AMENDMENT NUMBER 1
PARTICIPATING PROVIDER AGREEMENT

This Amendment Number 1 ("Amendment") is entered into as of October 1, 2024 (the "Amendment Effective Date") by and between Peach State Health Plan, Inc. ("Health Plan") and Centria Healthcare, LLC ("Provider"), collectively referred to herein as the "Parties."

WHEREAS, Health Plan and Provider have previously entered into a Participating Provider Agreement (the "Agreement") effective as of May 1, 2022 (defined in the Agreement as the "Effective Date"); and

WHEREAS, the Parties desire to amend the Agreement in accordance with the amendment provisions of the Agreement;

NOW THEREFORE, in consideration of the promises and mutual covenants herein contained, the Parties agree as follows:

1. Attachment A: Medicaid - Exhibit 1 - Compensation Schedule - Practitioner Services - Behavioral Health is hereby deleted from the Agreement in its entirety and replaced with a new Attachment A: Medicaid - Exhibit 1 - Compensation Schedule - Practitioner Services - Behavioral Health, which is attached to this Amendment as Attachment A: Medicaid - Exhibit 1 - Compensation Schedule - Practitioner Services - Behavioral Health.

2. Attachment C: Commercial-Exchange - Exhibit 1 - Compensation Schedule - Practitioner Services - Behavioral Health is hereby deleted from the Agreement in its entirety and replaced with a new Attachment C: Commercial-Exchange - Exhibit 1 - Compensation Schedule - Practitioner Services - Behavioral Health, which is attached to this Amendment as Attachment C: Commercial-Exchange - Exhibit 1 - Compensation Schedule - Practitioner Services - Behavioral Health.

3. All other terms and conditions of the Agreement and any amendments thereto, if any, shall remain in full force and effect. If the terms of this Amendment conflict with any of the terms of the Agreement, the terms of this Amendment shall prevail.

IN WITNESS WHEREOF, the Parties hereto have executed and delivered this Amendment as of the date above.

Health Plan:

Peach State Health Plan, Inc.

Authorized Signature

Dwayne Flowers (Aug 29, 2024 09:48 EDT)

Printed Name: Dwayne Flowers

Title: Vice President, Network Development & Contracting

Date: Aug 29, 2024

ICM #: ICMProviderAgreementAmendment_186882

PROVIDER:

Centria Healthcare, LLC

Authorized Signature

Jason Turk (Aug 29, 2024 08:11 CDT)

Printed Name: Jason Turk

Title: CFO

Date: Aug 29, 2024

Tax ID Number: 27-1402749

State Medicaid Number:

NPI: 1053641498

Attachment A: Medicaid

EXHIBIT 1
COMPENSATION SCHEDULE
PRACTITIONER SERVICES
BEHAVIORAL HEALTH

Centria Healthcare, LLC

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

The maximum compensation for practitioner Covered Services rendered to a Covered Person shall be the "Allowed Amount." Except as otherwise provided in this Compensation Schedule, the Allowed Amount for practitioner Covered Services is the lesser of: (i) Allowable Charges; or (ii) 100% of the Payor's Medicaid fee schedule. As applicable, the Allowed Amount may be reduced based on the Contracted Provider's specialty, provider type, licensing/certifications or education.

If there is no established payment amount on the Payor's Medicaid fee schedule for a Covered Service provided to a Covered Person, Payor may establish a payment amount to apply in determining the Allowed Amount. Until such time as Payor establishes such a payment amount, the maximum compensation shall be 25% of Allowable Charges.

Additional Provisions:

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

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

3. Claim Form - Professional. Contracted Provider when submitting outpatient or professional claims (billed on a CMS-1500 claim form, or its successor) spanning multiple dates of service: (i) is required to identify each date of service; and (ii) must contain modifiers as identified in the Provider Manual. Applicable modifiers should be placed in the first modifier field for claims payment.

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

5. Provider Type. Services must be provided by the appropriate provider type or specialty as defined in the Provider Manual. The Allowed Amount may be reduced based on the Contracted Provider's specialty, provider type, licensing/certifications or education as set forth in the Provider Manual.

6. Modifiers. Unless specifically indicated otherwise, fee amounts listed in the fee schedule represent global fees and may be subject to reductions based on appropriate Modifier (for example, professional and technical modifiers). As used in the previous sentence, "global fees" refers to services billed without a Modifier, for which the fee amount includes both the professional component and the technical component. Modifiers must be used as appropriate and be specific to primary contact, as applicable.

7. Place of Service Pricing Rules. This fee schedule follows CMS guidelines for determining when services are priced at the facility or non-facility fee schedule.

8. Provider Documentation. Provider is required to maintain treatment plans, progress notes, and other similar documentation as identified in the Provider Manual.

9. Authorizations. Authorization requirements are as defined in this Agreement or in the Provider Manual. Service limits, unless specified in this Compensation Schedule, are as defined by the Provider Manual.

