PARTICIPATING PROVIDER AGREEMENT

This Agreement is made by and between the provider named on the signature page of this Agreement ("Provider") and Managed Health Network, Inc. ("MHN, Inc."), and its Affiliates identified in Addendum A to this Agreement. The effective date of this Agreement is set forth on its signature page.

RECITALS

A. Provider is a duly licensed and certified individual, medical group, independent practice association, ancillary service or institutional health care provider whose field of practice is indicated on the signature page of this Agreement.

B. MHN, Inc. and its Affiliates identified on Addendum A (referred to collectively herein as "MHN") arrange for or administer the provision of mental health and substance abuse services and supplies.

C. MHN desires to enter into this Agreement to arrange for Provider to render Covered Services to Enrollees pursuant to this Agreement.

D. Provider desires to enter into this Agreement to render Covered Services to Enrollees pursuant to this Agreement.

NOW THEREFORE, it is agreed as follows:

1. Definitions. The defined terms set forth in this Section below are those words that are capitalized in this Agreement and its addenda.

   1.1 Affiliate. A company in which MHN, Inc. or any parent or subsidiary corporation of MHN, Inc., owns 51% or more of the voting stock.

   1.2 Agreement. This contract, including all appendices hereto, any policies and procedures referenced herein, rules or regulations issued pursuant to this contract, and all applicable state or federal requirements that are required to be incorporated as part of the Agreement.

   1.3 Benefit Plan. The obligation of MHN, Inc. and/or an Affiliate to pay for, provide, arrange for or administer Covered Services, provider networks, administrative or other related services pursuant to a written agreement between an employer or other entity or an individual and MHN, Inc. or an Affiliate. The Benefit Plans covered under this Agreement include, but are not limited to, any of the following lines of business of MHN, Inc. or an Affiliate: (a) MHN, Inc. and Affiliates: (g) the Civilian Health and Medical Program of the Uniformed Services ("CHAMPUS/TRICARE") business described in Addendum G.

   1.4 Coordination of Benefits. The allocation of financial responsibility between two or more Payors of health care services, each with legal duty to pay for Covered Services provided to an Enrollee at the same time.

   1.5 Copayment. The cost of Covered Services that an Enrollee is obligated to pay under a particular Benefit Plan, including deductibles and coinsurance.

   1.6 Clean Claim. A claim received for adjudication by MHN as a claims agent that requires no further information, adjustment or alteration by the Provider of the services in order to be processed and paid by MHN.

   1.7 Covered Services. Mental health and substance abuse services, ancillary services and supplies provided by Providers that are determined by MHN to be Medically Necessary and covered under a Benefit Plan, provided they have been authorized in advance by MHN.

1.8 CPT-4. Current Procedural Terminology, Fourth Edition, is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by health care providers. The purpose is to provide uniform language that accurately describes medical, surgical and diagnostic services for the reporting of services performed under government and private health insurance programs. CPT-4 is routinely updated and the updates are to be included in this definition.

1.9 Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition ("DSM"). A listing of diagnostic categories and criteria which provides guidelines for making diagnoses of mental disorders. The DSM is a widely accepted basis for describing the presence and type of mental disorder. A DSM diagnosis of mental disorder is a minimum requirement for the determination of Medical Necessity for Mental Health Care. The diagnosis must be contained in the most recent edition of the DSM.

1.10 Drug Formulary. Positive listing of medications eligible for coverage under an optional outpatient prescription medication benefit offered in conjunction with certain Benefit Plans.

1.11 Emergency Care. Emergency Services and Care means medical and/or psychiatric screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical and/or psychiatric condition or active labor exists and, if it does, the care, treatment, and surgery by a physician necessary to relieve or eliminate the emergency medical and/or psychiatric condition, within the capability of the facility. Emergency medical and/or psychiatric condition means a medical and/or psychiatric condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that, the absence of immediate medical and/or psychiatric attention could reasonably be expected to result in any of the following: (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part. In cases of the provision of Emergency Services and Care, Provider agrees to notify MHN or Affiliate as soon as possible, but no later than 24 hours after it could be reasonably determined that the patient is an Enrollee.

1.12 Enrollee. A person covered under a Benefit Plan for the provision of Covered Services, or a CHAMPUS beneficiary who is otherwise eligible to receive benefits under a CHAMPUS program and for whom prepayment fees have been paid to and accepted by MHN.

1.13 Excluded Services. Those services and supplies that are not Covered Services. Excluded Services that are rendered by Provider to Enrollees are not compensated hereunder.

1.14 Medical Director. A physician duly licensed to practice medicine that is employed or contracted by MHN to monitor the provision of Covered Services to Enrollees.

1.15 Medically Necessary. Covered Services which are determined by MHN to be: (a) necessary and appropriate for treatment of an Enrollee's symptoms and behaviors that demonstrate the presence of a mental or substance abuse disorder as described in the most recent edition of the DSM; (b) provided for the diagnosis or the direct care and treatment of a mental or substance abuse disorder as described in the most recent edition of the DSM; (c) the most appropriate type, level and length of service or supply to provide safe and adequate care and treatment; (d) within the generally accepted standards of good medical practice within the organized medical community; and (e) not primarily for the convenience of the Enrollee or Provider. To the extent that care is rendered by a professional, the professional must be properly licensed or certified pursuant to state or federal law and the care, treatment or supply must fall within the professional's permissible scope of practice as provided by applicable state and federal law and the rules and regulations of any supervising professional organization. For hospitalization to be Medically Necessary, acute care as an inpatient must be required for treatment or diagnosis and safe and adequate care cannot be received on an outpatient basis or in a less restrictive setting.

1.16 Mental Health Care. Medically Necessary care provided by a Participating Provider for, or in support of , the treatment of a mental health or behavioral illness or condition that MHN has determined (a) is a clinically significant behavioral or psychological syndrome or pattern; (b) is associated with a painful symptom, such as distress; (c) substantially or materially impairs a person's ability to function in one or more major life activities; and (d) is recognized by the American Psychiatric Association as a mental health or behavioral illness or condition. Without limiting the foregoing, Mental Health Care shall include professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism and that meet all of the following criteria:

(A) The treatment is prescribed by a physician and surgeon licensed pursuant to Chapter 5 (commencing with Section 2000) of, or is developed by a psychologist licensed pursuant to Chapter 6.6 (commencing with Section 2900) of, Division 2 of the Business and Professions Code.

(B) The treatment is provided under a treatment plan prescribed by a qualified autism service provider and is administered by one of the following:

(i) A qualified autism service provider.

(ii) A qualified autism service professional supervised and employed by the qualified autism service provider.

(iii) A qualified autism service paraprofessional supervised and employed by a qualified autism service provider.

(C) The treatment plan has measurable goals over a specific timeline that is developed and approved by the qualified autism service provider for the specific patient being treated. The treatment plan shall be reviewed no less than once every six months by the qualified autism service provider and modified whenever appropriate, and shall be consistent with Section 4686.2 of the Welfare and Institutions Code pursuant to which the qualified autism service provider does all of the following:

(i) Describes the patient's behavioral health impairments to be treated.

(ii) Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the patient's progress is evaluated and reported.

(iii) Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism.

(iv) Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate.

(D) The treatment plan is not used for purposes of providing or for the reimbursement of respite, day care, or educational services and is not used to reimburse a parent for participating in the treatment program. The treatment plan shall be made available to the health care service plan upon request

1.17 Non-Participating Provider. A person or entity that provides health care, hospital or ancillary services but has not entered into an agreement with MHN.

1.18 Participating Provider . A physician, Qualified Autism Service Provider (as defined in Section 3 of

Exhibit T hereto), licensed psychologist, licensed social worker, or other licensed masters level therapist such as MFT, credentialed, trained and licensed to provide Covered Services and having a written agreement with MHN, or a member of an independent practice association, or medical group which contracts with MHN, to provide Covered Services to Enrollees. Participating qualified autism service professional and qualified autism service paraprofessional are required to be employed and supervised by qualified autism service provider. Participating Providers contracted with a Participating Provider Group shall heretofore be referred to as a Group Member. All terms and conditions applicable to the Participating Provider Group shall apply to Group Members.

1.19 Participating Provider Group. A group practice, medical group or independent practice association having a written agreement with MHN to provide or arrange for Covered Services to Enrollees.

1.20 Payor**.** MHN or any other public entity which provides, administers, funds, insures or is responsible for paying Participating Providers for Covered Services rendered to Enrollees or CHAMPUS beneficiaries under a Benefit Plan covered under this Agreement. Under certain ASO Benefit Plans, MHN refers Enrollees to providers and authorizes treatment and claims payment. However, MHN is not the Payor and is not responsible for claims payment. In general, however, such Payors encourage Enrollees to use the network by offering financial incentives, such as reduced copayments and deductibles. In the event that MHN chooses to contract with a Payor that does not offer such financial incentives to Enrollees for use of network providers or actively encourage the use of the network in any other manner, MHN will notify Provider in writing and permit Provider to decline participation in such Payor's business.

1.21 Primary Care Physician. Physician who has the responsibility for providing primary care to Enrollees, maintaining the continuity of patient care and making Referrals under certain Benefit Plans.

1.22 Prior Authorization. Approval of coverage from MHN prior to the Enrollee obtaining Covered Services. Requests for Prior Authorization will be denied if not Medically Necessary, if in conflict with MHN's medical policies or otherwise are not Covered Services.

1.23 Provider Manual. All Provider Manuals issued by MHN, as updated from time to time, which are incorporated into this Agreement by this reference and available on MHN's website or on hardcopy upon request. Provider agrees to be contractually bound to comply with the Provider Manual, and any updates or revisions to such, forty five (45) business days following notice thereof from MHN via MHN's website, newsletter and/or contract amendment in the case of material updates and revisions. The Provider has the right to negotiate and agree to material changes. If agreement cannot be reached, the Provider has the right to terminate this Agreement prior to implementation of the material change. This 45-day notice requirement and right to negotiate shall not apply to changes required by state or federal law or accreditation entities and non-material changes; such changes will be effective as stated in the notice to the Provider. In the event that any provision in the Provider Manual or any updates thereto are clearly inconsistent with the terms of this Agreement, the terms of this Agreement, including any amendments, shall prevail.

1.24 Referral. The act or an instance of MHN or a physician referring an Enrollee to a physician, hospital, facility or other type of health care provider to obtain Covered Services. When required under a Benefit Plan, compensation for Mental Health Care rendered by a Provider is conditioned upon Referral from the Enrollee's Primary Care Physician and/or Prior Authorization from MHN.

1.25 Quality Improvement Program. A program to meet MHN standards approved by MHN, and designed to monitor the quality and appropriateness of Covered Services. Relevant provisions of MHN's quality improvement and utilization management program requirements and procedures are included in MHN's Provider Manual, which should be reviewed by Provider no less than fifteen (15) business days prior to execution of this Agreement.

1.26 Utilization Management Program. MHN's utilization management and medical management program under which MHN reviews the necessity and appropriateness of Mental Health Care services.

2. Obligations of Provider:

2.1 Scope of Covered Services. Except as otherwise provided below, Provider shall provide all Covered Services that are within the scope of Provider's license to all Enrollees entitled to coverage for such services under a particular Benefit Plan and pursuant to the requirements of such Benefit Plan. However, Provider is free to communicate with Enrollee any and all treatment options available to the Enrollee, including medication management options, regardless of Benefit Plan coverage limitations. Notwithstanding any provision in this Agreement to the contrary, Provider shall NOT provide Covered Services to any Enrollee assigned to a capitated participating medical group or individual practice association which is responsible for arranging and paying for the Enrollee's Mental Health Care, provided that the Provider is aware that Enrollee is assigned to a capitated participating medical group or individual practice association prior to rendering services. In any event, Provider will seek reimbursement for any capitated services rendered to Enrollees so assigned only from such capitated participating medical group or individual practice association.

Services required under this Agreement shall be delivered in the Enrollee's home or in a community or clinical environment, whichever is most appropriate for the Enrollee's needs.

2.2 Accessibility of Covered Services. Covered Services shall be available and accessible to Enrollees during reasonable hours of operation, with provision for after-hour services, if applicable. Emergency Care shall be available and accessible 24 hours a day, 7 days a week. At all times, Provider is obligated to include in all electronic responses to Enrollee inquires including but not limited to voicemail, pager, answering machine or email and via their answering service appropriate instructions in case of emergency. Provider shall monitor the accessibility of care to Enrollees, including average time to schedule an appointment and waiting time at scheduled appointments, and shall comply with MHN's efforts to monitor and evaluate same. Provider agrees that when it is necessary to reschedule an appointment, the appointment is promptly rescheduled in a manner that is appropriate for the Enrollee's health care needs and ensures continuity of care consistent with good professional practice. Provider agrees to return all calls from Enrollees within two (2) business days.

2.3 Treatment of Enrollees. Provider shall maintain offices, equipment and personnel as may be necessary to perform the Covered Services under this Agreement and in accordance with applicable MHN policies and procedures and state and federal laws. Provider and Provider's staff and administrative personnel shall treat Enrollees promptly, fairly and courteously by phone, in person or in writing and in accordance with MHN's Member Rights and Responsibilities Statement set forth in the Provider Manual.

2.4 Referral, Prior Authorization and Managed Care Requirements. Provider agrees to accept Enrollees upon Referral from MHN or Primary Care Physicians, when required under a particular Benefit Plan, and provided they have the capacity to provide Covered Services and continue to accept new patients from any other health care service plan. Compensation for referrals for Mental Health Care is limited to Covered Services rendered by Provider which have been authorized by Referral and, when required under a Benefit Plan, Prior Authorization by MHN has been obtained. Provider shall abide by MHN's medical policies and procedures governing Referrals, utilization management, and concurrent, retrospective and prospective review. It is Provider's responsibility to follow these policies and procedures and to provide sufficient information in a timely manner for MHN to complete its reviews. Such policies and procedures are further described in the Provider Manual.. In the event that MHN authorizes a specific type of treatment by Provider, MHN will not rescind or modify such authorization after Provider renders such health care service in good faith and pursuant to the authorization. Notwithstanding the foregoing, in no event will this section be construed to

expand or alter the benefits available to the Enrollee under the applicable Benefit Plan.

2.5 Excluded Services. Provider must advise the Enrollee in writing prior to providing Excluded Services that the services will not be covered by MHN and the Enrollee will be responsible for paying Provider directly for such services. A separate and distinct written advisement must be given to the Enrollee prior to rendering each Excluded Service and as close to the time the Excluded Service is provided as possible. The Provider also must verbally notify the Enrollee of any potential situation in which the delivery of Excluded Services may occur and document this notification in the medical record. Further, if an Enrollee requests such Excluded Services, Enrollee must waive in writing to Provider, in advance of the provision of services, the responsibility of MHN.

2.6 Reporting of Actions Against Provider. Provider shall notify MHN within five (5) calendar days of the occurrence of any of the following:

2.6.1 any action taken to restrict, suspend or revoke Provider's and/or a staff or Group Member's license or certification to provide the services described in this Agreement;

2.6.2 any suit or arbitration action brought against Provider and/or a staff or Group Member for malpractice (provide also a summary of the final disposition of such action);

2.6.3 any misdemeanor conviction or felony information or indictment naming Provider and/or a staff or Group Member (provide also a summary of the final disposition thereof);

2.6.4 any disciplinary proceeding or action naming Provider and/or a staff or Group Member before an administrative agency in any state;

2.6.5 any cancellation or material modification of the professional liability insurance required to be carried by Provider;

2.6.6 any action taken to restrict, suspend or revoke Provider's and/or a staff or Group Member's participation in Medicare, Medicaid or CHAMPUS;

2.6.7 any action which results in the filing of a report on Provider and/or a staff or Group Member under California Business & Professions Code Section 805 or any similar state laws and/or regulations;

2.6.8 any material Enrollee complaints against Provider and/or a staff or Group Member; or

2.6.9 any other event or situation that could materially affect Provider's ability to carry out Provider's duties and obligations under this Agreement.

2.7 Drug Formulary. Provider shall comply with the medication dispensing guidelines set forth in Drug Formularies, where applicable.

2.8 Quality of Covered Services. Provider shall be solely responsible for the quality and appropriateness of services that Provider renders to Enrollees. Said services shall meet professionally recognized standards of practice. MHN's professional review and credentialing committees shall monitor the quality of Covered Services rendered. Provider shall cooperate and comply with MHN's internal quality of care review system and the decisions of MHN's Medical Directors. Provider and Provider's staff and/or Group Members shall abide by MHN's policies and procedures for credentialing, Prior Authorization, utilization review, utilization management and quality management. Provider acknowledges that MHN's quality management program includes provisions for records audit, peer review, provider appeals, and a grievance process for Providers and Enrollees. Provider and Provider's staff and/or Group Members shall comply with all final determinations of MHN's peer review, provider appeal and Enrollee grievance processes. Upon recommendation of MHN's peer review committee, MHN may require a corrective action plan to ensure the Provider

meets the requirements of this Section 2.8. In the event that such plan does not correct the issues addressed, MHN may terminate this Agreement in accordance with Section 5 below and applicable MHN policies and procedures. Nothing in this Agreement shall be construed as limiting Provider's ability to communicate openly with Enrollees about all diagnostic testing and treatment options. Provider will not be terminated or penalized because of advocacy on behalf of Enrollees or for filing an appeal as permitted by MHN's policies and procedures and applicable state laws and regulations.

