UNITED HEALTHCARE OF TEXAS, INC.
AND
UNITED BEHAVIORAL HEALTH, INC.
BEHAVIORAL HEALTH NETWORK GROUP PARTICIPATION AGREEMENT

THIS AGREEMENT, effective on the date specified at the signature portion of this Agreement ("Effective Date"), is between **United HealthCare of Texas, Inc.** and **United HealthCare Insurance Company**, together known as ("United HealthCare"), **United Behavioral Health, Inc.** ("UBH"), and Centria Healthcare, LLC ("MHSA Group") and MHSA Group Providers (MHSA Group and MHSA Group Providers are individually and collectively referred to as "Provider."). United Behavioral Health shall sign this Agreement on behalf of United HealthCare. For purposes of this Agreement, the parties agree that United HealthCare issues, sponsors, or administers, including but not limited to: Health Maintenance Organization benefit contracts, Preferred Provider Organization benefit contracts, Point of Service benefit contracts, Exclusive Provider Organization benefit contracts, and Self-Funded benefit contracts. This Agreement sets forth the terms and conditions under which Provider shall participate in one or more networks of providers developed by UBH to render mental health and/or substance abuse services to Members, as defined in this Agreement. On the Effective Date, this Agreement supersedes and replaces any existing agreements between the parties related to the provision of mental health and/or substance abuse services to Members. This Agreement also supersedes and replaces any existing agreements between Provider and the following entities to the extent such agreements relate to the provision of mental health and/or substance abuse services to Members, and to the extent such entities sponsor, issue or administer a Benefit Contract, as defined in this Agreement: United Behavioral Systems, Inc., U.S. Behavioral Health, The MetraHealth Insurance Company (MHIC), The Travelers Insurance Company, and Metropolitan Life Insurance Company.

SECTION 1
Definitions

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

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

Member: An individual who is properly covered under a Benefit Contract. Also known as a Covered Person.

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

MHSA Group Provider: A psychiatrist, psychologist, social worker, family or other therapist, duly licensed and qualified under the laws of the jurisdiction in which MHSA Health Services are provided, who practices as a shareholder, partner or employee of Provider, and who has executed a MHSA Group Provider Participation Addendum, the form of which is attached to this Agreement.

MHSA Health Services: The mental health and/or substance abuse services and supplies covered by the Member's Benefit Contract. Also known as Health Services, Behavioral Health Services or Covered Services.

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

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

SECTION 2
Networks of Participating Providers

Provider shall provide MHSA Health Services to Members by participating in the networks of providers designated by UBH. Provider will be notified by UBH in the acceptance letter which network Provider shall participate in. When appropriate, Provider will be listed in the applicable provider directories.

SECTION 3
Duties of Provider

3.1 Member Status. To determine whether an individual is a Member and, therefore, entitled to receive MHSA Health Services, Provider shall ask the individual to present his or her identification card, which shall be provided to all Members by Payors, unless because of the type of Benefit Contract under which the Member has coverage no identification card applies. In addition, Provider may contact UBH to obtain Payor's most current information on the individual as a Member. However, Provider acknowledges that such information is subject to change retroactively: (1) if UBH does not receive proper and timely notification regarding termination of a Member's coverage; (2) as a result of the Member's final decision regarding continuation of coverage pursuant to state and

federal laws; or (3) if eligibility information UBH receives on the individual is later proven to be false.

If Provider provides health care services to an individual, and it is later determined the individual was not a Member at the time the health care services were provided, those services shall not be eligible for payment under this Agreement. Provider may then directly bill the responsible party for such services.

3.2 Provision of MHSA Health Services. Provider shall provide MHSA Health Services to all Members as authorized by UBH as Provider's patient load and appointment calendar permit and shall accept Members as new patients on the same basis as Provider is accepting non-Members as new patients without regard to race, religion, gender, color, national origin, age or physical or mental health status, or on any other basis deemed unlawful under federal, state or local law. Provider warrants and represents that it has the authority to enter into this Agreement on behalf of all Provider Providers. At all times, Provider shall require employed or subcontracted health care professionals and facilities including, but not limited to, MHSA Group Providers, to comply with the protocols and requirements of UBH and Payor and the requirements of all applicable regulatory authorities. Such requirements include, but are not limited to, not billing Members for any amounts except Member Expenses and charges for services not covered under the Member's Benefit Contract.

