PriorityHealth

BEHAVIORAL HEALTH
PRACTITIONER GROUP PARTICIPATION AGREEMENT (PPO)

THIS AGREEMENT is made and entered into as of 12/09/14, by and between PRIORITY HEALTH MANAGED BENEFITS, INC., a Michigan business corporation, management services company and licensed Third Party Administrator ("Managed Benefits"), and Centria Healthcare, LLC, a Michigan limited liability corp [INSERT "PROFESSIONAL CORPORATION," "PROFESSIONAL LIMITED LIABILITY COMPANY" OR "PARTNERSHIP" AS APPROPRIATE], ("Group").

RECITALS

Managed Benefits provides administrative services for Plans (as defined below). Group's desire to contract with Managed Benefits in order to provide professional services to persons eligible to receive benefits under a Plan for which Managed Benefits provides administrative services.

Group is comprised of Practitioners who are licensed to provide ABA therapy to ASD individuals (Qualified under MDCH and generally accepted guidelines) in the State of Michigan and desires to provide professional services to persons eligible to receive benefits under a benefit plan for which Managed Benefits provides administrative services.

NOW, THEREFORE, in consideration of the mutual covenants set forth below, Managed Benefits and Group agree as follows.

ARTICLE I
Definitions

Section 1.1. Covered Services. "Covered Services" means all behavioral health services that Managed Benefits must provide for a Participant under a Plan.

Section 1.2. Credentialing, Recredentialing and Hearing Policy. "Credentialing, Recredentialing and Hearing Policy" means the policy or policies that Managed Benefits will follow in credentialing a new applicant interested in becoming a Participating Provider with Managed Benefits, in recredentialing a Participating Provider every three years, and in resolving disputes with Group as set forth on Managed Benefits' Website.

Section 1.3. Facility. "Facility" means a duly licensed hospital, clinic or other health care provider under agreement with Managed Benefits to provide Covered Services to a Participant.

Section 1.4. Group Practitioner. "Group Practitioner" means a Practitioner who is a shareholder, participant, partner or employee of Group who will provide services on behalf of Group, pursuant to this Agreement. Each Group Practitioner shall agree to abide by the terms of this Agreement by signing the Managed Benefits Acknowledgement Form.

Section 1.5. Indemnity. "Indemnity" is Managed Benefits' plan option that provides medical benefits without a network of practitioner groups. Typically benefits are subject to deductible and out-of-pocket amounts, as well as reasonable and customary charge limitations. Participants are not required to select a Primary Care Practitioner group.

Section 1.6. Managed Benefits' Website. "Managed Benefits' Website" mean that website maintained by Managed Benefits and generally available to Facility at www.priorityhealth.com.

Section 1.7. Medically Necessary. "Medically Necessary" means Covered Services (inpatient and outpatient) required to identify or treat a Participant's mental illness or chemical dependency and which, as determined by a Practitioner in accordance with area standards pursuant to applicable utilization review and quality assurance standards, are (i) consistent with the symptoms or diagnosis and treatment of the Participant's condition, disease, ailment or injury; (ii) consistent with standards of appropriate professional practice; (iii) not solely for the convenience of the Participant, a Practitioner or other health care provider; and (iv) the most appropriate level of service which can be safely provided to the Participant. When specifically applied to a Participant receiving inpatient services, it also means that the Participant's symptoms or condition requires that the diagnosis or treatment cannot be provided to the Participant as an outpatient, consistent with Managed Benefits' or its delegatee's guidelines as identified in the Provider Manual, appropriate professional standards and the Participant's best interest.

Section 1.8. Overpayment. "Overpayment" means any payment that was made to which the person or entity had no entitlement to or any payment made in excess of the amount due, as described in the Managed Benefits Recovery Policy and including but not limited to takebacks and retro terminations.

Section 1.9. Participant. "Participant" means a person who has enrolled in a Plan (including enrolled dependents) and is entitled to receive Covered Services.

Section 1.10. Participating Provider. "Participating Provider" means a physician, facility, or other health care provider under agreement with Managed Benefits to provide Covered Services to a Participant.

Section 1.11. Plan. ""Plan" means a benefit plan for which Managed Benefits provides administrative services.

Section 1.12. Plan Sponsor. "Plan Sponsor" means any entity, public or private, or other sponsor of a Plan which (i) is responsible for payment to Participating Providers for Covered Services rendered to Participants under a Plan, including, but not limited to, self funded and fully funded health or insurance plans and (ii) contracts with Managed Benefits for administrative services.

