PHYSICIANS HEALTH NETWORK
ALLIED HEALTH PROFESSIONAL PARTICIPATION AGREEMENT

THIS AGREEMENT, effective on the date specified on the signature page of this Agreement ("Effective Date"), is between **Physicians Health Network**, ("HDN") and **Centria Healthcare LLC** ("Provider") and sets forth the terms and conditions under which Provider shall participate in one or more networks of providers developed by HDN to render health care services to Members, as defined in this Agreement. On the Effective Date, this Agreement supersedes and replaces any existing agreements between the parties related to the provision of Health Services to Members.

SECTION 1
Definitions

Benefit Contract: A benefit plan that includes health care coverage, is sponsored, issued or administered by Payor, contains the terms and conditions of a Member's coverage and is described on Exhibit 1 attached hereto.

Clean Claim: A claim that has all applicable claim fields completed with correct information and with no defect or impropriety, including lack of required substantiating documentation or particular circumstances requiring special treatment, and any other information as necessary to process the claim as required by HDN or Payor and set forth in Payor's Provider Manual.

Customary Charge: The fee for health care services charged by Provider that does not exceed the fee Provider would charge any other person regardless of whether the person is a Member.

Health Services: The health care services and supplies covered by the Member's Benefit Contract.

Member: An individual who is properly covered under a Benefit Contract.

Member Expenses: Any amounts that are the Member's responsibility to pay Provider in accordance with the Member's Benefit Contract, including copayments, coinsurance and deductibles.

Participating Provider: A health care professional or facility, including Provider, that has a written participation agreement in effect with HDN, directly or through another entity, to provide Health Services to selected groups of Members.

Payor: The entity or person authorized by HDN to access one or more networks of Participating Providers developed by HDN and that has the financial responsibility for payment of Health Services covered by a Benefit Contract.

Payor's Provider Manual: Payor's provider administration manual that describes and instructs Participating Providers about Payor's operational and administrative procedures. Payor's Provider Manual may be updated from time to time by Payor. Participating Provider shall be notified of changes and provided with appropriate substitute pages/sections within a reasonable time after changes are made.

Physicians Health Plan - HMO: The Michigan licensed health maintenance organization known as Physicians Health Plan and its wholly owned subsidiary, Sparrow PHP, a Michigan licensed health maintenance organization.

Primary Care Provider: A Doctor of Medicine ("M.D."), Doctor of Osteopathy ("D.O.") or another health care professional as required by applicable statutes and regulations, who is duly licensed and qualified under the laws of the jurisdiction in which Health Services are rendered and is a Participating Provider of

primary care Health Services.

Referral Process: The process whereby the Member's Primary Care Provider requests approval from Payor for a health care professional or facility to render certain Health Services to the Member, made in any electronic format prescribed by Payor. Approval shall be in the sole discretion of Payor and may be dependent on the type of health services requested and the Member's eligibility.

Referral Provider: An M.D. or a D.O. (1) who is a Participating Provider; (2) who is not a Primary Care Provider; and (3) to whom a Member is referred by a Primary Care Provider for the provision of certain Health Services.

SECTION 2
Networks of Participating Providers

Provider shall provide Health Services to Members covered under the Benefit Contract types described in Exhibit 1, which may be modified from time to time by Payor, and which include, but are not limited to, Benefit Contracts which offer a network of Participating Providers. When appropriate, Provider will be listed in the applicable provider directories.

SECTION 3
Duties of Provider

3.1 Member Status. To determine whether an individual is a Member and, therefore, entitled to receive Health Services, Provider shall ask the individual to present his or her identification card, which shall be provided to all Members by Payors, unless because of the type of Benefit Contract under which the Member has coverage, no identification card applies. In addition, Provider may contact HDN or Payor to obtain HDN or Payor's most current information on the individual as a Member. However, Provider acknowledges that such information is subject to change retroactively (1) if Payor does not receive proper and timely notification regarding termination of a Member's coverage; (2) as a result of a final decision about a Member's continuation of coverage pursuant to state and federal laws; or (3) if eligibility information Payor receives on the individual is later proven to be false. If Provider provides health care services to an individual, and it is later determined the individual was not a Member at the time the health care services were provided, those services shall not be eligible for payment under this Agreement. Provider may then directly bill the responsible party for such services.

