parties are not included on such Exclusion Lists. Group agrees to review the Exclusion Lists prior to initially hiring, appointing or contracting with any new Provider Related Party and at least once per month thereafter to confirm that Provider Related Parties are not included on such Exclusion Lists. Group agrees that if a Provider Related Party appears on an Exclusion List and/or is excluded from participation in any federally-funded health program, Group will immediately remove the Provider Related Party from any work related directly or indirectly to Company's Medicare Plans, and take all corrective actions required under applicable laws, rules or regulations.

2.3.3.2 Monitoring and Oversight. Group and Participating Group Providers acknowledge and agree to allow Company and CMS to monitor Group and Participating Group Providers' performance of Provider Services on an ongoing basis. If Company has reason to believe that Group and/or Participating Group Providers have failed to carry out the Provider Services in accordance with the terms of the Agreement or any attachments or schedule thereto, Company may take such steps, as it deems necessary, including but not limited to the following:

(i) Audit Group and/or Participating Group Providers' performance of the Provider Services.
(ii) Require Group and/or Participating Group Providers to submit, within a reasonable time frame specified by Company, a corrective action plan to address any compliance or other failure to carry out the Provider Services identified by Company.
(iii) Require Group and/or Participating Group Providers to implement, within ten (10) calendar days of notice, a corrective action plan approved by Company and permit increased audits of Group and/or Participating Group Providers' performance of Provider Services to ensure compliance with such plan.
(iv) Suspend Group and/or Participating Group Providers' performance of Provider Services pending the submission of a corrective action plan acceptable to Company and successful implementation of such plan as determined by Company.

Group and Participating Group Providers agree that it shall be a considered a material breach of the Agreement if a corrective action plan acceptable to Company cannot be developed and fully implemented within ten (10) calendar days or, in Company's sole discretion, at such other timeframe determined by Company. If such compliance or other failure to carry out the Provider Services cannot be corrected within such time period, Company may, in Company's sole discretion, either revoke delegation of services under the Agreement or terminate any schedule to the Agreement for Provider Services upon notice to Group.

2.4 Participating Group Providers.

Notwithstanding any contrary interpretation of this Agreement or of any contracts between Group and Participating Group Providers, Group acknowledges and agrees that all provisions of this Agreement applicable to Group shall apply with equal force to Participating Group Providers, unless clearly applicable only to Group. Group agrees that it is Group's responsibility to assure that the obligations of Participating Group Providers under this Agreement are fully satisfied, that Group will take all steps necessary to cause Participating Group Providers to comply with and perform the terms and conditions of this Agreement, and that Group's failure to do so shall constitute a material breach of this Agreement by Group. Group agrees, and shall require Participating Group Providers to agree, that in the event of any inconsistency between this Agreement and any contracts entered into between Group and Participating Group Providers, the terms of this Agreement shall control. Upon request by Company, Group shall provide copies of its contracts with Participating Group Providers, if any, to Company. Group agrees that each Participating Group Provider shall execute an individual participation agreement with Company.

Notwithstanding the provisions of the previous paragraph, if new Participating Group Providers ("New Participating Group Providers") are added to Group who at the time of their addition are participating with Company via an existing participation agreement, Company reserves the right to continue to pay such New Participating Group Providers according to the **Services and Compensation Schedules** of their existing agreement. New Participating Group Provider agrees to accept such payments as payment in full, until such time Company and Group negotiate and implement new rates acceptable to both parties or the New Participating Group Provider's existing agreement is terminated in accordance with its terms.

2.5 Group Capacity.

Group shall provide, at the earliest possible time, notice to Company of any significant changes in the capacity of Group to provide or arrange for the provision of Covered Services to Members as contemplated by this Agreement, including, but not limited to, any reduction in the number of Participating Group Providers. If Company determines at any time that Members' access to Participating Group Providers is unacceptable due to any reduction in the number of Participating Group Providers, or any change in the types or geographic mix of Participating Group Providers, Company may request that Group take corrective action acceptable to Company within thirty (30) days. If Group fails to take such corrective action within such thirty (30) day period, Company may terminate this Agreement as provided in Section 6.3.

2.6 Group Providers' Information.

Group shall provide to Company a complete list of Participating Group Providers, including names, office and/or service addresses, office hours, telephone and facsimile numbers, and area of practice or specialty. Group shall notify Company in writing within seven (7) business days of its acquiring knowledge of any change in this information. Group shall provide to Company at least ninety (90) days prior notice (or, if Group does not receive at least ninety (90) days notice, then such notice as Group actually receives) of the termination of Group's relationship with a Participating Group Provider. Group shall obtain a completed credentialing application to become a Participating Group Provider from each Group Provider, and shall, at Company's request, make available to Company any credentialing material held by or accessible to Group. Group shall obtain all necessary releases from Group Providers to permit Group to release said credentialing files to Company, and Company shall be entitled to presume that such releases have been obtained.

2.7 Group and Participating Group Providers' Insurance.

2.7.1 Group's Insurance. During the term of this Agreement, Group agrees to procure and maintain such policies of general and professional liability and other insurance or a comparable program of self-insurance at minimum levels as required by state law, or in the absence of a state law specifying a minimum limit, an amount customarily maintained by providers in the state or region in which the Group operates. Such insurance coverage shall cover the acts and omissions of Group and Participating Group Providers as well as Group and Participating Group Provider's agents and employees. Group agrees to deliver certificates of insurance or other documentation as appropriate to show evidence of such coverage to Company upon request. Group agrees to make best efforts to

provide to Company at least thirty (30) days advance notice, and in any event will provide notice as soon as reasonably practicable, of any cancellation or material modification of these policies.

2.7.2 Participating Group Providers' Insurance. During the term of this Agreement, each Participating Group Provider agrees to procure and maintain such policies of general and professional liability and other insurance or comparable program of self-insurance at minimum levels as required by state law, or in the absence of a state law specifying a minimum limit, an amount customarily maintained by Providers in the state or region in which Participating Group Provider operates. Such insurance coverage shall cover the acts and omissions of Participating Group Provider as well as Participating Group Provider's agents and employees. Participating Group Provider agrees to deliver certificates of insurance or other documentation as appropriate to show evidence of such coverage to Company upon request. Participating Group Provider agrees to make best efforts to provide to Company at least thirty (30) days advance notice, and in any event will provide notice as soon as reasonably practicable, of any cancellation or material modification of these policies.