3.3 Utilization Management, Quality Improvement and Other UBH or Payor Programs. Provider shall cooperate with all credentialing and recredentialing processes and all utilization management, quality improvement, peer review, Member grievance, on site review, or other similar UBH or Payor programs.

3.4 Protocols. Provider shall comply with protocols of UBH or Payor, including, but not limited to the following:

1. Be bound by the MHSA Provider Manual which is incorporated by reference, and the credentialing plan, as modified from time to time by UBH.
2. Obtain prior authorization for all MHSA Health Services from UBH by telephone prior to providing any services to a Member, regardless of the time of day or day of week or the requirements of the Benefit Contract regarding prior authorization. All MHSA Health Services, including but not limited to, all psychological testing, provided to Members by Provider must be prior authorized by UBH or its designee, which shall be confirmed by UBH in writing. Only emergency MHSA Health Services will be eligible for retroactive authorization at the sole discretion of UBH.
3. Follow approved billing procedures of UBH or Payor, as appropriate.
4. Provide or arrange for the provision of advice and assistance to Members in emergency situations 24 hours per day, 7 days per week.

Failure to comply with the above protocols may result in denial of payment to Provider and/or termination of this Agreement. If any payment to Provider is denied due to

Provider's failure to comply with the protocols set forth above, Provider shall not bill the Member for the denied amounts.

3.5 MHSA Group Providers. Acceptance of Provider as a MHSA Participating Provider is subject to the requirement that all MHSA Group Providers that join Provider become MHSA Group Participating Providers. However, Provider understands that all current and future MHSA Group Providers that join Provider must go through the UBH credentialing process before they are accepted as MHSA Participating Providers. Provider also understands that MHSA Group Providers may be individually terminated as MHSA Participating Providers pursuant to section 9.3 of this Agreement. Provider shall notify UBH of all MHSA Group Providers who are added to the staff of Provider as well as those who are no longer on the staff of Provider.

SECTION 4
Payment Provisions

4.1 Payment. For the provision of MHSA Health Services to a Member, Payor shall pay Provider the applicable amounts stated in the attached Appendices. The obligation for payment under this Agreement for MHSA Health Services rendered to a Member is solely that of Payor.

Any payments made directly or indirectly to Provider under any provision of this Agreement are not made as an inducement to reduce or limit necessary services to any Member.

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

4.2 Submission of Claims. Provider shall submit claims for MHSA Health Services to UBH in a manner and format prescribed by UBH, which may be an electronic format. All information necessary to process the claims must be received by UBH no more than 90 days from the date the MHSA Health Services are rendered. Provider agrees that claims received after this time period may be rejected for payment, at UBH's and/or Payor's discretion.

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

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

Payor shall have the right to make, and Provider shall have the right to request, corrective adjustments to a previous payment; provided however, that Payor shall have no obligation to pay additional amounts after 12 months from the date the initial claim was paid.

4.3 Prompt Payment. For the provision of MHSA Health Services to a Member, Payor shall pay Provider the applicable amounts stated in the attached Appendices within 45 days of UBH's receipt of all information necessary to process the claim.

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

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

4.6 Member Protection Provision. This provision supersedes and replaces the Financial Responsibility section when United HealthCare or UBH is the Payor, when required by a specific Payor other than United HealthCare or UBH, or when required pursuant to applicable statutes and regulations.

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

The provisions of this section shall: (1) apply to all MHSA Health Services rendered while this Agreement is in force; (2) with respect to MHSA Health Services rendered while this Agreement is in force, survive the termination of this Agreement regardless of the cause

of termination; (3) be construed to be for the benefit of the Members; and (4) supersede any oral or written agreement, existing or subsequently entered into, between Provider and a Member or person acting on a Member's behalf, that requires the Member to pay for such MHSA Health Services.

