PARTICIPATING PROVIDER SERVICE AGREEMENT

This Provider Services Agreement is made and entered into as of this **1st day of March, 2022** ("Effective Date") by and between **PacificSource Health Plans**, an Oregon non-profit corporation ("Health Plan"), and **Centria Healthcare LLC**, ("Provider").

RECITALS

A. Health Plan is a healthcare service contractor, which currently contracts for the provision of comprehensive healthcare services for its Members.

B. Provider is a physician or other health professional, hospital, or licensed healthcare facility, or other entity that provides healthcare services.

C. Health Plan has wholly-owned subsidiaries and affiliates, including one that is a Medicare Advantage Organization contracted with the Centers for Medicare and Medicaid Services ("CMS") to offer Medicare Advantage health insurance products.

D. Health Plan and Provider mutually desire to enter into an agreement to provide Members with Benefit Plans that are committed to high quality, cost effective care and service, positive patient outcomes, and Member satisfaction.

NOW, **THEREFORE**, in consideration of the mutual covenants and agreements contained herein, the parties hereby agree as follows:

I. DEFINITIONS.

1.1 **Benefit Plan**. The specific set of Covered Services, Copayments, Coinsurance and Deductible requirements, and limitations and exclusions contained in the contract between Health Plan and a Member or Subscriber Group.

1.2 **Claim.** A Statement prepared by a Provider or other healthcare entity for the purpose of completely itemizing all services and treatments provided to, and identifying all diagnoses for, a Member.

1.3 **Clean Claim.** A claim that complies with any and all regulatory requirements, and contains no defect or impropriety, such as a lack of any required substantiating documentation, or particular circumstances requiring special treatment that prevents timely payments from being made on the claim under this section.

1.4 **Coordination of Benefits.** The determination of whether Covered Services provided to a Member will be paid for, either in whole or in part, under any other private or government health benefit plan or any other legal or contractual entitlement, including, but not limited to, a private group indemnification or insurance program.

1.5 **Copayment, Coinsurance, and Deductible.** Any portion of the allowed amount charged to a Member that is provided for in Health Plan's contracts with a Member or Subscriber Group.

1.6 **Covered Services.** Medically Necessary healthcare services and supplies which are within Provider's license and scope of practice, which Provider routinely provides, and which a Member is entitled to receive from Health Plan pursuant to the applicable Benefit Plan.

1.7 **Dependent.** A person who is enrolled in and covered under a Benefit Plan on the basis of that individual's family relationship with a Subscriber, in accordance with the provisions of the applicable contract between Health Plan and an individual or a Subscriber Group.

1.8 **Emergency Medical Condition.** A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part. An Emergency Medical Condition is determined based on the presenting symptoms (not the final diagnosis) as perceived by a prudent layperson (rather than a health care professional) and includes cases in which the absence of immediate medical attention would not in fact have had the adverse results described in the previous sentence. An emergency shall include, but not be limited to, suspected heart attack or stroke, poisoning, loss of consciousness, severe respiratory distress, hemorrhaging, or convulsion. Health Plan may determine that other similarly acute conditions require Emergency Services. Health Plan will review and determine if the services meet this definition, in accordance with the Member's Benefit Plan; such services are subject to Health Plan's procedures for post-treatment utilization review consistent with the standards under federal or state law, as applicable.

1.9 **Emergency Services.** Covered Services furnished by a Practitioner that is qualified to furnish these services and that are needed to evaluate or stabilize an Emergency Medical Condition. "Emergency Services" include all inpatient and outpatient treatment that may be necessary to assure within reasonable medical probability that no material deterioration of the patient's condition is likely to result from, or occur during, discharge of the Member or transfer of the Member to another facility.

1.10 **Medically Necessary.** Services that Health Plan determines, through its professional review process, are (a) appropriate for the symptoms and diagnosis or treatment of a Member's medical condition, (b) provided for the diagnosis, or the direct care and treatment of that medical condition, (c) provided in accordance with standards of good medical practice, (d) not primarily for the convenience of the Member or the Member's Practitioner of care, and (e) the most appropriate level of service that can be safely provided to the Member. Health Plan may retroactively deny or adjust payments to any Practitioner if Health Plan subsequently determines that a service was not Medically Necessary.

1.11 **Member.** Any Subscriber or Dependent enrolled in a Benefit Plan, in accordance with the applicable eligibility requirements.

1.12 **Never Event.** A serious adverse event that is determined by Health Plan to be preventable according to its policies, as may be amended as necessary, and within the control of the Provider.

1.13 **Non-Covered Services.** Services not eligible for coverage under the terms of the applicable Benefit Plan.

