**PREMIER PHYSICIAN ALLIANCE, INC**
**dba INCENTIVE HEALTH IPA**

**AND**

**ABLE KIDS CO**
**APPLIED BEHAVIOR ANALYSIS (ABA) SERVICES**

**FEE FOR SERVICE**
**INDIVIDUAL AND MEDICAL GROUP**
**PHYSICIAN AGREEMENT**

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**EXHIBITS**

**PREMIER PHYSICIAN ALLIANCE, INC.**
**dba INCENTIVE HEALTH IPA**
**FEE FOR SERVICE INDIVIDUAL OR MEDICAL GROUP**
**PHYSICIAN AGREEMENT**

This Fee for Service Individual Physician or Medical Group Physician Agreement between **ABLE Kids Co;** hereinafter, ("Physician"), located at Provider's Address and **Premier Physician Alliance, Inc. dba Incentive Health IPA**, hereinafter, ("PPA"), located at P.O. Box 10688, Bakersfield, CA. 93389-0688 effective _____, _____ the ("Effective Date"), is made for the purpose of setting forth the terms and conditions under which Physician will participate in one or more networks of providers developed by PPA to render health care services to Members, as defined in this Agreement. On the Effective Date, this Agreement allows PPA to contract on behalf of Physician with Payors, as defined in this Agreement.

WHEREAS, PPA provides or arranges to provide health care services and performs related administrative services, as authorized under the laws of the State of California;

WHEREAS, PPA maintains contracts with health care facilities, physicians and other health care providers each of whom has agreed to provide health care services to Members, has agreed to certain rates of payment or reimbursement for their services, and has agreed to abide by certain procedures in order to manage the quality and cost of the health care services provided; and

WHEREAS, Payors such as health care service plans, Preferred Provider Organizations (PPO's), Exclusive Provider Organizations (EPO's), Accountable Care Organizations (ACO's), Federal, State and Local Governmental agency programs and agencies, self-funded employers, Labor Unions or Taft Hartley Trust Funds, Health Savings Account programs, Correctional Medicine Programs (as defined in this Agreement), insurance companies and other entities maintain insurance policies, plans, health care medical programs or other arrangements whereby persons covered by such policies, plans, contracts or arrangements are entitled to receive, or are entitled to indemnification or reimbursement of the cost of health care services rendered by health care providers; and are entitled to a higher level of service, payment or reimbursement if they use Contracting Providers, as defined in this Agreement, thereby encouraging the covered person to use the Contracting Providers; and

WHEREAS, PPA maintains an administrative management agreement with a designated Management Services Organization to provide administrative and management services on behalf of PPA; and

WHEREAS, PPA maintains contracts with such Payors whereby those Payors are entitled to designate PPA's Contracting Providers as described above; and

WHEREAS, Physician desires to contract with PPA in order to obtain designation from Payors as a Contracting Provider;

NOW, THEREFORE, in consideration of the promises and the mutual covenants and undertakings hereinafter set forth, and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree as follows:

1. DEFINITIONS. For purposes of this Agreement:

(a) "Affiliates" means any entity controlled by or contracted with PPA to provide administrative management services, medical management services or other identified services. Control will mean the right to direct the management of the affairs of the other entity.

(b) "Benefit Contract" means a contract issued by or an arrangement maintained by PPA or Payor that is in effect with any Payor under which payment for health care services is provided, and which may provide financial incentives for the use of designated health care providers.

(c) "Correctional Medicine Program" means patients of the California Department of Corrections and Rehabilitation (CDCR), the Department of State Hospitals (DSH); the Department of Justice (DOJ), County Sheriff's Departments (CSD's) or any other similar Federal, State or local agency.

(d) "Contracting Provider" means any medical group or medical organization, physician (also referred to herein as "Contracting Physician"), hospital (also referred to herein as "Contracting Hospital") and other health care providers, who have entered into a written agreement with PPA to provide Covered Services to Members.

(e) "Contract Year" means a period of twelve (12) months commencing on either the Effective Date of this Agreement or any subsequent anniversary of the Effective Date of this Agreement.

(f) "Covered Services" means only such medical care, treatment and supplies that (1) are provided by licensed health care providers to Members and (2) are benefits under the terms of such Members' Benefit Contracts.

(g) "Emergency" means an acute illness or accidental injury or condition that requires immediate medical or surgical care, which a reasonable person could believe that if not treated immediately might result in death, disability or serious medical complications.

(h) "Medical Director" means a licensed physician engaged by PPA or Payor to supervise and direct the conduct of the Medical Management program.

(i) "Medical Management" means the program administered by PPA with the specific goal of determining whether or not care or treatment meets the requirements of Section 6(i) hereof. The Medical Management program is described in Section 7, and may include also without limitation (1) pre-admission review, (2) concurrent review, (3) physician hospitalist services (4) retrospective review and/or (5) case management.

(j) "Member" or "Patient" means any individual covered under a Benefit Contract or governmental medical services program or other contract issued by PPA or Payor.

(k) "Payor" means an entity, governmental agency or person authorized and contracted with PPA to designate one or more of PPA's Contracting Providers and who has financial responsibility for payment of Covered Services.

(l) "Prior Authorization" means a determination in accordance with PPA's Medical Management program.

(m) "Telemedicine Services" means remote medical consultations, direction and evaluation of Members. Telemedicine Services may be considered Covered Services, as applicable under a Benefit Contract, as set forth on the applicable Attachment to Exhibit I for such Benefit Contract.

2. TERM AND TERMINATION. The initial term of this Agreement begins on the Effective Date of this Agreement and will continue in effect for a period of twelve (12) months. Thereafter, this Agreement will automatically be renewed for successive one (1) year terms until terminated as herein provided. This Agreement will terminate as specified within the initial term or thereafter upon the occurrence of any of the following events:

(a) Automatically and without notice upon the occurrence of any event set forth in Section 6(k).

