PARTICIPATING PROVIDER AGREEMENT

This Participating Provider Agreement (together with all Attachments and amendments, this "***Agreement***") is made and entered by and between Centria Healthcare, LLC ("***Provider***") and Health Net of Arizona, Inc. dba Arizona Complete Health, and its Affiliates, collectively referred to as ("Health Plan") (each a "***Party***" and collectively the "***Parties***"). This Agreement is effective as of the date designated by Health Plan on the signature page of this Agreement ("***Effective Date***").

WHEREAS, Provider desires to provide certain health care services to individuals in products offered by or available from or through a Company or Payor (as hereafter defined), and Provider desires to participate in such products as a Participating Provider (as defined herein), all as hereinafter set forth.

WHEREAS, Health Plan desires for Provider to provide such health care services to individuals in such products, and Health Plan desires to have Provider participate in certain of such products as a Participating Provider, all as hereinafter set forth.

NOW, THEREFORE, in consideration of the recitals and mutual promises herein stated, the Parties hereby agree to the provisions set forth below.

ARTICLE I - DEFINITIONS

When appearing with initial capital letters in this Agreement (including an Attachment(s)), the following quoted and underlined terms (and the plural thereof, when appropriate) have the meanings set forth below.

1.1. "Affiliate" means a person or entity controlling, controlled by, or under common control with Health Plan.

1.2. "Attachment" means any document, including an addendum, schedule or exhibit, attached to this Agreement as of the Effective Date or that becomes attached pursuant to Section 2.2 or Section 8.7, all of which are incorporated herein by reference and may be amended from time to time as provided in this Agreement.

1.3. "Clean Claim" has, as to each particular Product, the meaning set forth in the applicable Product Attachment or, if no such definition exists, the Provider Manual.

1.4. "Company" means (collectively or individually, as appropriate in the context) Health Plan and its Affiliates, except those specifically excluded by Health Plan.

1.5. "Compensation Schedule" means at any given time the then effective schedule(s) of maximum rates applicable to a particular Product under which Provider and Contracted Providers will be compensated for the provision of Covered Services to Covered Persons. Such Compensation Schedule(s) will be set forth or described in one or more Attachments to this Agreement, and may be included within a Product Attachment.

1.6. "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 and that provides Covered Services. The term "Contracted Provider" includes Provider for those Covered Services provided by Provider.

1.7. "Coverage Agreement" means any agreement, program or certificate entered into, issued or agreed to by Company or Payor, under which Company or Payor furnishes administrative services or other services in support of a health care program for an individual or group of individuals, and which may include access to one or more of Company's provider networks or vendor arrangements, except those excluded by Health Plan.

1.8. "Covered Person" means any individual entitled to receive Covered Services pursuant to the terms of a Coverage Agreement. Covered Person may also be referred to in certain Coverage Agreements as "Member" or "Beneficiary".

1.9. "Covered Services" means those services and items for which benefits are available and payable under the applicable Coverage Agreement and which are determined, if applicable, to be Medically Necessary under the applicable Coverage Agreement.

1.10. "Health Plan" means Health Net of Arizona, Inc. dba Arizona Complete Health and its Affiliates.

1.11. "Medically Necessary" or "Medical Necessity" shall have the meaning defined in the applicable Coverage Agreement or applicable Regulatory Requirements.

1.12. "Participating Provider" means, with respect to a particular Product, any physician, hospital, ancillary, or other health care provider that has contracted, directly or indirectly, with Health Plan to provide Covered Services to Covered Persons, that has been approved for participation by Company, and that is designated by Company as a "participating provider" in such Product.

1.13. "Payor" means the entity (including Company where applicable) that bears direct financial responsibility for paying from its own funds, without reimbursement from another entity, the cost of Covered Services rendered to Covered Persons under a Coverage Agreement and, if such entity is not Company, such entity contracts, directly or indirectly, with Company for the provision of certain administrative or other services with respect to such Coverage Agreement.

1.14. "Payor Contract" means the contract with a Payor, pursuant to which Company furnishes administrative services or other services in support of the Coverage Agreements entered into, issued or agreed to by a Payor, which services may include access to one or more of Company's provider networks or vendor arrangements, except those excluded by Health Plan. The term "Payor Contract" includes Company's or other Payor's contract with a governmental authority (also referred to herein as a "Governmental Contract") under which Company or Payor arranges for the provision of Covered Services to Covered Persons.

1.15. "Product" means any program or health benefit arrangement designated as a "product" by Health Plan (e.g., Health Plan Product, Medicaid Product, PPO Product, Payor-specific Product, etc.) that is now or hereafter offered by or available from or through Company (and includes the Coverage Agreements that access, or are issued or entered into in connection with such product, except those excluded by Health Plan).

1.16. "Product Attachment" means an Attachment setting forth requirements, terms and conditions specific or applicable to one or more Products, including certain provisions that must be included in a provider agreement under the Regulatory Requirements, which may be alternatives to, or in addition to, the requirements, terms and conditions set forth in this Agreement or the Provider Manual.

1.17. "Provider Manual" means the provider manual and any billing manuals, adopted by Company or Payor which include, without limitation, requirements relating to utilization management, quality management, grievances and appeals, and Product-specific, Payor-specific and State-specific requirements, as may be amended from time to time by Company or Payor.

1.18. "Regulatory Requirements" means all applicable federal and state statutes, regulations, regulatory guidance, judicial or administrative rulings, requirements of Governmental Contracts and standards and requirements of any accrediting or certifying organization, including, but not limited to, the requirements set forth in a Product Attachment.

1.19. "State" is defined as the state identified in the applicable Attachment.

ARTICLE II – PRODUCTS AND SERVICES

2.1. Contracted Providers. Provider shall, and shall cause each Contracted Provider, to comply with and abide by the agreements, representations, warranties, acknowledgements, certifications, terms and conditions of this Agreement (including the provisions of Schedule A that are applicable to Provider, a Contracted Provider, or their services, and any other Attachments), and the Provider Manual, and fulfill all of the duties, responsibilities and obligations imposed on Provider and Contracted Providers under this Agreement (including each Attachment), and the Provider Manual.

2.2. Participation in Products. Subject to the other provisions of this Agreement, each Contracted Provider may be identified as a Participating Provider in each Product identified in a Product Attachment designated on Schedule B of this Agreement or added to this Agreement in accordance with Section 2.2 hereof.

2.2.1. Provider shall, at all times during the term of this Agreement, require each of its Contracted Providers to, subject to Company's approval, participate as Participating Providers in each Product identified in a Product Attachment that is designated on Schedule B to this Agreement or added to this Agreement in accordance with Section 2.2 hereof.

2.2.2. A Contracted Provider may only identify itself as a Participating Provider for those Products in which the Contracted Provider actually participates as provided in this Agreement. Provider acknowledges that Company or Payor may have, develop or contract to develop various Products or provider networks that have a variety of provider panels, program components and other requirements. No Company or Payor warrants or guarantees that any Contracted Provider: (i) will participate in all or a minimum number of provider panels, (ii) will be utilized by a minimum number of Covered Persons, or (iii) will indefinitely remain a Participating Provider or member of the provider panel for a particular network or Product.

2.2.3. Attached hereto as Schedule C is the initial list of the Contracted Providers as of the Effective Date. Provider shall provide Health Plan, from time to time or on a periodic basis as requested by Health Plan, with a complete and accurate list containing the names, office telephone numbers, addresses, tax identification numbers, hospital affiliations, specialties and board status (if applicable), State license number, and National Provider Identifier of Contracted Providers and such other information as mutually agreed upon by the Parties, and shall provide Health Plan with a list of modifications to such list at least sixty (60) days prior to the effective date of such changes, when possible. Provider shall provide such lists in a manner and format mutually acceptable to the Parties.

2.2.4. Provider may add new providers to this Agreement as Contracted Providers. In such case, Provider shall provide written notice to Health Plan of the prospective addition(s), and shall use best efforts to provide such notice at least sixty (60) days in advance of such addition. Provider shall maintain policies and procedures for each of its employed Contracted Providers and written agreements with each of its subcontracted Contracted Providers (other than Provider) that require the Contracted Providers to comply with Regulatory Requirements and the terms and conditions of this Agreement that apply to Contracted Providers.

2.2.5. If Company desires to add one or more Contracted Providers to an additional Product, Company or Payor, as applicable, will provide advance written notice (electronic or paper) thereof to Provider, along with the applicable Product Attachment and the new Compensation Schedule, if any. The applicable Contracted Providers will not be designated as Participating Providers in such additional Product if Provider opts out of such additional Product by giving Company or Payor, as applicable, written notice of its decision to opt-out within thirty (30) days of Company's or Payor's, as applicable, giving of written notice. If Provider timely provides such opt-out notice, the applicable Contracted Providers will not be considered Participating Providers in such Product. If Provider does not timely provide such opt-out notice, then each applicable Contracted Provider shall be a Participating Provider in such additional Product on the terms and conditions set forth in this Agreement and the applicable Product Attachment.

2.3. Covered Services. Each Contracted Provider shall provide Covered Services described or referenced in the applicable Product Attachment(s) to Covered Persons in those Products in which the Contracted Provider is a Participating Provider, in accordance with this Agreement. Each Contracted Provider shall provide Covered Services to Covered Persons with the same degree of care and skill as customarily provided to patients who are not Covered Persons, within the scope of the Contracted Provider's license and in accordance with generally accepted standards of the Contracted Provider's practice and business and in accordance with the provisions of this Agreement, the Provider Manual, and Regulatory Requirements.

2.4. Provider Manual; Policies and Procedures. Provider and Contracted Providers shall at all times cooperate and comply with the requirements, policies, programs and procedures ("Policies") of Company and Payor, which may be described in the Provider Manual and include, but are not limited to, the following: credentialing criteria and requirements; notification requirements; medical management programs; claims and billing, quality assessment and improvement, utilization review and management, disease management, case management, on-site reviews, referral and prior authorization, and grievance and appeal procedures; coordination of benefits and third party liability policies; carve-out and third party vendor programs; and data reporting requirements. The failure to comply with such Policies could result in a denial or reduction of payment to the Provider or Contracted Provider or a denial or reduction of the Covered Person's benefits. Such Policies do not in any way affect or remove the obligation of Contracted Providers to render care. Health Plan shall make the Provider Manual available to Provider and Contracted Providers via one or more designated websites or alternative means. Upon Provider's reasonable request, Health Plan shall provide Provider with a copy of the Provider Manual. In the event of a material change to the Provider Manual, Health Plan will use reasonable efforts to notify Provider in advance of such change. Such notice may be given by Health Plan through a periodic provider newsletter, an update to the on-line Provider Manual, or any other written method (electronic or paper).

2.5. Credentialing Criteria. Provider and each Contracted Provider shall complete Company's and/or Payor's credentialing and/or recredentialing process as required by Company's and/or Payor's credentialing Policies, and shall at all times during the term of this Agreement meet all of Company's and/or Payor's credentialing criteria. Provider and each Contracted Provider represents, warrants and agrees: (a) that it is currently, and for the duration of this Agreement shall remain: (i) in compliance with all applicable Regulatory Requirements, including licensing laws; (ii) if applicable, accredited by The Joint Commission or the American Osteopathic Association; and (iii) a Medicare participating provider under the federal Medicare program and a Medicaid participating provider under applicable federal and State laws; and (b) that all Contracted Providers and all employees and contractors thereof will perform their duties in accordance with all Regulatory Requirements, as well as applicable national, State and local standards of professional ethics and practice. No Contracted Provider shall provide Covered Services to Covered Persons or identify itself as a Participating Provider unless and until the Contracted Provider has been notified, in writing, by Company that such Contracted Provider has successfully completed Company's credentialing process.

2.6. Eligibility Determinations. Provider or Contracted Provider shall timely verify whether an individual seeking Covered Services is a Covered Person. Company or Payor, as applicable, will make available to Provider and Contracted Providers a method, whereby Provider and Contracted Providers can obtain, in a timely manner, general information about eligibility and coverage. Company or Payor, as applicable, does not guarantee that persons identified as Covered Persons are eligible for benefits or that all services or supplies are Covered Services. If Company, Payor or its delegate determines that an individual was not a Covered Person at the time services were rendered, such services shall not be eligible for payment under this Agreement. In addition, Company will use reasonable efforts to include or contractually require Payors to clearly display Company's name, logo or mailing address (or other identifier(s) designated from time to time by Company) on each membership card.

2.7. Referral and Preauthorization Procedures. Provider and Contracted Providers shall comply with referral and preauthorization procedures adopted by Company and or Payor, as applicable, prior to referring a Covered Person to any individual, institutional or ancillary health care provider. Unless otherwise expressly authorized in writing by Company or Payor, Provider and Contracted Providers shall refer Covered Persons only to Participating Providers to provide the Covered Service for which the Covered Person is referred. Except as

required by applicable law, failure of Provider and Contracted Providers to follow such procedures may result in denial of payment for unauthorized treatment.

2.8. Treatment Decisions. No Company or Payor is liable for, nor will it exercise control over, the manner or method by which a Contracted Provider provides items or services under this Agreement. Provider and Contracted Providers understand that determinations of Company or Payor that certain items or services are not Covered Services or have not been provided or billed in accordance with the requirements of this Agreement or the Provider Manual are administrative decisions only. Such decisions do not absolve the Contracted Provider of its responsibility to exercise independent judgment in treatment decisions relating to Covered Persons. Nothing in this Agreement (i) is intended to interfere with Contracted Provider's relationship with Covered Persons, or (ii) prohibits or restricts a Contracted Provider from disclosing to any Covered Person any information that the Contracted Provider deems appropriate regarding health care quality, medical treatment decisions or alternatives.

2.9. Carve-Out Vendors. Provider acknowledges that Company may, during the term of this Agreement, carve-out certain Covered Services from its general provider contracts, including this Agreement, for one or more Products as Company deems necessary or appropriate. Provider and Contracted Providers shall cooperate with and, when medically appropriate, utilize all third party vendors designated by Company for those Covered Services identified by Company from time to time for a particular Product.