2.8 Product Participation.
Group and Participating Group Providers agree to participate in the benefit products listed on the **Product Participation Schedule**. Company reserves the right to introduce and designate Group and Participating Group Providers' participation in new Specialty Programs and products during the term of this Agreement and will provide Group with written notice of such new Specialty Programs and products and the associated compensation.

Nothing in this Agreement shall require that Company identify, designate or include Group and Participating Group Providers as a preferred participant in any specific Specialty Program or product; provided, however, Group and Participating Group Providers shall accept compensation in accordance with this Agreement for the provision of any Covered Services to Members under a Specialty Program or product in which Group and Participating Group Providers have agreed to participate in this Agreement.

Company may sell, lease, transfer or otherwise convey to payers (other than Plan Sponsors) which do not compete with Company's product offerings in the geographic area where Group provides Covered Services, the benefits of this Agreement, including, without limitation, the **Services and Compensation Schedule** attached hereto, under terms and conditions which will be communicated to Group in each such case. For those programs and products which are not health benefit products, Group shall have thirty (30) days from receipt of the Company's notice to notify Company in writing if Group elects not to participate in these product(s).

2.9 Consents to Release Medical Information.
Group and Participating Group Providers will obtain from Members to whom Group and Participating Group Providers provide Provider Services, any necessary consents or authorizations to the release of Information and Records to Company, Plan Sponsors, their agents and representatives. In performing this covenant, Provider shall comply with any applicable Federal and state law or regulation.

2.10 Encounter Data.
For those services for which Group is compensated on a capitated basis, if any, Group and Participating Group Providers agree to provide Company with encounter data by type of Provider Service rendered to Members in the form and manner as specified by Company. There shall be no restrictions on Company's use of such encounter data. Furthermore, Company is under no obligation to return such encounter data to Group or Participating Group Providers.

3.0 COMPANY OBLIGATIONS

3.1 Company's Covenants.
Company or Plan Sponsors shall provide Members with a means to identify themselves to Participating Group Providers (e.g., identification cards), an explanation of Group's payments, a general description of

products (e.g., Quick Reference Card), a listing of Participating Providers, and timely notification of material changes in this information. Company shall provide Group and Participating Group Providers with a means to check Member eligibility. Company shall include Group and Participating Group Providers in the Participating Provider directory or directories for the Plans, Specialty Programs and products in which Group and Participating Group Providers are Participating Providers, including when Group and Participating Group Providers are designated as preferred participant, and shall make these directories available to Members. Company reserves the right to determine the content of provider directories.

3.2 Company Representations.
Company represents and covenants that: (a) it, where applicable, is licensed to offer, issue and administer Plans in the service areas covered by this Agreement by the applicable regulatory authority ("License"); (b) it will not lose such License involuntarily during the course of this Agreement; and (c) it is, and will remain throughout the term of this Agreement, substantially in compliance with all applicable Federal and state laws and regulations related to this Agreement and the services to be provided in this Agreement; including without limitation, any applicable prompt payment statutes and regulations.

3.3 Company's Insurance.
Company at its sole cost and expense agrees to procure and maintain such policies of general and/or professional liability and other insurance as shall be necessary to insure Company and its employees against any claim or claims for damages arising by reason of personal injuries or death occasioned directly or indirectly in connection with the performance of any service by Company under this Agreement and the administration of Plans.

4.0 CLAIMS SUBMISSIONS, COMPENSATION AND MEMBER BILLING

4.1 Claim Submission and Payment.

4.1.1 Obligation to Submit Claims. Group agrees to submit Clean Claims for non-capitated services to Company for Provider Services rendered to Members by Participating Group Providers. Group and Participating Group Providers represent that, where necessary, they have obtained signed assignments of benefits authorizing payment for Provider Services to be made directly to Group. Group and Participating Group Providers will submit all claims electronically to Company using the HIPAA required ASC X12N 837—Health Care Claim: Professional for professional claims and the ASC X12N 837—Health Care Claim: Institutional for institutional claims or an industry standard successor format ("Electronic Claim"). Group shall not submit a claim to Company in paper form unless Company fails to pay or otherwise respond to electronic claims submission in accordance with the timeframes required under this Agreement or applicable law or regulation. Group agrees that Company, or the applicable Plan Sponsor, will not be obligated to make payments for billing received more than one hundred and twenty (120) days from (a) the date of service or, (b) the date of receipt of the primary payer's explanation of benefits when Company is the secondary payer. This requirement will be waived in the event Group provides notice to Company, along with appropriate evidence, of extraordinary circumstances outside the control of Group that resulted in the delayed submission. In addition, unless Group notifies Company of any payment disputes or dispute regarding claim denial within one hundred eighty (180) days or such longer time as required by applicable state law or regulation, of receipt of payment or claim denial from Company, such payment or claim denial will be considered full and final payment or determination for the related claims. If Group does not bill Company or Plan Sponsors, or disputes any payment, timely as provided in this Section 4.1.1, Group's claim for payment will be deemed waived and Group will not seek payment from Plan Sponsors, Company or Members. Group shall pay on a timely basis all employees, independent contractors and subcontractors who render Covered Services to Members for which Group is financially responsible pursuant to this Agreement.

Group agrees to permit rebundling to the primary procedure those services considered part of, incidental to, or inclusive of the primary procedure and to allow Company to make other adjustments

for inappropriate billing or coding (e.g., duplicative procedures or claim submissions, mutually exclusive procedures, gender/procedure mismatches, age/procedure mismatches). In performing rebundling and making adjustments for inappropriate billing or coding, Company utilizes a commercial software package (as modified by Company for all Participating Providers in the ordinary course of Company's business) which commercial software package relies upon Medicare and other industry standards in the development of its rebundling logic.