1.14 **Other Payor.** Payors for healthcare services, including but not limited to Health Plan subsidiaries and affiliates, self-funded employers, trusts, and governmental entities or authorized contracting agencies or divisions, with whom Health Plan has entered into a contract.

1.15 **Participating Providers.** Providers that have met the credentialing requirements and entered into contracts directly with Health Plan, or that participate indirectly by being a member or contracting with a Participating Individual Practice Association, Medical Group, Hospital Organization or any other Provider contracting directly with Health Plan to provide Covered Services to Members.

1.16 **Physician.** A person duly licensed and qualified to practice medicine or osteopathy in the state where his or her practice is located.

1.17 **Practitioner.** A licensed health care provider, duly operating under his or her license, including without limitation a Physician.

1.18 **Primary Care Practitioner.** The Participating Provider selected by a Member, or attributed by Health Plan, whose Benefit Plan may require the designation of a Primary Care Practitioner, who shall have the responsibility of providing initial and primary care, and for referring, authorizing, supervising and coordinating the provision of all other Covered Services to the Member in accordance with Health Plan's Quality Assurance Program and Utilization Management and Review Program and as a Practitioner as defined or limited by state law and the Provider Manual. A Primary Care Practitioner may be either a family practitioner, general practitioner, nurse practitioner, internist, pediatrician, obstetrician, gynecologist or other women's healthcare provider as defined or limited by state law, or other Physician or Practitioner who has otherwise limited his or her practice of medicine to general practice or a Specialist Physician or Practitioner who Health Plan and Primary Care Practitioner have mutually agreed to be designated as a Primary Care Practitioner.

1.19 **Provider Manual.** Policies and procedures adopted by Health Plan for the administration of health benefits and the implementation of the terms and conditions of this Agreement, including outlining billing requirements, general benefit information, care management information and other relevant information. The Provider Manual is updated and/or amended from time-to-time, at Health Plan's sole discretion.

1.20 **Quality Assurance Program.** Program and processes established by Health Plan, and carried out by Health Plan in cooperation with Practitioners to monitor, maintain and improve the quality of services provided to Members, as described in the Provider Manual.

1.21 **Referral.** Shall mean the process by which the Member's Primary Care Practitioner directs the Member to seek Covered Services from other Participating Providers, when the Member's Benefit Plan requires a Referral.

1.22 **Specialist Practitioner.** A Participating Provider who practices a specialty and who will provide Covered Services to Members.

1.23 **Subscriber.** The person who is the primary policyholder and responsible for premium payment to Health Plan, or whose employment or other status, except for family dependency, is the basis for eligibility for membership in Health Plan.

1.24 **Subscriber Group.** The organization, firm, or other entity contracting with Health Plan to arrange for the provision of Covered Services for its employees or members and their Dependents.

1.25 **Utilization Management and Review Program.** The programs and processes established and carried out by Health Plan to authorize and monitor the utilization of Covered Services provided to Members, as described in the Provider Manual.

II. PROVIDER RESPONSIBILITIES.

2.1 Provision of Covered Services. Provider, in coordination with Health Plan, shall provide or arrange for the provision of Covered Services for Members enrolled in Health Plan's products listed in **Attachment A**. Services will be provided by or referred to Participating Providers unless such services are not available from Participating Providers (see Section 2.10). Nothing in this Agreement shall require Provider to directly provide or contract for all Covered Services and the practitioners may freely communicate with patients about their treatment, regardless of the benefit coverage limitations.

2.2 Provision of Services for Other Payors. Pursuant to each Health Plan agreement with any Other Payor, Provider shall provide Covered Services to the members or beneficiaries of that Other Payor pursuant to and in accordance with the provisions of this Agreement.

2.3 Standard of Care. Provider shall comply with all applicable federal and state laws, licensing requirements, and professional standards, and shall provide or arrange for the provision of Covered Services in accordance with generally accepted medical and surgical practices and standards prevailing in the applicable professional community at the time of treatment, and in conformity with the law of the state in which the Provider is licensed.

2.4 Credentialing and Re-Credentialing. Provider shall comply with any and all credentialing and re-credentialing policies adopted by Health Plan, as may be revised or modified from time-to-time, and shall cooperate with any and all credentialing and re-credentialing activities which Health Plan may undertake. Failure to comply with such policies and/or cooperate with such activities is a material breach of this Agreement. Upon request, Provider shall provide Health Plan with a copy of its credentialing plan, and supply evidence of any or all applicable licensure.