2.10. Disparagement Prohibition. Provider, each Contracted Provider and the officers of Company shall not disparage the other during the term of this Agreement or in connection with any expiration, termination or non-renewal of this Agreement. Neither Provider nor Contracted Provider shall interfere with Company's direct or indirect contractual relationships including, but not limited to, those with Covered Persons or other Participating Providers. Nothing in this Agreement should be construed as limiting the ability of either Health Plan, Company, Provider or a Contracted Provider to inform Covered Persons that this Agreement has been terminated or otherwise expired or, with respect to Provider, to promote Provider to the general public or to post information regarding other health plans consistent with Provider's usual procedures, provided that no such promotion or advertisement is specifically directed at one or more Covered Persons. In addition, nothing in this provision should be construed as limiting Company's ability to use and disclose information and data obtained from or about Provider or Contracted Provider, including this Agreement, to the extent determined reasonably necessary or appropriate by Company in connection with its efforts to comply with Regulatory Requirements and to communicate with regulatory authorities.

2.11. Nondiscrimination. Provider and each Contracted Provider will provide Covered Services to Covered Persons without discrimination on account of race, sex, sexual orientation, age, color, religion, national origin, place of residence, health status, type of Payor, source of payment (e.g., Medicaid generally or a State-specific health care program), physical or mental disability or veteran status, and will ensure that its facilities are accessible as required by Title III of the Americans With Disabilities Act of 1991. Provider and Contracted Providers recognize that, as a governmental contractor, Company or Payor may be subject to various State and federal laws, executive orders and regulations regarding equal opportunity and affirmative action, which also may be applicable to subcontractors, and Provider and each Contracted Provider agree to comply with such requirements as described in any applicable Attachment.

2.12. Notice of Certain Events. Provider shall give written notice to Health Plan of: (i) any event of which notice must be given to a licensing or accreditation agency or board; (ii) any change in the status of Provider's or a Contracted Provider's license; (iii) termination, suspension, exclusion or voluntary withdrawal of Provider or a Contracted Provider from any state or federal health care program, including but not limited to Medicaid; or (iv) any settlements or judgments in connection with a lawsuit or claim filed or asserted against Provider or a Contracted Provider alleging professional malpractice involving a Covered Person. In any instance described in subsection (i)-(iii) above, Provider must notify Health Plan or Payor in writing within ten (10) days, and in any instance described in subsection (iv) above, Provider must notify Health Plan or Payor in writing within thirty (30) days, from the date it first obtains knowledge of the pending of the same.

2.13. Use of Name. Provider and each Contracted Provider hereby authorizes each Company or Payor to use their respective names, telephone numbers, addresses, specialties, certifications, hospital affiliations (if any), and other descriptive characteristics of their facilities, practices and services for the purpose of identifying the Contracted Providers as "Participating Providers" in the applicable Products. Provider and Contracted Providers may only use the name of the applicable Company or Payor for purposes of identifying the Products in which they participate, and may not use the registered trademark or service mark of Company or Payor without prior written consent.

2.14. Compliance with Regulatory Requirements. Provider, each Contracted Provider and Company agree to carry out their respective obligations under this Agreement and the Provider Manual in accordance with all applicable Regulatory Requirements, including, but not limited to, the requirements of the Health Insurance Portability and Accountability Act, as amended, and any regulations promulgated thereunder. If, due to Provider's or Contracted Provider's noncompliance with applicable Regulatory Requirements or this Agreement, sanctions or penalties are imposed on Company, Company may, in its sole discretion, offset such amounts against any amounts due Provider or Contracted Providers from any Company or require Provider or the Contracted Provider to reimburse Company for such amounts.

2.15. Program Integrity Required Disclosures. Provider agrees to furnish to Health Plan complete and accurate information necessary to permit Company to comply with the collection of disclosures requirements specified in 42 C.F.R. Part 455 Subpart B or any other applicable State or federal requirements, within such time period as is necessary to permit Company to comply with such requirements. Such requirements include but are not limited to: (i) 42 C.F.R. §455.105, relating to (a) the ownership of any subcontractor with whom Provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request and (b) any significant business transaction between Provider and any wholly owned supplier or subcontractor during the five (5) year period ending on the date of the request; (ii) 42 C.F.R. §455.104, relating to individuals or entities with an ownership or controlling interest in Provider; and (iii) 42 C.F.R. §455.106, relating to individuals with an ownership or controlling interest in Provider, or who are managing employees of Provider, who have been convicted of a crime.

ARTICLE III – CLAIMS SUBMISSION, PROCESSING, AND COMPENSATION

3.1. Claims or Encounter Data Submission. As provided in the Provider Manual and/or Policies, Contracted Providers shall submit to Payor or its delegate claims for payment for Covered Services rendered to Covered Persons. Contracted Provider shall submit encounter data to Payor or its delegate in a timely fashion, which must contain statistical and descriptive medical and patient data and identifying information, if and as required in the Provider Manual. Payor or its delegate reserves the right to deny payment to the Contracted Provider if the Contracted Provider fails to submit claims for payment or encounter data in accordance with the Provider Manual and/or Policies.

3.2. Compensation. The compensation for Covered Services provided to a Covered Person ("Compensation Amount") will be the appropriate amount under the applicable Compensation Schedule in effect on the date of service for the Product in which the Covered Person participates. Subject to the terms of this Agreement and the Provider Manual, Provider and Contracted Providers shall accept the Compensation Amount as payment in full for the provision of Covered Services. Subject to the terms of this Agreement, Payor shall pay or arrange for payment of each Clean Claim received from a Contracted Provider for Covered Services provided to a Covered Person in accordance with the applicable Compensation Amount less any applicable copayments, cost-sharing or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement.

3.3. Financial Incentives. The Parties acknowledge and agree that nothing in this Agreement shall be construed to create any financial incentive for Provider or a Contracted Provider to withhold Covered Services.

3.4. Hold Harmless. Provider and each Contracted Provider agree that in no event, including but not limited to non-payment by a Payor, a Payor's insolvency, or breach of this Agreement, shall Provider or a

Contracted Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Covered Person or person acting on the Covered Person's behalf, other than Payor, for Covered Services provided under this Agreement. This provision shall not prohibit collection of any applicable copayments, cost-sharing or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement. This provision survives termination or expiration of this Agreement for any reason, will be construed for the benefit of Covered Persons, and supersedes any oral or written agreement entered into between Provider or a Contracted Provider and a Covered Person.

3.5. Recovery Rights. Payor or its delegate shall have the right to immediately offset or recoup any and all amounts owed by Provider or a Contracted Provider to Payor or Company against amounts owed by the Payor or Company to the Provider or Contracted Provider. Provider and Contracted Providers agree that all recoupment and any offset rights under this Agreement will constitute rights of recoupment authorized under State or federal law and that such rights will not be subject to any requirement of prior or other approval from any court or other government authority that may now have or hereafter have jurisdiction over Provider or a Contracted Provider.

ARTICLE IV – RECORDS AND INSPECTIONS

4.1. Records. Each Contracted Provider shall maintain medical, financial and administrative records related to items or services provided to Covered Persons, including but not limited to a complete and accurate permanent medical record for each such Covered Person, in such form and detail as are required by applicable Regulatory Requirements and consistent with generally accepted medical standards.

4.2. Access. Provider and each Contracted Provider shall provide access to their respective books and records to each of the following, including any delegate or duly authorized agent thereof, subject to applicable Regulatory Requirements: (i) Company and Payor, during regular business hours and upon prior notice; (ii) appropriate State and federal authorities, to the extent such access is necessary to comply with Regulatory Requirements; and (iii) accreditation organizations. Provider and each Contracted Provider shall provide copies of such records at no expense to any of the foregoing that may make such request. Each Contracted Provider also shall obtain any authorization or consent that may be required from a Covered Person in order to release medical records and information to Company or Payor or any of their delegates. Provider and each Contracted Provider shall cooperate in and allow on-site inspections of its, his or her facilities and records by any Company, Payor, their delegates, any authorized government officials, and accreditation organizations. Provider and each Contracted Provider shall compile information necessary for the expeditious completion of such on-site inspection in a timely manner.

4.3. Record Transfer. Subject to applicable Regulatory Requirements, each Contracted Provider shall cooperate in the timely transfer of Covered Persons' medical records to any other health care provider, at no charge and when required.

ARTICLE V – INSURANCE AND INDEMNIFICATION

5.1. Insurance. During the term of this Agreement and for any applicable continuation period as set forth in Section 7.3 of this Agreement, Provider and/or each Contracted Provider shall maintain policies of general and professional liability insurance and other insurance necessary to insure Provider and such Contracted Provider, respectively; their respective employees; and any other person providing services hereunder on behalf of Provider or such Contracted Provider, as applicable, against any claim(s) of personal injuries or death alleged to have been caused or caused by their performance under this Agreement. Such insurance shall include, but not be limited to, any "tail" or prior acts coverage necessary to avoid any gap in coverage. Insurance shall be through a licensed carrier acceptable to Health Plan, and in a minimum amount of one million dollars ($1,000,000) per occurrence, and three million dollars ($3,000,000) in the aggregate unless a lesser amount is accepted by Health Plan or where State law mandates otherwise. Provider and/or each Contracted Provider will provide Health Plan with at least fifteen (15) days prior written notice of cancellation, non-renewal, lapse, or adverse material modification of such coverage. Upon Health Plan's request, Provider and/or each Contracted Provider will furnish Health Plan with evidence of such insurance.

5.2. Indemnification by Provider and Contracted Provider. Provider and each Contracted Provider shall indemnify and hold harmless (and at Health Plan's request defend) Company and Payor and all of their respective officers, directors, agents and employees from and against any and all third party claims for any loss, damages, liability, costs, or expenses (including reasonable attorney's fees) judgments or obligations arising from or relating to any negligence, wrongful act or omission, or breach of this Agreement by Provider, a Contracted Provider, or any of their respective officers, directors, agents or employees.

5.3. Indemnification by Health Plan. Health Plan agrees to indemnify and hold harmless (and at Provider's request defend) Provider, Contracted Providers, and their officers, directors, agents and employees from and against any and all third party claims for any loss, damages, liability, costs, or expenses (including reasonable attorney's fees), judgments, or obligations arising from or relating to any negligence, wrongful act or omission or breach of this Agreement by Company or its directors, officers, agents or employees.

ARTICLE VI – DISPUTE RESOLUTION

6.1. Informal Dispute Resolution. Any dispute between Provider and/or a Contracted Provider, as applicable (the "Provider Party"), and Health Plan and/or Company, as applicable (including any Company acting as Payor) (the "Administrator Party"), with respect to or involving the performance under, termination of, or interpretation of this Agreement, or any other claim or cause of action hereunder, whether sounding in tort, contract or under statute (a "Dispute") shall first be addressed by exhausting the applicable procedures in the Provider Manual pertaining to claims payment, credentialing, utilization management, or other programs. If, at the conclusion of these applicable procedures, the matter is not resolved to satisfaction of the Provider Party and the Administrator Party, or if there are no applicable procedures in the Provider Manual, then the Provider Party and the Administrator Party shall engage in a period of good faith negotiations between their designated representatives who have authority to settle the Dispute, which negotiations may be initiated by either the Provider Party or the Administrator Party upon written request to the other, provided such request takes place within one year of the date on which the requesting party first had, or reasonably should have had, knowledge of the event(s) giving rise to the Dispute. If the matter has not been resolved within thirty (30) days of such request, either the Provider Party or the Administrator Party may, as its sole and exclusive forum for the litigation of the Dispute or any part thereof, initiate arbitration pursuant to Section 6.2 below by providing written notice to the other party.

6.2. Arbitration. If either the Provider Party or the Administrator Party wishes to pursue the Dispute as provided in Section 6.1, such party shall submit it to binding arbitration conducted in accordance with the Commercial Arbitration Rules of the American Arbitration Association ("AAA"). In no event may any arbitration be initiated more than one (1) year following, as applicable, the end of the sixty (60) day negotiation period set forth in Section 6.1, or the date of notice of termination. Arbitration proceedings shall be conducted by an arbitrator chosen from the National Healthcare Panel at a mutually agreed upon location within the State. The arbitrator shall not award any punitive or exemplary damages of any kind, shall not vary or ignore the provisions of this Agreement, and shall be bound by controlling law. Any arbitration in which the total amount in controversy is less than $100,000 shall be conducted in a single hearing day. The Parties and the Contracted Providers, on behalf of themselves and those that they may now or hereafter represent, agree to and do hereby waive any right to pursue, on a class basis, any Dispute. Each of the Provider Party and the Administrator Party shall bear its own costs and attorneys' fees related to the arbitration except that the AAA's Administrative Fees, all Arbitrator Compensation and travel and other expenses, and all costs of any proof produced at the direct request of the arbitrator shall be borne equally by the applicable parties, and the arbitrator shall not have the authority to order otherwise. The existence of a Dispute or arbitration proceeding shall not in and of itself constitute cause for termination of this Agreement. Except as hereafter provided, during an arbitration proceeding, each of the Provider Party and the Administrator Party shall continue to perform its obligations under this Agreement pending the decision of the arbitrator. Nothing herein shall bar either the Provider Party or the Administrator Party from seeking emergency injunctive relief to preclude any actual or perceived breach of this Agreement, although such party shall be obligated to file and pursue arbitration at the earliest reasonable opportunity. Judgment on the award rendered may be entered in any court having jurisdiction thereof. Because of the confidential nature of this Agreement, the Provider and Administrator Parties further agree that in any action to compel arbitration or enforce any arbitration

award, no party may file any part of this Agreement (including Attachments) in the court record, except this Section 6.2. Nothing contained in this Article VI shall limit a Party's right to terminate this Agreement with or without cause in accordance with Section 7.2.

