PARTICIPATING PROVIDER AGREEMENT

This Participating Provider Agreement (together with all Attachments and amendments, this "***Agreement***") is made and entered by and between Centrality Behavioral Support Training LLC ("***Provider***") and Coordinated Care Corporation, dba Managed Health Services ("***Health Plan***") (each a "***Party***" and collectively the "***Parties***"). This Agreement is effective as of the date designated by Health Plan on the signature page of this Agreement ("***Effective Date***").

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

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

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

ARTICLE I - DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ARTICLE II – PRODUCTS AND SERVICES

2.1. Contracted Providers. Provider shall, and shall cause each Contracted Provider, to comply with and abide by the agreements, representations, warranties, acknowledgements, certifications, terms and conditions of this

Agreement (including the provisions of Schedule A that are applicable to Provider, a Contracted Provider, or their services, and any other Attachments), and the Provider Manual, and fulfill all of the duties, responsibilities and obligations imposed on Provider and Contracted Providers under this Agreement (including each Attachment), and the Provider Manual.

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

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

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

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

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

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

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

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

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

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

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

2.8. Treatment Decisions. No Company or Payor is liable for, nor will it exercise control over, the manner or method by which a Contracted Provider provides items or services under this Agreement. Provider and Contracted Providers understand that determinations of Company or Payor that certain items or services are not Covered Services or have not been provided or billed in accordance with the requirements of this Agreement or the Provider Manual are administrative decisions only. Such decisions do not absolve the Contracted Provider of its responsibility to exercise independent judgment in treatment decisions relating to Covered Persons. Nothing in this Agreement (i) is

intended to interfere with Contracted Provider's relationship with Covered Persons, or (ii) prohibits or restricts a Contracted Provider from disclosing to any Covered Person any information that the Contracted Provider deems appropriate regarding health care quality, medical treatment decisions or alternatives.

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

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

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

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

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

2.14. Compliance with Regulatory Requirements. Provider, each Contracted Provider and Company agree to carry out their respective obligations under this Agreement and the Provider Manual in accordance with all applicable Regulatory Requirements, including, but not limited to, the requirements of the Health Insurance Portability and Accountability Act, as amended, and any regulations promulgated thereunder. If, due to Provider's

or Contracted Provider's noncompliance with applicable Regulatory Requirements or this Agreement, sanctions or penalties are imposed on Company, Company may, in its sole discretion, offset such amounts against any amounts due Provider or Contracted Providers from any Company or require Provider or the Contracted Provider to reimburse Company for such amounts.

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

ARTICLE III – CLAIMS SUBMISSION, PROCESSING, AND COMPENSATION

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

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

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

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

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

ARTICLE IV – RECORDS AND INSPECTIONS

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

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

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

ARTICLE V – INSURANCE AND INDEMNIFICATION

5.1. Insurance. During the term of this Agreement and for any applicable continuation period as set forth in Section 7.3 of this Agreement, Provider and each Contracted Provider shall maintain policies of general and professional liability insurance and other insurance necessary to insure Provider and such Contracted Provider, respectively; their respective employees; and any other person providing services hereunder on behalf of Provider or such Contracted Provider, as applicable, against any claim(s) of personal injuries or death alleged to have been caused or caused by their performance under this Agreement. Such insurance shall include, but not be limited to, any "tail" or prior acts coverage necessary to avoid any gap in coverage. Insurance shall be through a licensed carrier acceptable to Health Plan, and in a minimum amount of one million dollars ($1,000,000) per occurrence, and three million dollars ($3,000,000) in the aggregate unless a lesser amount is accepted by Health Plan or where State law mandates otherwise. Provider and each Contracted Provider will provide Health Plan with at least fifteen (15) days prior written notice of cancellation, non-renewal, lapse, or adverse material modification of such coverage. Upon Health Plan's request, Provider and each Contracted Provider will furnish Health Plan with evidence of such insurance.

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

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

ARTICLE VI – DISPUTE RESOLUTION

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

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

ARTICLE VII – TERM AND TERMINATION

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

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

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

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

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

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

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

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

Provider (including Provider, if applicable) will be compensated in accordance with this Agreement and shall accept such compensation as payment in full.

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

ARTICLE VIII - MISCELLANEOUS

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

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

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

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

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

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

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

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

8.7.2. Health Plan may amend this Agreement by giving Provider written notice (electronic or paper) of the proposed amendment. Unless Provider notifies Health Plan in writing of its objection to such amendment during the thirty (30) day period following the giving of such notice by Health Plan, Provider shall be deemed to have accepted the amendment. If Provider objects to any proposed amendment to either the base agreement or any Attachment, Health Plan may exclude one or more of the Contracted Providers from being Participating Providers in the applicable Product (or any component program of, or Coverage Agreement in connection with, such Product).

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

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

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

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

To Health Plan at:	To Provider at:
Attn: President	Attn: Dayna Shailor
Coordinated Care Corporation, dba Managed Health Services	Centrality Behavioral Support Training LLC
550 N. Meridian Street, Suite 101	27777 Inkster Rd Suite 100
Indianapolis, IN 46204	Farmington Hills, MI 48334
	Contracts@centriahealthcare.com

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

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

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

8.14. Authority. The individuals whose signatures are set forth below represent and warrant that they are duly empowered to execute this Agreement. Provider represents and warrants that it has all legal authority to contract on behalf of and to bind all Contracted Providers to the terms of the Agreement with Health Plan.

* * * * *

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

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

HEALTH PLAN:	**PROVIDER:**
Coordinated Care Corporation, dba Managed Health Services	Centrality Behavioral Support Training LLC
	(Legibly Print Name of Provider)
Authorized Signature: Jill E Claypool	Authorized Signature: Paul McDonald
Print Name: Jill E. Claypool	Print Name: Paul McDonald
Title: Vice President, Network Development and Contracting	Title: CFO
Signature Date: Sep 28, 2021	Signature Date: 6/15/2021
ECM #: 528592	Tax Identification Number: 46-4197524
To be completed by Health Plan only:	NPI Number: 1912329020
Effective Date: 7/15/2021	State Medicaid Number: 300036572
	State Medicare Number: N/A

PARTICIPATING PROVIDER AGREEMENT

SCHEDULE A
CONTRACTED PROVIDER-SPECIFIC PROVISIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PARTICIPATING PROVIDER AGREEMENT

SCHEDULE B
PRODUCT PARTICIPATION

Provider will be designated as a "Participating Provider" in the Product Attachments listed below only after: (i) the successful completion of credentialing in accordance with this Agreement; and (ii) such designation as a Participating Provider shall be effective as of the date designated by Health Plan on the signature page of this Agreement ("Effective Date").

List of Product Attachments:

Attachment A-1: Medicaid (Hoosier Healthwise and Healthy Indiana Plan)
Attachment A-2: Medicaid (Hoosier Care Connect)
Attachment B: [Reserved]
Attachment C: [Reserved]

PARTICIPATING PROVIDER AGREEMENT

SCHEDULE C
INFORMATION FOR CONTRACTED PROVIDERS

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

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

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

Attachment A-1: Medicaid

PRODUCT ATTACHMENT
INDIANA HEALTH COVERAGE PROGRAMS
(INCLUDING STATE-MANDATED PROVISIONS AND COMPENSATION SCHEDULE)

This Indiana Health Coverage Programs State Mandated Provision Attachment ("***Attachment A-1***") is incorporated into the Participating Provider Agreement (the "***Agreement***") entered into by and between Centrality Behavioral Support Training LLC ("***Provider***") and Coordinated Care Corporation, d/b/a Managed Health Services ("***Health Plan***"). This Attachment A-1 is effective on and after the Effective Date as defined in the Agreement.

I. RECITALS. This Attachment A-1 is intended to supplement the Agreement by setting forth the parties' rights and responsibilities related to the provision of Covered Services to eligible Medicaid Hoosier Healthwise ("***HHW***") and Healthy Indiana Plan ("***HIP***") (together "***Indiana Health Coverage Programs***" or "***IHCP***") recipients in the state of Indiana.

II. DEFINITIONS APPLICABLE TO THIS ATTACHMENT. The definitions listed below will supersede any meanings contained in the Agreement.

A. ***State Covered Person*** refers to a Hoosier Healthwise eligible member or a Healthy Indiana Plan member who is enrolled in State Medicaid program by the Indiana Family and Social Services Administration ("FSSA") Office of Medicaid Policy and Planning ("OMPP") or a contractor thereof, who is eligible for and has enrolled to receive Covered Services from Health Plan pursuant to the terms of the State Contract.

B. ***Covered Services*** means those benefits and services described in the State Contract that State Covered Persons are eligible to receive under their IHCP benefit plan.

C. ***Emergency Care*** means care provided by a Provider that is qualified to furnish such services under Medicaid that is needed to evaluate or stabilize a person for a medical condition that arises and manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to:

(i) place the individual's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

(ii) result in serious impairment to the individual's bodily functions; or

(iii) result in serious dysfunction of bodily organ or part of the individual.

D. ***Medically Reasonable and Necessary*** means a Covered Service that, in a manner consistent with accepted standards of medical practice, is reasonably expected to:

(i) prevent or diagnose the onset of an illness, injury, condition, primary disability or secondary disability;

(ii) cure, correct, reduce or ameliorate the physical, mental, cognitive or developmental effects of an illness, injury, or disability; or

(iii) reduce or ameliorate the pain or suffering caused by an illness, injury, condition, or disability.

E. ***Primary Medical Provider (PMP)*** means a Provider that is responsible for providing an ongoing source of primary care appropriate to the State Covered Person's needs.