4.1.2 Company Obligation to Pay for Covered Services. Company agrees to: (a) pay Group for Covered Services rendered to Members of Full Risk Plans, and (b) notify Plan Sponsors to forward payment to Company for payment to Group for Covered Services rendered to a Plan Sponsor's Members by Participating Group Providers. Such payment shall be made as follows: (a) for capitated services Group shall be paid according to the rates as described in the **Services and Compensation Schedule**; (b) for non-capitated services: the lesser of (i) Participating Group Provider's actual billed charges; or (ii) the rates set forth in the **Services and Compensation Schedule**. Payment for such non-capitated services shall be made within forty-five (45) days (or such time as permitted by applicable law or regulation) of actual receipt by Company of a Clean Claim. Group and Participating Group Providers will utilize online explanation of benefits, electronic remittance of advice and electronic funds transfer in lieu of receiving paper equivalents. While Company may pay claims on behalf of Plan Sponsors, Group, Participating Group Providers and Company acknowledge that Company has no legal responsibility for the payment of such claims for Covered Services rendered to a Plan Sponsor's Members; provided, however, that Company agrees to reasonably assist Group as appropriate in collecting any such payments.

Company may authorize a designee to perform pre-payment reviews of certain claims. This review may include, but not be limited to, a request for itemized bills or more specific detail with respect to claims contracted on a percentage of charges basis. Group acknowledges that Company may, as a result of the review, deny payment for, among other things, duplicate charges, errors in billing or categorization of capital equipment. Company and/or its designee may, from time to time, notify Group of overpayments to Group and Group agrees to return any such overpayment or payment made in error (e.g., a duplicate payment or payment for services rendered by a Participating Group Provider to a patient who was not a Member) within a reasonable period of time. In the event Company is unable to secure the return of any such payment within such reasonable time, Company reserves the right to offset such payment against any other monies due to Group under this Agreement provided Company has delivered to Group at least ten (10) days prior written notice and Group has otherwise failed to return such payment to Company. To the extent, if any, that the compensation under certain Plans is in the form of capitation payments or a case-based rate methodology, Group acknowledges the financial risks to Group of this arrangement and has made an independent analysis of the adequacy of this arrangement. Group, therefore, agrees and covenants not to bring any action asserting the inadequacy of these arrangements or that Group was in any way improperly induced by Company to accept the rate of payment, including, but not limited to, causes of actions for damages, rescission or termination alleging fraud or negligent misrepresentation or improper inducement.

4.1.3 Group's Payment to Participating Group Providers. Group shall be financially responsible for payment to all Participating Group Providers and subcontractors who render Covered Services to Members. Group shall require all Participating Group Providers and subcontractors who render such services to look solely to Group for payment. In addition, Group shall be financially responsible for payment to any other providers who render Covered Services to Members when Group has been compensated on a capitated basis, if any, for such services. Group shall pay on a timely basis all Participating Group Providers and other Providers who render Covered Services for which Group is financially responsible hereunder. Company shall forward any claims it receives for payment for such services to Group. Company reserves the right to pay, or to instruct Payers to pay, any Participating Provider or other provider for Covered Services for which Group is financially responsible and for which a valid, undisputed invoice, or portion thereof, is outstanding for more than fourteen (14) days beyond its due date, except that Company need not wait fourteen (14) days if Group has engaged in a pattern of late

payments in the past. Company may deduct any such payments from any and all amounts due and payable to Group hereunder.

4.1.4 Utilization Management. Company utilizes systems of utilization review/quality improvement/peer review to promote adherence to accepted medical treatment standards and to encourage Participating Providers to minimize unnecessary medical costs consistent with sound medical judgment. To further this end, Participating Group Providers agree, consistent with sound medical judgment: (a) to participate, as requested, and to abide by Company's utilization review, patient management, quality improvement programs, and all other related programs (as modified from time to time) and decisions with respect to all Members; (b) to comply with Company's precertification and utilization management requirements for all elective admissions and other Covered Services; (c) to regularly interact and cooperate with Company's nurse case managers; (d) to utilize Participating Providers including but not limited to Participating surgery centers and hospitals, to the fullest extent possible, consistent with sound medical judgment; (e) to abide by all Company's credentialing criteria and procedures, including site visits and medical chart reviews, and to submit to these processes biannually, annually, or otherwise, when applicable; (f) to obtain advance authorization from Company prior to any non-emergency admission, and in cases where a Member requires an emergency hospital admission, to notify Company, both in accordance with Company's rules, policies and procedures then in effect; and (g) to the extent required by the terms of the applicable Plan, Group and Participating Group Providers shall refer or admit Members only to Participating Physicians for Covered Services, and shall furnish such Physicians with complete information on treatment procedures and diagnostic tests performed prior to such referral or admission. In addition to the extent possible, Physician shall refer Members with out of network benefits to Participating Providers.

Except for Emergency Services, if a referral is required by the Member's Plan, Participating Group Provider shall provide Provider Services to Members only upon prior referral of such patients by a Primary Care Physician to Participating Group Provider on prescribed forms or by electronic means as instructed by Company. Except for Emergency Services, payment for retroactive referrals shall be subject to adjustment or denial by Company in accordance with Policies. Participating Group Provider shall render services to Members only at Participating Hospitals or other Participating Providers, or those inpatient, extended care, and ancillary service facilities which have otherwise been approved in advance by Company. Participating Group Provider agrees promptly to submit a report on the treatment of each Member to the referring Primary Care Physician, if such Member was referred to the Participating Group Provider by a Primary Care Physician in accordance with the Member's Plan.

For those Members who require services under a Specialty Program, Group and Participating Group Providers agree to work with Company in transferring the Member's care to a Specialty Program Provider.

4.2 Coordination of Benefits.
Company will coordinate benefits as allowed by state or federal law, or, in the absence of any applicable law, in accordance with plan requirements. If Medicare is the primary payer under coordination of benefit principles, Group or Participating Group Providers may not collect more than Medicare allows. In no event will Company pay more than the compensation due under this Agreement.