ARTICLE VII – TERM AND TERMINATION

7.1. Term. This Agreement is effective as of the Health Plan Effective Date, and will remain in effect for an initial term ("Initial Term") of three (3) year(s), after which it will automatically renew for successive terms of one (1) year each (each a "Renewal Term"), unless this Agreement is sooner terminated as provided in this Agreement or either Party gives the other Party written notice of non-renewal of this Agreement not less than one hundred-twenty (120) days prior to the end of the then-current term. In addition, either Party may elect to not renew a Contracted Provider's participation as a Participating Provider in a particular Product for the next Renewal Term, by giving Provider written notice of such non-renewal not less than one hundred-twenty (120) days prior to the, as applicable, last day of the Initial Term or applicable Renewal Term; in such event, Provider shall immediately notify the affected Contracted Provider of such non-renewal. Termination of any Contracted Provider's participation in a particular Product will not have the effect of terminating either this Agreement or the Contracted Provider's participation in any other Product in which the Contract Provider participates under this Agreement.

7.2. Termination. This Agreement, or the participation of Provider or a Contracted Provider as a Participating Provider in one or more Products, may be terminated or suspended as set forth below.

7.2.1. Upon Notice. This Agreement may be terminated by either Party giving the other Party at least one hundred-twenty (120) days prior written notice of such termination. The participation of any Contracted Provider as a Participating Provider in a Product may be terminated by either Party giving the other Party at least one hundred-twenty (120) days prior written notice of such termination; in such event, Provider shall immediately notify the affected Contracted Provider of such termination.

7.2.2. With Cause. This Agreement, or the participation of any Contracted Provider as a Participating Provider in one or more Products under this Agreement, may be terminated by either Party giving at least sixty (60) days prior written notice of termination to the other Party if such other Party (or the applicable Contracted Provider) is in breach of any material term or condition of this Agreement and such other Party (or the Contracted Provider) fails to cure the breach within the thirty (30) day period immediately following the giving of written notice of such breach. Any notice given pursuant to this Section 7.2.2 must describe the specific breach. In the case of a termination of a Contracted Provider, Provider shall immediately notify the affected Contracted Provider of such termination.

7.2.3. Suspension of Participation. Unless expressly prohibited by applicable Regulatory Requirements, Health Plan has the right to immediately suspend or terminate the participation of a Contracted Provider in any or all Products by giving written notice thereof to Provider when Health Plan determines that (i) based upon available information, the continued participation of the Contracted Provider appears to constitute an immediate threat or risk to the health, safety or welfare of Covered Persons, or (ii) the Contracted Provider's fraud, malfeasance or non-compliance with Regulatory Requirements is reasonably suspected. Provider shall immediately notify the affected Contracted Provider of such suspension. During such suspension, the Contracted Provider shall, as directed by Health Plan, discontinue the provision of all or a particular Covered Service to Covered Persons. During the term of any suspension, the Contracted Provider shall notify Covered Persons that his or her status as a Participating Provider has been suspended. Such suspension will continue until the Contracted Provider's participation is reinstated or terminated.

7.2.4. Insolvency. This Agreement may be terminated immediately by a Party giving written notice thereof to the other Party if the other Party is insolvent or has bankruptcy proceedings initiated against it.

7.2.5. Credentialing. The status of a Contracted Provider as a Participating Provider in one or more Products may be terminated immediately by Health Plan giving written notice thereof to Provider if the

Contracted Provider fails to adhere to Health Plan's credentialing criteria, including, but not limited to, if the Contracted Provider (i) loses, relinquishes, or has materially affected its license to provide Covered Services in the State, (ii) fails to comply with the insurance requirements set forth in this Agreement; or (iii) is convicted of a criminal offense related to involvement in any state or federal health care program or has been terminated, suspended, barred, voluntarily withdrawn as part of a settlement agreement, or otherwise excluded from any state or federal health care program. Provider shall immediately notify the affected Contracted Provider of such termination.

7.3. Effect of Termination. After the effective date of termination of this Agreement or a Contracted Provider's participation in a Product, this Agreement shall remain in effect for purposes of those obligations and rights arising prior to the effective date of termination. Upon such a termination, each affected Contracted Provider (including Provider, if applicable) shall (i) continue to provide Covered Services to Covered Persons in the applicable Product(s) during the longer of the ninety (90) day period following the date of such termination or such other period as may be required under any Regulatory Requirements, and, if requested by Company, each affected Contracted Provider (including Provider, if applicable) shall continue to provide, as a Participating Provider, Covered Services to Covered Persons until such Covered Persons are assigned or transferred to another Participating Provider in the applicable Product(s), and (ii) continue to comply with and abide by all of the applicable terms and conditions of this Agreement, including, but not limited to, Section 3.4 (Hold Harmless) hereof, in connection with the provision of such Covered Services during such continuation period. During such continuation period, each affected Contracted Provider (including Provider, if applicable) will be compensated in accordance with this Agreement and shall accept such compensation as payment in full.

7.4. Survival of Obligations. All provisions hereof that by their nature are to be performed or complied with following the expiration or termination of this Agreement, including without limitation Sections 2.8, 2.10, 3.2, 3.4, 3.5, 4.2, 5.1, 5.2, 5.3, 6.2, 7.3, and 7.4 and Article VIII, survive the expiration or termination of this Agreement.

ARTICLE VIII - MISCELLANEOUS

8.1. Relationship of Parties. The relationship between or among Health Plan, Company, Provider, Payor and any Contracted Provider hereunder is that of independent contractors. None of the provisions of this Agreement will be construed as creating any agency, partnership, joint venture, employee-employer, or other relationship. References herein to the rights and obligations of any Company or Health Plan, as applicable, under this Agreement are references to the rights and obligations of each such Company or Health Plan individually and not collectively. A Company or a Health Plan is only responsible for performing its respective obligations hereunder with respect to a particular Product, Coverage Agreement, Payor Contract, Covered Service or Covered Person. A breach or default by an individual Company or Health Plan shall not constitute a breach or default by any other Company or Health Plan.

8.2. Conflicts Between Certain Documents. If there is any conflict between this Agreement and the Provider Manual, this Agreement will control. In the event of any conflict between this Agreement and any Product Attachment, the Product Attachment will control as to such Product.

8.3. Assignment. This Agreement is intended to secure the services of and be personal to Provider and may not be assigned, sublet, delegated or transferred by Provider without Health Plan's prior written consent. Health Plan shall have the right, exercisable in its sole discretion, to assign or transfer all or any portion of its rights or to delegate all or any portion of its interests under this Agreement or any Attachment to an Affiliate, successor of Health Plan, or purchaser of the assets or stock of Health Plan, or the line of business or business unit primarily responsible for carrying out Health Plan's obligations under this Agreement.

8.4. Headings. The headings of the sections of this Agreement are inserted merely for the purpose of convenience and do not limit, define, or extend the specific terms of the section so designated.

8.5. Governing Law. The interpretation of this Agreement and the rights and obligations of Health Plan , Company, Provider and any Contracted Providers hereunder will be governed by and construed in accordance with applicable federal and State laws.

8.6. Third Party Beneficiary. This Agreement is entered into by the Parties signing it for their benefit, as well as, in the case of Health Plan, the benefit of Company, and in the case of Provider, the benefit of each Contracted Provider. Except as specifically provided in Section 3.4 hereof, no Covered Person or third party, other than Company, will be considered a third party beneficiary of this Agreement.

8.7. Amendment. Except as otherwise provided in this Agreement, this Agreement may be amended only by written agreement of duly authorized representatives of the Parties.

8.7.1. Health Plan may amend this Agreement by giving Provider written notice of the amendment to the extent such amendment is deemed necessary or appropriate by Health Plan to comply with any Regulatory Requirements. Any such amendment will be deemed accepted by Provider upon the giving of such notice.

8.7.2. Health Plan may amend this Agreement by giving Provider written notice (electronic or paper) of the proposed amendment. Unless Provider notifies Health Plan in writing of its objection to such amendment during the thirty (30) day period following the giving of such notice by Health Plan, Provider shall be deemed to have accepted the amendment. If Provider objects to any proposed amendment to either the base agreement or any Attachment, Health Plan may exclude one or more of the Contracted Providers from being Participating Providers in the applicable Product (or any component program of, or Coverage Agreement in connection with, such Product).

8.8. Entire Agreement. All prior or concurrent agreements, promises, negotiations or representations either oral or written, between Health Plan and Provider relating to a subject matter of this Agreement, which are not expressly set forth in this Agreement, are of no force or effect.

8.9. Severability. The invalidity or unenforceability of any terms or provisions hereof will in no way affect the validity or enforceability of any other terms or provisions.

8.10. Waiver. The waiver by either Party of the violation of any provision or obligation of this Agreement will not constitute the waiver of any subsequent violation of the same or other provision or obligation.

8.11. Notices. Except as otherwise provided in this Agreement, any notice required or permitted to be given hereunder is deemed to have been given when such written notice has been personally delivered or deposited in the United States mail, postage paid, or delivered in hard copy or electronically by a service that provides written receipt or acknowledgment of delivery, addressed as follows:

To Health Plan at:	To Provider at:
Attn: President	Attn: Paul McDonald
Health Net of Arizona, Inc. dba Arizona Complete Health	Centria Healthcare, LLC
1870 W. Rio Salado Parkway	2338 West Royal Palm Rd., Suite J
Tempe, AZ 85281	Phoenix, AZ 85021
	Contracts@centriahealthcare.com

or to such other address as such Party may designate in writing. Notwithstanding the previous paragraph, Health Plan may provide notices by electronic mail, through its provider newsletter or on its provider website.

8.12. Force Majeure. Neither Party shall be liable or deemed to be in default for any delay or failure to perform any act under this Agreement resulting, directly or indirectly, from acts of God, civil or military authority, acts of public enemy, war, riots, civil disorders, accidents, fires, explosions, earthquake, flood, lockouts, strikes or other work stoppages by either Party's employees, injunctions-intervention-acts, a governmental authority's failure or refusal to act, or any other similar cause beyond the reasonable control of the affected Party which that Party is unable to prevent by exercising reasonable diligence and that occurs without that Party's fault or negligence.

8.13. Proprietary Information. Each Party is prohibited from, and shall prohibit its Affiliates and Contracted Providers from, disclosing to a third party the substance of this Agreement, or any information of a confidential nature acquired from the other Party (or Affiliate or Contracted Provider thereof) during the course of this Agreement, except to agents of such Party as necessary for such Party's performance under this Agreement, or as required by a Payor Contract or applicable Regulatory Requirements. Provider acknowledges and agrees that all information relating to Company's programs, policies, protocols and procedures is proprietary information and Provider shall not disclose such information to any person or entity without Health Plan's express written consent.

8.14. Authority. The individuals whose signatures are set forth below represent and warrant that they are duly empowered to execute this Agreement. Provider represents and warrants that it has all legal authority to contract on behalf of and to bind all Contracted Providers to the terms of the Agreement with Health Plan.

* * * * *

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

IN WITNESS WHEREOF, the Parties hereto have executed this Agreement, including all Product Attachments noted on Schedule B, effective as of the date set forth beneath their respective signatures.

HEALTH PLAN:

Health Net of Arizona, Inc. dba Arizona Complete Health

Authorized Signature: Martha J Smith Digitally signed by Martha Smith Date: 2021.03.21 16:59:09 -07'00'

Print Name: Martha J. Smith

Title: Plan President & CEO

Signature Date: 3/21/2021

ECM #: 521580

To be completed by Health Plan only:

Effective Date: 06/01/2021

PROVIDER:

Centria Healthcare, LLC

(Legibly Print Name of Provider)

Authorized Signature: Paul McDonald

Print Name: Paul McDonald

Title: CFO

Signature Date: 3/3/2021

Tax Identification Number: 27-1402749

NPI: 1053641498

AHCCCS ID Number: 337877

Medicare ID Number (if applicable): _____

PARTICIPATING PROVIDER AGREEMENT

SCHEDULE A
CONTRACTED PROVIDER-SPECIFIC PROVISIONS

Provider and Contracted Providers shall comply with the applicable provisions of this Schedule A.

1. Hospitals. If Provider or a Contracted Provider is a hospital ("Hospital"), the following provisions apply.

1.1 24 Hour Coverage. Each Hospital shall be available to provide Covered Services to Covered Persons twenty-four (24) hours per day, seven (7) days per week.

1.2 Emergency Care. Each Hospital shall provide Emergency Care (as hereafter defined) in accordance with Regulatory Requirements. The Contracted Provider shall notify Company's medical management department of any emergency room admissions by electronic file sent within twenty-four (24) hours or by the next business day of such admission. "Emergency Care" (or derivative thereof) has, as to each particular Product, the meaning set forth in the applicable Coverage Agreement or Product Attachment. If there is no definition in such documents, "Emergency Care" means inpatient and/or outpatient Covered Services furnished by a qualified provider that are needed to evaluate or stabilize an Emergency Medical Condition. "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) 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 the following: (i) 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; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

1.3 Staff Privileges. Each Hospital shall assist in granting staff privileges or other appropriate access to Company's Participating Providers who are qualified medical or osteopathic physicians, provided they meet the reasonable standards of practice and credentialing standards established by the Hospital's medical staff and bylaws, rules, and regulations.

1.4 Discharge Planning. Each Hospital agrees to cooperate with Company's system for the coordinated discharge planning of Covered Persons, including the planning of any necessary continuing care.

1.5 Credentialing Criteria. Each Hospital shall: (a) currently, and for the duration of this Agreement, remain accredited by the Joint Commission or American Osteopathic Association, as applicable; and (b) ensure that all employees of Hospital perform their duties in accordance with all applicable local, State and federal licensing requirements and standards of professional ethics and practice.

1.6 National Committee for Quality Assurance ("NCQA") Accreditation of Health Plans Standards. Each Hospital agrees to: (i) cooperate with Quality Management and Improvement ("QI") activities; (ii) maintain the confidentiality of a Covered Persons information and records pursuant to the Agreement; and (iii) allow the Company to use Hospital's performance data.

2. Practitioners. If Provider or Contracted Provider is a physician or other health care practitioner (including physician extenders) ("Practitioner"), the following provisions apply.