Section 1.13. Practitioner. "Practitioner" means a psychiatrist, addictionologist, psychologist, clinical social worker, clinical nurse specialist or other Master's level clinician who will provide services pursuant to this Agreement.

Section 1.14. Primary Care Physician. "Primary Care Physician" means a physician who has the responsibility for providing initial and primary care to and for managing the total patient care of Participants. A "Primary Care Physician" may be a general practitioner, internist, pediatrician, family practitioner, obstetrician/gynecologist, or qualified advanced practice provider.

Section 1.15. Provider Manual. "Provider Manual" means those policies and procedures, instructions, rules and regulations established by Managed Benefits which govern the provision of Covered Services by Group and other Participating Providers to Participants.

Section 1.16. Psychiatric Emergency. "Psychiatric Emergency" means an immediate and unscheduled admission of a Participant evidencing a DSM-III-R or DSM-IV diagnosis with symptoms of such severity that the impairment of functioning presents an immediate danger to self or others. Managed Benefits shall determine, in its reasonable discretion, whether a particular set of facts constitutes a Psychiatric Emergency.

Section 1.17. Underpayment. "Underpayment" means any payment made that was made to Group Practitioner that is less than the amount due, not including Participant financial obligations.

Section 1.18. Utilization and Quality Management. "Utilization and Quality Management" means the prospective, concurrent, and retrospective utilization management and quality management protocols, if any, that Managed Benefits applies to Covered Services to assure that Participating Providers provide Participants with high quality efficient behavioral health care.

ARTICLE II
Group's Agreements and Obligations

Section 2.1. Group Practitioner's General Obligations. Each Group Practitioner agrees that he or she:

(a) Will provide Medically Necessary Covered Services with reasonable promptness in compliance with standards set forth in the Provider Manual and will be accessible by telephone or otherwise to Participants, either personally or through back-up coverage from other Participating Providers (or non-Participating Providers, if Medically Necessary), twenty-four (24) hours per day, seven (7) days per week, three hundred sixty five (365) days per year, in accordance with the Participant's Plan. In the case of a Psychiatric Emergency, Practitioner agrees to obtain, where feasible and consistent with the appropriate standard of care, from a 24-hour on-call service provided by Managed Benefits, prior approval for any services not pre-authorized by Managed Benefits.

(b) Will refer a Participant to Managed Benefits in the event any mental health or chemical dependency treatment or other medical services are required by the Participant which are beyond the scope of any Covered Services authorized under this Agreement.

(c) Will comply with all provisions of the Credentialing, Recredentialing and Hearing Policy and:

(i) Practitioner represents and warrants that he or she has applied and successfully completed the credentialing procedure of the Credentialing, Recredentialing and Hearing Policy and that the information he or she provided with respect to the Credentialing, Recredentialing and Hearing Policy, including but not limited to the information provided in Practitioner's application, continues to be true and complete.

(ii) Practitioner acknowledges that this Agreement gives Managed Benefits the right to limit, suspend or terminate Practitioner's participation in the Managed Benefits provider network pursuant to the Credentialing, Recredentialing and Hearing Policy.

(iii) Practitioner agrees to notify Managed Benefits within a reasonable time of material changes in any information Practitioner has provided to Managed Benefits.

(d) If the need to refer a Participant to another provider occurs, will refer Participants to Participating Providers, if available and medically appropriate.

Section 2.2. General Obligations. Group agrees that it:

(a) Will notify Managed Benefits within a reasonable time of material changes in any information Group has provided to Managed Benefits, including the names of any Group Practitioners who have joined the Group and any Group Practitioners who have left.

(b) Understands that Managed Benefits will comply with the reporting requirements imposed by the Health Care Quality Improvement Act, 42 U.S.C. § 11101 et seq. (The National Practitioner Data Bank)

(c) Will not discriminate against Participants because of race, color, ancestry, religion, age, sex, national origin, marital status, health status or disability.

(d) Will render Covered Services to Participants in the same manner, in accordance with the same standards and within the same time availability as Practitioner offers the same services to Group's non-Plan patients, or according to the requirements of the Provider Manual, whichever is stricter.

(e) Consents to being referred to as a provider who participates with Managed Benefits in marketing and other materials.

(f) Will abide by the provisions of the Provider Manual.