(b) Upon sixty (60) days prior written notice from PPA to Physician if Physician changes affiliations, admitting privileges or specialty status in such a way as to substantially limit Physician's range of services or access to Contracting Hospitals.

(c) By either party, by written notice thereof, if the other party commits a material breach of any warranties, covenants, or obligations, provided that the breaching party fails to cure that breach within thirty (30) days after written notice of default is given by the terminating party.

(d) Automatically and without notice on such date as either party becomes insolvent, or is adjudicated as bankrupt, or its business comes into possession or control, even temporarily, of any trustee in bankruptcy, or a receiver is appointed for it, or it makes a general assignment for the benefit of creditors. No interest in this Agreement will be deemed an asset or liability of either party, nor will any interest in this Agreement pass by the operation of law without the consent of the other party.

(e) By either party if at least forty-five (45) days prior written notice is given that it rejects any modification of Section 3 (Compensation) and elects to terminate this Agreement, such termination to be effective at the end of the last day before such modified rates or factors would become effective.

(f) Immediately upon written notice from PPA if Physician makes or has made any untrue statements of material fact or any intentional misrepresentation of any fact, whether or not material, in any claim for payment, in any application form or questionnaire, or in any statement made by Physician to PPA.

(g) Upon one hundred twenty (120) days prior written notice, given with or without cause by either party to the other.

(h) Immediately upon written notice from PPA if Physician fails to make refunds as specified under Section 6(g) (ii).

Following the effective date of termination of this Agreement, this Agreement will be of no further force or effect except that each party shall remain liable for any obligations or liabilities arising from activities undertaken prior to the effective date of termination.

3. COMPENSATION. For each Benefit Contract set forth on the Attachments to **Exhibit I**, PPA will pay or arrange to pay Physician pursuant to the Fee Schedule set forth on the Attachment to **Exhibit I** for such Benefit Contract, as such listing of Benefit Contracts and/or the Fee Schedule applicable to any Benefit Contract may be amended from time to time pursuant to Section 15(e) and/or Section 4, as full compensation for any Covered Services provided to Members and for which Physician has properly submitted an accurate and complete claim, minus any applicable deductibles, co-payments or coinsurance specified in the Member's Benefit Contract. Physician may bill Member for such deductibles, co-payments or coinsurance but may not bill Member for any additional charges unless provided for in the Member's Benefit Contract. Physician acknowledges and agrees that the compensation paid pursuant to this Agreement shall constitute full payment for Covered Services provided pursuant to this Agreement.

For all other Benefit Contracts, Physician shall look exclusively to the Payor for compensation for any Covered Services provided to Members and PPA will have no obligation to provide any compensation to Physician for such Covered Services. Physician may bill Member for such deductibles, co-payments or coinsurance but may not bill Member for any additional charges unless provided for in the Member's Benefit Contract.

4. MODIFICATION OF RATES AND FACTORS. Subject to the terms of Section 15(e) below, either party may propose changes to the rates or factors referenced in Section 3 (Compensation) by giving written notice via U.S. Mail, of at least ninety (90) days. If the proposed rates offered by PPA to Physician are unsatisfactory to Physician, the parties agree to meet and discuss in good faith the proposed changes. If no agreement can be reached, either party may elect to terminate this Agreement pursuant to Section 2(e).

5. RESPONSIBILITIES OF PPA

(a) Regulatory Compliance. PPA will comply with all applicable requirements of the law and regulations of governmental agencies relating to the business of PPA under this Agreement, and will obtain and maintain in effect all permits, licenses and governmental approvals necessary for that purpose.

(b) Promotion. For those Benefit Contracts set forth in **Exhibit I**, PPA will make available and promote the Benefit Contracts, subject to the standards of lawfulness, reasonableness and protection of the health and interests of Members. For all other Benefit Contracts, Physician shall look to Payor to make available and promote the Benefit Contracts, subject to the standards of lawfulness, reasonableness and protection of the health and interests of Members.

(c) Claim Payment. For those Benefit Contracts set forth in **Exhibit I**, PPA will use best efforts to pay or arrange to pay the Physician for Covered Services within thirty (30) days of payment by the Payor to PPA, and where PPA is in receipt of a properly submitted claim from Physician.

(d) Medical Management. PPA will conduct a Medical Management program in accordance with the provisions of Section 7 hereof.

(e) Member Access. PPA will use its best efforts to contract with sufficient physicians and other health care providers to allow Members access to medical services to the extent required by applicable law and regulations of governmental agencies relating to the business of health care.

(f) Member Identification. For those Benefit Contracts set forth in **Exhibit I**, PPA will supply Members with a means of identifying themselves to Physician (e.g., an identification card), which indicates the Member's participation in a Benefit Contract or governmental program. Physician will make a good

faith effort in using the Eligibility/Benefits Verification telephone number on the identification card to confirm that the individual presenting the identification card is in fact the Member whose name appears on the identification card and is eligible for coverage. For all other Benefit Contracts, Physician shall look to Payor to supply Members with a means of identifying themselves to Physician (e.g., an identification card), which indicates the Member's participation in a Benefit Contract or governmental program.

(g) Designation. Where applicable, PPA will provide written notice to Physician of all Payors that have designated Physician in such Payors' lists of network providers.

6. RESPONSIBILITIES OF THE PHYSICIAN .

(a) Quality of Care. Physician will ensure that medical and health care services are rendered in a manner which assures availability, adequacy and continuity of care to Members, both during the term and as required after termination hereof, and that all decisions pertaining to health care services to be rendered by Physician to Members are based on such Members' medical needs. Physician's primary consideration shall be the quality of health care services rendered to Members. Physician will remain solely responsible for the quality of medical and health care services provided by Physician and will ensure such services are rendered in accordance with professionally recognized standards. In the event that Physician denies services to any Member or any Member experiences an adverse outcome, Physician will notify PPA within two (2) days of such an event.