2.9 Coordination of Benefits. Provider shall cooperate with MHN with respect to health coverage, which is maintained by an Enrollee, including, but not limited to, prompt notification to MHN of any third party entity who may be responsible for payment and collection of Copayments. MHN will administer Coordination of Benefits in compliance with applicable state and federal laws. MHN will seek recovery from other group health plans as is necessary and lawful to accomplish Coordination of Benefits. The proceeds and savings derived from Coordination of Benefits are the exclusive property of MHN and its designees. When an Enrollee has coverage which is primary through another Payor, Provider will bill the primary Payor first and MHN's financial liability hereunder will be limited to the unpaid balance of the Provider's claim, if any, up to the compensation payable hereunder. Provider shall not bill Enrollees for any portion of Covered Services not paid by the primary carrier when MHN is the secondary carrier, but shall, instead, look to MHN for payment of same. When an Enrollee is covered by two MHN Benefit Plans, Provider may not collect a Copayment from the Enrollee, but must seek payment for all receivables from MHN.

2.10 Billing Practices. Provider agrees to collect any Copayments due from Enrollee and accept payment from MHN as payment-in-full for Covered Services rendered to Enrollees referred to them, except for authorized Copayments, and agrees not to bill Enrollees and shall hold them harmless for such services regardless of whether or not payment is received from MHN. In the event that Enrollee misses or cancels an appointment, Provider may not bill Enrollee for the Copayment. Provider also agrees to follow the billing and reimbursement procedures contained in the Provider Manual.

2.11 Third Party Liability and Workers' Compensation Recoveries. Provider shall cooperate with MHN and its designees to procure third party liability and Workers' Compensation recoveries. The proceeds of such recoveries are the exclusive property of MHN and its designees.

2.12 Record Keeping Requirements. Provider shall maintain medical and mental health records of Enrollees receiving Covered Services and all related administrative records necessary for compliance with all applicable local, state and federal laws, rules and regulations, for the longer of, seven (7) years after the date of the delivery of services (and records for a minor shall be kept for at least one (1) year after the minor has reached the age of eighteen (18), but in no event less than seven (7) years) or such time period as may be required by applicable law or regulation. Additionally, MHN shall maintain such financial, administrative and other records as may be necessary for compliance by MHN with all applicable local, State and federal laws, rules and regulations, including, but not limited to, the Department of Managed Health Care and applicable state insurance and health services departments, the United States Department of Health and Human Services, the United States Department of Defense and any other agency or organization with regulatory and/or accreditation authority over MHN, Payor and/or any health plan or insurance carrier doing business with MHN. Upon request, MHN and such agencies, organizations and authorities shall have access at reasonable times to the books, records and papers of Provider relating to Enrollees, Covered Services, the cost thereof, Copayments received from Enrollees, and the financial condition of Provider and to conduct site evaluations and inspections of Provider's offices and service locations. At the end of seven (7) years or such longer period as required by applicable laws, Provider may destroy Enrollee records by shredder. The requirements of this section shall survive the termination of this Agreement. After termination of this Agreement, MHN and Payors shall continue to have access to the Provider's records as necessary to fulfill the requirements of this Agreement and to comply with all applicable laws, rules and regulations.

2.13 Professional Liability and Other Insurance. Facilities and physician providers shall maintain professional liability insurance equal to amounts sufficient for their anticipated risk, but at least in the

amounts of one million dollars ($1,000,000) per claim and three million dollars ($3,000,000) in the aggregate of all claims per policy year; non-physician providers shall maintain professional liability insurance equal to one million dollars ($1,000,000) per claim and one million dollars ($1,000,000) in the aggregate of all claims per policy year. All insurance policies maintained to provide the coverages required herein shall be issued by insurance companies authorized to do business in the state in which work is performed, and by companies rated, at a minimum, "A - VII" by A.M. Best. Provider shall deliver to MHN prior to the effective date of this Agreement, certificates of insurance or other evidence of insurance reasonably satisfactory to MHN indicating that this insurance is in effect and naming MHN as an additional insured, if possible. MHN shall be provided not less than thirty (30) calendar days advance written notice prior to any cancellation, non-renewal or material change in this coverage. Provider also shall maintain a policy or program of comprehensive general liability insurance (or other risk protection) with minimum coverage including a Combined Single Limit Bodily Injury and Property Damage Insurance of not less than one million dollars ($1,000,000) per claim, and Provider's employees shall be covered by Workers' Compensation Insurance in an amount and form meeting all requirements of applicable provisions of the California Labor Code or similar state laws and/or regulations.

2.14 Non-Discrimination. Provider shall provide or arrange for the provision of Covered Services to Enrollees in the same manner as services are provided to or arranged for all other patients and/or clients of Provider. The quality of Covered Services shall be no less than the quality of services provided to other patients and/or clients. Provider shall not discriminate against Enrollees on the grounds that the Enrollee files a complaint against either Provider or MHN, or because of the Enrollee's race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, age, income level, physical handicap, medical or mental health condition or on the basis of health maintenance organization membership.

2.15 Reporting Changes of Provider Information. Provider shall notify MHN, in writing, at least thirty (30) calendar days prior to any change in Provider's and/or Group Member's address, business telephone number, office hours, tax identification number, bilingual language abilities, professional license number and, if applicable, Drug Enforcement Agency registration number. Provider Group shall notify MHN of additions and deletion to their Group membership 30 calendar days prior to a change or as soon as reasonably possible. New Group Members shall be subject to MHN's credentialing requirements as described in Section 2.16 of this Agreement. Provider Groups shall submit to MHN a complete roster of their membership upon request.

2.16 Credentialing Requirements. Provider and/or Group Members as applicable shall, prior to providing services under this Agreement, meet MHN's credentialing requirements in effect at the time this Agreement is executed for each line of business of MHN as set forth in this Agreement, including CHAMPUS certification. Provider acknowledges that credentialing requirements may be modified from time to time by MHN as new laws, regulations and other conditions arise and agrees to comply with any new credentialing requirements as a material condition of this Agreement. Facility providers also must establish and follow their accrediting agency's approved procedures for granting of admitting/attending privileges to physicians. In the event that such procedures are modified in any way, Provider shall notify MHN of such modification. Upon expiration and renewal, Provider and/or Group Member shall send to MHN's Credentialing Department updated copies of Provider's and/or Group Member's license, professional liability insurance and, if appropriate, DEA and/or accreditation certificate. In the event that at any time during the term of this Agreement Provider and/or Group Member fails to meet the then current credentialing requirements of MHN and/or of any accrediting agency, MHN may terminate this Agreement or a Group Member's Participating Provider status as provided in Section 5.

2.17 License Requirements. Provider and/or Group Members shall maintain all appropriate licenses, certifications and standards required by applicable state and federal laws.

2.18 Non-Solicitation. Neither Provider nor any entity or person associated with Provider shall solicit Enrollees on behalf of any other health plan in any way, including: (a) use of membership lists; (b)

letters to Enrollees; and (c) any other solicitation of Enrollees. Such solicitation shall be a material breach of this Agreement.

2.19 Requirements for Submission of Claims by Provider. Claims for payment shall be paid only if submitted to MHN or its designee within ninety (90) days, or in accordance with applicable state regulations. Provider shall not seek payment for claims submitted after this period from MHN or Enrollees, in the event that MHN does not pay for a claim not timely submitted. Notwithstanding the foregoing, in the event that MHN denies a claim submitted after the 90-day deadline on the basis that it was not submitted timely, upon demonstration by Provider of good cause for the delay through the provider dispute resolution process, MHN will adjudicate the claim as if it were timely submitted. Forms used in submitting claims shall be in a format approved by MHN (generally, HCFA 1500, CHAMPUS 500 or 501 and UB-92 forms are in an approved format). Claims shall include the following information: date(s) of service, patient name, Enrollee identification number or military identification number, sponsor's identification number, referring physician's names and license number, number of service units, diagnosis, billed dollar amount, Copayment amount (if applicable), CPT Code and procedure description.

2.20 Clinical Laboratory Improvement Act. If Provider provides laboratory services, Provider represents and warrants that such services are in compliance with the Clinical Laboratory Improvement Act ("CLIA") at such time as Health Care Financing Administration ("HCFA") mandates enforcement of the provisions of CLIA.

2.21 Referrals and Admissions to Non-Participating Providers. In the event a Provider determines that a Medically Necessary Covered Service required by an Enrollee is not available from a Participating Provider, Provider agrees to contact MHN before referring the Enrollee to a Non-Participating Provider, or, in the case of any Emergency Care, no later than the next business day, and will only refer to such Non-Participating Provider who Provider reasonably believes meets the credentialing standards established by MHN.

2.22 Facility and Participating Provider Groups. Facility (except where facility's contracted rate includes professional fees) and Participating Provider Groups agree that no physician or other Mental Health Care provider who is or becomes associated with such facility or Participating Provider Group, shall be allowed to render Covered Services to Enrollees, unless or until MHN has approved and contracted with such provider. Provider understands and agrees that MHN shall be free to deny participation under this Agreement to any such providers without any obligation to: (a) state a cause or provide an explanation for denying such addition; or (b) provide such provider with any right to appeal or any other due process.

2.23 Eligibility Determinations. Except for Emergency Care, Provider shall verify eligibility of Enrollees before providing Covered Services (and within 24 hours of Emergency Care). MHN shall make a good faith effort to confirm the eligibility of any Enrollee. Provider shall not hold MHN or the Payor financially responsible for services rendered to any person who was not eligible for benefits as determined by MHN or Payor.

2.24 Utilization Management Program. Provider agrees to participate in and cooperate fully with the provisions of and all decisions rendered in connection with MHN's Utilization Management Program. Provider agrees to render Covered Services at the most appropriate and least restrictive level of treatment, supply or care (including levels of acute care as determined by the clinical status of the Enrollee) which can safely be provided to the Enrollee, consistent with professionally recognized standards of practice. For hospitalization, this means that the Enrollee requires acute care as an inpatient due to the nature of the services the Enrollee is receiving, or the severity of the Enrollee's condition, and that safe and adequate care cannot be received as an outpatient or at a less restrictive setting.

2.25 Quality Improvement Program. The quality of Covered Services rendered to Enrollees shall be monitored under MHN's Quality Improvement Program, as modified from time to time upon forty

five (45) business days prior written notice in the case of material changes not required to comply with state or federal law or accreditation entities, and Provider agrees to participate in and cooperate fully with such Quality Improvement Program and to comply with decisions rendered by MHN in connection therewith. Provider agrees to provide medical and other records within five (5) calendar days of receipt of written notice, or within twenty four (24) hours when required in response to a regulatory review of an Enrollee grievance, at Provider's own expense, and review data and other information as may be required or requested under such Quality Improvement Program, including reporting in accordance with, but not limited to, the current Health Plan Employer Data and Information Set, or its successor. In the event that Provider's performance, including, but not limited to, its structures, processes or outcomes, is found unacceptable under any Quality Improvement Program, MHN shall give written notice to Provider to correct such deficiencies within the time period specified in the notice. Provider shall correct such deficiencies within that time period. In the event that Provider fails to correct such deficiencies to the satisfaction of MHN, MHN may terminate this Agreement as provided in Section 5.

2.26 Regulatory and Accreditation Surveys. Provider shall participate in and assist MHN with any review conducted by a regulatory agency or any accreditation survey or study.

2.27 Member Harmless. Provider agrees that, in no event, including, but not limited to, non-payment by MHN or Payor, insolvency of MHN or Payor, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against Enrollees, the State of California or persons or entities other than MHN or Payor for Covered Services provided under this Agreement, except for any applicable Copayment by Enrollee under a particular Benefit Plan.

Provider further agrees that: (a) this provision shall survive termination of this Agreement regardless of the cause giving rise to the termination and shall be construed to be for the benefit of Enrollees; and (b) this provision supersedes any oral or written contrary agreement existing or hereafter entered into between Provider and Enrollees or persons acting on their behalf. Any modification, addition or deletion of or to the provisions of this clause shall not be effective on a date earlier than fifteen (15) days after the applicable state regulatory agency has received written notice of such proposed change and has approved such changes.

2.28 Reimbursement of Overpayments. In the event that MHN determines that, in reimbursing a claim for provider services, the Provider has been overpaid, and then notifies Provider in writing through a separate notice within 365 days of the overpayment identifying the amount of the overpayment, Provider shall reimburse MHN within 30 working days of receipt by Provider of the notice of overpayment unless such overpayment or portion thereof is contested by the Provider, in which case MHN shall be notified, in writing, within 30 working days. The notice that an overpayment is being contested shall identify the portion of the overpayment that is contested and the specific reasons for contesting the overpayment. In the event the Provider fails to make payment of any undisputed amounts after two written notices, MHN will send a third notice stating that the undisputed amounts owed may be offset against future payments. When offsetting against future payments, MHN will identify the specific claim and amount that is being used to offset.

3. MHN'S Obligations.

3.1 Compensation to Provider. In consideration of the Medically Necessary Covered Services that Provider renders to Enrollees hereunder, MHN shall reimburse Provider in accordance with the following provisions and the Addenda hereto. Where any Addendum sets forth a provision that is inconsistent with the following provisions, the terms of the Addendum shall govern.

Notwithstanding any provision in the Agreement to the contrary, where MHN pays a Participating Provider Group or facility on a fee-for-service, all-inclusive per diem, program or capitated rate basis, and the Participating Provider Group or facility is responsible for payment of professional services, Provider shall look only to the Participating Provider Group or facility for payment of

Covered Services rendered to Enrollees.

3.1.1 Rate of Compensation. Provider shall accept as payment in full for Medically Necessary Covered Services rendered to Enrollees hereunder the lesser of billed charges or the amounts payable by Payor as set forth in Addendum M-1, or the rate schedule referenced in the Addendum or Addenda to the Agreement that applies to the Covered Service, less Copayments payable solely by Enrollees in accordance with the applicable Benefit Plan.

3.1.2 Exclusive Compensation by Payor. In the event that Payor fails, for whatever reason, to pay for Covered Services, the Enrollee receiving such services shall not be liable to Provider for sums owed by Payor under this Agreement, and Provider shall not maintain an action at law or initiate collection efforts against such Enrollee to collect such sums. Provider shall not charge Enrollee a fee for Covered Services other than the Copayments allowed under the applicable Benefit Plan. MHN shall take appropriate action upon notice that a surcharge is made in contravention of this Section.

MHN shall not be under any obligation to pay Provider for any claim, payment of which is the responsibility of another Payor under a particular Benefit Plan. However, in the event that Payor fails to pay Provider, MHN shall use reasonable efforts to assist Provider in obtaining such payment.

Neither an Enrollee nor Payor shall be liable for payment for (1) any service which is determined by MHN to be not Medically Necessary, (2) any service for which Prior Authorization of coverage and/or Primary Care Physician Referral is required under the applicable Benefit Plan as a prerequisite of coverage but which is not obtained, or (3) any service which is otherwise not covered under the Enrollee's Benefit Plan, except as otherwise provided in Section 2.5.

3.1.3 Time Requirements for Payment by MHN. Payor shall pay Provider within thirty (30) business days of receipt by Payor of a completed Clean Claim for Covered Services (45 business days in the case of HMO claims). Payor shall process all "unclean" claims within thirty (30) business days of their being made "clean". As used in this paragraph, a Clean Claim is one that is accurate, complete (i.e., inclusive of all information necessary to determine Payor liability), not a claim on appeal, and not contested (i.e., not reasonably believed to be fraudulent and not subject to a necessary release, consent or assignment). Provider shall submit requests for adjustments and/or appeals regarding claim payments to Payor within one hundred eighty (180) calendar days after the date of the payment of such claim to Provider. In the event that Provider fails to appeal a claim within such time period, Provider shall not have the right to appeal such claim.

3.1.4 Upon rejecting a claim from Provider or an Enrollee, and upon their demand, MHN will disclose the specific rationale used in determining why the claim was rejected.

3.2 Monitor Quality Management. MHN shall monitor Provider's quality management activities and compliance with MHN's quality management policies and procedures. MHN also shall monitor Provider's compliance with its credentialing, recredentialing and disciplinary policies and procedures.

3.3 Grievances and Appeals. MHN shall have primary and final responsibility for administering Enrollee and Provider grievances and appeals as described in MHN's policies and procedures and the Provider Manual.

3.4 Marketing. MHN and its designees shall conduct marketing, advertising and publicity relative to the solicitation of Benefit Plans as it deems necessary in MHN's sole discretion. Nothing in this Agreement shall be construed to require MHN to market the services of Provider or to refer a minimum or maximum number of Enrollees to Provider.

3.5 Adjudication and Payment of Provider Claims. Payor shall process and reimburse Provider's claims for Covered Services provided to Enrollees consistent with its claims procedures, medical policies and terms of the pertinent Benefit Plan.

3.6 Right of Set-off. In relation to any collection and payment of monies owed by Provider to Payor, Payor shall have the right to set-off any payments owed to Provider against any funds owing by Provider to MHN.

4. Term. This Agreement will have an initial term beginning on the Effective Date indicated on the signature page through September 30 of the following calendar year. The Agreement will renew automatically on October 1 of the following year and October 1 every year thereafter for successive one-year terms, unless either party notifies the other party at least ninety (90) calendar days prior to the scheduled renewal date of such party's intent not to renew this Agreement, or otherwise terminated as provided in Section 5.

5. Termination Provisions.

5.1 Termination by Either Party Without Cause. This Agreement may be terminated without cause by either party at any time upon ninety (90) calendar days prior written notice to the other party. In the event that MHN provides Provider with such notice, MHN may, at its option, begin to transition Enrollees immediately under this Agreement to another Participating Provider.

