FILED
AT 4:00 O'CLOCK P M
JUL 11 2017
ARTURO GUAJARDO, JR. COUNTY CLERK
HIDALGO COUNTY, TEXAS
BY NGC DEPUTY

PROVIDER AGREEMENT

PRODUCT PARTICIPATION AND SIGNATURE SHEET

The Provider Agreement consists of the following parts:

i) This **Product Participation and Signature Sheet** (the "**Signature Sheet**") which lists the types of Products that Provider will participate in as of the Effective Date;
ii) **General Terms and Conditions** applicable to Provider's network participation;
iii) One or more **State Compliance Addenda** that contain state-specific requirements applicable to certain types of Products and/or health care provider-types; and
iv) One or more **Product Addenda** that set forth additional terms of Provider's participation in specific Products;
v) One or more service and rate, reimbursement or compensation schedules (the "**Service and Rate Schedules**") that contain the rates and related provisions for specific Products.

The **Signature Sheet, General Terms and Conditions, State Compliance Addenda, Product Addenda** and **Service and Rate Schedules**, together with any related exhibits, addenda and appendices, are collectively referred to throughout the documents as the "**Agreement**." In the event of a conflict in language between the **General Terms and Conditions** and a **Product Addendum** or **Service and Rate Schedule**, the terms of the applicable **Product Addendum** and corresponding **Service and Rate Schedule** will prevail. In the event of a conflict between an applicable **State Compliance Addendum** and any other part of the Agreement, the terms of the **State Compliance Addendum** will prevail, but only with respect to the particular line of business (e.g., fully insured HMO) or Product. Various Products may be offered by separate Company Affiliates and each such Affiliate is deemed to be a Party to the Agreement.

By executing this **Signature Sheet**, Provider agrees to participate in the Product categories identified below with a check mark. Each Product category is described more fully in the applicable **Product Addendum**. New types and categories of Products may be added and participation in specific Products may be added or terminated in accordance with the terms of the Agreement:

✓	Commercial Health
✓	Medicare
	Institutes of Excellence® (IOE) Transplant Network (subject to separate approval by Company)
	Medical Rental Network
	Workers' Compensation Network
	Auto Network
	Other

As required by Texas Insurance Code § 1458.101 and with respect to fully-insured Plans, Provider accepts participation in the following lines of business, as defined under such section, and compensated in accordance with the Product references as described below.

[Texas Dept. of Insurance lines of business	**Products**	**Product Compensation References** – Products are referenced in the Service and Rate Schedule as outlined below	**Product Compensation References** – Products *may* be referenced in the Services and Rate Schedule as outlined below	**Provider Acceptance Signature**
HMO	Commercial Health Benefit Product or Commercial Gated Health Benefit Product	Rate in the Service and Rate Schedule	Gatekeeper products	Ramon Garcia Ramon Garcia (May 17, 2017)
EPO	Commercial Health Benefit Product or Commercial Gated Health Benefit Product	Rate in the Service and Rate Schedule	Gatekeeper products	Ramon Garcia Ramon Garcia (May 17, 2017)
PPO	Commercial Health Benefit Product or Commercial Non-Gated Health Benefit Product	Rate in the Service and Rate Schedule	Non Gatekeeper products	Ramon Garcia Ramon Garcia (May 17, 2017)
Medicare	Government Programs	Rate in the Service and Rate Schedule	Government Programs	Ramon Garcia Ramon Garcia (May 17, 2017)

In consideration of the mutual covenants and promises stated herein and for other good and valuable consideration, **Hidalgo County Health and Human Services Department**, on behalf of itself and any and all Group Providers, and all persons and entities that provide Covered Services billed under the Agreement (collectively referred to in the Agreement as **"Provider")**, and Aetna Health Inc., a Texas corporation on behalf of itself and its Affiliates (collectively referred to in the Agreement as "**Company**"), agree to be bound by the Agreement. The **Effective Date** of the Agreement is June 15, 2017.

Provider

By: Ramon Garcia
Ramon Garcia (May 17, 2017)

Printed Name: Ramon Garcia

Title: Hidalgo County Judge

Date: May 17, 2017

FEDERAL TAX I.D. NUMBER: 7460007017

Provider contract notice address:

1304 S. 25th Ave.
Edinburg, Texas 78542

Provider contract notice email address:

ramon.garcia@co.hidalgo.tx.us

COMPANY

By: Karen Chotiner

Printed Name: Karen Chotiner

Title: Network Market Head

Date: May 22, 2017

Company:

Aetna
Provider Contract Management
2777 N. Stemmons Freeway, Suite 1450
Dallas, TX 75207

For Behavioral Health Providers:

Aetna Behavioral Health
1425 Union Meeting Road
PO Box 5
Blue Bell PA 19422

AETNA PROVIDER AGREEMENT

Hidalgo County for Health and Human Services Department

Approved in Commissioner's Court on May/16/2017 – AI 59774

Attest:

Hidalgo County Clerk
100 North Closner
Edinburg, Texas 78539

Arturo Guajardo Jr., County Clerk

COMMISSIONERS COURT
HIDALGO COUNTY, TEXAS

TABLE OF CONTENTS FOR GENERAL TERMS AND CONDITIONS

GENERAL TERMS AND CONDITIONS

1.0 DEFINITIONS

When used in this Agreement, all capitalized terms shall have the following meanings:

1.1 Affiliate. Any corporation, partnership or other legal entity, except for MHNet Inc., directly or indirectly owned or controlled by, or which owns or controls, or which is under common ownership or control with Company.

1.2 Clean Claim. Unless otherwise required by law or regulation, a claim which: (a) is submitted within the proper timeframe as set forth in this Agreement; (b) has: (i) detailed and descriptive medical and patient data; (ii) a corresponding referral (whether in paper or electronic format), if required for the applicable claim; and (iii) whether submitted via an electronic transaction using permitted standard code sets (e.g., CPT-4, ICD-10 or its successor standard, HCPCS) as required by the applicable Federal or state regulatory authority (e.g., U.S. Dept. of Health & Human Services, U.S. Dept. of Labor, state law or regulation) or otherwise, all the data elements of the UB-04 or CMS-1500 (or successor standard) forms (including but not limited to Member identification number, national provider identifier ("NPI"), date(s) of service, and complete and accurate breakdown of services); (c) does not involve coordination of benefits; and (d) has no defect or error (including any new procedures with no CPT code, experimental procedures or other circumstances not contemplated at the time of execution of this Agreement) that prevents timely adjudication.

1.3 Confidential Information. Any information that identifies a Member and is related to the Member's participation in a Plan, the Member's physical or mental health or condition, the provision of health care to the Member or payment for the provision of health care to the Member. Confidential Information includes, without limitation, "individually identifiable health information," as defined in 45 C.F.R. § 160.103 and "non-public personal information" as defined in laws or regulations promulgated under the Gramm-Leach-Bliley Act of 1999, as amended from time to time.

1.4 Covered Services. Those health care services for which a Member is entitled to receive coverage or program benefits under the terms and conditions of a Plan.

1.5 Emergency Services. Except as otherwise required by law or otherwise defined in the applicable Plan, those services necessary to treat a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (a) placing the health of the individual (or, with respect to a pregnant woman, her pregnancy or health or the health of her fetus) in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part.

1.6 Group. A Provider that consists of more than one licensed health care provider whose services are provided and billed under the terms of this Agreement.

1.7 Group Provider. A duly licensed, certified and qualified health care/ancillary services provider (e.g., nurse practitioner, chiropractor, mental health/substance abuse professional, optometrist, podiatrist, primary care physician, specialist physician, etc...) rendering Provider Services to Members who, when Provider is a Group, is: (a) employed by Provider; (b) a partner or shareholder of Provider; (c) contracted with Provider to provide services under this Agreement.