(b) Hours of Coverage. Physician will provide Covered Services, including, if applicable under a Benefit Contract, Telemedicine Services, as set forth on the Attachment to **Exhibit I** for such Benefit Contract.

(c) Member Referral and Transfer. When referrals are appropriate, Physician will follow the procedures identified by PPA and will exercise best efforts to refer Members to designated Contracting Providers, and to admit Members to designated Contracting Hospitals. In the event a Member requires transfer to a Contracting Hospital, Physician will cooperate with such transfer provided that such activity is consistent with good medical judgment and applicable law.

(d) Referrals. Physician will accept non-Emergency or specialty referrals from other Contracting Providers and such other Contracting Providers will be required to accept non-Emergency and specialty referrals from Physician.

(e) Hospital Privileges. Physician will have admitting privileges at PPA-designated Contracted Hospitals, which meet the requirements for the hospital services to which Members are entitled. Alternatively, Physician will arrange for the provision of such services.

(f) Prescription Drugs. Physician will exercise best efforts to prescribe generic drugs and pharmaceutical products and to comply with Payors' or PPA's formulary.

(g) Collections from Members.

(i) Except as described in Section 8 herein, Physician will not seek or require any Member to tender a deposit or similar payment during the Member's course of treatment with respect to Covered Services rendered pursuant to this Agreement, other than any applicable deductibles, coinsurance or co-payments specified in the applicable Benefit Contract or governmental program. Except for co-payments, deductibles, coinsurance and non-covered services, Physician will not bill Member prior to receipt of

Payor's or PPA's Explanation of Benefits. Physician will fully advise Members of their financial responsibility prior to rendering any services that are not covered.

(ii) Notwithstanding anything in this Agreement to the contrary, in no event, including but not limited to nonpayment by PPA or Payor, the insolvency of PPA or Payor, or breach of this Agreement, will any Member be liable for any amount owing to Physician by PPA or Payor, and Physician will not bill, charge, collect a deposit or other sum, or seek compensation, remuneration or reimbursement from, or maintain any action or have any recourse against, or make any surcharge upon a Member or any person acting on a Member's behalf. Whenever any such charge has occurred, Physician will refund such charge to the Member within fifteen (15) days of discovering, or receiving notification of, the charge. If PPA or Payor receives notice of any such charge, PPA or Payor may take appropriate action to remedy the situation, including, without limitation, offsetting any such charge against amounts due to Physician and/or immediate termination pursuant to this Agreement. The obligations set forth in this paragraph will survive the termination of this Agreement regardless of the cause giving rise to the termination and will be construed for the benefit of the Members.

(h) Equitable Treatment. Physician will not differentiate or discriminate against Members, and each will render health services to all such patients in the same manner, in accordance with the same standards and with the same time availability as offered Physician's other patients.

(i) Compliance. Physician will cooperate and comply fully with the Medical Management program, quality assurance plan, and PPA policies and procedures, including updates thereof. Any failure to do so will be deemed a material breach of this Agreement. For services requiring Prior Authorization, Physician must obtain such Prior Authorization from the PPA or Payor. PPA or Payor, as applicable, will determine whether to certify the services based on whether the services meet all of the following criteria:

(i) They are appropriate given the symptoms and patient history, and are consistent with the diagnosis, if any, of the Member. As used in this Section 6(i)(i), "appropriate" means that the type, level and duration of services, and setting are necessary to provide safe and adequate care and treatment;

(ii) They are rendered in accordance with professionally recognized standards;

(iii) They are not generally regarded as experimental or unproven by recognized medical professionals or appropriate governmental agencies, such as, but not limited to, the United States Department of Health and Human Services, Office of Pre-Paid Health Planning, the Food and Drug Administration and the Public Health Service Office of Health Technology Assessment; and

(iv) They are permitted by the licensing statutes which apply to the provider who renders that service.

(j) Claim Payments. Physician will submit all claims for payment promptly after Physician furnishes Covered Services and in no event later than sixty (60) days after the Covered Services described in any such claim has been rendered. The forms on which such claims will be submitted and the manner respecting the payment and other procedures will be governed by the Payor terms as described in such Payor's benefit plan program or governmental requirements for government paid programs.

(k) Notice of Impairment of Physician. As soon as Physician receives notice thereof, Physician will send written notice to PPA of any action undertaken with respect to Physician, which action could materially impair the ability of Physician to carry out the duties and obligations of this Agreement,

including but not limited to actions related to: (1) cancellation of Physician's general and professional liability insurance maintained in accordance with Section 11; (2) Physician's suspension from participation in any Medicare or Medicaid program due to fraud or abuse; (3) upon the indictment, arrest or conviction of Physician for (i) any felony or (ii) any criminal charge relating to the practice of medicine; (4) Practitioner's license to practice medicine in the State of California is restricted, suspended or terminated, regardless of the availability of civil or administrative hearing rights or judicial review with respect thereto; or (5) Physician's medical staff membership or clinical privileges at any hospital are denied, suspended, restricted, revoked or voluntarily relinquished, regardless of the availability of civil or administrative hearing rights or judicial review with respect thereto.

(l) Grievances. Physician agrees to cooperate in resolving all grievances relating to the provision of medical services to Members in accordance with the grievance procedures established by PPA. Physician agrees to participate in and provide assistance and information as may be necessary or helpful to PPA. In the event Physician receives any complaint regarding PPA or Physician, Physician agrees to notify PPA within five (5) days concerning all details of such complaint. Conversely, if PPA directly receives a complaint regarding Physician, PPA will promptly notify Physician of such complaint.

