BLUE CROSS AND BLUE SHIELD OF TEXAS,
A DIVISION OF HEALTH CARE SERVICE CORPORATION

MEDICAL GROUP AGREEMENT FOR HMO NETWORK PARTICIPATION

This Agreement is entered into by and between Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association, ("HMO Blue"), and HIDALGO COUNTY HEALTH DEPARTMENT a professional entity organized in the state of Texas ("Medical Group").

As of the date executed, this Agreement includes the following:

Yes	No		
☒	☐	Medical Group Agreement	Compensation Paid Directly to:
☐	☒	Hospital Based Medical Group Provider Attachment	☒ Group ☐ Group Provider
☒	☐	Attachment A, Compensation – Fee For Service	

HMO Blue has entered into an agreement to delegate one or more activities to Medical Group. HMO Blue's Vice President of Network Management represents HMO Blue concerning delegation agreement matters. This Delegation Agreement includes:

☐	☒	Attachment B, Part 1 Delegated Activities and Monitoring Plan and the following:
☐	☒	Attachment B, Part 2 Credentialing
☐	☒	Attachment B, Part 3 Utilization Management
☐	☒	Attachment B, Part 4 Claims
☐	☒	Attachment C, Performance Incentives
☐	☒	Business Associate Addendum

In addition, Medical Group has entered into:

☐	☒	Financial Assurance Agreement
☐	☒	Subdelegation Consent Agreement

Medical Group is a:
☒ Specialist Group
☐ Primary Care Physician Group
☐ Primary and Specialty Care Group

Any Notice to be given pursuant to the terms and provisions of this Agreement shall be sent to HMO Blue at:

HMO Blue® Texas
4444 Corona, #120
Corpus Christi, TX 78411

and to Medical Group and/or Medical Group Providers at:

HIDALGO COUNTY HEALTH DEPARTMENT
1304 S 25TH AVE
EDINBURG, TX 785427205

Multiple Counterparts. The Agreement may be executed in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

IN WITNESS WHEREOF, the undersigned have executed this Agreement to be effective as of the Effective Date set forth below.

HMO BLUE	**MEDICAL GROUP**
A scanned, imaged, electronic, photocopy or stamp of the signatures hereunder shall have the same force and effect as an originally executed signature.	
Authorized Signature:	Authorized Signature:
_____	_____
Printed Name: M. Shannon Stansbury	Printed Name: _____
Title: Vice President, Network Management	Title: _____
Date: _____	Date: _____
Effective Date: _____	NPI: 1932146636

MEDICAL GROUP AGREEMENT

PART I. DEFINITIONS

AFHC Program means Blue Cross and Blue Shield Association's Away From Home Care® Program.

Agreement means this contract and all attachments and amendments appended hereto.

Applicable Laws means all federal and Texas laws and regulations that are applicable to any provisions of this Agreement, including, without limiting the foregoing, laws applicable to an HMO certified under the Texas Insurance Code.

Capitated Services means those Covered Services (that are not Out-of-Network Services) as defined in Attachment A for which a Participating Provider receives Capitation in lieu of fee-for-service payments.

Capitation means a payment system which pays a fixed actuarially determined amount per month for each HMO Blue Member and which may be based on such factors as age, sex and benefit plan.

Capitation Fees means, if applicable, the amount prepaid by HMO Blue in exchange for a Participating Provider's obligation to render the Capitated Services set forth in Attachment A pursuant to the terms of the Agreement.

Clean Claim means a clean claim as defined by applicable Texas law and regulation.

Coinsurance means, if applicable, the specified percentage of the fee for a Covered Service that is payable by the Member pursuant to the Membership Agreement. The Member's obligation to make Coinsurance payments may be subject to an annual out-of-pocket maximum specified in the Membership Agreement.

Copayment means the amount required to be paid to Medical Group or Medical Group Provider by or on behalf of a Member in connection with the services rendered by the Medical Group or Medical Group Provider.

Covered Services means those health services specified and defined as Covered Services under the terms of a Member's Health Plan.

Debarment means the prohibition of a Provider from receiving compensation for services provided under any federal health benefit plan or program, including, without limiting the foregoing, Medicare, Medicaid, and the Federal Employees Health Benefits Plan ("FEP"), as reported by the federal Office of Personnel Management ("OPM"), Office of the Inspector General ("OIG"), the Center for Medicare and Medicaid Services ("CMS"), Office of Foreign Assets Control ("OFAC") or other applicable agency.

Deductible means, if applicable, the specified annual amount of payment for certain Covered Services, expressed in dollars, that the Membership Agreement requires the Member to pay before the Member can receive any benefits under the Membership Agreement for the Covered Services to which the Deductible applies.

Delegated Entity means an entity other than a health maintenance organization that, by itself, or through subcontracts with one or more entities, is contracted with HMO Blue to arrange for or to provide medical care or health care to Members in exchange for predetermined payment on a prospective basis and that accepts responsibility to perform on behalf of Health Plan any function regulated by the Texas Insurance Code. The term does not include an individual physician or a group of employed physicians practicing medicine under one federal tax identification number and whose total claims paid to providers not employed by the group is less than twenty percent (20%) of the total collected revenue of the group calculated on a calendar year basis.

Delegated Network means any Delegated Entity that assumes total financial risk for more than one of the following categories of health care services: medical care, hospital or other institutional services, or prescription drugs, as defined by applicable law regulating pharmacies in the state of Texas. The term does not include a Delegated Entity that shares risk for a category of services with a health maintenance organization.

Designated Members means those Members who have selected or been assigned to, and been accepted by, a Medical Group Provider who is acting as the Members' Primary Care Physician.

Emergency Care means health care services provided in a Hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that such person's condition, sickness or injury is of such a nature that failure to get immediate medical care could result in: (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part; (4) serious disfigurement; or (5) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Health Plan means any group or individual health benefits plan whether insured or self-funded which provides its participants access to health care services that is operated, administered or underwritten, in whole or in part by HMO Blue, a subsidiary, an affiliate of HMO Blue, and that has entered into any agreement to provide or administer Covered Services. The term affiliate includes, but is not limited to, any licensed entity associated with the Blue Cross and Blue Shield Association that participates in the AFHC Program, or in which Health Care Service Corporation has an ownership interest.

Hospital means either: (1) a licensed and accredited health facility which is, for compensation, primarily engaged in providing medical, diagnostic and surgical facilities for the care and treatment of sick and injured patients on an Inpatient basis, and which provides such facilities under the supervision of a staff of physicians and twenty-four (24) hour a day nursing service by registered nurses (a facility which is principally a rest home, nursing home or home for the aged is not included); (2) a psychiatric Hospital licensed as a health facility and accredited by the Joint Commission on Accreditation of Healthcare Organizations; or (3) a licensed health facility operated primarily for the treatment of alcoholism and/or drug abuse accredited by the Joint Commission on Accreditation of Healthcare Organizations.

In-Network Services means Covered Services provided to Members of HMO Health Plans and of POS Plans to the extent the Covered Services are provided in accordance with the Health Plan's requirements for in-network benefits set forth in the applicable Membership Agreement. Except for Emergency Care, such services generally must be provided in the Service Area by Members' Primary Care Physicians or obtained through a network of Participating Providers with a Proper Referral and with Preauthorization, where required.

Inpatient means a Member admitted to a Hospital as a registered bed patient and who requires the acute bed patient overnight setting.

Institutional and Other Services means those non-physician Covered Services provided by or through a state licensed facility or entity. Such services include, but are not limited to, Inpatient or Outpatient Hospital services, skilled nursing facility services, ambulance services and pharmacy services.

Limited Provider Network means a subnetwork within an HMO delivery network in which contractual relationships exist between physicians, certain Providers, independent physician associations and/or physician groups which limit Members' access to only the physicians and Providers in the subnetwork.

Medical Director means a physician designated by HMO Blue, or such physician's designee, who is responsible for monitoring the provision of Covered Services to Members.

Medical Group means the above named entity that has entered into this Agreement with HMO Blue to provide or arrange for the provision of Covered Services to Members. Where applicable by context, Medical Group also means Medical Group Providers. Medical Group shall require that Medical Group Providers comply with the provisions of this Agreement that are applicable by context to Medical Group Providers.

Medical Group Provider means an individual physician or Provider appropriately licensed to provide health care services who participates with Medical Group and includes, without limiting the foregoing, Medical Group Primary Care Physician, Medical Group Specialist, and Medical Group Obstetrician/Gynecologist.

Medically Necessary or **Medical Necessity** means health care services that a Medical Group or Medical Group Provider, exercising prudent clinical judgment, would provide to a Member for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the Member's illness, injury or disease; and (c) not primarily for the convenience of the Member, Medical Group or Medical Group Provider, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that Member's illness, injury or disease. For these purposes, "generally accepted standards

of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

Member means an individual who is eligible to receive Covered Services under a Health Plan.

Membership Agreement means the Member's group or individual service agreement/certificate of coverage, schedule of benefits and any supplemental benefit riders, or comparable contractual documents describing the scope and conditions of coverage under the Member's Health Plan.