1.8 Material Change. Any change in Policies that could reasonably be expected, in Company's determination, to have a material adverse impact on: (i) Provider's rate for Provider Services; or (ii) Provider administration.

1.9 Medically Necessary. Health care services that a physician exercising prudent clinical judgment, would provide to a patient 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 patient's illness, injury or disease; and (c) not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than 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 patient'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 or otherwise consistent with the standards set forth in (b) above.

1.10 Member. An individual covered by or enrolled in a Plan. Member includes the subscriber and any of the subscriber's eligible dependents.

1.11 Participating Provider. Any duly licensed and certified health care provider involved in the delivery of health care or ancillary services who or which has entered into or is bound by a current valid contract with Company to provide Covered Services to Members, and, where applicable, has been credentialed according to Company's Participation Criteria and policies, by Company or its designee.

1.12 Participation Criteria. Participation criteria of Company, as updated from time to time, that apply to various types of Participating Providers and which must be satisfied and maintained in order for Provider to serve and continue to serve as a Participating Provider.

1.13 Party. Company or Provider, as applicable.

1.14 Payer. A plan sponsor and/or other person or entity that is authorized by Company to access one or more networks of Participating Providers and which: (a) is liable for funding or underwriting payments for benefits provided under a Plan, and/or has financial responsibility to pay for Covered Services rendered to Members; or (b) which is not financially responsible to pay for Covered Services but which contracts with persons or entities that are financially responsible to pay for Covered Services rendered to Members. Payers include, but are not limited to, Company, insurers, employers, third party administrators, labor unions, trusts, and associations.

1.15 Plan. A Member's health care benefits or program as set forth in the Member's summary plan description, certificate of coverage, evidence of coverage, Medicare Plan or other applicable coverage or program document.

1.16 Policies. The policies and procedures of Company which relate to this Agreement and applicable Products. Policies include, but are not limited to, Participation Criteria, Plan appeals policies and those policies and procedures set forth in Company's manuals, health care professional toolkits, clinical policy bulletins and other policies and procedures (as modified from time to time), and made available via Company's internet website, letter, newsletter, electronic mail or other media. Policies may vary by Affiliate and/or Plan.

1.17 Primary Care Provider. A Participating Provider whose area of practice and training is family practice, general medicine, internal medicine or pediatrics, or who is otherwise designated as a Primary Care Provider by Company, and who has agreed to provide primary care services and to coordinate and manage all Covered Services for Members who have selected or been assigned to such Participating Provider, if the applicable Plan provides for a Primary Care Provider. This term may also include a nurse practitioner and/or physician assistant practicing within the applicable scope of practice, provided such provider meets Company standards and Policies.

1.18 Product. A health care product, plan, or program, in which Provider participates under this Agreement, as set forth in the applicable **Product Addendum(a)**.

1.19 Proprietary Information. Any and all proprietary, non-public information of a Party, whether prepared by a Party, its advisors or otherwise, relating to such Party, whether furnished prior to or after the Effective Date.

1.20 Provider Services. Those health care services which are within the scope of the respective Provider's license and certification to practice.

1.21 Specialty Program. A Company established program for a targeted group of Members with certain types of illnesses, conditions or cost or risk factors (e.g., organ transplants, women's health, other disease management programs, etc.).

2.0 PROVIDER SERVICES AND OBLIGATIONS

2.1 Provision of Services.

2.1.1 Availability of Services and Rates. Provider will provide Covered Services to Members in accordance with this Agreement including, but not limited to, the terms and rates set forth in the applicable **Product Addenda** and **Service and Rate Schedules**. Except as stated otherwise in the applicable Participation Criteria, Provider will make Provider Services available to Members on a twenty-four (24) hour per day, seven (7) day per week basis, according to generally accepted standards of medical practice. Provider understands and agrees that no health care provider shall render Covered Services to Members under this Agreement or otherwise serve as a Participating Provider unless and until such Provider: (a) has fully and satisfactorily completed Company's credentialing process and is approved by the applicable peer review committee; and (b) continues to comply with Company's Participation Criteria.

2.1.2 Services by Providers who are Groups. Except as specifically stated otherwise in the Agreement or specifically inapplicable to the provider type, all provisions of and obligations under the Agreement applicable to Provider shall also apply to all Group Providers and other persons and entities that provide Covered Services to Members, whether on a regular or on-call coverage basis.

2.2 Non-Discrimination.

2.2.1 Equitable Treatment of Members. Provider shall render Provider Services to Members with the same degree of care and skill as customarily provided to Provider's patients who are not Members, according to generally accepted standards of medical practice. Provider and Company agree that Members and non-Members should be treated equitably. Provider agrees not to discriminate against Members on the basis of race, ethnicity, gender, creed, ancestry, lawful occupation, age, religion, marital status, sexual orientation, mental or physical disability, medical history, color, national origin, place of residence, health status, claims experience, evidence of insurability (including conditions arising out of acts of domestic violence), genetic information, source of payment for services whether as a private purchasers of the plan or as participants in publicly financed programs of health care services, cost or extent of Provider Services required, Medicare or Medicaid beneficiary status, or on any additional grounds prohibited by law or this Agreement.

2.2.2 Affirmative Action. Company is a Federal contractor and an Equal Opportunity Employer which maintains an Affirmative Action Program. Provider is an Equal Opportunity Employer which maintains an Affirmative Action Program. Whether or not providing services to Members of government programs, Provider, on behalf of itself and any subcontractors, agrees to comply with the following, as amended from time to time: Executive Order 11246, the Vietnam Era Veterans' Readjustment Assistance Act, the Drug Free Workplace Act of 1988, Section 503 of the Rehabilitation Act of 1973, Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") Administrative Simplification Regulations at 45 CFR parts 160, 162, and 164, the Americans with Disabilities Act, Federal laws, rules and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of Federal criminal law, the False Claims Act (31 U.S.C. 3729 et. seq.), and the anti-kickback statute (Section 1128B(b)) of the Social Security Act), and any similar

laws, regulations or other legal mandates applicable to recipients of Federal funds and/or transactions under or otherwise subject to any government contract of Company.

2.3 Provider Representations.

2.3.1 Contracting Authority. Provider acknowledges, represents and warrants that: (a) it has the legal authority to negotiate and enter into this Agreement on behalf of itself, all Group Providers and any and all other persons and entities that provide Covered Services subject to this Agreement and that it is authorized to bind all such persons and entities to the terms hereof; (b) except as specifically stated otherwise in this Agreement, all provisions of the Agreement, including, but not limited to, all applicable **Product Addenda** and **Services and Rate Schedules**, shall apply to all Group Providers and other persons and entities that provide Covered Services under this Agreement; (c) it shall take all steps necessary to cause all Group Providers and all other persons and entities that provide Covered Services under this Agreement to comply with the Agreement and all applicable Federal and state laws, rules and regulations and, if applicable, to perform all requirements applicable to government programs (including, but not limited to Medicare, if applicable); (d) it shall require all Group Providers and all other persons and entities that provide Covered Services under this Agreement to accept the rates set forth in the Agreement and to look solely to Provider for payment; and (e) this Agreement has been signed by its duly authorized representative.