Any modification, addition or deletion to this section shall become effective on a date no earlier than 15 days after the commissioner of insurance has received written notice of such proposed changes.

SECTION 5
Liability of Parties, Laws, Regulations and Licenses

5.1 Provider Liability Insurance. Provider shall procure and maintain, at Provider's sole expense: (1) medical malpractice insurance for each Provider who is a Medical Doctor in the amount of One Million Dollars ($1,000,000) per occurrence and Three Million Dollars ($3,000,000) aggregate; (2) medical malpractice insurance for each MHSA Group Provider who is not a Medical Doctor in the amount of One Million Dollars ($1,000,000) per occurrence and aggregate; and (3) comprehensive general and/or umbrella liability insurance in the amount of One Million Dollars ($1,000,000) per occurrence and aggregate. Provider shall also require that all health care professionals employed by or under contract with Provider to render MHSA Health Services to Members procure and maintain malpractice insurance, unless they are covered under Provider's insurance policies. Provider's and other health care professionals' medical malpractice insurance shall be either occurrence or claims made with an extended period reporting option under such terms and conditions as may be reasonably required by UBH. Prior to the Effective Date of this Agreement and at each policy renewal thereafter, Provider shall submit to UBH in writing evidence of insurance coverage.

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

SECTION 6
Notices

Provider shall notify UBH within 10 days of knowledge of the following:

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

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

3. A change in Provider's name, ownership or Federal Tax I.D. number.

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

5. Claims or legal actions for professional negligence or bankruptcy.

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

SECTION 7
Records

7.1 Confidentiality of Records. United and Provider shall maintain the confidentiality of all Member records in accordance with any applicable statutes and regulations.

7.2 Maintenance of and United HealthCare or UBH's Access to Records. Provider will maintain adequate medical, financial and administrative records related to MHSA Health Services rendered by Provider under this Agreement. In order to perform its utilization management and quality improvement activities, United HealthCare and UBH shall have access to such information and records, including claims records, within 14 days from the date the request is made, except that, in the case of an audit by United HealthCare or UBH such access shall be given at the time of the audit. If requested by United HealthCare or UBH, Provider shall provide copies of such records free of charge. Unless a longer time period is required by applicable statutes or regulations, United HealthCare and UBH shall have access to and the right to audit information and records

during the term of this Agreement and for 3 years following its termination. It is Provider's responsibility to obtain any Member consent required in order to provide United HealthCare or UBH with requested information and records or copies of records.

7.3 Government and Accrediting Agency Access to Records. The federal, state and local government, or accrediting agencies including, but not limited to, the National Committee for Quality Assurance (the "NCQA"), and any of their authorized representatives, shall have access to, and United HealthCare, UBH and Provider are authorized to release, in accordance with applicable statutes and regulations, all information and records or copies of such, within the possession of United or Provider, which are pertinent to and involve transactions related to this Agreement if such access is necessary to comply with accreditation standards, statutes or regulations applicable to United HealthCare, UBH, Payor or Provider.

SECTION 8
Resolution of Disputes

The parties will work together in good faith to resolve any disputes about their business relationship. If the parties are unable to resolve the dispute within 30 days following the date one party sent written notice of the dispute to the other parties, and if any party wishes to pursue the dispute, it shall be submitted to binding arbitration in accordance with the rules of the American Arbitration Association ("AAA"). In no event may arbitration be initiated more than one year following the sending of written notice of the dispute. Any arbitration proceeding under this Agreement shall be conducted in a location agreed to by the parties or as selected by the AAA if the parties cannot agree on a location. The arbitrators may construe or interpret but shall not vary or ignore the terms of this Agreement, shall have no authority to award any extracontractual damages of any kind, including punitive or exemplary damages, and shall be bound by controlling law. If the dispute pertains to a matter which is generally administered by certain UBH procedures, such as a credentialing or quality improvement plan, the procedures set forth in that plan must be fully exhausted by Provider before Provider may invoke its right to arbitration under this section. The parties acknowledge that because this Agreement affects interstate commerce the Federal Arbitration Act applies.