4.3 Member Billing.

4.3.1 Permitted Billing of Members. Group and Participating Group Providers may bill or charge Members only in the following circumstances: (a) applicable Copayments, Coinsurance and/or Deductibles not collected at the time that Covered Services are rendered; (b) a Plan Sponsor becomes insolvent or otherwise fails to pay Group in accordance with applicable Federal law or regulation (e.g., ERISA) provided that Group has first exhausted all reasonable efforts to obtain payment from the Plan Sponsor; and (c) services that are not Covered Services only if: (i) the Member's Plan provides and/or Company confirms that the specific services are not covered; (ii) the Member was advised in writing

prior to the services being rendered that the specific services may not be Covered Services; and (iii) the Member agreed in writing to pay for such services after being so advised. Notwithstanding the foregoing, Group will bill or charge Member contracted rates if the Member has exhausted applicable plan benefits. Group acknowledges that Company's denial or adjustment of payment to Group based on Company's performance of utilization management as described in Section 4.1.4 or otherwise is not a denial of Covered Services under this Agreement or under the terms of a Plan, except if Company confirms otherwise under this Section 4.3. Group may bill or charge individuals who were not Members at the time that services were rendered.

4.3.2 Holding Members Harmless. Group and Participating Group Providers hereby agree that in no event, including, but not limited to the failure, denial or reduction of payment by Company, insolvency of Company or breach of this Agreement, shall Group or Participating Group Providers bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse (i) against Members or persons acting on their behalf (other than Company) or (ii) any settlement fund or other asset controlled by or on behalf of, or for the benefit of, a Member for Covered Services. This provision shall not prohibit collection of Copayments, Coinsurance, Deductibles or other supplemental charges made in accordance with the terms of the applicable Plan. Group and Participating Group Providers further agree that Medicare Members will not be held liable for payment of any fees that are the legal obligation of Company. Group and Participating Group Providers further agree that this Section 4.3.2: (a) shall survive the expiration or termination of this Agreement regardless of the cause giving rise to termination and shall be construed for the benefit of Members; and (b) supersedes any oral or written contrary agreement or waiver now existing or hereafter entered into between Group and Participating Group Providers and Members or persons acting on their behalf. Where required by applicable law no modification of this provision shall be effective without the prior written approval of such applicable regulatory agency.

4.3.3 Cost Sharing Protections for Dual Eligible Members. Group and Participating Group Providers acknowledge and agree that Medicare Members who are also enrolled in a State Medicaid plan ("Dual Eligible Members") are not responsible for paying to Group or Participating Group Providers any Copayments, Coinsurance or Deductibles for Medicare Part A and Part B services ("Cost Sharing Amounts") when the State Medicaid plan is responsible for paying such Cost Sharing Amounts. Group and Participating Group Providers further agree that they will not collect Cost Sharing Amounts from Dual Eligible Members when the State is responsible for paying such Cost Sharing Amounts, and will, instead, either accept the Company's payment for Covered Services as payment in full for Covered Services and applicable Cost Sharing Amounts, or bill the applicable State Medicaid plan for the appropriate Cost Sharing Amounts owed by the State Medicaid plan.

To protect Members, Group and Participating Group Providers agree not to seek or accept or rely upon waivers of the Member protections provided by this Section 4.3.

4.4 Risk Adjustment Data Validation.

This Section applies in the event that Group participates in Government Programs. For purposes of this Section: (1) "risk adjustment data" shall have the meaning set forth in 42 C.F.R. Section 422.310(a), as may be amended from time to time, and (2) "Diagnosis" shall mean an International Classification of Diseases, 9th Revision, Clinical Modification ("ICD-9-CM") diagnosis code, or its successor (such as ICD-10-CM or ICD-10-PCS), that Group submits to Company for a Medicare Member. In accordance with 42 C.F.R. § 422.310, Company is required to obtain risk adjustment data from Group and Participating Group Providers for Medicare Members, and Group and Participating Group Providers agree to provide complete and accurate risk adjustment data to Company for Medicare Members that conforms to the requirements of this section and all standards and requirements including, but not limited to, CMS regulations and instructions that apply to risk adjustment data. In accordance with 42 C.F.R. § 422.504(l)(3), Group and Participating Group Providers certify, based on best knowledge, information and belief, that any risk adjustment data that Group and/or Participating Group Providers submit to Company for Medicare Members is accurate, complete and truthful. Group and Participating Group Providers acknowledge and agree that risk adjustment data is used to

determine CMS payments to Company and, as a result, Group and Participating Group Providers agree to immediately notify Company if any risk adjustment data that Group and Participating Group Providers submitted, directly or indirectly, to Company for Medicare Members is inaccurate, incomplete or erroneous, and follow procedures established by Company to correct erroneous risk adjustment data to ensure Company's compliance with applicable standards and requirements.

Group and Participating Group Providers further agree to maintain accurate, legible and complete medical record documentation for all risk adjustment data submitted to Company for Medicare Members in a format that meets all standards and requirements including, but not limited to, CMS regulations and instructions, and allow any federal governmental authorities with jurisdiction or their designees ("Government Officials") to: (1) confirm that the appropriate diagnoses codes and level of specificity are documented; (2) verify the date of service is documented and within the risk adjustment data collection period; and (3) confirm that the appropriate provider's signature and credentials are present ("Medical Records").

In accordance with 42 C.F.R. § 422.310 and 422.504(i)(2), Group and Participating Group Providers agree to provide Company and Government Officials, or their designees, with medical records and any other information or documentation required by Government Officials for the validation of risk adjustment data ("Audit Data"). Group and Participating Group Providers agree to provide Company with Audit Data within the timeframe established by Company to ensure Company's compliance with deadlines imposed by Government Officials for the submission of Audit Data. In the event that CMS conducts a review that includes the validation of risk adjustment data submitted by Group or Participating Group Providers, Company will submit to Group or Participating Group Providers a copy of the CMS written notice of such review, along with a written request from Company for Audit Data.