10. Level of Care. All reimbursement under this Compensation Schedule shall correspond to the level of care authorized by Payor.

11. Payment under this Compensation Schedule. Claims should be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative (CCI) Policy Manual, CCI table edits and other CMS guidelines). All payments under this Compensation Schedule are subject to the terms and conditions set forth in the Agreement, the Provider Manual, and any applicable billing manual and in accordance with Medicare and Health Plan or Payor's claims processing policies.

Definitions:

1. **Allowable Charges** means a Contracted Provider's billed charges for services that qualify as Covered Services.

2. **Allowed Amount** means the amount designated as the maximum amount payable to a Contracted Provider for any particular Covered Service provided to any particular Covered Person, pursuant to this Agreement or its Attachments for Covered Services. As applicable, the Allowed Amount may be reduced based on the Contracted Provider's specialty, provider type, licensing/certifications or education.

3. **Contracted Provider** means a physician, hospital, health care professional or any other provider of items or services that is employed by or has a contractual relationship with Provider, also known in the Agreement as

"Group", "Practitioner" or "Facility". The term "Contracted Provider" includes Provider for those Covered Services provided by Provider.

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

Attachment C: Commercial-Exchange

EXHIBIT 1
COMPENSATION SCHEDULE
PRACTITIONER SERVICES
BEHAVIORAL HEALTH

Centria Healthcare, LLC

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

The maximum compensation for behavioral health practitioner Covered Services rendered to a Covered Person shall be the "Allowed Amount." Except as otherwise provided in this Compensation Schedule, the Allowed Amount for behavioral health practitioner Covered Services is the lesser of (i) Allowable Charges or (ii) 100% of the Payor's fee schedule. As applicable, the Allowed Amount may be reduced based on the Contracted Provider's specialty, provider type, licensing/certifications or education.

Reimbursement for Drugs and Biologicals. The reimbursement for drugs and biologicals shall be 100% of the Average Sales Price (ASP) plus 6%. In the event the item is not listed on the ASP fee schedule, then the reimbursement shall be 100% of the Average Wholesale Price (AWP) less 20%.

Additional Provisions:

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

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

3. Fee Sources. In the event CMS contains no published fee amount, alternate (or "gap fill") fee sources may be used to supply the fee basis amount for deriving fee amount (the "Alternative Fee Source Amount"). Health Plan

will utilize such Alternative Fee Source Amount until such time that CMS publishes its own resource-based relative value scale (RBRVS) value. At such time in the future as CMS publishes its own RBRVS value for that CPT/HCPCS code, Payor will use the CMS fee amount for that code and no longer use the Alternate Fee Source Amount. If CMS has no published fee amount or a gap fill fee source is not available for a Covered Service provided to a Covered Person, Payor may establish a payment amount to apply in determining the Allowed Amount. Until such time as Payor establishes such a payment amount, the maximum compensation shall be 30% of Allowable Charges.

4. Claim Form - Professional. When submitting outpatient or professional claims (billed on a CMS-1500 claim form, or its successor) spanning multiple dates of service, Contracted Provider (i) is required to identify each date of service and (ii) claims must include modifiers as identified in the Provider Manual. Applicable modifiers shall be placed in the first modifier field for claims payment.

5. Primary Contact Billing. If Covered Person sees more than one health care professional during an encounter, the National Provider Identifier (NPI) billed on the CMS-1500 claim form, or its successor form, shall indicate the primary contact. The "primary contact" is defined as the health care professional who spends the greatest amount of time with the client during services.

6. Provider Type. Services must be provided by the appropriate provider type or specialty as defined in the Provider Manual. The Allowed Amount may be reduced based on the Contracted Provider's specialty, provider type, licensing/certifications or education as set forth in the Provider Manual.

7. Modifiers. Unless specifically indicated otherwise, fee amounts listed in the fee schedule represent global fees and may be subject to reductions based on appropriate modifier (for example, professional and technical modifiers). As used in the previous sentence, "global fees" refers to services billed without a modifier, for which the fee amount includes both the professional component and the technical component. Modifiers must be used as appropriate and be specific to primary contact, as applicable.

8. Place of Service Pricing Rules. This fee schedule follows CMS guidelines for determining when services are priced at the facility or non-facility fee schedule.

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11. Level of Care. All reimbursement under this Compensation Schedule shall correspond to the level of care authorized by Payor.

12. Payment Under This Compensation Schedule. Claims should be coded appropriately according to industry standard coding guidelines (including, but not limited to, UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative (CCI) Policy Manual, CCI table edits and other CMS guidelines). All payments under this Compensation Schedule are subject to the terms and conditions set forth in the Agreement, the Provider Manual and any applicable billing manual and claims processing policies.

Definitions:

1. **Allowable Charges** means a Contracted Provider's billed charges for services that qualify as Covered Services.

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

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