2.5 Primary Care Practitioner. If the Benefit Plan so requires, Health Plan shall, at time of enrollment in a plan requiring a Primary Care Practitioner, require Members to select a Primary Care Practitioner. Upon selection and notification, the Primary Care Practitioner shall assume responsibility for coordinating, supervising, and monitoring the Members' overall healthcare, subject to the terms of this Agreement. If Provider acts as a Primary Care Practitioner or has Primary Care Practitioners under this Agreement, Provider agrees to notify Health Plan in writing at least thirty (30) days in advance of the date that Provider or one of its Primary Care Practitioners will close his/her medical practice to new patients or terminate the relationship with Provider.

2.6 Practitioner Licensure and Medical Staff Privileges. Provider warrants and represents that all Practitioners under this Agreement are, and will continue to be as long as this Agreement remains in effect, holders of a valid, current, and unrestricted license to practice and provide their respective services in the state(s) where the Practitioner cares for Members. Provider's Practitioners are members in "good standing" of the medical staff of one or more contracted hospitals, if applicable. Provider agrees to comply with all policies, procedures and standards as detailed in the Provider Manual. In the event that a Practitioner is found guilty of a criminal offense or acts contrary to this Agreement, the Practitioner or Provider shall immediately discontinue providing services to

Members. Nothing in this Agreement shall prohibit a Practitioner while using the degree of care, skill, and diligence which is used by ordinarily careful practitioners in the same or similar circumstances in the practitioner's community, from advocating a decision, policy or practice without being subject to termination or penalty for the sole reason of such advocacy.

2.7 Facilities, Equipment and Personnel. Provider shall provide and maintain sufficient facilities and equipment, and shall provide sufficient personnel and administrative services, including any training that may be necessary, to perform the duties and responsibilities set forth in this Agreement.

2.8 Accessibility and Hours of Service. Provider shall deliver or arrange for the provision of Covered Services to Members on a readily available and accessible basis, including, but not limited to, during normal business hours at the usual place of business of Provider. Emergency Services and access to Provider by telephone shall be available and accessible to Members on a twenty-four (24) hour, seven (7) day a week basis. Provider shall arrange for an appropriate call schedule to provide for such availability and accessibility of services.

2.9 Nondiscrimination. Provider shall not differentiate or discriminate in its provision of Covered Services to Members because of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, age or for any reason or purpose prohibited by applicable federal or state law. Provider shall make available Covered Services to Members in the same manner, in accordance with the same standards, and within the same time availability as offered to non-Member patients. Nothing in this Agreement shall prohibit Provider from withdrawing from the care of a patient when, in his or her professional judgment, it is in the best interest of the patient to do so.

2.10 Referrals. Provider shall refer Members only to Participating Providers for the provision of Covered Services except in cases of Emergencies or if no Participating Provider is available to perform the appropriate Covered Service. Provider shall make all Referrals for Covered Services in accordance with Health Plan's policies.

2.11 Member Medical Records. Provider shall establish and maintain a medical record for each Member. The record shall contain information normally included in accordance with generally accepted medical and surgical practices and standards prevailing in Provider's professional community. Provider will also include supporting documentation in a Member's medical record for all diagnosis codes identified by Provider. Provider shall facilitate the sharing of medical information with other Practitioners if required to authorize Referrals. Sharing of medical records is subject to applicable federal and state laws and professional standards regarding the confidentiality of medical records, Provider shall provide Health Plan reasonable access to electronic medical records where available and, if not available, Provider shall make available at no charge to Health Plan records that are necessary for Health Plan's administration of the Benefit Plan and this Agreement, including without limitation: Coordination of Benefits, Quality Assurance Program, Utilization Review, third party claims administration, underwriting, pre-existing conditions investigations, benefits administration, and CMS Risk Adjustment Data Validation. Provider shall make records available to appropriate federal or state authorities as required under applicable law.

2.12 Grievance and Appeals Procedures. Provider shall comply with the complaint and grievance procedures established by Health Plan, which may be revised or modified from time-to-time, as described in the Provider Manual. Health Plan shall have the option to deduct any claims cost related to resolution of any such dispute, where it is determined the service is a Non-Covered Service or not Medically Necessary, from the compensation payable to Provider per this Agreement.

2.13 Prescriptions. Subject to generally accepted medical and surgical practices and standards prevailing in Provider's professional community, Provider shall comply with any drug formularies and policies regarding the prescription of generic or lowest cost alternative brand name pharmaceuticals adopted by Health Plan, and shall recognize the authority of pharmacists to substitute generic drugs for trade name drugs consistent with federal and/or state law.

2.14 Prior Authorizations. Provider shall comply with the prior authorization process as detailed in the Provider Manual, which may be amended or updated as necessary. Failure to follow the prior authorization process may result in the services being deemed Non-Covered Services.