If Group and Participating Group Providers are compensated on a fee for service basis and a Government Official imposes a financial adjustment or penalty on Company based on a finding that there is insufficient information or documentation to support a Diagnosis ("Audit Finding"), Company may recoup the total amount that Company paid to Group or Participating Group Providers for the Current Procedural Terminology (CPT), Diagnostic Related Groupings (DRG) codes, or other nationally recognized medical codes used to bill Company for inpatient and outpatient Covered Services rendered to treat such Diagnosis ("Billing Codes"). Company shall only recoup payments made to Group or Participating Group Providers for Billing Codes associated with dates of service that are within the calendar year(s) that is described in the Audit Finding. Prior to recouping any payments made to Group or Participating Group Providers for a Diagnosis for which an Audit Finding was issued, Company will provide Group or Participating Group Providers with copies of: (1) the pertinent portion(s) of the final written audit report prepared by a Government Official demonstrating that an Audit Finding was issued relating to the Diagnosis, and (2) a copy of the Medical Records submitted by Company to the Government Official for the Diagnosis.

4.5 Medicare Payment Adjustment.

The Parties acknowledge and agree that payments under the Medicare program to providers, suppliers, and Medicare Advantage organizations may be adjusted as the result of legislation, regulation, executive order or other federal mandate ("Medicare Payment Adjustment"). Furthermore, any such Medicare Payment Adjustment could result in an increase or decrease in Medicare payments. In accordance with the terms of this Agreement, the Parties agree that, in the event of a Medicare Payment Adjustment, Company's payment to Group or Participating Group Providers will be adjusted in accordance with the Medicare Payment Adjustment. Company shall adjust payments under this Agreement for Covered Services rendered by Group or Participating Group Providers on and after the effective date of the Medicare Payment Adjustment, and shall continue to adjustment payments to Group or Participating Group Providers for until the earlier of (i) the Medicare Payment Adjustment is discontinued or (ii) is replaced by a subsequent Medicare Payment Adjustment.

5.0 COMPLIANCE WITH POLICIES

5.1 Policies.

Group and Participating Group Providers agree to accept and comply with Policies of which Group knows or reasonably should have known (e.g., Clinical Policy Bulletins or other Policies made available to Group and Participating Group Providers). Company may at any time modify Policies. Company will provide ninety (90) days prior notice by letter, newsletter, electronic mail or other media, of Material Changes. Failure by Group to object in writing to any Material Change within thirty (30) days following receipt thereof constitutes Group's acceptance of such Material Change. In the event that Group reasonably believes that a Material Change is likely to have a material adverse financial impact upon Group, Group agrees to notify Company, specifying the specific bases demonstrating a likely material adverse financial impact, and the Parties will negotiate in good faith an appropriate amendment, if any, to this Agreement. Group and Participating Group Providers agree that noncompliance with any requirements of this Section 5.1 or any Policies will relieve Company or Plan Sponsors and Members from any financial liability for the applicable portion of the Provider Services.

5.2 Notices and Reporting.

To the extent neither prohibited by law nor violative of applicable privilege, Group and Participating Group Providers agree to provide notice to Company, and shall provide all information reasonably requested by Company regarding the nature, circumstances, and disposition, of: (a) any litigation brought against Group and Participating Group Providers or any of its employees or affiliated providers which is related to the provision of health care services and could have a material impact on the Provider Services provided to Members; (b) comply with any Company requirements regarding reporting of self-referrals, loss of licensure or accreditation, and claims by governmental agencies or individual regarding fraud, abuse, self-referral, false claims, or kickbacks; and (c) any material change in services provided by Group and Participating Group Providers or licensure status related to these services. Group agrees to use best efforts to provide Company with prior notice of, and in any event will provide notice as soon as reasonably practicable notice of, any actions taken by or against Group or Participating Group Providers described in this Section 5.2.

5.3 Information and Records.

5.3.1 Maintenance of Information and Records. Group and Participating Group Providers agree: (a) to maintain Information and Records (as such terms are defined in Section 5.3.2) in a current, detailed, organized and comprehensive, accurate and timely manner and in accordance with customary medical practice, applicable Federal and state laws, and accreditation standards; (b) that all Member medical records and Confidential Information shall be treated as confidential and in accordance with applicable laws, including but not limited to, the requirements set forth in 42 C.F.R. §§ 422.136; and (c) to maintain such Information and Records for the longer of six (6) years after the last date Provider Services were provided to Member, or the period required by applicable law. This Section 5.3.1 shall survive the termination of this Agreement, regardless of the cause of the termination.

5.3.2 Access to Information and Records. Group and Participating Group Providers agree that (a) Company (including Company's authorized designee) and Plan Sponsors shall have access to all data and information obtained, created or collected by Group and Participating Group Providers related to Members and necessary for payment of claims, including without limitation Confidential Information ("Information"); (b) Company (including Company's authorized designee), Plan Sponsors and Federal, state, and local governmental authorities and their agents having jurisdiction, upon request, shall have access to all books, records and other papers (including, but not limited to, medical and financial records, contracts and computer or other electronic systems) and information relating to this Agreement and to those services rendered by Participating Group Providers to Members ("Records"); (c) consistent with the consents and authorizations required by Section 2.9 hereof, Company or its agents or designees shall have access to medical records for the purpose of assessing quality of care, conducting medical evaluations and audits, including pre-payment review, and performing utilization management functions; (d) applicable Federal and state authorities and their agents shall have access to medical records for assessing the quality of care or investigating Member grievances or complaints; (e) medical information relating to Members is released only in accordance with applicable federal or state law, or pursuant to court orders or subpoenas; and (f) Members shall have timely access to their health

information as required by 45 C.F.R. § 164.524 and applicable state law, be provided with an accounting of disclosures of information when and as required by 45 C.F.R. § 164.528 and applicable state law, and have the opportunity to amend or correct the information as required by 45 C.F.R. § 164.526 and applicable state law. Group and Participating Group Provider agree to supply copies of Information and Records within fourteen (14) days of the receipt of a request, where practicable, and in no event later than the date required by any applicable law or regulatory authority. Except as required by applicable state or federal law, Group and Participating Group Providers agree that Company (including Company's authorized designee), Plan Sponsors and Members shall not be required to reimburse Group or Participating Group Providers for expenses related to providing copies of patient records or documents to any local, State or Federal agency: (i) pursuant to a request from any law or regulatory agency; (ii) pursuant to administration of Company's utilization management; or (iii) in order to assist Company in making a determination regarding whether a service is a Covered Service for which payment is due; or (iv) for any other purpose. Group or where applicable, Participating Group Providers agree to provide Company data necessary for Company to comply with reporting requirements related to the Affordable Care Act ("ACA"), including but not limited to information related to the ACA's medical loss ratio requirements. This Section 5.3.2 shall survive the termination of this Agreement, regardless of the cause of termination.

