Priority Health

PROVIDER GROUP PARTICIPATION AGREEMENT

THIS AGREEMENT ("Agreement") is made and entered into as of _____, 2025, by and between PRIORITY HEALTH ("Priority Health"), PRIORITY HEALTH CHOICE, INC., ("PHC"), a Michigan nonprofit corporation and licensed health maintenance organization, and PRIORITY HEALTH MANAGED BENEFITS, INC., ("Managed Benefits"), a Michigan business corporation, management services company and licensed Third Party Administrator, and affiliates (collectively, "Priority Health"), and, _____ providers licensed under the laws of the State of Michigan ("Group").

R E C I T A L S

WHEREAS, Priority Health arranges for the provision of health maintenance and other services to its Members (defined below) and administrative services for Plans (as defined below).

WHEREAS, Priority Health has entered into a Medicare Advantage contract with the Centers for Medicare and Medicaid Services to provide managed health care services to certain Medicare beneficiaries (the "Medicare Advantage Program").

WHEREAS, PHC is a Michigan nonprofit corporation and licensed health maintenance organization that has contracted with the State of Michigan to provide managed health care services to the State's Medicaid enrollees.

WHEREAS, Group is comprised of providers who are duly licensed as health care providers, in their designated specialty in the State of Michigan.

WHEREAS, Priority Health desires to enter into a participation agreement with Group for the provision of health care services to its Members that contains a compensation arrangement and financial incentives for the efficient utilization of health care services by Members.

WHEREAS, Group desires to contract with Priority Health so that its providers may provide professional services to persons eligible to receive benefits under a Plan for which Priority Health provides services.

WHEREAS, Group agrees to provide health care services to Priority Health Members in accordance with the terms and conditions of this Agreement.

NOW, THEREFORE, in consideration of the mutual covenants set forth below, Priority Health and Group agree as follows:

GENERAL TERMS AND CONDITIONS:

This Agreement may have an Exhibit I HMO/PPO Plan Product Schedule Reimbursement Methodology, Exhibit II Medicare Advantage Plan Product Schedule Reimbursement Methodology, Exhibit III Medicaid Plan Product Schedule Reimbursement Methodology, and Exhibit IV Reimbursement Rates, as applicable, which are included and incorporated into this Agreement.

Additional language will be included in the Plan Product Schedule, as applicable, and each specific Plan Product Schedule shall be a part of and be governed by the terms and conditions of this Agreement. Where a term in this Agreement contemplates that in which the Plan Product Schedule may provide otherwise, the term in the Plan Product Schedule shall control with respect to that particular Plan.

ARTICLE I
Definitions

The following capitalized terms when used in this Agreement shall have the meanings as defined in this Article I, additional capitalized terms shall have the meanings as defined in the Plan Product Schedules, attached to this Agreement.

Section 1.1. Certificate of Coverage. "Certificate of Coverage" means the document that Members receive from Priority Health that describes Members' and Priority Health's rights and duties. It includes the enrollment form, amendments and attachments to the document.

Section 1.2. Clean Claims. "Clean Claims" means claims that conform to the Clean Claim requirements per the Michigan Insurance Code MCL 500.2006 or set forth in MCL 400.111i, or for equivalent claims under Original Medicare, as applicable.

Section 1.3. Covered Services. "Covered Services" means all health care services that Priority Health must provide for a Member under a Plan.

Section 1.4. Credentialing, Recredentialing and Hearing Policy. "Credentialing, Recredentialing and Hearing Policy" means the policy or policies that Priority Health will follow in credentialing a new applicant interested in becoming a Participating Provider with Priority Health, in recredentialing a Participating Provider every three (3) years, and in resolving disputes with Providers as set forth on Priority Health's Website.

Section 1.5. Group, Group Provider or Provider. "Group", "Group Provider" or "Provider" means an appropriately licensed health care professional who has successfully completed the credentialing procedure in accordance with Section 2.1 (d) and who is a shareholder, member, partner or employee of Group or sub-contracted health care professional who will provide services on behalf of Group, pursuant to this Agreement. Each non-employed or sub-contracted health care professionals shall agree to abide by the terms of this Agreement.

Section 1.6. Medically Necessary. "Medically Necessary" means those Covered Services and supplies which are provided in accordance with recognized professional medical and surgical practices and standards which are evidence-based and are determined to be: (a) appropriate and necessary for the symptoms, diagnosis or treatment of the Member's medical condition; and (b) provided for the diagnosis and direct care and treatment of such medical condition; and (c) not furnished primarily for the convenience of the Member, the Member's family, or the treating provider or other provider; and (d) furnished at the most appropriate level which can be provided consistent with generally accepted medical standards of care.

Section 1.7. Member. "Member" means a person, participant, or Medicare beneficiary, who has enrolled in a Plan (including enrolled dependents) and is entitled to receive Covered Services.

Section 1.8. Overpayment. "Overpayment" means any payment that was made to which the person or entity had no entitlement to or any payment made in excess of the amount due, as described in Correcting Payments in the Provider Center on the Priority Health website, and including but not limited to takebacks and retro terminations

Section 1.9. Participating Provider. "Participating Provider" means a physician, facility, or other health care provider credentialed and contracted with Priority Health to provide Covered Services to a Member.

Section 1.10. Partners For Performance Group. "Partners For Performance Group" means the group of physicians (or Group) that a physician designates as his or her group for purposes of Priority Health's computation of reimbursement under this Agreement.

Section 1.11. Payment Integrity Programs. "Payment Integrity Programs" means programs and initiatives, activities, inspection of or reviews of Clean Claims to prevent fraud, waste, billing errors and improper payment in accordance with state and federal coding guidelines.

Section 1.12. Plan. "Plan" means a benefit plan in which Group is invited to participate, permitted under the Michigan Insurance Code, or product for which Priority Health provides services, including administrative services, which may include any HMO, PPO, Medicare Advantage Program and/or PHC Medicaid managed care plan.

Section 1.13. Plan Sponsor. "Plan Sponsor" means any entity, public or private, or other sponsor of a Plan which (i) is responsible for payment to Participating Providers for Covered Services rendered to Members under a Plan, including, but not limited to, self-funded and fully-funded health or insurance plans and (ii) contracts with Priority Health for administrative services.

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

Section 1.15. Priority Health's Website. "Priority Health's Website" means that website maintained by Priority Health and generally available to Providers at www.priorityhealth.com.

Section 1.16. Provider Manual. "Provider Manual" means the location on the Priority Health website which contains Priority Health's and/or Plan's policies and procedures that Participating Providers shall be required to follow, including without limitation, a description of internal mechanism to resolve disputes concerning the interpretation or application of the terms of this Agreement. The Provider Manual is incorporated into and made a part of this Agreement.

Section 1.17. Quality Assessment and Performance Improvement. "Quality Assessment and Performance Improvement" means the prospective, concurrent, and retrospective quality assessment and performance improvement protocols required by CMS that Priority Health applies to Covered Services to assure that Participating Providers provide Members with high quality efficient health care as described in the Priority Health Quality Assessment and Performance Improvement manual or other program documents.

Section 1.18. Specialty Care Provider. "Specialty Care Provider" means a physician who is not a Primary Care Provider and who is professionally qualified to practice his or her designated specialty.

Section 1.19. Underpayment. "Underpayment" means any payment that was made to Group that is less than the amount due, not including Member financial obligations.

Section 1.20. Utilization and Quality Management. "Utilization and Quality Management" means the prospective, concurrent, and retrospective utilization management and quality management protocols that Priority Health applies to Covered Services to assure that Participating Providers provide Members with high quality efficient health care.

ARTICLE II
Group's Agreements and Obligations

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

(a) If a Primary Care Provider, Provider will

(i) provide those Medically Necessary Covered Services constituting initial and primary care to, and manage the total patient care of, Members selecting or assigned to such Group Provider, and

(ii) maintain its practice open to new Members, and continue to treat any of its current patients who become Members, and

(iii) be available no less than twenty (20) hours per week at any practice location (including the hours of any physician assistant or nurse practitioner supervised by such Primary Care Provider) during such hours as shall be convenient to, and not discriminatory against, Members;

(iv) assist Priority Health in identifying Members with complex or serious medical conditions; assessing those conditions using medical procedures to diagnose and monitor them on an ongoing basis; and establishing and implementing a treatment plan that is appropriate to those conditions including an adequate number of direct access visits to specialists consistent with the treatment plan, is time-specific and updated periodically, and ensures adequate coordination of care among providers;

(v) assist Priority Health in making a best effort attempt to conduct an initial assessment of each Member's health care needs, including following up on unsuccessful attempts to contact a Member within ninety (90) days of the effective date of the Member's enrollment in the Plan; and

(vi) give Priority Health sixty (60) days' prior written notice of the closing of Group's office to new Members and the date on which Group will again accept new Members; provided that, if Group closes its practice, Group will continue to treat any of its current patients who become Members.