SECTION 9
Term and Termination

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

9.2 Termination. This Agreement may be terminated as follows:

1. by mutual agreement of United HealthCare, UBH and Provider.
2. by Plan with respect to Plan Members upon 90 days prior written notice to all parties.
3. by UBH or Provider upon 90 days prior written notice to all parties.
4. by Plan with respect to Plan Members in the event of a breach of this Agreement by Provider, upon 30 days prior written notice to all parties.
5. by UBH or Provider, in the event of a breach of this Agreement by another party, upon 30 days prior written notice to the other parties.
6. by Plan with respect to Plan Members or by UBH immediately upon written notice to all parties, due to Provider's loss of insurance required under this Agreement.
7. by Plan with respect to Plan Members or by UBH immediately if in the sole discretion of the Plan or UBH, the health, safety, or welfare of Members may be jeopardized by the continuation of this Agreement.
8. by Provider upon 30 days prior written notice to all parties due to an amendment made to this Agreement pursuant to section 10.1.

Termination by Plan with respect to Plan Members does not constitute the termination of the entire Agreement.

United HealthCare or UBH shall have the right to notify Members of the termination of this Agreement.

9.3 Termination of MHSA Group Provider. A MHSA Group Provider's participation with United may be individually terminated under the same conditions Provider's participation may be terminated, as specified above. In addition, a MHSA Group Provider's participation with United may be terminated by Plan with respect to Plan Members or UBH: (1) immediately upon written notice to the MHSA Group Provider due to his or her loss or suspension of licensure or certification, or loss of insurance as required under this Agreement; and (2) in accordance with UBH's credentialing process.

Provider shall receive notice of termination by UBH of any MHSA Group Provider.

In the event of the termination of a MHSA Group Provider, that MHSA Group Provider shall not provide MHSA Health Services to Members after the effective date of termination, unless otherwise agreed to by UBH in writing.

The termination of any MHSA Group Provider shall not constitute termination of the entire Agreement.

9.4 Termination Procedures. For purposes of this section, MHSA Group Provider and Provider shall be referred to as "treating provider" or "provider." In the event that any language in this section conflicts with other provisions of this Agreement, the language in this section shall prevail.

1. The termination of a MHSA Group Provider or Provider, except for reason of medical competence or professional behavior, does not release UBH or Payor from the obligation to reimburse the treating provider who is treating a Member of special circumstance. "Special circumstance" means a condition such as a disability, acute condition, or life-threatening illness in which the treating provider reasonably believes that transferring the Member's care to another provider could cause harm to the Member. If the treating provider believes that a special circumstance exists, the treating provider may request permission to provide continuing treatment to the Member. Procedures for resolving disputes regarding the necessity for continuing treatment by the treating provider shall be resolved using the appeal procedure for medical necessity determinations as described in the MHSA Provider Manual. Reimbursement to the treating provider for MHSA Health Services of special circumstance shall be made at the negotiated rates as set forth in this Agreement. The treating provider agrees not to seek payment from the Member for any amounts which would have been covered as MHSA Health Services if the treating provider were still a Participating Provider. UBH or Payor shall not be obligated to reimburse the treating provider for ongoing treatment of a Member that is provided:

   a) 90 days or more after the effective date of the treating provider's termination; or
   b) beyond nine months in the case of a Member who at the time of the treating provider's termination has been diagnosed with a terminal illness.

2. To aid in the continuity of treatment, the treating provider shall transfer the Member's medical records to the Member's new provider. UBH shall provide reasonable notice to Members regarding the impending termination of his or her treating provider. Reasonable notice is defined as 30 days prior to termination or as soon thereafter as reasonably possible.