3.2 Provision of Health Services. Provider shall provide Health Services to all Members in accordance with the standard of practice of the community in which Provider renders Health Services. Provider shall provide Health Services to all Members as Provider's patient load and appointment calendar permit, and shall accept Members as new patients on the same basis as Provider is accepting non-members as new patients, without regard to race, religion, creed, sex, sexual orientation, color, national origin, ancestry, age, marital status, physical or mental health status or status as a Medicaid enrollee. Provider shall not, other than for reasons of safety, segregate Medicaid enrollees in any way or treat them in a location or manner different from any other Members.

In the event Provider is a Primary Care Provider, he or she shall: (i) be available to see patients a minimum of 20 hours per practice location per week, and (ii) provide or arrange for twenty-four hours per day, seven days per week, three hundred sixty-five days per year, on-call coverage to all Members assigned to such provider. A Member's Primary Care Provider shall be responsible for supervising, coordinating and providing all primary care services to that Member, as well as for initiating referrals for specialty care, maintaining continuity of Member's health care and maintaining Member's medical records. In addition, Provider shall assist in the transfer of such Member to a different Physicians Health Plan - HMO Primary Care Provider if such Member's health or safety is in jeopardy.

3.3 Utilization Management, Patient Safety, Quality Improvement and Other HDN or Payor Programs. Provider shall cooperate with all care coordination initiatives, including patient safety initiatives that are endorsed by Michigan State Medical Society, Michigan Osteopathic Association and/or Michigan Association of Health Plans, quality management review, peer review, or other such programs as may be established by Payor or HDN to promote the provision of quality health care including, but not limited to, on site concurrent reviews. The Quality Management Plan, as outlined in Payor's Provider Manual, may be periodically updated by Payor. Provider shall be notified about such updates.

3.4 Protocols. Provider shall comply with all policies, procedures and protocols of Payor, including, but not limited to the following:

1. Refer Members only to other Participating Providers unless Health Services are not available through Participating Provider and are authorized by Payor.
2. Be bound by any provider manual and credentialing plan as modified from time to time by Payor.
3. Obtain prior authorization for certain Health Services as defined by Payor.
4. Follow approved billing procedures of Payor, as appropriate.
5. If a Member's Benefit Contract requires the Member to receive certain Health Services from or upon referral by a Primary Care Provider, all Referral Providers must adhere to the following additional protocols when those Health Services are provided:
    a) Referrals to other Participating or non-Participating Providers must first be authorized by the Member's Primary Care Provider.
    b) Health Services must be provided pursuant to the terms and limitations of the Referral Authorization issued by or on behalf of the Member's Primary Care Provider.
6. Provider shall comply with the following requirements when admitting Members to a hospital:
    a) Admit Members on the day of surgery, unless the Member's medical condition requires otherwise and Provider has obtained prior authorization from Payor, as appropriate.
    b) Notify Payor, as appropriate, by telephone at least five (5) days prior to a scheduled admission of a Member.
    c) Notify Payor, as appropriate, immediately if Provider admits a Member to a hospital for an emergency or for observation.
    d) If the Provider providing the Health Services is a Referral Provider, the Provider must also notify the Member's Primary Care Provider of all admissions in accordance with the above time frames.
7. Comply with Payor's drug formulary policy.
8. Comply with Payor's office laboratory lists and billing procedures.
9. Provider may elect to perform all or part of the laboratory services listed in Payor's office laboratory list. Laboratory services not listed in Payor's office laboratory list, or laboratory services not performed by Provider, shall be performed by Payor's designated laboratory. Provider shall be reimbursed only for those laboratory services listed in Payor's office laboratory list and performed, in whole or in part, for a Member being treated directly by Provider.
10. Provider shall comply with Payor's Anti-Kickback Policy Relevant to the State of Michigan, Temporary High Risk Pool Program and PHP's Business Transaction Authorization Policy.
11. Ownership of Contractual Changes: Provider shall submit, within thirty-five (35) days of the date of a request by the Secretary of the Department of Health and Human Services, the Michigan Department of Community Health, or any successor agency, full and complete information about (a) the ownership of any subcontractor with whom Provider has had business transactions totaling more than $25,000 during the twelve (12) month period ending on the date of such request; and (b) any significant business transactions between the Provider and any wholly owned supplier, or between the Provider and any subcontractor, during the five (5) year period ending on the date of such request.