(m) Regulatory Compliance. Physician will comply with all applicable requirements of the law and regulations relating to the furnishing of medical and health care services to the public, and now has and will obtain in effect all permits, licenses and governmental or board approvals which may from time to time be necessary for that purpose.

(n) PPA or Payor Display. If requested by PPA, Physician will display the emblem, logo or similar representation of PPA or Payor at each of Physician's facilities.

(o) Transfer of Files. Upon the effective date of termination of this Agreement or upon the transfer of a Member to another Contracting Provider, at the request of PPA, Physician will, at his or her own expense, copy all medical files of Member and forward such files to the succeeding provider of Covered Services.

(p) Application and Credentialing Forms. Physician will submit PPA approved application and credentialing forms with the executed Agreement as applicable. Physician will notify PPA within ten (10) days of any changes to information on the forms.

(q) Maintenance of Financial and Medical Records. Physician will prepare and maintain appropriate financial and medical records for each designated patient and member assigned to or referred to Physician. Such records will be maintained in accordance with generally accepted medical, accounting and bookkeeping practices. Records will be maintained as may be necessary for compliance with the provisions of the laws of California, including but not limited to any Federal requirements and will be provided to the PPA medical director or Payor medical director as required by contract, government code, law, statute or regulatory requirements.

7. MEDICAL MANAGEMENT. All Covered Services furnished to Members will be subject to Medical Management in accordance with the procedures and guidelines attached as **Exhibit II**. Such procedures and guidelines may be modified by PPA from time to time upon thirty (30) days written notice.

8. COORDINATION OF BENEFITS AND SUBROGATION/RIGHT OF RECOVERY.

(a) Cooperation. Physician will cooperate with PPA or Payors to identify any and all third parties, other than PPA or a Payor, which may be responsible for payment of, or reimbursement for, Covered Services, and for the purpose of coordinating benefits with other Payors.

(b) Coordination of Benefits. When a third party, other than PPA or a Payor, is identified as having primary responsibility for payment of, or reimbursement for, Covered Services, under the Coordination of Benefits provision of a Member's Benefit Contract or the Payor's agreement with PPA, Physician will bill, and make all reasonable efforts to collect from, such party for the value of Covered Services.

(c) Subrogation/Right of Recovery. When a third party, other than PPA or Payor, is identified as a responsible party with respect to whom the Subrogation/Right of Recovery provision of a Member's Benefit Contract applies, PPA or Payor will be responsible for using its best efforts to obtain any and all recoveries allowable under such provision. After application of such recoveries to reimburse PPA or Payor for any and all amounts paid or payable by PPA or Payor with respect to the injury or illness giving rise to the recovery, PPA or Payor will pay the remaining amount, if any, to Physician to compensate Physician for the value of Covered Services rendered with respect to the injury or illness giving rise to the recovery. Such payment to Physician will be valued in accordance with the Fee Schedule as shown in applicable Attachment to **Exhibit I** and any applicable amendment to this Agreement.

9. RIGHT TO AUDIT AND ACCESS INFORMATION.

(a) Inspection. Subject to any applicable legal restrictions, Physician agrees to allow inspection and duplication by PPA or Payor, and by any properly identified governmental regulatory authority of all billings and other financial records and all medical records maintained on Members under this Agreement. PPA or Payor will have access at all reasonable times upon demand to the books, records and papers of Physician relating to the health care services provided to Members, to the cost thereof, and to payments received by Physician from Members (or from others on their behalf). PPA will protect the confidentiality of such records in accordance with applicable legal standards. Such inspection and duplication will occur during regular working hours upon receipt of seventy-two (72) hours prior written notice from PPA. PPA or Payor will reimburse Physician for all reasonable copying costs incurred by Physician as a result of said record inspection and duplication. Physician will notify PPA of any inspection by a governmental regulatory authority.

(b) Record Retention. All records required to be maintained by Physician under this Agreement will be retained by Physician for at least ten (10) years. The obligations under Sections 9(a) and 9(b) will not terminate upon the termination of this Agreement, whether by recision or otherwise.

10. INDEPENDENT CONTRACTOR. It is understood that Physician will maintain a physician-patient relationship with Members and will be responsible to the Members for medical care and treatment. Physician is an independent contractor relative to PPA. Nothing in this Agreement will be construed as, or be deemed to create, a relationship of employer and employee, or principal and agent, or any relationship other than that of independent parties contracting with each other solely for the purpose of carrying out the provisions of this Agreement.

11. LIABILITY INSURANCE.

(a) General Liability Coverage. In order to protect the other party, each party, at its sole cost and expense, will procure and maintain a policy of general liability insurance or maintain adequate resources to insure itself and its respective officers, agents and employees against any liability or claims or damages arising by reason of personal injuries or death occasioned directly or indirectly by such party or its officers, agents or employees in connection with the performance or nonperformance of such party's responsibilities under this Agreement.

(b) Professional Liability Coverage. Physician will maintain professional liability insurance, with limits of at least one million dollars ($1,000,000) per occurrence and at least three million dollars ($3,000,000) in the aggregate covering Physician. If Physician is classified as Class 1 by the insurance carrier providing said professional liability insurance, the limits for Physician are at least five hundred thousand dollars ($500,000) per person per occurrence with at least one million dollars ($1,000,000) in the aggregate. Class 1 is hereby defined as those nonsurgical specialties which said insurance carrier or PPA has determined to be in the lowest liability risk category.

(c) Third Party Liability. Nothing in this Agreement will be construed to make PPA, Physician, or his or her respective agents or representatives, liable to persons not parties hereto. Nor will anything herein be construed as, or be deemed to create, any rights or remedies in any third party, including but not limited to any Members or hospital.

(d) PPA Professional Liability Coverage. PPA maintains professional liability insurance covering the Medical Management and, if applicable, Telemedicine function(s) with current limits as required by the Payor agreements.