3. No retaliatory action shall occur, including termination or refusal to renew a contract, against a provider, because the provider has, on behalf of a Member, reasonably filed a complaint against UBH or has appealed a decision of UBH.

4. UBH will provide the provider with a written explanation of the reason for termination. The provider may request and is entitled to a review of the proposed termination prior to the effective date of the termination and within 60 days of such request except: (a) in cases in which there is imminent harm to patient health, or (b) an action by a state medical board, licensing board or other governmental agency that effectively impairs the provider's ability to provide MHSA Health Services, or (c) in cases of fraud or malfeasance. The decision of the advisory panel must be considered but is not binding on UBH. UBH shall provide the affected provider, upon request, a copy of the recommendation of the advisory review panel and UBH's determination.

5. UBH and provider will remain liable for any obligations or liabilities arising from conduct prior to termination. Provider shall notify any Member seeking his/her professional services after the date of termination that provider is no longer a Participating Provider. If provider provides services to a Member after the date of termination and fails to provide notice as described in this section, provider agrees that payment for such services shall be made at the rates set forth in this Agreement. This Section survives the termination of this Agreement.

SECTION 10
Miscellaneous

10.1 Amendment. United HealthCare or UBH may amend this Agreement by sending a copy of the amendment to Provider at least 30 days prior to its effective date. The signature of Provider shall not be required. United HealthCare or UBH may also amend this Agreement to comply with the requirements of state and federal regulatory authorities, and shall give written notice to Provider of such amendment and its effective date. Unless such regulatory authorities direct otherwise, the signature of Provider will not be required.

10.2 Assignment. United HealthCare or UBH may assign all or any of its rights and responsibilities under this Agreement to any entity controlling, controlled by or under common control with United HealthCare or UBH. Provider may assign any of its rights and responsibilities under this Agreement to any person or entity only upon the prior written consent of United HealthCare or UBH, which consent shall not be unreasonably withheld.

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

10.4 Relationship Among the Parties. The relationship among the parties is solely that of independent contractors and nothing in this Agreement or otherwise shall be construed or deemed to create any other relationship, including one of employment, agency or joint venture.

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

10.6 Confidentiality. No party shall disclose to third parties any confidential or proprietary business information which it receives from the other party, including, but not limited to, financial statements, business plans, protocols and programs; except that: (1) Provider may disclose information to a Member relating to the Member's treatment plan and the payment methodology, but not specific rates, and (2) United HealthCare or UBH may disclose certain terms to Payors or designees that need the information to process claims or administer a Benefit Contract, and may file the form of this Agreement with any federal or state regulatory entity as may be required by applicable law.

10.7 Communication. United HealthCare and UBH encourages Provider to discuss with Members treatment options and their associated risks and benefits, regardless of whether the treatment is covered under the Member's Benefit Contract. Nothing in this Agreement is intended to interfere with Provider's relationship with Members as patients of Provider, or with UBH's ability to administer its quality improvement, utilization management and credentialing programs.

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

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

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

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

10.12 Medicare Members. If a Medicare Appendix is attached to this Agreement, Provider agrees to provide MHSA Health Services to Members who are enrolled in a Benefit Contract for Medicare beneficiaries. Provider also understands that United HealthCare's and UBH 's agreements with Participating Providers are subject to review and approval by the Health Care Financing Administration ("HCFA"). Provider is in compliance with any applicable HCFA regulations including those related to private contracts.

10.13 Posting of Complaint Procedure. As required by Texas law, Provider shall post a notice in Provider's office notifying Members of the process for resolving complaints with United HealthCare or UBH. The notice must include the Texas Department of Insurance's toll-free number for filing complaints.

