ANCILLARY SERVICES AGREEMENT
BETWEEN
HEALTH ALLIANCE PLAN OF MICHIGAN
AND
CENTRIA HEALTHCARE, LLC

This Ancillary Services Agreement by and between HEALTH ALLIANCE PLAN OF MICHIGAN, HAP PREFERRED INCORPORATED, and ALLIANCE HEALTH AND LIFE INSURANCE COMPANY (collectively "HAP") and, CENTRIAL HEALTHCARE, LLC ("Provider") is effective as of the date determined by HAP and indicated on the signature page of this Agreement ("Effective Date"). HAP and Provider desire to enter into an Agreement to arrange and provide Covered Services to Enrollees.

RECITALS

1. Health Alliance Plan of Michigan is a Michigan nonprofit corporation and is licensed by the State of Michigan as a health maintenance organization. Alliance Health and Life Insurance Company is a Michigan business corporation and maintains a certificate of authority, issued by the State of Michigan, to sell health insurance products. HAP Preferred Incorporated is a Michigan business corporation that arranges for the provision of comprehensive managed health care and other medical services for Enrollees on behalf of employer groups. Alliance Health and Life Insurance Company and HAP Preferred Incorporated are each wholly-owned subsidiaries of Health Alliance Plan of Michigan. In this Agreement, these corporations are referred to collectively as "HAP" for convenience.

2. Provider wishes to contract with HAP to provide medical professional services to HAP's enrollees.

In consideration of the covenants and undertakings set forth herein, the sufficiency of which is hereby acknowledged, the HAP and Provider agree as follows:

ARTICLE 1

DEFINITIONS

1.01 AFFILIATE means with respect to Provider an entity that, directly or indirectly, owns or controls, is owned or controlled by, or is under common ownership or control with Provider. Provider's Affiliates, if any, delivering health care services to Enrollees under this Agreement are listed in attached Exhibit A, which is incorporated herein by reference.

1.02 AGREEMENT means this Ancillary Services Agreement between HAP and Provider, including all Attachments, Exhibits, Policies and Procedures referenced herein.

1.03 CLEAN CLAIM means a paper or electronic claim or encounter document that: (1) identifies sufficiently the health professional or health facility that provided services to verify, if necessary, affiliation status and includes any identifying numbers required by HAP; (2) sufficiently identifies the Enrollee; (3) lists the date and place of service; (4) is a claim for Covered Services provided to an Enrollee for which HAP is fully or partially responsible for payment; (5) if necessary, substantiates the medical necessity and appropriateness of the service provided; (6) if prior authorization is required, contains information sufficient to establish that prior authorization was obtained; (7) identifies the Covered Service rendered using a generally accepted industry standard system of procedure or service coding; (8) includes additional information, documentation, and data as required by HAP (9) is submitted on a form approved for use by the Center for Medicare and Medicaid Services ("CMS"); and (10) is submitted within the timeframes specified in this Agreement.

1.04 COORDINATION OF BENEFITS means those procedures by which HAP in conjunction with HAP Providers and others seek to recover costs of Covered Services that may be covered by another insurer, service plan, governmental payer, third party payer, or other organization. HAP may recover costs by exercising its subrogation rights.

1.05 COINSURANCE is a fixed percentage of the cost of Covered Services that an Enrollee may be required to pay under the terms of a Subscriber Contract.

1.06 CO-PAYMENT is a fixed fee for Covered Services that an Enrollee may be required to pay under the terms of a Subscriber Contract.

1.07 COVERED SERVICES are Medically Necessary preventive, diagnostic, and treatment services that an Enrollee receives under the terms of a Subscriber Contract.

1.08 DEDUCTIBLE is that portion of the cost of Covered Services that an Enrollee may be required to pay before HAP pays for Covered Services.

1.09 ENROLLEE is a member, subscriber or is a dependent of a member, enrollee or subscriber who is eligible to receive Covered Services pursuant to a Subscriber Contract.

1.10 HAP POLICIES AND PROCEDURES are those policy and procedure statements, performance standards, utilization management program statements, quality management program statements, or formularies that HAP may establish from time to time. HAP Policies and Procedures may be presented in the form of a provider manual, provider bulletins, or on the HAP Website and may include policies and procedures that are implemented by a duly authorized representative of HAP on its behalf.

1.11 HAP PRODUCTS means the health maintenance organization (HMO), preferred provider organization (PPO), or other types of health care and administrative services

programs offered by HAP from time to time. HAP may add or remove products and programs it offers at any time, and, in its sole discretion, will determine if Provider is selected for participation.

1.12 HAP PROVIDER is a licensed corporation, partnership, professional limited liability corporation, other form of legal entity, or person credentialed by HAP (or its designee) contracted with HAP to provide Covered Services to Enrollees. HAP Providers include, but are not limited to, hospitals, physician organizations, physician-hospital organizations, physicians, and ancillary service providers. Provider is a HAP Provider pursuant to the terms of this Agreement.

1.13 HAP WEBSITE means the website maintained by HAP and generally available to providers at www.hap.org.

1.14 HEALTH BENEFIT PLAN means a health benefit plan for which HAP provides administrative services or to which HAP is obligated to make available their provider networks for the provision of Covered Services to Enrollees through contractual arrangements.

1.13 MEDICALLY NECESSARY SERVICES are health care services that HAP, in accordance with well-established professional medical standards as reflected in scientific and peer-reviewed medical literature, determines are: (1) appropriate and consistent with and essential for the diagnosis and treatment of an Enrollee's condition, disease, ailment, or injury; (2) the most appropriate supply or level of service that can be provided safely; (3) provided for the diagnosis or direct care and treatment of an Enrollee's condition, disease, injury, or ailment; (4) not provided primarily for the convenience of the Enrollee, his/her family or other caretaker, or physician; and (5) more likely to result in benefit than harm. Except for preventive and well baby care, Medically Necessary Services must be related to diagnosis or treatment of an existing illness or injury. Experimental or investigative health services are not Medically Necessary Services and are excluded under the Subscriber Contract. The term "Medical Necessity", when used in relation to services, will have the same meaning as Medically Necessary Services.

1.14 OVERPAYMENT is any payment that was made to which the person or entity had no entitlement to, or any payment made in excess of the amount due, including, but not limited to, take backs and retroactive terminations.

1.15 PAYER means an entity that is ultimately responsible to make payments for Covered Services on behalf of an Enrollee who is covered under a Health Benefit Plan. In certain circumstances, HAP may be the Payer.

1.16 SUBSCRIBER CONTRACT is the document that Enrollees receive from HAP that describes the Enrollee's health care coverage, including the terms and conditions for receipt of Covered Services agreed to by Plan and the Enrollee. The Subscriber Contract includes the enrollment form, amendments (sometimes referred to as "riders"),

and any additional attachments. The document describing an Enrollee's and HAP's rights and duties may be labeled an insurance certificate or policy depending upon the HAP Product to which the document relates. For purposes of this Agreement, all such documents are encompassed in the term "Subscriber Contract".

1.17 THIRD PARTY ADMINISTRATOR OR TPA means an entity that process health benefit claims and provide administrative services for the Payer related to the Subscriber Contract.

1.18 UNDERPAYMENT is any payment made by either party to the other in an amount less than the amount due under this Agreement, not including Enrollees financial obligations.

ARTICLE II

PROVIDER RESPONSIBILITIES

2.1 PROVISION OF COVERED SERVICES. Provider shall furnish Covered Services to Enrollees that are within the scope of Provider's licenses and/or certifications, as limited by this Agreement, and as described in **Exhibit D**. Further, Provider will not furnish any Covered Services to Enrollees unless and until it has received written confirmation that Provider has been fully credentialed by HAP. Provider will participate in the HAP Products described in **Exhibit E** and the related appendices that follow, which are attached hereto and incorporated herein by reference, on the same terms and conditions as set forth in this Agreement or as may be specified in an amendment hereof. In the event HAP develops a new HAP Product, and Provider is selected for participation in the same, Provider will deliver care to Enrollees in the new HAP Product on the terms and conditions set forth in this Agreement, or as may be specified in an amendment hereof.

2.1.1 Accessible and Available Care. Provider will provide, at a minimum, access to care in accordance with HAP's established standards and will conform in its provision of care with applicable state and federal laws and regulations and National Committee for Quality Assurance (NCQA) guidelines.

2.1.2 Hours of Operation. Provider will ensure that Covered Services are available via telephone or in person twenty-four (24) hours a day, seven (7) days a week, if applicable for Provider's license and scope of practice. Provider will at all times use its best clinical judgment in referring patients to the most appropriate health care setting.

2.1.3 Eligibility Verification. Provider agrees to accept presentation of the HAP identification card, subject to telephone or internet based confirmation, as evidence of an individual's eligibility to receive Covered Services. Provider will follow HAP's eligibility verification procedures to determine Enrollee eligibility and

if contemplated services to be provided are Covered Services. Provider agrees that failure to confirm individual eligibility and network assignment in accordance with HAP's Policies and Procedures may result in nonpayment by HAP. HAP reserves the right to retroactively change an Enrollee's status based upon enrollment and eligibility information obtained from employer groups and Enrollees.

2.1.4 Assignment of Benefits. Provider will obtain from all Enrollees for whom Covered Services are provided signed assignments of benefit authorizing payment for Covered Services to be made directly to Provider or its designee.

2.1.5 Compliance. Provider will comply with applicable written policies and procedures as established or modified by HAP from time to time, including, but not limited to, HAP's quality, referral, and utilization management programs. In the event HAP determines that a service is not Medically Necessary, HAP will notify Provider or Provider's designee. If Provider disagrees with HAP's determination, Provider may appeal the decision as provided in HAP's Policies and Procedures.

2.1.6 Provider Directories. Provider acknowledges that HAP may use its name, specialties, address, services, phone numbers and hours of operation in HAP's directories and other similar marketing materials. HAP may publish price and quality information about Provider for the benefit of HAP Enrollees and purchasers provided that Provider has an opportunity to verify the accuracy of any such information. Provider will be allowed access to any web site or mailings used by HAP to share directory information with Enrollees and purchasers.