2.3.2 General Representations. Provider represents and warrants that, as applicable, it and all Group Providers: (a) have and shall maintain, throughout the term of this Agreement, all license(s), certification(s) and accreditation(s) required by Federal and/or state law, as well as by Company's applicable Participation Criteria; (b) with respect to each Group Provider that is a physician or who is serving as a Primary Care Provider or who is otherwise prescribing medication, as well as any other provider type so required by Company's Participation Criteria, shall: (i) maintain an unrestricted DEA certification and license to practice medicine in all state(s) in which Provider maintains offices and provides Covered Services to Members; (ii) be board certified in the applicable specialty (or board eligible if approved by Company's exception process); and (iii) have and maintain throughout the term of this Agreement unrestricted hospital privileges at a Participating Provider hospital; (c) have not been excluded: (i) from participation in any Federal or state-funded health program; or (ii) the National Practitioner Data Bank ("NPDB"); (d) will remain throughout the term of this Agreement, in compliance with all applicable Federal and state laws and regulations related to this Agreement and the services to be provided under this Agreement; and (e) are certified for participation under Medicare and Medicaid (Titles XVIII & XIX) of the Social Security Act for all Provider Services.

2.3.3 Qualified Personnel. Provider represents that it has established an ongoing quality assurance/assessment program which includes, but is not limited to, credentialing of employees and subcontractors. Upon request, Provider shall supply to Company the relevant documentation, including, but not limited to, internal quality assurance/assessment protocols, state licenses and certifications and Federal agency certifications and registrations. Provider further represents that all personnel employed by, associated or contracted with Provider who treat Members: (a) are and shall remain throughout the term of this Agreement appropriately licensed and/or certified and supervised (when and as required by state law), and qualified by education, training and experience to perform their professional duties; and (b) shall act within the scope of their licensure or certification, as the case may be. Company may audit compliance with this Section 2.3.3 upon prior written notice.

2.3.4 Financial Interest. Unless disclosed in advance and in writing to Company and the affected Member, Provider shall not provide or accept kickbacks or payments, or refer or accept referrals from, any hospitals, physician practices or other persons or entities in which it has a financial interest. Provider represents and warrants that any such payments and/or referrals shall be in full compliance with applicable Federal and state laws and regulations. Provider shall not impose financial penalties or other additional costs on Members who elect not to receive services from health care providers in whom Provider has a financial interest.

2.3.5 Offshoring. Provider represents and warrants that it does not use any individual or entity (including, but not limited to, any employee, contractor, subcontractor, agent, representative or other individual or entity) to perform any services for Plans if the individual or entity is physically located outside of one of the fifty United States or one of the United States Territories ("Offshore Entity"), unless Company, in its sole discretion, agrees in advance, in writing, to the use of such Offshore Entity and Provider and such Offshore Entity consent to Company's right to audit prior to and during the provision of Provider Services for Plans. Provider understands and agrees that certain Payers may not allow Provider to serve as a participating provider for their Plans if Provider utilizes Offshore Entities.

2.3.6 Notice of Breach/Additions or Deletions of Group Providers. Provider shall notify Company in writing, within five (5) business days, of its becoming aware of a breach of or failure to maintain compliance with any of the requirements of Section 2.3.

2.4 Group Provider Participation/New Group Providers.
Except as specifically directed otherwise by Company, or agreed otherwise in advance, in writing, by Company, all Group Providers must serve as Participating Providers, subject to the requirements of this Agreement. Provider agrees, and shall require Group Providers to agree, that in the event of any inconsistency between this Agreement and any other contracts into which Group Provider may have entered with Provider or another Group Provider, the terms of this Agreement shall control. Upon request by Company, Provider shall provide or cause to be provided copies of its contracts with Group Providers, if any, to Company. Notwithstanding the foregoing, if, after the Effective Date, a new provider becomes a Group Provider, including, but not limited to, as the result of an acquisition or otherwise, and such provider is already participating with Company via an existing participation agreement, Company reserves the right to continue to pay such new Group Provider according to the terms of its existing agreement(s) with Company. Provider shall, at Company's request, require any such new Group Providers to accept their already existing contract rates with Company as payment in full, until such time as Company and Provider negotiate and implement new rates acceptable to both parties or the new Group Provider's existing agreement is terminated in accordance with its terms.

2.5 Provider Capacity.
Provider shall provide, at the earliest possible time, notice to Company of any significant changes in the capacity of Group or Group Providers to provide or arrange for the provision of Covered Services to Members as contemplated by this Agreement, including, but not limited to, any material reduction in the number of Group Providers.

2.6 Provider/Group Provider Information.
Prior to the Effective Date, and for each office/site in which Provider Services are rendered to Members, Provider shall provide or cause to be provided to Company a complete list of its and of all Group Providers' names, office and/or service addresses, office hours, email addresses, telephone and facsimile numbers, areas of practice or specialty and tax identification numbers. Provider shall notify or cause to be notified Company, in writing, within seven (7) business days of any change in this information, as well as any additions to the list of Group Providers. Provider shall provide to Company at least ninety (90) days prior notice (or, if Provider does not receive at least ninety (90) days prior notice, then such notice as Provider actually receives) of the termination, for any reason, of a Group Provider's relationship with Provider. Provider shall obtain a completed credentialing application to become a Group Provider from each Group Provider, and shall, at Company's request, make available to Company any credentialing material held by or accessible to Provider. Provider shall obtain all necessary releases from Group Providers to permit Provider to release said credentialing files to Company, and Company shall be entitled to presume that such releases have been obtained.

2.7 Administrative Obligations of Primary Care Providers.
Each Primary Care Provider, if any, providing Covered Services under this Agreement shall comply with the following:

2.7.1 Coordination of Care. Primary Care Providers shall arrange and coordinate the overall provision of Covered Services to Members under the terms and conditions of the applicable Plan. Primary Care Providers shall provide or arrange for the provision of Covered Services, including, without limitation, urgently needed services or Emergency Services, regardless of whether the Primary Care Provider has previously seen or treated the Member.

2.7.2 Closed Panel. Provider and Company agree that a broad selection of physicians is important to Members and that Members expect physicians listed in Company's directories to be available to them. Accordingly, only upon at least ninety (90) days prior written notice with good cause acceptable to Company, Provider or any Group Provider may prospectively decline to accept new Members as patients. To prevent discrimination against Company or its Members, for such time as Provider or a Group Provider declines to accept new Members as patients, such Provider or Group Provider shall not accept as patients additional members from any insurer, entity or organization which competes with Company.

2.8 Administrative Obligations of Group Providers Other than Primary Care Providers.
To the extent a referral is required by the applicable Plan, Provider/a Group Provider who is not a Primary Care Provider shall, except for Emergency Services, provide Covered Services to Members only upon prior referral of such patients by a Primary Care Provider on prescribed forms or by electronic means as instructed by Company; and promptly submit a report on the treatment of each Member to the referring Primary Care Provider, if applicable. Except for Emergency Services, payment for retroactive referrals shall be subject to adjustment or denial by Company.

2.9 Referrals and Prescriptions.

2.9.1 Referrals and Utilization of Participating Provider. For all Plans, except as prohibited by law, Provider agrees to refer, and/or admit or arrange for admission of Members only to Participating Provider hospitals and facilities (including, but not limited, to surgery centers), and other Participating Providers directly contracted with Company unless the referral, and/or admission is either authorized in advance by Company, or in cases of Emergency Services after informed consent of the patient has been documented, in writing, as set forth in subsection 2.9.2 below.

For the purpose of providing quality care to Members, Provider shall furnish to other physicians and providers treating a Member all relevant medical information, including treatments and diagnostic tests, related to such Member.