(b) If a Group Provider is a Specialty Care Provider, will provide Medically Necessary Covered Services within his or her designated specialty for a Member upon referral from a Primary Care Provider, as applicable.

(c) In the case of a psychiatric emergency, Group Provider agrees to:

(i) Obtain, where feasible and consistent with the appropriate standard of care, from a twenty-four (24) hour on-call service provided by Priority Health, prior approval for any services not pre-authorized by Priority Health.

(ii) Will refer a Member to Priority Health in the event any mental health or chemical dependency treatment or other medical services are required by the Member, which are beyond the scope of any Covered Services authorized under this Agreement.

(d) Will comply with all provisions of the practice guidelines, utilization management guidelines, policies and procedures and the Credentialing, Recredentialing and Hearing Policy and:

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

(ii) Each Group Provider acknowledges that this Agreement gives Priority Health the right to limit, suspend or terminate such Group Provider's participation in the Priority Health provider network pursuant to the Credentialing, Recredentialing and Hearing Policy.

(e) If a physician, agrees that Priority Health will designate each physician a Primary Care Provider or a Specialty Care Provider, in accordance with Priority Health's policies (and the CMS Contract for each Member, as applicable).

(f) Will provide Medically Necessary Covered Services for Members within his or her designated specialty and will be accessible by telephone or otherwise to Members, either personally or through back-up coverage from other Participating Providers (or Non-Participating Providers, if medically necessary), twenty-four (24) hours per day, seven (7) days per week, three hundred sixty-five (365) days per year in accordance with the Member's Plan and the Priority Health policy pertaining to After Hours Coverage.

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

(h) Will report all communicable disease and other reportable health events as required by law.

(i) Will permit a Member to review, request to amend and obtain a copy of his or her medical record upon request.

(j) If the need to refer a Member to another provider occurs, will refer Members to Participating Providers, if available and medically appropriate.

(k) Acknowledges and agrees that Members may directly access (through self-referral to Participating Providers) screening mammography and influenza vaccine Covered Services. Further, female Members may directly access (through self-referral to Participating Providers who are women's health specialists) women's routine and preventive Covered Services.

(l) Will notify Priority Health within a reasonable time of material changes in any information Group or any Group Provider has provided to Priority Health, including any addition of Provider(s) to or deletion of Provider(s) from the Group.

(m) Agrees to cooperate with Priority Health site visits in connection with the credentialing process and shall provide access to practice sites upon reasonable notice from Priority Health, including access to medical recordkeeping and confidentiality processes, as applicable.

(n) Understands that Priority Health will comply with all federal and state reporting requirements including but not limited to those imposed by the Health Care Quality Improvement Act, 42 U.S.C. § 11101 et seq. (The National Practitioner Data Bank), the Healthcare Effectiveness Data and Information Set (HEDIS), and the Consumer Assessment of Healthcare Providers and Systems (CAHPS). Group understands that Priority Health is required by the Centers for Medicare and Medicaid Services ("CMS") to maintain a health information system that collects, analyzes and integrates all data necessary to compile, evaluate and report certain statistical data, including encounter data.

Group agrees to submit all complete and accurate data necessary for Priority Health to fulfill their obligations within the timeframes as specified by Priority Health.

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

(p) Will not deny, limit, or condition the provision of services to Members on the basis of any factor related to health status, including, but not limited to, the following:

(i) medical condition, including both mental and physical illness;

(ii) claims experience;

(iii) receipt of health care;

(iv) medical history;

(v) genetic information;

(vi) evidence of insurability, including conditions arising out of acts of domestic violence; and

(vii) disability.

(q) Will render Covered Services to Members in the same manner, in accordance with the same standards and within the same time availability as Group offers the same services to Group's non-Plan patients.

(r) Consents to being referred to as a provider who participates with Priority Health in marketing and other materials.

(s) Will participate in Utilization Management and Quality Improvement programs, including safety initiatives and HEDIS reviews, and will, when appropriate, initiate review or action pursuant to such programs.

(t) Will comply with and participate in, as applicable, Priority Health's grievance system and will cooperate with Priority Health in resolving any grievances related to the provision of Covered Services. Group agrees to abide by all final grievance decisions.

(u) Acknowledges that all materials relating to practice guidelines, pricing structures, contracts, and the internal functioning of Priority Health and all other materials bearing the name or logo of Priority Health are proprietary. Group agrees to maintain the confidential nature of such materials and to return them to Priority Health upon termination of this Agreement.

(v) Will verify Member eligibility for Covered Services before providing such services.

(w) Will comply with coding standards as set forth by International Classification of Diseases, 10th Edition, Clinical Modification/Procedure Coding System, or subsequently released versions of the same.

(x) Will comply with Priority Health's policies and procedures as outlined in the Provider Manual.

(y) Will cooperate with and be subject to Payment Integrity programs according to provisions of the Provider Manual as set forth on Priority Health's Website.

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

(aa) Will notify Priority Health in writing within seven (7) business days of receipt of notification of any and all claims, lawsuits, arbitration, or settlement relating to services rendered by Group to Priority Health Members.

(bb) Will submit Member Laboratory result data directly to Priority Health or to a designated third party for use in determination of HEDIS measures and other quality and/or efficiency programs.

Section 2.2. Provision of Covered Services. Group agrees that all mental health or chemical dependency services shall be rendered by qualified mental health clinicians authorized to practice in the jurisdiction in which such services are rendered. Clinical services may be rendered under appropriate clinical supervision by the following types of clinicians: psychiatrists, addictionologists, psychologists, clinical social workers, clinical nurse specialists and other Master's level clinicians. Group agrees not to refer any professional duties to any other health professional without the approval of Priority Health.

Section 2.3. Delegation. Group agrees not to delegate any professional duties to any other Provider without the approval of Priority Health. Group shall submit to Priority Health credentials for providers to whom professional duties may be delegated. Group shall supervise and review all Covered Services rendered to Members by another provider to ensure compliance with the terms of this Agreement.

Section 2.4. Member Self-Determination. Group acknowledges that Members have the right under state and federal law to make decisions regarding medical care including the right to accept

or refuse life-sustaining treatment. Group agrees to provide information regarding treatment options to Members in a culturally competent manner, including the option of no treatment. Group Provider agrees to comply with the Patient Self-Determination provisions of the Omnibus Budget Reconciliation Act of 1990, and state law to the extent these laws apply to services Group Provider provides to Members pursuant to this Agreement. The parties agree that, although Priority Health has the duty to compensate Group for Covered Services, nothing in this Agreement shall prohibit or otherwise interfere with free communications between Group Provider and Members regarding all treatment options appropriate for their conditions even if such options are not Covered Services.

Section 2.5. Record Keeping. Group will maintain medical, financial, and administrative records concerning Covered Services provided to Members and will keep these records for at least ten (10) years from the date Group rendered the Covered Services.

(a) Group agrees that Priority Health, together with duly authorized third parties, will have the right to inspect, review, and make copies of records directly related to the Covered Services rendered to Members, upon reasonable notice, during regular business hours. Group also agrees that authorized regulatory agencies may inspect, review, and make copies of records to the extent permitted by law.

(b) Group acknowledges that Priority Health generally obtains from Members at enrollment their consent to release their medical records to Priority Health. Group agrees to assist Priority Health in obtaining additional consents from Members upon Priority Health's request.

(c) Group shall maintain the confidentiality of Member information and records as required by federal law and regulations, which require reasonable administrative, technical, and physical safeguards to ensure the integrity and confidentiality of Member information. Group and each Group Provider will only release such information to third parties upon the written consent of the Member; provided, however, that Group Providers agree to release Member information to Priority Health for the purpose of administering the Plans.

(d) Group acknowledges that Priority Health is a "Covered Entity" and the Group is or may be a "Business Associate" of Priority Health pursuant to this Agreement and the Health Insurance Portability and Accountability Act, Public Law 104-191, and any amendments thereto ("HIPAA"). If and only to the extent HIPAA defines Group as a Business Associate of Priority Health, Group and Priority Health agree to amend this Section 2.5 as is necessary for Priority Health to comply with applicable law, including the rules of professional conduct and HIPAA as amended from time to time.

(e) Provider shall ensure that any subcontractor or other entity to whom it provides or allows to create for Provider any Protected Health Information or Electronic Protected Health Information (PHI) as defined under HIPAA enters into with Provider a Business Associate Agreement (BAA) as defined under HIPAA. The use of any such subcontractor or other entity domiciled and/or providing any portion of the aforementioned services in a location outside of the United States must be approved in advance by Priority Health.

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

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

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

(c) Group will provide workers' compensation insurance for all of his, her, or its employees working in the State of Michigan, as applicable.

(d) Group will notify Priority Health at least thirty (30) days prior to the termination, cancellation, lapse or reduction of such insurance.

(e) Upon request by Priority Health, Group will provide Priority Health with policies or other documents evidencing such insurance.