2.1 Contracted Professional Qualifications. At all times during the term of this Agreement, Practitioner shall, as applicable, maintain medical staff membership and admitting privileges with at least one hospital that is a Participating Provider ("Participating Hospital") with respect to each Product in which the Practitioner participates. Upon Company's request, Practitioner shall furnish evidence of the foregoing to Company. If Practitioner does not have such admitting privileges, Provider or the Practitioner shall provide Company with a written statement from another Participating Provider who has such admitting privileges, in good

standing, certifying that such individual agrees to assume responsibility for providing inpatient Covered Services to Covered Persons who are patients of the applicable Practitioner.

2.2 Acceptance of New Patients. To the extent that Practitioner is accepting new patients, such Practitioner must also accept new patients who are Covered Persons with respect to the Products in which such Practitioner participates. Practitioner shall notify Company in writing forty-five (45) days prior to such Practitioner's decision to no longer accept Covered Persons with respect to a particular Product. In no event will an established patient of any Practitioner be considered a new patient.

2.3 Drug List/Drug Formulary. If applicable to the Covered Person's coverage, Practitioners shall use commercially reasonable efforts, when medically appropriate under the circumstances, to comply with formulary or preferred drug list when prescribing medications for Covered Persons.

2.4 National Committee for Quality Assurance ("NCQA") Accreditation of Health Plans Standards. Each Practitioner agrees to: (i) cooperate with Quality Management and Improvement ("QI") activities; (ii) maintain the confidentiality of a Covered Persons information and records pursuant to the Agreement; and (iii) allow the Company to use Practitioner's performance data.

3. Ancillary Providers. If Provider or Contracted Provider is an ancillary provider (including but not limited to a home health agency, durable medical equipment provider, sleep center, pharmacy, ambulatory surgery center, nursing facility, laboratory or urgent care center)("Ancillary Provider"), the following provisions apply.

3.1 Acceptance of New Patients. To the extent that Ancillary Provider is accepting new patients, such Ancillary Provider must also accept new patients who are Covered Persons with respect to the Products in which such Ancillary Provider participates. Ancillary Provider shall notify Company in writing forty-five (45) days prior to such Ancillary Provider's decision to no longer accept Covered Persons with respect to a particular Product. In no event will an established patient of any Ancillary Provider be considered a new patient.

3.2 National Committee for Quality Assurance ("NCQA") Accreditation of Health Plans Standards. Each ancillary provider agrees to: (i) cooperate with Quality Management and Improvement ("QI") activities; (ii) maintain the confidentiality of a Covered Persons information and records pursuant to the Agreement; and (iii) allow the Company to use ancillary provider's performance data.

4. FQHC. If Provider or a Contracted Provider is a federally qualified health center ("FQHC"), the following provision applies.

4.1 FQHC Insurance. To the extent FQHC's employees are deemed to be federal employees qualified for protection under the Federal Tort Claims Act ("FTCA") and Health Plan has been provided with documentation of such status issued by the U.S. Department of Health and Human Services (such status to be referred to as "FTCA Coverage"), Section 5.1 of this Agreement will not apply to those Contracted Providers with FTCA Coverage. FQHC shall provide evidence of such FTCA Coverage to Health Plan at any time upon request. FQHC shall promptly notify Health Plan if, any time during the term of this Agreement, any Contracted Provider is no longer eligible for, or if FQHC becomes aware of any fact or circumstance that would jeopardize, FTCA Coverage. Section 5.1 of this Agreement will apply to a Contracted Provider immediately upon such Contracted Provider's loss of FTCA Coverage for any reason.

5. Facility Providers. If Provider or a Contracted Provider is a facility (including but not limited to Clinic, FQHC, LTAC, Nursing Home, Rehab, Rural Health Clinic, Skilled Nursing) ("Facility Provider") the following provision applies.

5.1 National Committee for Quality Assurance ("NCQA") Accreditation of Health Plans Standards. Each facility agrees to: (i) cooperate with Quality Management and Improvement ("QI") activities; (ii) maintain the confidentiality of a Covered Persons information and records pursuant to the Agreement; and (iii) allow the Company to use facility's performance data.

6. Long Term Services and Supports ("LTSS") Provider. If Provider or a Contracted Provider is a provider of LTSS, the following provisions apply.

6.1 Definition. LTSS generally includes assistance with daily self-care activities (e.g., walking, toileting, bathing, and dressing) and activities that support an independent lifestyle (e.g., food preparation, transportation, and managing medications). The broad category of LTSS also includes care and service coordination for people who live in their own home, a residential setting, a nursing facility, or other institutional setting. Home and community-based services ("HCBS") are a subset of LTSS that functions outside of institutional care to maximize independence in the community.

6.2 Acknowledgement. Health Plan acknowledges that Provider is a provider of LTSS and is not necessarily a provider of medical or health care services. Nothing in this Agreement is intended to require Provider to provide medical or health care services that Provider does not routinely provide, but would not prohibit providers from offering these services, as appropriate.

6.3 Notification Requirements. Provider or the applicable Contracted Provider shall provide the following notifications to Health Plan, via written notice or via telephone contact at a number to be provided by Health Plan, within the following time frames:

6.3.1 Provider or the applicable Contracted Provider shall notify Health Plan of a Covered Person's visit to urgent care or the emergency department of any hospital, or of a Covered Person's hospitalization, within 24 hours of becoming aware of such visit or hospitalization.

6.3.2 Provider or the applicable Contracted Provider shall notify Health Plan of any change to the designated/assigned services being provided under a Covered Person's plan of care and/or service plan, within 24 hours of becoming aware of such change.

6.3.3 Provider or the applicable Contracted Provider shall notify Health Plan if a Covered Person misses an appointment with Provider, within 24 hours of becoming aware of such missed appointment.

6.3.4 Provider or the applicable Contracted Provider shall notify Health Plan of any change in a Covered Person's medical or behavioral health condition, within 24 hours of becoming aware of such change. (Examples of changes in condition are set forth in the Provider Manual.)

6.3.5 Provider or the applicable Contracted Provider shall notify Health Plan of any safety issue identified by Provider or Contracted Provider or its agent or subcontractor, within 24 hours of the identification of such safety issue. (Examples of safety issues are set forth in the Provider Manual.)

6.3.6 Provider or the applicable Contracted Provider shall notify Health Plan of any change in Provider's or Contracted Provider's key personnel, within 24 hours of such change.

6.4 Minimum Data Set. If Contracted Provider is a nursing facility, Provider or such Contracted Provider shall submit to Health Plan or its designee the Minimum Data Set as defined by CMS and required under federal law and Health Plan policy as it relates to all Covered Persons who are residents in Contracted Provider's facility. Such submission shall be via electronic mail, facsimile transmission, or other manner and format reasonably requested by Health Plan.

6.5 Quality Improvement Plan. Each Contracted Provider shall participate in Health Plan's LTSS quality improvement plan. Each Contracted Provider shall permit Health Plan to access such Contracted Providers' assessment and quality data upon reasonable advance notice, which may be given by electronic mail.

6.6 Electronic Visit Verification. If Contracted Provider provides in-home services, Contracted Provider shall comply with 21st Century Cures Act and Health Plan's electronic visit verification system requirements where applicable and accessible.

6.7 Criminal Background Checks. Provider shall conduct a criminal background check on each Contracted Provider prior to the commencement of services under this Agreement and as requested by Health Plan thereafter. Provider shall provide the results of such background checks to Health Plan and member, if self-directed, upon request. Provider agrees to immediately notify Health Plan of any criminal convictions of any Contracted or sub-contracted Provider. Provider shall pay any costs associated with such criminal background checks.

7. Person-Centered Planning, Care/Service Plan, and Services ("PCSP"). If Provider or a Contracted Provider is a provider of PCSP, the following provisions apply.

7.1 Provider shall comply with all state and federal regulatory requirements related to person-centered planning, care/service plans, and services including, but not limited to:

7.1.1 Members shall lead the person-centered planning process and can elect to include, and/or consult with, any of their Long Term Services and Supports ("LTSS") providers in the care/service plan development process.

7.1.2 The care/service plan must be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation through the mechanism required by state and federal requirements. Non-medical service providers (such as meals or assistive technology) can signify their agreement through this contract or written agreement in lieu of directly in the plan, if permitted by the member.

7.1.3 LTSS providers shall be aware of, respect, and adhere to a member's preferences for the delivery of services and supports.

7.1.4 LTSS providers shall ensure services and supports are culturally appropriate, provided in plain language (where applicable), and accessible to members and the person(s) supporting them who have disabilities and/or are limited English proficient.

7.1.5 Health Plan agrees to complete the care/service plan in a timely manner (within at least 120 days of enrollment or annually, or less if state requirements differ) and provide a copy to all LTSS providers responsible for implementation.

7.2 Any Member communications furnished by Subcontractor shall be subject to review and approval by Contractor and shall contain Contractor's name.

7.3 Notwithstanding any provision of this Agreement, Contractor may terminate this Agreement immediately in the event that Contractor reasonably determines that the continuation of this Agreement presents a risk to Member health and safety.

PARTICIPATING PROVIDER AGREEMENT

SCHEDULE B
PRODUCT PARTICIPATION

Provider will be designated as a "Participating Provider" in the Product Attachments listed below as of the date of successful completion of credentialing in accordance with this Agreement.

List of Product Attachments:

Attachment A: Medicaid - Product Attachment
Attachment B: [Reserved] - Product Attachment
Attachment C: Exchange - Product Attachment
Attachment D: [Reserved] - Product Attachment

PARTICIPATING PROVIDER AGREEMENT

SCHEDULE C
CONTRACTED PROVIDERS

ENTITY/GROUP/CLINIC/FACILITY NAME	TAX ID #	NPI #	Medicare ID #	AHCCCS ID #
Centria Healthcare, LLC	27-1402749	1053641498		337877

NOTE: This Schedule is intended to capture all groups, clinics and facilities participating under the Agreement (i.e., are Contracted Providers under this Agreement) as of the Effective Date, enter the organizational and/or group information. A separate roster of all individual practitioners associated with each entity, group, clinic or facility is required using the Health Plan's designated roster format to ensure expedited loading of the Contracted Providers.

Attachment A: Medicaid

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)
AHCCCS COMPLETE CARE PRODUCT ATTACHMENT

This AHCCCS Complete Care Product Attachment (the "***AHCCCS Product Attachment***") is incorporated into the Participating Provider Agreement (the "***Agreement***") entered into by and between Centria Healthcare, LLC ("***Provider***") and Health Plan (as defined in the Agreement).

Provider understands and agrees that (i) the obligations of "***Contractor***" and "Health Plan" set forth in this AHCCCS Product Attachment shall be the obligations of Health Net of Arizona, Inc. dba Arizona Complete Health , and not the obligations of any Affiliate of Health Plan and (ii) the obligations of "Subcontractor" shall be the obligations of Provider. To the extent that any definition, term, condition or provision set forth in this AHCCCS Product Attachment is inconsistent or in conflict with any definition, term, condition or provision set forth in the Agreement, the definition, term, condition or provision set forth in this Product Attachment shall control with respect to the Medicaid AHCCCS Complete Care program.

The following provisions are required pursuant to Arizona law to be included in this addendum/attachment verbatim.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)
Minimum Subcontract Provisions

The provisions referred to by AHCCCS as "Minimum Subcontract Provisions", including all subsequent updates published by AHCCCS, apply to Provider and are fully set forth in the following internet link:
https://www.azahcccs.gov/PlansProviders/HealthPlans/minimumsubcontractprovisions.html/.

Attachment A: Medicaid

EXHIBIT 1
COMPENSATION SCHEDULE
PROVIDER SERVICES

Centria Healthcare, LLC

This compensation schedule ("Compensation Schedule") sets forth the maximum reimbursement amounts for 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 AHCCCS provider Covered Services rendered to a Covered Person shall be the "Allowed Amount". Except as otherwise provided in this Compensation Schedule, the Allowed Amount for AHCCCS provider Covered Services is the lesser of: (i) Allowable Charges; or (ii) the applicable "Contracted Rate" set forth below in Table 1. This Compensation schedule is subject to any modifications that may be implemented from time to time by AHCCCS.

Table 1.

Service Category	Identifier Code	Contracted Rate
Contracted Services delivered by Provider, excluding services listed below:	---	90% of AHCCCS MCO Capped Fee Schedule
Contracted Services delivered by a Mid-Level Practitioner (as defined by AHCCCS), excluding services listed below:	---	80% of AHCCCS MCO Capped Fee Schedule, without applying AHCCCS mandated mid-level reductions
Applied Behavior Analysis (ABA):		
Behavior identification assessment, administered by a physician or other qualified health care professional, each 15 minutes of the physician's or other qualified health care professional's time face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan.	97151	$36.10
Behavior identification-supporting assessment, administered by one technician under the direction of a physician or other qualified health care professional, face-to-face with the patient, each 15 minutes.	97152	$36.10
Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with one patient, each 15 minutes.	97153	$26.50
Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with two or more patients, each 15 minutes.	97154	$5.00

Service Category	Identifier Code	Contracted Rate
Adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes.	97155	$26.50
Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s), each 15 minutes.	97156	$26.50
Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers, each 15 minutes.	97157	$10.60
Group adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, face-to-face with multiple patients, each 15 minutes.	97158	$10.60
Behavior identification supporting assessment, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administration by the physician or other qualified health care professional who is on site; with the assistance of two or more technicians; for a patient who exhibits destructive behavior; completion in an environment that is customized to the patient's behavior.	0362T	$36.10
Adaptive behavior treatment with protocol modification, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administration by the physician or other qualified health care professional who is on site; with the assistance of two or more technicians; for a patient who exhibits destructive behavior; completion in an environment that is customized to the patient's behavior.	0373T	$26.50

Additional Provisions:

The following payment conditions supplement but do not replace any conditions or requirements contained in Health Plan Policies, and apply to all payments made to Provider for Contracted Services under this Agreement:

1. AHCCCS Value Based Purchasing (VBP) Differential Adjusted Payments. To the extent that the Provider and the Covered Services qualify for any VBP Differential Adjusted Payment pursuant to Section D – Differential Adjustment Payments, on page 162 of the Governmental Contract (and, as applicable, any AHCCCS guidelines, policies or manuals), and the Provider has notified Health Plan of such qualification, Health Plan's payments to the Provider will include such VBP Differential Adjusted Payments.