2.9.2 Requirements for Utilization of Non-Participating Providers. For Members who have a Plan that allows for benefits for services rendered by providers who are not Participating Providers, if Provider admits or arranges for admission to a non-Participating Provider (including, but not limited, to surgery centers), or refers a Member to a non-Participating Provider, Provider shall document the Member's written consent, and that the Member has been provided with notice of the following information:

1) the hospital, facility, or provider is not a Participating Provider; and
2) the Member's Plan may, therefore, provide reduced benefits; and
3) the non-Participating Provider will not be restricted to seeking payment only from Company; and
4) the non-Participating Provider may bill the Member for amounts other than deductibles, co-payments, coinsurance, and medical services not covered under the Member's Plan; and
5) Provider's affiliation or financial ownership interest in or with the non-Participating Provider, if any.

A copy of the Member's written consent and the notice outlined above shall be kept in the patient's file. Company shall make available a form which may be used for such purpose.

2.9.3 Emergency Care. Emergency admission to and continued hospital stay at non-Participating Providers shall be reviewed by Company, and Provider shall cooperate and facilitate Company's review of any

emergency admissions at a non-Participating Provider to determine whether the Member should be transferred to continue care to a Participating Provider hospital in order to receive the maximum benefits available under the Member's Plan.

2.9.4 Prescribing Medications. For Members with Company pharmacy plans, Providers agree to use best efforts to prescribe medications in accordance with the applicable drug formulary. The drug formulary(ies) may be modified from time to time by Company.

2.10 Providers' Insurance.

Provider agrees to procure and maintain, throughout the term of this Agreement, such policies of general and professional liability and other insurance or a comparable program of self-insurance at minimum levels as required by state law, or in the absence of a state law specifying a minimum limit, an amount customarily maintained by physicians in the state or region in which the Provider operates. Such insurance coverage shall cover the acts and omissions of Provider as well as those of any Group Providers and its/their agents and employees. Provider agrees to deliver certificates of insurance or other documentation as appropriate to show evidence of such coverage to Company upon request. Provider agrees to make best efforts to provide to Company at least thirty (30) days advance notice, and in any event will provide notice as soon as reasonably practicable, of any cancellation or material modification of these policies.

2.11 Product Participation.

As of the Effective Date, Provider agrees to participate in the Products designated on the **Signature Sheet** to this Agreement. Company reserves the right to introduce and designate Provider's (and/or any specific Group Provider(s)') participation in new Specialty Programs or products (including, but not limited to, Medicare and/or other government program products) during the term of this Agreement and will provide Provider with at least ninety (90) days advance written notice of such new Specialty Programs/products, along with associated terms and rates and, if applicable, new or amended **Product Addendum(a)** that describe the applicable Specialty Program/products. Provider shall have thirty (30) days from receipt of Company's notice to notify Company in writing that Provider elects not to participate in a new Specialty Program/product; provided, however, that a variation of a current Specialty Program or Product at then-current rates and terms shall not be considered to be a new Specialty Program or product under this paragraph. Provider's failure to provide such notice shall automatically be deemed to constitute Provider's acceptance of the new Specialty Program or product and associated terms and rates.

Nothing in this Agreement shall require that Company identify, designate or include Provider and/or Group Providers as a participant or preferred participant in any specific Specialty Program, Product (or Product variation), generally, or for any specific Payers/customer(s); provided, however, that Provider shall accept compensation in accordance with the applicable **Product Addendum** and **Service and Rate Schedule** for the provision of any Covered Services to Members under a Specialty Program or Product.

Company may sell, lease, transfer or otherwise convey to third parties the benefits of this Agreement, including, but not limited to, the applicable **Service and Rate Schedule(s)**.

2.12 Consents to Release Medical Information.

Provider will obtain from Members to whom Provider provides Provider Services, any necessary consents or authorizations to the release of Information and Records to Company, Payers, their agents and representatives. In performing this covenant, Provider shall comply with any applicable Federal and state laws and regulations.

2.13 Encounter Data.

For those services for which Provider is compensated on a capitated basis, if any, Provider agrees to provide Company with encounter data by type of Provider Service rendered to Members in the form and manner as specified by Company. There shall be no restrictions on Company's use of such encounter data. Furthermore, Company is under no obligation to return such encounter data to Provider.

3.0 COMPANY OBLIGATIONS

3.1 Company's Covenants.
Except as specified otherwise on the applicable **Product Addendum**, Company or Payers shall provide Members with a means to identify themselves to Provider (e.g., identification cards), an explanation of provider payments, a general description of products (e.g., a quick reference guide), a listing of Participating Providers, and timely notification of material changes in this information. Company or Payer shall provide Provider with a means to check Member eligibility. Company or the applicable Payer shall include Provider in the Participating Provider directory or directories for the Plans, Specialty Programs and Products in which Provider is in the network, and shall make these directories available to Members. Company reserves the right to determine the content of provider directories.

3.2 Company Representations.
Company represents and covenants that: (a) where applicable, it is licensed to offer, issue and administer Plans in the service areas covered by this Agreement by the applicable regulatory authority ("License"); (b) it will not lose such License involuntarily during the course of this Agreement; and (c) it is, and will remain throughout the term of this Agreement, substantially in compliance with all applicable Federal and state laws and regulations related to this Agreement and the services to be provided under this Agreement, including without limitation, any applicable prompt payment statutes and regulations.

3.3 Company's Insurance.
Company at its sole cost and expense agrees to procure and maintain such policies of general and/or professional liability and other insurance and/or maintain an appropriate program of self-insurance as shall be necessary to insure Company and its employees against any claim or claims for damages arising directly or indirectly in connection with the performance of any service by Company under this Agreement.

4.0 CLAIMS SUBMISSIONS, RATE AND MEMBER BILLING

4.1 Claim Submission and Payment.

4.1.1 Obligation to Submit Claims. Provider agrees to submit Clean Claims to Company for non-capitated Provider Services rendered to Members. Provider represents that, where necessary, it has obtained signed assignments of benefits authorizing payment for Provider Services to be made directly to Provider and/or Group Providers. Provider will submit all claims electronically using the HIPAA required ASC X12N 837—Health Care Claim: Professional for professional claims and the ASC X12N 837—Health Care Claim: Institutional for institutional claims or an industry standard successor format ("Electronic Claim"). Provider shall not submit a claim in paper form unless Company or the applicable Payer, fails to pay or otherwise respond to electronic claims submission in accordance with the timeframes required under this Agreement, or applicable law or regulation. Provider agrees that Company, or the applicable Payer, will not be obligated to make payments for billing received more than one hundred and twenty (120) days from: (a) the date of service or date of discharge, as applicable; or (b) from the date of receipt of the primary payer's explanation of benefits when Company or Payer is the secondary payer. This requirement will be waived in the event Provider provides notice to Company, along with appropriate evidence, of extraordinary circumstances outside the control of Provider that resulted in the delayed submission. In addition, unless Provider notifies Company of any payment dispute or dispute regarding claim denial within one hundred eighty (180) days or such longer time as required by applicable state law or regulation, of receipt of payment or claim denial, such payment or claim denial will be considered full and final payment or determination for the related claims. If Provider does not bill Company or Payer, or timely dispute any payment as provided in this Section, Provider's claim for payment will be deemed waived and Provider will not seek payment from Payer, Company or Members.

Provider agrees to permit rebundling to the primary procedure those services considered part of, incidental to, or inclusive of the primary procedure and to allow other adjustments for inappropriate

billing or coding (e.g., duplicative procedures or claim submissions, mutually exclusive procedures, gender/procedure mismatches, age/procedure mismatches). In performing rebundling and making adjustments for inappropriate billing or coding, Company may utilize one or more commercial software packages (as modified by Company in the ordinary course of Company's business) which commercial software package(s) may rely upon Medicare and/or other industry standards in the development of rebundling logic.