F. ***State*** refers to the State of Indiana.

G. ***State Contract*** means the agreement then in effect between Health Plan and the State, as revised or replaced from time to time (including, but not limited to, the State Contract awarded to Health Plan under the State risk-based managed care program for certain Hoosier Healthwise and Healthy Indiana Plan enrollees pursuant to Request for Proposal ("RFP") 16-035, as supplemented or revised from time to time) pertaining to the provision of services by Health Plan to State Covered Persons who are beneficiaries of IHCP and who enroll to receive care through Health Plan.

III. COMPLIANCE WITH STATE HEALTH COVERAGE PROGRAM REQUIREMENTS.

A. Provider shall perform its duties under this Agreement, as those duties pertain to State Covered Persons, in accordance with the terms and conditions of the State Contract, incorporated herein by reference, including RFP 16-035 and Health Plan's response to RFP-16-035, this Agreement and all federal and State laws, regulations and policies, as amended from time to time, applicable to Covered Services provided under the Indiana Health Coverage Programs, including the Healthy Indiana Plan. In the event of a conflict between or among any of these documents involving the provision of Covered Services to State Covered Persons or any other conflict involving a matter addressed in the State Contract, the terms of the State Contract shall govern. Health Plan shall provide Provider with a copy of the State Contract and all other documents included therein upon the request of Provider.

B. Provider understands that Covered Services provided under this Agreement are funded by State and federal funds under the Indiana Health Coverage Programs. Provider is subject to all State and federal laws, rules and regulations that apply to persons or entities receiving State and federal funds. Provider understands that any violation by Provider of a State or federal law relating to the delivery of Covered Services under this Agreement, or any violation of the State Contract could result in liability of the Provider for contract money damages, and/or civil and criminal penalties and sanctions under State and federal law.

C. The Agreement between Health Plan and Provider is subject to review by the FSSA.

D. Provider is not required to exclusively contract with Health Plan.

E. This Agreement is subject to State and federal fraud and abuse statutes. Provider shall cooperate in the investigation and prosecution of any suspected fraud or abuse and shall provide any and all requested originals and copies of records and information, free of charge on request, to any State or federal agency with authority to investigate fraud and abuse in the Indiana Health Coverage Programs, as well as Health Plan's Special Investigations Unit. The Indiana Medicaid Fraud Control Unit and other State or federal agencies will be allowed to conduct private interviews of Health Plan personnel, Provider and its personnel, witnesses, contractors and patients. Requests for information are to be complied with in the form and the language requested. Health Plan employees and contractors and Provider and its employees and contractors must cooperate fully in making themselves available in person for interviews, consultation, grand jury proceedings, pre-trial conference, hearings, trial and in any other process, including investigations, at Health Plan's and Provider's own expense, respectively.

F. Provider shall comply with applicable Health Insurance Portability and Accountability Act (HIPAA), State and federal regulatory requirements relating to the confidentiality of State Covered Person's information as enacted and amended from time to time.

G. Provider shall comply with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, the Title IX of the Education Amendment of 1972, the Affordable Care Act, and all requirements imposed by the regulations implementing these acts, and all amendments to the laws and regulations. The regulations provide in part that no person in the United States shall, on the grounds of race, color, national origin, sex, age, disability,

political beliefs, sexual orientation, gender identity, or religion, be excluded from participation in, or denied, any aid, care, service or other benefits, or be subjected to any discrimination under any program or activity receiving federal funds.

H. Provider shall comply with the provisions of Executive Order 11246, as amended by 11375 and 13672, relating to Equal Employment Opportunity.

I. Provider shall maintain a current IHCP provider agreement, be duly licensed in accordance with the appropriate State licensing board, remain in good standing with the board and respond to the cultural, racial and linguistic needs of State Covered Persons. Provider acknowledges that Health Plan must terminate its contractual relationship with Provider as soon as Health Plan has knowledge that the Provider's license or IHCP provider agreement was terminated. Provider will promptly notify Health Plan of changes related to its IHCP enrollment, as well as any changes to information that appears in the Health Plan provider directory.

J. Notwithstanding anything else in the Agreement to the contrary, Provider's agreement to serve Health Plan's State Covered Persons under this Product Attachment shall terminate at the end of the Health Plan's State Contract in accordance with I.C. 12-15-30-5(b). Termination of services to Hoosier Healthwise and Healthy Indiana Plan members caused by the application of I.C. 12-15-30-5(b) will not cause the termination of agreements to provide services to persons receiving other state health coverage or commercial insurance.

K. Upon termination of the Provider's Agreement with Health Plan for any reason to provide Covered Services pursuant to Health Plan's State Contract, Provider shall submit all encounter claims for Covered Services rendered to the Health Plan's State Covered Persons while serving as the Health Plan's network provider. Instructions and technical specifications are at indianamedicaid.com under Claims and Billing Procedures Modules as amended from time to time.

L. Health Plan shall not impose restrictions upon Provider's free communication with State Covered Persons about such State Covered Person's medical conditions, treatment options, Health Plan referral policies, and other Health Plan policies, including financial incentives or arrangements and the risk-based managed care plans with whom Provider contracts. In accordance with 42 CFR 438.102(a), the Health Plan shall allow Provider to advise State Covered Person on alternative treatments that may be self-administered and provide State Covered Person with any information needed to decide among relevant treatment options. Provider is free to advise State Covered Person on the risks, benefits and consequences of treatment or non-treatment. The Health Plan shall not prohibit Provider from advising State Covered Person of their right to participate in decisions regarding their health, including the right to refuse treatment and express preferences for future treatment methods. The Health Plan shall not take punitive action against a Provider who requests an expedited resolution or supports a State Covered Person's appeal. Health Plan shall not interfere with such communication as long as Provider is acting within his/her lawful scope of practice. Health Plan shall not penalize Provider financially or in any other manner for making a disclosure permitted herein.

M. Health Plan provides a provider dispute resolution procedure. The Health Plan will promptly respond to provider complaints and appeals and document and maintain policies and procedures for registering and responding to complaints.

(i) Health Plan follows the requirements set forth in the Indiana Administrative Code ("IAC") at 405 IAC 1-1.6-1 et. seq for reimbursement dispute resolution. Further information about claims dispute process are available in the MHS Provider Manual, incorporated herein by reference.

(ii) If Provider wishes to complain to Health Plan about any aspect of Health Plan's operation, including plan administration, Provider may file a complaint orally or in writing. Health Plan will acknowledge receipt of the complaint within five (5) business days. Health Plan will investigate the complaint and provide Provider with a written response within thirty (30) days of receiving the complaint. If Provider is not satisfied with Health Plan's resolution of the complaint, Provider may appeal the decision by presenting his/her appeal in writing or before a complaint appeal panel convened by

Health Plan. Health Plan will provide Provider with written notice of its appeal decision within thirty (30) days of receiving the appeal.

N. If Provider is an entity not involved in the actual delivery of medical care, Provider will indemnify and hold harmless the State of Indiana, its officers and employees from all claims and suits, including court costs, attorney's fees and other expenses, brought because of injuries or damage received or sustained by any person, persons or property that is caused by an act or omission of the Health Plan, the Provider, or both. The State shall not provide such indemnification to the Provider.

O. Provider and Health Plan agree to be bound the terms of Indiana Code 12-15-13-6; any significant modification, addition, or deletion of the provisions of this Agreement or those contained within the provider manual will become effective no earlier than thirty (30) calendar days after Health Plan give notice to Provider of the change in writing. Notwithstanding anything to the contrary in this paragraph, modifications, additions or deletions which are required by changes in State or federal law or regulation shall be effective as necessary to comply with said legal change.

P. Provider understands and agrees that the State is not liable or responsible for payment to Provider for any Covered Services provided under this Agreement except as provided herein.

Q. In accordance with 42 CFR 438.106, the Provider acknowledges that State Covered Persons are not held liable for any of the following:

(i) Any payments for Covered Services furnished under a contract, referral or other arrangement to the extent that those payments are in excess of the amount that the State Covered Person would owe if Health Plan provided the services directly;

(ii) Covered Services provided to the member for which the State does not pay the Health Plan;

(iii) Covered Services provided to the State Covered Person for which the State or Health Plan does not pay the Provider that furnishes the services under a contractual, referral or other arrangement;

(iv) Health Plan's debts or a Health Plan subcontractor's debts, in the event of the entity's insolvency.

Provider shall not balance bill (charge for Covered Services above the amount paid to the Provider by the Health Plan) its members. Provider shall look only to the Health Plan and agree to hold State Covered Persons harmless for compensation for all Covered Services provided to State Covered Persons during the term of this Agreement. In no event shall Provider, or an agent, trustee, representative or assignee of Provider, take legal action against a State Covered Person to collect sums owed to Provider by Health Plan.

Under no circumstances, including but not limited to, nonpayment by Health Plan, Health Plan insolvency, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, or seek compensation, remuneration, or reimbursement from, or have any recourse against the State, State Covered Persons or persons (other than Health Plan) acting on the State Covered Person's behalf for State Covered Services provided pursuant to this Agreement. This provision shall not prohibit collection of applicable copayments on Health Plan's behalf made in accordance with the applicable plan document. This provision does not affect the right of Provider to collect fees for services provided to State Covered Persons which are not Covered Services where the State Covered Person properly accepted responsibility for payment of the services in accordance with the terms of the State's Provider and Member Utilization Review module published at indianamedicaid.com and the State's MCE Policies and Procedures Manual.

Provider further agrees that this section shall: (i) survive the termination of this Agreement, regardless of the reason for termination; (ii) supersede any oral or written agreement now existing or hereafter entered into between Provider and a State Covered Person or persons acting on the State Covered Person's behalf (other than Health Plan).

R. In the event of Health Plan's insolvency or cessation of operations, Provider's sole recourse shall be against Health Plan through the bankruptcy or receivership estate of Health Plan. This does not prevent Provider from seeking cost-based reimbursement, if available, from the State of Indiana in accordance with applicable federal and State law.