2.15 Identification of Provider. Provider shall notify Health Plan promptly and in advance of any change or of the addition or termination of a Practitioner. Provider agrees that Health Plan may list the name, address, telephone number and other identifying information of Provider in Health Plan publications furnished to Practitioners, Members and Subscriber Groups, and may identify Provider as a Health Plan Participating Provider in advertising and marketing materials. Provider acknowledges that Health Plan will make updates to Provider's information within thirty (30) days of receiving Provider's notification of a change and Provider agrees that Members are entitled to the benefits of this Agreement during that time frame.

2.16 Promotional Materials. Provider agrees to display promotional materials provided by Health Plan and approved by Provider in Provider's office.

2.17 Out-of-Area Transfers. For any Member who has selected or been assigned to Provider as his or her Primary Care Practitioner, or is otherwise seeing Provider for regular care, but is receiving Emergency or other authorized care from non-participating hospitals, Physicians or Practitioners, Provider shall assist Health Plan in facilitating the transfer of that Member to a participating hospital. The participating hospital must be one in which the Member's attending Physician or Practitioner, or another suitable Participating Provider, has determined to be medically acceptable, subject to review by the Health Plan's Medical Director, and where such provider has medical staff privileges.

2.18 Provider Agreements. Provider shall require that all Practitioners, either employed or sub-contracted by Provider, comply with the applicable terms and conditions of this Agreement by entering into a written participation agreement which shall include, but shall not be limited to, the following provisions:

a. Accepting Members for care subject to the Nondiscrimination provisions specified in Section 2.9;
b. Accepting, as payment in full, (less Copayments, Coinsurance and Deductibles), all applicable reimbursement arrangements, including, but not limited to, capitation, discounted rates and/or acceptance of a withhold from usual, customary and reasonable charges, agreed to by Provider;
c. Hospitalizing Members for non-Emergency Services only in accordance with the admission approval procedures set forth in Health Plan's Utilization Management and Review Program;
d. Maintaining in force professional liability insurance in accordance with the standards established by Provider and Section 5 of this Agreement;
e. Complying with and accepting as final the decisions of the Quality Assurance Program and Utilization Management and Review Program, as applicable and in consideration to Health Plan's appeal and grievance procedures;
f. Following the procedures established by Health Plan for verifying eligibility of Members and authorizing Covered Services;
g. Providing and maintaining sufficient facilities, equipment, personnel, and services to provide specified Covered Services to Members on a readily available and accessible basis;

h. Complying with all applicable federal and state laws, licensing requirements, and professional standards and providing Covered Services in accordance with generally accepted medical and surgical practices and standards prevailing in the applicable professional community at the time of treatment;
i. Resolving disputes and controversies in accordance with the provisions of Section 7 of this Agreement;
j. Provider shall provide to Health Plan, without charge, copies of sub-contractor agreements or such other documentation at Health Plan's request; and
k. Provider shall require all of its Physicians and Practitioners to comply with the termination procedures described in this Agreement.

2.19 Coordination of Benefits and Subrogation. Provider agrees that the procedures used for Coordination of Benefits shall be in conformity with the applicable Benefit Plan, the Provider Manual, and applicable law.

2.20 Provider Manual. Provider shall comply with the Provider Manual, including any revisions thereto. The terms of the Provider Manual are incorporated herein by reference. Health Plan may revise and update the Provider Manual by its sole discretion as necessary. Provider agrees that such revisions become a part of the Agreement. Provider agrees to regularly review the Provider Manual.

2.21 Bill Review and Audit. Provider agrees to cooperate with any requests by Health Plan, or its agent to review and audit any claims or bills submitted by Provider to determine whether a bill submitted for a Covered Service rendered to a Member, was properly billed relative to the services provided (as reflected on the medical record), and that payments made to Provider were accurate, in accordance with the terms and conditions set forth herein.

2.22 Quality Improvement Programs. Provider will participate and/or promote applicable quality improvement programs, which may include, but is not limited to CMS, National Committee for Quality Assurance, Healthcare Effectiveness Data and Information Set, Consumer Assessment of Healthcare Provider and Systems, Health Outcomes Survey, Risk Adjustment Data Validation, Leapfrog, National Quality Corp., diagnosis code information sharing, and other initiatives to improve quality experience and health outcomes. Provider will also participate in Health Plan's Medicare 5-Star success initiatives which include diagnosis code data sharing via access to Provider electronic health records, participation in Health Plan 5-Star incentive programs, and, if applicable, the provision of annual wellness or routine physical exams by Provider. Further details are available in the Provider Manual and may be amended, altered, or revised at any time, without prior notice.