4.1.2 Company Obligation to Pay for Covered Services. Subject to applicable law and the terms of each applicable **Product Addendum**, and except for applicable Member copayments, coinsurance and deductibles, Company agrees: (a) when it is the Payer, to pay Provider for Covered Services rendered to Members; and (b) when it is not the Payer, to notify Payers to forward payment to Provider for Covered Services rendered to the applicable Members, according to the rates set forth in the applicable **Service and Rate Schedule**, within forty-five (45) days of actual receipt by Company/Payer of a Clean Claim. Provider will utilize online explanation of benefits, electronic remittance of advice and electronic funds transfer, in lieu of receiving paper equivalents. While Company may remit payment for claims on behalf of Payers who are not Company Affiliates, Provider and Company acknowledge that Company has no legal responsibility for the payment of such claims for Covered Services rendered to a Payer's Members; provided, however, that Company agrees to use commercially reasonable efforts to assist Provider, as appropriate, in collecting any such payments.

Company or its designee may perform pre-payment reviews of certain claims. This review may include, but not be limited to, a request for itemized bills or more specific detail with respect to claims contracted on a percentage of charges basis. Provider acknowledges that, as a result of the review, payment may be denied for, among other things, duplicate charges, errors in billing or categorization of capital equipment. Company and/or its designees may, from time to time, notify Provider or Group Providers of overpayments, and Provider agrees to return any such overpayment or payment made in error (e.g., a duplicate payment or payment for services rendered to a patient who was not a Member) within a reasonable period of time. In the event Company is unable to secure the return of any such payment within such reasonable time, Company reserves the right to offset such payment against any other monies due under this Agreement provided that Provider has been provided with at least ten (10) days prior written notice and Provider has otherwise failed to return such payment. To the extent, if any, that the compensation under certain Plans is in the form of capitation payments or a diagnosis/case-based rate methodology, Provider acknowledges the financial risks to Provider of this arrangement and has made an independent analysis of the adequacy of this arrangement. Provider, therefore, agrees and covenants not to bring any action asserting the inadequacy of these arrangements or that Provider was in any way improperly induced by Company to accept the rate of payment, including, but not limited to, causes of actions for damages, rescission or termination alleging fraud or negligent misrepresentation or improper inducement.

4.1.3 Payment to Group Providers. Provider shall be financially responsible for payment to all Group Providers as well as to any subcontractors or other persons or entities who render Covered Services to Members under this Agreement. All Group Providers and other such persons/entities shall look solely to Provider for payment and Provider shall be responsible for enforcing this provision. In addition, Provider shall be financially responsible for payment to any other providers who render Covered Services to Members when Provider has been compensated on a capitated basis, if applicable, for such services. Provider shall pay on a timely basis all Group Providers, subcontractors and other persons or entities who provide Covered Services for which Provider is financially responsible hereunder. Company shall forward any claims it receives for payment for such services to Provider.

4.1.4 Utilization Management. Company utilizes systems of utilization review/quality improvement/peer review to promote adherence to accepted medical treatment standards and to encourage Participating Physicians to minimize unnecessary medical costs consistent with sound medical judgment. To further this end, Provider agrees, consistent with sound medical judgment: (a) to participate, as requested, and to abide by Company's utilization review, patient management, quality improvement programs, and all other related programs (as modified from time to time) and decisions with respect to all Members; (b)

to regularly interact and cooperate with Company's nurse case managers; (c) to abide by all Company's Participation Criteria and procedures, including site visits and medical chart reviews, and to submit to these processes biannually, annually, or otherwise, when applicable; (d) to obtain advance authorization from Company prior to any non-emergency admission, and in cases where a Member requires an emergency hospital admission, to notify Company, both in accordance with Company's rules, policies and procedures then in effect; and (e) to the extent required by the terms of the applicable Plan, Provider shall refer or admit Members only to Participating Providers for Covered Services, and shall furnish such Participating Providers with complete information on treatment procedures and diagnostic tests performed prior to such referral or admission. For those Members who require services under a Specialty Program, Provider agrees to work with Company in transferring the Member's care to a Specialty Program Provider.

4.2 Coordination of Benefits.
Company will coordinate benefits as allowed by state or Federal law, or, in the absence of any applicable law, in accordance with Plan requirements. If Medicare is the primary payer under coordination of benefit principles, Provider may not collect more than Medicare allows. In no event will a Payer pay more than the compensation due under this Agreement.

4.3 Member Billing.

4.3.1 Permitted Billing of Members. Provider may bill or charge Members only in the following circumstances: (a) applicable copayments, coinsurance and/or deductibles not collected at the time that Covered Services are rendered; (b) except as prohibited by law or governmental directive, if a Payer that is not a Company Affiliate (e.g., a self-funded plan sponsor) becomes insolvent or otherwise fails to pay Provider in accordance with applicable Federal law or regulation (e.g., ERISA), provided that Provider has first exhausted all reasonable efforts to obtain payment from the Payer; and (c) services that are not Covered Services only if: (i) the Member's Plan provides and/or Payer or Company confirms that the specific services are not covered; (ii) the Member was advised in writing prior to the services being rendered that the specific services may not be Covered Services; and (iii) the Member agreed in writing to pay for such services after being so advised. Notwithstanding the foregoing, Provider agrees that it will bill or charge Members at the contracted rates set forth in this Agreement when Provider Services would be Covered Services but for the Member's exhaustion of applicable plan benefits. Unless confirmed otherwise in writing by Company or Payer, Provider acknowledges that denial or adjustment of payment to Provider based on performance of utilization management as described in Section 4.1.3 or otherwise is not a denial of Covered Services under this Agreement or under the terms of a Plan. Provider may bill or charge individuals who were not Members at the time that services were rendered. Provider shall not institute or maintain any collection activities or proceed with any action at law or in equity against a Member to collect any sums that are owed by a Payer unless Provider provides at least thirty (30) days prior written notice to Company and Payer of Provider's intent to institute such action.

4.3.2 Holding Members Harmless. Provider hereby agrees that in no event, including, but not limited to the failure, denial or reduction of payment, insolvency of Company or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse: (i) against Members or persons acting on their behalf (other than Company); or (ii) any settlement fund or other asset controlled by or on behalf of, or for the benefit of, a Member for Covered Services. This provision shall not prohibit collection of copayments, coinsurance, deductibles or other supplemental charges made in accordance with the terms of the applicable Plan. Provider further agrees that Members will not be held liable for payment of any fees that are or are alleged by Provider to be the legal obligation of Company and/or in any circumstances under which billing of Members is prohibited by law or regulation. Provider further agrees that this section: (a) shall survive the expiration or termination of this Agreement regardless of the cause giving rise to termination and shall be construed for the benefit of Members; and (b) supersedes any oral or written contrary agreement or waiver now existing or hereafter entered into between Provider and Members or persons

acting on their behalf. Where required by applicable law no modification of this provision shall be effective without the prior written approval of the applicable regulatory agency.

5.0 COMPLIANCE WITH POLICIES

5.1 Policies.

Provider agrees to accept and comply with Policies of which Provider knows or reasonably should have known (e.g., clinical policy bulletins or other Policies made available to Participating Providers). Provider will utilize the electronic real time HIPAA compliant transactions, including but not limited to, eligibility, precertification and claim status inquiry transactions. Company may at any time modify Policies. Company will provide Provider with ninety (90) days prior notice by letter, newsletter, electronic mail or other media, of Material Changes to Policies. Failure by Provider to object in writing to any Material Change within thirty (30) days following receipt thereof shall constitute Provider's acceptance of such Material Change. Provider agrees that noncompliance with any requirements of this section or any Policies will relieve Company, Payers and Members from any financial liability for the applicable portion of the Provider Services.