S. Nothing in this agreement shall be construed as interfering with a provider's ability to hold HIP members liable for emergency services copayments or payment of Covered Services with POWER Account funds before the member's deductible has been met. However, if the Health Plan permits provider to bill a member for services that require authorization, but for which authorization is denied as a non-Covered Service, POWER Account funds shall not be used to reimburse the provider for the non-Covered Service.

T. Provider shall submit all claims that do not involve a third party payer for Covered Services rendered to the State Covered Person within ninety (90) calendar days from the date of service. Health Plan shall waive the timely filing requirement in the case of claims for members with retroactive coverage, such as presumptively eligible pregnant women and newborns. Provider may not refuse to furnish Covered Services to a State Covered Person who is eligible for medical assistance under a Medicaid Product on account of a third party's potential liability for the service(s). Health Plan may recoup payments made to Provider in the event a State Covered Person has other insurance coverage. If the State Covered Person is a Healthy Indiana Plan member and the reason for the recoupment is that the member had other insurance coverage, then the Provider must submit the affected claim(s) following the billing process required by Medicare or other insurance coverage. Under Medicare rules, Provider has six (6) months from date of recoupment notification to submit such claims. Provider may not pursue reimbursement from the member under any circumstance.

U. Health Plan shall pay Provider for Covered Service that are Medically Reasonable and Necessary and that are rendered to State Covered Persons in accordance with the standards set forth in Ind.Code §§ 12-15-13-1.6 and 12-15-13-1.7, unless Health Plan and Provider agree to an alternate payment schedule and method. Health Plan shall pay or deny electronically filed clean claims within twenty one (21) calendar days of receipt, and clean paper claims within thirty (30) calendar days of receipt. If Health Plan fails to pay or deny a clean claim within these timeframes, but subsequently pays the claim, the Health Plan must also pay Provider interest as required under I.C. 12-15-13-1.7(d). As set forth in I.C. 12-15-13.0.6, a clean claim is one in which all information required for processing the claim is present. These standards also apply to out-of-network claims for which the Health Plan is responsible and any other claims submitted by Providers that have not agreed to alternate payment arrangements.

V. Provider shall not interfere with or place liens upon the State's right or Health Plan's right, with state approval, to recovery from third party resources. Provider shall not seek recovery in excess of the payable amount under the Indiana Health Coverage Programs or otherwise violate applicable State and federal laws, regulations or policies.

W. In the event FSSA imposes a financial penalty or sanction on Health Plan for default under the State Contract that was caused by any action, error, or omission by Provider and/or its agents, Provider shall be obligated to reimburse Health Plan for the full amount of the financial penalty or sanction within fifteen (15) days of receipt of written notice from Health Plan.

X. Health Plan and Provider shall participate in any internal and external quality assurance, utilization review, peer review, vendor oversight and grievance procedures established by Health Plan, in conjunction with the FSSA. Health Plan and Provider may jointly review results of auditing and monitoring processes and routine intervals in accordance with State requirements and Health Plan vendor oversight policies and procedures. Health Plan shall monitor Provider and apply corrective actions for those who are out of compliance with the State Contract's or Health Plan's requirements.

Y. Provider shall comply with the encounter, utilization, quality, and financial reporting requirements imposed by FSSA or as otherwise required under the State Contract, including the report filing times and report format

requirements. Provider shall provide for inspection of any records deemed pertinent to the State Contract by FSSA, and Provider shall maintain an adequate record system for recording services, charges, data and all other commonly accepted information elements for Covered Services rendered to State Covered Persons.

Z. State and Federal agencies may evaluate, through inspection or other means, the quality, appropriateness and timeliness of Covered Services performed.

AA. Provider shall maintain State Covered Person's medical records in a detailed and comprehensive manner that conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and facilitates an accurate system for follow-up treatment. Medical records must be legible, signed and dated, and maintained for at least seven (7) years as required by applicable State and federal regulations. Provider's medical records must document all medical services that the State Covered Person receives in accordance with 405 I.A.C 1-5-1. Provider's medical record must include, at a minimum:

(i) Prescriptions for medications

(ii) Inpatient discharge summaries

(iii) Patient histories (including immunization) and physicals

(iv) A list of substances used and/or abused, including alcohol, smoking and legal and illegal drugs

(v) A record of outpatient, inpatient and emergency care, Specialty Physician referrals, ancillary care, laboratory and x-ray tests and findings.

BB. Provider shall document in the State Covered Person's medical record whether the State Covered Person has executed an advance directive and agrees to comply with all federal and State laws regarding advance directives. Medical records of State Covered Persons shall be treated as confidential so as to comply with all federal and State laws and regulations regarding the confidentiality of the patient records.

CC. Provider shall provide a copy of the medical record upon reasonable request by the State Covered Person at no charge, and Provider shall facilitate the transfer of the medical record to another provider at the State Covered Person's request. Confidentiality of medical records must be maintained to the standards mandated in HIPAA and State requirements. Provider shall permit Health Plan and representatives of the State review the State Covered Person's medical record for the purposes of monitoring Provider's compliance with the medical record standards or capturing information for clinical studies.

From time to time, Health Plan may require Provider to produce medical records for routine oversight purposes, investigations, HEDIS submissions, or other activities required under State or federal law or the State Contract. The cost of production of records by the Provider is included in Provider's reimbursement rate. Pursuant to 43 CFR 447.15, neither the Health Plan nor the State shall pay Provider (or Provider's vendor) for the cost of production and release of these records. In the event Provider does use a vendor to supply records to Health Plan, Provider shall be responsible for 100% of its vendors charges, including (but not limited to) charges related to record creation, production, and release. Access to any records pertinent to the State Contract must be granted during the term of the State Contract and any applicable retention periods required therein.

DD. If applicable, Provider shall ensure that its Specialty Physicians send a record of consultation and recommendations to a State Covered Person's PMP for inclusion in the State Covered Person's medical record, and that the Specialty Physicians report encounters to the PMP and/or to Health Plan.

EE. If necessary for Health Plan to comply with requirements under applicable laws and/or the State Contract, Provider shall provide applicable financial information as reasonably requested by Health Plan. Health Plan shall also collect performance and financial data from Provider and conduct formal, periodic and random

reviews. Specifically, if Provider accepts financial risk to provide Covered Services and is paid an amount equal to or greater than five percent (5%) of the premium/revenue, Health Plan will request certain documents on a quarterly and annual basis to monitor the Provider's financial stability. Health Plan shall take corrective action if deficiencies are identified during any such review.

FF. The State Covered Person must receive an appropriate medical screening examination under section 1867 of the Emergency Medical Treatment and Active Labor Act.

Assuming the State Covered Person has an available and accessible alternate non-emergency services provider and a determination has been made that the individual does not have an emergency medical condition, if the Provider is a hospital, the Provider must inform the State Covered Person before providing non-emergency services that:

- Provider may require payment of the copayment before the service can be provided;
- Provider provides the name and location of an alternate non-emergency services provider that is actually available and accessible;
- An alternative provider can provide the services without the imposition of the copayment; and
- Provider provides a referral to coordinate scheduling of this treatment.

GG. Providers must be available to see State Covered Persons during hours of operation that are no less than those offered to patients with commercial coverage. If Provider is a PMP, the Provider must provide or arrange for coverage of services 24-hours-a day, seven-days-a-week and must have a mechanism in place to offer State Covered Persons direct contact with them, or the PMP's qualified clinical staff person, through a toll-free telephone number 24-hours-a-day, seven-days-a week in English and Spanish. The Health Plan must ensure that the PMP provide "live voice" coverage after normal business hours, such as an answering service or a shared-call system with other medical providers.

HH. When applicable, Provider will allow member to choose their treating health professional to the extent possible and appropriate.

II. In the event the Provider is required to submit a Notice of Pregnancy (NOP) form, such submission shall be made in accordance with IHCP policy as amended from time to time.

JJ. To the extent applicable, Provider or another Participating Health Care Provider, through whom Provider has made arrangements, shall be the admitting or attending physician for inpatient hospital care, except for emergency medical or behavioral health conditions or when the admission is made by a Specialty Physician to whom the State Covered Person has been referred by the Provider. Provider shall assess the advisability and availability of outpatient treatment alternatives to inpatient admissions. Provider shall provide or arrange for pre-admission planning for non-emergency inpatient admissions to a network facility and discharge planning for State Covered Persons. Provider must call the emergency room with relevant information about the State Covered Persons, and Provider must provide or arrange for follow-up care after emergency or inpatient care.

KK. Provider shall make necessary arrangements with home and community support services to integrate the State Covered Person's needs. This integration may be delivered by coordinating the care of State Covered Persons with other programs, public health agencies and community resources which provide medical, nutritional, behavioral, educational, and outreach services available to State Covered Persons.

LL. Provider shall utilize the IHCP Prior Authorization Request Form available on the Indiana Medicaid website for submission of prior authorization requests to the Health Plan.

MM. If applicable, Provider shall provide primary care services and continuity of care to State Covered Persons who are enrolled with or assigned to the Provider. Primary care services are all services required by a State Covered Person for the prevention, detection, treatment and cure of illness, trauma, disease or disorder, which

are covered and or required services under the State Contract. All Covered Services must be provided in compliance with generally accepted medical and behavioral health standards for the community in which Covered Services are rendered. Provider shall provide children under the age of 21 Covered Services in accordance with the American Academy of Pediatric recommendations.

NN. If Provider is a PMP, Provider may contract as a PMP with one or multiple Health Plans. Provider may also participate as a Specialty Physician in another Hoosier Healthwise MCO.

OO. State Covered Persons are encouraged to establish and maintain a relationship with their Health Plan and with their PMP. The Health Plan may take State Covered Person's request for PMP changes. If Provider is a PMP, Provider shall, in good faith, establish and maintain a relationship with State Covered Person.