Failure to comply with the above may result in denial of payment to Provider, sanctions pursuant to Payor's

policy and procedures set forth in Payor's Provider Manual which may include one or more of the following: termination of eligibility for incentive plans or special fee schedule incentives, ceasing to refer members to Provider, automatic forfeiture of financial allowance, monetary adjustments for reimbursement due to Provider, suspension of participation in HDN, restriction of participation in HDN and/or termination of this Agreement. Provider agrees that Provider shall not bill the Member for the denied amounts.

3.5 Continuation of Care. Provider agrees to continue to furnish Health Services to Members who are under the Provider's care as of the date of termination of this Agreement, until the Member is discharged if the Member is an inpatient and if the Provider is a primary care physician, as long as and until the Member is assigned to a different primary care physician or as otherwise set forth in Section 9.3. Payor shall make payments pursuant to this Agreement for such Health Services provided after the date of termination.

SECTION 4
Payment Provisions

4.1 Payment for Health Services. For the provision of Health Services to a Member, Payor shall pay Provider the applicable amounts stated in the attached Appendices. The obligation for payment under this Agreement for Health Services rendered to a Member is solely that of Payor. Provider shall accept as payment in full for Health Services rendered to Members such amounts as are paid by Payor pursuant to this Agreement, and shall not bill Members for non-covered charges which result from Payor's reimbursement methodologies. In no event shall Provider bill a Member for the difference between Customary Charges and the amount Provider has agreed to accept as full reimbursement under this Agreement. Provider may collect Member Expenses from the Member. If Payor denies payment for services rendered by Provider on grounds that the services are not medically necessary, as defined in the Member's Benefit Contract, Provider shall not collect payment from the Member for the services unless Provider first obtains the Member's written consent.

Payor shall reimburse Provider for Health Services rendered to a Member by Provider, pursuant to Member's assignment of benefits, as necessary, pursuant to the attached Appendices and the Member's Benefit Contract. Provider and HDN agree that any reimbursement hereunder based on Provider's Customary Charge shall be reimbursed as the lesser of Provider's Customary Charge or the average provider charge for the particular Health Service as defined by Payor's designee and consistent with databases of national provider charges. Payor shall pay interest at a rate of twelve percent (12%) per annum on any commercial or Medicaid Clean Claims paid forty-five (45) days or more after Payor's receipt of a Clean Claim.

4.2 Submission of Claims. Provider shall submit claims for Health Services to Payor as appropriate in any electronic format prescribed by Payor. Provider understands and agrees to pay any charges that may be required for the submission of claims. In order to receive payment, Clean Claims must be received by Payor no later than twelve (12) months from the date the Health Services are rendered. Provider agrees that claims received after this time period may be rejected for payment, at HDN's and/or Payor's discretion.

Unless otherwise directed by Payor, Provider shall submit claims using current Centers for Medicare and Medicaid Services ("CMS") 1500 (HCFA 1500) or UB92 forms, whichever is appropriate, with applicable coding including, but not limited to, ICD9, CPT, Revenue and HCPCs coding. Provider shall include in a claim the Member number, Customary Charges for the Health Services rendered to a Member during a single instance of service, Provider's Federal Tax I.D. number and/or other identifiers requested by Payor.

Provider shall not bill the Member for Health Services if Provider fails to submit claims in accordance with the above provisions.

Payor shall have the right to make corrective adjustments to any previous payment for a claim for Health

Services; provided however, that any corrections shall be made (1) within twelve (12) months from receipt by Payor or Payor's designee of such claim; or (2) as part of an annual reconciliation procedure, as mutually agreed to by the parties, or (3) an audit of Provider's claims by Payor or Payor's designee.