2.23 CMS Risk Adjustment Data Validation Audit for Medicare and Exchange (ACA) Members. Provider will include supporting documentation in a Member's medical record for all diagnosis codes identified by Provider to Health Plan. In the event of a CMS RADV audit, Provider will be required to submit medical records for the validation of risk adjustment data. Provider acknowledges its obligation to cooperate with Health Plan and/or CMS during such audits and to timely produce, or provide access for retrieval of, requested medical records in accordance with 42 CFR 422.310(e) and/or attestations to correct signature deficiencies in the medical record.

III. DUTIES OF HEALTH PLAN

3.1 Administrative Services. Health Plan will provide administrative services, which may include without limitation: (a) orientation and education programs (b) review of Provider Complaints and Grievances; (c) practitioner credentialing services noted in section 2.4; and (d) claims and benefit administration services, including third party and Coordination of Benefits.

3.2 Final Medical and Mental Health Decisions. A doctor of medicine or osteopathy shall be retained by Health Plan and shall be responsible for all final medical and mental health decisions relating to coverage or payment made by Health Plan.

IV. COMPENSATION

4.1 Billing. Provider agrees to submit billings to Health Plan directly for services and supplies rendered as soon as reasonably possible, and not later than three hundred and sixty five (365) days, after services are provided and using current industry standard forms or in an electronic mode. Provider will submit billings, including full itemizations for charges (using current industry standard coding methods, when applicable), dates of service, and billing Health Plan as secondary insurance, when applicable. Additionally, Provider shall ensure that the amount billed to Health Plan is the same amount that would be billed to the general public and to other Payors; Provider also agrees that claims received more than three hundred and sixty five (365) days from the date of service will not be reimbursed by Health Plan or Member.

4.2 Utilization Management and Review Program. As a condition for payment for Covered Services, Provider agrees to participate in and comply with the Utilization Management and Review Program utilized by Health Plan to promote the efficient use of resources. Provider shall comply with, and subject to Provider's right to appeal as provided in this Agreement and described in the Provider Manual, be bound by such program. Failure by Provider to comply with the requirements of this paragraph shall be deemed a material breach of this Agreement.

4.3 Compensation. Except as otherwise provided for in this Agreement, Health Plan shall pay Provider the lesser of the billed amount, or the terms set forth in **Attachment A**. Compensation shall be considered payment in full for Covered Services, except for Copayments, Coinsurance, Deductibles, or amounts due as a result of Coordination of Benefits or other third party liability. Any modifications to **Attachment A** shall be attached to this Agreement by written amendment.

a. Health Plan shall make payment to Provider according to the provisions of this Agreement within thirty (30) days of receiving a Clean Claim, unless additional time is permitted by statute or administrative rule. Health Plan shall make interest payments when required by applicable state law. Provider acknowledges that some Other Payors may not be subject to interest payments and that interest payments will be limited to those required by applicable state law.

b. To the extent that any payment(s) for Covered Services under the terms of this Agreement are based, either in whole or in part, on funds obtained from any state or federal program, of any nature, those payments are subject to modification as a result of any change in state or federal law, rule, regulation, or Executive Order.

4.4 Member Non-Liability. Provider shall look solely to Health Plan for compensation for Covered Services. Provider, or other designee or agent of Provider, shall not attempt to collect from Members any sums owed to Provider by Health Plan, notwithstanding the fact that either party fails to comply with the terms of this Agreement. Provider further agrees that if Health Plan determines that a Covered Service was not Medically Necessary, or that Covered Services are provided outside of generally accepted treatment protocols, Provider shall not attempt to collect from Member or Health Plan any sums deemed not reimbursable by Health Plan.

4.5 Member Hold Harmless. Pursuant to applicable state law, Provider agrees that in no event, including but not limited to nonpayment by Health Plan, Health Plan insolvency, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, payment or

reimbursement from, or have any recourse against a Member or person (other than Health Plan) acting on Member's behalf for services pursuant to this Agreement or for Covered Services where payment is denied because Provider failed to comply with the terms of this Agreement. This provision shall not prohibit collection from Members of amounts due for Copayments, Coinsurance, Deductibles and Non-Covered Services under the applicable health policy, which has not otherwise been paid by a primary or secondary carrier according to the terms of this Agreement. Provider agrees, in the event of Health Plan's insolvency, to continue to provide the services promised in this Agreement to Members for the duration of the period for which premiums on behalf of the Member were paid to Health Plan or until the Member's discharge from inpatient facilities, whichever time is greater. The provisions of this section shall survive termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of Members. This provision shall also supersede any oral or written contrary agreement now existing or henceforth entered into between Provider and Members or persons acting on a Member's behalf.

4.6 Never Events. Provider agrees not to seek payment from either Health Plan or Member for costs resulting from a Never Event.

4.7 Payment for Non-Covered Services. Provider may seek payment directly from or on behalf of Members for Non-Covered Services.