2.2 PROVIDER REPRESENTATIONS. Provider represents and warrants that: (a) Provider is legally authorized to negotiate on behalf of its Affiliates, employees and subcontractors and to bind its employees and subcontractors to the terms of this Agreement and HAP's Polices and Procedures, as amended from time to time; (b) Provider has executed this Agreement through its duly authorized representatives; and (c) executing and performing the obligations set forth in this Agreement shall not cause Provider to violate any term or covenant of any other arrangement now existing or hereafter executed. During the term of this Agreement, Provider will comply with all federal, state, and local laws, regulations, reporting requirements, and instructions, including but not limited to Medicare laws and CMS instructions, and will maintain at all times (aa) appropriate licenses, registrations, and certifications required under state and federal law to conduct the Provider's business and operate its facilities, including applicable accreditation and/or certification by recognized accrediting bodies acceptable to HAP; and (bb) certification to participate in Medicare and Medicaid under Titles XVIII and XIX of the Social Security Act.

2.2.1 Credentialing. Provider agrees that it will not furnish Covered Services to Enrollees unless and until Provider has received written confirmation that Provider has been fully credentialed by HAP, consistent with HAP Policies and Procedures. Provider represents and warrants that (a) all credentialing applications have been submitted along with required materials; (b) the information with respect to the application process is complete and remains true and complete during the term of this Agreement. HAP will credential and re-credential Provider in accordance with HAP's then-current credentialing policies and procedures. Provider will immediately notify HAP of any change in status, failure to meet HAP's credentialing criteria, or other information affecting Provider's ability to render services to Enrollees as provided under this Agreement. Provider hereby agree to notify HAP within thirty (30) days of: 1) any action or proceeding against Provider with respect to its licenses or any change in its certification or accreditation by any association or organization; 2) any legal action filed or threatened against Provider in connection with services rendered during the term of this Agreement; 3) any adverse judgments (whether or not involving a Beneficiary) against Provider arising out of Provider's service activities during the term of this Agreement (whether or not involving incidents prior to the term of this Agreement).

2.2.2 Provider Exclusions. Provider warrants that Provider is a duly qualified and approved to act as a provider of health care services to Medicare Beneficiaries under Title XVIII of the Social Security Act (whether considered "participating" in Medicare or not). Further, Provider represents and warrants to HAP that (a) neither Provider nor any of its Affiliates are excluded from participation in any federal health care program, as defined under 42 U.S.C. 1320a-7b (f); (b) Provider has not arranged or contracted (by employment or otherwise) with any employee, contractor or agent that Provider or its Affiliates know or should know are excluded from participation in any federal health care program to provide items or services hereunder; and (c) no final adverse action, as such term is defined under 42 U.S.C. 1320a-7e (g), has occurred or is pending or threatened against Provider or its Affiliates or to Provider's knowledge against any employee, contractor or agent engaged to provide items or services under this Amendment (collectively "Exclusions/Adverse Actions"). Provider, during the term of this Agreement, shall notify HAP of any Exclusions/Adverse Actions or any basis therefore within two (2) business days of Provider's learning of any such Exclusions/Adverse Actions or any basis therefore.

Cooperation and Compliance. Except as specifically set forth in this Agreement, Provider, and any subcontractor or downstream entity engaged by Provider to fulfill Provider's obligations under the terms of this Agreement, agree to: (a) cooperate with HAP's quality improvement, credentialing, and utilization management programs; (b) comply with applicable HAP's Policies and Procedures as established or modified by HAP from time to time; and (c) cooperate and comply with HAP's Enrollee grievance procedure. Provider acknowledges that HAP may cease Covered Services rendered by Provider to

Enrollees because of Provider's lack of cooperation or compliance with HAP's quality improvement, credentialing, or utilization management programs. Provider acknowledges and agrees that HAP may adopt or amend any policy or procedure applicable to this Agreement. Provider acknowledges and agrees that HAP may unilaterally amend any policies or procedures to remain in compliance with state or federal laws or regulations or NCQA accreditation standards.

2.3 PROVIDER-PATIENT RELATIONSHIP. This Agreement is not intended, nor shall it be construed, to affect any provider-patient relationship. Provider acknowledges that HAP does not practice medicine or control the provision of Covered Services to Enrollees. HAP and Provider acknowledge that it is the attending health care provider who is responsible for the care and treatment of Enrollees under such provider's care. Accordingly, Provider acknowledges that HAP encourages open communication between Provider and Enrollees regarding appropriate treatment alternatives and does not penalize Provider for discussing with HAP Medically Necessary and appropriate care for an Enrollee. Provider is responsible for the provision of and arrangement for appropriate medical care for Enrollees, and for taking any and all actions necessary to ensure that the Enrollee is fully advised regarding treatment options without regard to whether such options are Covered Services.

2.3.1 Standard of Care. Provider will render services to Eligible Enrollees in accordance with the highest applicable standards of care in the local health care community. Provider will deliver Covered Services in a prompt manner, consistent with professional, clinical, and ethical standards, and in the same manner as provided to its other patients.

2.3.2 Nondiscrimination. Provider will not discriminate in the provision of or arrangement for Covered Services on any basis prohibited by law, including, but not limited to, an Enrollee's age, race, color, creed, religion, gender, weight, sexual preference, national origin, health status, benefits, use of Covered Services, Coordination of Benefits, income level, the filing by an Enrollee of a complaint or grievance, enrollment in HAP, or eligibility for Medicare or Medicaid. Provider will not discriminate in the selection or retention of providers on any basis prohibited by law or due to a provider's participation in HAP. Provider will not segregate any Enrollee or treat any Enrollee in a location or manner different from other patients, unless medically indicated.

2.3.3 Patient Self-Determination. Provider acknowledges that (1) Enrollees have the right under state and federal law to make decisions regarding medical care, including the right to accept or refuse life-sustaining treatment; and (2) that HAP is subject to the Patient Self Determination provision of the Omnibus Budget Reconciliation Act of 1990. Provider agrees to comply with the Patient Self Determination Act and to abide by HAP Policies and Procedures as they relate to an Enrollee's rights to make medical treatment decisions.

2.3.4 Enrollee Grievances. Provider will cooperate with and participate in HAP's grievance policy and procedure, including adherence to the timelines outlined therein, providing HAP the information necessary to resolve the grievance. The Provider will assist HAP to resolve any grievance related to the provision of Covered Services, and will abide by the final decision of the grievance committee.

2.3.5 Co-payments, Coinsurance, Deductibles; Non-Covered Services. Provider has the right to bill and collect co-payment, coinsurance, and deductible amounts from an Enrollee as specified in the Enrollee's Subscriber Contract. For a Covered Service that is considered a "basic health service" under state law, no co-payment or coinsurance charged to an Enrollee will exceed fifty (50%) of the amount Provider receives as reimbursement from HAP for the particular service. Provider may bill and collect its usual billed charge from an Enrollee for any service rendered that is not a Covered Service provided that the Provider has advised the Enrollee in advance that a particular service is not a Covered Service and Enrollee has agreed in writing (using a HAP-approved form; available on HAP Website) that he or she will be responsible for Provider's usual billed charge for the non-covered service. Nothing contained in this section shall limit Provider's ability to collect deductibles and co-payments that may be due and owing from Enrollees.

2.3.6 Enrollee Hold Harmless. Provider will look only to HAP for compensation for services rendered to an Enrollee when such services are Covered Services. Provider agrees not to bill, charge, collect a deposit from, seek compensation from, seek remuneration from, surcharge or have any recourse against an Enrollee or person acting on behalf of an Enrollee, except as to co-payments, coinsurance, or deductibles as may be provided in the Enrollee's Subscriber Contract or as permitted under Section 4.5 of this Agreement. Provider agrees not to maintain any action at law or in equity against an Enrollee to collect sums that are owed by HAP to Provider under the terms of this Agreement, even in the event that HAP fails to pay, becomes insolvent, or otherwise breaches the terms and conditions of this Agreement. This section shall survive termination of this Agreement, regardless of the cause of termination and shall be construed to be for the benefit of Enrollees. This section is not intended to apply to services provided after this Agreement has been terminated, except as otherwise provided in this Agreement, or to Non-Covered Services. Provider further agrees that this provision supersedes any oral or written agreement, entered into between Provider and Enrollee or persons acting on Enrollee's behalf, insofar as such agreement relates to payment for services provided under this Agreement.

2.3.7 HAP Insolvency. In the event of HAP's insolvency or cessation of operations, Provider will continue to deliver Covered Services to Enrollees as provided in Section 6.4 of this Agreement.

2.4 SITE EVALUATIONS. Provider shall permit HAP, the U.S. Department of Health and Human Services ("DHHS"), CMS, the National Committee for Quality Assurance ("NCQA") and other authorized regulatory, certification and accreditation agencies to conduct on-site evaluations of its healthcare facilities, offices and records periodically in accordance with the terms of this Agreement and federal and state laws and regulations and to review all phases of healthcare services covered by this Agreement. Provider further agrees to comply with required recommendations such agencies may make. HAP shall give Provider reasonable notice of the intent to conduct a site visit and will give Provider reasonable notice of any agency's plans to conduct a site visit, provided HAP receives such notice. Provider shall retain the right to schedule such visits to minimize the disruption to its normal business operations.

2.5 RECORDS. Provider agree to maintain all medical records of Enrollees in accordance with state and federal law and regulation, and in compliance with all confidentiality and privacy rules related to personal health information. Upon request, Provider will furnish HAP with a statement outlining its procedures for ensuring conformance with applicable laws and regulations. Provider will provide such information to HAP and the U.S. Department of Health and Human Services as may be necessary or appropriate for HAP's continued compliance with law, or for compliance with the obligations assumed by HAP in Subscriber Contracts.

2.5.1 HAP Access. Provider will grant to HAP, or its designee, access to all data and information obtained, created or collected by Provider, including, without limitation, Enrollee medical records, financial, accounting, and administrative records, books and papers relating to the provision of Covered Services. HAP includes in its Subscriber Contracts a provision which allows HAP and its authorized representatives to examine Enrollee medical records and business records pertaining to the Enrollee's care. The Enrollee medical information that HAP requests may include information that relates to mental health, chemical dependency, or communicable diseases, and other information necessary to perform quality management, utilization management, grievance, benefit determination, credentialing, or other functions.