5.2 Immediate Termination. This Agreement shall immediately terminate upon notice to the effected party in the event of the occurrence of any of the following:

5.2.1 either party's violation of law or regulation pertinent to this Agreement, upon notice of said violation;

5.2.2 any act or conduct for which any of Provider's license, certifications or accreditation, to provide Covered Services may be revoked or suspended or for which Provider's ability to provide Covered Services in accordance with this Agreement is otherwise materially impaired;

5.2.3 Provider's failure to comply with MHN's Utilization Management Program, Quality Improvement Program, Benefit Plans, quality management policies, utilization management policies, credentialing criteria, medical policies, grievance and appeal procedures, or a determination of MHN's Medical Directors or designee;

5.2.4 any misrepresentation or fraud by either party, upon notice to such party;

5.2.5 Provider's failure to maintain professional liability insurance in accordance with this Agreement; or

5.2.6 MHN's determination that the health, safety or welfare of any Enrollee may be in jeopardy if this Agreement is not terminated.

5.3 Termination by Either Party Due to Material Breach of Agreement. Except as otherwise set forth above, this Agreement may be terminated by either party upon thirty (30) calendar days prior written notice to the other party if the party to whom notice is given is in material breach of any provisions of this Agreement. MHN may not terminate a Provider's Agreement on the grounds that Provider i) advocated on behalf of a member; ii) filed a complaint against MHN; iii) appealed a decision of MHN; or iv) requested a review or challenged a termination decision. The party claiming the right to terminate will set forth in the notice of intended termination the facts underlying the claim that the other is in breach of this Agreement. Remedy of the breach to the satisfaction of the party giving notice, within thirty (30) calendar days of receipt of notice, will nullify the intended termination and will revive this Agreement for the remaining term. In the event that such breach is not remedied to the satisfaction of the party giving notice within such 30-day period, such termination shall be

effective immediately upon the expiration of any applicable notice periods.

5.4 Termination by Change in Law or Regulation. This Agreement may be terminated by a change in law or regulation or a judicial interpretation thereof, which renders the terms of this Agreement illegal or unenforceable. Termination under this paragraph shall be effective on the effective date of the change in law or regulation, or judicial interpretation thereof.

5.5 No Further Force or Effect after Termination. Except as otherwise specified within this Agreement, following the effective date of termination, this Agreement will be of no further force or effect. Each party will remain liable for any obligations or liabilities arising from activities occurring prior to the effective date of termination.

5.6 Continuation of Certain Services. If any Enrollees are receiving Covered Services as of the date of termination of this Agreement (with or without cause), Provider will continue to arrange for the provision of Covered Services to those Enrollees in accordance with the terms of this Agreement until MHN arranges for alternative treatment, which will be arranged as soon as practicable, but in no event, beyond the termination date of the Enrollee's coverage under the pertinent Benefit Plan. Provider further agrees that in the event of MHN's and/or the applicable Payor's insolvency or other cessation of operations, benefits to Enrollees will continue until the effective date of the Enrollee's coverage in a successor plan selected through either open enrollment or the allocation process. Compensation for such Covered Services shall be at the rates contained in the applicable Addendum.

In the event that MHN terminates this Agreement for reasons other than quality of care concerns, Enrollees may request continuity of care from Provider for a period of up to ninety (90) calendar days (or additional time if required by applicable state or federal laws or regulations), for Medically Necessary care for treatment of acute or serious chronic conditions. Such period may be longer if necessary to facilitate an appropriate transition to another provider, as determined by MHN, in consultation with Provider, consistent with good professional practice. Provider agrees to be subject to the same contractual terms and conditions that are imposed herein, including, but not limited to, rates, credentialing, hospital privileging, utilization review, peer review and quality assurance requirements. In the event that Provider does not agree to and/or comply with such requirements, MHN shall not be obligated to continue Provider's services beyond the termination date.

5.7 Transfer of Enrollees after Termination. Upon notice of termination of this Agreement, MHN will provide notice of such termination to Enrollees who are receiving a course of treatment from Provider. Provider agrees to cooperate in an orderly transfer of Enrollees to other designated health care providers to protect the medical and mental health needs of Enrollees in the transfer. MHN will direct to who this transfer is to be made.

5.8 Termination with Respect to Any Line of Business or Affiliate. MHN may terminate this Agreement with respect to any line of business or Affiliate upon thirty (30) calendar days prior written notice to Provider. Such termination shall not affect any other line of business or Affiliate.

6. Confidentiality Provisions. The parties hereby agree to hold all confidential or proprietary information or trade secrets of each other in trust and confidence and agree that such information shall be used only for the purposes contemplated herein, and shall not be used for any other purpose. Specifically, Provider acknowledges that the names, addresses and other identifying information concerning Enrollees, employers and other groups contracting with MHN constitute confidential information which derives independent economic value from not being generally known or readily accessible to others who can obtain economic value from its disclosure or use. Moreover, it is understood that Provider and MHN shall release Enrollee-related behavioral health information and records that contain individual identifying information and Provider-specific information only in accordance with applicable state and federal laws. Provider also shall keep strictly confidential all compensation arrangements set forth in this Agreement and its addenda.

Notwithstanding the above, Provider agrees to maintain for each Enrollee, who obtains services, a consolidated medical record which shall meet generally acceptable professional standards and applicable legal

and MHN requirements, and document all services provided to Enrollees by Provider. Such information shall be maintained by the parties hereto pursuant to procedures designed to protect the confidentiality of patients' medical records in accordance with applicable state and federal requirements, recognized standards of professional practice and MHN's policies and procedures. This provision shall survive termination of this Agreement.

7. Audit Rights. To the extent permitted by applicable laws and regulations, MHN and state and federal governmental departments, agencies, authorities and peer review organizations, shall have the right to conduct, at reasonable times, upon reasonable advance notice, financial audits, medical audits and evaluations of Provider's records and facilities with respect to services provided under this Agreement. In conducting any medical audit, MHN shall not be entitled to examine medical or mental health records of patients who are not Enrollees. Provider shall furnish copies of financial, medical and mental health records, when requested by MHN for the purpose of an audit, at no charge to MHN.

8. Mandatory Arbitration. The parties agree to meet and confer in good faith to resolve any problems or disputes that may arise under this Agreement. Such negotiation shall be a condition precedent to the filing of any arbitration demand by either party.

   The parties agree that any controversy or claim arising out of or relating to this Agreement (and any previous agreement between the parties if this Agreement supersedes such prior agreement) or the breach thereof, whether involving a claim in tort, contract or otherwise, shall be settled by final and binding arbitration in accordance with the provisions of the American Arbitration Association. The parties waive their right to a jury or court trial.

   The arbitration shall be conducted in the state where the Provider practices. A single, neutral arbitrator who is licensed to practice law shall conduct the arbitration. The complaining party serving a written demand for arbitration upon the other party initiates these arbitration proceedings. The written demand shall contain a detailed statement of the matter and facts supporting the demand and include copies of all related documents. MHN shall provide Provider with a list of three neutral arbitrators from which Provider shall select its choice of arbitrator for the arbitration. Each party shall have the right to take the deposition of one individual and any expert witness designated by another party. At least thirty (30) days before the arbitration, the parties must exchange lists of witnesses, including any experts (one of each for MHN and Provider), and copies of all exhibits to be used at the arbitration. Arbitration must be initiated within 6 months after the alleged controversy or claim occurred by submitting a written demand to the other party. The failure to initiate arbitration within that period constitutes an absolute bar to the institution of any proceedings.

   Judgment upon the award rendered by the arbitrator may be entered in any court having competent jurisdiction. The decision of the arbitrator shall be final and binding. The arbitrator shall have no authority to make material errors of law or to award punitive damages or to add to, modify or refuse to enforce any agreements between the parties. The arbitrator shall make findings of fact and conclusions of law and shall have no authority to make any award that could not have been made by a court of law. The prevailing party, or substantially prevailing party's costs of arbitration, are to be borne by the other party, including reasonable attorney's fees.

9. Relationship of Parties. MHN and Provider are independent contractors in relation to one another and no joint venture, partnership, employment, agency or other relationship is created by this Agreement. Neither MHN nor Provider is authorized to represent the other for any purposes. Neither of the parties hereto, nor any of their respective officers, agents or employees shall be construed to be the officer, agent or employee of the other party.

10. Indemnification of Parties. Neither Provider nor MHN (nor any of their respective agents, officers or employees) shall be liable to the other for any acts or omission of the other party. Provider agrees to indemnify, defend and hold harmless MHN, its agents, officers and employees from and against any and all liabilities, losses, damages, claims and expenses of any kind, including costs and legal fees, incurred in connection with claims for damages of any nature whatsoever, including but not limited to, bodily injury, death, personal injury or property damage arising from or in connection with the Provider's performance of,

or failure to perform its duties and obligations under this Agreement. Likewise, MHN agrees to indemnify, defend and hold harmless Provider, its agents, officers and employees from and against any and all liabilities, losses, damages, claims and expenses of any kind, including costs and legal fees, incurred in connection with claims for damages of any nature whatsoever, including but not limited to, bodily injury, death, personal injury or property damage arising from or in connection with the MHN's performance of, or failure to perform its duties and obligations under this Agreement.

11. No Third Party Beneficiary. Nothing in this Agreement is intended to be construed or deemed to create any rights or remedies in any third party beneficiary, including an Enrollee.

12. No Notice to Beneficiaries. Provider and MHN reserve the right to amend this Agreement and any of its provisions, to waive any rights granted to either party hereunder, and to terminate this Agreement without notice or consent of any Enrollee.

13. Governing Law. This Agreement shall be governed by the laws of the state in which Provider practices, except where otherwise required by federal law, such as CHAMPUS business which shall be governed by federal law in general and specifically by CHAMPUS Regulations (found at DoD 6010.8-R), and the CHAMPUS/TRICARE Operations Manual and Policy Manual.

14. Knox-Keene Health Care Service Plan Act of 1975. (California only). Managed Health Network, one of the Affiliates of MHN, Inc. and Health Net of California, Inc., is subject to the requirements of the Act as amended and the regulations promulgated thereunder, and any provision required to be in this Agreement by either of the above shall bind Managed Health Network and Health Net of California, Inc. whether or not provided herein, and Provider, in turn, shall be similarly obligated to the extent that such obligations are to be performed by Provider under this Agreement.

15. Amendments. All amendments to this Agreement proposed by Provider must be agreed to in writing in advance of the effective date by MHN. Any material amendments to this Agreement proposed by MHN will be deemed effective upon the expiration of forty-five (45) business days' written notice to Provider of the proposed amendment unless, within such 45-day period, Provider notifies MHN in writing of Provider's rejection of the requested amendment. Amendments required because of legislative, regulatory, accreditation or legal requirements, as well as non-material changes, are not subject to this 45-day requirement and will be effective immediately on the proposed effective date thereof.

16. Separate Obligations. The rights and obligations of MHN under this Agreement shall apply to each Affiliate listed on Addendum A to this Agreement only with respect to the Benefit Plans provided or administered by such Affiliate. No such Affiliate shall be responsible for the obligations of any other Affiliate under this Agreement with respect to the other Affiliate's Benefit Plans. In no event shall MHN or an Affiliate be responsible for any payment that is the financial responsibility of another Payor, and Provider shall seek compensation for such services only from the applicable Payor.

17. Non-Exclusive Contract. This Agreement is non-exclusive and shall not prohibit Provider and MHN from entering into agreements with other health care providers or purchasers of health care services.

18. Entire Agreement. This Agreement supersedes any and all other agreements, either oral or written, between the parties with respect to the subject matter hereof, and no other agreement, statement or promise relating to the subject matter of this Agreement will be valid or binding.

19. Addenda. All addenda mentioned in the body of this Agreement are hereby incorporated by reference as if set forth in full herein.

20. Assignment. Provider may not assign this Agreement, or delegate or subcontract any duties, rights and obligations under this Agreement, to any other person or entity. For purposes of the Agreement, any effective changes in control of ownership of Provider, including sale of stock of Provider or sale of all or substantially all assets of Provider shall be construed hereunder as an assignment and thus require MHN's prior written consent. MHN shall have the right to sell, transfer, convey or assign this Agreement to any successor,

subsidiary, parent or Affiliate and such assignee shall acquire all of the rights, duties and obligations of MHN as set forth herein.

21. Notice. Any notice required under this Agreement will be given in writing and sent by certified mail, return receipt requested or overnight courier to the applicable address appearing on the signature page of this Agreement. Any changes to these addresses shall be designated by notice.

22. Severability. The provisions of this Agreement are severable. If any provision of this Agreement is held to be invalid, illegal or otherwise unenforceable in any jurisdiction, the holding shall not affect the remaining provisions of this Agreement and shall not in any other jurisdiction, unless the effect of the severance would be to substantially alter this Agreement or the obligations of the parties hereto, in which case, this Agreement may be immediately terminated pursuant to Section 5.4.

23. Waiver of Breach. The waiver of any breach of this Agreement by either party hereto will not constitute a continuing waiver or a waiver of any subsequent breach of either the same or any other provision of this Agreement.

24. Insolvency. For California providers, in the event of MHN's insolvency, any provision of this Agreement inconsistent with Health & Safety Code Section 1394.8© will be void.

ADDENDUM A

MHN, INC. AND AFFILIATES

Upon execution of this Agreement, the Affiliates primarily using this Agreement include, but are not limited to, the following: Health Net Federal Services, LLC, and any other Affiliate as defined in Section 1.1 of this Agreement.

ADDENDUM B, C, D, E, F

Not applicable

ADDENDUM G
TRICARE PROGRAM

This Agreement ("Agreement") is made between Managed Health Network, Inc. ("MHN") and ("Provider") and entirely supercedes the terms of prior Agreements as respect to Provider's provision of Contracted Services to Beneficiaries enrolled in the TRICARE Program. For purposes of this Agreement, Health Net Federal Services, LLC ("HNFS") a wholly-owned subsidiary of Centene Corporation is made a party to the Agreement.

RECITALS

A. Provider has the legal authority to enter into this Agreement, and to deliver or arrange for the delivery of Contracted Services.

B. HNFS has the legal authority to enter into this Agreement and to perform the obligations of HNFS hereunder with respect to the TRICARE Program.

C. The parties desire to enter into this Agreement to arrange for Provider to participate in HNFS' network of providers that render Contracted Services to Beneficiaries of the TRICARE Program.

AGREEMENT

I. DEFINITIONS

The following terms are capitalized throughout this Agreement to indicate that they are defined as set forth in this Section.

1.1 **Beneficiary.** A person who is properly enrolled in and/or eligible to receive Covered Services under the TRICARE Program at the time services are rendered**.**

1.2 **Clean Claim.** A Clean Claim means a request submitted to HNFS by Provider for payment of Contracted Services that may be processed by HNFS: (i) without obtaining additional information from Provider or from a third party; (ii) without requiring special treatment or (iii) when HNFS has no reason to believe that the claim has been submitted fraudulently. The specific data elements required for a claim to be deemed a Clean Claim are included in HNFS Policies and may be modified from time to time by HNFS in its sole discretion with notice to Provider.

1.3 **Contracted Services.** All Covered Services that are (a) within the appropriate scope of practice of Provider and (b) provided to a Beneficiary under the terms of the TRICARE Program in effect at the time services are rendered and (c) compensated in accordance with this Agreement. Contracted Services shall not include Excluded Services.

1.4 **Coordination of Benefits (COB).** The allocation of financial responsibility between two or more payors of health care services, each with a legal duty to pay for or provide Covered Services to a Beneficiary at the same time.

1.5 **Cost-Share.** The amount a Beneficiary must pay for covered inpatient and outpatient services (other than the Deductible, the annual TRICARE Prime enrollment fee, the balance billing amount, or disallowed amounts) as set forth in 32 C.F.R. §§ 199.4, 199.5, and 199.17. Under TRICARE, Cost-Shares are expressed in one of two ways: coinsurance, whereby the Beneficiary's Cost-Share is expressed as a percentage of allowed charges; and copayment, whereby the Beneficiary's Cost-Share is expressed as a predetermined, fixed amount.

1.6 **Covered Services.** The health care services, equipment and supplies that are covered under the TRICARE Program.

1.7 **Deductible.** The amount of money that a Beneficiary must pay before the TRICARE Program pays certain benefits for Covered Services. Deductibles do not include Cost-Shares.

1.8 **Emergency.** The term "Emergency" shall mean a medical condition manifesting itself by acute symptoms of sufficient severity, including but not limited to, severe pain, psychiatric disturbances and/or symptoms of substance abuse such that a prudent layperson who possesses average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: (a) placing the health of the individual (and in the case of a pregnant woman, her health or that of her unborn child) in serious

jeopardy; (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part.

1.9 **Emergency Services.** Covered Services that are needed immediately because of an Emergency.

1.10 **Excluded Claim.** A claim retained while being developed for missing or discrepant information that cannot be obtained from in-house sources; a third party liability claim requiring development; a claim requiring Government intervention; or a claim requiring interface with other contractors.

1.11 **Excluded Services.** Those health care services, equipment and supplies that are determined by HNFS not to be Covered Services under the TRICARE Program in effect at the time Contracted Services are rendered and for which Provider may bill the Beneficiary.

1.12 **Facility(ies).** All service locations operated or subcontracted by Provider at the time that Contracted Services are provided under this Agreement. Provider's service locations and their respective accreditations/certifications as of the date this Agreement is executed by the parties are listed on the signature page of this Agreement. Provider shall update the listing of service locations and accreditations/certifications on the signature page of this Agreement as changes, additions or deletions occur, but failure to update shall not be deemed or construed to exclude any service location from the definition of Facilities under this Section.