Notice means any notice required or allowed to be given pursuant to the terms and provisions of this Agreement. Notices shall be sent in writing by United States mail, certified mail, traceable commercial delivery, or electronic transmission, and shall be deemed to be given when received. Notices sent by United States mail shall be deemed to be received on the third business day following their deposit in the United States mail.

Obstetrician/Gynecologist means a Participating Specialist who may be selected by a female Member to provide: (1) well-woman exams; (2) obstetrical care; (3) care for all active gynecological conditions; and (4) diagnosis, treatment and referral for any disease or condition within the scope of the professional practice of the Obstetrician/Gynecologist.

Out-of-Network Services means Covered Services provided to Members of POS Plans which are not In-Network Services.

Outpatient means a Member receiving Covered Services but not as an Inpatient.

Participating means a Provider is under contract with HMO Blue or an affiliate of HMO Blue to provide Covered Services to Members. The Participating Provider may be contracted either (1) directly, or (2) indirectly through a subcontract with a Participating Medical Group, independent practice organization or physician hospital organization or similar organization.

Payer means an entity other than HMO Blue that is financially responsible for payment for Covered Services under a Health Plan.

POS Plan means a point-of-service Health Plan offered or administered by an HMO under which a Member can choose, at the time Member seeks covered non-emergency care, whether to obtain In-Network Services or Out-of-Network Services.

Preauthorization means HMO Blue's prior approval of the Medical Necessity of certain services provided to Members under the terms of their Membership Agreement.

Primary Care Physician means a Participating physician who has agreed to be responsible for providing basic health services, coordinating the care of individual Members, and as applicable, referring those Members to other Participating Providers.

Proper Referral means a referral issued by a Member's Primary Care Physician pursuant to the applicable UM Program, for a Member to receive a particular In-Network Service within a specified time frame. Proper Referrals are required for all In-Network Services provided to Members that are not provided by the Member's Primary Care Physician, except for: (1) Emergency Care, (2) In-Network Services, including behavioral health services, obtained by a Member by self-referral to a Participating Provider, as expressly permitted by Member's Membership Agreement or as required by Applicable Laws; (3) Obstetrical and Gynecological care; and (4) Urgent Care services which are Covered Services under Member's Membership Agreement. A Proper Referral from the Member's Primary Care Physician must identify the particular Participating Provider (or non-Participating Provider, if approved by HMO Blue or the applicable UM Agent) who is to provide the service. Where the Membership Agreement requires a particular In-Network Service to be Preauthorized in order to be a Covered Service, a Proper Referral must include such Preauthorization.

Provider means any appropriately licensed provider of health care services.

Provider Manual means HMO Blue policies, procedures, and guidelines as set forth in a manual as supplemented by written materials, including HMO Blue Provider correspondence and the Blue Cross and Blue Shield of Texas Web site, which may be revised from time to time, subject to the provisions of **Part X, General Provisions, Section N, Modifications**. In the event of a conflict between the Provider Manual and terms of this Agreement, the terms of this Agreement shall apply.

Service Area means that geographic area served by HMO Blue.

Specialist means a Participating Provider who is a physician or health care professional, other than a Primary Care Physician.

UM Agent means an entity that is a licensed utilization review agent under Applicable Laws and is designated to perform utilization management ("UM") in connection with the care of Members of a Health Plan, which is usually indicated on the Member's identification card. The administrator of the applicable Health Plan may designate HMO Blue or another licensed utilization review agent to act as UM Agent for purposes of this Agreement and may designate one or more UM Agents to perform various UM activities. To the extent that HMO Blue has been designated as the UM Agent, HMO Blue may delegate any of HMO Blue's obligations to perform UM to any other entity licensed or otherwise permitted, in accordance with Applicable Laws, to perform UM in Texas.

UM Program means the guidelines, standards and procedures for UM activities that are used in connection with the applicable Health Plan, as more fully described in this Agreement.

Urgent Care means medical care that is delivered in a facility dedicated to the delivery of unscheduled, walk-in medical care that is not Emergency Care to any Member outside of a Hospital emergency department or comparable facility.

PART II. OBLIGATIONS OF MEDICAL GROUP

A. **Covered Services.**

1. If Medical Group includes Primary Care Physicians, each Medical Group Primary Care Physician shall provide all primary care services to Designated Members within the scope of Primary Care Physician's practice or license and agrees to assume primary responsibility for coordinating the overall health care of Designated Members and to provide or arrange for all other Covered Services subject to the terms and conditions of this Agreement. Further, such Primary Care Physician shall make available to Members those health education programs routinely provided by Primary Care Physician.

2. If Medical Group includes Specialists, each Medical Group Specialist shall accept as patients those Members who are referred by a Primary Care Physician or Obstetrician/Gynecologist, or as a result of Emergency Care, and shall provide to such Members those Covered Services that such Specialist commonly performs within Specialist's scope of practice or license subject to the terms and conditions of this Agreement.

B. **Availability**. Medical Group shall ensure that Covered Services are readily available during Medical Group's regular business hours on business days, and that Emergency Care Covered Services are available twenty-four (24) hours per day, seven (7) days per week, including holidays. Medical Group shall provide such services in the same manner, in accordance with the same standards, and within the same time availability as such services are provided to other patients without regard to the degree or frequency of utilization of such Covered Services by Members. In the event Medical Group Provider is temporarily unavailable, Medical Group Provider may provide Covered Services through a designee, provided that such designee, must have an equivalent competence and specialty, and must agree to provide Covered Services to Members under the same compensation arrangements and comply with HMO Blue procedures. Medical Group may make a special arrangement with HMO Blue in the event of the extended temporary absence of a Medical Group Provider. A Primary Care Physician or designee shall be available at all times to direct patient care rendered by Hospital emergency department personnel for determination of appropriateness and Medical Necessity and to provide post-stabilization treatment to Members following Emergency Care. Medical Group acknowledges and agrees that such requests must be responded to by Medical Group within the time appropriate to the circumstances, but in no case to exceed one (1) hour.

C. **Standard of Care**. Medical Group shall, and shall require Medical Group Providers to, comply with Applicable Laws and all applicable professional standards, and shall provide Covered Services in accordance with generally accepted medical and surgical practices and standards prevailing at the time of treatment. In addition, Medical Group and Medical Group Providers shall comply with the standards adopted by HMO Blue's quality improvement and UM Program set forth in the Provider Manual.

D. **Licensure and Medical Staff Requirements.** Medical Group warrants and represents as a material term of this Agreement that each Medical Group Provider has and will continue to have, as long as this Agreement remains in effect, all the requisite licenses/certifications required by the state of Texas and such other governmental and professional boards and bodies having authority over Medical Group Provider's business/profession, including, where applicable, a currently valid, unrestricted license to practice medicine in the state of Texas, and further that each Medical Group Provider who is a physician is and will be a member in good standing with admitting privileges at, and on the staff of at least one Participating Hospital. Except with respect to stabilization following Emergency Care, Medical Group will require that Members be admitted only to Participating Hospitals unless HMO Blue Preauthorizes the admission.

E. **Proper Referral and Preauthorization.**

1. Medical Group Primary Care Physicians or Medical Group Obstetrician/Gynecologists referring a Member to another Provider for treatment shall comply with all Proper Referral and Preauthorization procedures set forth in this Agreement and in the Provider Manual. Medical Group Providers will only refer to Participating Providers except in cases of Emergency Care or, if Preauthorized by HMO Blue, when no Participating Providers are available to provide the necessary services as required by the Applicable Laws.

2. Medical Group Specialist shall comply with all Proper Referral and Preauthorization procedures set forth in this Agreement and in the Provider Manual. Medical Group Specialists shall provide Covered Services to Members only upon a Proper Referral or Preauthorization, as applicable, except in cases requiring Emergency Care. Medical Group Specialist shall discuss with and seek approval from the referring Participating physician prior to rendering or arranging any continuing treatment which is beyond the specific treatment described in the Proper Referral. In addition, Medical Group Specialist shall not refer a Member to another physician or Provider without the prior concurrence of the Member's Primary Care Physician or Obstetrician/Gynecologist, as applicable.

3. Members may directly access an Obstetrician/Gynecologist and such Obstetrician/Gynecologist shall provide Covered Services for: (a) well woman exams; (b) obstetrical care; (c) care for all active gynecological conditions; and (d) diagnosis, treatment and referral for any disease or condition within the scope of the professional practice of the Obstetrician/Gynecologist. Information regarding Member's care will be shared with Member's Primary Care Physician. If Member's Primary Care Physician is in a Limited Provider Network, a Member may only directly access an Obstetrician/Gynecologist who is in the same Limited Provider Network unless no such Obstetrician/Gynecologist is available. Preauthorization by HMO Blue is necessary for a Member to access an Obstetrician/Gynecologist who is not in the Member's Limited Provider Network.

4. Subject to the terms of Member's Membership Agreement, Member may directly access Covered Services that are Urgent Care. Information regarding Member's care will be shared with Member's Primary Care Physician. If Member's Primary Care Physician is in a Limited Provider Network, a Member may only obtain Urgent Care in a facility that is in the same Limited Provider Network unless no such facility is available. Preauthorization by HMO Blue is necessary for a Member to access such a facility that is not in the Member's Limited Provider Network.