2.5.2 Enrollee Access. Subject to applicable privacy and confidentiality requirements, Enrollees' medical records will be made available to any physician attending the Enrollee with the Enrollee's written authorization. Enrollees will have access to their own medical records during Provider's normal business hours. Notwithstanding anything contained herein to the contrary, Provider will not charge more for copies than may be acceptable under the provisions of the Health Insurance Portability and Accountability Act, as amended and its regulations, or state law, whichever is less. In the event that an Enrollee requests a copy of his/her medical records as a result of a site closure, Provider will make such copies available to the Enrollee at no cost.

2.5.3 Transfer or Termination. Upon termination of this Agreement, or upon the request of HAP in connection with an Enrollee's transfer to another HAP Provider or HAP Physician, Provider will furnish a copy of all or any portion of such Enrollee's medical records to HAP or a physician or entity affiliated with or designated by HAP, as permitted by law.

2.5.4 Federal Access. Until the expiration of ten (10) years after the furnishing of services provided under this Agreement, Provider will make available to the Secretary, U.S. Department of Health and Human Services, and the U.S. Comptroller General, and their representatives, this contract and all related books, documents and records necessary to certify the nature and extent of the costs of services. If Provider carries out its duties under this Agreement through a subcontract worth Ten Thousand ($10,000) Dollars or more over a twelve (12) month period with a related organization, contractor, or subcontractor, the subcontract will also contain this access to records clause to permit access by the Secretary, Comptroller General and their representatives to the books and records of the related organization, contractor, or subcontractor.

2.5.5 Survival. The obligations set forth in this section 2.5 will survive termination of this Agreement.

2.6 MEDICAL RECORD AND BILLING REVIEWS. Subject to applicable law and the confidentiality provisions set forth in this Agreement, Provider will allow HAP or its designee to conduct reviews of Provider's medical and billing records related to Covered Services provided to Enrollees under this Agreement. Except for reviews involving fraud, waste, or abuse, HAP will give thirty (30) days' prior written notice to Provider regarding the review, including charge audit reviews, and setting forth the scope of the medical and billing records to be reviewed. Such audits will be limited to a timeframe of one hundred and eighty (180) days from the date of payment by HAP, except for reviews for fraud, waste, or abuse.

2.6.1 Scope of Audit. Consistent with prevailing audit standards, HAP will determine the scope and methodology used in an audit, including charge change audits. Provider will give HAP or its designee on-site access during Provider's regular business hours and at a mutually agreeable time to its medical and billing records related to Covered Services provided to Enrollees as may be necessary for benefit determination, compliance with applicable billing requirements, and/or verification of compliance with the requirements of the Utilization and Quality Management programs. HAP reviewers will use their best efforts to minimize disruption to normal operations while conducting medical and billing record reviews.

2.6.2 Review Findings. The findings resulting from a review undertaken pursuant to this section 2.6 will be submitted in writing to Provider for comment. If the review indicates an overpayment, Provider will repay HAP within sixty (60) days after receiving the findings from the review. HAP may offset overpayment amounts against future payments to Provider. Provider may submit a matter involving audit and review findings to HAP's provider claims appeal procedure.

2.7 INSOLVENCY OF PAYER(S). In the event a Payer goes out of business, ceases operation or becomes insolvent, Provider shall continue to provide Covered Services to Enrollee until the later of (i) termination of the Subscriber Contract; or (ii) the discharge of Enrollee from an inpatient facility or a physician's care. Providers may take all legal actions against Payer(s) for uncompensated services. HAP shall not be held liable for payments due from insolvent Payers.

2.8 NEW PRODUCTS. In the event HAP develops a new product line or line of business, Provider shall participate in such product line or line of business upon terms for reimbursement to be mutually agreed to by the parties at that time.

2.9 PUBLICATION OF COST AND QUALITY DATA. HAP may publish price and quality information about Provider for the benefit of HAP consumers and purchasers provided that Provider has an opportunity to ensure that any such information is accurate and clear to consumers and purchasers. Upon request, Provider will be provided access to any web site or mailing used by HAP to share this information with consumers and purchasers.

ARTICLE III

RESPONSIBILITIES OF HAP

3.1 LICENSURE AND ACCREDITATION. Health Alliance Plan of Michigan will maintain its licensure by the state of Michigan as an HMO and its accreditation by NCQA. HAP will notify Provider within ten (10) days after receipt of any adverse action against Health Alliance Plan of Michigan's state licensure or accreditation.

3.2 CONFORMANCE WITH STATE AND FEDERAL LAWS. HAP will perform its obligations under this Agreement in conformance with applicable state and federal law and regulation, including, but not limited to, laws and regulations relating to its participation as a contractor under the Medicare program.

3.3 QUALITY AND UTILIZATION MANAGEMENT. HAP will establish and maintain quality and utilization management programs as necessary to meet the requirements of state and federal law and NCQA standards.

3.4 ENROLLMENT. HAP will enroll Enrollees, maintain eligibility data with reliance upon information provided by enrolled groups, provide Enrollee identification cards, and make eligibility information available to Provider via internet and telephone.

3.5 INQUIRY SERVICES. HAP will provide telephone and/or internet inquiry services that allow Provider to determine Enrollee eligibility for benefits, status of claims, request claims adjustments, or make other inquiries about HAP products, programs, and HAP Policies and Procedures. These inquiry services will be reasonably available and consistent with local standards.

3.6 HAP POLICIES AND PROCEDURES. HAP will maintain a compilation of its policies and procedures in a written Provider Manual and/or on the HAP Web site. HAP will give Provider sixty (60) days advance notice of any material change to a HAP Policy or Procedure. Notice may appear on the HAP Web site or be sent to Provider in written form. Notwithstanding the foregoing, any amendment to HAP Policies and Procedures required by federal or state law or to remain in compliance with NCQA accreditation standards will become effective in accordance with such legal requirements.

3.7 COMPENSATION STANDARDS. Consistent with NCQA guidelines, HAP does not offer incentives or compensation to staff involved in Utilization Management decisions that would tend to encourage denials of coverage or service. Utilization management and case management decisions are based solely upon appropriateness of care and service.

ARTICLE IV

CLAIMS SUBMISSION AND PAYMENT ADMINISTRATION

4.1 TIMING OF CLAIMS SUBMISSION. Provider will submit Clean Claims within sixty (60) days of the date of service. In no circumstance will Provider submit claims more than one (1) year after the date of service; or, for self-funded plans, the time period prescribed in a plan sponsor's summary plan description; or, in cases where coverage is coordinated, no more than ninety (90) days after settlement with an Enrollee's primary payer. Provider hereby waives its right to payment for any claim submitted after the applicable filing limit. Provider will submit claims in accordance with generally accepted industry standards for billing and coding practices, and in accordance with applicable HAP policies and procedures.

4.2 METHOD OF CLAIMS SUBMISSION. If Provider elects not to transmit claims to and receive reports from HAP electronically, Provider agrees to comply with such policies and procedures as HAP may establish. Any costs associated with non-electronic transmission will be the responsibility of Provider. If Provider accesses or stores medical information about Enrollees electronically, Provider will establish procedures to safeguard the integrity, confidentiality, and security of such medical information.

4.3 PAYMENT. If HAP is the primary payer, HAP will pay Clean Claims within forty-five (45) days, and/or in accordance with state of Michigan regulatory requirements referenced in the Michigan Insurance Code of 1956, Act 218, amended section 500.2006, as may be amended from time to time. If HAP is acting on behalf of the primary Payer, HAP will process claims as provided in Exhibit E and the applicable appendices. Provider agrees that HAP's payment hereunder is in full discharge of any amounts owed by HAP to Provider. HAP shall compensate Provider in accordance with the financial terms set forth in Exhibit E. Provider agrees to accept such compensation as payment in full for all Covered Services rendered to Enrollees, less applicable copayments, coinsurance, deductibles, or withholds. Provider shall have the right to bill and collect from an Enrollee, the amount specified in the Subscriber Contract as Enrollee's copayments, coinsurance and deductibles.

4.4 COORDINATION OF BENEFITS. HAP and Provider will cooperate and exchange information regarding Enrollees' alternate health coverage and other information relative to Coordination of Benefits. Provider will seek reimbursement from third-party primary payers prior to billing HAP in the event that HAP has secondary payer responsibility. If HAP has secondary responsibility for payment, HAP will pay no greater amount to Provider than that which it would have paid had HAP been the primary payer, when added to amounts payable from other sources under applicable Coordination of Benefit rules.

4.5 PAYMENT WHEN HAP IS SECONDARY PAYER. When HAP is the secondary payer, payment for Covered Services provided by Provider under this Agreement will be

made pursuant to the Coordination of Benefits provisions of the HAP Provider Manual, which is available for review on the HAP Website. Provider agrees to cooperate with HAP for proper determination of benefits coordination. Provider will bill and collect from other payers such charges as the other payer is responsible for paying. If there is an Enrollee responsibility portion due from the primary payer, HAP will pay the Enrollee responsibility portion up to the negotiated rates specified in this Agreement.

4.6 OVERPAYMENTS. Provider will notify HAP immediately if it becomes aware of an overpayment. Provider agrees to return to HAP the overpaid amount within sixty (60) days after Provider becomes aware of such overpayment or after Provider receives notice from HAP of an overpayment. HAP may offset overpayment amounts against future payments to Provider. If HAP pays Provider less than is due to Provider under the applicable HAP Product financial arrangement, HAP will pay the additional amount owed to Provider within sixty (60) days after HAP receives notice of such underpayment from Provider. Underpayments and/or overpayments must be reported as identified by either party within 12 months of the date of the Covered Service.

4.7 DENIALS OF PAYMENT; APPEAL PROCESS. Provider may submit a matter involving a denied claim to HAP's provider claims appeal procedure. Provider acknowledges and agrees that the claims appeal procedure is not available for a denial of payment due to Provider's failure to meet its obligations as specified in this Agreement, and Provider will not charge Enrollees for Covered Services that HAP has denied as provided in section 2.3.6 of this Agreement.