1.13 **Group Providers.** The physicians and allied health professionals who contract with Provider, or are employed by Provider, to provide Covered Services to Beneficiaries, when Provider is not an individual practitioner (i.e., when Provider is not a natural person).

1.14 **HNFS.** A network of managed health care delivery or indemnity companies, owned, controlled, controlling, under common control with, managed or administered in whole or in part now or hereafter, by Centene Corporation, its successors and assigns.

1.15 **HNFS Policies.** The policies, procedures and programs established by HNFS and applicable to Network Providers in effect at the time Contracted Services are rendered, including without limitation HNFS's grievance and appeal procedures, provider dispute and/or administrative review process, drug formulary or preferred drug list, fraud detection, recovery procedures, eligibility verification, payment and coding guidelines, anti-discrimination requirements, medical management programs, TRICARE Program requirements, and the Network Provider Manual. The medical management program includes HNFS's credentialing, utilization management, quality improvement, peer review, medical and other record reviews, outcome rate reviews, Prior Authorization, Referral and other policies related to the rendition by Network Providers of Covered Services to Beneficiaries.

1.16 **Inpatient Services.** Those Covered Services which include, but are not limited to: (a) bed and board; (b) medical, nursing, surgical, pharmacy and dietary services; (c) all diagnostic and therapeutic services required by Beneficiary when ordered by an attending physician with appropriate medical and clinical staff privileges; (d) use of Facilities, and medical, mental health, social, and discharge planning services required for the provision of Covered Services; (e) drugs while an inpatient, take-home drugs, implants, supplies, appliances and equipment; (f) transportation services subsequent to admission and prior to discharge required in providing Covered Services; (g) services, including but not limited to, diagnostic testing or Emergency Services rendered within three (3) days at the hospital prior to a Beneficiary's admission as an inpatient, which are related to the condition for which the Beneficiary is admitted and (h) observation services.

1.17 **Institutional Provider.** The facilities, organizations, systems and other health care entities which are not Professional Providers, but are owned, or contracted by, or managed by Provider and which have been accepted by HNFS to provide Contracted Services to Beneficiaries.

1.18 **Medically Necessary.** Those Covered Services which are determined under the applicable Utilization Management Program to be:

(a) Appropriate and necessary for the symptoms, diagnosis or treatment of a medical condition;
(b) Provided for the diagnosis or direct care and treatment of a medical condition;
(c) Within standards of good medical practice within the organized medical community of the treating provider;
(d) Not primarily for the convenience of the Beneficiary or the treating provider;
(e) Consistent with HNFS Policies and TRICARE Regulations; and
(f) The most appropriate and cost-effective service or supply consistent with generally accepted medical standards of care. For inpatient stays, this means that acute care as an inpatient is necessary due to the

kind of services the Beneficiary is receiving or the severity of the Beneficiary's condition, and that safe, cost-effective and adequate care cannot be received as an outpatient or in a less intensive medical setting.

1.19 **Medicare Eligible.** A Beneficiary age sixty-five (65) or older or a disabled Beneficiary under age sixty-five (65) who is eligible for care under Parts A and B of the Medicare entitlement program.

1.20 **Military Treatment Facility (MTF).** A military hospital or clinic.

1.21 **National Quality Monitoring Contractor (NQMC).** A NQMC is a national, external, independent, and impartial peer review contractor responsible for oversight of review related activities conducted under the TRICARE Program, including responsibility for provision of reconsideration, review of concurrent review denial determinations and appeal of reconsiderations of underwritten contractor review decisions.

1.22 **Network Provider.** A Facility, physician, physician organization, other health care professional, supplier, or other entity engaged in the delivery of health care services which are licensed and/or certified as required under applicable federal and state law and which has been duly credentialed by HNFS and has, or is governed by, an effective written agreement directly with HNFS, or indirectly through another entity, such as another Network Provider, to provide Covered Services.

1.23 **Network Provider Manual.** Manuals and/or handbooks provided by the TRICARE Program or HNFS for Network Providers in the HNFS TRICARE Program. The Network Provider Manual will be updated from time-to-time as well as through provider newsletters, bulletins or supplemental manuals or handbooks.

1.24 **Organizational Provider.** When Provider is other than an individual practitioner

1.25 **Outpatient Services.** Those services generally and customarily provided at a Facility to a Beneficiary who is not admitted to an inpatient facility, including without limitation, Emergency Services, observation, outpatient and short stay surgery, day program, clinic care, and related nursing, surgical, pharmaceutical, dietary, diagnostic and ancillary services.

1.26 **Preventive Care.** Those Covered Services intended to remove or reduce disease risk factors and promote early detection of disease or precursor states. Health education and behavior modification are two of the most effective and economical means of disease control.

1.27 **Primary Care Manager (PCM).** A TRICARE Prime military/civilian network provider or network clinic site, or clinic site at an MTF whose primary responsibility is to coordinate and manage the delivery of Covered Services to Beneficiaries selected or assigned to such provider.

1.28 **Prior Authorization.** Prior approval by HNFS for the rendition of Covered Services that may be required under the TRICARE Program or a HNFS Policy.

1.29 **Professional Provider.** The physicians, allied health professionals and other health care providers who contract with Provider, or are employed by Provider, and who have been accepted by HNFS to provide Contracted Services to Beneficiaries.

1.30 **Quality Management and Improvement Program.** The functions, including, but not limited to, credentialing and certification of providers, recredentialing and recertification of providers, review and audit of medical and other records, Health Plan Employer Data and Information Set (HEDIS) or similar measure evaluations, outcome rate reviews, peer review and administrative review and grievance procedures performed or required by HNFS, or any other person or entity designated by HNFS or the Department of Defense, to review the quality of Covered Services rendered to Beneficiaries.

1.31 **Referral.** The written approval from the Beneficiary's PCM and usually for a specified number of visits, treatments, or period of time not to exceed one (1) calendar year, in relation to the diagnosis as indicated by the Beneficiary's PCM, required under a Utilization Management Program for a Beneficiary to receive Covered Services from a physician (usually a specialist) or other health care professional or organization.

1.32 **Retained Claim.** A claim that contains sufficient information to allow processing to completion or for which any missing information may be developed from in-house sources, including DEERS and contractor operated or maintained electronic, paper, or film files.

1.33 **Supplemental Health Care Program (SHCP).** A program for U.S. military active duty personnel who are referred to a civilian provider for care, usually for a specific test, procedure or consultation.

1.34 **TRICARE Prime.** An HMO-like option, provided as part of the TRICARE Program under 32 C.F.R. § 199.17, where Beneficiaries elect to enroll in a voluntary enrollment program which provides TRICARE benefits and enhanced primary and preventive benefits with nominal Beneficiary cost-sharing. TRICARE

Prime generally requires Beneficiaries to use a PCM located at either an MTF or from a TRICARE contractor's network.

1.35 **TRICARE Prime Areas.** A forty (40) mile radius around each (i) catchment area (i.e., geographic area determined by the Assistant Secretary of Defense for Health Affairs that is defined by a set of five digit zip codes, usually within an approximately forty (40) mile radius of a military inpatient treatment facility), (ii) Department of Defense Base Realignment and Closure (BRAC) sites, and (iii) all additional areas or sites designated by HNFS or the TRICARE Program.

1.36 **TRICARE Prime Remote (TPR).** Active duty service members (and family dependents, where applicable) who are assigned to permanent duty stations that are not near sources of military medical care.

1.37 **TRICARE Program (TRICARE).** The Department of Defense's managed health care program for U.S. military active duty personnel, service families, retirees and their families, survivors, and other TRICARE-eligible Beneficiaries purchased by the United States Government through the authorized agency pursuant to Chapter 55 of Title 10 of the United States Code and the regulations promulgated thereunder. TRICARE is a blend of the military's direct care system of hospitals and clinics and civilian providers.

1.38 **TRICARE Regulations.** All applicable TRICARE regulations, operations manuals, system manuals, policy manuals and reimbursement manuals, including, but not limited to: Title 10, United States Code, Chapter 55; 32 C.F.R., Part 199; TRICARE Operations Manual (TOM); TRICARE Policy Manual (TPM); TRICARE Reimbursement Manual (TRM); and TRICARE Systems Manual (TSM) .

1.39 **Urgent Care**. Medically Necessary treatment that is required for illness or injury that would not result in further disability or death if not treated immediately. The illness or injury does require professional attention, and should be treated within twenty-four (24) hours to avoid development of a situation in which further complications could result if treatment is not received.

1.40 **Utilization Management Program.** The functions, including, but not limited to Prior Authorization, Referral and prospective, concurrent and retrospective review, performed or required by HNFS, or any other person or entity, to review and determine whether medical services or supplies which have been or will be provided to Beneficiaries are covered under the TRICARE Program and are Medically Necessary.

II. REPRESENTATIONS AND DUTIES OF PROVIDER

2.1 **Contracted Services.** Provider shall provide Contracted Services to Beneficiaries in accordance with the terms and conditions of the TRICARE Program and TRICARE Regulations. Provider shall be solely responsible for the quality of Contracted Services rendered by Provider to Beneficiaries. In the event that Provider is uncertain as to whether or not a service is a Contracted Service, Provider shall make reasonable efforts to contact HNFS to obtain a coverage determination subject to Section 4.5 hereof prior to the rendition of the service. If applicable, Provider shall render Preventive Care to Beneficiaries during each office visit and document such Preventive Care in the medical record in accordance with external reporting and accrediting bodies such as the National Committee on Quality Assurance (NCQA), The Joint Commission (TJC), or the Utilization Review Accreditation Commission (URAC).

Notwithstanding the foregoing, Provider understands and agrees that HNFS does not have an obligation under this Agreement to assign or refer to Provider any minimum number of Beneficiaries. HNFS has not represented or guaranteed to Provider that any Beneficiaries shall receive Covered Services from Provider or that Provider shall participate in all networks offered by or through HNFS.

2.2 **Representations, Warranties and General Obligations.** Provider represents, warrants and agrees on behalf of itself, and each of its Facilities and Professional Providers, as applicable, that:

2.2.1 Provider is licensed without restriction or limitation by the applicable state to provide Contracted Services;

2.2.2 Provider operates and provides Contracted Services in compliance with all applicable local, state, and federal laws, rules, regulations and institutional and professional standards of care;

2.2.3 Provider is a TRICARE-authorized and certified provider pursuant to 32 C.F.R. § 199.6;

2.2.4 Provider shall comply with all applicable TRICARE Regulations;

2.2.5 Provider, where applicable, holds a current DEA narcotic registration certificate and/or current state narcotics license;

2.2.6 Provider shall maintain all required professional credentials and meet all continuing education

requirements necessary to retain Board certification or eligibility in Provider's area(s) of practice;

2.2.7 Provider shall participate on all claims and submit claims on behalf of all Beneficiaries;

2.2.8 Provider shall maintain a professional relationship with each Beneficiary for whom Provider renders Contracted Services, and shall be responsible solely to such Beneficiary for treatment and medical care;

2.2.9 Provider, where applicable, shall maintain staff privileges in a hospital accredited by The Joint Commission ("TJC") or comply with alternative qualification standards as established by HNFS;

2.2.10 Provider is certified to participate in Medicare under Title XVIII of the Social Security Act, for those classes of providers recognized by Medicare, and in Medicaid under Title XIX of the Social Security Act and other applicable state law pertaining to Title XIX of the Social Security Act. Provider has either signed a participation agreement with Medicare or agrees to participate with Medicare on a claim-by-claim basis;

2.2.11 Provider is accredited or certified by the accrediting or certifying organization(s) listed on the signature page of this Agreement, if any;

2.2.12 Provider shall notify HNFS in writing, thirty (30) days in advance, of any changes to Provider's federal tax identification numbers. Provider agrees to compensate HNFS for any IRS fine associated with incorrect federal tax identification numbers, should Provider fail to notify HNFS in writing, prior to the change;

2.2.13 Provider shall maintain applicable licensure, compliance, certification and accreditation throughout the term of this Agreement;

2.2.14 Provider has the unqualified authority to, and hereby does bind itself, and any Facilities and Professional Providers covered by this Agreement (referred to herein collectively as "Provider"), to the terms and conditions of this Agreement, including any HNFS Policies, appendices, schedules, attachments and exhibits, extensions and renewals, as applicable in effect at the time Covered Services are rendered. In the event Provider does not possess the right to legally bind any of its Facilities or Professional Providers to this Agreement, Provider shall ensure that each such Facility or Professional Provider executes a statement in a form acceptable to HNFS attesting to the fact that he/she/it has read this Agreement and agrees to be bound thereto;

2.2.15 If Provider renders services on behalf of, or as an affiliate, contractor or agent for another healthcare organization, entity or individual that is contracted with HNFS, where that other healthcare organization, entity or individual is to be compensated by HNFS and/or has assumed responsibility for claims payment for certain Beneficiaries, Provider agrees that it shall hold HNFS harmless and will seek payment under the terms of this Agreement for services rendered to those Beneficiaries solely and exclusively from that healthcare organization, entity or individual, and shall not under any circumstances seek payment directly from HNFS or from a Beneficiary. Provider further agrees that any claims for such services submitted directly to HNFS shall be denied as a duplicate payment. Provider shall comply with HNFS Policies during the term of this Agreement and any extensions or renewals thereof;

2.2.16 Provider shall render Contracted Services using the same standard of care, skill and diligence as is customarily used by similar providers in the United States of America, and in the same manner, and with the same availability, as Provider renders services to its other patients;

2.2.17 Provider shall maintain such physical plant, equipment, patient service personnel and allied health personnel as may be necessary to provide Contracted Services;

2.2.18 Provider, if a PCM, will cooperate with HNFS to assure twenty-four (24) hour, seven (7) day a week coverage for Emergency Services and Urgent Care;

2.2.19 Provider acknowledges that HNFS is relying upon the representations, warranties, and general agreements set forth in this section in making its decision to enter into this Agreement and in performing its obligations under this Agreement. The representations, warranties and general agreements set forth in this Section 2.2 are continuing and shall survive termination of this Agreement with respect to Contracted Services delivered during the term of this Agreement and any extensions or renewals thereof.

2.2.20 With respect to the submission of a claim by a physician or supplier or their representative, Provider

certifies that the services shown on the claim are medically indicated and necessary for the health of the patient and were personally furnished by the physician/supplier or furnished incident to his/her professional service by his/her employee under his/her immediate personal supervision, except as otherwise permitted by Medicare or TRICARE regulations. For services to be considered as "incident" to a physician's professional service:

•They must be rendered under the physician's immediate personal supervision by his/her employee;

•They must be an integral, although incidental part of a covered physician's service;

•They must be of kinds commonly furnished in physician's offices; and

•The services of non-physicians must be included on the physician's bills.

2.2.21 Provider, as a non-institutional network provider/supplier, further certifies that he/she (or any employee) who rendered services is not an active duty member of the Uniformed Services or a civilian employee of the U.S. Government (refer to 5 United States Code (USC) 5536). Anyone who misrepresents or falsifies essential information to receive payment from Federal funds may upon conviction be subject to fine and imprisonment under applicable Federal law.

2.2.22 Provider shall provide HNFS with a current and working facsimile (fax) number, e-mail address, and Prior Authorization and Referrals fax number as set forth herein. The information requested in this paragraph shall initially be provided in provider agreement, as set forth on signature line. Subsequently, Provider agrees that if any of the below fax numbers or e-mail address change, Provider agrees to formally notify HNFS within five (5) business days in accordance with Section 7.11 and provide new numbers or addresses within that time frame.

(a) Provider shall provide a current, updated fax number to be utilized for official legal notices with respect to modifications or other contract changes, as well as for general information notice purposes;

(b) Providers shall provide a current, updated e-mail address to be utilized for official legal notices with respect to modifications or other contract changes, as well as for general information notice purposes; and,

(c) Providers shall provide a current, updated fax number for Prior Authorization and Referral purposes.

2.3 **Organizational Provider.** When Provider is other than an individual practitioner:

(a) Provider warrants that Provider has the authority to contract on behalf of the Group Providers and to bind them to all of the terms and provisions of this Agreement. Provider will provide HNFS with representative agreements or certified excerpts thereof demonstrating such authority. Provider will notify Group Providers of their rights and duties under this Agreement, and of all amendments and modifications thereto.

(b) Provider agrees to provide HNFS with copies of Provider's current standard agreements with Group Providers concurrently with the execution of this Agreement and, thereafter, upon each anniversary of the Agreement's Effective Date, Provider's written policies and procedures pursuant to such agreements, and Provider's bylaws and articles of incorporation and any modifications thereto. No such modification shall affect the terms of the Agreement unless HNFS and Provider agree in writing to make such modification part of this Agreement within ninety (90) days of the Agreement's renewal date.

(c) Provider represents that the terms of this Agreement do not conflict with the terms of its agreements with Group Providers; nonetheless, Provider represents that the terms of this Agreement shall apply in any situation where there is an inconsistency or conflict with the terms of any agreement between Provider and any of the Group Providers or with respect to any matter which is not addressed in any such agreement, and that Provider shall be responsible to HNFS for any such inconsistency or conflict in terms. This provision shall supersede any similar provision in any agreement between Provider and any of the Group Providers.

(d) Provider shall provide HNFS with a list of the names; specialties; gender; practice locations; work address, work fax number, work telephone number and work email address for each practice location; federal tax identification numbers; medical practice license numbers; DEA number; Medicare certification number; professional practice name and legal partnerships; whether or not

they are accepting new or additional Beneficiaries; status as a member of the Reserve Component or National Guard; and the business hours of all physicians and allied health professionals that contract with Provider, and such other information as HNFS may reasonably request, in a format acceptable to Provider and HNFS. HNFS shall notify Provider of all such physicians and allied health professionals approved by HNFS to be Group Providers. Provider shall provide HNFS with at least a monthly list of additions, deletions and address changes to the list of Group Providers, and shall provide HNFS a complete listing of Group Providers annually. Nothing herein shall prohibit or restrict Provider from seeking to include additional physicians and other providers of health care as Group Providers under this Agreement.