5. When Medical Group is a Limited Provider Network or a Delegated Entity, if Medically Necessary Covered Services are not available for a Member through Medical Group Providers, Medical Group must, on request of a physician who is a Medical Group Provider, allow a Proper Referral to a Provider that is not Participating. Medical Group shall fully compensate the non-Participating Provider at the usual and customary or an agreed upon rate when Medical Group is a Delegated Entity. The Proper Referral shall be allowed within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but not later than the 5th business day after the date any reasonably requested documentation is received by Medical Group. The Member may not be required to change the Member's Primary Care Physician or specialist Providers to receive Medically Necessary Covered Services that are not available within Medical Group. The decision of Medical Group must be subject to a review by a specialist of the same or similar specialty as the type of Provider to whom a referral is requested before Medical Group may deny a referral. A denial of a referral for services by a non-Participating Provider under this section is subject to appeal under the provisions for appeal of adverse determinations contained in the Texas Insurance Code.

6. Costs of services rendered by Medical Group without a Proper Referral or Preauthorization where required shall be the financial responsibility of Medical Group. The involvement of HMO Blue or other administrator of any Health Plan and/or the applicable UM Agent or a Delegated Entity in decisions relating to the coverage of services rendered to Members under Health Plans shall not diminish the ultimate and sole responsibility of Medical Group for any professional authority over their professional practice with respect to the care of such Members. Covered Services of Hospital based physicians and Providers are authorized when they are associated with Covered Services for which a Proper Referral has been issued.

7. Subject to the procedures contained in the Provider Manual, Preauthorization is not an assurance or guarantee of payment; however, Payer or HMO Blue will not deny a claim for Preauthorized services solely on the basis that they were not Medically Necessary unless the requesting Provider has materially misrepresented the proposed services or the Member's condition. HMO Blue may deny a claim for a Preauthorized service when the Provider has substantially failed to perform the proposed services.

F. **Facilities, Equipment and Staff**. The following requirements shall be met or performed by Medical Group and/or Medical Group Providers, as applicable:

1. Provide and maintain facilities and/or equipment which are of adequate capacity, clean, safe, readily accessible to Members and, where appropriate, properly licensed and/or registered.

2. Assure the appropriate supervision of, licensure/certification of, and insurance coverage for, all employed or subcontracted staff that provide Members Covered Services that are performed under the direction of Medical Group Providers.

3. Have written policies that are implemented and enforced and that describe the duties of any employed or subcontracted physician assistants, advanced practice nurses and other individuals other than physicians in accordance with statutory requirements for licensure, delegation, collaboration and supervision as appropriate.

4. If Medical Group is a Limited Provider Network, maintain a sufficient number of physicians and Providers to provide Covered Services to Members within the Limited Provider Network.

If any employee or subcontractor of Medical Group violates any of the provisions of Applicable Laws or the Provider Manual or commits any act or engages in any conduct for which Medical Group's license/certification may be revoked or suspended by the state of Texas (whether or not such authority revokes or suspends said license/certification) or is otherwise disciplined by such licensing authority or any professional organization having authority over such employee or contracting agent, HMO Blue may immediately require such employee or subcontractor to cease providing services to Members under this Agreement.

G. **Administrative Services**. Medical Group shall perform or contract for all administrative and support services necessary for Medical Group to perform Medical Group's obligations under this Agreement and as set forth in the Provider Manual.

H. **HMO Blue Complaint Procedures.** Medical Group and Medical Group Providers shall cooperate with HMO Blue in identifying, processing and in supporting HMO Blue's resolution of all Member complaints and grievances pursuant to the Member complaint procedures set forth in the Membership Agreement. Medical Group also agrees to cooperate with HMO Blue in identifying, processing and resolving all Provider complaints and use the Provider complaint procedure described in the Provider Manual, in the event Medical Group has a complaint from a Medical Group Provider, a non-Medical Group Participating Provider or a non-Participating Provider. Each Medical Group Provider shall post in Medical Group Provider's office(s) a notice to Members regarding the process for resolving complaints with HMO Blue substantially in the form recommended by the Texas Department of Insurance (TDI). The notice must include TDI's toll-free telephone number for filing complaints. Medical Group shall forward to HMO Blue all written and oral complaints from Members within four (4) calendar days of receipt, unless a shorter period is required by Applicable Laws or applicable accreditation standards. Medical Group shall respond in an accurate, appropriate and complete manner to HMO Blue inquiries and document requests within three (3) calendar days when they relate to TDI complaints, and within five (5) calendar days when they relate to Member and Provider inquiries and complaints. When Medical Group is a Delegated Entity under Part 3 or Part 4 of Attachment B, of the Delegation Agreement, Medical Group shall maintain a log containing all Member and Provider complaints setting forth the date and nature of each complaint, where the complaint originated, and whether the complaint was made orally or in writing. The logs shall be

available for review by HMO Blue during normal business hours and copies must be provided by Medical Group to HMO Blue upon request.

I. **Member Identification**. Medical Group Provider shall request Member to present Member's HMO Blue identification card each time Member seeks Covered Services and, if applicable, by checking the membership list provided by HMO Blue in accordance with this Agreement. For patients claiming enrollment in HMO Blue, but not appearing on the membership list, Medical Group Provider shall request eligibility information by telephoning HMO Blue or by other electronic means established by HMO Blue. However, obtaining information concerning eligibility at the time of service by Medical Group as described in this Agreement is not verification and does not guarantee payment by HMO Blue in the event that Member is later determined to have been ineligible for benefits at the time of service.

J. **Termination of the Medical Group/Patient Relationship.**

1. Under certain circumstances, Medical Group Provider may terminate Medical Group Provider's professional relationship with a Member as provided for and in accordance with the provisions of the Provider Manual. Medical Group Provider may not terminate Medical Group Provider's relationship with a Member because of such Member's medical condition or the amount, types or cost of Covered Services that are required by the Member.

2. Medical Group acknowledges that a Member may request transfer to another Participating physician or Medical Group Provider's care in accordance with the Member's Membership Agreement. Medical Group shall require that the Medical Group Provider provide patient records, reports and other documentation regarding such Member at no cost upon request in order to facilitate such transfer.

K. **Required Disclosures**. Medical Group shall notify HMO Blue at least thirty (30) days in advance if there is a change in the business address, telephone number, hours of operation, tax identification number, other billing information or services provided by Medical Group or Medical Group Provider. Additionally, Medical Group shall notify HMO Blue immediately in writing upon the occurrence of any of the following events:

1. Medical Group's, Medical Group Provider's, or any Medical Group employee's or subcontractor's applicable license or certification to practice in Texas or DEA/DPS registration is suspended, revoked, terminated or subject to terms of probation or other restriction (whether or not such action is stayed); or Debarment of Medical Group, Medical Group Provider, or any Medical Group employee or subcontractor, or inclusion of Medical Group, Medical Group Provider, or any Medical Group employee or subcontractor in the OFAC/OIG/GSA/OPM list;

2. A Medical Group Provider's medical staff privileges at any Hospital are denied, suspended, restricted, revoked or voluntarily relinquished in lieu of disciplinary action;

3. Medical Group, Medical Group Provider or any Medical Group employee or subcontractor, becomes the subject of any disciplinary proceeding, Debarment or action before the Texas State Board of Medical Examiners or a similar agency in any state;

4. A Medical Group Provider, or any Medical Group employee or subcontractor, is charged with or indicted for, or convicted of, fraud or a felony;

5. An act of nature or any event beyond Medical Group's reasonable control occurs, which substantially interrupts all or a portion of Medical Group's business or practice or which has a materially adverse effect on Medical Group's ability to perform Medical Group's obligations under this Agreement;

6. The material modification or termination, or reduction in the amount, of the insurance coverage required for participation in HMO Blue, or replacement of coverage which is canceled or terminated;

7. Medical Group or Medical Group Provider learns of any claim or malpractice action or other lawsuit or other action brought against Medical Group or any Medical Group Provider, or Medical Group employee or subcontractor, or becomes aware of a malpractice judgment or settlement against Medical Group, Medical Group Provider or any Medical Group employee or subcontractor;

8. Significant changes in administrative capacity, including information systems, and operational staff that may have a material adverse effect on Medical Group's ability to perform Medical Group's obligations under this Agreement; or

9. Any other situation which could reasonably be expected to affect the ability of Medical Group to carry out Medical Group's obligations under this Agreement.

L. **Provider Directory.** Medical Group agrees that HMO Blue may list such information as Medical Group or Medical Group Provider's name, specialty, address, telephone number and board status and other information in HMO Blue publications provided to Participating physicians, Participating Providers and Members and may use such information in advertising and marketing materials.

M. **Medical Group Status.**

1. Medical Group certifies that neither Medical Group, Medical Group Providers nor Medical Group's employees or subcontractors have been: (a) charged with a criminal offense in connection with obtaining, attempting to obtain, or performing of a public (federal, state or local) contract or subcontract, (b) listed by a federal governmental agency as debarred, (c) proposed for Debarment or suspension or otherwise excluded from federal program participation, (d) been convicted of or had a civil judgment rendered against Medical Group, Medical Group Providers, Medical Group's employees or subcontractors regarding dishonesty or breach of trust, including but not limited to, the commission of a fraud including mail fraud or false representations, violation of a fiduciary relationship, violation of federal or state antitrust statutes, securities offenses, embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, tax evasion, or receiving stolen property; or (e) within a three (3) year period preceding the date of this Agreement, had one or more public transactions (federal, state or local) terminated for cause or default.