(g) Will participate in Utilization and Quality Management programs and will, when appropriate, initiate review or action pursuant to such programs. Group will actively cooperate with any on-site review program, including HEDIS reviews, such cooperation to include, without limitation, granting access to records, and facilitating interviews with appropriate Group staff. Group will cooperate with patient safety initiatives including computerized physician order entry systems, physician ICU staffing standards, and evidence-based hospital referral standards. Group will provide Managed Benefits with requested patient safety data.

(h) Will comply with and participate in, as applicable, Managed Benefits' grievance system and will cooperate with Managed Benefits in resolving any grievances related to the provision of Covered Services. Group agrees to abide by all final grievance decisions.

(i) Acknowledges that all materials relating to practice guidelines, pricing structures, contracts, and the internal functioning of Managed Benefits or any delegatee and all other materials bearing the name or logo of Managed Benefits and Plan Sponsors are proprietary. Practitioner agrees to maintain the confidential nature of such materials and to return them to Managed Benefits upon termination of this Agreement.

(j) Will verify Participant eligibility for Covered Services before providing such services.

(k) Will notify Managed Benefits in writing within seven (7) business days of receipt of notification of any and all claims, lawsuits, arbitration, or settlement relating to services rendered by Group to Managed Benefits Participants.

(l) Will discuss with Participants all treatment options, including medication options if applicable, available to such Participants, regardless of benefit coverage limitations

(m) Report all communicable diseases and other reportable health events as required by law.

(n) Will permit a Participant to review, amend and obtain a copy of his or her medical record upon request unless medically contraindicated as indicated by Group Practitioner in the medical record.

(o) Group Practitioner will use best efforts to comply with Managed Benefits utilization protocols as stated in this Agreement and the Provider Manual. If Group Practitioner provides Medically Necessary services to a Participant and Facility fails to comply with such utilization protocols, and should Managed Benefits deny payment of a claim due to Group Practitioner's failure to comply with such utilization protocols, Group

Practitioner has the right to utilize the appeals process to seek payment for the services. If a) at the time that the service was provided it i) met Interqual criteria for Medically Necessary services, or ii) was consistent with the applicable guidelines for the appropriate professional colleges and societies, or iii) met the requirements under Medicare review policies; b) the Participant was eligible on the date of service, and c) the service was a Covered Service, Managed Benefits agrees to pay the claim according to Exhibits A-F to the Agreement. Thus, the appeal decision will be based solely on the criterion of Medical Necessity. This subsection does not apply to American Imaging Management (AIM).

(p) Will comply with coding standards as set forth by International Classification of Diseases, 10th Edition, Clinical Modification/Procedure Coding System.

(q) Has not been excluded from any federal healthcare program, and does not appear on any of the following lists or databases: The U.S. Department of Health & Human Services Office of Inspector List of Excluded Individuals and Entities (LEIE), the U.S. General Services Administration Excluded Parties List System (EPLS), the U.S. Department of Treasury Office of Foreign Assets Control Specially Designated Nationals (SDN) List, or on any individual state provider exclusion or sanction list or database including, but not limited to, state Office of Medicaid Inspector exclusion lists. Group or Group Practitioner shall not employ or contract with any individual who appears on any of the aforementioned lists, and acknowledges and agrees that Managed Benefits may immediately terminate this Agreement should Group or Group Practitioner or any employee, contractor, or agent of Group or Group Practitioner appear on any of the aforementioned lists.

(r) Will submit Participant Laboratory result data directly to Managed Benefits or to designated third party for use in determination of HEDIS measures and other quality and/or efficiency programs.

Section 2.3. Provision of Covered Services. Group agrees that all mental health or chemical dependency services shall be rendered by qualified mental health clinicians authorized to practice in the jurisdiction in which such services are rendered. Clinical services may be rendered under appropriate clinical supervision by the following types of clinicians: psychiatrists, addictionologists, psychologists, clinical social workers, clinical nurse specialists and other Master's level clinicians. Group agrees not to refer any professional duties to any other health professional without the approval of Managed Benefits.

Section 2.4. Representation. Group represents and warrants that it is (i) in full compliance with all applicable law, including licensing laws; (ii) accredited by the Joint Commission on Accreditation of Healthcare Organizations ("The Joint Commission") or a recognized accrediting body Managed Benefits deems the equivalent of The Joint Commission; and (iii) in good standing under the Federal Medicare Program. Facility shall promptly notify Managed Benefits of any action to suspend, revoke, or restrict its license, accreditation, or Federal Medicare Program good standing.