4.8 Copayments, Coinsurance and Deductibles. Provider shall be responsible for the collection of applicable Copayments, Coinsurance and Deductibles from or on behalf of Members.

4.9 Overpayment / Underpayment. Provider agrees that Health Plan may deduct from any payment owed to Provider, any overpayments received due to error, improper billing, Coordination of Benefits or third party payment, which results in duplicate or excessive payment for Covered Services. Health Plan will provide written notification to Provider of such credit. All requests for a refund of an overpayment(s) or payment of amounts believed to be underpaid, by either Party, shall be paid in accordance with applicable state and/or federal law and regulations as detailed in the Provider Manual, as updated from time to time. Applicable state law is determined based on the location where services are provided.

4.10 Member's Benefit Plan. Notwithstanding any other provision of this Agreement, nothing in this Agreement shall be construed to modify the rights and benefits contained in the Member's Benefit Plan. The provisions in this section shall survive termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for benefit of Members.

V. INSURANCE

5.1 Health Plan Liability Insurance. Health Plan, at its sole cost and expense, shall procure and maintain such policies of general liability, professional liability, and other insurance as shall be necessary to insure it and its employees, contractors, agents, shareholders, directors, and officers against any claim or claims for damages arising by reason of personal injuries or death occasioned directly or indirectly in connection with the performance of or failure to perform any services required and provided hereunder.

5.2 Provider Liability Insurance. Provider, at its sole cost and expense, shall procure and maintain such policies of general liability, professional liability, and other insurance as shall be necessary to insure it and its employees, contractors, agents, shareholders, directors, and officers against any claim or claims for damages arising by reason of personal injuries or death occasioned directly or indirectly in connection with the performance of or failure to perform any services required and provided hereunder. Provider further agrees to require each Practitioner that may provide Covered Services

on its behalf, to procure and maintain, at Provider's expense, appropriate general and professional liability insurance coverage as specified in the Provider Manual. Provider shall provide Health Plan evidence of the required coverage upon request and shall give Health Plan not less than fifteen (15) days advance written notice of any cancellation, reduction, or other material change in the amount or scope of such coverage.

VI. TERM AND TERMINATION

6.1 Term of Agreement. The term of this Agreement shall be for one (1) year beginning on the Effective Date and shall automatically renew for successive one (1) year terms, unless terminated as set forth in this Agreement. Any modification of the rates and/or arrangements reflected in this Agreement must be in compliance with Section 8.1.

6.2 Termination.

a. With Cause. Either Party may terminate this Agreement for cause by giving ninety (90) days prior written notice to the other Party. Provider is entitled to those rights of appeal as described in the Provider Manual.

b. Without Cause. Either Party may terminate this Agreement without cause by giving one hundred twenty (120) days prior written notice to the other Party. Provider is entitled to those rights of appeal as described in Health Plan's Provider Termination Appeal Policy and the Provider Manual.

c. Mandatory. Provider or any eligible personnel providing services pursuant to this Agreement will be terminated retroactively as of the date of the event if any of the following events have occurred. Such personnel shall cease to be a Participating Provider, and shall perform no further services for Members effective immediately on occurrence of the event: (a) loss of licensure, DEA certificate (if issued), certification, registration or other legal authorization to provide healthcare services; (b) loss of insurance coverage as required by this Agreement; (c) failure to meet Health Plan's credentialing or re-credentialing criteria; (d) relocation out of Health Plan's service area; (e) dissolution of Provider's practice; (f) prohibition from participation in any federal or state health care entitlement program; or (g) fraudulent billing.

6.3 Transfer of Records. In the event of termination of this Agreement, Provider shall submit to Health Plan, or its designee, such information and records, or copies thereof, as Health Plan may request concerning its Members.

VII. DISPUTE RESOLUTION

7.1 Dispute Resolution. Disputes that are not grievance and appeals as provided for in Section 2.12, between Provider and Health Plan shall be resolved, to the extent possible, by informal meetings and discussions in good faith between appropriate representatives of the Parties.

7.2 Arbitration. In the event the Parties are unable to resolve the controversy, the parties hereto agree to submit any dispute under this Agreement to binding arbitration located in city and state in which Provider provides services, and in accordance with the rules of procedure and evidence then in effect as adopted by the American Health Lawyer's Arbitration Association Alternative Dispute Resolutions Services or another nationally recognized arbitration association acceptable to Health Plan. The prevailing party in the action shall be entitled to payment of its attorneys' fees and costs.