2. Medical Group acknowledges and agrees that Medical Group has a continuing obligation to notify HMO Blue in writing within seven (7) business days if any of the above-referenced representations change. Medical Group further acknowledges and agrees that any misrepresentation of Medical Group's status or any change in Medical Group's status at any time during the term of this Agreement may be grounds for immediate termination of this Agreement, at the sole discretion of HMO Blue.

N. **HMO Blue Credentialing Procedures**. Medical Group shall cooperate and comply with, and be subject to, HMO Blue credentialing and recredentialing policies and procedures. Medical Group further acknowledges and agrees, except as may be required by Applicable Laws, a Medical Group Provider will not become a Participating Provider in HMO Blue until approved by HMO Blue pursuant to such credentialing policies and procedures and that continued participation in HMO Blue is subject to the recredentialing process at intervals provided for in such policies and procedures.

O. **Capacity**. Each Member shall select a Primary Care Physician in accordance with the procedures set forth in the Membership Agreement. Medical Group and each Medical Group Provider who is a Primary Care Physician agree to accept Members who have selected or who have been assigned to the Primary Care Physician unless Medical Group notifies HMO Blue that the Primary Care Physician's entire practice is closed to new patients of HMO Blue as well as new patients of all other health plans or unless the Primary Care Physician's practice contains 300 Members. Medical Group must give HMO Blue not less than ninety (90) day prior Notice of closing a Primary Care Physician's practice to new Members. Notwithstanding practice closure, Medical Group agrees to accept all existing patients who are or become Members. Medical Group agrees that HMO Blue shall have no obligation to guarantee any minimum number of Members to Medical Group and that Medical Group shall accept all patients enrolling as HMO Blue Members.

P. **Medical Group Subcontracts with Physicians and Providers.**

1. Medical Group shall furnish to HMO Blue in advance of its use the standard form of all subcontracts between Medical Group and any Medical Group Providers, including any material changes to such forms, in accordance with Applicable Laws and the Provider Manual. In addition, Medical Group shall provide to HMO Blue the executed signature page of each such contract and any material changes to such contract. Medical Group will ensure such Medical Group Providers comply with all terms and conditions set forth in the Membership Agreement and this Agreement.

2. Contracts between Medical Group and Medical Group Providers must contain provisions requiring such Medical Group Providers to comply with the provisions of this Agreement, and the Provider Manual where applicable, and must allow such Medical Group Providers to terminate such contracts on ninety (90) days advance Notice, and may not contain restrictions on such Provider's right to contract directly, or indirectly, through another medical group, with HMO Blue after termination of such Medical Group Provider's contract with Medical Group.

PART III. OBLIGATIONS OF HMO BLUE

A. **Provider Manual**. HMO Blue shall make available to Medical Group the Provider Manual. The Provider Manual may be revised by HMO Blue from time to time and in accordance with this Agreement. Where practicable, HMO Blue shall use best efforts to provide advance Notice to Medical Group of substantive changes to the Provider Manual.

B. **Identification Cards**. HMO Blue shall issue identification cards to Members.

C. **Membership List**. If applicable, HMO Blue shall notify Medical Group of Designated Members selecting Medical Group as their Primary Care Physician and will provide membership lists to Medical Group as set forth in the Provider Manual.

D. **Assignment of Members**. If a Member does not select a Primary Care Physician at the time of application or enrollment, HMO Blue may assign Member to a Primary Care Physician. If HMO Blue elects to assign Member, the assignment shall be made in a manner that results in a fair and equal distribution of Members among Primary Care Physicians. If applicable, HMO Blue shall notify Medical Group of Designated Member's assignment within thirty (30) working days of the assignment.

E. **Service Preauthorizations**. HMO Blue shall Preauthorize Covered Services as set forth in the Provider Manual and in accordance with provisions of this Agreement.

F. **Administrative Services**. HMO Blue shall be responsible for all administrative activities necessary or required for the operation of a health maintenance organization. Such activities shall include, but are not limited to, marketing, advertising, customer service, underwriting, establishment and collection of premiums, maintenance of membership (non-medical) records, accounting, maintenance of a medical management information system and negotiation of contracts with Providers of Covered Services.

G. **Advisory Review Panel**. HMO Blue may establish one or more health services delivery advisory review panels to advise HMO Blue on a variety of issues. Medical Group Providers may be requested from time to time by HMO Blue to serve as members on such panels.

H. **Credentialing**. HMO Blue shall administer a credentialing and recredentialing program pursuant to which the credentials of Provider applicants are reviewed and approved for acceptance as Participating Providers.

I. **Complaints.** HMO Blue will establish and maintain a complaint procedure as required by the Provider Manual and Applicable Laws.

PART IV. COMPENSATION

A. **Payment**.

1. **Claims Payment**. HMO Blue or Payer shall pay Medical Group for Covered Services rendered to Members less any applicable Member Copayments, Coinsurance or Deductible amounts as described in **Attachment A, Compensation/Claims Submission**. Medical Group shall accept such compensation, and any applicable Member Copayment, Coinsurance or Deductible as Medical Group's only compensation for Covered Services. HMO Blue or Payer shall make such payment for services within forty-five (45) days of receipt of Clean Claims in a nonelectronic format or within thirty (30) days of receipt of Clean Claims that are electronically submitted. If the Health Plan is a secondary insurer, then a claim must include the amount paid as a covered claim by the primary insurer to be a Clean Claim. Any dispute arising from such payment shall be resolved in accordance with **Part X, General Provisions, Section I, Dispute Resolution**.

2. **Recovery of Overpayments and Underpayments.**

a. In the event that HMO Blue determines an overpayment, including a duplicate payment, has

been made, Medical Group and/or Medical Group Provider agrees to promptly make repayment to HMO Blue or Payer when requested. If Medical Group and/or Medical Group Provider fail to make such repayment or appeal such determination within the time period specified in Applicable Laws, Medical Group and/or Medical Group Provider shall allow overpayments to be deducted from future payments, for the same or different Members, with an explanation of the action taken.

b. Overpayments determined by Medical Group and/or Medical Group Provider on a claim or claims, including duplicate payments, shall be refunded promptly to HMO Blue, but in no event later than thirty (30) days following such determination.

c. Any underpayments shall be added to future payments by HMO Blue to Medical Group and/or Medical Group Provider.

d. Any dispute arising from a deduction or payment with respect to an overpayment or underpayment shall be resolved in accordance with the Provider complaint procedures set forth in **Part II, Obligations of Medical Group, Section H, HMO Blue Complaint Procedures**.

3. **Deadline for Reconsideration**. Requests for reconsideration of claims payment determination must be in writing, include all pertinent information, and sent as directed and within the deadline, all as specified in the Provider Manual.

B. **Copayments, Coinsurance and Deductibles**. The collection of Member Copayments, Coinsurance or Deductible amounts is the sole responsibility of Medical Group Provider. Medical Group shall require Medical Group Providers to diligently pursue, and have responsibility for, collection of any applicable Copayment, Coinsurance or Deductible amount from Members and shall in no event offer, publicize or advertise any waiver or other reduction of any Copayment, Coinsurance or Deductible amount unless specifically authorized in writing by HMO Blue. All Copayments, Coinsurance and Deductible amounts shall be as specified in the Membership Agreement, and the amounts of the Copayments, Coinsurance or Deductible which Medical Group Provider is authorized to collect from the Member shall not exceed the amounts so specified.

C. **Claims and Encounter Data**. Medical Group shall submit complete and properly executed claims or encounter information to HMO Blue within the required filing period, as described in **Attachment A, Compensation/Claims Submission**.

D. **Member Nonliability and Hold Harmless**.

1. Medical Group hereby agrees that in no event, including, but not limited to, non-payment by HMO Blue or Payer, insolvency of HMO Blue or Payer or breach of this Agreement, shall Medical Group or Medical Group Providers bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Member or persons other than HMO Blue acting on Member's behalf for Covered Services. This provision shall not prohibit collection of supplemental charges or Copayments, Coinsurance or Deductible amounts payable in accordance with the terms of Member's Membership Agreement.

2. Medical Group further agrees that: (a) this provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Member; and (b) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Medical Group or a Medical Group Provider and Member or persons acting on their behalf.

3. Any modifications, additions or deletions to the provisions of this section shall become effective on a date no earlier than fifteen (15) days after the Commissioner of Insurance has received written notice of such proposed changes.

E. **Services Included in Medical Group Compensation**. Compensation by HMO Blue for Covered Services provided by Medical Group within the scope of Medical Group's practice or license is inclusive of the cost of incidental services in support of such Covered Services. Compensation for such incidental services may not be billed separately by Medical Group or another Provider or other entity; provided that professional services necessary for the treatment of the Member that require the use of equipment that is supplied or arranged for by Medical Group may be billed separately by the person providing those professional services. Only Medical Group may bill HMO Blue for all services provided to Member at Medical Group's or Medical Group Provider's facility.