3 N/A – not Medicare certified or applicable

Section 2.5. Record Keeping. Group will provide Managed Benefits, without charge, copies of all medical and other information that Managed Benefits reasonably requires to determine benefits. Group will maintain medical, financial, and administrative records concerning Covered Services provided to Participants and will keep these records for at least 7 years from the date Group rendered the Covered Services.

(a) Notwithstanding anything to the contrary in this Agreement, Group agrees that Managed Benefits and the Plan Sponsor, together with duly authorized third parties, will have the right to inspect, review, and make copies of records directly related to the Covered Services rendered to Participants, upon reasonable notice, during regular business hours. A Plan Sponsor may only inspect, review and make copies of the records of Participants covered by the applicable Plan and may do so only as the trustee of the Plan subject to the restrictions imposed by the Employee Retirement Income Security Act, as amended. Group also agrees that authorized regulatory agencies may inspect, review, and make copies of records to the extent permitted by law.

(b) Group acknowledges that Managed Benefits or the Plan Sponsor generally obtains from Participants at enrollment their consent to release their medical records to Managed Benefits. Group agrees to assist Managed Benefits in obtaining additional consents from Participants upon Managed Benefits' or the Plan Sponsor's request.

(c) Group shall maintain the confidentiality of information about Participants as required by federal law and regulations, which require reasonable, administrative, technical, and physical safeguards to ensure the integrity and confidentiality of Participant information. Group will only release such information to third parties upon written consent of Participant; provided, however, that group agrees to release Participant information to Managed Benefits for the purpose of administering the Plans.

(d) Group agrees to cooperate with Managed Benefits in any system that will facilitate, to the extent feasible, the maximum sharing of records between health care clinicians and providers obligated to render services to Participants. This shall include sending a copy of a Participant's treatment record to those clinicians and providers without charge.

(e) Group acknowledges that Managed Benefits is a "Covered Entity" and the Group is or may be a "Business Associate" of Managed Benefits pursuant to this Agreement and the Health Insurance Portability and Accountability Act, Public Law 104-91, and any amendments thereto ("HIPAA"). If and only to the extent HIPAA defines Group as a Business Associate of Managed Benefits, Group and Managed Benefits agree to amend this Section 2.3 as is necessary for Managed Benefits to comply with applicable law, including the rules of professional conduct and HIPAA as amended from time to time and any privacy security or other administrative simplification regulations.

Section 2.6. Insurance. Group will maintain insurance to insure against any claim or claims for damages due to personal injury or death arising out of or in any way connected with the acts or omissions to act of Group, any Group Practitioner, or his, her or its agents or employees.

(a) Group will maintain current professional liability insurance coverage with limits of at least $100,000 per occurrence and $300,000 aggregate for a year.

(b) Group will also maintain comprehensive general liability insurance coverage with limits of at least $200,000 for each claim and $600,000 aggregate for a year.

(c) Group will notify Managed Benefits at least 30 days prior to the termination, cancellation, lapse or reduction of such insurance.

(d) Upon request by Managed Benefits, Group will provide Managed Benefits with policies or other documents evidencing such insurance.

(e) If Group procures a "claims-made" policy rather than an "occurrence" policy, Group agrees to procure and maintain, prior to termination of such insurance, "tail" coverage to extend and maintain coverage satisfying the requirements of this Agreement after the end of the term of the "claims-made" policy.

Section 2.7. Payment Administration.

(a) Group will submit itemized claims for billable Covered using the appropriate billing form and in accordance with Managed Benefits' billing requirements. Group will submit claims for billable Covered Services within one (1) year from the date of service, or, in those instances in which Managed Benefits is the secondary payor, one (1) year from the date of service or 90 days from the date that Group receives a notice of payment decision from the primary payor, whichever is later. Managed Benefits may deny any claims submitted (i) after one (1) year from the date of service or, (ii) in those instances in which Managed Benefits is the secondary payor, one (1) year from the date of service or 90 days from the date that Group receives notice of payment decision from the primary payor, whichever is later, or (iii) greater than 180 days after Managed Benefits has requested additional information from Group as set forth on Managed Benefits' Website.