PP. If Provider is a PMP, PMP may terminate its agreement with Health Plan without cause upon at least ninety (90) days advance written notice. If a PMP disenrolls from the Hoosier Healthwise program or Healthy Indiana Program, but remains an IHCP provider, the PMP must provide continuous care for State Covered Persons for a minimum of sixty (60) calendar days or until the State Covered Person's link to another PMP becomes effective.

QQ. If Provider is a behavioral health Provider, the Provider will document and share the following information for each State Covered Person receiving behavioral health treatment to the State Covered Person's PMP and the Health Plan:

(i) A written summary of each member's treatment session

(ii) Primary and secondary diagnoses

(iii) Findings from assessments

(iv) Medication prescribed

(v) Psychotherapy prescribed

(vi) Any other relevant information

If the State Covered Person's visit is an initial visit, Provider will submit the information listed above to Health Plan within five (5) days of such visit. In addition, Provider shall notify Health Plan of any significant changes in the State Covered Person's mental health status or level of care. While disclosure of mental health records by the behavioral health Provider to the Health Plan and PMP is permissible under HIPAA and state law (IC 16-39-2-6(a)) without consent of the State Covered Person because it is for treatment; for substance abuse medical records, consent from the State Covered Person is required. All Providers, including behavioral health Providers, shall ask and encourage State Covered Persons to sign a consent that permits release of substance abuse treatment information to the Health Plan and to the PMP or behavioral health Provider, if applicable. In addition, behavioral health Providers are strongly encouraged to share the same clinical information directly with the State Covered Person's PMP.

RR. If Provider is a behavioral health care Provider, Provider must ensure that State Covered Persons receiving inpatient psychiatric services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge. This treatment must be provided within seven (7) business days from the date of the State Covered Person's discharge. If a State Covered Person misses an outpatient follow-up or continuing treatment, the behavioral health care Provider must contact that State Covered Person within three (3) business days of the missed appointment.

SS. If Provider is a behavioral health care Provider, Provider shall complete Health Plan sponsored training about cultural diversity of Health Plan member populations, or equivalent training, within twelve (12) months of entering into this agreement.

TT. If Provider is serving the HIP population, Provider shall comply with all state-required terms pertaining to POWER account use and reimbursement policy. Provider will, if economically prudent, use an EBT-style card reader to facilitate POWER account processes. Provider shall use best commercial efforts to collect required copayments for services rendered to HIP Basic and HIP Basic State Plan members. If Provider is serving Hoosier Healthwise members, Provider shall use best commercial efforts to collect required copayments for services rendered to Package C members.

IV. CMS REGULATORY REQUIREMENTS.

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

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

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

(iii) LTSS providers shall be aware of, respect, and adhere to a member's preferences for the delivery of services and supports.

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

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

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Attachment A-1: Medicaid

EXHIBIT 1
COMPENSATION SCHEDULE
HOOSIER HEALTHWISE
MEDICAL GROUP SERVICES
BEHAVIORAL HEALTH

Centrality Behavioral Support Training LLC

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

Professional Services. The maximum compensation for practitioner Covered Services rendered to a Covered Person shall be the "Allowed Amount." Except as otherwise provided in this Compensation schedule, the Allowed Amount for practitioner Covered Services is the lesser of: (i) Allowable Charges or (ii) the applicable "Contracted Rate" set forth below in Table 1.

Table 1

Contracted Rate					
Fee Schedule	**Practitioner**				
	MD	**HSPP**	**PhD** (HP or AH)	**Masters** (HO or AJ)	**ANP, ARNP** (SA)
Indiana Health Coverage Programs Fee Schedule	100%	100%	75%	75%	75%

Additional Provisions:

1. Reimbursement Methodology. Covered Services paid in accordance with the Medicare fee schedule and reimbursement methodology. Provider will receive reimbursement in accordance with the percentage allowed for their specialty by Medicare. Services for which the Medicare payment is inclusive of the mid-level practitioner will be treated as inclusive payments by Payor. Payor will recognize Master's level clinicians not traditionally recognized by Medicare, including Licensed Professional Counselors and Licensed Marriage and Family Therapists, in accordance with the Medicare pricing for Clinical Social Workers. Medicare rates will be adjusted for the Indiana Geographic Practice Cost Index (GPCI). Payment for inpatient and outpatient services are subject to the HIP Reimbursement Procedures manual published by the Office of Medicaid Policy and Planning, as amended from time to time.

2. Claim Form - Professional. Contracted Provider when submitting outpatient or professional claims (billed on a CMS-1500 claim form, or its successor) spanning multiple dates of service is: (i) required to identify each date of service; and (ii) must contain modifiers as identified in the Indiana Medicaid Handbooks. Applicable modifiers should be placed in the first modifier field for claims payment. Professional services for mid-level practitioners must be billed under the supervision of a Health Service Provider in Psychology (HSPP) or a Psychiatrist. The supervisor must be registered with the State as a supervisor with the facility. A Nurse Practitioner that has been registered with the Indiana Health Coverage Programs and granted billing privileges may submit a claim without

utilizing a supervisor. Services billed for a nurse practitioner should be billed with modifier SA in the first position and modifier HE in the second position.

3. Modifiers. Services requiring a modifier that designates the health care professional providing the service shall have the appropriate modifier billed to receive proper reimbursement. Modifiers include, but are not limited to, the following:

   AF (Specialty Physician),
   AH (Clinical Psychologist),
   AJ (Clinical Social Worker),
   HE (Mental Health Program),
   HO (Master's Degree Level),
   HP (Doctoral Level) and
   SA (Nurse Practitioner rendering service in collaboration with Physician).

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

5. Claim Form – HCPCS Codes. Covered Services provided by professionals must be submitted in an approved electronic format or on a CMS-1500 form, or its successor claim form, using the appropriate HCPCS codes to receive reimbursement.

6. Payment for Professional Services. The Provider or supervisor's NPI, Tax Identification Number and billing address provided on a claim must match the State file or the claim will be rejected by Payor.

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

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

9. Reimbursement Credentials. Reimbursement made to Provider shall be based on licensure, not academic credentials. Reimbursement may be subject to service location and/or licensure limitations set forth by State in the Covered Person's benefit plan.

10. National Correct Coding Initiative (NCCI). All claims submissions should be compliant with the NCCI as it is updated and modified from time to time.

11. Payment under this Compensation Schedule. All payments under this Compensation Schedule are subject to the terms and conditions set forth in the Agreement, the Provider Manual and the billing manual.

Definitions:

1. **Allowed Amount** means the amount designated in this Compensation Schedule as the maximum amount payable to a Contracted Provider for any particular Covered Service provided to any particular Covered Person, pursuant to this Agreement or its Attachments.

2. **Allowable Charges** mean those professional charges that qualify as Covered Services and are eligible for reimbursement under the Plan, less any applicable coinsurance and copayments.

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

Attachment A-1: Medicaid

EXHIBIT 1
COMPENSATION SCHEDULE
HEALTHY INDIANA PLAN
PROFESSIONAL SERVICES
BEHAVIORAL HEALTH

Centrality Behavioral Support Training LLC

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

Professional Services. The maximum compensation for practitioner Covered Services rendered to a Covered Person shall be the "Allowed Amount." Except as otherwise provided in this Compensation schedule, the Allowed Amount for practitioner Covered Services is the lesser of: (i) Allowable Charges or (ii) the applicable "Contracted Rate" set forth below in Table 1.

Table 1

Contracted Rate					
Fee Schedule	**Practitioner**				
	MD	**HSPP**	**PhD** (HP or AH)	**Masters** (HO or AJ)	**ANP, ARNP** (SA)
Medicare Fee Schedule[1]	100%	100%	100%	75%	85 %
[1]*For Covered Services for which there is a corresponding Medicare rate.*					
Indiana Health Coverage Programs Fee Schedule[2]	130%	130%	97.5%	97.5%	97.5%
[2]*For Covered Services for which there is not a corresponding Medicare rate.*					

Additional Provisions:

1. Reimbursement Methodology. Covered Services paid in accordance with the Medicare fee schedule and reimbursement methodology. Provider will receive reimbursement in accordance with the percentage allowed for their specialty by Medicare. Services for which the Medicare payment is inclusive of the mid-level practitioner will be treated as inclusive payments by Payor. Payor will recognize Master's level clinicians not traditionally recognized by Medicare, including Licensed Professional Counselors and Licensed Marriage and Family Therapists, in accordance with the Medicare pricing for Clinical Social Workers. Medicare rates will be adjusted for the Indiana Geographic Practice Cost Index (GPCI). Payment for inpatient and outpatient services are subject to the HIP Reimbursement Procedures manual published by the Office of Medicaid Policy and Planning, as amended from time to time.

2. Claim Form - Professional. Contracted Provider when submitting outpatient or professional claims (billed on a CMS-1500 claim form, or its successor) spanning multiple dates of service is: (i) required to identify each date of service; and (ii) must contain modifiers as identified in the Indiana Medicaid Handbooks. Applicable modifiers

should be placed in the first modifier field for claims payment. Professional services for mid-level practitioners must be billed under the supervision of a Health Service Provider in Psychology (HSPP) or a Psychiatrist. The supervisor must be registered with the State as a supervisor with the facility. A Nurse Practitioner that has been registered with the Indiana Health Coverage Programs and granted billing privileges may submit a claim without utilizing a supervisor. Services billed for a nurse practitioner should be billed with modifier SA in the first position and modifier HE in the second position.

3. Modifiers. Services requiring a modifier that designates the health care professional providing the service shall have the appropriate modifier billed to receive proper reimbursement. Modifiers include, but are not limited to, the following:

   AF (Specialty Physician),
   AH (Clinical Psychologist),
   AJ (Clinical Social Worker),
   HE (Mental Health Program),
   HO (Master's Degree Level),
   HP (Doctoral Level) and
   SA (Nurse Practitioner rendering service in collaboration with Physician).