F. **Billing for Non-Covered Services**. In the event that HMO Blue determines and informs Medical Group that a proposed service is not a Covered Service, including but not limited to services that are determined to be experimental/investigational or not Medically Necessary, Medical Group must inform the Member in writing in advance of the service being rendered that the service is a non-Covered Service in order to be allowed under this Agreement to bill the Member for the service rendered. The Member must also acknowledge this disclosure in writing and agree to accept the service as a non-Covered Service billable directly to the Member. In the event that the Member's benefits are exhausted, Medical Group may continue to provide treatment to the Member if the Member agrees in writing to pay for those services; provided, however, that Medical Group may not charge the Member more than the amount allowed as described in Attachment A.

G. **Third Party Collections**. Medical Group shall cooperate with HMO Blue in the collection on HMO Blue's behalf of third party payments including workers' compensation, third party liens and other third party liability according to the procedures set forth in the Provider Manual. Medical Group agrees that Medical Group or Medical Group Provider will file claims and encounter information with HMO Blue even if Medical Group believes or knows that there is third party liability and the existence of third party liability will not affect Medical Group's or Medical Group Provider's total compensation for Covered Services.

H. **Coordination of Benefits**. Medical Group shall comply with the requirements of Applicable Laws and the Provider Manual regarding Covered Services involving coordination of benefits. Medical Group agrees to submit applicable claims and encounter information concerning other carriers to HMO Blue even if Medical Group believes that coordination of benefits may apply and HMO Blue is not the primary carrier.

PART V. QUALITY IMPROVEMENT AND UTILIZATION MANAGEMENT

A. **HMO Blue Responsibilities**. HMO Blue shall conduct peer review, quality improvement and the UM Program in accordance with Applicable Laws. HMO Blue's UM Program may include the establishment of advisory review panels to conduct quality of care and utilization review activities in accordance with Applicable Laws. All HMO Blue quality improvement and UM forms, records and other information shall remain the property of HMO Blue and shall remain confidential.

B. **Medical Group Responsibilities**. Medical Group agrees to comply with and be subject to the quality improvement program and the UM Program conducted by HMO Blue and cooperate with peer review activities, all as set forth in the Provider Manual, and to promote Member participation in HMO Blue disease management programs as applicable. These programs may be revised from time to time, and may include, but are not limited to, Preauthorization of elective Inpatient services, concurrent review of Inpatient lengths of stay, review of referrals, internal peer review and external audit systems. Medical Group shall have sole authority and responsibility for the care of any Member who is a patient of Medical Group.

C. **Shared Records**. Upon request, Medical Group shall make available to HMO Blue's quality improvement and utilization review committee any records of Medical Group's quality improvement and utilization review activities pertaining to Members. HMO Blue will protect the confidentiality of information that is the product of Medical Group's peer review process.

PART VI. RECORDS

A. **Member Record**. Medical Group and Medical Group Providers shall establish and maintain an accurate medical record, for each Member with whom Medical Group Providers have an encounter that, at a minimum, shall include such information about the Member and a description of all services rendered to the Member as dictated by generally accepted medical and surgical practices and standards and as required by the Provider Manual ("Medical Record"). Medical Group Provider shall maintain accurate financial books and records, including electronic records, concerning Covered Services provided to each Member, including any charges to and payments received from the Member by Medical Group ("Financial Record"). Medical Group shall maintain the Medical Records and Financial Records for a period of at least ten (10) years after the records cease to be active records. The obligations of Medical Group to maintain and provide access to records under this **Part VI. Records**, does not cease upon termination of this Agreement without cause or for any cause.

B. **Access to Medical Records**. Subject to compliance with Applicable Laws and professional standards regarding the confidentiality of Medical Records, Medical Group and Medical Group Provider shall:

1. Provide HMO Blue, upon request and at no charge, copies of specified sections of Member Medical Records that are in the custody of Medical Group or Medical Group Provider;

2. Upon five (5) days advance notice or such shorter notice as may be reasonably required by the circumstances, allow HMO Blue authorized personnel access to inspect and copy Medical Records on Medical Group's premises during regular business hours;

3. Transmit information from Member's Medical Records by telephone to HMO Blue for purposes of Preauthorization or other UM activities or quality improvement; and

4. Provide copies of specified sections of a Member's Medical Record, upon reasonable request and at no charge, to any other Provider treating such Member.

C. **Access to Financial Records**. Upon five (5) days advance notice, or such shorter notice as may be reasonably required by the circumstances, HMO Blue shall have access to inspect, audit and copy all Financial Records during regular business hours. Medical Group shall maintain Financial Records and provide copies of such information to HMO Blue, upon HMO Blue's reasonable request, at no charge.

D. **Regulatory Compliance**. Medical Group shall maintain such records and information and provide them to the Texas Department of Insurance and other applicable regulatory agencies as may be necessary for compliance by HMO Blue with Applicable Laws. All such records shall be open to inspection during regular business hours by state and federal authorities.

PART VII. INSURANCE AND INDEMNIFICATION

A. **Medical Group Insurance**. Medical Group and each Medical Group Provider agree to maintain such policies of general and professional liability insurance as are necessary to insure Medical Group, Medical Group Providers and their employees or subcontractors against any claims for damages arising by reason of personal injuries or death occasioned directly or indirectly in connection with the performance by Medical Group, Medical Group Provider, or any Medical Group employees or subcontractors of Medical Group's obligations under this Agreement. HMO Blue determines the limits of coverage necessary.

B. **Certificates**. Certificates of insurance or other evidence indicating the term and extent of the insurance required by **Part VII, Section A, Medical Group Insurance**, shall be provided by Medical Group to HMO Blue upon HMO Blue's request.

C. **HMO Blue Insurance**. HMO Blue shall procure and maintain such policies of general and professional liability and other insurance, which may include self-insurance, as shall be necessary to insure HMO Blue and HMO Blue's employees against any claim or claims for damages arising by reason of personal injuries or death occasioned directly or indirectly in connection with the performance of any services by HMO Blue, the use of any property and facilities provided by HMO Blue, and activities performed by HMO Blue in connection with this Agreement.

D. **Indemnification.** Medical Group and HMO Blue understand that this Agreement is not one to insure and/or indemnify and shall not be so construed. Each party shall be solely responsible for its own negligence, acts or omissions.

PART VIII. TERM AND TERMINATION

A. **Term**. This Agreement shall be effective as of the Effective Date and shall continue until otherwise terminated in accordance with this Agreement.

B. **Termination Notice Period**.

1. Either party may terminate this Agreement at any time without cause or for any cause by giving the other party at least ninety (90) days advance Notice.

2. Medical Group may terminate this Agreement upon thirty (30) days advance Notice to be given within thirty (30) days following Medical Group's receipt from HMO Blue of information concerning a decrease in compensation, or the posting of such information on the Blue Cross and Blue Shield Web site, pursuant to **Part X, Section E, Compensation Information**.

C. **Immediate Termination or Suspension**. HMO Blue may, in its sole discretion, immediately suspend or terminate this Agreement, or may suspend or terminate the participation of Medical Group Provider, upon Notice by HMO Blue to Medical Group if there is a threat of imminent harm to patient health, action against Medical Group's or Medical Group Provider's license to practice, or fraud or malfeasance, including without limiting the foregoing any of the following:

1. Failure to comply with the requirements contained in **Part II, Obligations of Medical Group, Section C, Standard of Care**, including:

   a. Suspension, surrender, or revocation of Medical Group's or Medical Group Provider's narcotics number or license to practice medicine or render services in any state;

   b. Professional or other conduct by Medical Group, Medical Group Provider, or Medical Group employee or subcontractor, which is detrimental to patient welfare and care;

   c. Conviction of Medical Group, Medical Group Provider, or Medical Group employee or subcontractor, of a felony involving lying, cheating, stealing, abuse of controlled substances, or sexual misconduct.

2. Becoming subject to the grounds for termination set forth in **Part II, Obligations of Medical Group, Section M, Medical Group Status**.

D. **Review of Termination**. In the event of termination of Medical Group by HMO Blue, if Medical Group is terminated for reasons other than at Medical Group's request, HMO Blue shall provide a written explanation to Medical Group of the reason(s) for termination. Except in a case of termination under **Part VIII, Section C, Immediate Termination or Suspension**, Medical Group may, within thirty (30) days following the Notice of termination, request in writing that a review be conducted by HMO Blue's advisory review panel and HMO Blue will conduct such a review consistent with Applicable Laws. Within sixty (60) days following receipt of Medical Group's written request for review, HMO Blue will notify Medical Group of HMO Blue's review decision. At Medical Group's request, Medical Group shall be entitled to an expedited review of such termination by HMO Blue's advisory review panel. At Medical Group's request, HMO Blue will provide Medical Group with a copy of the recommendation of the advisory review panel. The decision of the advisory review panel must be considered by, but is not binding upon, HMO Blue.

E. **Effect of Termination**. As of the date of termination, this Agreement shall be considered of no further force or effect and each of the parties shall be relieved and discharged from this Agreement except that:

1. Termination shall not affect any rights or obligations hereunder which have previously accrued or shall hereafter arise with respect to any occurrence prior to termination and such rights and obligations shall continue to be governed by the terms of this Agreement.