12. INDEMNIFICATION. PPA and Physician are each responsible for their own acts or omissions, and are not liable for the acts or omissions of, or the costs of defending others. Nothing in this section shall preclude a finding of liability on the part of PPA or Physician based on the doctrines of equitable indemnity, comparative negligence, contribution, or other statutory or common law basis for liability.

13. NON-EXCLUSIVITY. Nothing herein will be construed to restrict the rights of Physician or PPA to participate in other comparable provider plans, such as but not limited to preferred provider plans, health maintenance organizations or other health care programs. Nothing herein will be construed to restrict the rights of PPA to enter into contracts or arrangements for services with any other health care provider serving any geographic area.

14. PROPRIETARY INFORMATION; TRADEMARKS.

(a) PPA's Proprietary Information. All information and materials provided by PPA to Physician remain proprietary to PPA, including but not limited to subscriber lists, contracts, fee schedules, a Physician Handbook and any other operations manuals. Physician will not disclose any such information or materials or use them except as may be required to carry out their respective obligations hereunder.

(b) Trademarks. Neither Physician nor PPA will use each other's trademarks, name or symbols without express written permission; provided however, that Physician agrees that PPA may use the Physician's name, office address, telephone number, specialty and factual description of practice in Payor and Benefit Plan directories and other promotional materials.

(c) Physician's Proprietary Information. All information and materials provided by Physician to PPA will remain proprietary to Physician, including but not limited to contracts, fee schedules, Medical Management procedures and administrative procedures. PPA will not disclose any such information or materials or use them except as may be required to carry out its respective obligations hereunder.

(d) Non-Solicitation. Physician will not directly or indirectly solicit Payors' Members during the term of this Agreement and for a period of twelve (12) months after the termination of this Agreement. Solicitation will mean any act or practice designed to encourage Payors' Members to terminate their coverage with PPA.

(e) Survival. The obligations of this Section 14 shall survive the termination of this Agreement.

15. GENERAL PROVISIONS .

(a) Scope of Agreement; Governing Law; Severability; Amendment; Waiver. This Agreement, together with all Exhibits, Attachments and Amendments attached hereto, constitutes the entire Agreement between PPA and Physician. It will be construed and governed in accordance with the laws of California. Any provision required to be in this Agreement by the laws of California will bind PPA and Physician whether or not provided in this Agreement. Any provision herein that is inconsistent will be of no effect and will be severable without affecting the validity or enforceability of the remaining provisions of this Agreement. Except as otherwise specified herein, this Agreement may not be modified or amended except by mutual consent in writing by the duly authorized representatives of PPA and Physician. Waiver of breach of any provision of this Agreement will not be deemed a waiver of any other breach of the same or a different provision.

(b) Assignment and Subcontracting. No assignment, subcontracting or delegation of the rights, duties or obligations of this Agreement will be made by either party without the express written approval of the other party; provided, that either party may freely assign, subcontract or delegate the rights, duties or obligations of this Agreement hereunder to an Adventist Health owned, managed or affiliated licensed professional, professional corporation or other health care provider organization.

(c) Dispute Resolution. All disputes related to this Agreement may be submitted to PPA in writing at the address specified in the "Notices" section of this Agreement. PPA will respond to all submitted disputes within thirty (30) days, except in urgent situations in which case PPA will respond as soon as is practical. If either party is not satisfied with the disposition of a submitted dispute, the dispute may be submitted to voluntary mediation if both parties agree. The use of voluntary mediation will not affect any other rights of the parties under this Agreement and the failure to pursue or exhaust the remedies or to engage in the procedures described in this section shall not preclude the use of any other remedy provided by this Agreement or by the law.

(d) Arbitration. Any controversy or claim arising out of or relating to this Agreement, or the breach thereof, will be settled by arbitration in accordance with the Rules of the American Arbitration Association (Commercial Rules), and judgment upon the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof. Notwithstanding anything to the contrary in this Agreement, the initiation of any and all arbitration proceedings initiated pursuant to this Agreement will be approved by Physician's liability insurance carrier(s) prior to the initiation of said proceedings. If not so approved, within thirty (30) days of the demand or request for arbitration, this provision will be of no force and effect and either party may file an action in a court of competent jurisdiction to resolve the dispute.

(e) Additional Participating Payor Benefit Contracts. Notwithstanding the terms of Section 4 above, PPA shall provide written notification to Physician of any new Payor Benefit Contract being added to this agreement, which meets or exceeds one hundred percent (100%) of the CMS Medicare physician fee schedule, which is based on the CMS Medicare physician fee schedule, as published on the CMS website on the date the Covered Services are rendered by Physician, as adjusted, for the Medicare region area, less Member expenses. The Physician must notify PPA in writing within 15 calendar days from the date notice was first given to Physician by PPA, if Physician is not in agreement with the addition of the designated Payor Benefit Contract to this Agreement (such notification, a "Disagreement Notification"). If a Disagreement Notification is received, PPA shall either notify Physician that such Payor Benefit Contract with not be added to this Agreement, or the potential addition of such Payor Benefit Contract shall become subject to the terms of Section 4 of this Agreement. If a Disagreement Notification is not received, Physician shall be understood to be in agreement with the addition of new Payor Benefit Contract.

(f) Amendments. Unless otherwise set forth herein, no amendment or modification will be effective unless made in writing and signed by both parties. All amendments required by an appropriate regulatory authority will be deemed effective upon receipt by Physician from PPA and incorporated into and made part of this Agreement without either party's execution.

(g) Notices. Any notice required to be given pursuant to the terms and provisions of this Agreement will be in writing, postage prepaid and will be sent via U.S. mail to Physician at the following address:

**ABLE Kids Co**
4980 Hillsdale Circle
El Dorado Hills, CA 95762-5726

and directly to PPA at the following address:

**PREMIER PHYSICIAN ALLIANCE, Inc**
**dba INCENTIVE HEALTH IPA**
P.O. Box 10688
Bakersfield, CA. 93389-0688
Attn: Donald Cornforth M.D., President

or at such other address as the parties may designate by written notice. Any such notice will be effective upon receipt at such address.