(b) Group will cooperate in Managed Benefits' claims payment administration including, but not limited to, provision to Managed Benefits of all information and documents it requires to determine benefits under a Plan, coordination of benefits, subrogation, verification of coverage, prior certification, and record keeping, and will follow such procedures as Managed Benefits provides to Group in writing.

(c) Group or Group Practitioner, as applicable, and Managed Benefits shall notify each other if either party becomes aware of an Overpayment or

Underpayment. If Managed Benefits pays Group or Group Practitioner more than is provided for in the applicable Plan, Group or Group Practitioner agrees to return, within 90 days after Group or Group Practitioner receives notice of (or becomes aware of) such Overpayment, such amounts to Managed Benefits. Managed Benefits may offset against future payments: (i) Overpayments of $200 or less to a Practitioner, (ii) Overpayments of $5,000 or less to a Hospital, and (iii) Overpayments that have not been repaid to Managed Benefits within 90 days of notice to Group or Group Practitioner of the Overpayment. If Managed Benefits pays Group or Group Practitioner less than is provided for in the applicable Plan, Managed Benefits shall pay the additional amount owed within 90 days after Managed Benefits receives notice of (or becomes aware of) such Underpayment from Group or Group Practitioner.

(d) If Practitioner group elects to transmit claims to and receive reports from Managed Benefits electronically, Practitioner group agrees to comply with such policies and procedures as Managed Benefits may establish. Any costs associated with such transmission shall be the responsibility of Practitioner group. If Practitioner group accesses or stores medical information about Participants electronically, Practitioner group shall establish procedures to safeguard the integrity, confidentiality and security of such medical information.

(e) If Practitioner group fails to participate, to Managed Benefit's satisfaction, in the Utilization and Quality Management programs, or to submit a timely claim, Managed Benefits may deny or reduce payments to Practitioner group.

Section 2.8. Compensation Liability. Group agrees that he, she or it will not look to Participants for payment for Covered Services rendered to a Participant, except (a) to the extent that the applicable Plan specifies a copayment or deductible, (b) as permitted under the coordination of Benefits Act, or (c) after consultation with Managed Benefits and together determined the Plan has failed to make timely payment to Group.

(a) It is recognized that Participants may occasionally request Non-Covered Services of Facility that are not authorized or covered by the Plan and are, therefore, payable by Participants. Facility agrees to look to Participant for payment for these services and agrees to use best efforts to advise Participant of their payment responsibility prior to rendering such services, i.e., in conjunction with admitting or registration procedures.

(b) Group acknowledge that the Plan Sponsor, rather than Managed Benefits, is the payor and is responsible for payment due Group under this Agreement.

Section 2.9. Medical Record and Billing Reviews.

(a) Subject to all applicable laws and the confidentiality provisions set forth in Section 2.5(c) of this Agreement, Group shall allow Managed Benefits to conduct reasonable standard reviews of Group's medical and billing

records related to Covered Services provided to Participants under this Agreement. Group shall receive thirty (30) days advance written notice from Managed Benefits advising Group of the standard review and setting forth the scope of the medical and billing records to be reviewed, except for reviews involving fraud or abuse. Group shall provide Managed Benefits with on-site access during Group's regular business office hours to all appropriate medical and billing records of Covered Services to Participants as may be necessary for benefit determination, and/or verification of compliance with the requirements of the Utilization and Quality Management programs. At the request of Managed Benefits, Group shall provide Managed Benefits with copies of such requested medical and billing records within a reasonable time from the date of request and in exchange for payment equal to $.25 per page.

(b) All standard field reviews shall be initiated and initial audit findings submitted to Group and each Group Practitioner within none (9) months from the date of notification by Managed Benefits of the review. Managed Benefits reviewers will use their best efforts to minimize disruption to normal operations while conducting standard medical and billing record reviews. All standard field reviews shall be initiated and completed, including receipt by Facility of a Notice of Determination, within eighteen (18) months from the date of payment, excluding cases under appeal. At the request of Managed Benefits, Facility shall provide Managed Benefits with copies electronically.

(c) The results of findings resulting from any standard review undertaken pursuant to this Section shall be submitted in writing to Group or Group's designee, for comment. If the review shows that Managed Benefits has overpaid group, Group shall repay Managed Benefits within 30 days after receiving the findings from the review. If Group does not repay Managed Benefits within such 30 day, Managed Benefits may offset amounts owed according to the process set forth in Section 2.7(c), unless Group has notified Managed Benefits in writing that Facility disagrees with the results of the review. If Group notifies Managed Benefits of a dispute within 30 days, Managed Benefits will not offset any amounts owed by Group. The parties will attempt to resolve the matter informally; however, if the parties are unsuccessful in reaching agreement, either party may invoke the dispute resolution provisions in Section 5.6 of this Agreement.