2. Termination of this Agreement shall not release Medical Group from the obligation to continue ongoing treatment under the terms of this Agreement and in accordance with the dictates of medical prudence, of a Member of "special circumstance," as defined by Applicable Laws, including but not limited to, Members with a disability, acute condition or life-threatening illness, or Members past the 24th week of pregnancy, or HMO Blue or Payer from the obligation to reimburse Medical Group for such Covered Services at the rate set forth in this Agreement. Special circumstance shall be identified by Medical Group, who must request that the Member be permitted to continue under Medical Group's care and who must agree not to seek payment from Member for any amounts for which Member would not be responsible if the Agreement had not terminated. Disputes regarding continuity of care will be resolved according to the dispute resolution procedures set forth in the Provider Manual and this Agreement. Medical Group's and HMO Blue's obligations hereunder shall continue until the earlier of the appropriate transfer of Member's care to another Participating Provider or the expiration of ninety (90) days from the effective date of termination of the Agreement. Additionally, Medical Group's and HMO Blue's obligations hereunder shall continue up to nine (9) months in the case of a Member who at the time of the termination has been diagnosed with a terminal illness and shall extend through delivery of a child, immediate postpartum care, and the follow-up checkup within the first six (6) weeks of delivery for a Member who, at the time of the termination, is past the 24th week of pregnancy. Medical Group agrees to cooperate in the referral of Members to other Participating Providers in order to assure continuation of care. In the event that HMO Blue has not used due diligence to make alternative care arrangements available to Member within ninety (90) days after receipt by HMO Blue of Notice from Medical Group or Member, and such arrangements

are not available to Member within such ninety (90) day period, HMO Blue shall thereafter compensate Medical Group for continued care at the HMO Blue allowable amount for comparable services provided by a comparable Provider that is not a Participating Provider. Nothing herein shall be construed as requiring HMO Blue to agree to cover continued care rendered by Medical Group that HMO Blue deems unfit to care for Members by reason of incompetence or unprofessional behavior or otherwise.

3. Medical Group agrees, at HMO Blue's option, to provide Covered Services to Members assigned or referred to Medical Group during the notice period set forth in **Part VIII, Section B**, including any Members who become eligible during such period under the terms of the Member's Membership Agreement and in accordance with the terms of this Agreement. Medical Group shall be compensated for Covered Services rendered in accordance with this Section and the fees set forth in Attachment A of this Agreement, until appropriate transfer of Members is achieved or alternate compensation for Covered Services acceptable to Medical Group has been determined.

4. In the event of termination of the Agreement, HMO Blue will provide reasonable advance Notice to Members receiving care from Medical Group of the impending termination, except that if Medical Group is terminated for a reason other than at the request of Medical Group and has made a timely request for review by an advisory review panel, HMO Blue will not notify Members of Medical Group's termination prior to the time the advisory review panel makes a formal recommendation. If Medical Group is terminated or suspended immediately pursuant to **Part VIII, Section C, Immediate Termination or Suspension**, HMO Blue may notify Members immediately. Medical Group agrees to cooperate with HMO Blue and upon request to provide reasonable assistance to effect such Notice.

F. **Termination Effective Date for Primary Care Physicians**. Except for termination of this Agreement pursuant to **Part VIII, Section C, Immediate Termination or Suspension**, the termination of this Agreement if Medical Group includes Medical Group Primary Care Physicians, or the termination of the participation of a Medical Group Primary Care Physician under this Agreement, shall be effective the last day of a month.

PART IX. RELATIONSHIP OF PARTIES

A. **Independent Contractors**. None of the provisions of this Agreement are intended to create nor shall be deemed or construed to create any relationship between HMO Blue and Medical Group other than that of independent entities contracting with each other hereunder solely for the purpose of effecting the provisions of this Agreement. Neither of the parties hereto, nor any of their respective employees, shall be construed to be the agent, employer or representative of the other. None of the provisions of this Agreement shall be construed to in any way limit HMO Blue's authority or responsibility to comply with all regulatory requirements.

B. **Blue Cross and Blue Shield Association**. Medical Group hereby expressly acknowledges that this Agreement constitutes a contract solely between Medical Group and HMO Blue, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting HMO Blue to use the Blue Cross and Blue Shield Service Marks in the state of Texas, and that HMO Blue is not contracting as the agent of the Association. Medical Group further acknowledges and agrees that Medical Group has not entered into this Agreement based upon representations by any person other than HMO Blue and that no person, entity, or organization other than HMO Blue shall be held accountable or liable to Medical Group for any of HMO Blue's obligations to Medical Group created under this Agreement. This paragraph shall not create any additional obligations whatsoever on the part of HMO Blue other than those obligations created under other provisions of this Agreement.

C. **No Third Party Beneficiary**. This Agreement is entered into by and between Medical Group and HMO Blue solely for their benefit. Except for **Part IV, Compensation, Section D, Member Nonliability and Hold Harmless**, there is no intent by either party to (a) create or establish any third party beneficiary status or (b) increase the rights of any Member or any other person, firm or other entity not a party to this Agreement with respect to the duties of either party to any person or create any rights on behalf of any person with respect to either party.

PART X. GENERAL PROVISIONS

A. **Administrative Functions.** HMO Blue and Medical Group acknowledge that HMO Blue may delegate certain responsibilities or activities that are provided for in this Agreement.

B. **AFHC Program**. Medical Group acknowledges and agrees that, pursuant to the AFHC Program, Medical Group shall provide Covered Services to Members covered through the AFHC Program while such Members are in the HMO Blue Service Area set forth in this Agreement and subject to the same terms and conditions of this Agreement as are applicable to provision of Covered Services to other Members.

C. **Assignment.** No part of this Agreement, or any rights, duties or obligations described herein, shall be assigned, encumbered or delegated except as expressly provided for in this Agreement without the prior express written consent of both parties. If Medical Group is a Delegated Entity, it shall not undergo a substantial change of ownership or a merger without the prior express written consent of HMO Blue. Notwithstanding the foregoing, HMO Blue, without Medical Group's consent, may validly assign this Agreement to any affiliate of HMO Blue. HMO Blue's standing or routine contractual arrangements for the acquisition and use of facilities, services, supplies, equipment and personnel from other parties shall not constitute an assignment under this Agreement.

D. **Captions.** The captions contained herein are for reference purposes only and shall not affect the meaning of this Agreement.

E. **Compensation Information**. Medical Group is entitled, upon written request, and in accordance with Applicable Laws, to all information necessary to determine that Medical Group is being compensated in accordance with the terms of this Agreement. Medical Group may consult the Blue Cross and Blue Shield of Texas Web site for further information and instructions.

F. **Compliance**. Each party shall comply with Applicable Laws, and with applicable provisions of the Provider Manual.

G. **Confidentiality of Proprietary Information.** Each of the parties and the parties' employees shall maintain in confidence during the term of this Agreement and thereafter, except as otherwise required by Applicable Laws: (1) all Member information including medical information, learned through the operation of this Agreement, (2) all confidential Provider information, including information disclosed as part of the peer review process, (3) quality assurance and utilization review information, (4) all financial information related to this Agreement, (5) all proprietary business information that has been identified as confidential and maintained as confidential by the other party, (6) the provisions of any amendment to this Agreement that would have been protected as confidential had they originally been contained herein, and (7) any other information required to be maintained in confidence by Applicable Law (collectively "Confidential Information"), unless disclosure of a specific part of the Confidential Information is otherwise required to accomplish the purposes of this Agreement and is permitted by Applicable Laws. Each of the parties and the parties' employees shall use best efforts to safeguard and protect Confidential Information against any unauthorized disclosure by any person and shall refrain from using or allowing any other person to use Confidential Information in any way that is considered detrimental to the other party or the Member. The parties each hereby acknowledge that the remedy at law for a breach of this Confidentiality provision of this Agreement will be inadequate and the non-breaching party shall be entitled to injunctive relief to enforce these provisions of this Agreement in addition to any other remedy the non-breaching party may have.

H. **Cooperation of Parties**. Medical Group and HMO Blue agree to meet and confer in good faith on common problems including, but not limited to, problems concerning utilization of services, credentialing, Preauthorization, encounters/claims or reporting procedures and information and forms provided to Medical Group for use in conjunction with Members.

I. **Dispute Resolution.** HMO Blue or Medical Group, as the case may be, shall give Notice to the other of the existence of a dispute. In order to avoid the cost and time consuming nature of litigation, any dispute between HMO Blue and Medical Group arising out of, relating to, involving the interpretation of, or in any other way pertaining to this Agreement or any prior Agreement between HMO Blue and Medical Group shall be resolved using alternative dispute resolution mechanisms instead of litigation. HMO Blue and Medical Group agree and acknowledge that it is their mutual intention that this provision be construed broadly so as to provide for mediation and/or arbitration of all disputes arising out of their relationship as third-party Payer and Medical Group. The parties further agree that resolution of any dispute pursuant to this Agreement shall be in accordance with

the procedures detailed below.

1. **External Review Process**.