VIII. GENERAL PROVISIONS

8.1 Amendment. Except as otherwise provided herein, this Agreement and its Attachments may be amended at any time during the term of this Agreement by Health Plan with sixty (60) days prior written notice to Provider. Provider shall have sixty (60) days from the date of such notice in which to object to the amendment by giving written notice of such objection to Health Plan. When Health Plan receives the objection it may, at its sole option, withdraw the amendment and notify Provider that the amendment has been withdrawn. If the amendment is not withdrawn, Health Plan shall notify Provider that the amendment has not been withdrawn and the amendment shall become effective as outlined. If Provider does not withdraw the objection, Provider may terminate this Agreement by providing a 90 day written notice to Health Plan, in compliance with this Agreement. Failure by Provider to provide written notice to Health Plan shall constitute Provider's acceptance of said amendment. Except as provided above, any other amendment or modification of this Agreement shall be in writing and executed by each party hereto. Any provision of an amendment, addendum or exhibit, which conflicts with any provision of this Agreement, shall take precedence and supersede the conflicting provision(s) of this Agreement. The applicable amendment(s), addendum(s) and exhibit(s) together with this Agreement, shall constitute the Agreement of the parties.

8.2 Amendments Required by Law. If state or federal laws or regulations require a change to any provision of this Agreement, this Agreement will be deemed amended to conform to law or regulation on the date the law or regulation becomes effective. Health Plan will use its best efforts to give Provider prior written notice of such changes.

8.3 Confidentiality. Except to the extent that state or federal law requires disclosure, all information pertaining to the provisions of services under the Agreement will be treated in a confidential manner, and in compliance with state and federal laws. This applies to the following types of information: patient-specific information, the financial terms of the Agreement, or statistical reports shared between the parties to this Agreement.

8.4 Waiver. The waiver by either Party of a breach or violation of any provision of this Agreement shall not operate as or be construed to be a waiver of any subsequent breach thereof.

8.5 Governing Law. This Agreement shall be governed in all respects by the laws of the state in which this Agreement was issued.

8.6 Non-Assignment. Except as provided in this Agreement for Other Payors, this Agreement shall not be assigned, delegated, or transferred by either party without the written consent of the other party. Any assignment, delegation, or transfer without prior written approval shall be void.

8.7 Notices. Any notice required to be given pursuant to the terms and provisions hereof shall be in writing and shall be delivered (a) in-person, (b) sent by certified mail, return receipt requested, postage prepaid, or (c) via email to Health Plan or Provider at their respective addresses set forth on the signature page hereof or as otherwise designated in writing as necessary by the Parties; provided, however, that notice to an Idaho based Provider for the purposes identified in 41-1847, Idaho Code, as allowed in this Agreement for Other Payors, shall be sent electronically. Notice shall be deemed received (a) at the time of personal delivery, (b) five days after deposit in the United States mail, or (c) at the time of emailing with delivery receipt requested and received or other proof of delivery.

8.8 Hold Harmless. The Parties agree to indemnify and hold each other harmless from and against any and all claims or suits, losses, damages, liabilities, judgments, expenses, attorney fees, and court costs in any way arising out of services or supplies that they render hereunder. In the event of alleged improper medical treatment of a Member, Provider agrees to indemnify and hold Health Plan harmless.

8.9 Independent Entities. None of the provisions of this Agreement are intended to create, be deemed or construed to create any relationship between the parties hereto other than that of independent entities or persons contracting with each other hereunder solely for the purpose of effecting the provisions of the Agreement. Neither of the parties hereto, nor any of their respective agents or employees, shall be construed to be the agent, employee or representative of the other.

8.10 Severability. If any provision of this Agreement is declared invalid or otherwise unenforceable, the enforceability of the remaining provisions shall be unimpaired, and the parties shall replace the invalid or unenforceable provision with a valid and enforceable provision that reflects the original intentions of the parties as nearly as possible in accordance with applicable law.

8.11 Entire Agreement. This Agreement contains all the terms and conditions agreed upon by the parties regarding the subject matter of this Agreement. Any prior agreements, promises, negotiations, or representations, either oral or written, relating to the subject matter of this Agreement not expressly set forth in this Agreement are of no force or effect.

8.12 Continuity of Care. It is agreed that when continuity of care is required under the health plan or by applicable law, the parties agree to provide such continuity of care to members as provided in the health plan or applicable law.

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

8.14 Non-Exclusivity. This Agreement is not exclusive, and nothing herein shall preclude either party from contracting with any other person or entity for any purpose. Health Plan makes no representation or guarantee as to the number of Health Plan members who may select Provider for the purpose of receiving Covered Services.

IN WITNESS WHEREOF, the parties have executed this Agreement as of the Effective Date.