Section 2.10. Compliance with Policies and Procedures. Group shall abide by and participate in any and all policies and procedures of Managed Benefits and Plan, including without limitation, those regarding credentialing, recredentialing, utilization management and quality improvement, grievance, dispute resolution, medical records, confidentiality, peer review, audit, independent quality review and improvement, medical management and comply with all final decisions rendered by or pursuant to such policies or procedures; provided however, that if any provision in such policy or procedure is inconsistent with any provision in this Agreement the applicable provision of this Agreement shall prevail. Copies of said policies and procedures shall be made available to Group for review, upon request, prior to execution of this Agreement, within fourteen (14) days after the date of a written request and on Managed Benefits' Website.

If any change to the polices or procedures shall have a significant impact on Group's operations or reimbursement, such policies and procedures shall be distributed to Group at least fifteen (15) days prior to becoming effective, unless such changes are required by Federal or State law or regulation, in which case the modifications shall become effective immediately.

ARTICLE III
Agreements and Obligations of Managed Benefits

Section 3.1. Payment. Managed Benefits will, upon receipt of satisfactory claims data and if it is the primary payor, pay Group Practitioner in accordance with Exhibit A, as payment in full for Covered Services provided by such Group Practitioner to Participants.

Section 3.2. Information. Managed Benefits will:

(a) Provide descriptions of Plans to Group.

(b) Arrange for the distribution of identification cards to Participants. Each card will include a toll-free number that Group may use during normal business hours to check eligibility for benefits.

(c) Maintain Managed Benefits' Website such that it contains all policies and procedures with which Group are required, by the terms of this Agreement, to comply.

(d) Inform Group of the applicable billing procedures for each Plan.

Section 3.3. Insurance. Managed Benefits will maintain insurance to insure against any claim or claims for damages arising out of or in any way connected with the acts or omissions to act of Managed Benefits, its agents, or employees.

(a) Managed Benefits will maintain current professional liability insurance coverage with limits of at least $1,000,000 per occurrence and $3,000,000 aggregate for a year.

(b) Managed Benefits will also maintain comprehensive general liability insurance coverage with limits of at least $1,000,000 for each claim and $3,000,000 aggregate for a year.

Section 3.4. Compensation Standards. In support of the National Council for Quality Assurance (NCQA) guidelines, Managed Benefits does not offer incentives or compensation to staff involved in Utilization management decisions to encourage denials of coverage or service. Utilization management/Case management decisions are based only on appropriateness of care and service.

Section 3.5. Payment When Managed Benefits Is Secondary Payer. When Managed Benefits is the secondary payer, payment for Covered Services provided by Group under this Agreement shall be pursuant to Section 3.1 as modified by the coordination of benefits provisions of the Provider Manual as set forth on Managed Benefits' Website.

When primary and secondary benefits are coordinated, determination of liability will be in accordance with the Medicare Secondary Payor rules. Group agrees to cooperate with Managed Benefits for proper determination of coordination of benefits and to bill and collect from other payors such charges as the other payor is responsible for.

ARTICLE IV
Term and Termination

Section 4.1. Term. The term of this Agreement will commence on the date first written above. The Agreement will continue in effect for a period of 12 months, and will automatically renew thereafter for 1-year terms, unless terminated pursuant to this Article IV.

Section 4.2. Termination. The parties may terminate this Agreement as follows.

(a) Either party may terminate this Agreement without cause upon 90 days' prior written notice to the other party.

(b) Either party may terminate this Agreement upon the other party's material breach if the non-breaching party has given 60 days prior written notice specifying the material breach to the breaching party and if at the end of the 60 days the breaching party has not cured the stated breach.

(c) Managed Benefits may terminate this Agreement pursuant to the Credentialing, Recredentialing and Hearing Policy.

(d) Managed Benefits may terminate this Agreement immediately and without notice upon Managed Benefits' determination that Practitioner has materially failed to comply with the Utilization and Quality Management protocols.