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

5. Claim Form – HCPCS Codes. Covered Services provided by professionals must be submitted in an approved electronic format or on a CMS-1500 form, or its successor claim form, using the appropriate HCPCS codes to receive reimbursement.

6. Payment for Professional Services. The Provider or supervisor's NPI, Tax Identification Number and billing address provided on a claim must match the State file or the claim will be rejected by Payor.

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

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

9. Reimbursement Credentials. Reimbursement made to Provider shall be based on licensure, not academic credentials. Reimbursement may be subject to service location and/or licensure limitations set forth by State in the Covered Person's benefit plan.

10. National Correct Coding Initiative (NCCI). All claims submissions should be compliant with the NCCI as it is updated and modified from time to time.

11. Payment under this Compensation Schedule. All payments under this Compensation Schedule are subject to the terms and conditions set forth in the Agreement, the Provider Manual and the billing manual.

Definitions:

1. **Allowed Amount** means the amount designated in this Compensation Schedule as the maximum amount payable to a Contracted Provider for any particular Covered Service provided to any particular Covered Person, pursuant to this Agreement or its Attachments.

2. **Allowable Charges** mean those professional charges that qualify as Covered Services and are eligible for reimbursement under the Plan, less any applicable coinsurance and copayments.

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

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

Attachment A-2: Medicaid

MEDICAID PRODUCT ATTACHMENT

This MEDICAID PRODUCT ATTACHMENT ("***Attachment***") is made and entered between Coordinated Care Corporation, dba Managed Health Services ("***Health Plan***") and Centrality Behavioral Support Training LLC ("***Provider***").

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

WHEREAS, pursuant to the provisions of the Agreement, the Contracted Providers identified herein will be designated and participate as "***Participating Providers***" in the Medicaid Product;

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

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

1. Definitions. For purposes of the Medicaid Product (as herein defined), the following terms have the meanings set forth below. All capitalized terms not specifically defined in this Attachment, including on Schedule A, will have the meanings given to such terms in the Agreement, or, if not defined herein, the meanings given to such terms in the State Contract (as defined below).

1.1 "***Medicaid Product***" refers to those programs and health benefit arrangements offered by Health Plan or Company pursuant to contract(s) with one or more state agency(ies), or any successors thereto, to provide specified services and goods (including healthcare and pharmacy services) to covered beneficiaries under state funded program(s) in connection with the Indiana Medicaid Hoosier Care Connect Programs ("***IHCP***"), and to meet certain performance standards while doing so, including the agreement awarded to Health Plan under the State risk-based managed care program for certain Hoosier enrollees pursuant to Request-For-Proposal ("***RFP***") 20-041 and all attachments, addendums and other documents incorporated therein, as supplemented or revised from time to time, (each a "***State Contract***"). The Medicaid Product does not apply to any Coverage Agreements that are specifically covered by another Product Attachment to the Agreement.

2. Medicaid Product.

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

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

2.3 Attachment. This Attachment constitutes the Product Attachment and Compensation Schedule for the Medicaid Product.

2.4 Construction. This Product Attachment supplements and forms a part of the Agreement. Except as otherwise provided herein or in the terms of the Agreement, the terms and conditions of the Agreement will remain unchanged and in full force and effect as a result of this Product Attachment. In the event of a conflict between the provisions of the Agreement and the provisions of this Product Attachment, this Product Attachment will govern with respect to health care services, supplies or accommodations (including Covered Services) rendered to Covered Persons enrolled in or covered by a Medicaid Product. To the extent Provider or any Contracted Provider is unclear about its, his or her respective duties and obligations, Provider or the applicable Contracted Provider will request clarification from Health Plan. To the extent any provision of the Agreement (including any exhibit, attachment, or other document referenced herein) is inconsistent with or contrary to any provision of the State Contract, the relevant provision of the State Contract will have priority and control over the matter.

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

4. State Mandated Program and Regulatory Requirements. Schedule A to this Product Attachment, which is incorporated herein by this reference, sets forth the provisions that are required by the State Contract to be included in the Agreement with respect to the Medicaid Product. Schedule B to this Product Attachment, which is incorporated herein by this reference, sets forth the provisions that are required by State law to be included in the Agreement. To the extent that a Coverage Agreement is subject to the law cited in the parenthetical at the end of a provision on Schedule B, such provision will apply to the rendering of Covered Services to a Covered Person with such Coverage Agreement. Any additional requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product may be set forth in the Provider Manual or another Attachment and are incorporated herein by this reference.

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

Attachment A-2: Medicaid

SCHEDULE A
GOVERNMENTAL PROGRAM REQUIREMENTS

This Schedule sets forth the special provisions that are specific to the Indiana Hoosier Care Connect Medicaid Product under the State Contract.

1. Definitions. For purposes of the Medicaid Product, the following terms have the meanings set forth below.

1.1 ***Covered Person*** means a Hoosier Care Connect eligible member or a Healthy Indiana Plan member who is listed by the Indiana Family and Social Services Administration, who is eligible and has enrolled to receive Covered Services from Company pursuant to the terms of the State Contract.

1.2 ***Emergency Care*** means care needed to evaluate or stabilize a person for a medical condition that arises and manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to: (i) place the individual's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) result in serious impairment to the individual's bodily functions; or (iii) result in serious dysfunction of bodily organ or part of the individual.

1.3 ***Medically Necessary*** means a Covered Service that, in a manner consistent with accepted standards of medical practice, is reasonably expected to: (i) prevent or diagnose the onset of an illness, injury, condition, primary disability or secondary disability; (ii) cure, correct, reduce or ameliorate the physical, mental, cognitive or developmental effects of an illness, injury, or disability; or (iii) reduce or ameliorate the pain or suffering caused by an illness, injury, condition, or disability. (Attachment I of 20-041, § 3.0)

1.4 ***Primary Medical Provider*** or ***PMP*** means the single provider to which a Covered Person is assigned or that a Covered Person selects that is responsible for coordinating care and, in a PMP model, making referrals to specialists. At a minimum, providers allowed to serve as a PMP include physicians, physician assistants and advanced practice registered nurses.

1.5 ***State*** means the State of Indiana.

1.6 ***State Agency*** or ***FSSA*** means the Indiana Family and Social Services Administration or other State agency(ies) which administers the State Medicaid risk-based managed care program, as implemented from time to time.

2. State Contract Compliance. Provider and each Participating Provider will perform his, her or its duties under the Agreement in accordance, and otherwise comply with, with the applicable terms and conditions of the State Contract, which are incorporated herein by reference. Provider and each Participating Provider agree that the applicable terms and conditions set out in the State Contract and all applicable federal and state laws, regulations and policies, as amended, govern the duties and responsibilities of Provider and Participating Providers with regard to the provision of services to Covered Persons. Provider or Participating Providers will furnish Covered Services in an amount, duration or scope reasonably expected to achieve the purpose for which the services are furnished, and will not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of diagnosis, type of illness, or condition of the Covered Person. (Attachment I of RFP 20-041, §§ 2.3, 3.0, 6.5)

3. Responsibility for Covered Services. Provider understands and agrees that Company or Payor has the sole responsibility for payment of Covered Services rendered by Provider under the Agreement. In the event of Company's insolvency or cessation of operations, Provider's sole recourse will be against Company through the bankruptcy or receivership estate of Company. This does not prevent Provider from seeking cost-based reimbursement, if available, from the State in accordance with applicable federal and State law.

4. Copayments. Provider understands and agrees that neither the State nor the Covered Person is liable or responsible for payment to Provider for any Covered Services provided under the Agreement except as provided herein. Provider and Participating Providers will use best commercial efforts to collect required copayments for services rendered to Covered Persons. (Attachment I of RFP 20-041, § 6.5)

5. Covered Person Payment Liability. In accordance with 42 CFR 438.106, Provider and Participating Providers agree that Covered Persons will not held liable for any of the following: (a) any payments for Covered Services furnished under a contract, referral or other arrangement to the extent that those payments are in excess of the amount that the Covered Person would owe if Company provided the services directly; (b) Covered Services provided to the Covered Person for which FSSA does not pay the Company; (c) Covered Services provided to the Covered Person for which FSSA, Company or Payor does not pay the provider that furnishes the services under a contractual, referral or other arrangement; and (d) Company's debts or a Company subcontractor's debts, in the event of the entity's insolvency. Provider and Participating Providers are prohibited from balance billing Covered Persons. Balance billing is defined as charging the Covered Person for Covered Services above the amount paid to Provider or a Participating Provider by the Company. Provider and Participating Providers will look only to the Company or Payor and agree to hold Covered Persons harmless for compensation for all Covered Services provided to Covered Persons during the term of the Agreement. Under no circumstances, including but not limited to, nonpayment by Company or Payor, Company or Payor insolvency, or breach of the Agreement, will Provider or a Participating Provider bill, charge, collect a deposit from, or seek compensation, remuneration, or reimbursement from, or have any recourse against the State, Covered Persons or persons (other than Company) acting on the Covered Person's behalf for State Covered Services provided pursuant to the Agreement. This provision will not prohibit collection of applicable copayments on Company's behalf made in accordance with the applicable plan document, nor does this provision affect the right of Provider or Participating Providers to collect fees for services provided to Covered Persons which do not constitute Covered Services (unless payment is denied on the basis that the service is not Medically Necessary or Provider's or a Participating Provider's failure to comply with the terms and conditions of the Agreement), or for which Covered Person has specifically otherwise assumed financial responsibility, in writing, prior to the time that services were rendered. Provider or each Participating Provider must maintain documentation that the Covered Person voluntarily chose to receive the service, knowing that the ICHP did not cover the service. Provider and Participating Providers further agree that this Section will: (i) survive the termination of the Agreement, regardless of the reason for termination; (ii) supersede any oral or written agreement now existing or hereafter entered into between Provider or a Participating Provider and a Covered Person or persons acting on the Covered Person's behalf (other than Company). In no event will Provider or a Participating Provider, or an agent, trustee, representative or assignee thereof, take legal action against a Covered Person to collect sums owed to Provider or the Participating Provider by Company. (Attachment I of RFP 20-041, § 6.11)