5.2 Notices and Reporting.

To the extent neither prohibited by law nor infringement of applicable privilege, Provider agrees to provide notice to Company, and shall provide all information reasonably requested by Company, regarding the nature, circumstances, and disposition of any: (a) litigation brought against Provider, a Group Provider or any of its employees or affiliated providers which is related to the provision of health care services and that could have a material impact on the Provider Services provided to Members; (b) claims by governmental agencies or individuals regarding fraud, abuse, self-referral, false claims, or kickbacks; (c) change in the ownership or management of Provider; and (d) material change in services provided by Provider or licensure or certification status related to these services. Provider agrees to use best efforts to provide Company with prior notice of, and in any event will provide notice as soon as reasonably practicable of, any actions described in this section.

5.3 Information and Records.

5.3.1 Maintenance of Information and Records. Provider agrees: (a) to maintain Information and Records (as such terms are defined in Section 5.3.2) in a current, detailed, organized and comprehensive, accurate and timely manner and in accordance with customary medical practice, applicable Federal and state laws, and accreditation standards; (b) that all Member medical records and Confidential Information shall be treated as confidential and in accordance with applicable laws, including but not limited to, the requirements set forth in 42 C.F.R. §§ 422.118 and 423.136; and (c) to maintain such Information and Records for the longer of six (6) years after the last date Provider Services were provided to Member, or the period required by applicable law. This section shall survive the termination of this Agreement, regardless of the cause of the termination.

5.3.2 Access to Information and Records. Provider agrees that: (a) Company (including Company's authorized designee) and Payers shall have access to all data and information obtained, created or collected by Provider related to Members and necessary for payment of claims, including without limitation Confidential Information ("Information"); (b) Company (including Company's authorized designee), Payers and Federal, state, and local governmental authorities and their agents having jurisdiction, upon request, shall have access to all books, records and other papers (including, but not limited to, medical and financial records, contracts and computer or other electronic systems) and information relating to this Agreement and to those services rendered by Provider to Members ("Records"); (c) consistent with the consents and authorizations required by Section 2.12 hereof, Company, Payers and their agents or designees shall have access to medical records for the purpose of assessing quality of care, conducting medical evaluations and audits, including pre-payment review, and performing utilization management functions; (d) applicable Federal and state authorities and their agents shall have access to medical records, including, but not limited to, for the purpose of assessing the quality of care or investigating Member grievances or complaints; (e) medical information relating

to Members is released only in accordance with applicable Federal or state law, or pursuant to court orders or subpoenas; and (f) Members shall have access to their health information as required by 45 C.F.R. § 164.524 and applicable state law, be provided with an accounting of disclosures of information when and as required by 45 C.F.R. § 164.528 and applicable state law, and have the opportunity to amend or correct the information as required by 45 C.F.R. § 164.526 and applicable state law. Provider agrees to supply copies of Information and Records within fourteen (14) days of the receipt of a request, where practicable, and in no event later than the date required by any applicable law or regulatory authority. Except as required by applicable state or Federal law, Provider agrees that Company (including Company's authorized designee), Payers and Members shall not be required to reimburse Provider for expenses related to providing copies of patient records or documents: (i) pursuant to a request from any governmental or regulatory agency; (ii) pursuant to administration of utilization management; or (iii) in order to assist Company or a Payer in making a determination regarding whether a service is a Covered Service for which payment is due hereunder; or (iv) for any other purpose. Provider agrees to provide Company and Payers data necessary for them to comply with reporting requirements related to the Affordable Care Act ("ACA"), including but not limited to information related to the ACA's medical loss ratio requirements. This Section shall survive the termination of this Agreement, regardless of the cause of termination.

5.4 Quality, Accreditation, Review and Reporting Activities.
Provider agrees to cooperate with any Company quality activities or review of Company, a Payer or a Plan conducted by, as applicable, the National Committee for Quality Assurance ("NCQA"), the Utilization Review Accreditation Commission ("URAC") or other applicable accrediting organizations, or a state or Federal agency with authority over Company and/or the Plan, as applicable. Provider shall also comply with Healthcare Effectiveness Data Information Set ("HEDIS") and similar data collection and reporting requirements as required by Company.

5.5 Proprietary Information.
Each Party agrees that the Proprietary Information of the other Party is the exclusive property of such Party and that each Party has no right, title or interest in the Proprietary Information. Unless such Proprietary Information is otherwise publicly available, each Party agrees to keep the Proprietary Information strictly confidential and agrees not to disclose any Proprietary Information to any third party without the other Party's consent, except: (i) to governmental authorities having jurisdiction; (ii) in the case of Company's disclosure, to Members, Payers, consultants or vendors under contract with Company; and (iii) in the case of Provider's/Group Providers' disclosure, to Members for the purpose of advising a Member of potential treatment options and costs. Except as otherwise required under applicable Federal or state law, each Party agrees to not use any Proprietary Information of the other Party, and at the request of the other Party to this Agreement, return or destroy any Proprietary Information upon termination of this Agreement for whatever reason. Provider shall keep the rates and the development of rates and other terms of this Agreement confidential; provided, however, that Provider is encouraged to discuss Company's provider payment methodology with patients, including descriptions of the methodology under which the Provider and/or Group Providers are paid. In addition, Provider and Group Providers **may freely communicate with patients about their treatment options, regardless of benefit coverage limitations**. The restrictions under this Section 5.5 shall survive the termination of this Agreement for one (1) year, regardless of the cause of termination.

6.0 TERM AND TERMINATION

6.1 Term.
This Agreement shall be effective for an initial term ("Initial Term") of three (3) year(s) from the Effective Date, and thereafter shall automatically continue for additional terms of one (1) year each, unless and until terminated in accordance with this Section 6.0.

6.2 Termination without Cause.

This Agreement may be terminated by either Party with at least one hundred and twenty (120) days prior written notice to the other Party or non-renewed by either Party as of the anniversary date of the Effective Date with at least one hundred and twenty (120) days written notice to the other Party prior to such anniversary date; provided, however, that no termination or non-renewal under this Section shall be effective before the end of the Initial Term. Company may also terminate the participation of one or more individual Group Providers by providing Group and the individual Group Provider with at least ninety (90) days written notice prior to the date of termination.

Notwithstanding the foregoing, a Provider with fewer than five (5) individual Group Providers rendering Provider Services to Members may terminate this Agreement at any time, upon at least ninety (90) days prior written notice to Company.

6.3 Termination for Breach.

This Agreement may be terminated at any time by either Party upon at least sixty (60) days prior written notice of such termination to the other Party upon material default or substantial breach by the other Party of one or more of its obligations under this Agreement, unless such material default or substantial breach is cured within sixty (60) days of the notice of termination; provided, however, if such material default or substantial breach is incapable of being cured within such sixty (60) day period, any termination pursuant to this section will be ineffective for the period reasonably necessary to cure such breach if the breaching party has taken all steps reasonably capable of being performed within such sixty (60) day period.

Notwithstanding the provisions of this Section 6.3, the effective date of such termination may be extended pursuant to Section 6.6 of this Agreement. In the event of a termination for breach, termination shall not be the exclusive remedy, but shall be in addition to, any other remedies available at law or in equity to the non-breaching Party.