2. 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.

3. 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.

4. Carve-Out Services. With respect to any "Carve-Out" Covered Services as contemplated in this Agreement, any payment arrangement entered into between Provider and a third party vendor of such services shall supersede compensation hereunder.

5. Obstetric Case Rates. Obstetric Case Rates include professional services for antepartum care, delivery and postpartum care. Facility services are not included in Case Rate and shall be billed separately by facility.

6. Payment under this Compensation Schedule. 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 claim processing policies.

Definitions:

1. **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 this Agreement or its Attachments.

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

3. **Case Rate** means a pricing method in which a single comprehensive payment is made to a provider for a group of related services. Outpatient Case Rates are an all-inclusive case rate, including but not limited to supplies, implants, prosthetics, durable medical equipment, emergency room charges, observation room, diagnostic services, therapeutic services and pharmaceuticals.

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 B: Medicare

MEDICARE PRODUCT ATTACHMENT
(INCLUDING REGULATORY REQUIREMENTS AND COMPENSATION SCHEDULE)

Not applicable at this time.

Attachment C: Exchange

PRODUCT ATTACHMENT
(INCLUDING REGULATORY REQUIREMENTS AND COMPENSATION SCHEDULE)

THIS PRODUCT ATTACHMENT (this "***Attachment***") is incorporated into the Participating Provider Agreement (the "***Agreement***") entered into by and between Centria Healthcare, LLC ("***Provider***") and Health Plan (as defined in the Agreement).

WHEREAS, Health Plan and Provider entered into that certain Participating Provider Agreement, as the same may have been amended and supplemented from time to time (the "***Agreement***"), pursuant to which Provider and its Contracted Providers or other Downstream Entities participate in certain Products offered by or available from or through a Company; and

WHEREAS, pursuant to the provisions of the Agreement, this Product Attachment is identified on Schedule B of the Agreement and, as such, the Contracted Providers identified herein will be designated and participate as Participating Providers in the exchange Products described in this Product Attachment, and will be considered to be and will be governed under this Product Attachment as Downstream Entities as defined in this Product Attachment; and

WHEREAS, the Agreement is modified or supplemented as hereafter provided.

NOW THEREFORE, in consideration of the recitals, the mutual promises herein stated, the parties hereby agree to the provisions set forth below.

1. Defined Terms. For purposes of the Exchange Product, the following terms have the meanings set forth below. All capitalized terms not specifically defined in this Product Attachment will have the meanings given to such terms in the Agreement.

1.1 "***Exchange Product***" refers to those programs and health benefit arrangements offered by a Company that provide incentives to Covered Persons to utilize the services of certain contracted providers. The Exchange Product includes those Coverage Agreements entered into, issued or agreed to by a Payor under which a Company furnishes administrative services or other services in support of a health care program for an individual or group of individuals, which may include access to one or more of the Company's provider networks or vendor arrangements, and which may be provided in connection with a state or governmental-sponsored, employer-sponsored or other private health insurance exchange, except those excluded by Health Plan. The Exchange Product does not apply to any Coverage Agreements that are specifically covered by another Product Attachment to the Agreement.

1.2 "***Delegated Entity***" means any party, including an agent or broker, that enters into an agreement with Health Plan to provide administrative services or health care services to qualified individuals, qualified employers or qualified employees and their dependents (as such terms are defined in 45 C.F.R. §156.20).

1.3 "***Downstream Entity***" means any party, including an agent or broker, that enters into an agreement with a Delegated Entity or with another Downstream Entity for purposes of providing administrative or health care services related to the agreement between the Delegated Entity and Health Plan. The term "Downstream Entity" is intended to reach the entity that directly provides administrative services or health care services to qualified individuals, qualified employers, or qualified employees and their dependents (as such terms are defined in 45 C.F.R. §156.20).

1.4 "***Emergency" or "Emergency Care***" has the meaning set forth in the Covered Person's Coverage Agreement.

1.5 "***Emergency Medical Condition***" has the meaning set forth in the Covered Person's Coverage Agreement.

1.6 "***State***" means the State of Arizona, or such other state to the extent that a Coverage Agreement or Covered Person is subject to such other state's law.

2. Exchange Product. This Product Attachment constitutes the "Exchange Product Attachment" and is incorporated into the Agreement between Provider and Health Plan. It supplements the Agreement by setting forth specific terms and conditions that apply to the Exchange Product with respect to which a Participating Provider has agreed to participate, and with which a Participating Provider must comply in order to maintain such participation. This Product Attachment applies with respect to the provision of health care services, supplies or accommodations (including Covered Services) to Covered Persons enrolled in or covered by an Exchange Product.

3. Participation. Except as otherwise provided in this Product Attachment or the Agreement, all Contracted Providers under the Agreement will participate as Participating Providers in this Exchange Product, and will provide to Covered Persons enrolled in or covered by an Exchange Product, upon the same terms and conditions contained in the Agreement, as supplemented or modified by this Product Attachment, those Covered Services that are provided by Contracted Providers pursuant to the Agreement. In providing such services, Provider shall, and shall cause Contracted Providers, to comply with and abide by the provisions of this Product Attachment and the Agreement (including the Provider Manual).

4. Attachments. This Product Attachment includes, Schedule A, the Regulatory Requirements with which Participating Providers are required to comply based on State laws governing the applicable Coverage Agreement or Covered Person and a Compensation Schedule Exhibit for the Exchange Product, each of which are incorporated herein by reference.

5. Construction. This Product Attachment supplements and forms a part of the Agreement. Except as otherwise provided herein or in the terms of the Agreement, the terms and conditions of the Agreement will remain unchanged and in full force and effect as a result of this Product Attachment. In the event of a conflict between the provisions of the Agreement and the provisions of this Product Attachment, this Product Attachment will govern with respect to health care services, supplies or accommodations (including Covered Services) rendered to Covered Persons enrolled in or covered by an Exchange Product. To the extent Provider or any Contracted Provider is unclear about its, his or her respective duties and obligations, Provider or the applicable Contracted Provider shall request clarification from the Company.

6. Term. This Product Attachment will become effective as of the Effective Date, and will be coterminous with the Agreement unless a Party terminates the participation of the Contracted Provider in this Exchange Product in accordance with the applicable provisions of the Agreement or this Product Attachment.

7. Federal Requirements. The following requirements apply to Delegated and Downstream Entities under this Exchange Product Attachment, which includes but is not limited to Provider and all Contracted Providers.

7.1 Provider's delegated activities and reporting responsibilities, if any, are specified in the Agreement or applicable ancillary document or attachment to the Agreement (e.g., Delegated Credentialing Agreement, Delegated Services Agreement, Statement or Work, or other scope of services attachment) attached to this Agreement. If such attachment is not executed, no administrative functions shall be deemed as delegated.

7.2 CMS, Health Plan and Payor reserve the right to revoke the delegation activities and reporting requirements or to specify other remedies in instances where CMS, Health Plan or the Payor determine that Provider or any Downstream Entity has not performed satisfactorily.

7.3 Provider and all Downstream Entities must comply with all applicable laws and regulations relating to the standards specified under 45 CFR §156.340(a);

7.4 Provider and all Downstream Entities must permit access by the Secretary and OIG or their designees in connection with their right to evaluate through audit, inspection or other means, to the Provider's or Downstream Entities' books, contracts, computers, or any other electronic systems including medical records and documentation, relating to Health Plan's obligations in accordance with federal standards under 45 CFR §156.340(a) until ten (10) years from the termination date of this Product Attachment.

8. Other Terms and Conditions. Except as modified or supplemented by this Product Attachment, the compensation hereunder for the provision of Covered Services by Contracted Providers to Covered Persons enrolled in or covered by the Exchange Product is subject to all of the other provisions in the Agreement (including the Provider Manual) that affect or relate to compensation for Covered Services provided to Covered Persons.

Attachment C: Exchange

SCHEDULE A
REGULATORY REQUIREMENTS

This Schedule sets forth the provisions that are required by State or federal law to be included in the Agreement with respect to this Exchange Product. Any additional Regulatory Requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product may be set forth in the Provider Manual or another Attachment. To the extent that a Coverage Agreement, or a Covered Person, is subject to the law cited in the parenthetical at the end of a provision on this Schedule A, such provision will apply to the rendering of Covered Services to a Covered Person with such Coverage Agreement, or to such Covered Person, as applicable.

AZ-1 No Gag Clause. Neither the Payor nor HMO shall restrict or prohibit a Participating Provider's good faith communication with the Participating Provider's patients concerning any such patient's health care or medical needs, treatment options, health care risks or benefits. HMO shall not terminate or refuse to renew the Agreement, or a Participating Provider's participation in this Product Attachment, solely because the Participating Provider in good faith does any of the following: (a) advocates in private or in public on behalf of a patient; (b) assists a patient in seeking reconsideration of a decision made by the Payor to deny coverage for a health care service; or (c) reports a violation of law to an appropriate authority. (A.R.S. §§°20-118; 20-1061).

AZ-2 Hold Harmless. If the Payor fails to pay for Covered Services as set forth in the Covered Person's Coverage Agreement, the Covered Person is not liable to the Participating Provider for any amounts owed by the Payor and the Participating Provider shall not bill or otherwise attempt to collect from the Covered Person the amount owed by the Payor. (A.R.S. § 20-1072)

AZ-3 Continuation of Care After Insolvency. Each Participating Provider shall provide Covered Services to Covered Persons at the same rates and subject to the same terms and conditions established in the Agreement for the duration of the period after the Payor is declared insolvent, until the earliest of the following: (a) the expiration of the period during which the Payor is required to continue benefits as described in A.R.S. § 20-1069.01(A); (b) notification from the receiver pursuant to A.R.S. § 20-1069.01(A) or a determination by the court that the Payor cannot provide adequate assurance it will be able to pay the Participating Provider's claims for Covered Services that were rendered after the Payor is declared insolvent; (c) a determination by the court that the insolvent Payor is unable to pay the Participating Provider's claims for health care services that were rendered after the Payor is declared insolvent; (d) a determination by the court that continuation of the Agreement would constitute undue hardship to the Participating Provider; or (e) a determination by the court that the Payor has satisfied its obligations to all Covered Persons under the applicable Coverage Agreements. (A.R.S. § 20-1074(B)

Attachment C: 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 an 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) 90% 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.

Applied Behavior Analysis (ABA):		
Behavior identification assessment, administered by a physician or other qualified health care professional, each 15 minutes of the physician's or other qualified health care professional's time face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan.	97151	$36.10
Behavior identification-supporting assessment, administered by one technician under the direction of a physician or other qualified health care professional, face-to-face with the patient, each 15 minutes.	97152	$36.10
Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with one patient, each 15 minutes.	97153	$26.50
Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with two or more patients, each 15 minutes.	97154	$5.00
Adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes.	97155	$26.50
Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s), each 15 minutes.	97156	$26.50
Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers, each 15 minutes.	97157	$10.60

Group adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, face-to-face with multiple patients, each 15 minutes.	97158	$10.60
Behavior identification supporting assessment, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administration by the physician or other qualified health care professional who is on site; with the assistance of two or more technicians; for a patient who exhibits destructive behavior; completion in an environment that is customized to the patient's behavior.	0362T	$36.10
Adaptive behavior treatment with protocol modification, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administration by the physician or other qualified health care professional who is on site; with the assistance of two or more technicians; for a patient who exhibits destructive behavior; completion in an environment that is customized to the patient's behavior.	0373T	$26.50

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. Fee Sources. In the event CMS contains no published fee amount, alternate (or "gap fill") fee sources may be used, including state Medicaid sources, 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 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 there is no established payment amount on the current Payor fee schedule 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 (25%) of Allowable Charges.

4. 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.

5. 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.

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.

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

10. 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.

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 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 D: Commercial

PRODUCT ATTACMENT
(INCLUDING REGULATORY REQUIREMENTS AND COMPENSATION SCHEDULE)

Not applicable at this time.

ARIZONA COMPLETE HEALTH

BUSINESS ASSOCIATE AGREEMENT

This **BUSINESS ASSOCIATE AGREEMENT** ("***Agreement***") is entered into on this 1st day of June, 2021 (the "***Effective Date***") by and between Health Net of Arizona, Inc. dba Arizona Complete Health for the benefit of itself and its affiliates ("***Covered Entity***") and Centria Healthcare, LLC on behalf and for the benefit of itself and its affiliates ("***Business Associate***") (each, a "Party" and collectively, the "Parties").

WHEREAS, Covered Entity has affiliates (each, a Covered Entity "affiliate") that create, receive, transmit, maintain and/or disclose (collectively, "Use") "***Protected Health Information***" or "***PHI***" (as such terms are defined at 45 C.F.R. Section 160.103 et seq.), and Covered Entity and/or one or more of its affiliates desire to obtain services from Business Associate and/or the affiliates of Business Associate (each, a Business Associate "affiliate") that will result in the Use of such PHI by Business Associate and/or its affiliates pursuant to a contract (in effect as of, or after, the effective date of this Agreement) between Business Associate and/or any of its affiliates, on one hand, and Covered Entity and/or any of its affiliates, on the other hand (each contract, a "***Services Agreement***");

WHEREAS, irrespective of the Covered Entity affiliates and the Business Associate affiliates that are parties to any Services Agreement, Covered Entity and Business Associate desire this Agreement to govern the Use of all PHI by and between the Parties and their respective affiliates and to supersede all other agreements (including all other business associate agreements) between such entities regarding the Use of PHI; and

WHEREAS, pursuant to the authorities set forth above, Business Associate and its affiliates may Use PHI only in accordance with this Agreement.

NOW, THEREFORE, Covered Entity and Business Associate agree as follows:

1. **Definitions**.