(e) Provider shall utilize its best efforts to ensure that all Group Providers comply with all applicable terms and conditions of this Agreement and that such terms and conditions are included in Provider's agreements with individual Group Providers.

(f) Provider shall notify HNFS in writing at least ninety (90) days prior to any action by Provider to terminate Provider's agreement with one of the Group Providers or Provider's agreement with any individual provider who is associated with the Group Providers. When ninety (90) days prior notice is not possible, Provider shall provide as much advance notice of such action as possible. Provider shall immediately notify HNFS whenever one of the Group Providers fails to renew his or her agreement with Provider, whenever Provider has reason to believe one of the Group Providers will fail to renew his or her agreement with Provider, and whenever Provider knows of an occurrence constituting grounds for the immediate termination of one of the Group Providers under this Agreement.

(g) Provider shall terminate the participation of one of the Group Providers under this Agreement immediately upon request of HNFS, after consultation with the group, in the event of:

(i) The provider's failure to comply with HNFS's Utilization Management Program, Quality Management and Improvement Program and/or HNFS's credentialing and recredentialing criteria;

(ii) Any misrepresentation or fraud by the provider in the credentialing and recredentialing process;

(iii) Any action by the provider which, in the reasonable judgment of HNFS, constitutes gross misconduct;

(iv) The provider's failure to maintain professional liability insurance in accordance with the Agreement;

(v) The provider's loss, suspension or restriction of his or her license to practice medicine, narcotic registration certificate issued by the Drug Enforcement Administration ("DEA"), certification to participate in Medicare or Medicaid, or loss of medical staff privileges.

2.4 **Performance Provisions.** Provider shall provide Covered Services to Beneficiaries in accordance with the following terms:

(a) Provider will cooperate with HNFS in the assumption and conduct of review activities;

(b) Provider will allocate adequate space for the conduct of on-site review;

(c) Provider will photocopy and deliver to HNFS all required information within thirty (30) days of a request for off-site review;

(d) Provider will provide Beneficiaries, in writing, their rights and responsibilities, as specified in the Network Provider Manual;

(e) Provider will inform HNFS within three (3) days if it issues a notice that the Beneficiary no longer requires inpatient care;

(f) Provider will assure that each case subject to preadmission/procedure review Prior Authorization has been reviewed and approved by HNFS;

(g) Provider agrees, when it fails to obtain Prior Authorization as required, to accept financial liability for any Covered Service admission subject to preadmission review for Prior Authorization that was not reviewed;

(h) Provider agrees to accept full financial liability for any admission Covered Service that is subsequently found to be medically unnecessary or provided at an inappropriate level;

(i) Provider agrees to provide sufficient information and opportunity for Beneficiaries to decide among treatment options consistent with the informed consent process;

(j) Provider agrees to discuss all treatment options with Beneficiaries in a culturally competent manner, including the option of no treatment at all;

(k) Provider agrees to ensure that Beneficiaries with disabilities have effective communications with members of the health system in making such decisions;

(l) Provider agrees to discuss all current treatments with a Beneficiary that the Beneficiary may be undergoing;

(m) Provider agrees to discuss all risks, benefits, and consequences to treatment or nontreatment to a Beneficiary;

(n) Provider agrees to give a Beneficiary the opportunity to refuse treatment and to express preferences about future treatment decisions;

(o) Provider agrees to discuss the use of advance directives -- both living wills and durable powers of attorney for health care -- with Beneficiaries and their designated family members; and

(p) Provider agrees to abide by the decisions made by their Beneficiaries and/or their designated representatives consistent with the informed consent process; and

(q) HNFS will provide detailed information on the review process and criteria used, including financial liability incurred by failing to obtain Prior Authorization.

2.5 **TRICARE Maximum Allowable.** Provider acknowledges and agrees that the maximum amount reimbursed for services provided by the Provider under this Agreement is prescribed by TRICARE/CHAMPUS regulations as published in the Federal Register, and regardless of what is stated in this Agreement and/or Compensation Schedule, the Provider shall not receive and/or shall not accept any reimbursement in excess of the TRICARE/CHAMPUS Maximum Allowable, as determined by the category or type of provider the Provider was, per the TRICARE/CHAMPUS regulations, at the time Covered Services were rendered.

2.6 **Verification of Eligibility.** Provider shall verify Beneficiaries' eligibility via the Beneficiary's military identification card and HNFS's electronically or telephonically available system before providing Contracted Services.

2.7 **Non-Discrimination.** Provider shall not discriminate against any Beneficiary in the provision of Contracted Services hereunder, whether on the basis of the Beneficiary's coverage under the TRICARE Program, age, sex, marital status, sexual orientation, race, color, religion, ancestry, national origin, disability, handicap, health status, source of payment, utilization of medical or mental health services, equipment, pharmaceuticals or supplies, or other unlawful basis including, without limitation, the filing by such Beneficiary of any complaint, grievance or legal action against Provider or HNFS. Provider agrees to make reasonable accommodations for Beneficiaries with disabilities or handicaps, in accordance with all applicable law, including but not limited to, providing such auxiliary aides and services to Beneficiaries at the Provider's expense as are reasonable, necessary and appropriate for the proper rendering of Contracted Services.

2.8 **HNFS Policies.** Provider agrees to participate in, cooperate with and comply with all HNFS Policies, including without limitation its medical management programs. Provider also agrees to provide to HNFS and state and federal regulatory agencies at no cost, medical and other records within five (5) days of notice, and such review data and other information as may be required or requested under a HNFS Policy, including outcome reporting in accordance with, but not limited to, the Health Plan Employer Data and Information Set (HEDIS), Version 3.0, or its successor.

2.9 **Prior Authorization.** Provider specifically acknowledges and agrees that Prior Authorization is not a guarantee of payment and that payment determinations are made at the time the claim is submitted to HNFS, based on a variety of factors, including without limitation, the eligibility of the Patient and whether the service is a Covered Service. Nonetheless, when Prior Authorization is required for the rendition of a health care service, the receipt of the required Prior Authorization is a prerequisite to payment of the claim for such service. HNFS will not retroactively deny reimbursement for a Contracted Service provided to a Beneficiary who relied on HNFS's Prior Authorization, provided that there was no material

misrepresentation or fraud in the request for Prior Authorization. In an Emergency, Provider agrees to notify HNFS and the appropriate PCM as applicable, as soon as possible, but no later than twenty-four (24) hours or by the next working day after providing Contracted Services that would otherwise require Prior Authorization. Subject to administrative review, HNFS shall have the final binding authority to make decisions regarding what constitutes an Emergency or Emergency Services for purposes of determining Covered Services consistent with TRICARE Program requirements. If HNFS determines that an Emergency did not exist, it will reimburse the Facility the rate set forth herein for the medical screening examination and services provided in a Facility's emergency room shall be deemed Excluded Services, for which Provider may bill Beneficiary directly. Provider acknowledges that HNFS shall not be liable for, nor will exercise control or direction over, the manner or method by which Provider renders any Contracted Services (or any other medical or healthcare services) to Beneficiaries under this Agreement. Notwithstanding the foregoing, HNFS agrees that nothing within this Agreement is intended to, or shall be deemed to, transfer liability for HNFS's own acts or omissions, by indemnification or otherwise, to Provider.

2.10 **Referrals.** Provider understands that, when required by the TRICARE Program, the MTF is the first resource for health care for TRICARE Beneficiaries, and that Beneficiaries gain access to the civilian TRICARE provider network only through Referral or Prior Authorization. Provider agrees to provide services to TRICARE Beneficiaries for non-Emergency Services only after obtaining appropriate Referral and/or Prior Authorization in accordance with HNFS Policies. Provider agrees to participate in surveys and inquiries initiated by HNFS regarding Provider's Referral practices, and acknowledges that Referral to a non-Network Provider requires Prior Authorization.

Provider acknowledges and agrees that in TRICARE Prime Areas that include an MTF, the MTF has the right of first refusal for all Referrals, meaning that the MTF must have the opportunity to review each Referral from a civilian provider to determine if the MTF has the capability and capacity to provide the treatment.

Provider shall refer TRICARE Beneficiaries only to providers with respect to which Provider does not have an economic interest.

2.11 **Network Providers.** Except in an Emergency, as otherwise permitted in the TRICARE Program, or as otherwise required by applicable federal or state law, Provider shall refer Beneficiaries only to Network Providers and shall use Network Providers to provide Facility-based physician and other ancillary services included in Covered Services. In the event Provider knowingly refers a Beneficiary to a non-Network Provider without a Referral or without Prior Authorization when either or both are required by the TRICARE Program, Provider agrees to be responsible for payment of claims incurred for the unauthorized Covered Service, and Provider agrees to hold harmless the Beneficiary for such claims. Provider shall use best efforts to assist HNFS in its efforts to contract with Provider's Facility-based physicians. HNFS requires that the most cost-effective, qualified Network Provider be utilized.

2.12 **Credentialing Program.** Provider shall submit to HNFS or its designee a credentials application which meets minimum requirements of HNFS. In no event will this Agreement be executed by HNFS, nor will Provider or any Professional Provider or subcontractor begin performing Provider's obligations under this Agreement, until Provider's and/or Professional Provider's or subcontractor's credentials application has been approved by HNFS.

2.13 **Provider Information.** If Provider is an individual practitioner (not an Organizational Provider), Provider agrees to provide HNFS with Provider's specialty, gender, work address, work fax number, work telephone number and work email address for each of Provider's health care delivery sites, whether or not Provider is accepting new patients or additional TRICARE Beneficiaries, Provider's status as a member of the Reserve Component or National Guard, and such other information as HNFS may reasonably request, in a format acceptable to HNFS. Provider agrees to notify HNFS within ten (10) days of any change to such information.

2.14 **Access Requirements.** Provider shall meet the following standards for Beneficiary access to care: wait time for an appointment for a well-patient visit or a specialty care referral shall not exceed four (4) weeks; for a routine visit, the wait time for an appointment shall not exceed one (1) week; and for an Urgent Care visit, the wait time for an appointment shall not exceed twenty-four (24) hours. Office waiting times in non-Emergency circumstances shall not exceed thirty (30) minutes, except when Emergency care is being provided to patients and the normal schedule is disrupted.

2.15 **Specialty Consultation and Referral Reports.** A specialty provider shall provide clearly legible specialty care consultation or Referral reports, operative reports, and discharge summaries for the Beneficiary's initiating provider. Such reports shall be submitted to referring Provider and/or referring MTF in accordance with HNFS Policies and within seven (7) days of the specialty encounter. In urgent/emergent situations, Provider shall convey a preliminary report of a specialty consultation to the Beneficiary's initiating provider and to Beneficiary's PCM Provider and/or MTF PCM within twenty-four (24) hours (unless best medical practices dictate less time is required for a preliminary report) by telephone, fax, or other means, and shall further subsequently convey a formal written report prepared by Provider within the standard seven (7) days.

2.16 **Notice of Adverse Action.** Provider shall notify HNFS within five (5) days of the occurrence of any of the following:

2.16.1 Any action taken to restrict, suspend or revoke Provider's, a Facility's and/or a Professional Provider's license or certification to provide Covered Services;

2.16.2 Any suit or arbitration action brought by a Beneficiary against Provider, a Facility and/or a Professional Provider for malpractice. In addition, Provider shall send HNFS a summary of the final disposition of such action;

2.16.3 Any misdemeanor conviction or felony information or indictment naming Provider, a Facility and/or a Professional Provider. In addition, Provider shall send HNFS a summary of the final disposition thereof;

2.16.4 Any disciplinary proceeding or action naming Provider, a Facility and/or a Professional Provider before an administrative agency in any state. In addition, Provider shall send HNFS a summary of the final disposition thereof;

2.16.5 Any cancellation or material modification of the professional liability insurance required to be carried by Provider, a Facility and/or a Professional Provider under the terms of this Agreement;

2.16.6 Any action taken to restrict, suspend or revoke Provider's, a Facility's and/or a Professional Provider's participation in Medicare, Medicaid or CHAMPUS, TRICARE or any succeeding program. In addition, Provider shall send HNFS a summary of the final disposition thereof;

2.16.7 Any action which results in the filing of a report on Provider, a Facility and/or a Professional Provider under applicable laws and/or regulations relating to the provision of, or the billing and payment for, Covered Services. In addition, Provider shall send HNFS a summary of the final disposition thereof;

2.16.8 Any material Beneficiary complaints against Provider, a Facility and/or a Professional Provider; or

2.16.9 Any other event or situation that could materially affect Provider's ability to carry out Provider's duties and obligations under this Agreement.

2.17 **Provider Education.** Provider agrees to participate in TRICARE education efforts, and agrees to require its staff members to participate in TRICARE education efforts, so that Provider and Provider's staff members understand applicable TRICARE Program requirements, policies, and procedures to allow them to carry out the requirements of this Agreement in an efficient and effective manner which promotes Beneficiary satisfaction.

2.18 **Billing**. Provider shall submit all claims electronically to HNFS. All paper claims submitted by Provider will be returned to Provider with directions to submit electronically. Provider may elect to submit claims directly to HNFS's claims processor, PGBA, LLC or to use XPressClaim, an Internet-based claims processing system offered by PGBA, LLC which is available through the www.HealthNetFederalServices.com or www.MyTRICARE.com web sites, a claims clearinghouse of Provider's choice, or the claims clearinghouse designated by HNFS. If Provider uses HNFS's designated claims clearinghouse for the submission of claims pursuant to this Agreement, Provider agrees to comply with the administrative requirements of the claims clearinghouse and to enter into such written agreement with the claims clearinghouse as may be required. Provider shall specify Provider's elected means of claim submission on the signature page to this Agreement.

Provider may change Provider's selection of means for electronically submitting claims pursuant to this Agreement upon sixty (60) days advance notice to HNFS. Claims shall be submitted as complete, accurate Clean Claims in a format approved by HNFS for Covered Services rendered to Beneficiaries. Claims shall be submitted within ninety (90) days after such services are rendered, provided that where HNFS is the

secondary payor under Coordination of Benefits, such ninety (90) day period shall commence once the primary payor has made payment on or has denied the claim, as evidenced by the date on the Explanation of Benefits (EOB) statement. HNFS shall not be under any obligation to pay Provider on any claims not submitted in a timely manner. Claims received by HNFS more than twelve (12) months after the date services were rendered or the date of the primary payor's EOB shall be denied in accordance with government policy. Provider shall not seek payment from the Beneficiary in the event HNFS fails to pay Provider for a claim not submitted in a timely manner. Additionally, claims must comply with standardized electronic transactions and code sets as required by the Administrative Simplification section of the Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations."

Provider agrees to comply with HNFS Policies when billing and collecting and/or seeking administrative review of payment for Contracted Services rendered pursuant to this Agreement. Provider agrees that HNFS shall have the right to determine the accuracy and appropriateness of all Clean Claims submitted to it, including but not limited to verification of diagnostic codes, DRG assignment, procedure codes and other elements of the submitted claim that affect the liability of HNFS. Based on its review of the accuracy and appropriateness of claim information submitted by Provider, HNFS may modify such information and use the modified information as the basis for payment of Contracted Services. HNFS shall include with its payment an explanation of the reasons for any modification of submitted information.

2.19 **Responsibilities to Department of Veterans Affairs.** Provider agrees to permit HNFS to report Provider to the Department of Veterans Affairs ("VA") as a TRICARE network provider. If Provider is a non-institutional provider, Provider is requested to accept requests from the VA to provide care to veterans. If Provider is an individual, home health care, freestanding laboratory, or free-standing radiology provider who accept VA patients, then Provider is required to serve as a participating provider and to accept assignment with the VA. Provider shall be deemed willing to receive VA inquiries and shall notify HNFS immediately in any change in willingness to receive VA inquiries. If the Provider is willing to receive VA inquiries as to availability then the Provider shall be clearly identified with readily discernable markings on all public network provider listings. The VA has the right to directly contact Provider and request the provision of care to veteran patients on a case by case basis. Provider is not obligated to see the veteran patient, but, if seen by Provider, any documentation of the care rendered to the veteran patient and reimbursement for the care is a matter between the referring VA Medical Center ("VAMC") and Provider. The referral and instructions for seeking reimbursement from the VAMC will be provided by the VA patient to Provider at the time of the appointment. The VA and Provider may establish a direct contract relationship if they so desire. A direct contract relationship between Provider and the VA takes precedence over the requirements of this section.

2.20 **Responsibilities to Civilian Health and Medical Program of the Department of Veterans Affairs.** Provider agrees to permit HNFS to report Provider to the Civilian Health and Medical Program of the Department of Veterans Affairs ("CHAMPVA") as a TRICARE network provider. If Provider is an individual, home health care, freestanding laboratory, or free-standing radiology provider who accept CHAMPVA patients, then Provider is required to serve as a participating provider and to accept assignment with the VA. Provider shall be deemed willing to receive VA inquiries and shall notify HNFS immediately in any change in willingness to receive VA inquiries. If the Provider is willing to accept CHAMPVA inquiries as to availability then the Provider shall be clearly identified with readily discernable markings on all public network provider listings. Such a Provider need see CHAMPVA beneficiaries only when Provider's practice availability allows and shall not give preferential appointment scheduling to CHAMPVA over TRICARE appointments. Such a Provider is encouraged to meet access standards for CHAMPVA beneficiaries. HNFS will provide Provider with CHAMPVA claims processing instructions on submitting CHAMPVA claims to the VA Health Administration Center for payment.