4.3 Coordination of Benefits. Provider shall be paid in accordance with Payor's coordination of benefits rules.

4.4 Financial Responsibility. HDN shall notify Provider in writing if HDN determines that a Payor other than a licensed health maintenance organization has failed to maintain its responsibility to pay for services rendered. Any services which have been rendered by Provider prior to and after such notification, and which were not paid for by such Payor, shall be considered ineligible for reimbursement under this Agreement, and Provider may bill the Member directly for such services.

4.5 Member Protection Provision. This provision supersedes and replaces the Financial Responsibility section when a health maintenance organization is the Payor, when required by a specific Payor other than a health maintenance organization, or when required pursuant to applicable statutes and regulations.

In no event, including, but not limited to, non-payment by Payor for Health Services rendered to Members by Provider, insolvency of Payor, or breach by HDN of any term or condition of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member or persons acting on behalf of the Member for Health Services eligible for reimbursement under this Agreement; provided, however, that Provider may collect from the Member, Member Expenses or charges for services not covered under the Member's Benefit Contract.

Provider agrees not to maintain any action at law or in equity against a Member to collect sums that are owed to Provider by HDN or Payor under the terms of this Agreement, even in the event that the HDN or Payor fails to pay, becomes insolvent or otherwise breaches the terms and conditions of this Agreement.

The provisions of this section shall (1) apply to all Health Services rendered while this Agreement is in force; (2) with respect to Health Services rendered while this Agreement is in force, survive the termination of this Agreement regardless of the cause of termination; (3) be construed to be for the benefit of the Members; and (4) supersede any oral or written agreement, existing or subsequently entered into, between Provider and a Member or person acting on a Member's behalf, that requires the Member to pay for such Health Services.

4.6 Participation in Utilization Management Activities. Provider understands and agrees that utilization management shall be based on appropriateness of care and service only. HDN and/or Payor does not provide any compensation whatsoever to Provider for conducting utilization review or for issuing denials of coverage or service.

SECTION 5
Liability of Parties, Laws, Regulations and Licenses

5.1 Provider Hold Harmless and Indemnification. Provider shall defend, hold harmless and indemnify HDN and Payor against any and all claims, liabilities, damages, or judgments and all costs, including attorney fees, asserted against, imposed upon or incurred by HDN and Payor that arise out of the malpractice or negligence of Provider or Provider's employees, agents, or representatives in the discharge of its or their professional responsibilities to a Member or performance under this Agreement.

5.2 Payor Hold Harmless and Indemnification. HDN shall defend, hold harmless and indemnify Provider against any and all claims, liabilities, damages, or judgments asserted against, imposed upon or

incurred by Provider that arise out of the negligence of HDN or its employees, agents, and representatives in its performance under this Agreement.

5.3 Provider Liability Insurance. Provider shall procure and maintain, at Provider's sole expense, (1) professional malpractice insurance in an amount satisfactory to Payor and (2) comprehensive general and/or umbrella liability insurance in an amount satisfactory to Payor. Specific amounts of required coverage shall be in accordance with the requirements described in the Provider Manual. Provider shall also require that all health care professionals employed by or under contract with Provider to render Health Services to Members procure and maintain malpractice insurance, unless they are covered under Provider's general liability insurance policies. If applicable, Provider's and other health care professionals' medical malpractice insurance shall be either occurrence or claims made with an extended period reporting option under such terms and conditions as may be reasonably required by Payor. Prior to or within thirty (30) days following execution of this Agreement by Provider and at each policy renewal thereafter, Provider shall submit to Payor evidence of insurance coverage. Provider shall notify Payor in writing to the attention of the President, of any changes in carriers, termination of, or other material changes in Provider's liability insurance. Payor shall provide Provider with thirty (30) days prior written notice of increases in required insurance coverage amounts.

5.4 Laws, Regulations and Licenses. Provider shall maintain all federal, state and local licenses, certifications and permits, without material restriction, which are required to provide health care services according to the laws of the jurisdiction in which Health Services are provided, and shall comply with all applicable statutes and regulations. Provider shall also require that all health care professionals employed by or under contract with Provider to render Health Services to Members, comply with this provision.