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

Section 2.7. Medical Record and Billing Reviews

(a) Subject to all applicable laws and the confidentiality provisions set forth in Section 2.5(c) of this Agreement, Group and each Group Provider shall allow Priority Health to conduct reasonable standard reviews of Group's and each Group Provider's medical and billing records related to Covered Services provided to Members under this Agreement. Group and/or any Group Provider shall receive thirty (30) days advance written notice from Priority Health advising Group or any Group Provider of the standard review and setting forth the scope of the medical and billing records to be reviewed, except for reviews involving fraud or abuse. Group and each Group Provider shall provide Priority Health with on-site access during Group's or such Group Provider's regular business office hours to all appropriate medical and billing records of Covered Services to Members as may be necessary for benefit determination, and/or verification of compliance with the requirements of the Utilization and Quality Management and Payment Integrity programs.

(b) All standard field reviews shall be initiated, and initial audit findings submitted to Group or any Group Provider within nine (9) months from the date of notification by Priority Health of the review. Priority Health reviewers will use their best efforts to minimize disruption to normal operations while conducting standard medical and billing record reviews. All standard field reviews shall be initiated and completed, including receipt by

Group of a Notice of Determination, within eighteen (18) months from the date of payment, excluding cases under appeal. At the request of Priority Health, Group shall provide Priority Health with copies electronically.

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

(d) At the request of Priority Health for the purpose of standard Medical Record and Billing Record reviews, Group shall provide Priority Health with direct remote electronic access for such requested medical and billing records through a web-based portal such as EpicCare Link or similar tool, if feasible. Where direct remote access is not feasible, centralized on-site EMR access will be made available. Where direct remote and on-site access are not feasible, electronic copies of requested medical records will be submitted in exchange for payment equal to as follows:

(i) for paper copies, reimbursement equals to $0.25 per page, not to exceed $50.00 per record; or

(ii) for reviews, onsite at Group location and Priority Health provides the paper, a reimbursement equal to $0.10 per page will be provided; or

(iii) for approved electronic medium, such as, FTP, flash-drive, or CD, a reimbursement equal to $0.10 per page will be provided, not to exceed $50.00 per record.

Group will allow access and/or submit such medical records within Sixty (60) days from the date of the request.

Reimbursement for medical record requests will require an invoice from Group and must be received by Priority Health within sixty (60) days from the date Priority Health received the requested records. Invoice will include the date of service, full name and date of birth of member(s) records requested. Priority Health will pay only for requested record or pages, reimbursement for blank pages or records not relevant to the review will not be made. This reimbursement does not apply to medical records requested for the purpose of a provision of a service, predetermination of a service or claim adjudication. Priority Health does not pay hourly rate for medical record requests. Group shall be responsible for

assuring that any third-party medical record fulfillment contractors will abide by the provisions of this Section 2.7 of the Agreement.

Section 2.8. Compliance with Policies and Procedures. Group and each Group Provider shall abide by and participate in any and all policies and procedures of Priority Health and Plan posted on provider portal, including without limitation, those regarding website access, information systems security, credentialing, recredentialing, utilization management and quality improvement, grievance, dispute resolution, medical records, confidentiality, peer review, audit, independent quality review and improvement, medical management and comply with all final decisions rendered by or pursuant to such policies or procedures; provided however, that if any provision in such policy or procedure is inconsistent with any provision in this Agreement the applicable provision of this Agreement shall prevail.

Section 2.9. Partners For Performance ("PFP") Groups. If applicable and except as otherwise provided below, Group will designate, on the contract signatory page, the Partners For Performance Group ("PFP Group") within which Priority Health will include Group for its calculation of Group incentive payments, in accordance with the then current Partners In Performance Technical Specifications Manual. All changes in PFP Groups must be approved by Priority Health, such approval not to be unreasonably withheld.

(a) Group represents that current and future Group's Participating Providers consent to membership in the PFP Group designated on such contract signatory page.

(b) Group agrees to maintain PFP status of eligible practitioners in accordance with Partners in Performance Technical Specifications Manual.

(c) Group may amend Group's designation of PFP Group annually at the renewal date of this Agreement upon ninety (90) days prior written notice to Priority Health. Group may change its PFP Group under the following circumstances only:

(i) Change in contract status (e.g., individual, group, PHO)

(ii) Change of hospital affiliation

(iii) Change of employment status

ARTICLE III
Agreements and Obligations of Priority Health

Section 3.1. Information. Priority Health will:

(a) Make available descriptions of Plans to Group.

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

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

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

(e) Notify Group of all Member complaints involving Group or any Group Provider.

(f) Make available to Group monthly summaries of age/sex membership listing, by Primary Care Provider (PCP) and by product line. Group may audit the monthly reports of the age/sex membership lists at its own expense.

(g) Make available to Group a listing of Members enrolled with Group Primary Care Providers. Priority Health will offer said list monthly, either in document form or electronically.

Section 3.2. Insurance. Priority Health will maintain insurance to insure against any claim or claims for damages arising out of or in any way connected with the acts or omissions to act of Priority Health, its agents, or employees.

(a) Priority Health will maintain current professional liability insurance coverage with limits of at least one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) aggregate for a year.

(b) Priority Health will also maintain comprehensive general liability insurance coverage with limits of at least one million dollars ($1,000,000) for each claim and three million dollars ($3,000,000) aggregate for a year.

Section 3.3. No Restriction. Priority Health may not prohibit or otherwise restrict Group or Group Providers from acting within the lawful scope of practice, from advising, or advocating on behalf of, a Member with respect to:

(a) The Member's health status, medical care, or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to provide an opportunity for the Member to decide among all relevant treatment options;

(b) The risks, benefits, and consequences of treatment or non-treatment; or

(c) The opportunity for the Member to refuse treatment and to express preferences about future treatment decisions.

Section 3.4. Non-Discrimination. Priority Health shall not discriminate, in terms of participation, reimbursement, or indemnification, against any health care professional who is acting within the scope of his or her license or certification under state law, solely on the basis of the license or certification, subject to the discretionary elements allowed by 42 CFR §422.205.

Section 3.5. Group Contracts. Priority Health and Plan must approve or disapprove the participation of any Group or Group Provider participating in this Agreement.

ARTICLE IV
Payment Terms and Obligations

Section 4.1. Payment Administration.

(a) Group will bill accurate and timely claims in accordance with standardized coding and billing practices for services rendered. Group will submit itemized, Clean Claims for billable Covered Services using the appropriate billing form and in accordance with Priority Health's billing requirements. Group will submit claims for billable Covered Services within one (1) year from the date of service, or, in those instances in which Priority Health is the secondary payor, one (1) year from the date of service or ninety (90) days from the date that Group receives a notice of payment decision from the primary payor, whichever is later. Priority Health may deny any claims submitted (i) after one (1) year from the date of service or, (ii) in those instances in which Priority Health is the secondary payor, one (1) year from the date of service or ninety (90) days from the date that Group receives notice of payment decision from the primary payor, whichever is later, or (iii) greater than one-hundred eighty (180) days after Priority Health has requested additional information from Group as set forth on Priority Health's Website.

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

(c) Group or Group Provider, as applicable, and Priority Health shall notify each other if either party becomes aware of an Overpayment or Underpayment. If Priority Health pays Group or a Group Provider more than is provided for in the applicable Plan, Group or the Group Provider agrees to return, within sixty (60) days after Group or the Group Provider receives notice of (or becomes aware of) such Overpayment, such amounts to Priority Health. Priority Health may offset against future payments: (i) Overpayments of $200 or less to a Group Provider, (ii) Overpayments of $5,000 or less to a Hospital, and (iii) Overpayments that have not been repaid to Priority Health within sixty (60) days of notice to Group or the Group Provider of the Overpayment. If Priority Health pays Group or a Group Provider less than is provided for in the applicable Plan, Priority Health shall pay the additional amount owed within sixty (60) days after Priority Health receives notice of (or becomes aware of) such Underpayment from Group or Group Provider. Overpayment and Underpayment adjustments will be made according to provisions of the Provider Manual as set forth on Priority Health website.

(d) Group agrees that if any Group Provider fails to participate to Priority Health's satisfaction in the Utilization and Quality Management program, or if Group fails to submit a timely claim, Priority Health may deny or reduce payments to Group.

(e) If Group elects to transmit claims to and receive reports from Priority Health electronically, Group agrees to comply with such policies and procedures as Priority Health may establish. Any costs associated with such transmission shall be the responsibility of Group. Group and any Group Provider who accesses or stores medical information about Members electronically shall establish procedures to safeguard the integrity, confidentiality and security of such medical information.

Section 4.2. Compensation Liability. Group and each Group Provider agrees that it, he or she will hold Members harmless from payment offers that are the legal obligation of Priority Health and shall not look to Members for payment for Covered Services rendered to a Member.

(a) Group and each Group Provider agree not to bill, charge, collect a deposit from, seek compensation from, seek remuneration from, surcharge, attempt in any way to hold a Member liable, or have any recourse against a Member or persons acting on behalf of a Member, except to the extent that the applicable Plan specifies a copayment, coinsurance or deductible or as permitted under the Coordination of Benefits Act.