2.21 **Subcontracting.** Provider shall not subcontract for the performance of Covered Services under this Agreement without the prior written consent of HNFS.

2.22 **Utilization Management Program.** Provider agrees to comply with all provisions of the Utilization Management Program, including the provision of medical records and other documentation for cases being reviewed by HNFS in compliance with these programs. Provider agrees to participate in and cooperate with the Utilization Management Program and agrees to participate in, cooperate with and comply with all decisions rendered by HNFS in connection with the Utilization Management Program. Provider also agrees to provide medical and other records and such review data and other information as may be required or requested under a Utilization Management Program within ten (10) days of receipt of notice at no cost to

the requesting HNFS entity. Provider authorizes HNFS to release all review data obtained through medical record and other document audit to NQMCs. Provider further authorizes NQMCs to release all review data obtained through medical record and other document audits to HNFS. In the event that Provider's practices are found to be unacceptable under the Utilization Management Program, HNFS shall give notice to Provider to correct the specified deficiencies within the time period specified in the notice. Provider shall correct such deficiencies within that time period.

2.23 **Quality Management and Improvement Program.** The quality of Covered Services rendered by Provider to Beneficiaries shall be monitored under the Quality Management and Improvement Program applicable to the TRICARE Program. Provider agrees to participate in and cooperate with the Quality Management and Improvement Program and agrees to participate in, cooperate with and comply with all decisions rendered by HNFS in connection with the Quality Management and Improvement Program. Provider also agrees to provide such medical and other records and such review data and other information as may be required or requested under a Quality Management and Improvement Program within ten (10) days of receipt of notice at no cost to the requesting HNFS entity. In the event that the standard or quality of care furnished by Provider is found to be unacceptable under the Quality Management and Improvement Program, HNFS shall give notice to Provider to correct the specified deficiencies within the time period specified in the notice. Provider shall correct such deficiencies within that time period.

2.24 **TRICARE for Medicare Eligibles.** Provider agrees to render Covered Services to Medicare Eligible Beneficiaries of the TRICARE Program in accordance with the terms and conditions of the TRICARE Program and all applicable Medicare laws, regulations and Centers for Medicare & Medicaid Services (CMS) instructions, provided that the foregoing shall not apply to Provider in the event that Provider has received a waiver of Medicare requirements or may be a class of provider not recognized by Medicare.

2.25 **Listing of Provider.** Provider shall not use or display the trade names, trademarks, or other identifying information of HNFS without HNFS's prior written approval of both form and content. Provider shall supply all printed materials and other information relating to its operations within seven (7) days of HNFS's request. Provider shall update such information on a monthly basis through www.MyTRICARE.com, www.HealthNetFederalServices.com, or in written correspondence to HNFS as specified in the Network Provider Manual. Provider agrees that HNFS may list the name, address, telephone number and other factual information of Provider, each Facility and Professional Provider, and of Provider's subcontractors and their facilities in HNFS's provider directories, marketing and informational materials, and electronic media. In no event shall Provider market/advertise the TRICARE Program without the prior written consent of HNFS.

2.26 **Patient Transfer.** Provider shall cooperate with HNFS's coordination of the care and transfer of Beneficiaries who require a transfer from one location to another.

2.27 **Assignment of Beneficiaries.** Where required under the TRICARE Program, HNFS shall require Beneficiaries to select a PCM at the time of enrollment. In the event a Beneficiary does not select a PCM, HNFS shall automatically assign the Beneficiary to an appropriate PCM based upon the zip code in which the Beneficiary resides. Upon automatic assignment of PCM, the Beneficiary may change to another PCM of choice. HNFS will use best efforts to comply with Provider's requested limitations on accepting new patients.

2.28 **New or Additional Benefit Plan Designs.** Provider agrees to accept any new or additional benefit plan designs developed by TRICARE and shall provide Covered Services pursuant thereto.

2.29 **Payment of Applicable Taxes.** Provider shall be solely responsible for the payment of any sales, use or other applicable taxes on the sale or delivery of medical services.

2.30 **Professional Liability Insurance.** Provider shall maintain professional liability insurance in an amount no less than the greater of the following: (i) the amount required by law **of the authorizing State;** (ii) the amount required by the Federal Acquisition Regulation; (iii) the amount required by the accrediting body having jurisdiction over Provider; (iv) the amount required, if any, by the Provider's participation in a state liability pool / fund; or (v) for Institutional Provider three million dollars ($3,000,000) per claim and ten million dollars ($10,000,000) in the aggregate of all claims per policy year, and for Professional Provider two hundred thousand ($200,000) per claim and six hundred thousand ($600,000) in aggregate of all claims per policy year. Provider agrees to provide HNFS with written evidence, acceptable to HNFS, of such insurance coverage within three (3) days of such request by HNFS. Provider also agrees to notify, or to ensure that its insurance carriers notify, HNFS at least thirty (30) days prior to any proposed termination,

cancellation or material modification of any policy for all or any portion of the coverage required herein. If the policy is on a claims-made basis, an extended reporting endorsement (tail) for a period of not less than 3 years after the end of the contract term must also be provided, or as long as may be required by local law or ordinance.

2.31 **Non-Solicitation.** Neither Provider nor any employee, agent or subcontractor of Provider shall solicit or attempt to convince or otherwise persuade any Beneficiary to discontinue participation in any health benefits program offered by HNFS or in any other manner interfere with HNFS's contract and/or property rights. Notwithstanding the foregoing, HNFS in no way restricts Provider from discussing medical treatment options with Beneficiaries. Provider will not be terminated or penalized solely because of advocacy on behalf of Beneficiary or for filing a request for administrative review as permitted by HNFS Policies and federal regulations. Further, HNFS and Provider, and its employees and subcontractors shall portray each other in a positive light to Beneficiaries and the public.

2.32 **Referral and Prior Authorization Submissions.** Provider shall use an electronic process to submit requests for, and retrieve all responses regarding, Referrals and Prior Authorizations. Provider use of an electronic process will be in compliance with HNFS Policies and the Network Provider Manual.

III. REPRESENTATIONS AND DUTIES OF HNFS

3.1 **HNFS Policies.** HNFS shall develop policies and operate programs to promote the delivery of cost-effective health care services by Network Providers. HNFS shall furnish Provider with operation manuals containing the provisions of relevant HNFS Policies and the methods of administration of this Agreement, including without limitation, administrative review procedures, and billing and accounting of Contracted Services rendered hereunder. HNFS shall have the right to modify, add or delete HNFS Policies from time to time in HNFS's sole discretion and shall use reasonable efforts to provide timely notification to Provider of any such modifications, additions or deletions.

3.2 **Insurance.** HNFS shall maintain insurance programs or policies appropriate and necessary to protect itself and its employees against any claim for damages arising by reason of personal injury or death of a Beneficiary.

3.3 **Reporting to Regulators.** HNFS shall accept sole responsibility for filing reports, obtaining approvals and complying with applicable laws and regulations governing HNFS; provided, however, that Provider agrees to cooperate in providing HNFS with any information and assistance reasonably required in connection therewith, including without limitation, permitting the regulatory agencies to conduct periodic site evaluations of Provider, Facilities, Professional Providers and any of their equipment, operations, and billing and medical records of Beneficiaries.

3.4 **Premiums and Fees.** HNFS shall make reasonable efforts to collect premiums and other revenue to which HNFS is entitled. HNFS shall make payment to Provider for Contracted Services in accordance with Article IV of this Agreement.

Overdue payments shall bear interest in accordance with applicable law and HNFS Policies. Payment of interest shall be Provider's sole remedy for failure of HNFS to make timely payments. In no event shall HNFS be under any obligation to pay Provider for any claim, payment of which is the responsibility of another payor.

IV. COMPENSATION

4.1 **Payment.**

(a) **Payment**. Unless the claim is an Excluded Claim, HNFS shall make payment on each of Provider's complete, accurate and timely Retained Claims for Covered Services rendered to a Beneficiary within thirty (30) days of receipt of each such claim. All Providers and Professional Providers, both Network and non-Network, agree to accept the TRICARE determined allowable payment, or the negotiated rate, whichever is lower, combined with the Cost-Share, Deductible, and other health insurance amounts payable by, or on behalf of, the Beneficiary, as full payment for TRICARE allowed services. Such rate shall be set forth in **ADDENDUM G-3, the TRICARE Compensation Schedule;** provided that, in the event that Provider is party to more than one agreement with HNFS for the provision of Contracted Services to Beneficiaries, HNFS shall determine, in HNFS' sole discretion, under which agreement reimbursement will be made to the individual provider. If Prior Authorization or Referral is required, but not obtained prior to services being rendered, the payment will be reduced by ten percent (10%). For Contracted

Services rendered to TRICARE Prime Beneficiaries who self-refer pursuant to their point-of-service option, HNFS shall pay Provider fifty percent (50%) of the contracted reimbursement rate and the Beneficiary shall be responsible for paying the remaining fifty percent (50%) directly to Provider as Coinsurance.

(b) **Administrative Review.** Provider may request reconsideration or adjustment of claims payments in accordance with the timeframes and procedures outlined in HNFS Policies and the Network Provider Manual. Provider must submit any request for administrative review to HNFS within ninety (90) days from the date the TRICARE explanation of benefits was issued. Any available relevant documentation must be submitted as part of the administrative review. The review will be conducted by other than those involved in day-to-day claims payment. HNFS shall issue a written determination within ten (10) days of receipt of all necessary documentation necessary to process the review. Providers may seek review of an adverse determination on an administrative review through the arbitration provision described herein.

(c) **Payment Disputes.** Provider may dispute payment considered to be less than agreed to under this Agreement by filing a request for review to: TRICARE / Health Net Federal Services, P.O. Box 870141, Surfside Beach, SC 29587-9741. The request for review shall be submitted within ninety (90) days of the date of the TRICARE EOB (explanation of benefits) relating to the alleged underpayment and shall identify, in detail, why Provider believes the reimbursement amount was incorrect. Failure to submit a request for review within these parameters and within this time-frame shall constitute a waiver of any such claim.

4.2 **U.S. Military Active Duty Personnel.** Provider shall render Covered Services to U.S. military active duty personnel and seek compensation for services rendered to Beneficiaries eligible under SHCP and/or TPR from HNFS at the same rates as provided in the Exhibit to this Agreement.

4.3 **Beneficiary Held Harmless.** Provider agrees that in no event, including, but not limited to, non-payment by HNFS, insolvency of HNFS, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against Beneficiaries or persons acting on their behalf other than HNFS for Contracted Services provided pursuant to this Agreement. This provision shall not prohibit collection of Cost-Shares or Deductibles made in accordance with the TRICARE Program requirements. Provider further agrees that: (a) this provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of Beneficiaries; (b) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Beneficiaries or persons acting on their behalf. At HNFS's option, the terms of the binding arbitration provisions of this Agreement shall not apply to HNFS's actions to enforce the terms of this provision against Provider, Professional Providers, Facilities, or any of their subcontractors; specifically, in the event Provider fails to cure to HNFS's reasonable satisfaction breach of this provision immediately upon notice, HNFS may pursue legal or regulatory action to enforce the terms of this section in addition to any other remedy granted to HNFS under law or in equity. Provider shall reimburse HNFS for HNFS's reasonable attorney's fees and costs of enforcement. Further, Provider agrees to address any and all concerns Provider has with claims payment through HNFS's administrative review process pursuant to HNFS Policies.

4.4 **Charges.** Provider agrees not to charge TRICARE Beneficiaries for the following services: services for which Provider is entitled to payment from TRICARE (other than any applicable Cost-Shares/Deductibles); services for which the Beneficiary would be entitled to have TRICARE payment made had Provider complied with TRICARE Regulations and procedural requirements; services not Medically Necessary and appropriate for the clinical management of the presenting symptoms, and illness, injury, disorder or maternity; services for which a Beneficiary would be entitled to payment but for a reduction or denial in payment as a result of quality review; and services rendered during a period in which Provider was not in compliance with one or more conditions of TRICARE authorization.

4.5 **Eligibility.** Except in an Emergency, Provider shall verify the eligibility of Beneficiaries in accordance with Section 2.6 of this Agreement before providing Contracted Services. Provider acknowledges that (i) presentation of an identification card is not sufficient proof of eligibility; (ii) verification of eligibility by HNFS is based on information available to HNFS from its customers on the date Provider seeks verification; (iii) the eligibility of the Beneficiary may change between the verification date and the date of service; and (iv) HNFS's eligibility verification shall not under any circumstances be deemed as a

guarantee of payment of the claim. If Provider exercised reasonable care to determine eligibility in accordance with Section 2.6 above, and to seek payment from the patient or patient's other health insurance, but has been unable to obtain compensation, the Provider may submit the claim to HNFS for a good faith payment, subject to government approval, in accordance with TRICARE Regulations.

4.6 **Collection of Cost-Share/Deductible.** Provider shall use its best efforts to collect all Cost-Shares/Deductibles due from Beneficiaries, and shall not waive or fail to pursue collection of Cost-Shares/Deductibles from Beneficiaries, without the prior written consent of HNFS, provided that Provider shall not collect Cost-Shares/Deductibles from U.S. military active duty personnel.

4.7 **No Surcharges.** Provider shall not charge the Beneficiary any fees or surcharges for Covered Services rendered pursuant to this Agreement (except to the extent of authorized Cost Shares/Deductibles). If HNFS receives notice of any charge that may be in violation of this section, Provider shall fully cooperate with HNFS to investigate such allegations, and shall promptly refund any payment deemed improper by HNFS to the party who made the payment.

4.8 **Conditions for Reimbursement for Excluded Services.** Neither a Beneficiary nor HNFS shall be liable to pay Provider for any service rendered by Provider to a Beneficiary which is an Excluded Service under the TRICARE Program. It is provided, however, that Provider may bill a Beneficiary for Excluded Services rendered by Provider to such Beneficiary if the Beneficiary was informed that the services were excluded or excludable and the Beneficiary agreed in advance in writing to pay for the services. An agreement to pay must be evidenced by the written consent of the Beneficiary to pay for the Excluded Services. General agreements to pay, such as those signed by the Beneficiary at the time of admission or commencement of services, are not evidence that the Beneficiary knew specific services were excluded or excludable.

4.9 **Coordination of Benefits.** Provider agrees to be bound by the COB policies and procedures of HNFS which are established in accordance with applicable law, including without limitation, the prompt notification to HNFS of knowledge of any third party who may be responsible for payment. Provider agrees to maintain and make available to HNFS records reflecting collection of COB proceeds by Provider and, to the extent possible, records reflecting amounts paid directly to Beneficiary by third party payors.

4.10 **Third Party Recoveries.** Provider shall comply with HNFS Policies regarding third party recoveries.

4.11 **TRICARE Program Phase-Out.** Provider agrees to use its best efforts to submit all TRICARE claims within thirty (30) days from the date services are rendered or the date of the primary payor's EOB during the phase-out period of HNFS's TRICARE contract.

4.12 **Right of Offset.** Subject to the TRICARE Regulations and the Network Provider Manual, HNFS shall have the right to offset amounts due to HNFS from Provider.

V. TERM AND TERMINATION

5.1 **Term.** The term of this Agreement shall commence on the Effective Date, which shall be the first day of the month after HNFS has executed this Agreement, and shall continue for a period of one (1) year thereafter. This Agreement shall automatically renew for successive one (1) year periods, unless one party notifies the other in writing of its intent not to renew this Agreement, at least one hundred twenty (120) days prior to the next scheduled renewal date. Regardless of the Effective Date or any renewal date of this Agreement, Provider shall not begin providing Contracted Services to Beneficiaries and HNFS shall have no obligation to pay for such services, until the completion of HNFS's credentialing and certification processes.

5.2 **Immediate Termination.** HNFS may terminate this Agreement immediately upon notice to Provider with respect to Provider or with respect to any Facility or Professional Provider (collectively and individually referred to in this section as "Provider"), in the event of (a) Provider's violation of any applicable law, rule or regulation; (b) Provider's failure to maintain the professional liability insurance coverage specified hereunder; (c) any situation involving an investigation conducted or complaint filed by a state or federal agency or licensing board that restricts Provider's ability to operate a Facility or practice in a hospital; results in limitation, suspension, revocation of, or reportable discipline against, Provider's license, accreditation, or certification; (d) HNFS's determination that the health, safety or welfare of any Beneficiary may be in jeopardy if this Agreement is not terminated; (e) any indictment, charge, arrest or conviction of a misdemeanor or felony, or any criminal charge related to the medical, financial and other practices of Provider; (f) Provider's failure to meet any applicable HNFS or TRICARE credentialing

criterion. Further, HNFS, or its successor upon a change of control of HNFS, may terminate this Agreement upon notice to Provider at any time following such change of control, which termination shall be effective as of the date set forth in said notice, such effective date not to be later than thirty (30) days following receipt by Provider. (For purposes of Section 5.2, a "change of control" means either an acquisition of not less than fifty-one percent (51%) of HNFS's stock or assets, or an acquisition of not less than twenty-five percent (25%) of HNFS's stock together with the effective loss of control of HNFS's Board of Directors.)