SECTION 6
Notices

Provider shall notify HDN within ten (10) days of knowledge of the following:

1. Changes in liability insurance carriers, termination of, renewal of or any other material changes in Provider's liability insurance, including reduction of limits, erosion of aggregate, changes in retention or non-payment of premium.

2. Action which may result in the suspension, revocation, condition, limitation, qualification or other material restriction on a Provider's licenses, certifications and permits by any government under which a Provider is authorized to provide health care services; and, of any suspension, revocation, condition, limitation, qualification or other material restriction of a Provider's staff privileges at any licensed hospital, nursing home or other facility at which a Provider has staff privileges during the term of this Agreement.

3. A change in Provider's name, address, telephone number, ownership, Federal Tax I.D. number, and/or whether Provider's practice closed to new Members.

4. Indictment, arrest or conviction for a felony or for any criminal charge related to the practice of Provider's profession.

Unless otherwise specified in this Agreement, any notice or other communication required or permitted shall be in writing. All written notices or communication shall be deemed to have been given when delivered in person; or, if delivered by first-class United States mail, on the date mailed, proper postage prepaid and properly addressed to the appropriate party at the address set forth at the signature portion of this Agreement or to another more recent address of which the sending party has received written notice. The parties shall provide each other with proper addresses of all designees that should receive certain

notices or communication instead of that party.

SECTION 7
Records

7.1 Confidentiality of Records and Personal Information. Payor, HDN and Provider shall maintain the confidentiality of all Member records and personal information in accordance with any applicable statutes and regulations.

7.2 Maintenance of and Payor and HDN Access to Records. Provider will maintain adequate medical, financial and administrative records related to Health Services rendered by Provider under this Agreement. In order to perform its utilization management and quality improvement activities, HDN and Payor shall have access to such information and records, including claims records, within fourteen (14) days from the date the request is made, except that, in the case of an audit by HDN or Payor such access shall be given at the time of the audit. If requested by HDN or Payor, Provider shall provide copies of such records free of charge. Unless a longer time period is required by applicable statutes or regulations, HDN and Payor shall have access to and the right to audit information and records during the term of this Agreement and for 3 years following its termination. It is Provider's responsibility to obtain any Member consent required in order to provide HDN and Payor with requested information and records or copies of records.

7.3 Government and Accrediting Agency Access to Records. The federal, state and local government, or accrediting agencies and any of their authorized representatives, shall have immediate and complete access to, and HDN, Payor and Medical Group are authorized to release, in accordance with applicable statutes and regulations, all information and records or copies of such, within the possession of HDN, Payor or Medical Group, which are pertinent to Members, if such access is necessary to comply with accreditation standards, statutes or regulations applicable to HDN, Payor or Medical Group.

SECTION 8
Resolution of Disputes

HDN, Payor and Provider will work together in good faith to resolve any disputes about their business relationship. If the parties are unable to resolve the dispute within thirty (30) days following the date one party sent written notice of the dispute to the other party, and if HDN or Provider and any Payor (that has consented in writing to arbitration) wishes to pursue the dispute, it shall be submitted to binding arbitration in accordance with the rules of the American Arbitration Association. In no event may arbitration be initiated more than one year following the sending of written notice of the dispute. Any arbitration proceeding under this Agreement shall be conducted in Ingham County, Michigan. The arbitrators may construe or interpret but shall not vary or ignore the terms of this Agreement, shall have no authority to award any punitive or exemplary damages, and shall be bound by controlling law. If the dispute pertains to a matter which is generally administered by certain Payor procedures, such as a credentialing or quality improvement plan, the procedures set forth in that plan must be fully exhausted by Provider before Provider may invoke its right to arbitration under this section. The decision of the arbitrator shall be final and binding on the parties and judgment including specific enforcement of the decision shall be entered upon the decision in any court of proper jurisdiction.

SECTION 9
Term and Termination

9.1 Term. This Agreement shall begin on the Effective Date and it shall remain in effect for one (1) year, and shall automatically renew until it is terminated as provided below.

9.2 Termination. This Agreement may be terminated as follows:

1. by mutual agreement of HDN and Provider.

2. by either party upon sixty (60) days prior written notice to the other party.