6. Federal Requirements.

6.1 Federal Laws. Provider and each Participating Provider will comply with the following: (a) Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which Company receives Federal financial assistance under the State Contract; (b) Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified handicapped individual in the United States shall, solely by reason of his/her handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which Company receives Federal financial assistance under the State Contract; (c) the Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which Company receives Federal financial assistance under the State Contract; (d) the Americans with

Disabilities Act of 1990 (Pub. L. 101-336), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Justice (28 C.F.R. 35.101 et seq.), to the end that in accordance with the Act and Regulation, no person in the United States with a disability shall, on the basis of the disability, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any program or activity for which Company receives Federal financial assistance under the State Contract; (e) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§ 1681, 1683, and 1685-1686), and all requirements imposed by or pursuant to regulation, to the end that, in accordance with the Amendments, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any program or activity for which Company receives Federal financial assistance under the State Contract. Provider and Participating Provider understand that Covered Services provided under the Agreement are funded by State and federal funds under the Indiana Health Coverage Programs. Provider and Participating Provider are therefore subject to all State and federal laws, rules and regulations that apply to persons or entities receiving State and federal funds. Provider and Participating Provider understand that any violation by Provider of a State or federal law relating to the delivery of Covered Services under the Agreement, or any violation of the State Contract could result in liability of the Provider for contract money damages, and/or civil and criminal penalties and sanctions under State and federal law. (Attachment B of RFP 20-041, § 51.B)

6.2 Ownership and Control Reporting Requirements. Provider and each Participating Provider agree to provide the disclosures required under the State Contract, including those pursuant to 42 CFR §§ 455.100 – 455.106, and including at all of the following times: (a) upon submission of the provider application, (b) upon executing the Agreement, (c) upon request of the Medicaid agency during the re-validation of enrollment process under § 455.414, and (d) within 35 days after any change in ownership. Provider and each Participating Provider will further provide any additional information necessary for the FSSA to perform exclusion status check pursuant to 42 CFR 455.436. (Attachment B of RFP 20-041; §51.G; Attachment I of RFP 20-041, § 7.4)

7. Fraud and Abuse. The Agreement is subject to State and federal fraud and abuse statutes. Provider and each Participating Provider will cooperate in the investigation and prosecution of any suspected fraud or abuse and will provide any and all requested originals and copies of records and information, free of charge on request, to any State or federal agency with authority to investigate fraud and abuse in the Indiana Health Coverage Programs.

8. MFCU. The Indiana Medicaid Fraud Control Unit and other State or federal agencies will be allowed to conduct private interviews of Provider and Participating Providers and their personnel, witnesses, contractors and patients. Requests for information are to be complied with in the form and the language requested. Provider, Participating Providers and their employees and contractors must cooperate fully in making themselves available in person for interviews, consultation, grand jury proceedings, pre-trial conference, hearings, trial and in any other process, including investigations, at Provider's or a Participating Provider's own expense.

9. Nondiscrimination. Pursuant to the Indiana Civil Rights Law, specifically Ind. Code § 22-9-1-10, and in keeping with the purposes of the federal Civil Rights Act of 1964, the Age Discrimination in Employment Act, and the Americans with Disabilities Act, Provider covenants that neither it nor a Participating Provider will discriminate against any employee or applicant for employment relating to the State Contract with respect to the hire, tenure, terms, conditions or privileges of employment or any matter directly or indirectly related to employment, because of the employee's or applicant's race, color, national origin, religion, sex, age, disability, ancestry, status as a veteran, or any other characteristic protected by federal, state, or local law ("Protected Characteristics"). Provider and each Participating Provider certify compliance with applicable federal laws, regulations, and executive orders prohibiting discrimination based on the Protected Characteristics in the provision of services. Breach of this paragraph may be regarded as a material breach of the Agreement, but nothing in this paragraph shall be construed to imply or establish an employment relationship between the State and any applicant or employee of Provider or any subcontractor (including a Participating Provider). The State is a recipient of federal funds, and therefore, where applicable, the Provider and any subcontractors (including a Participating Provider) will comply with requisite affirmative action requirements, including reporting, pursuant to 41 CFR Chapter 60, as amended, and Section 202 of Executive Order 11246 as amended by Executive Order 13672. (Attachment B of RFP 20-041, § 33)

10. Amendments. Provider agrees that any significant modification, addition, or deletion of the provisions of this Medicaid Product Attachment will become effective no earlier than thirty (30) calendar days after Company notifies Provider of the change in writing. Notwithstanding the foregoing, any modifications, additions or deletions which are required by changes in State or federal law, regulation or other guidance shall be effective as necessary to comply with said legal change.

11. Sources of Payment. Provider shall not interfere with or place liens upon the State's right or Company's right, with state approval, to recovery from third party resources. Provider and a Participating Provider may not seek payment from the State for any service rendered to a Hoosier Care Connect member under the Agreement, may not seek recovery in excess of the payable amount under the Indiana Health Coverage Programs or otherwise violate applicable State and federal laws, regulations or policies. (Attachment I of RFP 20-041, § 6.5)

12. Disputes. Provider and Participating Providers will comply with the written provider claim dispute resolution process described in the Agreement and Provider Manual, which comply, to the extent required under the State Contract, with the requirements set forth in the Indiana Administrative Code ("IAC") at 405 IAC 1-1.6-1. If Provider wishes to complain to Company about any aspect of Company's operation, including plan administration, Provider may file a complaint orally or in writing. If Provider is not satisfied with Company's resolution of the complaint, Provider may appeal the decision by presenting his/her appeal in writing or before a complaint appeal panel convened by Company. (Attachment I of RFP 20-041, §§ 6.5, 8.5.1)

13. Primary Care; EPSDT. If a Participating Provider provides primary care services, the Participating Provider will provide primary care services and continuity of care to Covered Persons who are enrolled with or assigned to the Participating Provider. Primary care services are all services required by a Covered Person for the prevention, detection, treatment and cure of illness, trauma, disease or disorder, which are covered and or required services under the State Contract. A Participating Provider will provide all Covered Services in compliance with generally accepted medical and behavioral health standards for the community in which Covered Services are rendered. Participating Provider will provide children under the age of 21 Covered Services in accordance with the American Academy of Pediatric recommendations. A Participating Provider will ensure that all Covered Persons receive all Early and Periodic Screening, Diagnosis and Treatment services in accordance with the timeframes and other requirements under the State Contract. (Attachment I of RFP 20-041, § 3.2)

14. Home and Community-Based Services. Provider shall make necessary arrangements with home and community support services to integrate the Covered Person's needs. This integration may be delivered by coordinating the care of Covered Persons with other programs, public health agencies and community resources which provide medical, nutritional, behavioral, educational, and outreach services available to Covered Persons. If a Participating Provider is a PMP, the Participating Provider shall establish and maintain a relationship with Covered Person.

15. Inpatient Admissions. To the extent applicable, a Participating Provider or another Participating Provider with whom the Participating Provider has made arrangements will be the admitting or attending physician for inpatient hospital care, except for emergency medical or behavioral health conditions or when the admission is made by a specialist to whom the Covered Person has been referred by the Participating Provider. A Participating Provider will assess the advisability and availability of outpatient treatment alternatives to inpatient admissions. A Participating Provider will provide or arrange for pre-admission planning for non-emergency inpatient admissions to a network facility and discharge planning for Covered Persons. A Participating Provider must call the emergency room with relevant information about the Covered Persons, and the Participating Provider must provide or arrange for follow-up care after emergency or inpatient care.

16. Notification of Pregnancy. If a Participating Provider completes a Notice of Pregnancy ("NOP") form per FSSA's process, the Participating Provider will complete the standard NOP form, including Covered Person demographics, any high-risk pregnancy indicators and basic pregnancy information and, within five (5) calendar days of the visit during which the NOP form was completed, submit it via the IHCP Provider Healthcare Portal. (Attachment I of RFP 20-041, § 5.1.3)

17. No Exclusivity. Nothing in the Agreement or otherwise obligates a Participating Provider to participate under exclusivity agreements that prohibit a Participating Provider from contracting with other state contractors. (Attachment I of RFP 20-041, § 6.5)

18. Hours of Operation. A Participating Provider must offer hours of operation to Covered Persons that are no less than those offered to patients with commercial coverage, if the Participating Provider also serves patients with commercial coverage. Participating Providers will cooperate with Company to ensure that Covered Services are available 24-hours-a day, seven-days-a-week, when medically necessary.