Section 4.3. Obligations Following Termination. Group will continue to provide Covered Services to Participants it is actively treating (including any Participant who is hospitalized) at the time of termination until Group completes such treatment or until Managed Benefits makes arrangements to have another practitioner provide the services. The terms of this Agreement continue to apply after termination of this Agreement to all Covered Services provided by Group before the termination of this Agreement and to post-termination Covered Services Group provides within 90 days of the date of such termination. After such 90 day period, Managed Benefits shall pay Group its published rates, or an amount agreed to by both parties, for any Covered Services provided by Group to a Participant. Group shall notify affected Participants and/or their employer groups of terminations and obligations of Group 30 days prior to the date of termination as described in this Section.

ARTICLE V
General Provisions

Section 5.1. Assignment. Neither Group nor any Group Practitioner nor Managed Benefits will assign his, her or its rights, duties, or obligations under this Agreement

without the prior written consent of the parties. Group or Managed Benefits can assign its rights under this Agreement to any parent or subsidiary of Managed Benefits or any entity in common ownership with, or successor to, Managed Benefits upon notice to the parties. Any assignment of this Agreement must be subject to, and comply with, all applicable privacy and confidentiality requirements provided in this Agreement or otherwise required by law.

Section 5.2. Amendments. Either party may amend this Agreement upon written notice to the other if amendment is necessary in order to comply with applicable law. Managed Benefits may amend this Agreement upon 30 days' prior written notice to Group, unless Group objects in writing within 15 days of the date Managed Benefits sent the notice of amendment. If Managed Benefits receives such a timely objection, Managed Benefits and Group will make a good faith effort to resolve the objection. If the objection cannot be resolved to the mutual satisfaction of the parties, either party may terminate the Agreement upon 30 days' written notice to the other party.

Section 5.3. Independent Contractors. The parties expressly agree that Group shall render all services required of Group by this Agreement including, without limitation, mental health care services, peer review and other administrative services with respect to the Credentialing, Recredentialing and Hearing Policy, Utilization and Quality Management, and grievances, in his or her capacity as an independent contractor. Managed Benefits retains no control or supervision over the professional aspects of the services rendered by Group, including Group's medical judgments, diagnoses, or specific treatment regimens.

Section 5.4. Indemnification for Peer Review. Managed Benefits will indemnify and hold Group harmless against any and all liability or loss, including costs and expenses of defending any such claim, arising from Group's participation in Managed Benefits peer review activities.

Section 5.5. Dispute Resolution.

(a) The parties shall make reasonable attempts to resolve any and all disputes arising hereunder through informal discussions.

(b) The parties agree that any claim or dispute relating to this Agreement, or any other matters, disputes or claims between us, that cannot be resolved through informal discussions shall be subject to non-binding mediation if agreed to by you and us within thirty (30) days of you or us making a written request to the other. Any such mediation will be held in the federal judicial district in which Managed Benefits resides and shall be conducted under the auspices of the American Health Lawyers Association. The parties exclude the following matters from the operation of this mediation clause: any counterclaim, crossclaim or third party claim for indemnity or contribution between Group and Managed Benefits in any Participant's suit against Group, another Participating Provider or a payor unless a court requires the parties to submit Participant's entire claim to mediation.

(c) In the event the parties cannot satisfactorily resolve a dispute concerning this Agreement using the mediation process outlined in subparagraph (b) of this section, the parties will settle the dispute by arbitration in

accordance with the commercial arbitration rules of the American Health Lawyers Association then in effect. Either party may initiate such arbitration by making a written demand for arbitration on the other party within 30 days of the time the dispute arises. Within 30 days of that demand, Managed Benefits and Group will each designate an arbitrator and give written notice of such designation to the other. The two arbitrators selected by this process will select a third arbitrator and give notice of the selection to Managed Benefits and Group. The three arbitrators will hold a hearing and decide the matter within 30 days thereafter. If a unanimous award by the three arbitrators is not possible, the parties will permit the third arbitrator to render the award alone. The results of the arbitration will be final and binding on both parties. Any court that has jurisdiction may enter judgment upon an award rendered by the arbitrators. Managed Benefits will pay the fee of the arbitrator it chooses, Group will pay the fee of the arbitrator it chooses, and the parties will share equally the fee of the third arbitrator. The parties exclude the following matters from the operation of this arbitration clause: any counterclaim, crossclaim or third party claim for indemnity or contribution between Group and Managed Benefits in any Participant's suit against Group, another Participating Provider or a payor unless a court requires the parties to submit Participant's entire claim to arbitration.