(b) With respect to services Group and each Group Provider provides to Priority Health Members, Group and Group Provider agree not to maintain any action at law or in equity against a Member to collect sums that are owed to Group or any Group Provider under the terms of this Agreement, even if Priority Health fails to pay, becomes insolvent, or otherwise breaches the terms and conditions of this Agreement. This Section will survive termination of this Agreement, regardless of the cause of termination and will be construed to be for the benefit of Members. The parties do not intend this Section to apply to the collection of sums that are owed to Group or any Group Provider for services provided after this Agreement has terminated, except as otherwise provided in this Agreement, or to services that are not Covered Services or to copayments or deductibles. Group and each Group Provider further agree that this provision supersedes any oral or written agreement hereinafter entered into between Group or any Group Provider and any Member or person acting on such Member's behalf, insofar as such agreement relates to payment for services provided under the terms and conditions of this Agreement.

(c) It is recognized that Members may occasionally request non-Covered services of Group that are not authorized or covered by the Plan and are, therefore, payable by Members. Group agrees to look to Member for payment for these services and agrees to use best efforts to advise Member of their payment responsibility prior to rendering such services. Group and each Group Provider agree not to charge Members for services other than Covered Services and applicable deductibles, copayments and/or co-insurance unless:

(i) the Member has been informed in writing prior to receiving the non-Covered services that the services are not covered under the Plan, and

(ii) the Member has agreed in writing to pay for such non-Covered service. Group may use its own form for this purpose except as may otherwise be required by Priority Health from time to time.

(d) Group agrees that if a Group Provider's failure to participate in the Utilization and Quality Management program or Group's failure to submit a timely claim results in a denial or reduction of payment from Priority Health, Group or Group Provider will not charge Members for the resulting unpaid charges.

(e) Group and each Group Provider agree that for Members eligible for both Medicare and Medicaid as required by 422.504(g)(1)(iii), Group and each Group Provider will not hold Members liable for Medicare Part A and B cost sharing when the state is responsible for paying such amounts. Priority Health agrees to inform Group and each Group Provider of Medicare and Medicaid benefits and rules for enrollees eligible for Medicare and Medicaid. Priority Health agrees that it may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under title XIX if the individual were not enrolled in such a plan. Group and each Group Provider agree that it will:

(i) Accept Priority Health's payment as payment in full, or

(ii) Bill the appropriate state source.

Section 4.3. Timing of Payments. Priority Health will pay claims for Covered Services in accordance with the State of Michigan regulatory requirements referenced in Insurance Code of 1956, Act 218, Section 500.2006, the standard set forth in MCL 400.111i, or otherwise conforms to the Clean Claim requirements for equivalent claims under Original Medicare 42 CFR 422.520(b), as amended.

Section 4.4. Payment When Priority Health Is Secondary Payer. When Priority Health is the secondary payer, payment for Covered Services provided by Group under this Agreement shall be pursuant to Section 4.1 as modified by the coordination of benefits provisions of the Provider Manual as set forth on Priority Health's Website. When primary and secondary benefits are coordinated, determination of liability will be in accordance with the Medicare Secondary Payer rules. Group agree to cooperate with Priority Health for proper determination of coordination of benefits and to bill and collect from other payors such charges as the other payor is responsible for.

ARTICLE V
Term and Termination

Section 5.1. Term. The term of this Agreement will commence on the date first written above and the Agreement will continue in effect for a period of twelve (12) months. It will automatically renew thereafter for one (1) year terms unless terminated after the initial period of twelve (12) months pursuant to this Article V.

Section 5.2. Termination. The parties may terminate this Agreement as follows:

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

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

(c) Priority Health may terminate this Agreement with respect to Group or any Group Provider pursuant to the Credentialing, Recredentialing and Hearing Policy.

(d) Priority Health may terminate this Agreement with respect to Group or any Group Provider immediately and without notice upon Priority Health's determination that Group or any Group Provider has materially failed to comply with the Utilization and Quality Management protocols.

(e) Priority Health may terminate the Medicare Advantage Agreement upon the non-renewal or termination of its CMS Contract and will provide reasonable notice thereof.

(f) If Priority Health determines that Group or any Group Provider has not performed satisfactorily under this Agreement, the matter may be handled in accordance with Priority Health's corrective action plan and/or the matter may be considered an act of default under this Agreement pursuant to the terms and conditions of this Agreement.

Section 5.3. Obligations Following Termination.

(a) In the event of termination of this entire Agreement, or its termination as to only a particular Group Provider, Priority Health shall arrange for, and Group Provider(s) shall cooperate with, the orderly transfer of all Members then under the care of the affected Group Provider(s). At Priority Health's option, each Group Provider will continue to provide Covered Services to Members who are in Active Treatment at the time of termination until the "End Date," which shall be the greater of the date upon which both: (a) the Member is no longer in Active Treatment or 90 days; and (b) Priority Health assigns such Members to another Participating Provider. For purposes of this Section, a Member shall be considered to be in "Active Treatment" if he or she is: (i) hospitalized; (ii) undergoing treatment; or (iii) in the second or third trimester of pregnancy through the completion of normal post-partum care. Both parties will comply with the terms of this Agreement while the Member is in Active Treatment until the End Date, except that Priority Health shall compensate Group in accordance with the Priority Health Fee Schedule in effect at such time, and Group and Group Provider(s) shall not be entitled to any additional compensation during that time period. Group shall notify affected Members and/or their employer groups of terminations and obligations of Group thirty (30) days prior to the date of termination as described in this Section.

(b) Priority Health shall notify affected Members and/or their employer groups of terminations and obligations of Group Providers following termination as described in this Section.

(c) Upon termination, Group or Group Provider shall promptly supply to Priority Health all information necessary for the reimbursement of any outstanding claims.

(d) In the event of the insolvency of Priority Health, Group or Group Provider shall continue to provide Covered Services to Members until the end of the period for which Priority Health has received premiums from the State of Michigan or CMS, as applicable, or, if a Member is hospitalized on the date the contract with CMS terminates, through the date of discharge.

ARTICLE VI
General Provisions

Section 6.1. Assignment. Neither Group nor any Group Provider nor Priority Health will assign his, her or its rights, duties, or obligations under this Agreement without the prior written consent of the parties. Either party can assign its rights under this Agreement to any parent or subsidiary of the other party or any entity in common ownership with, or successor to, the party upon notice to the other party. Any assignment of this Agreement must be subject to, and comply with, all applicable privacy and confidentiality requirements provided in this Agreement or otherwise required by law.

Section 6.2. Amendments. Either party may amend this Agreement upon written notice to the other if amendment is necessary in order to comply with applicable law. Any other Amendments will require mutual written consent of the parties.

Section 6.3. Independent Contractors. The parties expressly agree that Group and each Group Provider shall render all services required of Group and each Group Provider by this Agreement including, without limitation, health care services, peer review and other administrative services with respect to the Credentialing, Recredentialing and Hearing Policy, Quality Assessment and Performance Improvement, Utilization and Quality Management, and grievances, in its, his or her capacity as an independent contractor. Priority Health retains no control or supervision over the professional aspects of the services rendered by Group or any Group Provider, including any Group Provider's medical judgments, diagnoses, or specific treatment regimens.

Section 6.4. Indemnification.

(a) Group and each Group Provider shall indemnify, defend and hold harmless Priority Health, its officers, directors, agents and employees from and against all claims, demands or causes of action (including malpractice claims and including all costs and reasonable attorneys' fees incurred in defending any claim, demand or cause of action) arising out of or resulting from the sole negligence of Group or each Group Provider in the provision of services pursuant to this Agreement. This provision shall survive termination of this Agreement with respect to any claims based on facts or conditions which occurred prior to termination.

(b) Priority Health shall indemnify, defend and hold harmless Group and each Group Provider from and against all claims, demands or causes of action (including malpractice claims and including all costs and reasonable attorneys' fees incurred in defending any claim, demand or cause of action) arising out of or resulting from the sole negligence of Priority Health in the carrying out of its obligations under this Agreement. This provision shall survive termination of this Agreement with respect to any claims based on facts or conditions that occurred prior to termination.

Section 6.5. Indemnification for Peer Review. Priority Health will indemnify and hold Group and each Group Provider harmless against any and all liability or loss, including costs and expenses of defending any such claim, arising from Group's or any Group Provider's participation in Priority Health's peer review activities.

Section 6.6. Dispute Resolution.