3. by either party, in the event of a breach of this Agreement by the other party, upon thirty (30) days prior written notice to the other party.

4. by HDN immediately upon written notice to Provider due to Provider's loss or suspension of licensure or certification or loss of insurance required under this Agreement, or exclusion, suspension or ineligibility to participate in a federal health care program.

5. by Provider upon sixty (60) days prior written notice to HDN due to an amendment made to this Agreement pursuant to Section 10.1.

Prior to termination of this Agreement, Payor and not Provider shall notify all affected Members and assist them in obtaining a referral to a Participating Provider.

9.3 Payment for Services. Except in the event that this Agreement is terminated by HDN pursuant to Section 9.2(3) or (4), Payor shall permit a Member to continue an ongoing course of treatment with Provider as follows:

(a) For ninety (90) days from the date of notice to Member of Provider's termination with Payor, and;

(b) If Member is in her second or third trimester of pregnancy at the time of Provider's termination, through postpartum care directly related to the pregnancy; or

(c) If Member is determined to be terminally ill prior to Provider's termination or knowledge of the termination and Provider was treating the terminal illness before the date of termination or knowledge of the termination, for the remainder of the Member's life for care directly related to the treatment of the terminal illness.

Provider shall be reimbursed for Health Services provided pursuant to this Section if Provider agrees to the following;

(a) To continue to accept as payment in full reimbursement from Payor at the rates applicable prior to the termination,

(b) To adhere to Payor's standards for maintaining quality health care and to provide to Payor necessary medical information related to the Health Services; and

(c) To otherwise adhere to Payor's policies and procedures, including, but not limited to, those concerning utilization review, referrals, preauthorizations, and treatment plans.

SECTION 10
Miscellaneous

10.1 Amendment. Except for changes to the payment methodology in the appendices, HDN may amend this Agreement by sending a copy of the amendment to Provider at least thirty (30) days prior to its effective date and the signature of Provider shall not be required. However, changes to the payment methodology (e.g., fee-for-service to capitation) shall require a written amendment executed by all parties. HDN may also amend this Agreement to comply with the requirements of state and federal regulatory authorities, and shall give written notice to Provider of such amendment and its effective date. Unless such regulatory authorities direct otherwise, the signature of Provider will not be required.

10.2 Assignment. HDN may assign all or any of its rights and responsibilities under this Agreement to any entity controlling, controlled by or under common control with HDN. Provider may assign any of its rights and responsibilities under this Agreement to any person or entity only upon the prior written consent

of HDN, which consent shall not be unreasonably withheld.

10.3 Administrative Responsibilities. HDN may delegate certain administrative responsibilities under this Agreement to another entity, including, but not limited to, Payor or its designee. In addition, certain Payor responsibilities may actually be performed by its designee.

10.4 Relationship Between HDN and Provider. The relationship between HDN and Provider is solely that of independent contractors and nothing in this Agreement or otherwise shall be construed or deemed to create any other relationship, including one of employment, agency or joint venture.

10.5 Name, Symbol and Service Mark. During the term of this Agreement, Provider, HDN and Payor shall have the right to use each other's name solely to make public reference to Provider as a Participating Provider. Provider, HDN and Payor shall not otherwise use each other's name, symbol or service mark without prior written approval.

10.6 Confidentiality. Neither party shall disclose to third parties any confidential or proprietary business information which it receives from the other party, including, but not limited to, financial statements, business plans, protocols and programs; except that (1) Provider may disclose information to a Member relating to the Member's treatment plan and the payment methodology, but not specific rates, and (2) HDN may disclose certain terms to Payors or designees that need the information to process claims or administer a Benefit Contract, and may file the form of this Agreement with any federal or state regulatory entity as may be required by applicable law.

10.7 Communication. HDN encourages Medical Group to discuss with Members treatment options and their associated risks and benefits, regardless of whether the treatment is covered under the Member's Benefit Contract. Nothing in this Agreement shall prohibit or restrict Medical Group from advising or advocating on behalf of a Member (a) for the Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered; (b) for any information the Member needs in order to decide among all relevant treatment options; (c) for the risks, benefits, and consequences of treatment or non-treatment; and (d) for the Member's right to participate in decisions regarding the Member's health care, including the right to refuse treatment, and to express preferences about future treatment decisions. Nothing in this Agreement is intended to interfere with Medical Group's relationship with Members as patients of Medical Group, or with HDN's ability to administer its quality improvement, utilization management and credentialing programs.