4.8 VERIFICATION OF MEDICAL NECESSITY. Provider shall verify medical necessity as required by HAP's Policies and Procedures. Provider acknowledges that failure to verify medical necessity prior to rendering services may result in nonpayment by HAP. In the event HAP determines that a service is not Medically Necessary, HAP will notify Provider. If Provider disagrees with the determination of HAP, Provider may appeal the determination in accordance with HAP's Polices and Procedures.

4.9 FINANCIAL RESPONSIBILITY OF HAP. For any Subscriber Contract where HAP is the TPA, the appropriate Payer shall have the full and final responsibility and liability for payment of claims for Covered Services rendered pursuant to the terms of this Agreement. When acting as a TPA, HAP is not the insurer, guarantor, or underwriter of the liability of Payer to reimburse Provider or Enrollees for Covered Services. HAP when acting as a TPA shall not be liable for the payment from its own funds of any claims for Covered Services, except that HAP when acting as a TPA, shall have full and final responsibility for making disbursements to Provider of claims payment amounts transferred between Payer and HAP on behalf of Provider.

ARTICLE V

INSURANCE AND INDEMNIFICATION

5.1 INSURANCE. At its sole expense, Provider will maintain such policies of general and professional liability insurance, or equivalent self-insurance programs, as is satisfactory to HAP and necessary to insure Provider, its employees and agents against any claims for damages arising in connection with the performance of services hereunder and/or the use of Provider's property or facilities. Provider will provide HAP with notice of non-renewal, cancellation, or termination of any insurance coverage required by this Agreement within a reasonable time after cancellation or termination of such coverage. In no event shall the liability limits of such insurance policies be less than $1,000,000 per occurrence and $5,000,000 in aggregate, unless approved in writing by HAP. In the event that Provider's insurance coverage is of the claims-made variety, Provider shall maintain coverage for two (2) years beyond the termination of this Agreement or purchase tail coverage upon the termination of this Agreement. This provision shall survive the termination of this Agreement.

5.2 HAP INSURANCE. At its sole expense, HAP will maintain such policies of general and professional liability insurance, or equivalent self-insurance programs, as necessary to insure HAP, its employees and agents against any claims for damages arising in connection with the performance of HAP's obligations under this Agreement.

5.3 INDEMNIFICATION. Each party agrees to indemnify and hold harmless the other party, its officers, employees, and agents from and against third party fines, claims, demands, suits, actions, or costs, including reasonable attorneys' fees of any kind and nature, to the extent they arise by reason of the indemnitor's acts or failures to act as described in this Agreement. In no event will the foregoing sentence be construed to require that HAP indemnify Provider for acts or omissions of Provider in the rendering of medical care, the practice of medicine, or the provision of health care services.

ARTICLE VI

TERM AND TERMINATION

6.1 INITIAL TERM AND RENEWAL. The initial term of the Agreement is three (3) years, commencing on the Effective Date. The Agreement will automatically renew for subsequent one (1) year terms, unless either party gives written notice of its intent not to renew the Agreement to the other party at least one hundred and eighty (180) days' prior to the contract renewal date, or if earlier terminated as provided below.

6.2 TERMINATION WITHOUT CAUSE. This Agreement may be terminated without cause by either party at any time, by giving the other party one hundred and eighty (180) days' prior written notice.

6.3 TERMINATION FOR CAUSE. Either party may terminate this Agreement for breach of a material obligation if the non-breaching party gives notice describing such breach, proposes a specific remedy and the breach is not cured within thirty (30) days following the breaching party's receipt of such notice. HAP may terminate this Agreement immediately due to: (a) a suspension, withdrawal, expiration, non-renewal or revocation of any license, certificate or other legal credential authorizing Provider to render healthcare services; (b) the charge, indictment, arrest, or conviction of any felony related to moral turpitude or the provision of healthcare services of Provider or any officer of Provider; (c) the cancellation, reduction, limitation or termination of Provider's participation in Medicare or Medicaid; (d) any false statement or material omission in said Provider's credentialing or recredentialing application(s) or Enrollee health information or records, including claims for compensation; or (e) HAP's determination, in its sole discretion, that continuation of Provider's participation hereunder could negatively affect the health, welfare or safety of Enrollees. Provider shall provide immediate notice to HAP of any of the aforesaid events. HAP shall notify Provider of the immediate termination for cause.

6.4 POST-TERMINATION OBLIGATIONS In the event of termination of this Agreement, for any reason, Provider shall notify all affected Enrollees prior to the effective date of the termination. In this case, affected Enrollees includes any Enrollee who has received services from Provider within the last six (6) months or who has chronic condition that could reasonably cause the Enrollee to seek services from Provider within six (6) months following termination. At HAP's option Provider shall furnish continuing Covered Services to any Enrollee then receiving treatment from Provider until the transfer by HAP of any such Enrollees to another HAP Provider and HAP will continue to compensate Provider for Covered Services at the rates specified in **Exhibit E** hereto. Upon notice of termination of this Agreement, Provider shall cooperate fully with HAP and comply with HAP's Policies and Procedures in the transfer of Enrollees to other HAP Providers.

ARTICLE VII

DISPUTE RESOLUTION

7.1 DISPUTE RESOLUTION. Controversies between HAP and Provider arising out of or relating to the interpretation or application of this Agreement, or actions of the Parties pursuant to this Agreement, will be resolved by direct negotiation between HAP and Provider. Should negotiations result in failure to reach agreement as determined by either party, the dispute resolution procedures set forth in sections 7.1.1 through 7.1.4 below will be followed. Notwithstanding the foregoing, the parties acknowledge and agree that this dispute resolution process is not intended to address (a) whether a service is Medically Necessary, (b) HAP's decision to approve or deny an application for credentialing or recredentialing, (c) disagreements regarding audit review findings as provided in section 2.6.2, or (d) appeal of denied claims as provided in section 4.7 of this Agreement. Provider may utilize HAP's provider appeal process for resolution of such matters as described in HAP's Policies and Procedures.

7.1.1 Informal Procedure.

a. A disputing party must first send a written statement within sixty (60) days to the other party outlining the nature and extent of the problem. The statement will contain all written documentation and supporting documents germane to the grievance. The disputing party will then schedule a meeting with the other party within forty-five (45) days to discuss the problem.

b. If the meeting set forth above does not resolve the problem between the parties, the responding party will send within ten (10) days a written response to the original written grievance. The response will specifically set forth the answer and/or statement of the responding party together with all supporting documentation, which will be the basis for Executive Level Review.

c. Discussions of the parties at the Informal Procedure and Executive Level Review will be treated as settlement discussions and statements made by either party will not be admissible against the party's interest in mediation, arbitration, or litigation.

7.1.2 Executive Level Review. In the event the Informal Procedure outlined above has not resolved the dispute, the disputing party will schedule a meeting between HAP's Chief Operating Officer and Provider's Chief Operating Officer, or between persons holding a comparable administrative position in the party's respective organizations. These officers will have thirty (30) calendar days to resolve the dispute. If additional meetings are held and resolution of the dispute occurs, the parties will produce a written document describing how the dispute has been resolved, or the parties may amend the Agreement to reflect the resolution. If no resolution is reached within ninety (90) calendar days from the initial executive level meeting, either party may pursue mediation, as applicable,

or arbitration of the matter as provided in sections 7.1.3 and 7.1.4 of this Agreement.

7.1.3 Third-Party Mediation. All disputes valued at One Hundred Thousand ($100,000) Dollars or less, or any dispute for which monetary payment is not at issue will be settled through a third-party mediation process. The parties will agree upon a single mediator, who possesses the qualifications, education, and experience, in the reasonable judgment of both parties, to address and resolve the subject matter of the dispute. The results of the mediation will be binding upon the parties, unless a resolution of any issue in dispute is not reached in which case the parties will proceed to arbitration as provided on section 7.1.4 of this Agreement. Any statements made by either party during the mediation process will be considered part of a settlement offer and will not be admitted in any arbitration proceeding or in litigation. The costs of the mediation, exclusive of each party's costs of legal counsel, will be shared equally between the parties.

7.1.4 Arbitration. In the event the parties cannot satisfactorily resolve a dispute concerning this Agreement, including those matters which the parties have mediated in accordance with section 7.1.3, the parties will settle the dispute by arbitration in accordance with the commercial arbitration rules of the American Arbitration Association then in effect. Either party may initiate arbitration by making a written demand for arbitration upon the other party within thirty (30) days of the time the dispute arises or from the date that a mediator determines that mediation has failed to resolve the matter. Within thirty (30) days of the demand, HAP and Provider will each designate an arbitrator and give written notice of such designation to the other. The two arbitrators selected will select a third arbitrator and give notice of the selection to the parties. The three arbitrators will hold a hearing and decide the matter within thirty (30) days thereafter. If a unanimous award by the three arbitrators is not possible, the parties will permit the third arbitrator to render the award alone. The results of the arbitration will be final and binding upon both parties. Any court that has jurisdiction may enter judgment upon the award of the arbitrators. HAP will pay the fee of the arbitrator it has selected, Provider will pay the fee of the arbitrator it selected, and the parties will share equally the fee of the third arbitrator. The parties exclude the following matters from the operation of this arbitration clause: any counterclaim, crossclaim, or third party claim for indemnity or contribution between Provider and HAP in an Enrollee's suit against Provider or a third-party payer, unless a court orders the parties to submit the Enrollee's entire claim to arbitration.

ARTICLE VIII

MISCELLANEOUS

8.1 CONFIDENTIALITY. Provider acknowledges that all materials relating to practice guidelines, pricing structures, contracts, the internal functioning of HAP, and materials bearing HAP's name or logo are proprietary. Provider agrees to maintain the confidential nature of such materials consistent with the provisions of this Agreement, and to return them to HAP, upon request upon the termination of this Agreement for any reason. During the term of this Agreement, and for a period of three (3) years following the date of expiration or termination of this Agreement, HAP and Provider agree that they will keep confidential, and will not, without the prior written approval of the disclosing party, use for itself or others, or disclose to any third party, any confidential information of the disclosing party, including, but not limited to, the terms of this Agreement and business or technical information that is disclosed by either party to the other in the course of the performance of this Agreement. This obligation will not apply to any information that either party can demonstrate with written evidence was already known to the receiving party as of the date of this Agreement or that is properly in the public domain, or, subject to compliance with the remainder of this section, that is required to be disclosed pursuant to an order of a court, regulatory agency, or by applicable federal or state law, rule or regulation. With respect to any information that either is requested or required to be disclosed pursuant to an order of a court, regulatory agency, or by applicable federal or state law, including, without limitation, by subpoena, request for information in litigation, or other legal process, each party will provide the originally disclosing party with prompt written notice of such request or requirement so that the originally disclosing party may seek a protective order or other appropriate remedy to maintain the confidentiality of such information, and/or limit or condition any disclosure thereof. If, in the absence of a protective order or other remedy, a party is required to disclose information pursuant to an order of a court, regulatory agency, or by applicable federal or state law, the party ordered to make the disclosure may disclose only that portion of the information which it is legally required to disclose in accordance with an opinion of legal counsel. The party ordered to make disclosure will take all actions available to it to preserve the confidentiality of information disclosed to the greatest extent possible in accordance with law.