6.4 Immediate Termination or Suspension.

Any of the following events shall result in the immediate termination or suspension of this Agreement by Company, upon notice to Provider, at Company's discretion at any time: (a) the suspension, termination, withdrawal, expiration, revocation or non-renewal of any Federal, state or local license, certification (including, but not limited to, for physicians, a valid DEA certification and right to prescribe controlled substances), approval or other legal credential authorizing Provider or a Group Provider to practice medicine and/or other area of specialty; (b) the bankruptcy or receivership of Provider, or an assignment by Provider for the benefit of creditors; (c) an indictment, arrest or conviction of a felony; or for any indictment, arrest or conviction of criminal charge related to or in any way impairing Provider's or a Group Provider's practice of medicine; (d) the loss or material limitation of Provider's insurance under Section 2.10 of this Agreement; (e) the exclusion, debarment or suspension of Provider or a Group Provider from participation in any governmental sponsored program, including, but not limited to, Medicare or Medicaid; (f) the listing of Provider or any Group Provider in NPDB; (g) the revocation or suspension of any accreditation required under Company's applicable company Participation Criteria; (h) change of control of Provider to an entity not acceptable to Company; (i) any false statement or material omission of Provider or a Group Provider in a network participation application and/or confidential information forms and all other requested information or (j) any adverse action with respect to Provider's or a Group Provider's hospital staff privileges, if applicable; and (k) a determination by Company that Provider's continued participation in provider networks could result in harm to Members. To protect the interests of patients, including Members, Provider will provide immediate notice to Company of any of the events described in Section 6.4 (a)-(j), including, but not limited to, notification of impending bankruptcy.

6.5 Obligations Following Termination.

Following the effective date of any expiration or termination of this Agreement or any Plan, Provider and Company will cooperate as provided in this Section 6.5. This Section 6.5 shall survive the termination of this Agreement, regardless of the cause of termination.

6.5.1 Upon Termination. Upon expiration or termination of this Agreement for any reason, Provider agrees to provide Provider Services at Company's discretion for the longer time period of either: (a) to any

Member under Provider's care who, at the time of the effective date of termination, is a registered bed patient at a hospital or facility until such Member's discharge or Company's orderly transition of such Member's care to another provider; or (b) such timeframe as required by applicable state law. The applicable **Service and Rate Schedule** shall apply to all services provided under this section.

6.5.2 Upon Insolvency or Cessation of Operations. If this Agreement terminates as a result of insolvency or cessation of operations of Company and/or as otherwise required by law, then in addition to other obligations set forth in Section 6.5, Provider shall continue to provide Provider Services to: (a) all Members for the period for which premium has been paid; and (b) Members confined in an inpatient facility on the date of insolvency or other cessation of operations until medically appropriate discharge. This provision shall be construed to be for the benefit of Members. If required by law, no modification of this provision shall be effective without the prior written approval of the applicable regulatory agencies.

6.5.3 Obligation to Cooperate. Upon notice of expiration or termination of this Agreement or of a Plan, Provider shall cooperate with Company and the applicable Payer and comply with Policies, if any, in the transfer of Members to other providers.

6.5.4 Obligation to Notify Members. Upon notice of termination of this Agreement or of a Plan, Company shall have the right to provide reasonable advance notice of the impending termination to Members of Plans currently under the treatment of Provider, or in the event of immediate termination, as soon as practicable after termination.

6.6 Obligations During Dispute Resolution Proceedings.
In the event of any dispute between the Parties in which a Party has provided notice of termination under Section 6.3 and the dispute is required to be resolved or is submitted for resolution under Section 8.0 below, the termination of this Agreement shall cease and the Parties shall continue to perform under the terms of this Agreement until the final resolution of the dispute.

7.0 RELATIONSHIP OF THE PARTIES

7.1 Independent Contractor Status/Relationship.
The relationship between Company and Provider, as well as their respective employees and other agents, is that of independent contractors, and neither shall be considered an agent or representative of the other Party for any purpose, nor shall either hold itself out to be an agent or representative of the other for any purpose. Company and Provider will each be solely liable for its own activities and those of employees and other agents, and neither Company nor Provider will be liable in any way for the activities of the other Party or the other Party's employees or other agents. Provider acknowledges that all Member care and related decisions are the responsibility of Provider and/or Group Providers and that Policies do not dictate or control Provider's and/or Group Providers' clinical decisions with respect to the care of Members. Provider agrees to indemnify and hold harmless Company from any and all claims, liabilities and third party causes of action arising out of Provider's and/or Group Providers' provision of care to Members. Company agrees to indemnify and hold harmless Provider and Group Providers from any and all third party claims, liabilities and causes of action arising out of the Company's administration of Plans. This provision shall survive the expiration or termination of this Agreement, regardless of the reason for termination.

7.2 Use of Name.
Provider consents to the use of its name and other identifying and descriptive material in provider directories and in other materials and marketing literature of Company and Payers in all formats, including, but not limited to, electronic media. Provider shall not use Company's or its Affiliates' or a Payer's names, logos, trademarks or services marks without Company's and/or the applicable Payer's prior written consent.

7.3 Interference with Contractual Relations.

Provider shall not engage in activities that will cause Company to lose existing or potential Members, including but not limited to: (a) advising Company customers, Payers or other entities currently under contract with Company to cancel, or not renew their contracts; (b) impeding or otherwise interfering with negotiations which Company or a Payer is conducting for the provision of health benefits or Plans; or (c) except as required under this Agreement or by a governmental authority or court of competent jurisdiction, using or disclosing to any third party membership lists acquired during the term of this Agreement including, but not limited to, for the purpose of soliciting individuals who were or are Members or otherwise to compete with Company. Nothing in this section is intended or shall be deemed to restrict: (i) any communication between Provider and a Member, or a party designated by a Member determined by Provider to be necessary or appropriate for the diagnosis and care of the Member and otherwise in accordance with Section 5.5; or (ii) notification of participation status with other HMOs or insurers. This Section shall continue to be in effect for a period of one (1) year after the expiration or termination of this Agreement.

8.0 DISPUTE RESOLUTION

8.1 Member Grievance Dispute Resolution.
Provider agrees to: (a) cooperate with, participate in and abide by decisions of Company's applicable medical necessity, appeal, grievance and external review procedures for Members (including, but not limited to, Medicare appeals and expedited appeals procedures); and (b) provide Company with the information necessary to resolve same.

8.2 Dispute Resolution and Mediation.
Company shall provide an internal mechanism under which Provider may raise issues, concerns, controversies or claims regarding the obligations of the Parties under this Agreement. Should the Parties be unable to resolve any contractual dispute through such internal mechanism, they shall endeavor to settle the controversy by mediation through a mediator jointly selected by the parties. If the parties are unable to agree upon a mediator, then the parties will select a mediator using the then current AAA Mediation Procedure.

Provider shall exhaust Company's internal mechanism, as well as the mediation process described in this section prior to instituting any arbitration or other permitted legal proceeding. The Parties agree that any discussions and negotiations held pursuant to this section shall be treated as settlement negotiations and shall be inadmissible into evidence in any court proceeding, except to prove the existence of a binding settlement agreement.