10.8 Appendices. Additional and/or alternative provisions, if any, related to certain Health Services rendered by Provider to Members covered by certain Benefit Contracts are set forth in the Appendices.

10.9 Entire Agreement. This Agreement constitutes the entire agreement between the parties in regard to its subject matter.

10.10 Governing Law. This Agreement shall be governed by and construed in accordance with applicable Michigan law and ERISA.

10.11 Medicaid Members. If a Medicaid Appendix is attached to this Agreement, Provider agrees to provide Health Services to Members enrolled in a Benefit Contract for Medicaid recipients and to comply with any additional requirements set forth in the Medicaid Appendix.

10.12 Corporate Compliance. Medical Group acknowledges that Physicians Health Plan - HMO has implemented a voluntary corporate compliance program known as the PHP Corporate Compliance Plan, which, through its standards of conduct, policies and procedures, attempts to assure that Physicians Health Plan - HMO complies with all applicable laws, regulations and policies. Physician agrees to comply with,

and support, the PHP Corporate Compliance Plan and any compliance efforts. Physician understands that as part of Physicians Health Plan - HMO's compliance efforts, Physicians Health Plan - HMO makes reasonable inquiry into whether any Participating Providers are listed by a federal agency as excluded, debarred, suspended or otherwise ineligible to participate in a federal health care program and that if Physician has been excluded, debarred, suspended or is otherwise ineligible to participate in a federal health care program, HDN shall terminate this Agreement immediately pursuant to Section 9.2.

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

The Effective Date of this Agreement is _____. (To be completed by HDN)

Physicians Health Network
P.O. Box 30377
Lansing, MI 48909-7877

By:_____
Dennis J. Reese

Its: President and Chief Executive Officer

Date:_____

Centria Healthcare LLC
41521 West 11 Mile Road
Novi, MI 48375
TIN: 27-1402749

By: :_____
Signature

Its: VP of Autism Services

Date: 1/17/17

Exhibit 1

Network of Participating Providers

Provider shall participate in the networks of Participating Providers established by HDN for the Benefit Contract types identified below:

- Traditional Commercial HMO Products which means all commercial HMO products offered by Physicians Health Plan - HMO.

- Self-insured or other insured products which means all products that are not HMO products and are paid in accordance with the attached commercial appendix with the exception of the financial allowance (withhold) which does not apply.

ALL PAYOR APPENDIX FEE SCHEDULE

APPLICABILITY

Unless another Appendix to this Agreement applies specifically to certain Benefit Contracts, the provisions of this Appendix apply to Health Services rendered by Provider to Members covered by Benefit Contracts sponsored, issued or administered by all Payors, which may include Physicians Health Plan - HMO, and which is described on Exhibit 1.

SECTION 1
Definitions

Initial Assessment and Reassessment: Either an initial or reassessment by a non-physician. May include but is not limited to; Skills Assessment, Functional Behavior Assessment, Functional Analysis or other assessment based on systematic evaluation of an individual's abilities and the development of a structured treatment program),

Board Certified Behavior Analyst (BCBA): A provider who is a Certified Behavior Analyst (BCBA) by the Behavior Analyst Certification Board (BACB) and who has successfully completed any applicable requirements imposed by the state of Michigan.

Board Certified Behavior Analyst- Doctorate (BCBA-D): A provider who is a Certified Behavior Analyst-Doctorate (BCBA-D) by the Behavior Analyst Certification Board (BACB) and who has successfully completed any applicable requirements imposed by the state of Michigan

Caregiver Training; Standard, but individualized, curriculum focused on the basics of ABA. Emphasizes skills training, which enables caregivers to become competent in implementing treatment protocols across settings and/or environments. Training usually occurs after an individualized behavioral assessment and treatment analysis or treatment recommendation formulation. Training can include general and individualized didactic presentations, modeling and demonstrations of the skills in a training setting, and practice with performance feedback for each specific skill. Ongoing parent training activities can involve supervision and coaching during implementation, refresher trainings, problem solving, and support in new environments. Training should promote generalization and maintenance of treatment.