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

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

(c) In the event the parties cannot satisfactorily resolve a dispute concerning this Agreement using the mediation process outlined in subparagraph (b) of this section, the parties will settle the dispute by arbitration in accordance with the commercial arbitration rules of the American Health Lawyers Association then in effect. Either party may initiate such arbitration by making a written demand for arbitration on the other party within thirty (30) days of the time the dispute arises. Within thirty (30) days of that demand, Priority Health and Group will each designate an arbitrator and give written notice of such designation to the other. The two (2) arbitrators selected by this process will select a third arbitrator and give notice of the selection to Priority Health and Group. The three (3) arbitrators will hold a hearing and decide the matter within thirty (30) days thereafter. If a unanimous award by the three (3) arbitrators is not possible, the parties will permit the third arbitrator to render the award alone. The results of the arbitration will be final and binding on both parties. Any court that has jurisdiction may enter judgment upon an award rendered by the arbitrators. Priority Health will pay the fee of the arbitrator it chooses, Group will pay the fee of the arbitrator it chooses, and the parties will share equally the fee of the third arbitrator. The parties exclude the following matters from the operation of this arbitration clause: any counterclaim, crossclaim or third-party claim for indemnity or contribution

between Group and Priority Health in any Member's suit against Group, another Participating Provider or a payor unless a court requires the parties to submit Member's entire claim to arbitration.

Section 6.7. Notice. All notices shall be in writing and mailed postage prepaid or delivered to the relevant party at the address given below or to such other address as a party may specify in writing. Notices shall be effective two (2) days after deposited in mail.

If to Priority Health:

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

Attn: Director, Provider Contracting
Priority Health
1231 East Beltline, N.E.
Grand Rapids, Michigan 49525-4501

If to Group:

Priority Health will send Group notices to Group's primary office address or such other address as Group may specify in writing.

Section 6.8. Trademarks. Neither party may use the other party's trademarks or service marks without the express written consent of the other party.

Section 6.9. Proprietary Information. Group acknowledges that materials and information developed by or belonging to Priority Health including but not limited to this Agreement, mailing lists, patient lists, employer lists, product related information and structure, quality data, claims data, utilization review procedures, formats and structure and related information and documents concerning Priority Health and operations of its Plans, all materials bearing Priority Health's logo, other information not in the public domain and the compensation payable to Group pursuant to the terms of this Agreement (collectively "Proprietary Information") is confidential. Group further agrees that upon termination of this Agreement, Group will return to Priority Health all of Priority Health's Proprietary Information or upon Priority Health's request will destroy such Proprietary Information and provide to Priority Health's satisfaction proof of such destruction.

Section 6.10. Confidentiality. Except as specified below, the parties agree not to disclose any information regarding this Agreement or services provided pursuant to this Agreement except as required by law or regulation. Notwithstanding anything else in this Agreement, Priority Health and Group may disclose information related to the quality and cost of services provided to third parties.

Section 6.11. Waiver. In the event a party waives any provision of this Agreement, the other party will not assert that the waiving party has waived that provision at any other time or waived any other provision.

Section 6.12. Severability. In the event any tribunal with jurisdiction rules that any provision of this Agreement is invalid or unenforceable, the remainder of the provisions of this Agreement will remain in full force and effect.

Section 6.13. Entire Agreement. This Agreement, including its Plan Product Schedule(s), and the contract signatory page, constitutes the entire agreement between the parties with respect to the matters addressed herein and supersedes all prior and contemporaneous oral and written understandings and agreements.

Section 6.14. Governing Law. This Agreement shall be governed by, and construed in accordance with, the laws of the State of Michigan applicable to contracts made and to be performed in the State of Michigan.

Section 6.15. Compliance with Laws. Priority Health and Group agree to comply with all applicable state and federal laws, rules, and regulations relating to the parties or this Agreement. The parties acknowledge and agree that payments received under this Agreement could be, in whole or in part, federal funds. As a recipient of federal funds, Group and Group Providers shall comply with all applicable state and federal laws, rules, and regulations in effect or as hereinafter amended applicable to recipients of federal funds including the following: (a) Title VI of the Federal Civil Rights Act; (b) Section 403 of the Federal Rehabilitation Act of 1973; (c) the Federal Age Discrimination Act of 1975 or the Americans with Disabilities Act, and other laws regarding privacy and confidentiality; (d) Titles I and II of the Federal Americans with Disabilities Act; (e) Section 542 of the Federal Public Health Service Act (pertaining to nondiscrimination against substance abusers); (f) 45 CFR part 46, pertaining to research involving human subjects; and (g) all Medicare laws, regulations and CMS instructions according to 42 CFR 422.504(i)(4)(v). Both parties agree to comply with all state and federal laws, rules, and regulations applicable to the provision of Covered Services to Members. Plan oversees and is accountable to CMS for any functions or responsibilities that are described in 42 CFR 422.502.

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Priority Health

CONTRACT SIGNATORY PAGE
PROVIDER GROUP PARTICIPATION AGREEMENT

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

Group

Signature: _____ Date: _____

Name (please print): _____

Federal Tax ID #: _____

Name of legal entity (please type/print): _____

_____

Priority Health

Authorized Signature: _____

Name: Michael A. Jasperson _____

Title: Senior Vice President, Provider Network Strategy _____

Date: _____

Priority Health

ATTACHMENT A

PARTICIPATING PROVIDER MEDICARE REQUIREMENTS

1. Activities and Responsibilities of Group Provider. Group Provider shall provide services as described in the Agreement.

2. Hold Harmless. Group Provider agrees that it, he or she will hold Members harmless from payment obligations that are the legal obligation of Priority Health and shall not look to Members for payment for Covered Services rendered to a Member.

(a) Group Providers agree not to bill, charge, collect a deposit from, seek compensation from, seek remuneration from, surcharge, attempt in any way to hold a Member liable or have any recourse against a Member or persons acting on behalf of Member for payment of any fees for covered services that are the responsibility of Priority Health, except to the extent that the Plan specifies a copayment, coinsurance or deductible or as permitted under Coordination of Benefits statutes, rules, and regulations. Members shall not have copayments or other cost-sharing imposed upon them for influenza or pneumococcal vaccine Covered Services.

(b) Group Provider agrees not to maintain any action at law or in equity against a Member to collect sums that are owed to Group Provider under the terms of this Agreement, even in the event Priority Health fails to pay, becomes insolvent, or otherwise breaches the terms and conditions of this Agreement. This Section will survive termination of this Agreement, regardless of the cause of termination and will be construed to be for the benefit of Members. Group Provider further agrees that this provision supersedes any oral or written agreement hereinafter entered into between Group Provider and Member or person acting on Member's behalf, insofar as such agreement relates to payment for services provided under the terms and conditions of this Agreement.

(c) Group Provider agrees not to charge Members for services other than Covered Services unless:

(i) the Member has been informed in writing prior to receiving the services that the services are not covered under the Plan, and

(ii) the Member has agreed in writing to pay for such services on such forms as may be required by Priority Health from time to time.

3. Record Keeping. Group Provider will maintain medical, financial, and administrative records concerning Covered Services provided to Members and will keep these records for at least ten (10) years from the date Group Provider rendered the Covered Services.

(a) Group Provider shall maintain such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under this Amendment. Group Provider will make available to Plan and CMS, or their designees, all records, including without limitation, prescription dispensing records, reports of service plan reports or complaints, grievances, quality and utilization data for fiscal audit, quality, utilization and risk management, and other periodic monitoring upon request of authorized representatives of Plan and authorized federal and state regulating agencies.

(b) Group Provider agrees that pursuant to 42 CFR 422.504(i)(2)(i) and (ii), CMS, HHS, the Comptroller General, or their designees (the "Entities") may audit, evaluate or inspect any books, contracts, medical records, documents, papers, patient care records, and other records of Group Provider, any treating entity, contractor, subcontractor, or transferee that pertains to any aspect of the services performed under this Agreement, reconciliation of benefit liabilities and determination of amounts payable, or as the Entities may deem necessary (the "Treatment Records"). The right of the Entities to audit, evaluate, and inspect extends ten (10) years after termination of the CMS Contract and this Agreement or the completion of an audit, whichever is later. Group Provider agrees to make available its physical premises, facilities, equipment, and all Treatment Records or additional information the Entities may require.

(c) Group Provider agrees to safeguard Member privacy and confidentiality and assure the accuracy of Member health records, according to 42 CFR 504(a)13. Group Provider shall safeguard the privacy and security of Member information and records as required by federal and state law and regulations, including the applicable provisions of the Health Insurance Portability and Accountability Act ("HIPAA"), which require reasonable administrative, technical, and physical safeguards to ensure the integrity and confidentiality of Member information. Physician will only use and release such information to third parties in accordance with HIPAA and applicable federal and state statutes, rules, and guidance or pursuant to court order or subpoena. Group Provider shall have procedures that specify for what purposes Member information will be used by Group Provider and to whom and for what purposes Group Provider will disclose Member information. Group Provider acknowledges that no formal consent is necessary for Group Provider to provide information to Priority Health for purposes of payment, treatment, or healthcare operations.

(d) Group Provider shall grant Members access to their records in accordance with applicable state and federal law, including right to review, request to amend, and obtain a copy.