HEALTH PLAN:

PACIFICSOURCE HEALTH PLANS

By: _____

Peter McGarry

Title: Vice President – Provider Network

Date: 7-20-22

Address: PO Box 7068
Springfield, OR 97475-0068

Email: ProviderContracting@pacificsource.com

PROVIDER:

CENTRIA HEALTHCARE LLC

By: Brian Bucher
(Signature)

Brian Bucher
(Print or type name)

Title: Chief Financial Officer

Date: 02/17/2022

Address: 27777 Inkster Rd., Ste 100
Farmington Hills, MI 48334

Email: contracts@centriahealthcare.com

ATTACHMENT A

Centria Healthcare LLC
Effective 03/01/2022

Reimbursement Schedule

These rates shall apply to applicable PacificSource Commercial and Coordinated Care Networks and Products

SERVICE/PROCEDURE	MAXIMUM ALLOWABLE
Carve outs (per 15 min. unit):	
0362T Behavior identification supporting assessment	$78.79 per unit
0373T Adaptive behavior treatment with protocol modification	$32.16 per unit
97151 Behavior identification assessment	$20.50 per unit
97152 Behavior identification supporting assessment	$19.70 per unit
97153 Adaptive behavior treatment by protocol	$18.09 per unit
97154 Group adaptive behavior treatment by protocol	$16.48 per unit
97155 Adaptive behavior treatment with protocol modification	$20.50 per unit
97156 Family adaptive behavior treatment guidance	$21.31 per unit
97157 Multiple-family group adaptive behavior treatment guidance	$10.85 per unit
97158 Group adaptive behavior treatment with protocol modification	$10.45 per unit
Services listed in the CMS Physician Fee Schedule, MD/DO:	
National RVUs for services listed in the July 2020 Medicare Physician Fee Schedule	$67.00 conversion factor[1]
PHD, PSYD	$56.95 conversion factor[1]
BCBA	$40.20 conversion factor[1]
Laboratory:	
Services listed in the CMS Clinical Diagnostic Laboratory Fee Schedule	100% of CMS allowed for State of OR[2]
Anesthesia:	
Services listed in the American Society of Anesthesiologists Relative Value Guide	$52.00 per unit ASA Conversion Factor[3]
Durable Medical Equipment, Prosthetics, Orthotics and Supplies:	
Services listed in the CMS DMEPOS & PEN Fee Schedules	100% of CMS allowed for State of OR[2]
Injectables, Vaccines, Immunizations:	
Services listed in the CMS Drug Pricing Files	100% of CMS allowed[2]
Services and procedures without an established unit value listed above:	
PacificSource Health Plans may establish such unit values for purposes of its Maximum Allowable rate determination.	PacificSource Health Plans Default Fee Allowance[4]

Note: Payment will be based upon the lesser of the billed amount or PacificSource negotiated rates in effect at the time the service or supplies are rendered or provided as specified above.

1. Facility and non-facility RVUs shall be used and determined by the setting in which the service occurs.
2. Updates to the schedules noted above shall be updated in accordance with CMS.
3. ASA Basic Unit Value and annual updates as defined by the American Society of Anesthesiologists Relative Value Guide. Time units shall be based on fifteen (15) minute increments.
4. PacificSource utilizes industry standard publications and rate methods to supplement codes not established by the above noted methodologies.

ATTACHMENT B

Centria Healthcare LLC
03/01/2022

Credentialing

1.0 In the event that Health Plan is responsible for the credentialing of physicians and/or practitioners, the following information will be necessary to satisfy Health Plan credentialing or validation requirements:

1.1 Completed application for each physician and/or practitioner to include:

(a) Physician or practitioner name

(b) Practice name

(c) Specialty

(d) Physical Address

(e) Billing Address

(f) Tax Identification Number

(g) DEA Number (if applicable)

(h) NPI Number

(i) Phone (Appointment/Billing)

(j) Fax Number

(k) Clinical privileges at primary admitting facility (if applicable)

(l) Current valid license (if applicable)

(m) Current valid DEA certificate (if applicable)

(n) Education/training, as applicable to the provider type

(o) Board Certification (if applicable)

(p) Current adequate professional liability coverage

(q) History of liability claims

(r) Work history

(s) Evidence of completion of background check (if applicable)

1.2 Signed, dated PacificSource authorization for information release

1.3 Signed, dated statements attesting to:

(a) Ability to perform the essential functions of the position, with or without accommodations

(b) Absence of present illegal drug use

(c) Any history of loss of license and/or felony convictions

(d) Any history of loss or limitation of privileges

(e) The correctness/completeness of the application

1.4 Copies of the following must accompany the application, as applicable:

(a) Current valid license (if applicable)

(b) Valid DEA Certificate (if applicable)

(c) Current professional liability face sheet

2.0 In the event Health Plan credentialing duties are delegated to Provider; those delegated credentialing requirements will be specified in a separate Delegated Credentialing Agreement between Health Plan and Provider.