1.1 The Health Insurance Portability and Accountability Act of 1996 ("***HIPAA***"), the Health Information Technology for Economic and Clinical Health Act ("***HITECH***"), and the implementing regulations thereunder, including but not limited to the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Parts 160 and 164 (the "***Privacy Rule***") and the Security Standards for the Protection of Electronic Health Information at 45 C.F.R. Parts 160 and 164 (the "***Security Rule***"), and the requirements of the final modifications to the HIPAA Privacy Rule, Security, Rule, et al., issued on January 25, 2013 and effective March 26, 2013, as may be amended from time to time, shall collectively be referred to herein as the "***HIPAA Authorities***." All other capitalized terms hereunder shall have the meaning ascribed to them elsewhere in this Agreement, or, if no such definition is specified herein, shall have the meaning set forth in the HIPAA Authorities.

1.2 "Affiliate" (capitalized or not) means any entity that controls, is controlled by or is under common control with a Party as well an any entity that is a subsidiary of an entity that controls a Party.

1.3 "Personally Identifiable Information" or "PII" shall include any data elements that identify an individual or that could be used to identify an individual, including but not limited to an individual's first name or initial and last name, all geographic subdivisions smaller than a state, all elements of dates (except year) for dates directly related to an individual including birth date, admission date, discharge date, date of death, telephone numbers, fax numbers, electronic mail addresses, social security numbers, medical record numbers, health plan beneficiary numbers, account numbers, certificate or drivers license numbers, vehicle identifiers and serial numbers, including license plate numbers, device identifiers and serial numbers, web universal resource locators (URLs), internet protocol (IP) address numbers, biometric identifiers, including finger and voice prints, full face photographic images and any comparable images; and any other unique identifying number, characteristic, code, or combination that allows identification of an individual.

1.4 "Protected Health Information" or "PHI" shall collectively refer to Protected Health Information, Electronic Protected Health Information ("ePHI"), each as defined by the HIPAA Authorities, and "Personal Identifiable Information" as defined above.

2. **Interpretation of Provisions of this Agreement; Application of Agreement**.

2.1 In the event of an inconsistency between the provisions of this Agreement and the mandatory terms of the HIPAA Authorities, the terms of the HIPAA Authorities shall prevail. Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Covered Entity and Business Associate to comply with the HIPAA Authorities. A reference in this Agreement to a section in the HIPAA Authorities means the section in effect or as amended. Titles or headings are used in this Agreement for reference only and shall not have any effect on the interpretation of this Agreement.

2.2 This Agreement governs the Use of all PHI that exists or arises in connection with a Services Agreement irrespective of the Covered Entity affiliate and Business Associate affiliate that may be parties to such Services Agreement. Each Party hereto represents and warrants that (i) it is validly existing under the laws of the state of its formation; (ii) it has the full right, authority, capacity and ability to enter into this Agreement for the benefit and, in the case of Business Associate, on the behalf of. itself and each of its affiliates and to carry out its and its affiliates' obligations hereunder; (iii) this Agreement is a legal and valid obligation binding upon it and it shall cause all of its affiliates that Use PHI pursuant to a Services Agreement to comply with the obligations hereunder of such Party; and (iv) its execution, delivery and performance of this Agreement does not conflict with any agreement, instrument, obligation or understanding to which it or any of its affiliates are bound.

3. **Obligations of Business Associate**.

3.1 Limits on Use and Disclosure. Business Associate agrees to not use or further disclose PHI other than as permitted by this Agreement or as Required by Law. Business Associate further agrees that to the extent it is carrying out one or more of the Covered Entity's obligations under the Privacy Rule, it shall comply with the requirements of the Privacy Rule that apply to the Covered Entity in the performance of such obligations.

3.2 Safeguards. Business Associate agrees to use reasonable and appropriate administrative, physical and technical safeguards to prevent use or disclosure of PHI other than as provided for by this Agreement. More specifically, as also provided for in Section 3.12 below, Business Associate agrees to establish, implement and maintain appropriate safeguards, and comply with the Security Rule with respect to Electronic PHI, as necessary to prevent any use or disclosure of PHI other than as provided for by this Agreement.

3.3 Mitigation of Harm. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Agreement or the HIPAA Authorities and shall take prompt steps to prevent the recurrence of any Incident, including any action required by applicable federal and state laws and regulations. All such efforts will be subject to Covered Entity's prior written approval. In the event of an Incident (as defined below), Business Associate shall promptly develop and provide to Covered Entity a written correction action plan which describes the measures to be taken to halt and/or contain such Incident.

3.4 Report of Improper Use or Disclosure. "Incident" means (i) any successful Security Incident, (ii) Breach of Unsecured PHI, or (iii) any loss, destruction, alteration or other event in which PHI cannot be accounted for. Successful Security Incidents shall not include pings and other broadcast attacks on Business Associate's firewall, port scans, unsuccessful log-on attempts, denials of service and any combination of the above, so long as no such incident results in unauthorized access, use or disclosure of PHI. Business Associate agrees to notify Covered Entity, in writing immediately upon discovery, but not later than the same day of discovery of any Incident (by Business Associate or by a Subcontractor) involving the acquisition, access, use or disclosure of the PHI not provided for by this Agreement of which Business Associate becomes aware. As soon as reasonably possible thereafter, in no case more than seven (7) calendar days following discovery of the Incident, Business Associate shall provide Covered Entity with a written report which shall include but not be limited to: i) a description of the

circumstances under which the Incident occurred; ii) the date of the Incident and the date that the Incident was discovered; iii) a description of the types of PHI involved in the Incident; iv) the identification of each Individual whose PHI is known or is reasonably believed by the Business Associate to have been affected; and v) any recommendations that the Business Associate may have, if any, regarding the steps that Individuals may take to protect themselves from harm. To the extent that Covered Entity reasonably determines that such Incident necessitates the notification of Individuals by Covered Entity under HITECH, Business Associate agrees that it shall immediately reimburse Covered Entity for the reasonable expenses of such notification process. Business Associate shall cooperate with any investigation (and/or risk assessment) of such Incident conducted by Covered Entity in connection with any report made pursuant to this Section. Business Associate shall make itself and any subcontractors and agents assisting Business Associate in the performance of its obligations available to Covered Entity to testify as witnesses, or otherwise, in the event of an Incident.

3.5 Subcontractors.

(a) Prior to the date on which any Subcontractor (including any affiliate that is a Subcontractor) creates, receives, maintains or transmits PHI on behalf of Business Associate in connection with Business Associate's obligations under the Services Agreement, Business Associate agrees to enter into a written agreement with any Subcontractor ("Subcontractor Agreement") to whom Business Associate provides PHI that requires them: (i) to comply with the same HIPAA Authorities that apply to Business Associate under the Agreement; and (ii) to comply with the same restrictions and conditions that apply to Business Associate through this Agreement with respect to such PHI.

(b) Upon Business Associate's knowledge of a material breach of the Subcontractor Agreement by Subcontractor, Business Associate shall immediately notify Covered Entity of such material breach in writing and, at its option (unless otherwise directed by Covered Entity), shall: (i) provide an opportunity for Subcontractor to cure the breach or end the violation and terminate this Agreement if Subcontractor does not cure the breach or end the violation within the cure period identified in the Services Agreement between Covered Entity and Business Associate, or if no cure period is identified in the Services Agreement, as specified by Covered Entity; (ii) immediately terminate this Agreement if Subcontractor has breached a material term of this Agreement and Business Associate (or Covered Entity) deems cure by the Subcontractor not to be possible; or (iii) if neither termination nor cure are feasible, report the violation to the Covered Entity.

(c) Business Associate agrees to provide Covered Entity with a list of any and all such Subcontractors and, in the event of an Incident, employees that create, receive, maintain or transmit PHI on behalf of Business Associate in in connection with Business Associate's obligations under the Service Agreement with Covered Entity within thirty (30) days of such a request.

3.6 Access to Records. At the request of Covered Entity and within five (5) business days of such request and in a reasonable manner designated by Covered Entity, Business Associate shall provide access to PHI in a Designated Record Set to Covered Entity or, as directed by Covered Entity, to an Individual, in a manner compliance with 45 CFR §164.524 and/or other applicable provisions of the HIPAA Authorities.

3.7 Amendments to PHI. At the request of Covered Entity, or, as directed by Covered Entity, at the request of an Individual, Business Associate shall make, within five (5) business days of such request and in a reasonable manner designated by Covered Entity, any amendment(s) to PHI in a Designated Record Set to which the Covered Entity has agreed pursuant to 45 CFR §164.526, or shall otherwise assist Covered Entity in complying with Covered Entity's obligations under 45 CFR §164.526.

3.8 Availability of Internal Practices, Books and Records. Business Associate shall make its internal practices, books and records available to Covered Entity or the Secretary for purposes of determining Covered Entity's compliance with the HIPAA Authorities, in a time and manner designated by Covered Entity or the Secretary, as applicable. Covered Entity reserves the right to request, and Business Associate shall provide, additional satisfactory assurances that Business Associate is meeting its applicable obligations under the HIPAA Privacy and Security Rules. Such requests may include, but are not limited to; an onsite audit, conducted by

Covered Entity or its designee, access to policies and procedures, risk assessment documentation, incident logs or information related to the Business Associate's Subcontractors compliance with their applicable obligations under the HIPAA Privacy and Security Rules.

3.9 Accounting of Disclosures. Business Associate shall document such disclosures of PHI and information related to such disclosures (i.e., (i) the date of the disclosure; (ii) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (iii) a brief description of the PHI disclosed; and (iv) a brief statement of the purpose of the disclosure that reasonably states the basis for the disclosure) as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR §164.528. Such documentation shall be maintained with regard to all disclosures of PHI, except for those disclosures that are expressly exempted from the documentation requirement under the HIPAA Authorities (see, e.g., 45 CFR §§164.502; 164.508; 164. 510; 164.512, etc.). Documentation required to be collected by the Business Associate under this Section shall be retained for a minimum of six (6) years, unless otherwise provided under the HIPAA Authorities. Business Associate shall further provide the information collected pursuant to this Section to Covered Entity or an Individual, within five (5) business days of the applicable request and in a reasonable manner designated by Covered Entity, as necessary to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR §164.528 or other applicable provision of the HIPAA Authorities.

3.10 Disclosure of Minimum PHI. Business Associate agrees that it shall request, use and/or disclose only the amount and content of PHI that is the Minimum Necessary for Business Associate to fulfill its obligations under the terms and conditions of this Agreement. Business Associate acknowledges that such Minimum Necessary standard shall apply with respect to uses and disclosures by and among members of Business Associate's workforce as well as by or to third parties as permitted hereunder.

3.11 Notification of Claims. Business Associate shall promptly notify Covered Entity upon notification or receipt of any civil or criminal claims, demands, causes of action, lawsuits, or governmental enforcement actions ("Actions") arising out of or related to this Agreement or PHI, or relating to Business Associate's conduct or status as a business associate for any covered entity, regardless of whether Covered Entity and/or Business Associate are named as parties to such Actions.

3.12 Security Rule Requirements. Business Associate shall implement Administrative, Physical, and Technical Safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Covered Entity as required by the Security Rule. Additionally, Business Associate shall comply with the Security & Privacy Requirements described in the attached Security & Privacy Addendum. Not more than once per calendar year, Business Associate shall within ten (10) days after request from Covered Entity truthfully complete and duly execute the Annual Attestation that is attached hereto or, alternatively, notify Covered Entity in writing of any facts or events that would render untrue any statement within the Annual Attestation. Business Associate shall document policies and procedures that implement the foregoing requirements and shall, upon request, provide them to Covered Entity, who may further disclose them to any governmental entity with regulatory oversight over Covered Entity. Business Associate agrees to report to Covered Entity any use or disclosure of PHI not provided for by this Agreement or the HIPAA Authorities of which it becomes aware, including any Incident. Accordingly, as also provided in Section 3.4, Business Associate agrees to report any Incident of which it becomes aware to Covered Entity immediately, but not later than the same day of discovery of the Incident. All reports required of the Business Associate pursuant to this Section shall be provided as specified in Section 3.4 of this Agreement, including the actions and the mitigation steps, if any, taken by Business Associate in response to the Incident(s).

3.13 Compliance with HIPAA Authorities. Requirements of the HIPAA Authorities that are made applicable with respect to business associates, or any other provision required to be included in this Agreement pursuant to the HIPAA Authorities, are incorporated into this Agreement by this reference.

3.14 Compliance with 45 CFR 164 Subpart E - To the extent Business Associate is to carry out one or more of Covered Entity's obligation(s) under Subpart E of 45 CFR Part 164, comply with the requirements of Subpart E that apply to Covered Entity in the performance of such obligation(s).

4. **Permitted Uses and Disclosures by Business Associate**.

4.1 Use or Disclosure to Perform Functions, Activities, or Services. Except as otherwise limited in this Agreement, Business Associate may use or disclose PHI to perform those functions, activities, or services that Business Associate performs for, or on behalf of, Covered Entity as specified in the Services Agreement, provided that such use or disclosure would not violate the Privacy Rule, or the policies and procedures of Covered Entity relating to the "Minimum Necessary Standard," if done by Covered Entity. Any such use or disclosure shall be limited to those reasons and those Individuals as necessary to meet the Business Associate's obligations under the Services Agreement.

4.2 Appropriate Uses of PHI. Except as may be otherwise limited in this Agreement, Business Associate may use PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.

4.3 Confidentiality Assurances and Notification. Except as may be otherwise limited in this Agreement, Business Associate may disclose PHI for the proper management and administration of the Business Associate, provided that disclosures are Required by Law, or Business Associate obtains reasonable assurances from the person to whom the PHI is disclosed that such PHI will remain confidential and used or further disclosed only as Required by Law or for the purpose for which such PHI was disclosed to the person, and the person notifies Business Associate of any instances of which it is aware in which the confidentiality of the PHI has been breached.

4.4 Data Aggregation Services. As applicable, Business Associate may use PHI to provide Data Aggregation services to Covered Entity as permitted by 42 CFR § 164.504(e)(2)(i)(B), except as may be otherwise provided by this Agreement.