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

The Effective Date of this Agreement is 9/8/16

United HealthCare of Texas, Inc.
5800 Granite Parkway Ste 90
Plano, TX 75024

Signature _____

Title CEO

Date Sep 8, 2016

United Behavioral Health, Inc.
425 Market St, 27th Floor
San Francisco, CA 94105-2426

Signature _____

Title Sr VP Clinical Network Services

Date Sep 8, 2016

Centria Healthcare, LLC
41521 West 11Mile Road
Novi, MI 48375

Signature Scott Barry
Scott Barry (Sep 1, 2016)

Title CEO

Date 9/1/2016

TIN 271402749

MHSA Group Provider
Participation Addendum

THIS ADDENDUM, effective 9/8/16, is made between United Behavioral Health, Inc. ("UBH") and **Centria Healthcare, LLC.** ("Provider") for the purpose of setting forth the terms and conditions under which MHSA Group Provider shall render MHSA Health Services to Members.

1. Credentialing. Provider shall supply all information requested by UBH for the purpose of credentialing MHSA Group Providers, and MHSA Group Provider must be approved for participation by UBH in writing before rendering MHSA Health Services to Members.

2. Rights and Obligations. MHSA Group Provider shall have the rights and obligations provided in the Agreement which are applicable to Provider, and understands that certain provisions of the Agreement shall also be individually binding on MHSA Group Provider, and that United may require performance of all provisions by MHSA Group Provider. MHSA Group Provider also understands that United and Provider may amend the Agreement, without right of review by or approval of MHSA Group Provider.

3. Reimbursement. MHSA Group Provider agrees to look solely to Provider for reimbursement for MHSA Health Services provided to Members.

United Behavioral Health, Inc.

Signature Deborah J. Adler

Title Sr VP Clinical Network Services

Date Sep 8, 2016

Centria Healthcare, LLC

Signature Scott Barry
Scott Barry (Sep 1, 2016)

Title CEO

Date 9/1/2016

All Payor Appendix
Fee Maximum

APPLICABILITY

Unless another Appendix to this Agreement applies specifically to certain Members, the provisions of this Appendix apply to MHSA Health Services rendered by Provider to Members covered by Benefit Contracts sponsored, issued or administered by all Payors.

SECTION 1
Definitions

Fee Maximums: The maximum fees for MHSA Health Services rendered by Participating Providers, as determined from time to time by UBH. The Fee Maximums for the same Health Service rendered pursuant to different Benefit Contracts may vary. Samples of the most recent Fee Maximums are available to Provider upon request.

SECTION 2
Payment

Payor shall pay Provider for MHSA Health Services rendered to a Member the lesser of (1) Provider's Customary Charge, less any applicable Member Expenses, or (2) the Fee Maximum for such MHSA Health Services, less any applicable Member Expenses.

REGULATORY ATTACHMENT – TEXAS
TO THE
UNITED BEHAVIORAL HEALTH, INC.
BEHAVIORAL HEALTH NETWORK GROUP PARTICIPATION AGREEMENT

The following provisions will supplement and/or modify the Agreement with respect to MHSA Health Services rendered to Members in the state of Texas. In the event of a conflict or inconsistency with any term or condition in the Agreement, the provisions in this Attachment shall control:

1. **Payment Methodologies.** Provider may request a description of Payor's coding guidelines, including any underlying bundling, recoding, or other payment processes and fee schedules applicable to specific procedures covered under this Agreement. UBH will provider 90 days written notice to Provider of any changes to the payment methodologies.

2. **Termination Provisions.** The following provisions shall apply to terminations:

   (a) Notice of Provider Termination to Members enrolled in HMO Benefit Contracts. UBH must provide reasonable advance notification of Provider's impending termination to Members receiving care from Provider. Notice given at least thirty (30) days before the effective date of the termination shall be deemed reasonable; provided, however, that if Provider's termination is for reasons related to imminent harm to Members, notification of termination may be given to Members immediately. If Provider is entitled to a review by UBH of UBH's decision to terminate Provider pursuant to Texas Insurance Code, Article 20A.18A(d), UBH will not notify Members of Provider's impending termination until the time the review panel makes its formal recommendation.

   (b) Notice of Provider Termination to Members enrolled in non-HMO Benefit Contracts. If Provider voluntarily terminates this Agreement, Provider shall give reasonable notice of such termination to the Members under Provider's care. UBH shall provide assistance to Provider in assuring that this notice requirement is met.