8.2 GOVERNING LAW. This Agreement will be governed in all respects by the laws of the State of Michigan, without regard to its choice of law rules.

8.3 AMENDMENTS AND MODIFICATIONS. No changes, amendments, or alterations to this Agreement will be effective, unless in a written amendment signed by both parties. Provided that HAP may amend this Agreement, upon written notice to Provider, to comply with any applicable law or regulation, NCQA accreditation standard, or any order or directive of a governmental agency. Notwithstanding anything contained herein to the contrary, HAP may adopt, amend, or curtail any or all of its Policies and

Procedures in its discretion, from time to time, and any such change will not be considered an amendment to this Agreement.

8.4 RELATIONSHIP OF THE PARTIES. The parties to this Agreement are independent contractors. This Agreement is not intended to create nor shall be construed to create any relationship between the parties other than that of independent entities contracting for the purpose of effecting provisions of this Agreement. Provider and its respective employees and agents will in no way be considered agents or representatives of HAP for any purpose, nor will Provider and its respective agents and employees assume or create any obligations or responsibilities, express or implied, on behalf of or in the name of HAP, or bind HAP in any manner whatsoever.

8.5 INTERFERENCE WITH CONTRACTUAL RELATIONS. Provider and its respective employees and agents will not counsel or advise Enrollees, payers, employers, subscriber groups, unions, union trusts, multiple employer welfare associations, voluntary employee beneficiary associations, or other entities who are currently under contract with HAP to cancel, modify, or not renew contracts with HAP.

8.6 USE OF NAME AND TRADEMARKS. HAP and Provider each reserve the right to and control of the use of their name, symbols, trademarks, copyrights, and service marks presently existing or later established. Except as provided in this Agreement, neither HAP nor Provider will use the other party's name, symbols, trademarks, copyrighted material, or service marks in advertising, promotional materials, or otherwise without the prior written consent of that party.

8.7 HIPAA COMPLIANCE. The parties agree to comply with the applicable provisions of the federal Health Insurance Portability and Accountability Act ("HIPAA) as may be amended from time to time.

8.8 NO WAIVER OF RIGHTS. The failure of either party to insist upon the strict observation or performance of any provision of this Agreement or to exercise any right or remedy will not impair or waive any such right or remedy in the future. Every right and remedy given by this Agreement to the parties may be exercised from time to time as often as appropriate.

8.9 SEVERABILITY. The invalidity or unenforceability of any of the terms or provisions of this Agreement will not affect the validity or enforceability of any other term or provision of this Agreement so long as the economic or legal substance of the transactions contemplated hereby is not affected in any manner materially adverse to any party. Upon the determination that any term or provision is invalid, illegal or incapable of being enforced, the parties will negotiate in good faith to modify this Agreement so as to effect the original intent of the parties as closely as possible in an acceptable manner in order that the transactions contemplated hereby are consummated as originally contemplated to the greatest extent possible.

8.10 CONSTRUCTION. The parties acknowledge that each party and its counsel have reviewed and revised this Agreement and that consequently any rule of construction to the effect that any ambiguities are to be resolved against the drafting party is not applicable in the interpretation of this Agreement or any amendments or exhibits hereto.

8.11 SURVIVAL. Sections 2.3.6, 2.3.7, 2.5 and its subsections, 2.6 and its subsections, 5.1 and its subsections, 6.4, 7.1 and its subsections, 8.1, 8.7, and 8.11 will survive termination of this Agreement.

8.12 ASSIGNMENT. This Agreement will not be assigned by Provider without the prior written consent of HAP, including by written assignment, transfer, delegation, and whether by merger or other operation of law, change of control, or otherwise. Any permitted assignee will assume all obligations of its assignor under this Agreement. No assignment will relieve a party of responsibility for the performance of any obligations that have already accrued. This Agreement will inure to the benefit of and be binding on each party, its respective successors and permitted assigns.

8.13 NO THIRD PARTY BENEFICIARIES. This Agreement is not intended to be a third party beneficiary contract or to confer any rights on any person other than the parties to this Agreement.

8.14 NOTICES. Any notice required to be given under the terms of this Agreement will be effective if given in writing and sent by facsimile with written confirmation of transmission, overnight delivery service with proof of receipt, or by certified mail with return receipt requested. Notices will be sent to the following addresses (which may be modified by giving notice in conformity with this section):

To Provider:
Chief Executive Officer
Centria Healthcare, LLC
41521 W. 11 Mile Rd
Novi, MI 48375

With a copy to:
Program Director
Centria Healthcare, LLC
41521 W. 11 Mile Rd
Novi, MI 48375

To HAP:
Attn: V President, Network Management
Health Alliance Plan
2850 W. Grand Boulevard
Detroit, MI 48202

With a copy to:
Legal Department
Health Alliance Plan
2850 West Grand Boulevard
Detroit, Michigan 48202

8.15 NON-EXCLUSIVE. This Agreement is not exclusive and nothing herein will preclude either party from contracting with any other person or entity.

8.16 COUNTERPARTS; FACSIMILE. This Agreement may be executed in counterparts, each of which will be deemed an original, but all of which together will constitute one and the same Agreement. This Agreement may be executed and

delivered by facsimile; however, the original signature copy will be delivered to the other party by overnight delivery. The failure to deliver the original signature copy and/or the non-receipt of the original signature copy will have no effect on the binding and enforceable nature of this Agreement.

8.17 HEADINGS. The headings contained in this Agreement are included for purposes of convenience only, and will not affect in any way the meaning or interpretation of any of the terms or provisions of this Agreement.

8.18 ENTIRE AGREEMENT. This Agreement and any exhibits properly incorporated from time to time are the complete agreement and understanding of the parties. This Agreement supersedes any prior agreements and understandings, whether written or oral, between the parties with respect to the subject matter hereof.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed by their duly authorized representatives as of the day and year first written above.

THIS AGREEMENT IS VALID AT THE TIME IT IS SIGNED BY HEALTH ALLIANCE PLAN OF MICHIGAN.

Centria Healthcare, LLC

By: _____

Printed Name: Scott Barry

Title: Chief Executive Officer

Date: 3/12/15

Agreed to on behalf of Health Alliance Plan of Michigan:

By: _____

Printed Name: Mark Zickel

Title: VP, Provider Network Management

Date: 3/19/2015

EFFECTIVE DATE OF THIS AGREEMENT ESTABLISHED BY HAP: 3-1-15

INCORPORATED ADDENDUM, EXHIBITS AND APPENDICES

Exhibit A	Provider Service and Performance Requirements
Exhibit B	Affiliated Providers/Facility Locations
Exhibit C	After-hours Alternate Provider Agreement
Exhibit D	Credentialing Standards
Exhibit E	Product Participation and Payment Terms
Exhibit F	Provisions Applicable to Medicare Advantage

EXHIBIT A

PROVIDER SERVICE AND PERFORMANCE REQUIRMENTS

1. During the term of this Agreement, Provider attests that it has and shall continuously possess and maintain the following qualifications, as applicable:

   a. a permanent license in the State of Michigan, subject to no revocation, corrective action, suspension, or other disciplinary action;

   b. licensure, certification, or registration under State and/or Federal laws and regulations, including but not limited to CAP accreditation or any other accreditation approved by HAP;

   c. participate in the Medicare Program or accept Medicare assignment and not have been suspended from Medicaid.

   d. maintain professional liability insurance consistent with industry standards and provide evidence of coverage, in the form of a copy of the certificate of insurance to HAP upon request.

2. During the term of this Agreement, Provider shall continuously meet the following requirements, as applicable:

   a. submit claims for payment utilizing HCFA Form 1500, or its successor electronic counterpart;

   b. immediately notify HAP of the initiation or conclusion of any proceedings concerning Provider which may adversely affect (i) any of Provider's licenses, registrations or certification to operate as a clinical laboratory under state and/or federal law and regulations, including the Clinical Laboratory Improvements Act of 1988, (ii) obtain or maintain professional liability insurance or self-insurance, (iii) participate as a participating provider under Medicare and Medicaid or (iv) any occurrence involving the Provider of any legal action arising out of a clinical laboratory/patient relationship.

EXHIBIT B

LIST OF PROVIDER AFFILIATES

First Name	Last Name	BACB Certification #
Cheri	Cramer	1 14 15741
Natasha	Flemings	1 14 16481
Anne	Hirsch	1 14 17530
Melissa	Leyanna	1 12 11586
John	Moore	1 14 9541
Donna	Smith	1 09 6320
Giovanni	Vitale	1 14 16561

BILLING ADDRESS

41521 W. 11 Mile Rd
Novi, MI 48375
NPI: 1053641498
TIN: 27-1402749

FACILITY LOCATIONS

19855 Outer Drive
Ste. 101
Dearborn, MI 48124
NPI: 1730586710
TIN: 27-1402749

13101 Allen Rd.
Bldg. #5
Southgate, MI 48195
NPI: 1093112070
TIN: 27-1402749

EXHIBIT C

AFTER-HOUR ALTERNATE PROVIDER AGREEMENT

Purpose:
The purpose of the attached Agreement is to formalize the relationship between the Provider and any Alternate Provider with whom after-hour coverage for patients may be arranged. Unless Provider can provide 24-hour coverage, at least one Alternate Provider must be selected and utilized. A signed copy of the Alternate Provider Agreement must be submitted in order for this HAP Agreement to be complete.