5.3.3 Government Requirements Regarding Records for Medicare Members. In addition to the requirements of Sections 5.3.1 and 5.3.2, with respect to Medicare Plans, Group and Participating Group Providers, on behalf of itself and any Provider Related Parties, agree to provide Company and HHS, the Comptroller General or their designees (collectively, "Permitted Parties") access to all Information and Records (as defined in Section 5.3.2), and that this right of inspection, evaluation and audit will continue for the longer of: (i) a period of ten (10) years from the final date of the Final Contract Period of any contract between Company and CMS to offer Medicare Plans, or (ii) the completion of any audit. Group and Participating Group Providers also agree to maintain Information and Records for the longer of: (i) ten (10) years from the final date of the Final Contract Period of any contract between Company and CMS to offer Medicare Plans, or (ii) the completion of any audit.

In addition, to the extent applicable to Group and Participating Group Providers, Group and Participating Group Providers, on behalf of itself and any Provider Related Parties, agree to comply with 42 C.F.R. § 422.2480(c) and to maintain all Information and Records containing data used by Company to calculate Medicare Medical Loss Ratios ("MLRs") for Company's Medicare Plans and evidence needed by Company and/or federal governmental authorities with jurisdiction to validate MLRs (collectively, "MLR Information and Documentation") for a minimum of ten (10) years from the date such MLRs were reported by Company to CMS. Group and Participating Group Providers further agree that, with respect to Medicare Plans, Company, federal governmental authorities having jurisdiction, and their designees, upon request, shall have access to all MLR Information and Records, and that this right of inspection, evaluation and audit of MLR Information and Records shall continue for a minimum of ten (10) years from the date such MLRs were reported by Company to CMS.

This Section 5.3.3 shall survive the termination of this Agreement, regardless of the cause of termination.

5.4 Quality, Accreditation and Review Activities.
Group and Participating Group Providers agree to cooperate with any Company quality activities or review of Company or a Plan conducted by the National Committee for Quality Assurance ("NCQA") or a state or Federal agency with authority over Company and/or the Plan, as applicable.

5.5 Proprietary Information.
Each Party agrees that the Proprietary Information of the other Party is the exclusive property of such Party and that each Party has no right, title or interest in the Proprietary Information. Unless such Proprietary Information is otherwise publicly available, each Party agrees to keep the Proprietary Information and this Agreement strictly confidential and agrees not to disclose any Proprietary Information or the contents of this

Agreement to any third party without the other Party's consent, except (i) to governmental authorities having jurisdiction, (ii) in the case of Company's disclosure to Members, Plan Sponsors, consultants or vendors under contract with Company, and (iii) in the case of Participating Group Providers' disclosure to Members for the purposes of advising Members of potential treatment options and costs. Except as otherwise required under applicable Federal or state law, each Party agrees to not use any Proprietary Information of the other Party, and at the request of the other Party to this Agreement, return any Proprietary Information upon termination of this Agreement for whatever reason. Notwithstanding the foregoing, Participating Group Providers are encouraged to discuss Company's provider payment methodology with patients, including descriptions of the methodology under which the Group or Participating Group Providers are paid. In addition, Participating Group Providers may freely communicate with patients about their treatment options, regardless of benefit coverage limitations. This Section 5.5 shall survive the termination of this Agreement for one (1) year, regardless of the cause of termination.

6.0 TERM AND TERMINATION

6.1 Term.
This Agreement shall be effective for an initial term ("Initial Term") of three (_3_) year(s) from the Effective Date, and thereafter shall automatically continue for additional terms of one (1) year each, unless and until terminated in accordance with this Article 6.0.

6.2 Termination without Cause.
This Agreement may be terminated or non-renewed as of the anniversary date of the Effective Date by either Party with at least one hundred twenty (120) days prior written notice to the other Party prior to such anniversary date of the Effective Date; provided, however, that no termination of this Agreement pursuant to this Section 6.2 shall be effective during the Initial Term hereof.

6.3 Termination for Breach.
This Agreement may be terminated at any time by either Party upon at least sixty (60) days prior written notice of such termination to the other Party upon material default or substantial breach by the other Party of one or more of its obligations under this Agreement, unless such material default or substantial breach is cured within sixty (60) days of the notice of termination; provided, however, if such material default or substantial breach is incapable of being cured within such sixty (60) day period, any termination pursuant to this Section 6.3 will be ineffective for the period reasonably necessary to cure such breach if the breaching party has taken all steps reasonably capable of being performed within such sixty (60) day period. Furthermore, Company may terminate the status of any Participating Group Provider as a Participating Provider for default or breach of said Participating Group Provider's obligations hereunder upon at least sixty (60) days notice to said Participating Group Provider, unless such default or breach is cured within the notice period. Notwithstanding the foregoing, the effective date of such termination may be extended pursuant to Section 6.6 of this Agreement.