19. Primary Medical Providers. If a Participating Provider is a PMP, this Section applies. The Participating Provider must provide or arrange for coverage of services 24-hours-a day, seven-days-a-week and must have a mechanism in place to offer Covered Persons direct contact with PMP, or the PMP's qualified clinical staff person, through a toll-free telephone number 24-hours-a-day, seven-days-a week. Participating Provider will be available to see Covered Persons at least three days per week for a minimum of 20 hours per week at any combination of no more than two locations. The Participating Provider must provide "live voice" coverage after normal business hours, such as an answering service or a shared-call system with other medical providers. The Participating Provider will ensure that Covered Persons have telephone access to him or her (or appropriate designee such as a covering physician) in English and Spanish 24-hours-a-day, seven-days-a-week. The Participating Provider Providers may hold a maximum panel of 2,500 Covered Persons, unless a larger panel limitation is mutually agreed upon by both Parties. (Attachment I of RFP 20-041, § 6.2)

20. Records. Provider and each Participating Provider shall comply with the encounter, utilization, quality, and financial reporting requirements imposed by FSSA or as otherwise required under the State Contract, including the report filing times and report format requirements. Provider and Participating Providers will allow inspection of any records deemed pertinent to the State Contract by FSSA, and will maintain an adequate record system for recording services, charges, data and all other commonly accepted information elements for Covered Services rendered to Covered Persons. Provider and Participating Providers will maintain all books, documents, papers, accounting records, and other evidence pertaining to all costs incurred under the State Contract, and make such materials available at Provider's or the Participating Provider's offices at all reasonable times during the term of the State Contract and for three (3) years from the date of final payment under the State Contract, for inspection by the State and the federal government or their authorized designees, representatives and agents. Provider will furnish copies of such materials at no cost to the State if requested. Copies of accounting records pertaining to the State Contract will be made available within ten days of a request. Provider and Participating Providers agree that FSSA, the Indiana Department of Insurance and other state and federal agencies and their respective authorized representatives or agents will have access to all accounting and financial records of any individual, partnership, firm or corporation insofar as they relate to transactions with any department, board, commission, institution or other state or federal agency connected with the State Contract. Provider and Participating Providers agree that the State and Federal agencies may evaluate, through inspection or other means, the quality, appropriateness and timeliness of Covered Services performed. (Attachment B of RFP 20-041, § 4; Attachment I of RFP 20-041, § 2.4)

21. Penalties. In the event FSSA imposes a financial penalty or sanction on Company for default under the State Contract that was caused by any action, error, or omission by Provider and/or its agents, Provider will be obligated to reimburse Company for the full amount of the financial penalty or sanction within fifteen (15) days of receipt of written notice from Company.

22. Specialists. If applicable, Provider will ensure that its Participating Providers who are specialists send a record of consultation and recommendations to a Covered Person's PMP for inclusion in the Covered Person's medical record, and that such Participating Providers report encounters to the PMP and to Company or Payor.

23. Compliance; Corrective Actions. Provider and Participating Providers will participate in any internal and external quality assurance, utilization review, peer review, grievance or other procedures established by Company in conjunction with FSSA. Provider and Participating Providers will cooperate with any corrective actions applied by Company as a result of its monitoring for those who are out of compliance with FSSA's or Company's requirements. (Attachment I of RFP 20-041, § 6.5)

24. State Indemnification. Provider and each Participating Provider will indemnify and hold harmless the State, its officers and employees from and against all claims, causes of action, damages, expenses, judgments and costs, including court costs, attorneys' fees and other expenses ("Losses"), directly or indirectly arising out of or in any way connected with any liability asserted by a third party related to injuries or damage received or sustained by any person, persons or property that is caused by an act or omission of the Provider, such Participating Provider and/or their respective subcontractors. The State does not provide such indemnification to Provider or Participating Provider. (Attachment I of RFP 20-041, § 2.3)

25. PMP Disenrollment. If a Participating Provider is a PMP and disenrolls from the Hoosier Care Connect program, but remains an IHCP provider, the Participating Provider must provide continuous care for Covered Persons for a minimum of sixty (60) calendar days or until the Covered Person's link to another PMP becomes effective.

26. Subcontractor Financial Stability. If necessary for Company or a Payor to comply with requirements under applicable laws and/or the State Contract, Provider or the Participating Provider will provide applicable financial information as reasonably requested by Company. Company may also collect performance and financial data from Provider and conduct formal, periodic and random reviews. Specifically, if Provider or a Participating Provider is paid an amount equal to or greater than five percent (5%) of the premium/revenue, Provider will provide to Company certain documents on a quarterly and annual basis to monitor Provider's or the Participating Provider's financial stability, including without limitation a statement of revenues and expenses, a balance sheet, cash flows and changes in equity/fund balance and incurred but not received estimates (and annually an actuarial opinion of such estimates). Provider and each Participating Provider will take corrective action if deficiencies are identified during any such review. (Attachment I of RFP 20-041, § 2.3)

27. FSSA Review. The Agreement between Company and Provider, and any amendments thereto, may be subject to review by FSSA. Approval by FSSA of all subcontracts, with the exception of network healthcare providers or ancillary medical providers, and any material changes to such subcontracts is required, unless waived, under the State Contract. (Attachment I of RFP 20-041, § 2.3)

28. Compliance with Laws; Licensure.

28.1. IHCP Enrollment; License. Provider and each Participating Provider will maintain a current IHCP provider agreement (i.e., be an IHCP-enrolled provider), be duly licensed in accordance with the appropriate state licensing board, remain in good standing with said board and respond to the cultural, racial and linguistic needs of the Hoosier Care Connect covered population. Company will terminate the Agreement, this Medicaid Product Attachment or a Participating Provider's participation under either of such documents as soon as Company has knowledge that Provider's or the Participating Provider's license or IHCP provider agreement was terminated. (Attachment I of RFP 20-041, §§ 2.3, 6.0, 6.5)

28.2. Compliance with Law. Provider and each Participating Provider will obtain and maintain all required permits, licenses, registrations, and approvals, and will comply with all health, safety, and environmental statutes, rules, or regulations in the performance of work activities for the State or State Agency. Failure to do so may be deemed a material breach of the Agreement and grounds for immediate termination and denial of further work with the State. (Attachment B of RFP 20-041, § 10.F)

28.3. Debarment; Suspension. Provider certifies by entering into the Agreement that neither it nor its principals nor any of its subcontractors (including Participating Providers) are: (a) presently debarred, suspended, proposed for debarment, declared ineligible or voluntarily excluded from participating under the State Contract by any federal agency or by any department, agency or political subdivision of the State of Indiana, (b) excluded by the Indiana Health Coverage Program, (c) excluded from participating in federal health care programs under Section 1128 or Section 1128A of the Social Security Act, or (d) debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or an affiliate, as defined in the Federal Acquisition Regulation, of such a person. The

term "principal" for purposes of this Section means an officer, director, owner, partner, key employee or other person with primary management or supervisory responsibilities, or a person who has a critical influence on or substantive control over the operations of the Provider, subcontractor or a Participating Provider, as applicable. Provider will immediately notify Company if Provider of any of its subcontractors (including a Participating Provider or its subcontractors) becomes debarred or suspended or otherwise becomes an individual described in this Section. Upon receipt of such notice, Company may immediately terminate the Agreement or a Participating Provider's participation thereunder. (Attachment B of RFP 20-041, § 14; Attachment I of RFP 20-041, §§ 2.3, 2.7, 6.4, 6.6)

28.4. Debarment Screening. Provider and each Participating Provider will comply with all federal requirements (42 CFR 1002) on exclusion and debarment screening. If Provider or a Participating Provider is a tax reporting provider entity that bills and/or receives Indiana Medicaid funds as the result of the State Contract, Provider or such Participating Provider will screen owners and employees against the federal exclusion databases (such as LEIE and EPLS). Provider and the Participating Provider agree that where the excluded individual is the provider of services or an owner of the provider, all amounts paid to such provider will be refunded as prescribed in the State Contract Section 7.4 Program Integrity Overpayment Recovery. (Attachment I of RFP 20-041, § 7.4)

28.5. Unauthorized Aliens. Provider hereby certifies to Company that, throughout the term of the Agreement, neither Provider nor any Participating Provider does or will knowingly employ or contract with an unauthorized alien, and that Provider (and, if applicable, the Participating Provider) is enrolled and is participating in the E-Verify program. (Attachment B of RFP 20-041, § 18)

28.6. Licensing Standards. Provider and Participating Provider will comply with all applicable licensing standards, certification standards, accrediting standards and any other laws, rules, or regulations governing services to be provided under the State Contract. The State will not pay Company, and neither Company nor Payor will pay Provider or Participating Provider, for any services performed when Provider or a Participating Provider is not in compliance with such applicable standards, laws, rules, or regulations. If any license, certification or accreditation expires or is revoked, or any disciplinary action is taken against an applicable license, certification, or accreditation, Provider will notify Company immediately and Company, at its option, may immediately terminate the Agreement or a Participating Provider's participation thereunder. (Attachment B of RFP 20-041, § 30)

29. Subcontracts.

29.1. Delegation. If Provider or Participating Provider performs delegated activities or obligations related to the State Contract, this Section applies. Provider and Participating Providers agree that such activities and obligations and any related reporting responsibilities are set forth in the Agreement (or an attachment thereto), and that such delegated activities may be revoked or other sanctions may be imposed by Company if Provider's or a Participating Provider's performance is inadequate or Company determines that Provider has not performed satisfactorily. Provider and each Participating Provider agree to comply with all Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions. Provider and each Participating Provider agree that the State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of Provider or Participating Provider, or of their respective subcontractors, that pertain to any aspect of services and activities performed, or determination of amounts payable under the State Contract. Provider and each Participating Provider will make available, for purposes of an audit, evaluation, or inspection, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid enrollees. The foregoing right to audit exists through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. If the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the Provider, Participating Providers or subcontractor at any time. (Attachment I of RFP 20-041, § 2.3; 42 CFR 438.230)

29.2. Coterminous with State Contract. Notwithstanding anything in the Agreement to the contrary, this Medicaid Product Attachment will automatically terminate at the end of the Company's State Contract in accordance with Ind. Code 12-15-30-5(b), except that this Medicaid Product Attachment will automatically renew consistent

with the term of the State Contract if the State Contract is re-awarded by subsequent procurement. (Attachment I of RFP 20-041, §§ 2.3, 6.5)

30. Without Cause Termination. Provider may terminate the Agreement, or a Participating Provider may terminate his, her or its participating thereunder, without cause upon at least ninety (90) days advance written notice to Company. Following termination, the applicable Participating Provider(s) will continue to provide benefits in accordance with the Agreement and applicable law. (Attachment I of RFP 20-041, § 6.5)