Procedure:
This Agreement must be signed by any alternate provider/practitioner for whom you wish to arrange any after-hour coverage for your patients. A signed copy must be approved and on file at Health Alliance Plan/Coordinated Behavioral Health Management prior to sending patients to this alternate provider/practitioner.

Each alternate provider that you intend to utilize must sign this Agreement. You may copy the attached Agreement and keep it on file in the event you wish to establish additional relationships.

Copies of all signed Alternate Provider Agreements must be sent to HAP/CBHM to the attention of Coordinated Behavioral Health Management, Credentialing Specialist, 2850 W. Grand Blvd., Detroit, MI 48202.

Exhibit C
Page Two

AFTER-HOUR ALTERNATE PROVIDER AGREEMENT

This Agreement is made between _____. (Provider) and _____ (Alternate Provider) on this _____ day of _____, 20__.

Provider Obligations:

1. To maintain a HAP Agreement to provide behavioral health services to HAP Enrollees.
2. To make specific arrangements with Alternate Provider to provide after hour coverage for Enrollees.
3. To notify CBHM that an alternate provider has provided services to an Enrollee.
4. To communicate with alternate provider to obtain the status of the case and also to keep CBHM informed of the status of the case.
5. To follow the policies and procedures of CBHM, including but not limited to, case management, Enrollee eligibility and claims submission and payment.
6. To admit Enrollees in need of inpatient care to a HAP contracted facility.
7. To notify Alternate Provider in the event the HAP Agreement is terminated.

Alternate Provider Obligations:

1. To maintain a HAP Agreement to provide behavioral health services to Enrollees.
2. To make specific arrangements with Provider to provide after hour coverage for Enrollees.
3. To coordinate the care of Enrollees by communicating with Provider the status of the case and also by keeping CBHM informed of the status of the case.
4. To follow the policies and procedures of CBHM, including but not limited to, case management, Enrollee eligibility and claims submission and payment.
5. To notify Provider in the event the HAP Agreement is terminated.
6. To admit Enrollees in need of inpatient care to a HAP contracted facility.
7. To bill and accept payment from HAP and/or Payor as required by your HAP Agreement for providing alternate care to Enrollees.

Both Provider and Alternate Provider agree to fulfill the obligations listed above. In the event this Alternate Provider Agreement is terminated for any reason, Provider must notify HAP of such termination within thirty (30) days.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement by their duly authorized officers.

PROVIDER: _____	ALTERNATIVE PROVIDER
By: _____ Print Name	By: _____ Print Name
Signature: _____	Signature: _____
Title: _____	Title: _____
Date: _____	Date: _____

EXHIBIT D
CREDENTIALING STANDARDS

Provider attests that it has and shall continuously possess and maintain the following qualifications. HAP reserves the right to modify its credentialing standards at any time.

a. A permanent license in the state in which services are provided, subject to no revocation, corrective action, suspension, or other disciplinary action, and a registration to conduct business within the State of Michigan;

b. Licensure, certification, or registration under State and/or Federal laws and regulations, including but not limited to College of American Pathologist (CAP) accreditation or any other accreditation applicable to Provider;

c. Participate in the Medicare Program or accept Medicare assignment and not have been suspended from Medicaid.

d. Maintain general and professional liability insurance as specified within the terms of this agreement. Evidence of coverage must be provided to HPI/AHL upon request.

e. Possess a laboratory registration certificate or waiver in accordance with the regulations of the Clinical Laboratory Improvement Act (CLIA) effective December 1, 1992 or its successor regulations.

CREDENTIALING STANDARDS

HAP/Coordinated Behavioral Management

- Required for all professional categories: Current professional liability insurance coverage in minimum amounts of $100,000/$300,000

I. Psychiatrist/Physician

- Current Michigan license to practice as an M.D. or D.O., with verifiable current competence
- Board certification in adult and/or child psychiatry, or recent completion of a board-approved residency or fellowship in adult and/or child psychiatry. For inpatient providers, admitting privileges in good standing at a HAP-affiliated hospital

II. Certified Social Worker

- Current Michigan license to practice as a Certified Social Worker, with verifiable current competence
- Master's degree in social work (MSW) with a major focus of study in the treatment of Behavioral Medicine or equivalent field, as defined by the Michigan Board of Examiner of Social Work
- Affiliation with a HAP/PHP contracted medical group or private practice

III. Fully Licensed Psychologist/Ph.D.

- Current Michigan license to practice as a Licensed Psychologist with verifiable current competence
- Doctoral degree in psychology from an institution and with a curriculum approved by the State of Michigan Board of Psychology
- Affiliation with a HAP/PHP-contracted medical group or private practice or eligible for affiliation as an independent provider

IV. Limited License Psychologist/LLP

- Current Michigan license to practice as a Limited License Psychologist with verifiable current competence and in conformance with licensing requirements regarding professional supervision
- Master's or doctoral degree in psychology from an institution and with a curriculum approved by the Michigan Board of Psychology
- Affiliation with a HAP/PHP-contracted medical group or private practice

V. Psychiatric Clinical Nurse Specialist

- Current Michigan License to practice as a Registered Nurse (RN), and

- Current Michigan specialist certification in one of the following:
  --Clinical Specialist in adult psychiatric and mental health nursing
  --Clinical Specialist in adolescent and child psychiatric and mental health nursing
  --Psychiatric and mental health nursing and verifiable current competence
- Master's degree in nursing from an institution acceptable to the state of Michigan with concentration in psychiatric/mental health nursing

VI. Licensed Professional Counselor

- Current Michigan license to practice as a Licensed Professional Counselor with verifiable current competence and in conformance with licensing requirements regarding professional supervision
- Master's degree from a program approved by the state Board of Counseling
- Affiliation with a HAP/PHP-contracted medical group or private practice

VII. Certified Addiction Counselor

- Current Michigan certification as a Certified Addiction Counselor, and
- Bachelor's degree in an area accepted as entrance to certification examination

VIII. Physician Assistant

- Current unrestricted Michigan license to practice as Physician's Assistant
- Completion of a Physician's Assistant training program accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP)
- Successful completion of the certifying examination conducted and scored by the National Commission on Certification of Physician Assistants
- Three years of full-time, supervised Behavioral Medicine clinical experience following completion of training. Acceptable behavioral health settings may include but are not limited to any of the following: psychiatric inpatient unit, subacute detoxification unit, ambulatory mental health or specialized nursing home behavioral health unit, geropsychiatric unit, child psychiatry unit, adolescent mental health or mental health or partial hospital program.
- Current supervision arrangement with a HAP/PHP contracted psychiatrist or HAP contracted facility
  - Affiliation with a HAP/PHP contracted behavioral medicine group or behavioral medicine group practice

IX. Board Certified Behavioral Analyst

- Must complete and pass a site visit which is conducted by a third party vendor.

- Completion of a BCBA approved Behavior Analyst program
- Master's or PhD degree
- Board certified Behavior Analyst (BCBA)
- At least one year experience of providing direct ABA services to children with autism spectrum disorders and supervision of line therapist. Experience consulting with families, educational and clinical staff is desired.

EXHIBIT E

PRODUCT PARTICIPATION AND PAYMENT TERMS

A. Product Participation.

Provider and HAP agree that the terms set forth in this Exhibit E and the attached appendices govern payment with respect to the following HAP Products:

Health Alliance Plan of Michigan (HMO and HMO Self-Funded)
Alliance Health and Life Insurance Company (AHLIC)
HAP Preferred Incorporated (HPI)
Medicare Advantage (HMO and PPO)

B. Payment Terms.

1. Health Alliance Plan of Michigan, Alliance Health and Life Insurance Company, and HAP Preferred Incorporated agree that each organization is responsible for payment to Provider for Covered Services delivered to Enrollees in the respective organization's products/programs. Provider acknowledges that each organization (i.e., Health Alliance Plan of Michigan, Alliance, and HPI) is individually responsible for payment to Provider for Covered Services delivered to Enrollees in the respective organization's managed care products/programs. Furthermore, Provider agrees to look solely for payment from each organization for its respective managed care products/programs. Provider agrees to accept as payment in full, the lesser of billed charges or the rates listed below, less applicable co-payments, coinsurance, deductibles, withholds, or any other amount reimbursed through a coordination of benefits mechanism.

2. For Products identified above in Section A, Provider agrees to accept as payment in full, **100% of the Prevailing HAP/HPI Fee Schedule;** or the lesser of approved billed charges or fifty-five percent (**55%**) of billed charges for unrepresented codes.

3. Covered Services: Center Based ABA and In-Home ABA.

4. When providing supervision visit the following conditions must be met: (a) patient and BCBA must be present in room (b) will not exceed 1 hour per 10 hours of direct care and (c) will not be billed concomitantly with direct care

5. All ABA services require prior authorization. If prior authorization isn't obtain this will result in a denial of payment.

To the extent not expressly set forth below, HAP's standard reimbursement methodologies as stated in HAP's Billing Manual and/or on HAP's website apply.

EXHIBIT F
PROVISIONS APPLICABLE TO MEDICARE ADVANTAGE

To the extent that any definition, term, condition or provision contained in this Attachment is inconsistent with or in conflict with the definitions, terms and conditions set forth in the Agreement, the definitions, terms, and conditions set forth in this Attachment will control with respect to the delivery of and payment for Medicare Covered Services rendered to Medicare Members. All other terms of the Agreement will continue to apply. The terms included herein will have the meaning required by law to be applicable to HAP and Provider under the terms of HAP's contract with CMS and the regulations promulgated in 42 CFR Part 422.

A. DEFINITIONS

1. Beneficiary means an individual entitled to and duly enrolled in Medicare.

2. CMS means the federal Centers for Medicare and Medicaid Services which administers the Medicare and Medicaid benefit programs.

3. Clean Claim means a claim for healthcare services rendered by Provider which accurately contains all the data elements including all data fields on a standard CMS 1500 or UB-92 form, or their electronic HIPAA compliant transaction set equivalent, that are required by Medicare as outlined in its program transmittals and manuals, where HAP has received along with the claim any applicable statements of other third party payment and where required, according to the Medicare Benefit Program, where HAP has received all necessary prior-authorizations and/or any other data element(s) required by HAP as specified in HAP's Provider Manual unless otherwise defined by state or federal law and regulation.