(e) Group Provider acknowledges that the CMS Contract requires Plan to submit to CMS all data necessary to characterize the context and purposes of each encounter between a Member and Group Provider, to certify the accuracy, completeness, and truthfulness of such data, and submit prescription records for validation of any such data. Group Provider agrees to cooperate with and assist Plan in meeting this requirement under the CMS

Contract. Group Provider agrees that each time it submits a claim to Plan for services rendered hereunder, Group Provider is certifying the accuracy, completeness, and truthfulness of the claim. Group Provider agrees to submit records to Plan, CMS, or their designees if requested to validate any claims submitted and being adjudicated.

4. Delegation. Group Provider agrees not to delegate any professional duties to any other provider without the prior written approval of Priority Health. According to 42 CFR 422.504 (i)(3)(iii), Group Provider acknowledges and agrees that any services or other activity performed by a related entity, contractor or subcontractor in accordance with a written agreement with Group Provider will be consistent and comply with Priority Health's obligations under the CMS Contract.

5. Prompt Payment. For timely submitted clean claims, Priority Health will make or deny payment within thirty (30) days. Such thirty (30) day, time period will begin when Priority Health receives a Clean Claim from Group Provider or Group Provider's agent, including all required supporting documentation. Plan will reimburse Group Provider at the applicable rates as set forth in the Agreement's Plan Product Schedule.

6. Compliance With Laws. The parties acknowledge and agree that payments received under this Agreement are, in whole or in part, federal funds. As a recipient of federal funds, Group Provider shall comply with all applicable state and federal laws, rules, and regulations in effect or as hereinafter amended applicable to recipients of federal funds including the following: (a) Title VI of the Federal Civil Rights Act; (b) Section 403 of the Federal Rehabilitation Act of 1973; (c) the Federal Age Discrimination Act of 1975; (d) Titles I and II of the Federal Americans with Disabilities Act; (e) Section 542 of the Federal Public Health Service Act (pertaining to nondiscrimination against substance abusers); (f) 45 CFR part 46, pertaining to research involving human subjects; and (g) all Medicare laws, regulations and CMS instructions according to 42 CFR 422.504(i)(4)(v). Both parties agree to comply with all state and federal laws, rules, and regulations applicable to the provision of Covered Services to Members. Plan oversees and is accountable to CMS for any functions or responsibilities that are described in 42 CFR 422.502.

7. Accountability. Plan oversees and is accountable to CMS for any functions or responsibilities that are described in 42 CFR 422.502.

8. Reporting Requirements. Group Provider understands that the Plan is required by CMS to maintain a health information system that collects, analyzes and integrates all data necessary to compile, evaluate and report certain statistical data, including encounter data. Group Provider agrees to submit all complete and accurate data necessary for the Plan to fulfill their obligations within the timeframes as specified by the Plan.

9. Benefit Continuation. In the event of termination of this Agreement Priority Health shall arrange for, and Group Provider shall cooperate with, the orderly transfer of all Members then under the care of the Group Provider:

(a) At Priority Health's option Group Provider will continue to provide Covered Services to Members who are in Active Treatment at the time of termination until the "End Date", which shall be the date upon which both: (i) the Member is no longer in Active Treatment; and (ii) Priority Health assigns such Members to another Participating Provider. For

purposes of this Section, a Member shall be considered to be in "Active Treatment" if he or she is: (a) hospitalized; (b) undergoing treatment; or (c) in the second or third trimester of pregnancy through the completion of normal post-partum care. Both parties will comply with the terms of this Agreement while the Member is in Active Treatment until the End Date, except that Priority Health shall compensate Group Provider in accordance with the standard Original Medicare rates, or an amount agreed to by both parties. Group Provider shall notify affected Members and/or their employer groups of termination and obligations of Group Provider following termination as described in this Section.

(b) Upon termination, Group Provider shall promptly supply to Priority Health all information necessary for the reimbursement of any outstanding claims.

(c) Upon termination, Group Provider shall continue to provide Covered Services to Members until the end of the period for which Priority Health has received premiums from CMS.

(d) In the event of the insolvency of Priority Health, Group Provider shall continue to provide Covered Services to hospitalized Members through discharge.

10. Exclusion of Services. Group Provider who has not been excluded from any federal healthcare program, and has not opted out of Medicare. Group Provider shall not employ or contract with any individual who is excluded from participation in the Medicare program, and acknowledges and agrees that Priority Health may immediately terminate this Agreement should Group Provider or any employee, contractor, or agent of Group Provider lose Medicare certification or be excluded or otherwise fail to participate in the Medicare program.

11. Preclusion List. In accordance with CMS-4185-F, precluded providers, after the expiration of the 60-day period specified in 42 CFR 422.222 will no longer be eligible for payment from the Plan and will be prohibited from pursuing payment from the beneficiary. As the provider will have received notification of the preclusion, the provider will hold financial liability for services, items, and drugs that are furnished, ordered, or prescribed after this 60-day period.

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Priority Health

EXHIBIT I

HMO/PPO PLAN PRODUCT SCHEDULE
REIMBURSEMENT METHODOLOGY

This Exhibit I HMO/PPO Plan Product Schedule is made and entered into, pursuant and subject to, the terms and conditions of this Group Participation Agreement and it describes the reimbursement methodology that Priority Health will use in order to define and determine payment Group Participating Providers will receive or is eligible to receive) pursuant to this Agreement. Capitalized terms when used in this Exhibit 1 shall have the meanings as defined in the Agreement, any additional capitalized terms shall have the meanings as defined below, as applicable.

Group Providers. Group Provider's total reimbursement for Covered Services rendered to Members during the term of this Agreement shall be the lesser of:

(i) The maximum fee for the particular Covered Service as determined by the applicable Priority Health Commercial Fee Schedule as described in Exhibit IV Group Reimbursement Rates grid, attached;

or

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

(iii) Less any applicable Member copayments, deductibles, or coinsurance.

Priority Health

EXHIBIT II

MEDICARE ADVANTAGE PLAN PRODUCT SCHEDULE
REIMBURSEMENT METHODOLOGY

This Exhibit II Medicare Plan Product Schedule is made and entered into pursuant, and subject to the terms and conditions of this Group ("PO") Participation Agreement and it describes the reimbursement methodology that Priority Health will use in order to define and determine payment Group Participating Provider will receive (or is eligible to receive) pursuant to this Agreement. Capitalized terms when used in this Plan Product Schedule shall have the meanings as defined in the Agreement, additional capitalized terms shall have the meanings as defined below.

A. Additional Definitions:

1. Emergency Services. "Emergency Services" means covered inpatient and outpatient services that are furnished by a provider qualified to furnish emergency services and needed to evaluate or stabilize an emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (a) serious jeopardy to the health of the individual or, in the case of a pregnant woman, to the health of the woman or her unborn child; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part.

2. Urgently Needed Services. "Urgently Needed Services" means Covered Services that are not Emergency Services that are provided when an enrollee is temporarily absent from the Priority Health service area when the services are medically necessary and immediately required: (a) as a result of an unforeseen illness, injury, or condition; and (b) it was not reasonable given the circumstances to obtain the services through Priority Health Participating Providers.

B. Agreements and Obligations: Group and each Group Provider agree that

1. Member Verification. Member verification or prior authorization shall not be required for Emergency Services or Urgently Needed Services, as defined above.

2. Delegation of Professional Duties.

   (i) Group agrees not to delegate any professional duties to any other provider without the prior written approval of Priority Health, except for the specific delegated activities and reporting responsibilities listed below in Subsection (b)

pursuant to 42 CFR 422.504(i)(4)(i). Group shall submit to Priority Health credentials for providers to whom professional duties may be delegated. Group shall supervise and review all Covered Services rendered to Members by another provider to ensure compliance with the terms of this Agreement.

(ii) According to 42 CFR 422.504 (i)(3)(iii), Group acknowledges and agrees that any services or other activity performed by a related entity, contractor or subcontractor in accordance with a written agreement with Group will be consistent and comply with Priority Health's obligations under the CMS Contract. Group also acknowledges and agrees that if any of Priority Health's activities or responsibilities under the CMS Contract are delegated to Group or other parties, all delegation requirements under applicable federal regulations must be met, including, but not limited to 42 CFR 422.504(i)(4)(ii) which provides that if CMS or Priority Health determines that Group has not satisfactorily performed such delegated activities and reporting requirements then CMS or Priority Health may revoke such delegated activities and reporting requirements. Priority Health must oversee and remain accountable to CMS for any delegated functions.

3. CMS Certification Regarding Physician Incentives. In 1996, the Health Care Financing Administration, currently known as CMS, published a physician incentive plan regulation in the Federal Register, which requires HMOs with Medicare contracts to disclose certain information to CMS or the State Medicare agency. Priority Health must disclose whether or not Group Providers are subject to "substantial financial risk" for referral services under arrangements between the Group and Group Providers themselves.

(i) Group agrees that it will inform Priority Health whether or not Group transfers substantial financial risk for referral services to Group Providers. Priority Health does not need to know the specific payment arrangements for Group Providers. Priority Health does need to know if Group Providers are at substantial financial risk for referral services.