   Medical Group may elect to subject certain disputes to an external review process ("External Review Election") as follows:

   a. Subject to the provisions of the Provider Manual, Medical Group may elect to subject certain disputes regarding claim payment to the Billing Dispute External Review Process as described therein. The resulting determination with respect to payment of any claims that are the subject of disputes so submitted shall be binding on the parties and not be subject to the other provisions contained herein for dispute resolution.

   b. Subject to the provisions of the Provider Manual, Medical Group may, if Medical Group is acting on behalf of a Member, elect to subject certain disputes concerning a determination by HMO Blue that a service is not or will not be a Covered Service because it is not Medically Necessary or is experimental or investigational in nature ("Adverse Determination") to the External Review process described in the Provider Manual. The resulting determination with respect to the appropriateness of such Adverse Determination shall be binding on the parties and not be subject to the other provisions contained herein for dispute resolution.

2. **Initial Resolution by Meeting or Mediation of Dispute**. If Medical Group has not made an External Review Election, and HMO Blue and Medical Group mutually agree that a meeting to attempt to resolve the dispute would be advantageous, representatives of HMO Blue and Medical Group shall meet not later than thirty (30) calendar days after delivery of the Initial Notice in order to attempt to resolve the dispute. Subsequent meetings may be held, if mutually agreed. If no meeting is mutually agreed, or if the dispute is not resolved at any meetings held, the party giving the Initial Notice shall submit the dispute to mediation by an organization or company specializing in providing neutral, third-party mediators. The mediation process shall be coordinated by the submitting party with the mediator and shall be subject to the following agreed-upon conditions:

   a. The parties agree to participate in the mediation in good faith;

   b. The parties agree to have present at the mediation one or more individuals with decision-making authority regarding the matters in dispute. Either party may, at that party's option, be represented by counsel. Medical Group may, at Medical Group's option, also have present at the mediation a representative of any professional society in which Medical Group is a member;

   c. The mediation will be held within sixty (60) days of the submission to mediation unless the parties mutually agree on a later date. The mediation will be held in one of the following cities, which is closest to the principal office of Medical Group, to be designated in writing by Medical Group, unless HMO Blue and Medical Group mutually agree to an alternative location: Abilene, Amarillo, Austin, Corpus Christi, Dallas, El Paso, Houston, Lubbock, Lufkin, Midland, Odessa, San Angelo, San Antonio, Texarkana, Waco, Wichita Falls, and Brownsville;

   d. The parties shall each bear their own costs and shall each pay one-half of the mediator's fees and costs, unless the mediator determines that one party did not participate in the mediation in good faith, in which case that party shall pay all of the mediator's fees and costs;

   e. The parties agree that the obligation to mediate (but not the obligation to arbitrate) is not applicable to any dispute that was pending in any court on the Effective Date of this Agreement, or that had been submitted to binding arbitration on or before the Effective Date of this Agreement.

3. **Binding Arbitration.** In the event Medical Group has not made an External Review Election and mediation is not successful in resolving the dispute, either HMO Blue or Medical Group may submit the dispute to final and binding arbitration under the commercial rules and regulations of the American Health Lawyers Association, subject to the following:

   a. The arbitration shall be conducted by a single arbitrator selected by the parties from a list furnished by the American Health Lawyers Association. If the parties are unable to agree on an arbitrator from the list, the arbitrator shall be appointed by the American Health Lawyers Association;

b. The arbitrator shall be required to render a written decision resolving all disputes, and designating one party as the "prevailing party";

c. Except in the case of fraud, no arbitration decision may require any adjustment in compensation or payments respecting any dispute involving services rendered more than eighteen (18) months prior to receipt of the Initial Notice;

d. The costs of arbitration, including the arbitrator's fee and any reporting or other costs, but excluding lawyers', consultants' and witness fees, shall be borne by the non-prevailing party unless the arbitrator determines as part of the award that such allocation is inequitable under the totality of the circumstances. In the event that the dispute in arbitration concerns the appropriateness of HMO Blue's adjudications of claims, the party challenging the adjudications shall have the initial burden of proving that there is a reasonable probability that the disputed claims adjudications were incorrect adversely to that party. When the other party reasonably determines that it is required in its defense, or is required by the discovery process or otherwise by law, to research the basis for the adjudications of challenged claims for which such reasonable probability has not been proven, the other party shall be awarded the administrative cost for such research for each such claim that is found in the arbitration proceeding, after such research, not to have been adjudicated incorrectly adversely to the challenging party;

e. The arbitration hearing will be held in one of the following cities, to be designated in writing by Medical Group, which is closest to the principal office of Medical Group, to be designated in writing by Medical Group unless HMO Blue and Medical Group mutually agree to an alternate location; Abilene, Amarillo, Austin, Corpus Christi, Dallas, El Paso, Houston, Lubbock, Lufkin, Midland, Odessa, San Angelo, San Antonio, Texarkana, Waco, Wichita Falls, and Brownsville;

f. Medical Group acknowledges that this arbitration provision precludes Medical Group from filing an action at law or in equity and from having any dispute covered by this Agreement resolved by a judge or a jury. Medical Group further acknowledges that this arbitration provision precludes Medical Group from participating in a class action filed by any other Medical Group or any other plaintiff claiming to represent Medical Group or Medical Group's interest. Medical Group agrees to opt-out of any class action filed against HMO Blue that raises claims covered by this Agreement to arbitrate, including, but not limited to, class actions that are currently pending.

4. **Exceptions.** The foregoing in this **Part X, Section I, Dispute Resolution**, to the contrary notwithstanding, the provisions thereof shall not be applicable to the following:

a. Any legal proceeding brought by a third party against HMO Blue, Medical Group or any Medical Group Provider (a "Defendant"), as well as any cross claim or third-party claim by such Defendant against HMO Blue, Medical Group or Medical Group Provider.

b. The rate of compensation payable to Medical Group for Covered Services pursuant to **Part IV, Compensation**.

c. Termination of this Agreement pursuant to **Part VIII, Section B, Termination Notice Period**.

J. **Entire Agreement**. This Agreement, together with any attachments hereto contains the entire understanding between the parties and supersedes all prior agreements, either oral or in writing, with respect to the subject matter hereof. In the event of any conflict between the provisions of the attachments to this Agreement and the provisions of this Agreement other than the attachments and addenda, the provisions of the attachments and addenda shall prevail.

K. **Force Majeure**. No party will be liable for any failure to timely perform obligations under this Agreement if prevented from doing so by a cause or causes beyond commercially reasonable control including, but not limited to, acts of God or nature, fires, floods, storms, earthquakes, riots, strikes, wars or restraints of government.

L. **Genders and Numbers**. Use of the masculine, feminine or neuter gender and the singular or plural numbers shall be deemed to include the others whenever the context so indicates or requires.

M. **Governing Law**. This Agreement shall be governed in all respects by the laws of the state of Texas as well as any regulations promulgated thereunder except as otherwise required by Applicable Laws.

N. **Modifications**. This Agreement may be amended and the Provider Manual may be revised as follows:

1. This Agreement may be amended by mutual written agreement of the parties. Notwithstanding the foregoing, however, HMO Blue may amend this Agreement and/or any attachment to the Agreement as follows:

   a. upon thirty (30) days prior Notice to Medical Group or such longer time period as may be required by Applicable Laws when the amendment is not materially adverse to Medical Group. In such event Medical Group may terminate this Agreement by giving Notice of such termination to HMO Blue within thirty (30) days of Medical Group's receipt of such Notice of amendment, to be effective no earlier than thirty (30) days after such termination Notice is given; or

   b. upon ninety (90) days prior Notice when the amendment is materially adverse to Medical Group. In such event, Medical Group may terminate this Agreement by giving Notice of such termination to HMO Blue within thirty (30) days of Medical Group's receipt of such Notice of amendment, to be effective no earlier than the end of such amendment Notice period, unless within sixty-five (65) days following the date of such amendment Notice HMO Blue gives Notice to Medical Group that HMO Blue will not carry into effect such amendment.

   Medical Group's failure to give Notice of termination to HMO Blue within thirty (30) days of Medical Group's receipt of a Notice of amendment shall constitute agreement to and acceptance of such amendment by Medical Group. The amendment shall be effective on the effective date provided in HMO Blue's Notice of amendment, provided that the amendment required by Applicable Laws shall be effective no later than the date required by such law or regulation and may be implemented beginning on that date by HMO Blue.

2. The Provider Manual may be revised by HMO Blue from time to time, or upon ninety (90) days prior Notice when the revision is materially adverse to Medical Group. In such event, Medical Group may terminate this Agreement by giving Notice of such termination to HMO Blue within thirty (30) days of Medical Group's receipt of such Notice of revision, to be effective no earlier than the end of such revision Notice period, unless within sixty-five (65) days following the date of such revision Notice HMO Blue gives Notice to Medical Group that HMO Blue will not apply such revision to Medical Group.

   Medical Group's failure to give Notice of termination to HMO Blue within thirty (30) days of Medical Group's receipt of a Notice of Provider Manual revision shall constitute agreement to and acceptance of such revision by Medical Group. The revision shall be effective on the effective date provided in HMO Blue's Notice of Provider Manual revision, provided the revision required by Applicable Laws shall be effective no later than the date required by such law or regulation and may be implemented beginning on that date by HMO Blue.