4. Evidence of Coverage means a supplement to the Medicare Benefit Contract that outlines specific benefits and exclusions.

5. Medicare Benefit Contract means an individual contract between a Medicare Member and HAP or between an employer group or other entity and HAP under which a Medicare Member is entitled to receive Medicare Covered Services under the terms of HAP's Medicare Benefit Program as described in the Medicare Benefit Program Evidence of Coverage

6. Medicare Benefit Program means a program to provide services to Medicare beneficiaries under a contract with CMS, authorized by the Balanced Budget Act of 1997 and the Medicare Prescription Drug, Improvement and Modernization Act of 2003, specifically a Medicare Advantage program, under which HAP is the payor for Medicare Covered Services provided to Medicare Members.

7. Medicare Covered Services means those health care services rendered to a Medicare Member for which HAP will provide coverage and payment in accordance with the terms of the Medicare Benefit Contract and this Attachment.

8. Medicare Defined Terms. The following terms as used in this Agreement will have the same meaning assigned to them by CMS: Hospital Specific Files, Pricers, Medicare Cost Reports, Graduate Medical Education ("GME"), Indirect Medical Education ("IME"), Fiscal Intermediary, Prospectively Priced Services ("PPS"), Disproportionate Share, Physician Fee Schedule, and Interim Rate Letter.

9. Medicare Member means a Medicare beneficiary entitled to receive coverage for certain health care services under the terms of the HAP's Medicare Benefit Program who has elected to enroll in HAP and whose enrollment with HAP has been confirmed by CMS.

10. Medicare Service Area means the area approved by CMS as being the area to which HAP may market and enroll Medicare beneficiaries in its Medicare Benefit Program.

11. Participating Provider means, for the purpose of the Medicare Benefit Program, any health care professional or other provider who has entered into a written agreement with HAP either directly or indirectly through a third party entity to provide Medicare Covered Services to a Medicare Member. The term Participating Provider will be inclusive of any of Provider's sub-contracted professional and other health care providers to the extent that they have been provided a copy of this Attachment and executed a Medicare Sub-Contractor Addendum.

B. PROVIDER OBLIGATIONS

1. Provision of Medicare Covered Services. Provider agrees to render Medicare Covered Services to Medicare Members eligible for coverage under Title XVIII of the Social Security Act, as amended (otherwise known as Medicare), in accordance with the terms and conditions of the Medicare Benefit Program. Such Medicare Benefit Program requirements include the provisions of HAP's applicable Evidence of Coverage, operational policies and procedures, Utilization Management Program and Quality Management Program requirements with which Provider will comply in rendering Medicare Covered Services. HAP will supply Provider with the Medicare Benefit Program requirements not set forth in this Attachment. Determination of Medicare Covered Services will be governed by coverage guidelines established by HAP and the Medicare Benefit Program, with HAP being solely responsible for final coverage determination, subject to the applicable appeal procedures.

2. Privacy. Provider agrees to safeguard Medicare Member privacy and confidentiality and assure the accuracy of Medicare Member health records. [42 CFR 422.118]

3. Audit. Provider acknowledges that HAP, as a Medicare Advantage Organization oversees and is accountable to CMS for any functions and responsibilities described in the Medicare Advantage regulations. HAP has the right to monitor and audit Provider and its contractors on an ongoing basis, including prospective and retrospective audits to prevent, detect, and correct fraud, waste and abuse. [42 CFR 422.503(b)(4)(vi)]

4. Compliance. Payments received by Provider for the provision of Medicare Covered Services are, in whole or in part, from federal funds, making Provider subject to all laws and regulations applicable to entities receiving federal funds. Provider agrees to comply with the HAP Policies and Procedures, Medicare laws, regulations, and CMS instructions, and all other applicable federal, state, and local laws, rules and regulations, now or hereafter in effect, regarding the performance of Provider's obligations hereunder, including, without limitation, laws or regulations governing the record timeliness and accuracy, confidentiality, privacy, appeal, and dispute resolution procedures related to Medicare Covered Services provided to a Medicare Member, to the extent that they directly or indirectly affect Provider, Provider's facilities, or HAP and bear upon the subject matter of this Exhibit F.

6. Non-Discrimination. Provider shall not discriminate against any Medicare Member in the provision of Medicare Covered Services whether on the basis of the Medicare Member's coverage under a Medicare Benefit Program, age, sex, marital status, sexual orientation, race, color, religion, ancestry, national origin, disability, handicap, health status, source of payment, utilization of medical or mental health services or supplies, or other unlawful basis including, without limitation, the filing by such Medicare Member of any complaint, grievance or legal action against Provider or HAP. [42 CFR 422.110]

7. Prohibition on Removal of Medicare Members. Neither Provider, Provider's employees, nor Provider's subcontractors under the Agreement shall request, demand, require or otherwise seek, directly or indirectly, the termination from the HAP Medicare Benefit of any Medicare Member based upon the Medicare Member's need for or utilization of medically required services, or in order to gain financially or otherwise from such termination. Provider agrees that HAP will have sole and ultimate authority to terminate a Medicare Member's coverage, and Provider understands that any requested termination is subject to prior approval by CMS. [42 CFR 422.74]

8. Record Maintenance. Provider shall maintain adequate medical, financial and administrative records related to Medicare Covered Services rendered by Provider under this Attachment in accordance with the standards established by HAP, taking into account professional standards, as set forth in this Attachment. [42 CFR 422.112(b)(4)(ii)] Unless a longer time period is required by applicable statutes or regulations, Provider shall maintain, and HAP, HHS, the General Accounting Office ("GAO") or their designees, and the National Committee for Quality Assurance ("NCQA") will have access to

and the right to audit the contracts and administrative, financial and medical records, patient care documentation, other records of Provider, subcontractors, or related entities during the term of this Agreement and for ten (10) years following (1) the end of any Agreement term, or (2) the date of completion of any audit, whichever is later. [42 CFR 422.504(d)]. Provider shall obtain the appropriate consent from a Medicare Member in order to comply with this section as consistent with federal privacy regulations. [42 CFR 422.118] Provider shall, upon request, attest to the accuracy and completeness of any encounter and/or claim data submitted to HAP for purposes of reimbursement. [42 CFR 422.311]

9. Reports and Administration. Provider shall comply, or assist HAP to comply, with the reporting requirements of 42 CFR Part 422, including, without limitation, all information necessary to administer and evaluate its Medicare Benefit Program. This includes encounter data, quality and performance indicators regarding disenrollment rates, member satisfaction, health outcomes, and Provider's performance under this Exhibit F as required by law. Provider shall certify the accuracy, completeness, and truthfulness of encounter data submitted to HAP. HAP will have sole responsibility for filing reports, obtaining approval from, and complying with the applicable laws and regulations of federal, state, and local governmental agencies having jurisdiction over HAP. HAP will perform all necessary administrative, accounting, enrollment, and other functions appropriate for the marketing and administration of its Medicare Benefit Program.

10. Continuation of Services After Termination and Hold Harmless. After termination of this Agreement, HAP will be liable for payment of Medicare Covered Services rendered by Provider to a Medicare Member, other than for applicable coinsurance, deductibles, or co-payments. Provider shall continue to deliver Medicare Covered Services to Medicare Members who retain eligibility or are under the care of Provider at the time of termination, until the services being rendered to the Medicare Member by Provider are completed, unless HAP makes reasonable and medically appropriate provision for the assumption of such services by another participating provider. HAP will reimburse Provider for all services rendered pursuant to this section 9 at the rate specified in the Medicare Advantage Payment Exhibit E of this Agreement and Provider shall accept such payment, together with any authorized coinsurance, deductible, or co-payment, as payment in full. This continuation of Medicare Covered Services and hold harmless obligation will be for the period for which the member premium has been paid to HAP by CMS, not to exceed a period of thirty (30) days, except for those Medicare Members who are hospitalized on an inpatient basis. For those Medicare Members who are hospitalized on an inpatient basis at the time this Agreement is terminated, Provider shall continue to arrange for Medicare Covered Services until the Medicare Member is discharged from the hospital. Provider shall deliver Medicare Covered Services and shall not bill, charge,

collect, or receive any form of payment from a Medicare Member (other than an authorized co-payment, coinsurance, or deductible), nor shall Provider collect a deposit from any Medicare Member or persons acting on their behalf, nor have any recourse against a Medicare Member or persons acting on their behalf, for Medicare Covered Services provided, either during or after a Medicare Member's enrollment with HAP, or after HAP ceases operations for any reason, including insolvency. Provider may bill and collect its usual billed charge from a Medicare Member for any service rendered that is not a Medicare Covered Service only if the Provider has advised the Medicare Member in advance that a particular service is not a Medicare Covered Service and the Medicare Member has agreed in writing (using a HAP-approved form available on the HAP Website) that he or she will be responsible for Provider's usual billed charge for the non-covered service. No modification of the provisions of this section B(9) is permitted without the prior written approval of the Secretary of HHS, or the Secretary's designee. [42 CFR 422.504(g), 42 CFR 422.318, etc.]

11. No Surcharges. Provider shall not charge the Medicare Member any fees or surcharges for Medicare Covered Services rendered pursuant to this Agreement (except for authorized coinsurance, deductibles, and co-payments). [42 CFR 422.504(g)] In addition, Provider shall not collect a sales, use, or any other applicable tax from a Medicare Member for the sale or delivery of medical services. In addition, when a Medicare Member receives an item or service under HAP's Medicare Benefit Program that is covered upon referral or preauthorization from a contracted provider of HAP's Medicare Benefit Program, the Medicare Member cannot be financially liable for more than the normal cost sharing under HAP's Medicare Benefit Program if the Medicare Member correctly identified himself or herself as a member of HAP's Medicare Benefit Program to the contracted provider before receiving the Medicare Covered Services. If HAP receives notice that a Medicare Member has incurred charges in violation of this provision, Provider shall fully cooperate with HAP to investigate such allegations, and Provider shall promptly refund any payment deemed improper by HAP to the party who made the payment. [42 CFR 422.105(a)]

11. Mutual Indemnification. Both parties agree to mutually indemnify and hold harmless the other party related to services performed under this Agreement. Provider and HAP will indemnify and hold harmless each other, and their respective employees or agents, against any third-party claims from, cause of action, liability, damage, cost, or expense, including attorney's fees, and court or proceeding costs, arising out of or in connection with any negligent or intentional commission or omission of conduct by Provider's or HAP's respective affiliate, employee, or agent related to services performed under this Agreement.