"Substantial financial risk" is determined by the following calculation:

$$\text{Referral Risk} = \frac{\text{Amount at risk for referral services}}{\text{Maximum potential payments}}$$

The "amount at risk for referral services" is the difference between the maximum potential referral payments and the minimum potential referral payments. Bonuses unrelated to utilization should not be counted toward referral payments. "Maximum potential payments" is defined as the maximum anticipated total payments that the physician could receive. Substantial financial risk is present when 25% of potential payments for Covered Services are at risk.

Here is an example that may help to explain. If Group Provider has potential earnings of $200,000, but $50,000 of that amount is based on how many referrals that Group Provider makes, then 25% of his or her income is at risk for referral services. If Group Provider has potential earnings of $200,000 and $50,000 of the total is based on how many patients he or she sees, then, even though 25% of his or her income is at risk, it would not be reportable under the regulations because the risk is not related to referrals.

(ii) Group hereby certifies that it is not transferring substantial financial risk to Group Providers. If Group is transferring substantial financial risk to Group Providers, Group agrees to promptly inform Priority Health.

4. Federal Appropriated Funds. Neither Group nor any Group Provider shall pay any federal appropriated funds to any person for influencing or attempting to influence an officer or employee of any federal agency, member of Congress, an officer or employee of Congress, or any employee of a member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement. If any funds other than federal appropriated funds have been paid or will be paid to any person influencing or attempting to influence an officer or employee of any federal agency, member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the CMS Contract, Comprehensive Health Care Program Contractor Agreement or this Agreement, Group and such Group Provider shall inform Priority Health and shall complete and submit any disclosures required by MDHHS or any duly authorized state or federal agency.

C. CMS Regulatory Requirements.

1. Record Inspection, Audit, and Retention. In accordance with 42 CFR 422.504(e)(2); 42 CFR 422.504(e)(3); 42 CFR 422.504(e)(4); 42 CFR 422.504(i)(2)(i); and 42 CFR 422.504(i)(2)(ii); Health & Human Services ("HHS"), the Comptroller General, or their designees have the right to inspect, evaluate, and audit any pertinent contracts, books, documents, papers, computer or other electronic systems, and records, including medical records, of the subcontractor involving transactions related to Priority Health's contract with CMS or that pertain to any aspect of services performed, pursuant to this Agreement. Only Priority Health or its designees shall have direct access to Group for these purposes, and Group will make such books and records available for such inspection, evaluation, and audit through Priority Health. With respect to all other downstream entities, HHS, CMS, the Comptroller General, and their designees shall have direct access (e.g., on site access) to such downstream entities, and the downstream entities will make such books and records directly available to HHS, CMS, the Comptroller General, or their designees for such inspection, evaluation,

and audit. This right exists through ten (10) years from the final date of this Agreement's termination date or from the date of completion of any audit, whichever is later. Group agrees to provide to Priority Health all books and records described above which Priority Health will then provide to CMS.

2. Delegation. In accordance with 42 CFR 422.504(i)(3)(iii); 42 CFR 422.504(i)(4); and 42 CFR 422.504(i)(5); Group agrees not to delegate any professional duties under this Agreement to any subcontractor without the approval of Priority Health. Upon Priority Health's approval, Group shall submit to Priority Health credentials for Group to whom professional duties may be delegated. Group acknowledges and agrees that any services or other activity performed by a related entity, contractor or subcontractor in accordance with a written agreement with Group will be consistent and comply with Priority Health's obligations under its contract with CMS. Group also acknowledges and agrees that if any of Priority Health's activities or responsibilities under its contract with CMS is delegated to Group or other parties, all delegation requirements under the applicable federal regulations must be met and Priority Health must oversee and remain accountable to CMS for any delegated functions. Priority Health shall monitor the performance of Group. Priority Health retains all its legal remedies, including the right of revocation, if the activities are not performed satisfactorily.

3. Hold Harmless. In accordance with 42 CFR 422.504(g)(1)(iii); and 42 CFR 422.504(i)(3)(i), the Medicare Member shall not be held liable for payment of any fees that are the legal obligation of Priority Health.

4. Compliance With Laws. Group acknowledges and agrees that payments received from Priority Health are, in whole or in part, federal funds. As a recipient of federal funds, Group shall comply with all applicable state and federal laws, rules, and regulations in effect or as hereinafter amended applicable to recipients of federal funds including the following: (a) Title VI of the Federal Civil Rights Act; (b) Section 403 of the Federal Rehabilitation Act of 1973; (c) the Federal Age Discrimination Act of 1975; (d) Titles I and II of the Federal Americans with Disabilities Act; (e) Section 542 of the Federal Public Health Service Act (pertaining to nondiscrimination against substance abusers); (f) 45 CFR part 46, pertaining to research involving human subjects; and (g) 42 CFR 422.504(i)(4)(v) all Medicare laws, regulations, and CMS instructions. Both parties agree to comply with all state and federal laws, rules, and regulations applicable to this Agreement.

5. Confidentiality and Enrollee Record Accuracy. In accordance with 42 CFR 422.118 and 42 CFR 422.504(a)(13); Group agrees to comply with all state and federal requirements for accuracy and confidentiality of Priority Health's Member's records, including the requirements established by Priority Health and CMS. For any medical records or other health and enrollment information Group maintains with respect to Priority Health's Members, Group will establish procedures to do the following:

(i) Abide by all federal and state laws regarding confidentiality and disclosure of medical records, or other health and enrollment information. Group will safeguard the privacy of any information that identifies a particular Member and have procedures that specify:

(a) For what purposes the information will be used within the organization; and

(b) To whom and for what purposes it will disclose the information outside the organization.

(ii) Ensure that medical information is released only in accordance with applicable federal or state law, or pursuant to court orders or subpoenas.

(iii) Maintain the records and information in an accurate and timely manner.

(iv) Ensure timely access by Members to the records and information that pertain to them.

6. Satisfactory Performance and Revocation. In accordance with 42 CFR 422.504(i)(3)(ii); and 42 CFR 422.504(i)(4)(ii), if CMS or Priority Health determines that Group has not performed satisfactorily under this Agreement, the delegated activities and reporting responsibilities of the Group may be revoked, the matter may be handled in accordance with Priority Health's corrective action plan, and/or the matter may be considered an act in default under this Agreement pursuant to terms and conditions of this Agreement.

7. Contract Compliance. In accordance with 42 CFR 422.504(i)(1) and 42 CFR 422.504(i)(3)(iii); notwithstanding anything to the contrary agreed to by the parties, Priority Health maintains ultimately responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS and for ensuring that Group satisfies its obligations.

8. Monitoring. In accordance with 42 CFR 422.504(i)(1); 42 CFR 422.504(i)(3)(ii); and 42 CFR 422.504(i)(4)(iii); Priority Health will establish and maintain ongoing monitoring and oversight of all aspects of Group's performance of its obligations.

9. Preclusion List. In accordance with CMS-4185-F, precluded providers, after the expiration of the 60-day period specified in 42 CFR 422.222 will no longer be eligible for payment from the Plan and will be prohibited from pursuing payment from the beneficiary. As the provider will have received notification of the preclusion, the provider will hold financial liability for services, items, and drugs that are furnished, ordered, or prescribed after this 60-day period.

I. Medicare Advantage Plan Reimbursement Methodology.

Priority Health's Medicare Advantage payments to Group Providers is comprised of the following components:

(i) Fee for Service Payments

(ii) Copayments from Members

A. Group Providers Fee for Service Payments.

Group Provider's total reimbursement for Covered Services rendered to Members shall be the lesser of:

(i) The maximum fee for the particular Covered Services as determined by the Priority Health Medicare Advantage fee schedule as described in Exhibit IV, or

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

(iii) Less any applicable Member copayments, deductibles, or coinsurance.

Priority Health

EXHIBIT III

MEDICAID PLAN PRODUCT SCHEDULE
REIMBURSEMENT METHODOLOGY

This Exhibit III Medicaid Plan Product Schedule is made and entered into pursuant, and subject to the terms and conditions of this Group Participation Agreement and it describes the reimbursement methodology that Priority Health will use in order to define and determine payment Group Participating Provider will receive (or is eligible to receive) pursuant to this Agreement. Capitalized terms when used in this Plan Product Schedule shall have the meanings as defined in the Agreement, additional capitalized terms shall have the meanings as defined below.

A. Additional Definitions.

1. Certificate of Coverage. In addition to the definition in the Article I of the Agreement, the Certificate of Coverage is also made part of the agreement between the State of Michigan and PHC.

2. Covered Services. Covered Service shall also include all required health care services as defined by (a) Section 400.105 of the Michigan Compiled Laws, (b) Title XIX of the federal Social Security Act, 42 USC 1396 et seq., (c) MDHHS Program Manuals and Bulletins, (d) the Medicaid program contractor agreement between PHC and the State of Michigan, and (e) additional services, if any, PHC offers Members within the scope of services provided by the licensed provider party to this Agreement.