5.3 **Termination Due to Material Breach.** Both parties agree to use best efforts to cure a material breach of this Agreement within thirty (30) days of receipt of notice to cure from the other (the "Cure Period"). If the breach is cured within the Cure Period, or if the breach is one which cannot reasonably be corrected within the Cure Period, and the defaulting party is making substantial and diligent progress toward correction during the Cure Period to the reasonable satisfaction of the non-defaulting party, this Agreement shall remain in full force and effect. Notwithstanding the foregoing, if the defaulting party fails to cure a material breach within the Cure Period, the non-defaulting party may terminate this Agreement by providing the defaulting party thirty (30) days prior notice of termination. The non-defaulting party may exercise this termination option, if at all, within thirty (30) days of the date the Cure Period expires. The provisions of this Section 5.3 shall not apply to the timeliness of claims payment which is governed by Article IV of this Agreement.

5.4 **Termination Without Cause.** Either party may terminate this Agreement for any reason or no reason upon one hundred twenty (120) days prior notice to the other party. In the event either party provides the other party with such notice, HNFS may, at its option, begin to transition Beneficiaries immediately under this Agreement to another Network Provider.

5.5 **Information to Beneficiaries.** The parties each agree to cooperate with each other in good faith and without disparagement in connection with information supplied by either party to Beneficiaries in connection with any termination or non-renewal of this Agreement. If Beneficiaries seek services or Network Providers order tests or seek services from Provider after the date of termination or any continuation period required by applicable law, Provider shall inform such Beneficiaries and Network Providers that Provider no longer has an agreement with HNFS to render Covered Services and shall direct them to HNFS's customer service department. Provider shall not otherwise initiate communications with Beneficiaries, verbally or in writing, concerning the termination of its participation with HNFS, unless the parties have agreed in writing to the content of such communications in the context of a mutually agreed communication plan. Nothing in this provision is intended nor shall it be construed to prohibit or restrict Provider, Professional Provider, or other Network Providers from disclosing to any Beneficiary information regarding treatments available, the risks, benefits and alternatives thereto, or the decision or process of HNFS to Prior Authorize or deny benefits under the TRICARE Program. The terms of this Section 5.5 shall survive termination of this Agreement.

5.6 **Continuation of Services After Termination.** In the event that this Agreement is terminated by either HNFS or Provider for any reason, Provider shall, at HNFS's option, be obligated to continue to provide Contracted Services to TRICARE Beneficiaries until the expiration of the term in effect at the time of such termination of HNFS's prime contract to provide or arrange for TRICARE services, or for such lesser period as HNFS shall require, provided that any post-termination extension of Provider's obligations hereunder shall not in any case exceed ninety (90) days from the date of termination of this Agreement.

5.7 **Sanctions for Violation of TRICARE Regulations.** In the event that Provider fails to materially comply with any applicable provision of the TRICARE Regulations, HNFS may terminate this Agreement or impose such lesser sanction as provided in the Network Provider Manual.

VI. RECORDS, AUDITS AND REGULATORY REQUIREMENTS

6.1 **Medical and Other Records.** Provider represents and warrants that it prepares and maintains and will prepare and maintain all medical records, financial records relating to this Agreement, and other books and records required by applicable law in a form maintained in accordance with the general standards applicable to such book or record keeping. Provider shall maintain contemporaneous clinical records that substantiate the clinical rationale for each course of treatment, periodic evaluation of the efficacy of treatment, and the outcome at completion or discontinuation of treatment. Provider agrees to maintain any data or information pertaining to the diagnosis, treatment or health of a Beneficiary confidential to the maximum extent permitted by law. Provider shall retain required documentation for a period of time that is

six (6) years (HIPAA retention requirement as of 2016) or the period required by local, State, Federal law or updated HIPAA regulations, whichever is longer. Additionally, Provider shall maintain such financial, administrative and other records as may be necessary for compliance by HNFS with all applicable laws and regulations, HEDIS and accrediting agency rules and regulations.

6.2 **Access to Records, Audits.** The records referred to in Section 6.1 shall be and remain the property of Provider. Subject only to applicable confidentiality or privacy laws, Provider shall permit HNFS, or its designated representatives, and designated representatives of regulatory agencies having jurisdiction over HNFS ("Regulatory Agencies"), access to Provider's records, at Provider's place of business during normal business hours, in order to inspect and review and make copies of such records. Such Regulatory Agencies shall include, but not be limited to, the United States Department of Health and Human Services and any of its representatives. Provider agrees that HNFS's access to records shall include access to Provider's records for the facilitation of activities undertaken pursuant to HNFS Policies, including, without limitation: access for purposes of COB; credentialing and recredentialing; grievances and appeals; provider disputes and/or administrative review; utilization management; quality improvement; peer review; medical and other record reviews; outcome rate reviews; and reviews for compliance with HNFS Policies, TRICARE Regulations and applicable law.

When requested by HNFS and/or Regulatory Agencies, Provider shall produce copies of any such records at no charge. Additionally, Provider agrees to permit HNFS and/or Regulatory Agencies or their representatives, to conduct audits, site evaluations and inspections of Provider's records, offices and service locations. Provider shall make available the access, audits, evaluations, inspections, records, and/or copies of records required by this Section at no cost to HNFS and/or the Regulatory Agency within a reasonable time period, but not more than five (5) days after the request is submitted to Provider.

6.3 **HIPAA Compliance.** Provider agrees to safeguard Beneficiary privacy and confidentiality as required by applicable law, including, but not limited to the United States Department of Health and Human Services Standards for Privacy of Individually Identifiable Health Information promulgated pursuant to the administrative simplification provisions of the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as set forth in 45 C.F.R. Subtitle A, Subchapter 3, Parts 160 and 164.

6.4 **Continuing Obligation.** The obligations of Provider under this Article VI shall not be terminated upon termination of this Agreement, whether by rescission, non-renewal or otherwise. After termination of this Agreement, HNFS and Regulatory Agencies shall continue to have access to Provider's records as necessary to fulfill the requirements of this Agreement and to comply with all applicable laws, rules and regulations.

6.5 **Regulatory Compliance.** Provider agrees to comply with all applicable laws, rules and regulations, now or hereafter in effect, regarding the performance of Provider's obligations hereunder, including without limitation, laws or regulations governing Beneficiary confidentiality, privacy, administrative review and dispute resolution procedures to the extent that they directly or indirectly affect Provider, Provider's Facility(ies), Provider's Professional Providers, a Beneficiary, or HNFS, and bear upon the subject matter of this Agreement. If HNFS is sanctioned under any regulatory body for non-compliance which is caused by Provider, Provider shall compensate HNFS for amounts tied to this sanction incurred by HNFS including HNFS's costs of defense and fees.

6.6 **Notification of Certain Employment Decisions.** Provider shall provide prompt written notification to HNFS of Provider's employment of an individual who, at any time during the twelve (12) months preceding such employment, was employed in a managerial, accounting, auditing, or similar capacity by an agency or organization which is responsible, directly or indirectly for decisions regarding Department of Defense payments to Provider.

VII. GENERAL PROVISIONS

7.1 **Amendments.** All amendments to this Agreement proposed by Provider must be agreed to in writing by HNFS in advance of the effective date thereof. Any amendment to this Agreement proposed by HNFS shall be effective thirty (30) days after HNFS has given notice to Provider of the amendment, and Provider has failed within that time period to notify HNFS in writing of Provider's rejection of the requested amendment. If Provider rejects any amendment, HNFS shall have the right to consider such rejection as an intent to terminate the Agreement, and HNFS may terminate this Agreement upon sixty (60) days prior notice. Amendments required because of legislative, regulatory or legal requirements do not require the

consent of Provider or HNFS and will be effective immediately on the effective date of the requirement. Any amendment to this Agreement requiring prior approval of or notice to any regulatory agency shall not become effective until all necessary approvals have been granted or all required notice periods have expired.

7.2 **Assignment.** Neither this Agreement, nor any of Provider's rights or obligations hereunder, is assignable by Provider without the prior written consent of HNFS, which consent will not be unreasonably withheld. HNFS expressly reserves the right to assign, delegate or transfer (any of which, an "Assignment") its rights, obligations and privileges under this Agreement without the consent of Provider.

7.3 **Confidentiality.** HNFS and Provider agree to hold the terms of this Agreement and all confidential or proprietary information or trade secrets of each other in trust and confidence and agree that such information shall be used only for the purposes contemplated herein, and not for any other purpose. Specifically, Provider, as well as HNFS, shall keep strictly confidential all compensation rates set forth in this Agreement and attached Schedule[s], except that this provision does not preclude disclosure by HNFS to potential customers, Beneficiaries and Regulatory Agencies of the method of compensation used by HNFS with respect to its Network Providers, e.g., fee-for-service, capitation, shared risk pool, DRG or per diem. HNFS and Provider agree that nothing in this Agreement shall be construed as a limitation of (i) Provider's rights or obligations to discuss with Beneficiaries matters pertaining to Beneficiaries' health or (ii) HNFS's rights or obligations with respect to subcontractors, including without limitation delegated providers. The terms of this Section 7.3 shall survive termination of this Agreement.

7.4 **Arbitration and Dispute Resolution.** Provider and HNFS agree to resolve any controversy or dispute that may arise out of or relate to this Agreement, or the breach thereof, whether involving a claim in tort, contract, or otherwise, (a "Dispute") pursuant to the terms of this Section 7.4. Either party may initiate the dispute resolution process set forth herein by giving the other party notice of a Dispute. Such notice shall set forth the precise nature of the Dispute. Provider and HNFS agree to meet and confer in good faith to resolve the Dispute and negotiation of the Disputer shall be a condition precedent to the filing of any arbitration demand by either party. No notice of a Dispute may be filed until the exhaustion of applicable HNFS internal administrative review procedures. If the parties are unable to informally resolve the Dispute within thirty (30) days of the date of the initial notice of the Dispute, the aggrieved party may send notice to the other party demanding arbitration under the terms of this Agreement (the "Arbitration Notice"). Such Arbitration Notice shall contain a detailed statement of the Dispute and facts and include copies of all related documents supporting the arbitration demand. In addition, should the parties, prior to submitting the Dispute to arbitration, desire to utilize other impartial dispute settlement techniques such as mediation or fact-finding, a joint request for such services may be made to the American Arbitration Association ("AAA"), Judicial Arbitration and Mediation Services ("JAMS"), or the parties may initiate such other procedures as they may mutually agree upon at such time. Notwithstanding the foregoing, nothing contained herein is intended to require arbitration of disputes for medical malpractice between a Beneficiary and Provider.

The parties further agree that upon the Arbitration Notice of either party, any Dispute shall be settled by final and binding arbitration under the appropriate rules of the AAA or JAMS, as agreed by the parties. The arbitration shall be conducted in Sacramento County, California by a single, neutral arbitrator who is licensed to practice law. Arbitration must be initiated within one (1) year after the date the Dispute occurred by submitting a written Arbitration Notice to the other party. The failure to initiate arbitration within that period shall mean the complaining party shall be barred forever from initiating such proceedings.

All such arbitration proceedings shall be administered by the AAA or JAMS, as agreed by the parties; however, the arbitrator shall be bound by applicable law, and shall issue a written opinion setting forth the reasons for an award. The parties agree that the decision of the arbitrator shall be final and binding as to each of them. Judgment upon the award rendered by the arbitrator may be entered in any court having jurisdiction. The arbitrator shall have no authority to make material errors of law or to award punitive damages or to add to, modify, or refuse to enforce this Agreement or to make any award that could not have been made by a court of law. The party against whom the award is rendered shall pay any monetary award and/or comply with any other order of the arbitrator within the earlier of sixty (60) days of the date of the award or the date of the entry of judgment on the award.

The administrative fees shall be advanced by the initiating party subject to final apportionment by the

arbitrator in this award. In all cases submitted to arbitration, the parties agree to share equally the administrative fee as well as the arbitrator's fee, if any, unless otherwise assessed by the arbitrator. The terms of this Section 7.4 shall survive termination of this Agreement.

7.5 **Entire Agreement.** This Agreement supersedes any and all other agreements, either oral or written, between the parties with respect to the subject matter hereof, and no other agreement, statement or promise relating to the subject matter of this Agreement shall be valid or binding.

7.6 **Indemnification.**

7.6.1 Each party shall be responsible for its own acts or omissions and for any and all claims, liabilities, injuries, suits, demands and expenses of all kinds which may result or arise out of any alleged malfeasance or neglect caused or alleged to have been caused by that party or its employees or representatives in the performance or omission of any act or responsibility of that party under this Agreement.

7.6.2 Provider agrees to indemnify, defend, and hold harmless HNFS, its agents, officers and employees from and against any and all liability expense including defense costs and legal fees incurred in connection with claims for damages of any nature whatsoever, including but not limited to, bodily injury, death, personal injury, or property damage to the extent such damages are caused by Provider's performance or failure to perform its obligations hereunder.

7.6.3 HNFS agrees to indemnify, defend, and hold harmless Provider, its agents, officers, and employees from and against any and all liability expense, including defense costs and legal fees incurred in connection with claims for damages of any nature whatsoever, including but not limited to, bodily injury, death, personal injury or property damage to the extent such damages are caused by HNFS's performance or failure to perform its obligations hereunder.

7.7 **Indemnification of United States.** Provider agrees to indemnify the United States Government for any liability that may be assessed against the United States Government that is attributable to any action or omission of Provider.

7.8 **Non-Exclusive Contract.** This Agreement is non-exclusive and shall not prohibit Provider or HNFS from entering into agreements with other health care providers or purchasers of health care services.

7.9 **No Third Party Beneficiary.** Nothing in this Agreement is intended to, or shall be deemed or construed to create any rights or remedies in any third party, including a Beneficiary, except as may be expressly provided herein. Nothing contained herein shall operate (or be construed to operate) in any manner whatsoever to increase the rights of any such Beneficiary or the duties or responsibilities of Provider or HNFS with respect to such Beneficiaries, except as may be expressly provided herein.

7.10 **Governing Law.** This Agreement shall be governed by and construed and enforced in accordance with federal law.

7.11 **Notice.** Any notice required or desired to be given under this Agreement shall be in writing. Notices shall be deemed given five (5) days post deposit in the U.S. mail, postage prepaid. If sent by hand delivery, overnight courier, e-mail, or facsimile, notices shall be deemed given upon documentation of receipt. All notices shall be addressed as indicated on the signature page(s) to this Agreement.

The addresses to which notices are to be sent may be changed by written notice given in accordance with this Section. In the event Provider fails to complete the notice information below or fails to notify HNFS of any changes to such information, HNFS reserves the right to send notice to the practice address included on the claim form.

7.12 **Regulation.** HNFS is subject to the requirements of various federal laws, rules and regulations. Any provision required to be in this Agreement by any of the above shall bind Provider and HNFS whether or not expressly set forth herein.

7.13 **Severability.** If any provision of this Agreement is rendered invalid or unenforceable by any law, rule or regulation, or declared null and void by any court of competent jurisdiction, the remainder of this Agreement shall remain in full force and effect.

7.14 **Status as Independent Entities.** None of the provisions of this Agreement is intended to create or shall be deemed or construed to create any relationship between Provider and HNFS other than that of independent entities contracting with each other solely for the purpose of effecting the provisions of this Agreement.

Neither Provider nor HNFS, nor any of their respective agents, employees or representatives shall be construed to be the agent, employee or representative of the other.

7.15 **Calculation of Time.** The parties agree that for purposes of calculating time under this Agreement, any time period of less than ten (10) days shall be deemed to refer to business days and any time period of ten (10) days or more shall be deemed to refer to calendar days.

7.16 **Separate Obligations.** For purposes of this Section 7.16, the term "Affiliate" shall mean HNFS, or an entity that controls, is controlled by, or is under common control with HNFS. The rights and obligations of HNFS under this Agreement shall apply only to HNFS and only with respect to the TRICARE Program. HNFS shall not be responsible for the obligations of any other Affiliate with respect to the other Affiliate's benefit programs. The person executing this Agreement on behalf of HNFS has been duly authorized by HNFS to execute this Agreement on its behalf. The terms of this Section 7.16 shall survive termination of this Agreement.

THIS AGREEMENT CONTAINS A BINDING ARBITRATION CLAUSE WHICH MAY BE ENFORCED BY THE PARTIES.

Notices: All TRICARE related notices shall be addressed as follows:

Health Net Federal Services; 2025 Aerojet Road; Rancho Cordova, CA 95742
Attn: Legal Department; Facsimile: (916) 985-8253
AND TO
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ADDENDUM G-1

TRICARE COMPREHENSIVE AUTISM CARE DEMONSTRATION

This Addendum G-1 applies to the Comprehensive Autism Care Demonstration Program for TRICARE. The Autism Care Demonstration combines all TRICARE-covered applied behavior analysis (ABA) services under one demonstration and provides coverage and services to TRICARE-eligible beneficiaries diagnosed with an autism spectrum disorder (ASD). All Covered Services delivered to Beneficiaries covered by the Autism Care Demonstration shall be paid in accordance with this Addendum G-3. Provider shall adhere to all applicable provisions of the Agreement including but not limited to Performance Provisions, Prior Authorization, HNFS Policies, Access Requirements, Utilization Management and Billing.

This Addendum includes each of the following with respect to the Autism Care Demonstration: (i) Exhibit G-2, the Autism Care Demonstration Network Provider and Group Provider Participation Requirements and (ii) Exhibit G-3, the TRICARE Compensation Schedule for Covered Services under this Addendum.

ADDENDUM G-2
AUTISM CARE DEMONSTRATION NETWORK PROVIDER AND GROUP PROVIDER PARTICIPATION REQUIREMENTS

I. Definitions: The following terms are capitalized throughout this Addendum to indicate they are defined as set forth in this Section.