Child Mental Health Professional (CMHP): Fully licensed psychologists or master's social workers with at least one year of experience in the examination and treatment of children with ASD, and who is able to diagnose within their scope of practice and professional license. The CMHP must be supervised by a BCBA, must enroll in a BCBA-eligible course sequence within one year of the time they begin providing ABA Services, must complete all coursework and experience requirements, and be certified as a BCBA no later than June 30, 2018.

Direct Care: Direct behavior analytic service provided to Member and implementation of ABA based methodologies, treatment plan or protocol as designed by the supervising BCBA, BCBA-D, or CMHP. Records behavioral data throughout each session.

Functional Behavior Assessment ("FBA"): Utilized when problem behaviors (e.g., aggression, self-injury, property destruction, stereotype) are present. Identifies the reason(s) behavior(s) occur and the skills and strategies necessary to decrease them.

Functional Analysis ("FA"): Involves the manipulation of consequent events that serve to maintain problem behaviors to confirm or modify hypothesized functions.

Licensed Psychologist (Doctorate): A provider who meets the state of Michigan criteria for such title.

Limit Licensed Psychologist: A provider who meets the state of Michigan criteria for such title.

Registered Behavior Technician (RBT): A provider who is registered as a Behavior Technician with the Behavior Analyst Certification Board (BACB) or meets all requirements listed by the BACB for such title and who has successfully completed any applicable requirements imposed by the state of Michigan, or who has a bachelors degree in a healthcare related discipline and who has successfully completed Provider's forty hours of in-house orientation training.

Skills Assessment: Assesses strengths and weaknesses of skill areas across skill domain areas; other assessments based on systematic evaluation of the Members abilities and the development of a structured treatment program.

Supervision of Direct Care: Clinical direction, supervision, and management across all phases including assessment, development and implementation of the treatment, and discharge. Summarize and analyze data, directly observe therapy, meet and evaluate performance of direct line staff, evaluate Member progress towards treatment goals, supervise implementation of treatment, adjust treatment protocols based on data, monitor treatment integrity, ensure satisfactory implementation of treatment protocols. Supervision may be done in person or via web-cameras, videotape, videoconferencing, or similar means in lieu of the supervisor being physically present; synchronous (real-time) observation is strongly encouraged.

Treatment Plan Development: The Treatment Plan Development shall include at a minimum, objective and measureable treatment goals, protocols, data collection systems, parent training goals and coordination of care. Adjustments shall be made to treatment protocols based on data and subsequent plan development to include a transition/discharge plan.

SECTION 2
Payment

Payor shall pay Provider for the Health Services rendered to Members, less any Member Expenses, as set forth in this Section 2 in accordance with the category Provider satisfies based on Provider's state licensure and degree status.

Description of Health Service with terms as defined by the American Medical Association Coding Effective 7-1-14	Billing Units	CODE	BCBA-D* with modifier HP	BCBA* or CMHP With modifier HO	RBT* With modifier HN or HM
Assessment	1	0359T	$107.00	$100.00	NA
Observational Behavioral Follow-Up Assessment	30 min.	0360T (First 30 min.) & 0361T (add'l. 30 min.)	$53.50	$50.00	$23.00
Exposure Behavioral Follow-Up Assessment	30 min.	0362T (First 30 min.) & 0363T (add'l. 30 min.)	$53.50	$50.00	$23.00
Adaptive Behavior Treatment by Protocol	30 min.	0364T (First 30 min.) & 0365T (add'l. 30 min.)	$53.50	$50.00	$23.00
Adaptive Behavior Treatment by Protocol Modification	30 min.	0368T (First 30 min.) & 0369T (add'l. 30 min.)	$53.50	$50.00	NA
Family and Multiple-Family Group Adaptive Behavior Treatment Guidance	30 min.	0370T (family) or 0371T (group)	$60.00	$58.50	NA

*Provider shall bill applicable modifier (including diagnosis) per the American Medical Association HCPCS manual.