Section 5.6. Notice. All notices shall be in writing and mailed postage prepaid or delivered to the relevant party at the address given below or to such other address as a party may specify in writing. Notices shall be effective two days after deposited in mail.

If to Managed Benefits:

Attn: General Counsel
Priority Health Managed Benefits, Inc.
1231 East Beltline, N.E.
Grand Rapids, Michigan 49525-4501

If to Group:

Managed Benefits will send notices to Group's primary office address, as specified in Group's application, or such other address as Group may specify in writing.

Section 5.7. Trademarks. Neither party may use the other party's trademarks or service marks without the express written consent of the other party.

Section 5.8 Proprietary Information. Group acknowledges that materials and information developed by or belonging to Managed Benefits including but not limited to this Agreement, mailing lists, patient lists, employer lists, product related information and structure, quality data, claims data, utilization review procedures, formats and structure and related information and documents concerning Managed Benefits and operations of its Plans, all materials bearing Managed Benefits' logo, other information not in the public domain and the compensation payable to Group pursuant to the terms of this Agreement (collectively "Proprietary Information") is confidential.

Group further agrees that upon termination of this Agreement, Group will return to Managed Benefits all of Managed Benefits' Proprietary Information or upon Managed Benefits' request will destroy such Proprietary Information and provide to Managed Benefits' satisfaction proof of such destruction.

Section 5.9. Confidentiality. Except as specified below, the parties agree not to disclose any information regarding this Agreement or services provided pursuant to this Agreement except as required by law or regulation.

Notwithstanding anything else in this Agreement, Managed Benefits and Group may disclose to Participants, employers, potential customers, and third party vendors, information related to the quality and cost of services provided by Group.

Section 5.10. Waiver. In the event a party waives any provision of this Agreement, the other party will not assert that the waiving party has waived that provision at any other time or waived any other provision.

Section 5.11. Severability. In the event any tribunal with jurisdiction rules that any provision of this Agreement invalid or unenforceable, the remainder of the provisions of this Agreement will remain in full force and effect.

Section 5.12. Entire Agreement. This Agreement, including its attachments and the contract execution page, constitutes the entire agreement between the parties with respect to the matters addressed herein and supersedes all prior oral and written understandings between the parties.

Section 5.13. Governing Law. This Agreement shall be governed by, and construed in accordance with, the laws of the State of Michigan applicable to contracts made and to be performed in the State of Michigan.

Section 5.14. Compliance with Laws. Managed Benefits, PPO and each Group Practitioner agree to comply with all applicable state and federal laws, rules, and regulations relating to the parties or this Agreement.

The remainder of this page intentionally left blank.

CONTRACT SIGNATORY PAGE
PRACTITIONER GROUP PARTICIPATION AGREEMENT (PPO)

IN WITNESS WHEREOF, the undersigned have executed this Practitioner Group Participation Agreement as of the date and year below written, to be effective the date first written in this Practitioner Group Participation Agreement.

Group

Signature Scott C Barry Date 11/4/14

Name (please print) Scott C Barry

Federal Tax ID # 27-1402749

Name of corporation or other legal entity (please print)

Centria Healthcare, LLC.

Priority Health Managed Benefits, Inc. Michael R. Koziara

Authorized Signature

Name (please print) Michael R. Koziara

Title Chief Operating Officer

Date 12/09/14

EXHIBIT A

GROUP PARTICIPATION AGREEMENT (PPO) REIMBURSEMENT FOR GROUP SERVICES

This Exhibit A describes the payments that Priority Health Managed Benefits, on behalf of the applicable Plan Sponsor, will make to Group pursuant to this Agreement for Covered Services Group provides for Participants. All such payments are subject to the terms of this Agreement and the applicable Plan. Any capitalized but undefined terms in this Exhibit shall have the same meaning as provided in the Agreement.

A. Reimbursement Rate for Covered Services. Group's total reimbursement for Covered Services rendered to Participants during the term of this Agreement shall be:

(1.) The lesser of:

(a) The maximum fee for the particular Covered Service as determined by Priority Health Managed Benefits (pursuant to the Priority Health Managed Benefits fee schedule); or

(b) Group's usual and customary charge for such services.

(2.) Less any applicable Participant copayments, deductibles or coinsurance.

Group is responsible for the submission of claim forms (HCFA/CMS-1500) for services in accordance with their requirements and Section 2.7 of this Agreement.