12. Provider Representations and Warranties. Provider warrants that its Employed Physicians and Licensed Health Professionals are duly qualified and approved to act as a provider of health care services to Medicare beneficiaries under Title XVIII of the

Social Security Act (whether considered "participating" in Medicare or not). Further, each Employed Physician and Licensed Health Professional represents and warrants to HAP that (a) neither he/she nor any of his/her affiliates are excluded from participation in any federal health care program, as defined under 42 U.S.C. §1320a-7b(f); (b) he/she has not arranged or contracted (by employment or otherwise) with any employee, contractor, or agent that he/she or his/her affiliates know or should know are excluded from participation in any federal health care program to provide items or services thereunder; and (c) no final adverse action, as such term is defined under 42 U.S.C. §1320a-7e(g), has occurred or is pending or threatened against him/her or his/her affiliates, or to his/her knowledge against any employee, contractor, or agent engaged to provide items or services under this Exhibit F (collectively "Exclusions/Adverse Actions"). Each Employed Physician and Licensed Health Professional, during the term of this Agreement, shall notify HAP of any Exclusions/Adverse Actions or any basis therefore within two (2) business days of his/her learning of any such Exclusions/Adverse Actions or any basis therefore.

12. Medicare Benefit Plan Administration and Compliance. HAP will perform or arrange for the performance of all administrative responsibilities necessary under this Agreement for the provision of Medicare Covered Services to Medicare Members except as otherwise specified herein. HAP will have the sole responsibility for filing reports, obtaining approval from, and complying with, the applicable laws and regulations of federal, state and local governmental agencies having jurisdiction over the Medicare Benefit Plan. Such compliance accountability includes monitoring of Employed Physicians' and Licensed Health Professionals' compliance with applicable regulations. HAP will perform all the necessary administrative, accounting, enrollment and other functions appropriate for the marketing and administration of its Medicare Benefit Program.

14. Medicare Parts C and D Program Requirements. Provider agrees to comply with HAP's Policies and Procedures for the Medicare Part C and Part D programs as well as all applicable federal, state, and local laws, rules, and regulations, now or hereafter in effect, including all Medicare laws, regulations, reporting requirements, and CMS instruction (collectively, the "Medicare Part C and Part D Laws and Regulations"). To the extent Provider is involved in the administration or delivery of Medicare prescription drug benefits governed by Medicare Part D, Provider shall comply with all federal laws and regulations governing Medicare Part D. Provider agrees and acknowledges that these Medicare Part D requirements are separate and distinct from the Medicare Part C requirements.

15. Medical Management and Quality Improvement Program Requirements. Provider shall cooperate and comply with HAP's medical policies, quality improvement programs, and medical management programs. Provide shall make available documentation related to Provider's medical policy, medical management, and quality improvement activities to the extent such Provider materials are necessary for HAP's quality improvement, medical management, and credentialing and re-credentialing programs. Providers that administer or deliver prescription drug benefits under Medicare Part D shall cooperate with HAP's quality assurance, drug utilization management, and medication therapy management programs and shall support electronic prescribing. [42 CFR 422.152 and 422.202]

16. Noninterference. Nothing in the Agreement or this Attachment is intended to prohibit or restrict Provider from advising or advocating on behalf of a Medicare Member regarding (1) Medicare Member's health status, medical care, or treatment options (including alternative treatments), including providing sufficient information so the Medicare Member has an opportunity to decide among all relevant treatment options; (2) the risk, benefits, and consequences of treatment or non-treatment; and (3) the opportunity for the Medicare Member to refuse treatment and express preferences about future treatment decisions. Provider shall, however, supply information regarding these treatment options in a culturally competent manner, including the option of not having treatment performed, and shall assure that individuals with disabilities receive effective communications to allow them to make decisions regarding treatment options. [42 CFR 422.206(a)]

17. CMS Risk Adjustment Validation Audits. Provider shall include supporting documentation in a Medicare Member's medical record for all diagnosis codes submitted to HAP for payment. Provider shall complete such documentation in accordance with CMS's coding guidance in effect at the time of completion. Provider shall timely supply HAP with medical records so that (1) HAP can comply with a CMS Risk Adjustment Validation Audit (RADV) and (2) HAP can conduct appropriate oversight and risk mitigation as it relates to HAP's risk adjustment processes. Provider shall submit complete and accurate risk adjustment data as requirement by CMS. Provider acknowledges its obligation to cooperate with HAP and/or CMS during RADV audits and to timely produce (a) requested medical records in accordance with 42 CFR 422.310(e) and/or (B) any required attestations to correct signature deficiencies in the medical records. [42 CFR 422.310]

18. Provider Compliance Plan. Provider shall have a compliance plan that includes: (a) measures to detect, correct, and prevent fraud, waste, and abuse; (b) written policies, procedures, and standards of conduct describing Provider's commitment to comply with all applicable federal, state, and local laws, rules and regulations; (c) the designation of a compliance officer and compliance committee accountable to senior management and responsible for high level oversight of Provider's compliance plan; (d) effective training and education for Provider's compliance officer, employees, governing body members, and Affiliates, including training on fraud, waste and abuse; (e) effective

lines of communication between the compliance officer and HAP and the compliance officer and Provider's employees, governing body members, and Affiliates; (f) enforcement of standards through well publicized disciplinary actions; (g) procedures for effective and routine internal monitoring and auditing; and (h) procedures for ensuring prompt responses to detected offenses and development of corrective action initiatives related to any evidence of fraud or misconduct. Provider shall attest to HAP annually that Provider meets the requirements set out in this section regarding Provider's compliance program and that Provider has conducted appropriate compliance training. Provider shall maintain, and make available to HAP, CMS, or any other governing body, training records for a period of ten (10) years. Such records shall include, at a minimum, attendance, topics covered, and test scores if Provider uses any subject-matter tests as part of its compliance program. [42 CFR 422.503(b)(4)]

19. Compliance & Fraud, Waste and Abuse. Provider agrees to internally monitor and audit its responsibilities and activities with respect to administration and delivery of health care services as set out in any agreements between HAP and Provider. Such monitoring shall include documenting and responding to any actual, suspected, or potential noncompliance, fraud, waste, or abuse concern, whether such concern is identified by Provider, HAP, CMS, HHS or any other governing agency. Provider shall, within five (5) business days of becoming aware of any actual, suspected, or potential compliance, fraud, waste, or abuse concern by Provider, Provider's governing body members, employees, contractors, or agents, report all such concerns to HAP. Provider shall report these concerns to Chief Compliance Officer. Provider shall coordinate with HAP to timely investigate any compliance, fraud, waste, or abuse concerns, take action to mitigate such concerns, and implement appropriate corrective actions. Provider shall allow HAP, CMS, HHS, or any other governing agency to oversee its documentation and implementation of corrective actions related to potential or actual noncompliance, fraud, waste, or abuse. Provider shall protect against retaliation against its governing body members, employees, contractors, or agents for reporting of compliance, fraud, waste, or abuse concerns. Provider shall ensure that these reporting requirements and non-retaliation policy are well publicized.

20. Right of Recovery. HAP shall have the right to recover amounts paid to Provider for (a) services that do not comply with HAP's medical, benefit, quality improvement, or other applicable HAP Policies and Procedures; (b) overpayments; (c) services not documented consistent with CMS coding guidelines in the Provider's medical records; and (d) any services provided when Provider's license was lapsed, restricted, revoked or suspended. Except as otherwise provided herein, HAP shall have the right to initiate recovery for such amounts paid for services up to twenty-four (24) months from the date of payment. There is no time limit for recoveries, however, where the recoveries are related to fraud.

C. COMPENSATION

Provider shall submit claims in accordance with Medicare's procedures and standards and accept as payment in full for rendering of Medicare Covered Services to Medicare Members, the compensation specified in HAP Medicare Advantage Payment Appendix E.

D. TERMINATION

1. Provider's Voluntary Termination. Provider or any of Provider's subcontractors as the case may be (collectively, "Provider") may voluntarily terminate this Exhibit F and participation in HAP's Medicare Benefit Program upon provision of ninety (90) days' prior written notice to HAP. Upon provision of such notice by Provider to HAP, the terms of this Exhibit F will be considered severable from the Agreement to which it is attached and the termination of participation in the Medicare Benefit Program will not jeopardize or prejudice Provider's participation in any other benefit program offered by HAP.

2. Termination of Medicare Benefit Program. This Exhibit F will terminate immediately upon the official cancellation of HAP's contract with CMS or official date of discontinuance of HAP's Medicare Benefit Program, whichever is later.

3. Provisions Surviving Termination. The provisions of Sections B(2), B(3), B(4), B(7), B(8), B(9), B(9), B(10), B(11), B(17), B(19), and B(20) will survive any termination of this Exhibit F.

E. OTHER

1. Regulatory Changes. HAP may unilaterally amend this Exhibit F, and or its policies and procedures at any time to comply with changes in regulatory requirements affecting HAP and /or Provider related to HAP's Medicare Benefit Program and Part D program by providing written or electronic notice of any such amendment to Provider along with the effective date of the amendment. HAP will use its best efforts to provide such written or electronic notice to Provider at least thirty (30) days in advance of the effective date of the amendment. Unless otherwise required by federal or state regulatory authorities, the signature of Provider will not be required for any such amendment.

2. Amendment for General Modifications. HAP may also amend this Exhibit F for general modifications by providing ninety (90) days' prior written or electronic notice, of such amendment. Provider's signature is not required to make the amendment effective.

3. Prompt Payment. Unless a claim for payment is disputed, HAP will promptly make payment on each Clean Claim, timely submitted by Provider, for Medicare Covered Services rendered to a Medicare Member, within the time frame specified in the Agreement. [42 CFR 422.520] All payments will be made in accordance with HAP Policies and Procedures.

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