5. **Indemnification**. Each party (the "***Indemnitor***") shall indemnify and hold harmless the other party (the "***Indemnitee***") against, and reimburse such Indemnitee for, any expense, loss, damages, fees, costs, claims or liabilities of any kind arising out of or related to any Actions asserted or threatened by a third party arising out of or related to the Indemnitor's acts and omissions associated with its obligations under this Agreement or its use or disclosure of PHI or, when the Indemnitor is the Business Associate, the Use of PHI by a Subcontractor or affiliate of Business Associate. Such indemnification shall include, but not be limited to, the payment of all reasonable attorney fees associated with any such Action.

6. **Obligations of Covered Entity**.

6.1 Notice of Privacy Practices. Covered Entity shall notify Business Associate of any limitation(s) in Covered Entity's notice of privacy practices, to the extent that such limitation(s) may affect Business Associate's use or disclosure of PHI.

6.2 Change or Revocation of Permission. Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by an Individual to use or disclose PHI, to the extent that such changes may affect Business Associate's permitted or required uses and disclosures of PHI. Business Associate shall comply with any such changes or revocations.

6.3 Restrictions on Use or Disclosure. Covered Entity shall notify Business Associate of any restriction on the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR § 164.522, to the extent such restriction may affect Business Associate's use or disclosure of PHI. Business Associate shall comply with any such restrictions. Business Associate shall immediately notify Covered Entity of any request for a restriction on the use or disclosure of an Individual's PHI that Business Associate receives from such Individual.

6.4 No Request to Use or Disclose in Impermissible Manner. Except as necessary for the Data Aggregation Services or management and administrative activities of the Business Associate as allowed herein, Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by Covered Entity.

7. **Term and Termination**.

7.1 Term. This Agreement shall be effective as of the earlier of the date first documented above or the effective date of the Services Agreement, and shall terminate upon termination of the Services Agreement for any reason or as otherwise provided in this Agreement.

7.2 Termination with Cause. Upon Covered Entity's knowledge of a material breach by Business Associate, or its Subcontractors, Covered Entity shall, at its option: (i) provide an opportunity for Business Associate to cure the breach or end the violation and terminate this Agreement if Business Associate does not cure the breach or end the violation within the cure period identified in the Services Agreement, or if no cure period is identified in the Services Agreement, as specified by Covered Entity; (ii) immediately terminate this Agreement if Business Associate has breached a material term of this Agreement and Covered Entity deems cure by Business Associate not to be possible; or (iii) if neither termination nor cure are feasible, report the violation to the Secretary.

7.3 Effect of Termination.

(a) Except as provided in paragraph 7.3(b) of this Section, upon termination of this Agreement for any reason, Business Associate shall return or destroy (at Covered Entity's election), and shall retain no copies of, all PHI in the possession of Business Associate.

(b) In the event that Business Associate determines that returning or destroying the PHI is infeasible, Business Associate shall provide to Covered Entity written notification of the conditions that make return or destruction infeasible. Upon Covered Entity's written approval, which shall not be unreasonably withheld, Business Associate may retain the PHI, but shall extend the protections of this Agreement (including, but not limited to, Sections 1 through 5) to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI.

8. **Standards for Electronic Transactions**. In connection with the Services to be provided to Covered Entity pursuant to this Agreement, Business Associate agrees that if it (or a Subcontractor) conducts an electronic transmission for which the Secretary has established a "standard transaction" under 45 C.F.R. Part 164, Subparts A, C, D and E, as applicable (the "*Electronic Transactions Standards*"), Business Associate (or its Subcontractor) shall comply with the requirements of the Electronic Transactions Standards. Business Associate specifically represents that it has obtained such compliance. Business Associate agrees that, in connection with the transmission of standard transactions, it will not (and will not permit any Subcontractor with which it might contract to): (i) change the definition, data condition, or use of a data element or segment in a standard; (ii) add any data elements or segments to the maximum defined data set; (iii) use any code or data elements that are either marked "not used" in the standard's implementation specification or are not in the standard's implementation specification; or (iv) change the meaning or intent of the standard's implementation specification(s). Business Associate understands that Covered Entity reserves the right to request an exception from the uses of a standard as permitted by 45 CFR § 162.940, and, if such an exception is sought, Business Associate agrees to participate in a test modification.

9. **Confidentiality of Business Information**.

9.1 Business Information. In the event the parties have not agreed to alternative confidentiality language with respect to business information in the Services Agreement or elsewhere, the following provisions will apply. Neither party will disclose to any third party any information related to this Agreement or to the business operations of the other party, or any proprietary information belonging to the other party (collectively, "***Confidential Business Information***") without the prior written consent of the other party, except as may be required under law or this Agreement; provided that a party required by law to disclose Confidential Business

Information shall inform the other party in order that the other party may contest such requirement. Each party hereby agrees that all Confidential Business Information communicated to it by the other party, whether oral or written, and whether before or after execution of this Agreement, was and will be received in strict confidence and will be used only for purposes set forth in the Services Agreement. Upon termination of this Agreement, each party shall, upon the request of the providing party, promptly return all such Confidential Business Information to the providing party or, at the providing party's option, shall destroy such Confidential Business Information and certify as to its destruction, except that each party shall be permitted to retain copies of Confidential Business Information as is reasonably necessary for its internal compliance and auditing purposes, provided the terms of this Section 9 shall continue to apply with respect to such retained Confidential Business Information for so long as it is retained. This obligation of confidentiality shall not apply to information i) which was known by the recipient without the obligation of confidentiality prior to its receipt of such information; ii) is or becomes publicly available without breach of this Agreement; or iii) is received from a third party without an obligation of confidentiality and without breach of this Agreement. This paragraph shall not apply to uses and disclosures of PHI, which shall be governed by the remaining provisions of this Agreement.

9.2 Response to Subpoena. Business Associate shall be permitted to disclose PHI and Confidential Business Information that Business Associate is required to disclose pursuant to court order, subpoena or other compulsory legal process, provided that prior to making any disclosure thereunder, Business Associate shall provide Covered Entity within five (5) calendar days prior written notice (or as much notice as reasonably practicable under the circumstances) of the intended disclosure, specifying the basis and nature of the same.

10. **Miscellaneous**.

10.1 Assignment; Waiver. This Agreement shall be binding upon and inure to the benefit of the respective legal successors of the parties. Neither this Agreement nor any rights or obligations hereunder may be assigned, in whole or in part, without the prior written consent of the other party. Except as provided herein, this Agreement shall create no independent rights in any third party or make any third party a beneficiary hereof. No failure or delay by either party in exercising its rights under this Agreement shall operate as a waiver of such rights, or of any prior, concurrent, or subsequent breach.

10.2 Property Rights. All PHI shall be and remain the exclusive property of Covered Entity. Business Associate agrees that it acquires no title or rights to the PHI, including any de-identified information, as a result of this Agreement.

10.3 Right to Cure. Business Associate agrees that in the event Business Associate fails to cure a breach of this Agreement pursuant to this Agreement, Covered Entity has the right, but not the obligation, to cure the same. Expenses, costs or fines reasonably incurred in connection with Covered Entity's cure of Business Associate's breach(es) shall be borne solely by Business Associate.

10.4 Injunctive Relief. Business Associate agrees that breach of the terms and conditions of this Agreement shall cause irreparable harm for which there exists no adequate remedy at law. Covered Entity retains all rights to seek injunctive relief to prevent or stop any breach of the terms of this Agreement, including but not limited to the unauthorized use or disclosure of PHI by Business Associate or any Subcontractor, contractor or third party that received PHI from Business Associate.

10.5 Survival; Severability. The respective rights and obligations of Business Associate under this Agreement, including but not limited to Business Associate's indemnification obligations, shall survive the termination of this Agreement. The parties agree that if a court determines that any of the provisions of this Agreement are invalid or unenforceable for any reason, such determination shall not affect the enforceability or validity of the remaining provisions of this Agreement.

10.6 Entire Agreement; Amendment. This document, together with any written Schedules, amendments and addenda, constitutes the entire agreement of the parties and supersedes all prior oral and written agreements or understandings between them with respect to the matters provided for herein. The parties agree to take such action

as is necessary to amend this Agreement from time to time as is necessary for Covered Entity and Business Associate to comply with the requirements of the HIPAA Authorities. Any modifications to this Agreement shall be valid only if such modifications are in accordance with the HIPAA Authorities, are made in writing, and are signed by a duly authorized agent of both parties.

10.7 Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the State of Arizona to the extent that the HIPAA Authorities do not preempt the same.

10.8 Notice. Any notice required or permitted to be given by either party under this Agreement shall be sufficient if in writing and hand delivered (including delivery by courier) or sent by postage prepaid certified mail return receipt requested, to the following address:

If Covered Entity:		**If Business Associate:**	
Name:	Cheyenne L. Ross	Name:	Paul McDonald
Title:	VP, Compliance	Title:	CFO
Company Name:	Health Net of Arizona, Inc. dba Arizona Complete Health	Company Name:	Centria Healthcare, LLC
Address:	1870 W. Rio Salado Parkway	Address:	2338 West Royal Palm Rd., Suite J
	Tempe, AZ 85281		Phoenix, AZ 85021
Phone:	(480) 567-9018	Phone:	(248) 436-4400

10.9 Independent Contractors. For purposes of this Agreement, Covered Entity and Business Associate, and Covered Entity and any Subcontractor of Business Associate, are and will act at all times as independent contractors. None of the provisions of this Agreement shall establish or be deemed or construed to establish any partnership, agency, employment agreement or joint venture between the parties.

Each party to this Agreement warrants that it has full power and authority to enter into this Agreement, and the person signing this Agreement on behalf of either party warrants that he/she has been duly authorized and empowered to enter into this Agreement.

COVERED ENTITY:		**BUSINESS ASSOCIATE:**	
By:	Digitally signed by Martha Smith Date: 2021.03.21 17:00:14 -07'00'	By:	Paul McDonald
Printed Name:	Martha J. Smith	Printed Name:	Paul McDonald
Title:	Plan President & CEO	Title:	CFO
Date:	3/21/2021	Date:	3/3/2021

SECURITY & PRIVACY ADDENDUM

Business Continuity, Enterprise Resilience, and Disaster Recovery

1. Business Impact Analysis:

   a) Critical IT systems and components must be identified and documented, including recovery time objective and recovery point objective.

2. Recovery Strategies

   a) The data center must maintain a back-up site(s).

   b) Mission critical information must be fully backed-up on a weekly basis and incrementally changes must be backed up daily.

   c) Backed-up information must be stored encrypted with FIPS 140-2 compliant encryption protocols.

   d) Backed-up information must be stored in a secure off-site facility.

   e) Backed-up information must be stored off-line.

   f) Restoration of critical data back-ups must be no less semi-annually (every 6 months).

   g) Contracts for outsourced services must include disaster recovery agreements.

3. Recovery Plans and Procedures, and Maintenance

   a) A documented business continuity plan for business functions must be updated and maintained.

   b) The business continuity plan must be stored off-site in a secure location.

   c) Arizona Complete Health must be alerted of any deficiencies discovered in the business continuity plan that would adversely affect Arizona Complete Health.

   d) A documented disaster recovery plan for information technology must be updated and maintained.

   e) The disaster recovery plan must be stored off-site in a secure location.

   f) The disaster recovery plan must include policies and procedures for facility access during a disaster.

4. Testing and Exercising

   a) The business continuity plan for business functions must be tested periodically.

   b) The disaster recovery plan for information technology must be tested periodically.

5. Escalation and Crisis Management

   a) The business continuity plan must contain notification procedures to alert Arizona Complete Health of service disruptions including off-hour and weekend coverage.

b) The disaster recovery plan must have notification procedures to alert Arizona Complete Health of service disruptions including off-hour and weekend coverage.

IT Risk and Compliance Management

1. Regulatory and Standards Implementation

a) The Company must remain in compliance with HIPAA and all other applicable national and state privacy and security regulations.

b) Confidential information, including PHI and ePHI, must never be stored outside of the United States.

c) An information security officer must be assigned.

d) An on-going and documented security awareness program must be established and communicated to all users to make them aware of the confidentiality of information, the company's security policies, standards, and good security practices.

e) Information Security awareness information must be distributed to all users on a periodic basis.

f) A privacy officer must be assigned.

g) An on-going and documented privacy awareness program must be established and communicated to all users to make them aware of the company's privacy policies and the requirements to protect the confidentiality of information.

h) Privacy awareness information must be distributed to all users on a periodic basis.

i) Mandatory privacy training must be delivered to, managed, and validated for all users on no less than an annual periodic basis.

j) All users are required to sign confidentiality and non-disclosure agreements.

2. Risk and Compliance Assessments

a) An accurate and thorough assessment of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of confidential information, including PHI and ePHI is conducted at least annually.

b) All users are required to have a national criminal background check, a local court background check for the past seven (7) years and a financial background check.

3. Policies, Standards, and Procedure Management

a) A documented risk management function and/or program supported by executive management must exist.

b) A documented information security function and/or program supported by executive management must exist.

c) A documented privacy function and/or program supported by executive management must exist.

d) The information security function/program must establish security policies and standards that are enforced through automated systems and administrative procedures that are maintained and updated as needed.

e) The privacy function/program must establish confidentiality policies which are maintained and updated as needed.

4. Issue and Corrective Action Management

a) Controls are implemented to reduce risks and vulnerabilities to a reasonable and appropriate level

b) A documented process must exist and be adhered to in order to report security issues affecting Arizona Complete Health to Arizona Complete Health's Information Security Officer.

c) A documented process must exist and be adhered to in order to report privacy issues affecting Arizona Complete Health PHI and ePHI to Arizona Complete Health's Privacy Officer.

5. Exception Management

a) Disciplinary measures for violations must be included in the Information Security and Privacy Program.

b) A documented security incident response plan must exist to ensure incidents are tracked, monitored, and investigated until closure is achieved.

c) A documented privacy incident response plan must exist to ensure that incidents are tracked, monitored, investigated and reported internally and to Covered Entity until remediation and closure is achieved.

Data Protection

1. Data Classification & Inventory

a) A documented information classification scheme must be utilized to ensure proper protection, use and destruction of Arizona Complete Health's data.