1.1 Autism Demonstration Corporate Service Provider (ACSPs): ACSPs include individual Board Certified Behavior Analyst (BCBA) and Board Certified Behavior Analyst–D (BCBA-D), ABA licensed/certified provider, autism centers, autism clinics that contract or employ assistant behavior analysts. Assistant behavior analysts include Board Certified Associate Behavior Analysts (BCaBAs) and Qualified Autism Services Practitioner (QASP) and Behavior Technicians (BTs). BTs include Registered Behavior Technicians (RBTs); Board Certified Autism Technicians (BCAT); and Applied Behavior Analysis Technician (ABAT).

1.2 Assistant behavior Analysts also known as Board Certified Associate Behavior Analysts (BCaBAs) or Qualified Autism Services Provider (QASP). BCaBAs have a scope of practice that allows them to assist the BCBAs, BCBA-Ds, ABA licensed/certified providers in clinical support and case management activities, to include assisting in the supervision of the Behavior Technicians and the training of TRICARE eligible family members/caregivers to implement ABA interventions in accordance with the ABA Treatment Plan (TP). However, under the BACB Guidelines (2012), BCaBAs may not practice independently of the supervision of a BCBA or BCBA-D. Although BCaBAs may assist in the supervision of Behavior Technicians, BCaBAs may not independently supervise Behavior Technicians. Supervision must be provided in accordance with the state licensure and certification requirements in the state in which ABA is practiced where such state-issued license or certification is available. Qualified Autism Services Provider (QASP) is a credential established by the QABA to raise accountability of those paraprofessionals and direct support professionals who are providing behavioral health services to individuals diagnosed with Autism and other related disabilities. QASPs understand autism as an autism spectrum disorder and demonstrate the principles of working with autism effectively.

1.3 Behavior Technician: formerly known as “tutors” work one-on-one with the beneficiary with Autism Spectrum Disorder in home, community, or school setting to implement the Applied Behavior Analysis protocol designed, monitored and supervised by BCBA, BCBA-D, or ABA licensed/certified provider. Behavior Technicians include RBTs; ABATs and BCATs and other behavior technicians certified by a certification body approved by the Director, DHA.

1.4 Registered Behavior Technician (RBT): A credential established by the Behavior Analyst Certification Board introducing training standards for behavior technicians who implement behavior plans directly with beneficiaries. The RBT credential reflects the education and training necessary for the duties of a behavior technician.

1.5 Applied Behavior Analysis Technician (ABAT): A credential established by the Qualified Applied Behavior Analysis Credentialing Board (QABA). ABAT is an entry level behavior technician who practices under the ongoing supervision of a QASP or other licensed or certified professional within the scope of ABA. The ABAT establishes recognition of the Behavior Technician as a professional role within the practice of Applied Behavior Analysis in the Behavioral Health sector.

1.6 Board Certified Autism Technicians (BCAT): A credential established by the Behavioral Intervention Certification Council (BICC). BCATs are qualified to implement evidence-based, autism-specific treatment using the principles and procedures of applied behavior analysis under the supervision of a qualified health professional.

1.7 Supervisors: BCBAs, BCBA-Ds and providers who are licensed or certified by their state to provide Applied Behavior Analysis (ABA) services under the Autism Care Demonstration who serve as direct supervisors of the assistant behavior analysts and BTs working under the BCBA/BCBA-D, or ABA licensed/certified provider. A Supervisor is responsible for ensuring that ABA provided by assistant behavior analysts and BTs meet the minimum standards promulgated by applicable BACB, BICC and/or QABA recommendations, rules and regulations. Supervision must be provided in accordance with the state licensure and certification requirements in the state in which ABA services are rendered.

II. ACSP Requirements

2.1 ACSP must submit evidence that professional liability insurance in the amounts of 1 million dollars per claim and 3 million dollars in aggregate is maintained in the ACSP's name, unless state requirements specify greater amounts;

2.2 ACSP must comply with all applicable organization and individual licensing or certification requirements that are extant in the State, county, municipality, or other political jurisdiction in which ABA services are provided under Autism Care Demonstration;

2.3 All ABA Supervisors, assistant behavior analysts and Behavior Technicians employed by or contracted with the ACSP must meet the education, training, experience, competency, supervision and Autism Care Demonstration requirements specified in TRICARE Operations Manual (TOM) Chapter 18, Section 18;

2.4 ACSP must maintain employment or contractual documentation in accordance with applicable Federal, State, and local requirements, and corporate policies regarding ABA Supervisors, assistant behavior analysts and Behavior Technicians;

2.5 ACSP must meet all requirements set forth in TRICARE Operations Manual (TOM) Chapter 18, Section 18 not otherwise specified herein;

2.6 Claims under the Autism Care Demonstration shall be submitted electronically using the CPT Category III codes defined in the TRICARE Operations Manual, Chapter 18, Section 18;

2.7 Within 45 days of hire all ABA Supervisors, assistant behavior analysts and BTs must have completed a Criminal History Background (CHBC) that includes Federal, State and County Criminal and Sex Offender reports for all locations the Behavior Technician has resided or worked during the previous 10 years;

2.8 If the ACSP is composed of an individual ABA Supervisor it will be the responsibility of MHN to perform the required CHBC as part of the credentialing process;

2.9 All ABA Supervisors, assistant behavior analysts and BTs must have received Basic Life (BLS) or a Cardiopulmonary Resuscitation (CPR) equivalent certification, as demonstrated by completion of a live course (no web-based programs) that includes practice on a dummy.

2.10 All BCBAs and BCBA-Ds who supervise assistant behavior analysts and/or BTs must have taken and passed the BACB eight-hour supervisory training course and competency course. All BCaBAs who supervise a BT must have taken and passed the BACB eight-hour supervisory training course and competency course. An equivalent eight-hour supervisory training course is required of QASPs certified by QABA.

2.11 All ABA Supervisors, assistant behavior analysts and BTs must have never been convicted of a felony.

III. Behavior Technicians

3.1All BTs must possess an RBT, ABAT, or BCAT certification, or certification from a body approved by the Director, DHA.

3.2 Behavior Technician must receive appropriate supervision in accordance with the BACB requirements for Behavior Technicians as well as any additional supervision required by the TRICARE Operations Manual, Chapter 18, Section 18. Supervision must be provided in accordance with the state licensure and certification requirements in the state in which ABA services are rendered.

3.3 Behavior Technician must have received all Behavior Technician training outlined in TRICARE Operations Manual (TOM) Chapter 18, Section 18.

V. Assistant Behavior Analysts

5.1 ACSP agrees that assistant behavior analysts employed or contracted by the ACSP must be approved by the MHN Credentialing Committee prior to assigning to a TRICARE Beneficiary. The credentialing requirements include but are not limited to the following:

(a) Have a bachelor's degree or above in a qualifying filed as defined by the state licensure or certification requirements, or by the BACB (BCaBAs) or QABA (QASPs) for states that do not regulate ABA,
(b) Have BLS or CPR equivalent certification, as demonstrated by the completion of a live course (no web-based programs) that includes practice on a dummy.
(c) All BCaBAs who supervise a BT must have taken and passed the BACB eight-hour supervisory training course and competency course. An equivalent eight-hour supervisory training course is required of QASPs certified by QABA.
(d) Have one of the following credentials:

A current, unrestricted State-issued license to provide ABA if residing in a state that offers licensure; or

i. A current, unrestricted State-issued certification as a provider of ABA if residing in a state that does not offer licensure but offers certification; or
ii. A current certification from BACB or QABA where such state-issued license or certification is not available;

5.2 In addition, the following requirements must be met by the assistant behavior analyst prior to assignment to a TRICARE Beneficiary:

(a) Assistant behavior analysts must receive supervision in compliance with the BACB or QABA (or those of another certification body approved by the Director, DHA) rules and regulations. Only direct supervision, where the authorized ABA supervisor directly observes the assistant behavior analyst providing services with the beneficiary, will be reimbursed.

(b) Claims for unsupervised services of an assistant behavior analyst shall be denied.

ADDENDUM H, I , J, K, L, N,O, P, Q, S

Not Applicable.

ADDENDUM R
LANGUAGE ASSISTANCE PROGRAM
(California Providers Only)

1. Definitions. Unless otherwise provided in this Amendment, capitalized terms have the same meaning as set forth in the Language Assistance Program Regulations.

2. Language Assistance Program. Plan shall establish and maintain an ongoing language assistance program to ensure Limited English Proficient ("LEP") Enrollees have appropriate access to language assistance while accessing health care services as required by the Language Assistance Program Regulations. Provider shall cooperate and comply, as applicable, with Plan's language assistance program; however, Plan shall maintain ongoing administrative and financial responsibility for implementing and operating on an ongoing basis the language assistance program for Enrollees.

3. Controlling Language. Except as specifically amended by this Amendment, the Agreement shall continue in full force and effect. Whenever the terms of the Agreement and this Amendment are in conflict, the terms of this Amendment shall control.

ADDENDUM T

California Applied Behavior Analyst (ABA) Providers Only

1. All terms, conditions and requirements under the Agreement shall be applicable to the provision of services covered by this Addendum except as otherwise provided herein.

2 Provider shall, in accordance with the provisions of this Addendum, provide Covered Services to Enrollees who are covered under a Benefit Plan issued by MHN or an Affiliate for any line of business listed or identified in Addendum M-1 and M-2 to this Agreement, in accordance with the terms and conditions of California Health and Safety Code section 1374.73 and the applicable implementing regulations.as well as all applicable state and federal laws and regulations.

3. PROVIDER agrees to the following:

3.1 PROVIDER is a Board Certified Behavior Analyst (BCBA), Board Certified Behavior Analyst – Doctoral (BCBA-D), or Group contracted by MHN either as an individual or as a member of a practice group for the provision of Behavior Analysis (ABA) services to members enrolled in health benefit plans of MHN or an affiliate. As such PROVIDER and the members of its Group if applicable agrees to meet all of the requirements for such certification as provided under the Behavior Analyst Certification Board (BACB) requirements and standards and/or under the laws, rules and regulations of of California, including but not limited to California Health and Safety Code section 1374.73 and the applicable implementing regulations.

3.2 PROVIDER agrees to only assign MHN members to those qualified autism professionals and qualified autism paraprofessionals that PROVIDER directly supervises and employs and meets the following minimum qualifications:

3.2.1 Qualified autism professional must be a behavioral service provider approved as a vendor by a California Regional Center to provide services as an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program as defined in Section 54342 of Title 17 of the California Code of Regulations.

3.2.2 Qualified autism professional must have training and experience in providing services for Pervasive Developmental Disorders or Autism pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code.

3.2.3 Qualified autism paraprofessional must have a High School Diploma or the equivalent and 500 hours of employment providing paraprofessional services which incorporates 30 hours of competency-based training designed by a certified behavior analyst, and has six months experience working with persons with developmental disabilities; or

3.2.4 Possesses an Associate's Degree in either a human, social, or educational services discipline, or a degree or certification related to behavior management, from an accredited community college or educational institution. At a minimum, the degree coursework must include 12 semester hours in psychology, education, social work, behavioral science, human development, or related fields and has six months experience working with persons with developmental disabilities.

3.2.5 Qualified autism paraprofessional must have completed a County, State, Federal and sex offender criminal background report for all locations the paraprofessional has resided or worked during the previous 7 years and this shall be completed prior to providing services to Enrollees. All background checks must have been completed within the past 12 months of the execution of the MHN Participating Provider Agreement unless the

group has a contract with a company which performs on-going monitoring by the Department of Justice. In such cases, the background check does not need to be re-run to meet the 12 month requirement. Paraprofessional must be free of any adverse findings that could negatively impact the services they are employed to provide under this Addendum T

3.3 PROVIDER will provide no less than one hour of supervision per 10 hours of ABA treatment for all supervisees. For qualified autism professionals (BCaBAs), PROVIDER will also provide no less than one hour of supervision per month, and annually at least two of these supervision sessions shall be conducted in-person, to include direct observation of actual service provision with individuals per BACB Guidelines. PROVIDER will also at a minimum, provide feedback regarding the performance of all supervisees at least once per two weeks or consistent with BACB requirements.

3.4 The qualified autism professionals and qualified autism paraprofessionals whom PROVIDER employs and supervises provide treatment and implement services under a treatment plan developed and approved by PROVIDER.

3.5 The qualified autism professionals and qualified autism paraprofessionals whom PROVIDER employs and supervises have the adequate education, training and experience, as required by where the treatment is delivered and meet the criteria set forth in all relevant BACB requirements and standards and state regulations (such as California - Section 4686.3 of the California Welfare and Institutions Code).

3.6 As training and certification requirements change, PROVIDER, as well as the qualified autism professionals and qualified autism paraprofessionals PROVIDER supervises and employs will comply with all BACB requirements and standards and all federal and state laws and regulations, including but not limited to California Health and Safety Code section 1374.73 and the applicable implementing regulations.

3.7 If a Group Provider, PROVIDER shall require each Group Member employed to provide applied behavior analysis services to MHN members, to sign a Statement of Understanding acknowledging and agreeing to all applicable MHN policies and applicable laws and regulations of including but not limited to California Health and Safety Code section 1374.73 and the applicable implementing regulations.

[Per Section 3.7 of Addendum T, all contracted Group members must sign the following Statement of Understanding to attest to compliance with SB 946, and any upcoming regulatory changes that may occur]

Group Provider Statement of Understanding

I, _____as a Board Certified Behavior Analyst (BCBA), Board Certified Assistant Behavior Analyst (BCaBA), or Board Certified BehaviorAanalyst-Doctoral (BCBA-D) contracted with X Group, to participate in Managed Health Network, Inc's commercial provider network for the provision of covered Applied Behavior Analysis (ABA) services to members enrolled in health benefit plans of Managed Health Network, Inc hereby represent:

1. I am a Board Certified Behavior Analyst (BCBA), Board Certified Associate Behavior Analyst (BCaBA, or Board Certified Behavior Analyst –Doctoral (BCBA-D), or Group contracted by MHN for the provision of Behavior Analysis (ABA) services to members enrolled in health benefit plans of MHN or an affiliate. I agree to meet all of the requirements for such certification as provided under the Behavior Analyst Certification Board (BACB) requirements and standards and/or under the laws, rules and regulations of the states in which services are or will be rendered;

2. If a BCBA or BCBA-D, I agree to only assign MHN members to those qualified autism professionals and qualified autism paraprofessionals who I directly supervise and employ. I agree that they meet the following minimum qualifications:

    i. Qualified autism professional must be a behavioral service provider approved as a vendor by a California Regional Center to provide services as an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program as defined in Section 54342 of Title 17 of the California Code of Regulations.
    ii. Qualified autism professional must have training and experience in providing services for Pervasive Developmental Disorders or Autism pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code.

    iii. Qualified autism paraprofessional must have a High School Diploma or the equivalent and 500 hours of employment providing paraprofessional services which incorporates 30 hours of competency-based training designed by a certified behavior analyst, and has six months experience working with persons with developmental disabilities; or
    iv. Possesses an Associate's Degree in either a human, social, or educational services discipline, or a degree or certification related to behavior management, from an accredited community college or educational institution. At a minimum, the degree coursework must include 12 semester hours in psychology, education, social work, behavioral science, human development, or related fields and has six months experience working with persons with developmental disabilities.
    v. Qualified autism paraprofessional must have completed a County, State, Federal and sex offender criminal background report for all locations the paraprofessional has resided or worked during the previous 7 years and this shall be completed prior to providing services to Enrollees. All background checks must have been completed within the past 12 months of the execution of the MHN Participating Provider Agreement unless the group has a contract with a company which performs on-going monitoring by the Department of Justice. In such cases, the background check does not need to be re-run to meet the 12 month requirement. Paraprofessional must be free of any adverse findings that could negatively impact the services they are employed to provide under this

Addendum T

3.3 If a BCBA or BCBA-D, I will provide no less than one hour of supervision per 10 hours of ABA treatment for all supervisees. For qualified autism professionals (BCaBAs), I will also provide no less than one hour of supervision per month, and annually at least two of these supervision sessions shall be conducted in-person, to include direct observation of actual service provision with individuals per BACB Guidelines. I will also at a minimum, provide feedback regarding the performance of all supervisees at least once per two weeks or consistent with BACB requirements.

3.4 If a BCBA or BCBA-D, the qualified autism professionals and qualified autism paraprofessionals whom I employ and supervise provide treatment and implement services under a treatment plan developed and approved by myself.

3.5 If a BCBA or BCBA-D, the qualified autism professionals and qualified autism paraprofessionals whom I employ and supervise have the adequate education, training and experience, as required by where the treatment is delivered and meet the criteria set forth in all relevant BACB requirements and standards and state regulations (such as California - Section 4686.3 of the California Welfare and Institutions Code).

3.6 If a BCaBA, I only treat cases under direct supervision of a BCBA or BCBA-D by whom I am supervised and employed. I am a behavioral service provider approved as a vendor by a California Regional Center to provide services as an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program as defined in Section 54342 of Title 17 of the California Code of Regulations. I also have training and experience in providing services for Pervasive Developmental Disorders or Autism pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code. In addition, I comply with the supervision regulations of the BACB as referenced in Section 3.3 of this Addendum T.

3.7 As training and certification requirements change, I, as well as the qualified autism professionals and qualified autism paraprofessionals I supervise and employs will comply with all BACB requirements and standards and all federal and state laws and regulations, including SB 946.

3.8 If a Group Provider, I shall require each Group Member employed to provide applied behavior analysis services to MHN members, to sign a Statement of Understanding to MHN acknowledging and agreeing to all applicable MHN policies and applicable laws and regulations of SB 946.