*[signature page follows]*

IN WITNESS WHEREOF, PPA and Physician or Medical Group have executed this Agreement through their duly authorized representative as of the date last entered below.

**PREMIER PHYSICIAN ALLIANCE, Inc.**
**dba INCENTIVE HEALTH IPA**

By:_____

Print Name: **Donald Cornforth M.D.**

Title: **President**

Date:_____

**PHYSICIAN**

**ABLE KIDS CO**

By: Renee Bingaman
(Electronic Signatures Accepted)

Print Name: Renee Bingaman

Title: Owner

Date: 12/9/2021

**EXHIBIT I**

**Benefit Contracts with applicable Fee Schedules and coverage requirements therefore**

**Attachments**

1. Incentive Health, LLC Program Contracted Employer Groups

**Attachment 1 to Exhibit I**

**Incentive Health, LLC Program Contracted Employer Groups**

**Coverage Requirements and Fee Schedule**

**ABLE Kids Co** and **Premier Physician Alliance, Inc.; dba Incentive Health IPA** shall be bound to the below fee schedule effective _____, _____ and will automatically be renewed for successive one (1) year terms in accordance with the Agreement between the parties.

***Note: Above effective date will be completed by PPA after this attachment is fully executed by both parties.***

**Coverage Requirements.**

Provider will make Covered Services available to Members on the same basis and quality as services or benefits are generally made available to Provider's other patients, on a pre-arranged basis during mutually agreed upon dates and times between PPA and Provider. Provider also will ensure that Members have access by phone to Provider or by referral to other provider twenty-four (24) hours per day and seven (7) days per week. When a Provider is unavailable to a Member, provider will arrange for coverage from another provider.

**Applied Behavior Analysis (ABA) Fee Schedule**.

In no event will PPA pay more than the Fee Schedule or the Contracting Provider's usual billed charges, whichever is less.

Compensation for Covered Services (other than Telemedicine Services) and/or products provided to Members shall be the lesser of: (i) the Contracting Provider's billed charges; or (ii) the attached reimbursement fee schedule, on the date the Covered Services are rendered by Provider, as adjusted, less Member expenses.

**Unlisted Items**: Where no fee is provided in the attached fee schedule, Payer shall reimburse Provider at seventy percent (70%) of billed charges, less any applicable copayment, coinsurance or deductible.

| CMS CPT/HCPSC Codes & Description | | Reimbursement Rate |
|---|---|---|
| **Autism Spectrum Disorder Screening Service Codes** | | |
| 99201 | Office/Outpatient Visit (New Patient) - 10 Minutes | $24.98 |
| 99202 | Office/Outpatient Visit (New Patient) - 20 Minutes | $37.42 |
| 99203 | Office/Outpatient Visit (New Patient) - 30 Minutes | $62.71 |
| 99204 | Office/Outpatient Visit (New Patient) - 45 Minutes | $75.17 |
| 99205 | Office/Outpatient Visit (New Patient) - 60 Minutes | $90.23 |
| 99211 | Office/Outpatient Visit (Established Patient) - 5 Minutes | $13.09 |
| 99212 | Office/Outpatient Visit (Established Patient) - 10 Minutes | $19.75 |
| 99213 | Office/Outpatient Visit (Established Patient) - 15 Minutes | $26.18 |

| | | |
|---|---|---|
| 99214 | Office/Outpatient Visit (Established Patient) - 25 Minutes | $40.91 |
| 99215 | Office/Outpatient Visit (Established Patient) - 40 Minutes | $62.71 |
| **Cognitive Diagnostic Evaluation Service Codes** | | |
| 92521 | Evaluation of Speech Fluency (per Evaluation) | $74.98 |
| 92522 | Evaluate Speech Production (per evaluation) | $64.11 |
| 92523 | Evaluate Sound Language Comprehension (per evaluation) | $130.58 |
| 92524 | Behavioral Quality Analysis Voice (per evaluation) | $62.08 |
| 96116 | Neurobehavioral Status Exam - provided by PhD/MD (per hour) | $61.31 |
| 96132 | Neuropsych Test by Psych/Phys (per hour) | $61.31 |
| 97165 | Occupational Therapy Evaluation (per evaluation) | $55.58 |
| 97166 | Occupational Therapy Evaluation (per evaluation) | $55.58 |
| 97167 | Occupational Therapy Evaluation (per evaluation) | $55.58 |
| 97168 | Occupational Therapy Re-evaluation (per evaluation) | $55.58 |

| **Assessment & Treatment Plan Service Codes** | | | |
|---|---|---|---|
| Modifier Descriptions | HO | BCAB and/or Licensed Practitioner | |
| | HN | Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant | |
| | HM | Paraprofessional | |
| | HP | Doctoral Level | |
| CPT Code | Modifier | Description | Rate per 15 Minute Unit |
| 97151 | All | Behavior identification assessment, administered by a physician or other qualified healthcare professional, each 15 minutes of the physician's or other qualified healthcare professional's (QHCP) time face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments & discussing findings & recommendations, & non face-to-face analyzing past data, scoring/interpreting the assessment, & preparing the report/treatment plan. | $32.00 |
| 97152 | All | Assessment by BCBA: Behavior identification supporting assessment, administered by one technician under direction of a physician or other QHCP, face-to-face with the patient, each 15 minutes. | $32.00 |
| 97153 | HO | Adaptive behavior treatment by protocol, administered by a technician under the direction of a physician or other qualified healthcare professional, face-to-face with one patient, every 15 minutes. | $19.00 |