2. Data Lifecycle Analysis

a) Systems containing confidential information, including PHI and ePHI, have been documented, including security and privacy controls.

b) Documents showing the flow of sensitive data through systems and business processes must exist.

3. Data Encryption & Obfuscation

a) Confidential information, including PHI and ePHI, must be encrypted during storage on all devices including handhelds, laptops, workstations, and removable media with FIPS 140-2 compliant encryption protocols.

b) Information containing PHI and ePHI must be encrypted during storage on servers with FIPS 140-2 compliant encryption protocols.

c) Confidential information, including PHI and ePHI, must be encrypted during transmission over public or untrusted networks, including wireless or email transmissions, with FIPS 140-2 compliant encryption protocols.

d) Business to business communications with confidential information, including PHI and ePHI, must be encrypted.

4. Data Loss Prevention

a) A documented policy and process must exist with regard to the removal or movement of confidential information, including PHI and ePHI to unsecured systems or media.

b) Confidential information, including PHI and ePHI, stored on removable media must be secured with restricted access to those with a business need.

c) Technical controls must exist to prevent transmission of confidential information, including PHI and ePHI to unauthorized recipients.

d) Technical controls must exist to prevent storage of confidential information, including PHI and ePHI, on unsecured systems.

5. Data Retention and Destruction

a) A documented policy and process must exist with regard to the removal or destruction of confidential information, including PHI and ePHI. When appropriate, confidential information, including PHI and ePHI, must be purged or destroyed using a NIST 800-88 approved process when no longer needed.

Third Party Risk Management

1. Evaluation & Selection

a) A documented process must exist to evaluate the privacy and security controls for the Company's agents, subcontractors and outsourced services prior to entering into any such approved subcontracts.

2. Contract & Service Initiation

a) Any subcontracts shall contain all privacy and security requirements and protections as set forth in this Security Addendum.

b) Information containing PHI or ePHI must only be disclosed to third parties when a Business Associate Agreement (BAA) and non-disclosure agreement are in effect.

3. Security & Compliance Review

a) A documented process exists to review the privacy and security controls of agents, subcontractors and outsources services on a periodic basis to reasonably assure they are maintaining the required level of protection.

4. Third Party Monitoring

a) Agents, subcontractors, and outsourced services that perform critical services that support this contract have been identified and documented.

b) Agents, subcontractors, and outsources services that are identified as providing critical services or that are handling PHI must be monitored on an ongoing basis for contract compliance.

Identity & Access Management

1. User Account Management

a) Access to systems and applications must require a unique identifier (e.g. user ID) and at minimum a password or equivalent control.

b) User IDs must be locked after 5 consecutive unsuccessful login attempts.

c) User IDs must be disabled after 60 days or less of inactivity.

d) Passwords must be issued to users in a secure manner and be changed at first login.

e) Password policies at a minimum must include minimum password length, alphanumeric composition, retention of password history, and password change frequency.

f) Passwords cannot be displayed on screens or on reports.

g) Passwords must be encrypted in transmission and storage.

2. Access Management

a) Access to confidential information, including PHI and ePHI, must be restricted to individuals that have a business need and access control mechanisms must be implemented that limit access to confidential information.

b) Security administration procedures must include procedures for access requests for a new user, changing access, prompt deletion of users involving terminations, user transfers and periodic verification of users and access rights.

c) All user access requests must be documented with management approval including privileged users.

d) Documented remote access policies must exist and be enforced.

3. Privileged User Management

a) All default supplied user IDs must be disabled, renamed, or deleted wherever possible.

b) System IDs must be documented describing their functions and risks.

c) System IDs must be required to have passwords and documented risk analysis if password change frequency is not enforced.

d) System ID passwords must be stored in encrypted files.

e) System IDs are not allowed to be scripted into the application.

f) System IDs must not be able to be accessed by an individual user for interactive use.

g) All vendor-supplied default passwords must be changed.

4. Data Platform Integration

   a) All systems containing confidential information, including PHI and ePHI, have system access controls to prevent unauthorized disclosure or modification.

   b) Single sign on technologies are leveraged wherever possible to eliminate the need for multiple access controls systems.

5. Access Reporting and Audit

   a) All user access to systems containing confidential data, including PHI and ePHI, must be revalidated at least annually.

   b) All User IDs and System IDs with privileged authorities must be revalidated at least quarterly.

6. Access Governance

   a) User access must be defined by job roles to ensure segregation of duties.

   b) User access must be logged and tracked to an individual for accountability.

7. Federation

   a) Access to systems by agents, subcontractors, or outsourced services are subject to the same Identity Management requirements as Company personnel.

Secure Development Lifecycle

1. Security and Risk Requirements

   a) A documented process exists to conduct an accurate and thorough assessment of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of confidential information, including PHI and ePHI, as part of the System Development Life Cycle.

   b) Security controls are considered throughout the System Development Life Cycle.

2. Security Design & Architecture

   a) Security controls are designed to eliminate a single point of failure.

   b) Systems are designed to use a common security architecture.

   c) Production, test, and development environments must be physically and/or logically separated.

3. Application Role Design and Access Privileges

   a) Application security controls are designed to ensure users can access only information for which they have an authorized business need.

   b) Access is controlled by a common access methodology or single sign on wherever feasible.

4. Secure Coding Guidelines

   a) Secure coding principles and practices are documented and followed.

b) Web application controls must be configured to prevent printing or downloading data to unauthorized workstation and/or mobile devices.

c) Production information must not be used in development and test environments unless such environments are secured to the same level as production, or data has been de-identified as specified in HIPAA (45 CFR 164.514).

5. Secure Build

a) New server and network equipment deployment procedures must ensure implementation of security configuration settings.

6. Security Testing

a) All security controls must be tested prior to implementing new systems or upgrades into production.

b) Where feasible, automated tools are used for code review.

7. Roll-out and Go-live Management

a) Staff other than developers are responsible for moving systems or applications into production environment to retain separation of duties.

b) All non-standard access paths are removed prior to move into production.

8. Application Security Administration

a) Development staff requires management approval to access production systems.

b) Technical staff must not have access to production data, programs, or applications unless required to perform their jobs.

Infrastructure, Operations and Network Security/Cyber Threat and Vulnerability Management

1. Antivirus (AV) & Malware protection

a) A documented policy and procedures exist for guarding against, detecting, and reporting malicious software.

2. Intrusion Detection and Prevention

a) Intrusion detection and prevention systems must be implemented for critical components of the network.

3. Network Access Controls

a) A documented policy and procedures exist to prevent unauthorized/unsecured devices from accessing the network.

4. Network and Application Firewalls

a) Firewalls must be implemented and configured to deny all except authorized documented business services.

b) Firewalls must be configured to fail in a prevent state.

5. Proxy/Content Filtering

a) A documented policy and procedures exist to prevent confidential information, including PHI and ePHI, from being transmitted to unauthorized recipients or stored in unauthorized locations.

6. Remote Access Controls

a) Two-factor authentication is implemented for all remote network access (e.g. VPN, Citrix, etc.).

7. Security Monitoring

a) A documented policy and procedures exist to monitor networks, systems, and applications for potential security events.

b) A documented process exists to respond to potential security events on a 24x7x365 basis.

c) All significant computer security relevant events must be securely logged.

d) Computer systems handling confidential information, including PHI and ePHI, must securely log all significant computer security relevant events including the following: (a) unauthorized attempts to enter the system, (b) unauthorized attempts to access protected information or resources, (c) all attempts to issue restricted commands, (d) security activities, (e) special privileged user activities and (f) violation activities.

e) All logs of computer security relevant events must be traceable to specific individuals wherever possible.

8. Wireless Security Controls

a) A documented policy and procedures exist to prevent unauthorized wireless access to production systems.

9. Database Security

a) A documented policy and procedures exist to prevent unauthorized updates to databases.

b) All database access must be traceable to specific individuals.

10. Network Device Security

a) All network devices supporting business critical systems have physical and logical access controls.

b) All network devices supporting business critical systems have secured out-of-band management.

Cyber Threat and Vulnerability Management

1. OS Hardening & Secure Configuration

a) Required security configuration settings must be selected and documented.

b) Documented processes must exist to periodically verify security configuration settings.

c) Any and all Workstations able to access any confidential information must actively and automatically blank the screen or enable a screen saver and require re-authentication after fifteen (15) minutes of inactivity or less.

2. Patch Management

a) A documented patch management process must exist and be enforced.

b) Prompt application of security patches, service packs, & hot fixes is required for all systems that store, process, manage, or control access to sensitive data, including PHI and ePHI.

3. Vulnerability Management

a) A documented process and procedures exist to identify, quantify, prioritize, track, and remediate vulnerabilities.

4. Recurring Vulnerability Assessments and Penetration Testing

a) Periodic third party penetration tests must be conducted from outside and within the network.

b) Vulnerability assessment must be performed at least quarterly.

5. Incident and Problem Management

a) A documented problem management system must exist.

b) Audit logs must be implemented on all systems storing or processing critical or confidential information.

c) Audit logs must be retained for a minimum of twelve (12) months.

d) Audit logs must be protected from unauthorized access and resistant to attacks including deactivation, modification or deletion.

e) Audit logs must be reviewed for inappropriate activities in a timely manner and appropriate actions must be taken to protect Arizona Complete Health associates, assets, systems, and data.

6. Capacity Management

a) A documented policy and process exists to evaluate current capacity against projected requirements.

7. Configuration and Change Management

a) A three-tiered architecture must be deployed to isolate web applications from production information in the “internal” network.

8. Release Management

a) Segregation of duties between change management, developer, and infrastructure staff must be maintained.

Developers must not be able to update production resources without proper change management procedures for production updates/fixes.

b) All production systems and application resources must be changed through an enforced and documented change management process which includes appropriate reviews, testing, and management approvals.

c) Production code and systems must not allow undocumented changes or updates.

9. Asset and Configuration Management

a) Documented network diagrams must exist.

b) An auditable and documented inventory of information technology assets must exist in case of loss or theft.

Physical Security

1. Policies, Standards, and Procedure Management

a) A documented physical security function and/or program must exist.

b) The physical security function/program must establish physical security policies and be enforced through automated systems and administrative procedures.

c) All servers storing or processing confidential information, including PHI and ePHI, must be located in a secure data center or equivalent secure facility.

2. Facility Access Controls

a) Employees must be required to wear identification badges at all times in sensitive facilities.

b) Visitors must be required to be identified, sign in, wear temporary visitor badges, and be escorted in facilities containing Arizona Complete Health data.

c) Data center access to sensitive areas, such as a computer room, must require two levels of authentication.

d) Data center and other sensitive facilities access must be periodically reviewed to ensure that access is still valid.

e) Facility access logs must be retained for at least six (6) months and be reviewed as needed.

3. Issue and Corrective Action Management

a) Any known HIGH risk physical security vulnerabilities affecting Arizona Complete Health must be communicated to Arizona Complete Health's Corporate Information Security Officer.

b) The Data Center facility must be equipped and maintained with fire detection/suppression, surge and brown-out, air conditioning, and other computing environment protection systems necessary to assure continued service for critical computer systems.

c) Policies and procedures must be in place to document repairs and modifications to physical components of facilities where PHI and ePHI are stored, which are related to security (for example, hardware, walls, doors and locks).

d) All hardware and electronic media containing PHI and ePHI must be identified and tracked during movement.

e) A retrievable exact copy of PHI and ePHI must be created from equipment before being moved.

Changes

Arizona Complete Health may change the above security requirements by providing new requirements in writing to Business Associate. Business Associate shall comply with such new security requirements within thirty (30) days after receipt of notice. In the event Business Associate's compliance with the new requirements materially increases its cost to provide services under the Services Agreement(s), Business Associate shall notify Arizona Complete Health of the amount Business Associate believes is necessary to reimburse Business Associate for its actual and reasonable additional costs. If Arizona Complete Health elects not to reimburse Business Associate for such costs, then Arizona Complete Health may terminate this Agreement and/or any or all of the Services Agreements, in whole or in part, by sending written notice to Business Associate indicating which Services Agreements are being terminated and the effective date of termination. Such termination shall be without charge to Arizona Complete Health, except that Arizona Complete Health shall pay for all services under such terminated contract(s) that were properly rendered until the effective date of termination.

* * * * *

ANNUAL ATTESTATION

("Business Associate") entered into that certain Business Associate Agreement (the "Agreement") with Health Net of Arizona, Inc. dba Arizona Complete Health ("Arizona Complete Health"). Business Associate submits this attestation to Arizona Complete Health based on Business Associate's best knowledge, information and belief after having made a diligent inquiry.

1. For the period commencing from the later of (i) the Agreement's effective date or (ii) the date of the last Annual Attestation through the execution date of this Attestation set forth below, Business Associate has:

    a. Promptly notified Arizona Complete Health in writing of all Incidents involving it, its affiliates and Subcontractors involving the PHI of any individual Business Associate and its affiliates have Used in connection with a Services Agreement.

    b. Adhered to the privacy and security standards and requirements contained in the Agreement.

    c. Incorporated into the contractual arrangement with any Subcontractor that Uses PHI the provisions required by the Agreement including executing a Business Associate Agreement between Business Associate and its business associate(s).

2. Business Associate has a documented security and privacy compliance program that complies with the requirements of (i) the HIPAA Authorities, (ii) applicable state security and privacy requirements, and (iii) all additional standards and obligations established by Arizona Complete Health pursuant to the Agreement and the Services Agreement(s).

3. Capitalized terms in this Attestation shall have the meaning ascribed to them in the Agreement unless defined otherwise herein.

Centria Healthcare, LLC
Name of Business Associate

Paul McDonald
Signature of Officer

CFO
Title of Signing Officer

Paul McDonald
Printed Name of Signing Officer

3/3/2021
Date

A signature below indicates that Business Associate no longer conducts the activities outlined in the Services Agreement(s) that require the Use of PHI and, consistent with state and federal law, has properly destroyed or returned to Arizona Complete Health all PHI in accordance with the Services Agreement(s) and the Agreement.

Signature of Officer

Title of Signing Officer

Printed Name of Signing Officer

Date