6.4 Immediate Termination or Suspension.
Company may immediately terminate this Agreement or, where applicable, the status of any Participating Group Provider as a Participating Provider, at Company's discretion at any time, due to any of the following events: (a) the suspension, withdrawal, expiration, revocation or non-renewal of any Federal, state or local license, certificate or other legal credential authorizing Group and/or Participating Group Providers to perform Provider Services; (b) a suspension or revocation of a Participating Group Provider's DEA certification or other right to prescribe controlled substances (unless such certification is not a criterion of participation for Participating Group Provider under the **Participation Criteria Schedule**); (c) an indictment, arrest or conviction of a felony; or for any indictment, arrest or conviction of criminal charge related to or in any way impairing Group's and Participating Group Provider's performance of Provider Services; (d) the loss or material limitation of Group's or Participating Group Provider's insurance under Section 2.8 of this Agreement; (e) the debarment or suspension of Group or Participating Group Providers from participation in any governmental sponsored program, including, but not limited to, Medicare or Medicaid; (f) the listing of Group or Participating Group Providers in the HIPDB; (g) change of control of Group to an entity not

acceptable to Company; (h) any false statement or material omission of Participating Group Provider in the participation application and/or confidential information forms and all other requested information, as determined by Company in its sole discretion; (i) any adverse action with respect to Participating Group Provider's hospital staff privileges, if Participating Group Provider is required to maintain such privileges under the **Participation Criteria Schedule**; or (j) a determination by Company that Group or Participating Group Provider's continued participation in provider networks could result in harm to Members. To protect the interests of patients, including Members, Group and/or Participating Group Providers will provide immediate notice to Company of any of the events described in this Section 6.4, including notification of impending bankruptcy.

6.5 Obligations Following Termination.
Following the effective date of any expiration or termination of this Agreement or any Plan, Group and Participating Group Providers and Company will cooperate as provided in this Section 6.5. This Section 6.5 shall survive the termination of this Agreement, regardless of the cause of termination.

6.5.1 Upon Termination. Upon expiration or termination of this Agreement for any reason, other than termination by Company in accordance with Section 6.4 above, Group and Participating Group Providers agree to provide Provider Services at Company's discretion: (a) to any Member under a Participating Group Provider's care who, at the time of the expiration or termination is a registered bed patient at a Participating Facility until such Member's discharge or Company's orderly transition of such Member's care to another provider; and (b) to any Member for up to one (1) calendar year. The **Services and Compensation Schedule** shall apply to all services under this Section 6.5.1.

6.5.2 Upon Insolvency or Cessation of Operations. If this Agreement terminates as a result of insolvency or cessation of operations of Company, then in addition to other obligations set forth in this Section 6.5, Group and Participating Group Providers shall continue to provide Provider Services to: (a) all Members for the period for which premium has been paid; and (b) Members confined in an inpatient facility on the date of insolvency or other cessation of operations until medically appropriate discharge. This provision shall be construed to be for the benefit of Members. No modification of this provision shall be effective without the prior written approval of the applicable regulatory agencies.

6.5.3 Obligation to Cooperate. Upon notice of expiration or termination of this Agreement or of a Plan, Group and Participating Group Providers shall cooperate with Company and comply with Policies, if any, in the transfer of Members to other providers.

6.6 Obligations During Dispute Resolution Proceedings.
In the event of any dispute between the Parties in which a Party has provided notice of termination under Section 6.3 and the dispute is required to be resolved or is submitted for resolution under Article 8.0 below, the termination of this Agreement shall cease and the Parties shall continue to perform under the terms of this Agreement until the final resolution of the dispute.

7.0 RELATIONSHIP OF THE PARTIES

7.1 Independent Contractor Status.
The relationship between Company and Group, as well as their respective employees and other agents, is that of independent contractors, and neither shall be considered an agent or representative of the other Party for any purpose, nor shall either hold itself out to be an agent or representative of the other for any purpose. Company and Group will each be solely liable for its own activities and those of its employees and other agents, and neither Company nor Group will be liable in any way for the activities of the other Party or the other Party's employees or other agents. Group and Participating Group Providers acknowledge that all Member care and related decisions are the responsibility of Participating Group Providers and that Policies do not dictate or control a Participating Group Providers' clinical decisions with respect to the care of Members. Group agrees to indemnify and hold harmless the Company from any and all claims, liabilities and third party causes of action arising out of the Participating Group Providers' provision of care to Members. Company

agrees to indemnify and hold harmless the Group from any and all claims, liabilities and third party causes of action arising out of the Company's administration of Plans. This provision shall survive the expiration or termination of this Agreement, regardless of the reason for termination.

7.2 Use of Name.
Group and Participating Group Providers consent to the use of Group and Participating Group Providers' names and other identifying and descriptive material in provider directories and in other materials and marketing literature of Company in all formats, including, but not limited to, electronic media.

7.3 Interference with Contractual Relations.
Group and Participating Group Providers shall not engage in activities that will cause Company to lose existing or potential Members, including but not limited to: (a) advising Company customers, Plan Sponsors or other entities currently under contract with Company to cancel, or not renew their contracts; (b) impeding or otherwise interfering with negotiations which Company is conducting for the provision of health benefits or Plans; or (c) using or disclosing to any third party membership lists acquired during the term of this Agreement for the purpose of soliciting individuals who were or are Members or otherwise to compete with Company. Nothing in this Section 7.3 is intended or shall be deemed to restrict (i) any communication between a Participating Group Provider and a Member, or a party designated by a Member, determined by Participating Group Provider to be necessary or appropriate for the diagnosis and care of the Member and otherwise in accordance with Section 5.5; or (ii) notification of participation status with other HMOs or insurers. This section shall continue to be in effect for a period of one (1) year after the expiration or termination of this Agreement.

8.0 DISPUTE RESOLUTION

8.1 Member Grievance Dispute Resolution.
Group and Participating Group Providers agree: to (a) cooperate with, participate in and abide by decisions of Company's applicable medical necessity appeal, grievance and external review procedures for Members (including, but not limited to, Medicare appeals and expedited appeals procedures); and (b) provide Company with the information necessary to resolve same.

8.2 Provider Dispute Resolution.
Company shall provide an internal mechanism under which Group may raise issues, concerns, controversies or claims regarding the obligations of the Parties under this Agreement. Group shall exhaust this internal mechanism for any contractual disputes prior to instituting any arbitration or other permitted legal proceeding. The Parties agree that any discussions and negotiations held pursuant to this Section 8.2 shall not be admitted into evidence in any court proceeding.