3. **Discounted Fee Arrangements.** If this Agreement contains a discounted fee arrangement, a Member may be billed only on the discounted fee and not the full charge.

4. **Claim Submission.** Provider shall submit claims to UBH or UBH's designee, no later than ninety-five (95) days from the date of service. If Provider fails to timely submit a claim, Provider forfeits the right to payment unless the failure to submit

the claim is the result of a catastrophic event that substantially interferes with the normal business operations of Provider. Provider may not submit a duplicate claim for payment before the forty-sixth (46th) day after the date the original claim was submitted.

If Provider mails the claim, the claim is presumed to have been received by UBH on the fifth (5th) day after the date the claim is mailed, or if the claim is mailed using overnight service or return receipt requested, on the date the delivery is signed. If the claim is submitted electronically, the claim is presumed to have been received on the date of the electronic verification of receipt by UBH or UBH's designee. If UBH or its designee does not provide confirmation within twenty-four (24) hours of submission by Provider, Provider's clearinghouse shall provide confirmation. If the claim is faxed, it is deemed received on the date of transmission acknowledgment. If the claim is hand delivered, the claim is presumed to have been received on the date the delivery receipt is signed.

UBH shall provide written notice to Provider of the addition or change in the data elements that must be submitted with a claim or any other change in claim processing and payment procedures to Provider not later than sixty (60) days before the date of any such addition or change. If UBH is a secondary payor on a claim, Provider shall submit claims within thirty (30) days after the receipt of the determination-of-benefits from the primary payor. If any claim is returned by UBH to Provider for any reason, Provider shall resubmit such claim within thirty (30) days of receipt of claim with information requested. It shall be assumed that any returned claim was received by Provider within ten (10) business days if sent by U.S. Postal Service. Provider understands that payment of claims will be denied for failure to follow correct submission procedures or failure to submit or resubmit claims within timelines as described herein. Provider shall waive any charges denied for late submission of claims or failure to follow correct claim submission procedures. Provider may appeal any claims denial decision for administrative reasons, late submission or resubmission of claim.

5. **Prompt Payment of Claims.** For each Clean Claim submitted by Provider non-electronically, not later than forty-five (45) days after the date of receipt of the Clean Claim from Provider, UBH shall make a determination of whether the claim is payable and either: (i) pay the total amount of the claim in accordance with the applicable payment schedule; (ii) pay the portion of the claim that is not in dispute and notify Provider in writing why the claim will not be paid; or (iii) notify Provider in writing why the claim will not be paid. For each Clean Claim submitted electronically, UBH shall complete (i), (ii), or (iii) of this section not later than thirty (30) days after the date of receipt of the Clean Claim from Provider. Alternatively, if UBH acknowledges coverage, but intends to audit the claim, UBH shall pay the charges submitted at 100 percent (100%) of the contracted rate for the claim not later than forty-five (45) days after the date of receipt of the Clean Claim from Provider, if submitted non-electronically, and

thirty (30) days after the date of receipt of the Clean Claim for claims submitted electronically. Any additional payment due Provider or any refund due shall be made not later than thirty (30) days after completion of the audit. As used herein, "Clean Claim" means a claim submitted by Provider for Covered Services rendered to a Member with documentation reasonably necessary to process the claim, and which contains the required data elements described in Tex. Ins. Code art. 3.70-3C (2003).

UBH shall have the right to recover such overpayment from Provider if: (1) not later than the 180th day after the date Provider receives the payment, UBH provides written notice of the overpayment to Provider that includes the reasons for the request for the recovery; and (2) Provider does not make arrangements for repayment of the requested funds on or before the forty-fifth (45th) day after the date Provider receives the notice. If Provider disagrees with a request for recovery of an overpayment, UBH shall provide Provider with an opportunity to appeal and may not attempt recovery of the overpayment until all appeal rights are exhausted.