O. **No Solicitation.** Medical Group shall not, and Medical Group shall use best efforts to assure that Medical Group Providers shall not solicit, influence or induce or attempt to solicit, influence or induce any Member to disenroll from any Health Plan or enroll in any other health care plan that would require such Member to disenroll from a Health Plan. Furthermore, Medical Group and Medical Group Providers shall not solicit, influence or induce employers or other entities with which HMO Blue has entered into agreements to provide health care benefits to cease doing business with HMO Blue or diminish or otherwise affect their business relationship with HMO Blue. HMO Blue shall not solicit, influence or induce or attempt to solicit, influence or induce any Member not to select Medical Group as Member's Primary Care Physician. The assignment by HMO Blue of new Members to Primary Care Physicians other than Medical Group shall not be deemed to be a breach of the foregoing.

P. **Partial Invalidity**. If for any reason any provision of this Agreement is held invalid, the remaining provisions shall remain in full force and effect.

Q. **Patient Communications**. Nothing contained in this Agreement is intended to prohibit or discourage Medical Group from discussing with or communicating in good faith to a current, prospective or former patient, or patient's designee, information or opinions regarding: (1) the

patient's health care, including, but not limited to, the patient's medical condition or treatment options, including alternative medications, regardless of HMO Blue coverage limitations; or (2) the provisions, terms, requirements or services of HMO Blue as they relate to the medical needs of the patient.

R. **Retaliation.** HMO Blue acknowledges and agrees not to engage in any retaliatory action against Medical Group, including termination of this Agreement, because Medical Group has, on behalf of a Member, reasonably filed a complaint against HMO Blue or has appealed a decision of HMO Blue.

S. **Self-Funded Plans.** Medical Group will provide services to persons ("Enrollees") enrolled in those employer-funded health benefit plans ("Self-Funded Plans"), for which HMO Blue provides administrative services and network access and management, on the same terms and conditions as Medical Group provides such services to Members. Medical Group will be compensated for providing services to Enrollees using the same methodology and on the same terms and conditions as are applicable for services provided to Members. Medical Group acknowledges and agrees that HMO Blue provides administrative and network management services but does not underwrite the Self-Funded Plans' benefits. The Self-Funded Plans, and not HMO Blue, have sole financial responsibility for all benefits for Self-Funded Plan Enrollees.

T. **Use of HMO Blue Name**. Medical Group agrees not to use the names, symbols, marketing names, trademarks or service marks of HMO Blue in any advertising or promotional material or literature without the express, prior, written consent of HMO Blue and will cease any and all usage previously consented to upon withdrawal by HMO Blue of such consent or termination of the Agreement.

U. **Waiver of Breach**. The waiver of any breach of this Agreement by either party shall not constitute a continuing waiver of any subsequent breach of either the same or any other provision of this Agreement.

MEDICAL GROUP AGREEMENT -- ATTACHMENT A

COMPENSATION / CLAIMS SUBMISSION

A. **Compensation.** Medical Group agrees to accept as compensation for Covered Services the lesser of (1) billed charges or (2) the fee for such service per the then current HMO Blue fee schedule, less any applicable Copayments, Coinsurance or Deductible amounts.

B. **Claims Submission.** Medical Group must submit a claim for Covered Services to HMO Blue or Payer not later than the 180th day after the date Medical Group provides the medical care or the health care services for which the claim is made. For a claim for which coordination of payments applies, the 180-day period does not begin for submission of the claim to the secondary Payer until Medical Group receives notice of the payment or denial from the primary Payer. If Medical Group fails to submit a claim in compliance with this paragraph, Medical Group forfeits the right to payment unless Medical Group has certified that the failure to timely submit the claim is a result of a catastrophic event.

Claims may be submitted (1) electronically in the CMS National Standard Format (NSF) or the current version of the ANSI 837 format or (2) on a completed current version of the applicable CMS claim form.

Medical Group may not submit a duplicate claim prior to the 46th day (for non-electronically filed claims) or the 31st day (for claims filed electronically) after the date the original claim is presumed to be received by HMO Blue. As used herein, "duplicate claim" means any claim submitted by a physician or provider for the same health care service provided to a particular individual on a particular date of service that was included in a previously submitted claim. The term does not include corrected claims.

HMO Blue and HMO Blue's clearinghouse may not refuse to process or pay an electronically submitted Clean Claim because the claim is submitted together with or in a Batch Submission with a claim that is deficient. As used herein, the term "Batch Submission" means a group of electronic claims submitted for processing at the same time within a HIPAA standard ASC X12N837 Transaction Set and identified by a batch control number.

AMENDMENT TO
BLUE CROSS AND BLUE SHIELD OF TEXAS,
A DIVISION OF HEALTH CARE SERVICE CORPORATION

MEDICAL GROUP AGREEMENT
FOR HMO NETWORK PARTICIPATION

This Amendment ("Amendment") is entered into by and between Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company ("HMO Blue") and Hidalgo County Health Department (" Medical Group ").

WHEREAS, HMO Blue and Medical Group have entered into that certain HMO Blue Medical Group Agreement ("Agreement"); and

WHEREAS, HMO Blue and Medical Group mutually desire to amend the Agreement as set forth herein.

NOW, THEREFORE, the parties hereto agree as follows:

1. The Agreement is amended as set forth in Attachment I hereto.

2. The provisions of this Amendment shall be treated as strictly confidential under the confidentiality provisions of the Agreement.

3. Except as modified by this Amendment, the Agreement remains unchanged and in full force and effect.

Multiple Counterparts. This Amendment may be executed in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

IN WITNESS WHEREOF, the undersigned have executed this Amendment to be effective as of the Effective Date set forth below.

HMO BLUE	**MEDICAL GROUP**
A scanned, imaged, electronic, photocopy or stamp of the signatures hereunder shall have the same force and effect as an originally executed signature	
Authorized Signature:	Authorized Signature:
_____	_____
Name: M. Shannon Stansbury	Name: _____
Title: Vice President, Health Care Delivery	Title: _____
Date: _____	Date: _____
Effective Date: _____	NPI: _____

AMENDMENT TO MEDICAL GROUP AGREEMENT

ATTACHMENT I

The Agreement is amended as follows:

1. The following definitions are added to the Agreement:

   Hospital Acquired Conditions (HAC) – means serious preventable medical events which have been identified by the Centers for Medicare Services (CMS) that should never occur in a hospital and as may be more fully described in the Provider Manual.

   Never Events – means, as defined by the National Quality Forum (NQF), adverse events that are serious, but largely preventable, and of concern to both the public and health care providers and as may be more fully described in the Provider Manual.

2. The Subscriber Nonliability and Hold Harmless provision of the Compensation section is amended to add a new paragraph as follows:

   In addition, Medical Group who is responsible in whole or in part for the Never Event or HAC agrees that in no event shall Medical Group bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Member for identified Never Event or HAC.

3. The Compensation section is amended to include the following new provisions:

   HAC and Never Events. Medical Group shall comply with the standards adopted by HMO Blue for HACs and Never Events as set forth in this Agreement and as may be more fully described in the Provider Manual.

   Disallowance of Services. Any disallowance of Inpatient services as a result of any utilization review, quality assurance, identified Never Event, or peer review activity shall be deducted from HMO Blue's payment obligations to Medical Group who is responsible in whole or in part for the Never Event or HAC. Medical Group has the right to appeal any such decision. All appeals must be in writing and submitted to HMO Blue.

AMENDMENT NUMBER 2 TO
BLUE CROSS AND BLUE SHIELD OF TEXAS,
A DIVISION OF HEALTH CARE SERVICE CORPORATION

MEDICAL GROUP AGREEMENT
FOR HMO NETWORK PARTICIPATION

This Amendment ("Amendment") is entered into by and between Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation ("HMO Blue") and Hidalgo County Health Department (" Medical Group ").

WHEREAS, HMO Blue and Medical Group have entered into that certain HMO Blue Medical Group Agreement effective 8/27/12 ("Agreement"); and

WHEREAS, HMO Blue and Medical Group mutually desire to amend the Agreement as set forth herein.

NOW, THEREFORE, the parties hereto agree as follows:

1. The Agreement is amended as set forth in Exhibit I hereto.

2. The provisions of this Amendment shall be treated as strictly confidential under the confidentiality provisions of the Agreement.

3. Except as modified by this Amendment, the Agreement remains unchanged and in full force and effect.

Multiple Counterparts. This Agreement may be executed in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

IN WITNESS WHEREOF, the undersigned have executed this Amendment to be effective as of the Effective Date set forth below.

BLUE CROSS AND BLUE SHIELD OF TEXAS, A DIVISION OF HEALTH CARE SERVICE CORPORATION

MEDICAL GROUP

A scanned, imaged, electronic, photocopy or stamp of the signatures hereunder shall have the same force and effect as an originally executed signature.

Authorized Signature: _____

Name: M. Shannon Stansbury

Title: Vice President, Health Care Delivery

Date: _____

Effective Date: _____

Authorized Signature: _____

Name: _____

Title: _____

Date: _____

NPI: _____

AMENDMENT TO MEDICAL GROUP AGREEMENT

EXHIBIT I

The Agreement is amended as follows:

1. **Page 1, Paragraph 1.** is amended to read as follows:

This Agreement is entered into by and between Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association, (" HMO Blue"), and Hidalgo County Health Department a government entity organized in the state of Texas (" Medical Group").