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|---|---|---|---|
| 97153 | HN | Adaptive behavior treatment by protocol, administered by a technician under the direction of a physician or other qualified healthcare professional, face-to-face with one patient, every 15 minutes. | $19.00 |
| 97153 | HM | Adaptive behavior treatment by protocol, administered by a technician under the direction of a physician or other qualified healthcare professional, face-to-face with one patient, every 15 minutes. | $19.00 |
| 97154 | HO | Group adaptive behavior treatment by protocol, administered by a technician under the direction of a physician or other qualified healthcare professional, with two or more patients, every 15 minutes. | $16.00 |
| 97154 | HN | Group adaptive behavior treatment by protocol, administered by a technician under the direction of a physician or other qualified healthcare professional, with two or more patients, every 15 minutes. | $16.00 |
| 97154 | HM | Group adaptive behavior treatment by protocol, administered by a technician under the direction of a physician or other qualified healthcare professional, with two or more patients, every 15 minutes. | $16.00 |
| 97155 | HO | Adaptive behavior treatment with protocol modification, administered by a physician or other qualified healthcare professional, which may include simultaneous direction of a technician, face-to-face with one patient, every 15 minutes. | $30.00 |
| 97155 | HN | Adaptive behavior treatment with protocol modification, administered by a physician or other qualified healthcare professional, which may include simultaneous direction of a technician, face-to-face with one patient, every 15 minutes. | $25.00 |
| 97156 | HO | Family adaptive behavior treatment guidance, administered by a physician or other qualified healthcare professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s), every 15 minutes. | $30.00 |
| 97156 | HN | Family adaptive behavior treatment guidance, administered by a physician or other qualified healthcare professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s), every 15 minutes. | $30.00 |
| 97157 | HO | Multiple-family group adaptive behavior treatment guidance, administered by a physician or other qualified healthcare professional (without the patient present), face-to-face with multiple sets of guardians/caregivers, every 15 minutes. | $20.00 |

| | | | |
|---|---|---|---|
| 97157 | HN | Multiple-family group adaptive behavior treatment guidance, administered by a physician or other qualified healthcare professional (without the patient present), face-to-face with multiple sets of guardians/caregivers, every 15 minutes. | $20.00 |
| 97158 | HO | Group adaptive behavior treatment with protocol modification, administered by a physician or other qualified healthcare professional, face-to-face with multiple patients, every 15 minutes. | $20.00 |
| 97158 | HN | Group adaptive behavior treatment with protocol modification, administered by a physician or other qualified healthcare professional, face-to-face with multiple patients, every 15 minutes. | $20.00 |
| 0362T | All | Behavior identification supporting assessment, every 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administered by the physician or other qualified healthcare professional who is on site; with the assistance of two or more technicians; for a patient who exhibits destructive behavior; completed in an environment that is customized to the patient's behavior. | $32.00 |
| 0373T | HO | Adaptive behavior treatment with protocol modification, every 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administered by the physician or other qualified healthcare professional who is on site; with the assistance of two or more technicians; for a patient who exhibits destructive behavior; completed in an environment that is customized, to the patient's behavior. | $25.00 |
| 0373T | HN | Adaptive behavior treatment with protocol modification, every 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administered by the physician or other qualified healthcare professional who is on site; with the assistance of two or more technicians; for a patient who exhibits destructive behavior; completed in an environment that is customized, to the patient's behavior. | $25.00 |

| | | | |
|---|---|---|---|
| 0373T | HM | Adaptive behavior treatment with protocol modification, every 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administered by the physician or other qualified healthcare professional who is on site; with the assistance of two or more technicians; for a patient who exhibits destructive behavior; completed in an environment that is customized, to the patient's behavior. | $20.00 |

| **Telehealth Services Codes** | | |
|---|---|---|
| The following telehealth codes are to be used only with CPT codes: H0031, H0032, H0046 and S5111 | | |
| Q3014 | Originating site: once a day, same recipient, same provider | $22.94 per day |
| T1014 | Originating site and distant site: maximum of 90 minutes per day (1 unit = 1 minute), same recipient, same provider | $0.24 per unit |

| **Speech Therapy Services and Codes**<br>Services to be provided by a licensed speech therapist | | |
|---|---|---|
| 92521-92523 | **Speech therapy:** evaluations and re-evaluations | $35.00 per evaluation or re-evaluation |
| 92507, 92508 | **Speech therapy:** Treatment of speech, language, voice, communication, and/or auditory processing disorder, individual | $75.00 per visit, all inclusive |

**Acknowledged and Agreed**

**By: ABLE KIDS CO**

**By:** Renee Bingaman
(Electronic Signatures Accepted)

Title: Owner

Date: 12/9/2021

**By: PREMIER PHYSICIAN ALLIANCE, INC. dba INCENTIVE HEALTH I.P.A**

Title: **Donald Cornforth M.D., President**

Date: _____

**EXHIBIT II**

**Medical Management**
The PPA Medical Management program consists of pre-authorization and concurrent review of proposed medical care treatment for medical, surgical, pediatric, psychiatric and chemical dependency cases. Prior Authorization for treatment (except Emergency procedures) is required in advance for most Members. Emergencies generally require authorization within forty-eight (48) hours.

The Medical Management Process:

1. The process is initiated by the Payor where applicable, the Physician or a representative of his/her office who submits a referral authorization request to PPA or calls the phone number on the Member's identification card or PPA for Prior Authorization of medical care and treatment. A member of the medical management department will collect information submitted on the referral request form or during the phone call and certify that the proposed treatment, location of service (inpatient or outpatient) and length of stay are medically appropriate. Cases that cannot be certified are referred to the Medical Director for more in-depth review.

2. Emergency cases are defined as those cases determined by the Physician to have life threatening or catastrophic health consequences if the treatment plan is not initiated within a twenty-four (24) hour period. The Physician is required to call the PPA Medical Review Service within forty-eight (48) hours of admission or by the next regular working day in those circumstances.