3. Plan. "Plan" shall also mean the PHC Medicaid managed care plan, which is part of the MDHHS program to provide medical assistance established by Section 105 of Act No. 280 of the Public Acts of 1939, as amended, being 400.105 et seq. of the Michigan Compiled Laws and Title XIX of the Federal Social Security Act, 42 U.S.C. 1396 et seq. and the Medicaid program agreement between PHC and the State of Michigan.

B. Agreements and Obligations. Group and each Group Provider agree that he, she or it:

1. Will report the provision of any EPSDT services to PHC and all communicable diseases and other reportable health events as required by law. "EPSDT" means the federal early and periodic screening, detection and treatment program for Medicaid eligible individuals under age twenty-one (21).

2. Will submit, within thirty-five (35) days of the date on a request by the Secretary of the United States Department of Health and Human Services. ("HHS") or the MDHHS, full and complete information about (a) the ownership of any

subcontractor with whom Group Provider has had business transactions totaling more than $25,000 during the twelve (12) month period ending on the date of the request; and (b) any significant business transactions between Group Provider and any wholly owned supplier, or between Group Provider and any subcontractor, during the 5-year period ending on the date of the request, in compliance with 42 CFR 455.105(b).

3. Will cooperate with PHC to ensure Members receive continuation of benefits when applicable.

4. CLIA Compliance. Group agrees to comply with Section 353 of the Public Health Service Act (42 U.S.C. 263a) as revised by the Clinical Laboratory Improvement Amendments ("CLIA") of 1988, and upon request shall provide PHC with a CLIA Certificate or a Certificate of Waiver as issued by the HHS with regard to Group.

5. Nondiscriminatory Hiring. In the performance of services pursuant to this Agreement, Group and each Group Provider agree not to discriminate against any employee or applicant for employment, with respect to their hire, tenure, terms, conditions or privileges of employment, or any matter directly or indirectly related to employment, because of race, color, religion, national origin, ancestry, age, sex, height, weight, marital status, physical or mental handicap or disability. This provision is required by MDHHS pursuant to the Elliot-Larsen Civil Rights Act, 1876 PA 453, as amended, MCL 37.2101, et seq., and the Michigan Handicapper's Civil Rights Act, 1976 PA 220, as amended, MCL 37.1101 et seq., and any breach of this provision may be regarded as a material breach of this Agreement. Further, Group and each Group Provider agree to comply with the provisions of the Americans with Disabilities Act of 1990 (42 USC 12101 et seq., and 47 USC 225).

6. No Unfair Labor Practices. Group and each Group Provider represent and warrant that neither Group's nor Group Provider's name appears in the current register of employers failing to correct an unfair labor practice compiled pursuant to Section 2 of 1980 PA 278 as amended, MCL 423.321 et seq. Group and each Group Provider agree and acknowledge that, pursuant to Section 4 of 1980 PA 278, MCL 423.324, PHC may void this Agreement as to Group or a particular Group Provider, if subsequent to the effective date of this Agreement, the name of Group or such Group Provider appears in the register.

7. Federal Appropriated Funds. Neither Group nor any Group Provider shall pay any federal appropriated funds to any person for influencing or attempting to influence an officer or employee of any federal agency, member of Congress, an officer or employee of Congress, or any employee of a member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement. If any funds other than federal appropriated funds have been paid or will be paid to any person influencing or

attempting to influence an officer or employee of any federal agency, member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the CMS Contract, Comprehensive Health Care Program Contractor Agreement or this Agreement, Group and such Group Provider shall inform Priority Health and shall complete and submit any disclosures required by MDHHS or any duly authorized state or federal agency.

8. CMS Certification Regarding Physician Incentives. In 1996, the Health Care Financing Administration, currently known as CMS, published a physician incentive plan regulation in the Federal Register, which requires HMOs with Medicaid contracts to disclose certain information to CMS or the State Medicaid agency. PHC must disclose whether or not Group Providers are subject to "substantial financial risk" for referral services under arrangements between Group and Group Providers themselves.

(a) Group agrees that it will inform PHC whether or not Group transfers substantial financial risk for referral services to Group Providers. PHC does not need to know the specific payment arrangements for Group Providers. PHC does need to know if Group Providers are at substantial financial risk for referral services.

"Substantial financial risk" is determined by the following calculation:

$$\text{Referral Risk} = \frac{\text{Amount at risk for referral services}}{\text{Maximum potential payments}}$$

The "amount at risk for referral services" is the difference between the maximum potential referral payments and the minimum potential referral payments. Bonuses unrelated to utilization should not be counted toward referral payments. "Maximum potential payments" is defined as the maximum anticipated total payments that a Group Physician could receive. Substantial financial risk is present when 25% of potential payments for covered services is at risk.

Here is an example that may help to explain. If Group Physician has potential earnings of $200,000, but $50,000 of that amount is based on how many referrals that Group Physician makes, then 25% of his or her income is at risk for referral services. If Group Physician has potential earnings of $200,000 and $50,000 of the total is based on how many patients he or she sees, then, even though 25% of his or her income is at risk, it would not be reportable under the regulations because the risk is not related to referrals.

(b) Group hereby certifies that it is not transferring substantial financial risk to Group Providers. If Group is transferring substantial financial risk to Group Providers, Group agrees to promptly inform PHC.

9. False Claims Act. Group and Group Provider represent and warrant that they comply with:

(a) Section 6032 of the Deficit Reduction Act of 2005 as codified by Section 1902(a)(68) of the Social Security Act commencing on January 1, 2007 or the effective date of this Agreement whichever is later; and

(b) All applicable provisions of the Federal False Claims Act and Michigan Medicaid False Claims Act.

10. Medicaid Ownership Form. In accordance with 42 CFR § 455.106(a), 42 CFR § 455.101 and 42 CFR § 455.104, Group shall complete the Disclosure Requirement Form for Medicaid Network Providers, as requested.

11. Member Rights. Group shall guarantee a Member his or her specific rights in compliance with 42 CFR § 438.100, including the right to:

(a) receive information in accordance with §438.10.

(b) be treated with respect and with due consideration for his or her dignity and privacy.

(c) receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand. (The information requirements for services that are not covered under the contract because of moral or religious objections are set forth in §438.10(f)(6)(xii).)

(d) participate in decisions regarding his or her health care, including the right to refuse treatment.

(e) be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other federal regulations on the use of restraints and seclusion.

(f) request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR §164.524 and 164.526.

(g) be furnished health care services in accordance with §§438.206 through 438.210.

(h) exercise his or her rights, and that the exercise of those rights does not adversely affect the way the Facility treats the Member.

12. Will not deny services to a Member who is eligible for the Covered Services due to the Member's inability to pay the applicable co-payment.

13. Understands that Priority Health may immediately transfer Members to another Participating Provider if Priority Health reasonable believes that the Member's health or safety is in jeopardy.

14. Pursuant to 42 CFR § 438.602(b)(1), all Participating Providers furnishing services must be enrolled through Community Health Automated Medicaid Processing System (CHAMPS) with the Michigan Medicaid Program as a requirement for reimbursement.

1. Medicaid Plan Reimbursement Methodology.

A. Group Providers.

Group Provider's total reimbursement for Covered Services rendered to Members during the term of this Agreement shall be the lesser of:

(i) The maximum fee for the particular Covered Service as determined by the applicable PHC Medicaid Fee Schedule as described in Exhibit IV. If the Covered Service is not on the PHC Medicaid Fee Schedule, the allowable amount in the Michigan Medicaid Fee Schedule.

or

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

(iii) Less any applicable Member copayments, deductibles, or coinsurance.

Fee schedules are available on the Priority Health website at: www.priorityhealth.com

Priority Health

EXHIBIT IV

GROUP REIMBURSEMENT RATES

This Exhibit IV Group Reimbursement Rates, describes the payment rate(s) that participating Provider is eligible to receive from Priority Health. The payment rate(s) identified typically reflect one payment methodology per Service Category:

(i) Percentage payment rate, percent of fee schedule OR*
(ii) Flat rate amount

*In most instances, there will NOT be multiple rates per Service Category.

Groups Provider total reimbursement for Covered Services are subject to the terms of this Agreement and the Member's applicable Plan and shall be the lesser of:

(i) The maximum fee for the particular Covered Services pursuant to the Group Reimbursement Rates in this Exhibit IV; or

(ii) Group's usual and customary charge for such Covered Service.

(iii) Less any applicable Member copayments, coinsurance, or deductibles.

Fee schedules may be available at www.priorityhealth.com.

LOB	Service Category	Rate
Commercial	Behavioral Health Statewide	100% of then current and applicable Priority Health Fee Schedule
Medicare	Professional Services	100% of then current and applicable Priority Health Fee Schedule
Medicaid	Professional Services	100% of then current and applicable Priority Health Fee Schedule

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