31. Submission of Encounters. Upon termination of the Agreement or a Participating Provider's participation thereunder, Provider or the applicable Participating Provider(s) will submit all encounter claims for services rendered to the Covered Persons during the term of, or participation under, the Agreement. As of the Effective Date, instructions and technical specifications for submission of encounters are set forth in the Provider Manual Chapter 4: General Billing Information and Guidelines. (Attachment I of RFP 20-041, § 6.5)

32. Claims Submission. Provider or the Participating Provider will submit all claims that do not involve a third party payer for services rendered to Covered Persons within ninety (90) calendar days or less from the date of service. Company shall waive the timely filing requirement in the case of claims for members with retroactive coverage, such as presumptively eligible pregnant women and newborns. Participating Provider may not refuse to furnish Covered Services to a Covered Person who is eligible for medical assistance under a Medicaid Product on account of a third party's potential liability for the service(s). Company may recoup payments made to Provider in the event a Covered Person has other insurance coverage. If the Covered Person is a Healthy Indiana Plan member and the reason for the recoupment is that the Covered Person had other insurance coverage, then Participating Provider must submit the affected claim(s) following the billing process required by Medicare or other insurance coverage. Under Medicare rules, Participating Provider has 6 months from date of recoupment notification to submit such claims. Neither Provider nor Participating Provider may pursue reimbursement from the Covered Person per federal rules for Covered Services under any circumstance. (Attachment I of RFP 20-041, § 6.5)

33. Medical Records. Provider or the Participating Provider will maintain Covered Person's medical records in a detailed and comprehensive manner that conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and facilitates an accurate system for follow-up treatment. Medical records must be legible, signed (manually or electronically) and dated, and maintained for at least seven (7) years as required by applicable state and federal regulations. Provider's or the Participating Provider's medical records must document all medical services that the Covered Person receives in accordance with 405 I.A.C 1-1.4-2. Provider's or the Participating Provider's medical record must include, at a minimum: (a) the identity of the individual to whom the service was rendered; (b) the identity, including dated signature or initials, of the provider rendering the service; (c) the identity, including dated signature or initials, and position of the provider employee rendering the service, if applicable; (d) date that the service was rendered; (e) diagnosis of the medical condition of the individual to whom the service was rendered, relevant to physicians and dentists only; (f) a detailed statement describing services rendered, including duration of services rendered; (g) the location at which services were rendered; (h) the amount claimed through Medicaid for each specific service rendered; (i) written evidence of physician involvement, including signature or initials, and personal patient evaluation will be required to document acute medical needs; (j) when required under Medicaid rules, physician progress notes as to the medical necessity and effectiveness of treatment and ongoing evaluations to assess progress and refine goals; and (k) X-rays, mammograms, electrocardiograms, ultrasounds, and other electronic imagine records. (Attachment I of RFP 20-041, § 6.7)

34. Access to Medical Records. Provider or the Participating Provider will provide a copy of a Covered Person's medical record upon reasonable request by the Covered Person at no charge, and Provider or the Participating Provider will facilitate the transfer of the medical record to another provider at the Covered Person's request. Provider and Participating Providers agree that confidentiality of, and access to, medical records will be provided in accordance with the standards mandated in HIPAA and all other state and federal requirements, including but not limited to, 42 CFR Part 2 specific to confidentiality of alcohol and drug abuse records. Provider and Participating Providers will permit Company and representatives of FSSA to review the Covered Person's medical record for the purposes of monitoring Provider's compliance with the medical record standards, capturing information for clinical studies,

monitoring quality or any other reason, in accordance with 405 IAC 1-1.4-2. (Attachment I of RFP 20-041, § 6.5, 6.7)

35. Behavioral Health Coordination of Care. The Participating Provider will document and reciprocally share between behavioral and physical health providers the following information for each Covered Person receiving behavioral health treatment: (a) primary and secondary diagnoses; (b) findings from assessments; (c) medication prescribed; (d) psychotherapy prescribed; and (e) any other relevant information. If a Participating Provider is a behavioral health care provider, the Participating Provider will notify Company within five (5) calendar days of each Covered Person's visit, and submit information about the treatment plan, the Covered Person's diagnosis, medications and other pertinent information. Provider or the Participating Provider will notify Company of any significant changes in the Covered Person's mental health status or level of care. While disclosure of mental health records by a behavioral health provider to the Company and other physicians is permissible under HIPAA and state law (Ind. Code 16-39-2-6(a)) without consent of the Covered Person because it is for treatment; for substance abuse medical records, consent from the Covered Person is required. Every Participating Provider, including behavioral health care providers, must ask and encourage Covered Persons to sign a consent that permits release of substance abuse treatment information to the Company and to the Covered Person's physical or behavioral health providers, if applicable. In addition, behavioral health providers are strongly encouraged to share the same clinical information directly with the Covered Person's PMP. (Attachment I of RFP 20-041, §§ 3.10.2)

36. Behavioral Health Continuity of Care. If a Participating Provider is a behavioral health care provider, this Section applies. Participating Provider must ensure that Covered Persons receiving inpatient psychiatric services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge. The Participating Provider will make every effort to ensure treatment must be provided within seven (7) calendar days from the date of the Covered Person's discharge. If a Covered Person misses an outpatient follow-up or continuing treatment, the Participating Provider will contact that Covered Person within three (3) business days of the missed appointment. (Attachment I of RFP 20-041, §§ 3.10.3; 6.5)

37. Cultural Diversity. If a Participating Provider is a behavioral health care provider, the Participating Provider will complete Company sponsored training about cultural diversity of Covered Person populations, or equivalent training, within twelve (12) months of beginning participating under the Agreement.

38. Hospital Communications Regarding Non-Emergency Services. When the Covered Person has an available and accessible alternate non-Emergency Services provider and a determination has been made that the Covered Person does not have an emergency medical condition and did not receive a waiver from the Company's 24-hour Nurse Call line, if a Participating Provider is a hospital, the Participating Provider will inform the Covered Person before providing non-Emergency Services: (a) that the Participating Provider may require payment of the copayment before the service can be provided; (b) of the name and location of an alternate non-Emergency Services provider that is available and accessible at the time the call is made to the Nurse Line; (c) that an alternative provider can provide the services without the imposition of the copayment; and (d) the Participating Provider provides a referral to coordinate scheduling of this treatment. (Attachment I of RFP 20-041; § 3.3.1)

39. Advance Directives. A Participating Provider will document in the Covered Person's medical record whether the Covered Person has executed an advance directive. Each Participating Provider will comply with all applicable federal and state laws regarding advance directives.

Attachment A-2: Medicaid

EXHIBIT 1
COMPENSATION SCHEDULE
HOOSIER CARE CONNECT
PROFESSIONAL SERVICES

Centrality Behavioral Support Training LLC

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

The maximum compensation for practitioner Covered Services rendered to a Covered Person shall be the "Allowed Amount." Except as otherwise provided in this Compensation schedule, the Allowed Amount for practitioner Covered Services is the lesser of: (i) Allowable Charges or (ii) the applicable "Contracted Rate" set forth below in Table 1.

Table 1

Contracted Rate					
Fee Schedule	**Practitioner**				
	MD	**HSPP**	**PhD** (HP or AH)	**Masters** (HO or AJ)	**ANP, ARNP** (SA)
Indiana Health Coverage Programs Fee Schedule	100%	100%	75%	75%	75%

Additional Provisions:

1. Claim Form - Professional. Contracted Provider when submitting outpatient or professional claims (billed on a CMS-1500 claim form, or its successor) spanning multiple dates of service is: (i) required to identify each date of service; and (ii) must contain modifiers as identified in the Indiana Medicaid Handbooks. Applicable modifiers should be placed in the first modifier field for claims payment. Professional services for mid-level practitioners must be billed under the supervision of a Health Service Provider in Psychology (HSPP) or a Psychiatrist. The supervisor must be registered with the State as a supervisor with the facility. A Nurse Practitioner that has been registered with the Indiana Health Coverage Programs and granted billing privileges may submit a claim without utilizing a supervisor. Services billed for a nurse practitioner should be billed with modifier SA in the first position and modifier HE in the second position.

2. Modifiers. Services requiring a modifier that designates the health care professional providing the service shall have the appropriate modifier billed to receive proper reimbursement. Modifiers include, but are not limited to, the following:

   AF (Specialty Physician),
   AH (Clinical Psychologist),
   AJ (Clinical Social Worker),
   HE (Mental Health Program),

HO (Master's Degree Level),
HP (Doctoral Level) and
SA (Nurse Practitioner rendering service in collaboration with Physician).

3. Payment for Professional Services. The Practitioner's or supervisor's NPI, Tax Identification Number and billing address provided on a claim must match the State file or the claim will be rejected by Payor.

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

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

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

7. Claims Form. Covered Services provided by professionals must be submitted in an approved electronic format or on a CMS-1500 form, or its successor claim form, using the appropriate HCPCS codes to receive reimbursement.

8. Reimbursement Credentials. Reimbursement made to Practitioner shall be based on licensure, not academic credentials. Reimbursement may be subject to service location and/or licensure limitations set forth by State in the Covered Person's benefit plan.

9. National Correct Coding Initiative (NCCI). All claims submissions should be compliant with the NCCI as it is updated and modified from time to time.

10. Payment under this Compensation Schedule. All payments under this Compensation Schedule are subject to the terms and conditions set forth in the Agreement, the Provider Manual and any applicable billing manual.

Definitions:

1. **Allowed Amount** means the amount designated in this Compensation Schedule as the maximum amount payable to a Contracted Provider for any particular Covered Service provided to any particular Covered Person, pursuant to this Agreement or its Attachments.

2. **Allowable Charges** mean those professional charges that qualify as Covered Services and are eligible for reimbursement under the Plan, less any applicable coinsurance and copayments.

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