8.3 Arbitration.
Any controversy or claim arising out of or relating to this Agreement including breach, termination, or validity of this Agreement,, except for temporary, preliminary, or permanent injunctive relief or any other form of equitable relief, shall be settled by binding arbitration. The parties agree that the AAA Optional Rules for Emergency Measures of Protection shall not apply to the proceedings. Upon mutual consent of the parties, the arbitration will be administered by the American Arbitration Association ("AAA") in accordance with the AAA Healthcare Payor-Provider Rules, except to the extent modified by this arbitration provision. If a party believes that the arbitrator has committed an error of law or legal reasoning, the party can appeal to a court of competent jurisdiction to correct any such error of law or legal reasoning. Depositions for discovery purposes shall not be permitted. The arbitrator may award only monetary damages in accordance with this Agreement.

8.4 Arbitration Solely Between Parties; No Consolidation or Class Action.
Any arbitration or other proceeding related to a dispute arising under this Agreement shall be conducted solely between them. Neither Party shall request, nor consent to any request, that their dispute be joined or

consolidated for any purpose, including without limitation any class action or similar procedural device, with any other proceeding between such Party and any third party.

9.0 MISCELLANEOUS

9.1 Amendments.
This Agreement constitutes the entire understanding of the Parties hereto and no changes, amendments or alterations shall be effective unless signed and agreed to by duly authorized representatives of both Parties, except as expressly provided herein. Notwithstanding the foregoing, at Company's discretion, Company may amend this Agreement upon written notice, by letter, newsletter, electronic mail or other media, to comply with applicable law or regulation, or any order or directive of any governmental agency. This Agreement shall be deemed to be automatically amended to conform with all laws and regulations promulgated at any time by any state or federal regulatory agency or authority of this Agreement.

9.2 Waiver.
The waiver by either Party of a breach or violation of any provision of this Agreement shall not operate as or be construed to be a waiver of any subsequent breach of this Agreement. To be effective, all waivers must be in writing and signed by an authorized officer of the Party to be charged. Group waives any claims or cause of action for fraud in the inducement or execution related to these waivers.

9.3 Governing Law.
This Agreement shall be governed in all respects by the laws of the State where Group's primary office is located.

9.4 Liability.
Notwithstanding Section 9.3, either Party's liability, if any, for damages to the other Party for any cause whatsoever arising out of or related to this Agreement, and regardless of the form of the action, shall be limited to the damaged Party's actual damages. Neither Party shall be liable for any indirect, incidental, punitive, exemplary, special or consequential damages of any kind whatsoever sustained as a result of a breach of this Agreement or any action, inaction, alleged tortious conduct, or delay by the other Party.

9.5 Severability.
Any determination that any provision of this Agreement or any application of it is invalid, illegal or unenforceable in any respect in any instance shall not affect the validity, legality and enforceability of such provision in any other instance, or the validity, legality or enforceability of any other provision of this Agreement.

9.6 Successors; Assignment.
This Agreement relates solely to the provision of Provider Services by Group and Participating Group Providers and does not apply to any other organization which succeeds to Group assets, by merger, acquisition or otherwise, or is an affiliate of Group. Neither Party may assign its rights or delegate its duties and obligations under this Agreement without the prior written consent of the other Party, which consent may not be unreasonably withheld. Company may assign its rights or delegate its duties and obligations to an Affiliate or successor in interest.

9.7 Notices.
Except for any notice required under Article 6, Term and Termination, or if otherwise specified, notices required pursuant to the terms and provisions hereof may be effective if sent by letter, electronic mail or other generally accepted media. With respect to notices required under Article 6, notice shall be effective only if given in writing and sent by overnight delivery service with proof of receipt, or by certified mail return receipt requested. For any notices not subject to the previous sentence and sent by regular mail or email, such notices shall be sent to the following addresses (which may be changed by giving notice in conformity with this Section 9.7). Group shall notify Company in writing at least seven (7) business days prior to any changes in the address information below.

To Group contract notice address at:

Centrality Behavior Support Training LLC
3725 East Southport Road
Suite F
Indianapolis IN, 46227

To Group at contract notice email address at:

To Company at:

With respect to Behavioral Health:

Aetna Behavioral Health
1425 Union Meeting Road
PO Box 5
Blue Bell PA 19422

9.8 Non-Exclusivity.
This Agreement is not exclusive, and does not preclude either Party from contracting with any other person or entity for any purpose. Company makes no representation or guarantee as to the number of Members who may select or be assigned to Group and Participating Group Providers.

9.9 Survival.
In addition to those provisions which by their terms survive expiration or termination of this Agreement (e.g. 4.3.2 and 5.3.1), Sections 5.5, 6.5 and 7.3 shall survive expiration or termination of this Agreement, regardless of the cause giving rise to expiration or termination of this Agreement.

9.10 Entire Agreement.
This Agreement including the Product Participation Schedule, Participation Criteria Schedules, Services and Compensation Schedules, if applicable and any additional attached schedules constitutes the complete and sole contract between the Parties regarding the subject matter described above and supersedes any and all prior or contemporaneous oral or written representations, communications, proposals or agreements not expressly included in this Agreement and may not be contradicted or varied by evidence of prior, contemporaneous or subsequent oral representations, communications, proposals, agreements, prior course of dealings or discussions of the Parties.

IN WITNESS WHEREOF, the undersigned parties have executed this Agreement by their duly authorized officers, intending to be legally bound hereby.

GROUP

By: Meagan M Dant
Meagan M Dant (Jul 10, 2014)
Printed Name: Meagan M Dant

Title: Clinical Director, BCBA

Date: Jul 10, 2014

FEDERAL TAX I.D. NUMBER: 46-4197524

COMPANY

By: Antonio Rocchino
Antonio Rocchino (Oct 10, 2014)
Printed Name: Antonio Rocchino

Title: Network Market Head

Date: Oct 10, 2014

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