3. If the PPA medical management department, at the direction of the PPA medical director, and the Payor where applicable, or Physician agree on the requested service necessity, as well as the location and duration decisions, the case is certified.

4. For selected cases, the medical management department contacts the Payor where applicable, or Physician by phone or verifies that the Member will be discharged on the expected day and to require the Physician to call if a length of stay extension is necessary.

5. In the event an extension is required, the Payor where applicable, Physician or representative should submit a referral authorization extension or call the PPA phone number provided or the number shown on the members identification card.

**PPA Medical Management Services.**
PPA shall provide through physician oversight of comprehensive Medical Necessity/ Utilization Management services on behalf of Payor for health care services provided or proposed for Members, under the definitions, terms and conditions described in this Agreement. Included in the oversight and approval of services provided to the covered member are the following:

1) Admission Review
2) Ambulatory Case Management
3) Concurrent Review
4) Hospitalist Program Services
5) Inpatient Case Management
6) Management Outcome Studies
7) Pre-Admission Review
8) Pre-Authorization Medical Review
9) Pre-Procedure Review

10) Referral Authorization and Management
11) Retrospective Review
12) Review Determination
13) Treatment Plan Review and Approval
14) Utilization Management

PPA shall also provide through physician oversight of all emergency department, Inpatient and Pre-admission comprehensive Medical Necessity/Utilization Management services on behalf of Payor for health care services provided or proposed for Members, under the definitions, terms and conditions described in this Agreement. Included in the oversight and approval of the following services provided to the covered member are the following services:

**Hospitalist and Hospitalist Services.**
The Hospitalist will serve as the "physician team leader" and shall coordinate with the primary and specialty care physician consultants and with internal hospital utilization management department personnel on behalf of a covered member. The hospitalist is to be responsible for coordinating the development of a patient care treatment plan for the covered member that encompasses testing, procedures and consultations by specialty care physicians. The treatment plan will be created and revised in coordination with the covered members medical care needs, consultation with patient's physician, and any physician consultants.

The treatment plan is to be regularly monitored and modified based upon patient prognosis, recovery progress, and overall response to the care being provided by the patient care treatment team. The hospitalist will provide for oversight of patient medical care while the covered member is being cared for within the hospital environment. The hospitalist shall perform patient triage, necessary rounds as required and needed to ensure appropriate care, consultations, testing and procedures are performed as the covered members treatment plan warrants. The hospitalist will ensure that testing, procedures and timely physician consultations occur as needed to meet patient treatment needs, hospital criteria, and Milliman stay guidelines. The hospitalist and medical treatment team will provide for timely patient discharge in coordination with the patient's physician(s), case manager and in conjunction with family support capabilities.

**Medical Necessity/Utilization Management Procedures, Guidelines, Screening Criteria and Norms**.
PPA shall establish, maintain and provide all services relating to Medical Necessity/Utilization Management procedures, guidelines, screening criteria and norms governing the services provided pursuant this Agreement.

**The Physician Appeals Process:**

**Review Determination Process.**
If PPA determines that an admission, continued treatment or planned procedure, services by Physician or prior authorization is not Medically Necessary, PPA will notify the Member, the Attending Physician, the Facility, the Hospitalist and the Payor or its claims administrator of such determination. By making such determination, PPA does not, in any way, restrict the right of Member's Attending Physician, Medical Director or Hospitalist to provide any treatment which, in the professional judgment of the Attending Physician, Medical Director or Hospitalist is appropriate.

**Reconsideration.**
The Member, Attending Physician and/or Facility may request a reconsideration of a Review Determination by PPA that services are not Medically Necessary. After ruling on the request for

reconsideration, the Member, Attending Physician, Facility and the Payor or its claims administrator will be notified of the decision in writing.

**Appeals Procedure.**
The Member, Attending Physician and/or Facility may appeal a Review Determination after being notified of the results of the reconsideration. After deciding the appeal, PPA in conjunction with Payor will notify the Covered Member, Attending Physician, Facility and the Payor of the decision in writing. Once a request for appeal has been received, the appeals procedure is as follows:

**First Level Appeals.**
1. If the appealing party has requested an expedited appeal, the appeal decision must be made within seventy-two (72) hours of receipt of the appeal. If the appeal circumstances do not warrant expedited processing or a standard appeal is requested, the appeal decision must be made within thirty (30) days of the appeal request. An extension of up to fourteen (14) days to the decision timelines may be granted in order to collect additional information, with permission of the party who requested the appeal.

2. An acknowledgement letter is sent to the appealing party within five (5) days of receipt of the appeal.

3. The appeal coordinator gathers all of the available information regarding the case, including any medical records sent in by the treating provider and any clinical notes in the PPA clinical information system, and forwards this information to a physician who was not involved in the denial decision.

4. The PPA physician reviews all available materials and makes an appeal determination based on the appropriate expedited or standard timeline requirements, and forwards his or her determination to the appeal coordinator.

5. The appeal coordinator would notify the facility/provider the payor as well as the employee/dependent of the appeal outcome via certified letter. The appeal letter includes information on how to access the Second level of appeal.

6. Appeals processing and tracking of information is documented in PPA's clinical documentation and data system so that we can run reports on quantity, timeliness and outcomes.

**Second Level Appeals.**
In general, second level appeals are processed by the Payor directly through the Payor CAO's office. For this program, Second level appeals decisions are made by the Payor's office. PPA supports the Payor by forwarding the information gathered during the First level appeal and by sending out the Second level appeal determination letter once instructed to do so by the Payor. This occurs in regularly scheduled meetings with the Payor and PPA staff.

**Third Level Appeals.**
An Independent Review Organization (IRO) would undertake this level of appeal. PPA would assist the Payor in identifying an IRO for use within this appeal level.