8.3 Arbitration.
Any controversy or claim arising out of or relating to this Agreement including breach, termination, or validity of this Agreement, except for temporary, preliminary, or permanent injunctive relief or any other form of equitable relief, shall be settled by binding arbitration. **COMPANY AND PROVIDER UNDERSTAND AND AGREE THAT, BY AGREEING TO THIS ARBITRATION PROVISION, EACH MAY BRING CLAIMS AGAINST THE OTHER ONLY IN THEIR INDIVIDUAL CAPACITY, AND NOT AS A PLAINTIFF OR CLASS MEMBER IN ANY PURPORTED CLASS OR REPRESENTATIVE PROCEEDING FOR ANY DISPUTE ARISING OUT OF OR RELATING TO THIS AGREEMENT.** The arbitration will be governed by the Commercial Rules of the American Arbitration Association ("AAA Rules"), as modified by these arbitration provisions and conducted by a sole arbitrator with at least 20 years of litigation experience as a practicing lawyer and/or district court judge. The arbitration will be administered by the AAA. The arbitrator will require initial disclosures relating to any underlying provider billing claims as outlined in Rule 18(e) of the AAA Healthcare Payor Provider Arbitration Rules (2011), and will allow discovery, the filing of dispositive motions, and the exchange of expert reports and hearing exhibits, in accordance with the Federal Rules of Civil Procedure. The Federal Rules of Evidence shall apply to the arbitration. The arbitrator will issue a reasoned award sufficient to explain the essential findings and conclusions on which the award is based. Notwithstanding anything to the contrary herein, the parties shall have the right to appeal any award rendered by the arbitrator in accordance with the AAA's Appellate Arbitration Rules (2013), and the appeal will be considered by another sole arbitrator with at least twenty (20) years of litigation experience as a practicing lawyer and/or federal court

judge. In the case of a claim asserted by Provider, an arbitrator may award only compensatory damages for breach of contract, and is not empowered to award punitive, exemplary, or extra-contractual damages.

9.0 MISCELLANEOUS

9.1 No Third Party Beneficiaries.
Other than as expressly set forth in this Agreement, no third persons or entities are intended to be or are third party beneficiaries of or under the Agreement, including, but not limited to, Members. Nothing in the Agreement shall be construed to create any liability on the part of Company, Payers, Provider or their respective directors, officers, shareholders, employees or agents, as the case may be, to any such third parties for any act or failure to act of any Party hereto.

9.2 Entire Agreement/Amendments.
This Agreement constitutes the entire understanding of the Parties hereto and no changes, amendments or alterations shall be effective unless signed and agreed to by duly authorized representatives of both Parties, except as expressly provided herein. Notwithstanding the foregoing, at Company's discretion, Company may amend this Agreement upon written notice, by letter, newsletter, electronic mail or other media, to Provider to comply with applicable law or regulation, or any order or directive of any governmental agency. This Agreement shall be deemed to be automatically amended to conform with all laws and regulations promulgated at any time by any state or Federal regulatory agency or authority related to this Agreement.

9.3 Waiver.
The waiver by either Party of a breach or violation of any provision of this Agreement shall not operate as or be construed to be a waiver of any subsequent breach of this Agreement. To be effective, all waivers must be in writing and signed by an authorized officer of the Party to be charged. Provider waives any claims or cause of action for fraud in the inducement or execution related to these waivers.

9.4 Governing Law.
Except as otherwise required by law, this Agreement shall be governed in all respects by the laws of the State where Provider is located, without regard to such state's choice of law provisions.

9.5 Liability.
Notwithstanding Section 9.4, either Party's liability, if any, for damages to the other Party for any cause whatsoever arising out of or related to this Agreement, and regardless of the form of the action, shall be limited to the damaged Party's actual damages. Neither Party shall be liable for any indirect, incidental, punitive, exemplary, special or consequential damages of any kind whatsoever sustained as a result of a breach of this Agreement or any action, inaction, alleged tortious conduct, or delay by the other Party.

9.6 Severability.
Any determination that any provision of this Agreement or any application of it is invalid, illegal or unenforceable in any respect in any instance shall not affect the validity, legality and enforceability of such provision in any other instance, or the validity, legality or enforceability of any other provision of this Agreement.

9.7 Successors; Assignment.
Provider may not assign this Agreement without Company's prior written consent. In addition to all other rights of Company under the Agreement, this Agreement may be assigned by Company, at any time and from time to time, in whole or in part, to an Affiliate or successor in interest. At Company's option, the Agreement shall survive, without any other change in its terms, as a distinct, separate agreement with Company for those products/lines of business designated by Company and in duplicate form as a separate, distinct participating provider agreement with the applicable Affiliate(s)/successor(s) for the products/lines of business assigned to such entity(ies). In the event of any assignment under this paragraph, Company shall provide advance written notice to Provider.

9.8 Notices.

Any notice that: (a) is required under Section 6, Term and Termination; or (b) Provider is required to provide under Section 2.11 above shall be effective only if given in writing and sent by overnight delivery service with proof of receipt, or by certified mail return receipt requested. All other written notices may be sent by letter, electronic mail or other generally accepted media. Notice addresses are specified on the Signature Sheet to this Agreement and may be changed by either Party upon at least seven (7) days prior written notice to the other.

9.9 Non-Exclusivity.

This Agreement is not exclusive, and does not preclude either Party from contracting with any other person or entity for any purpose. Company makes no representation or guarantee as to the number of Members who may select or be assigned to Provider.

9.10 Representation by Counsel.

Each party acknowledges that it has had the opportunity to be represented by counsel of such Party's choice with respect to the Agreement. In view of the foregoing and notwithstanding any otherwise applicable principles of construction or interpretation, the Agreement shall be deemed to have been drafted jointly by the Parties and in the event of any ambiguity, shall not be construed or interpreted against the drafting Party.

State Compliance Addendum

TEXAS

The State Compliance Addendum attached to this Agreement, is expressly incorporated into this Agreement and is binding upon the Parties to this Agreement. In the event of any inconsistent or contrary language between the State Compliance Addendum and any other part of this Agreement, including but not limited to exhibits, attachments or amendments, the Parties agree that the provisions of the State Compliance Addendum shall prevail, but, if applicable, only with respect to a particular line of business (e.g., fully-insured HMO) and/or Product.

1.2 Clean Claim

Section 1.2 Clean Claim shall be deleted and replaced with the following:

"A clean claim is a claim that contains the information that is required by applicable Texas law and regulations adopted by the Commissioner of Insurance, and is submitted consistent with Company's established processing procedures to the extent Company establishes the information and processing procedure requirements consistent with applicable Texas law and regulations."

1.16 Policies

The following shall be added to the end of Section 1.16 Policies:

"Precertification" when used in this Agreement, means the utilization review process to determine whether the requested service procedure, prescription drug, or medical service meets the Company's clinical criteria for coverage. Precertification does not mean verification which is defined by Texas law, as a reliable representation of payment of care or services to fully insured HMO and PPO members."

2.1.1 Availability of Services and Rates

The last sentence of Section 2.1.1 Availability of Services and Rates, shall be deleted and replaced with the following:

"Unless otherwise permitted by applicable law or regulation, Provider understands and agrees that no health care provider shall render Covered Services to Members under this Agreement or otherwise serve as a Participating Provider unless and until such Provider: (a) has fully and satisfactorily completed Company's credentialing process and is approved by the applicable peer review committee; and (b) continues to comply with Company's Credentialing Criteria."

2.9.1 Referrals and Utilization of Participating Provider

Section 2.9.1 Referral and Utilization of Participation Provider, shall be deleted and replaced with the following:

"Unless such Covered Services are not available from a Participating Provider and for all Plans, except as prohibited by law, Provider agrees to refer, and/or admit or arrange for admission of Members only to Participating Provider hospitals and facilities (including, but not limited, to surgery centers), and other Participating Providers directly contracted with Company unless the referral, and/or admission is either authorized in advance by Company, or in cases of Emergency Services after informed consent of the patient has been documented, in writing, as set forth in subsection 2.9.2 below.

In accordance with 28 Texas Administration Code Section 3.3703 (27), except for instances of emergency care as defined under TX Insurance Code §1301.155(a), when referring Member to a facility for surgery Provider and/or Group Provider must: (a) notify Member of the possibility that out-of-network providers may provide treatment and

that the Member can contact Company for more information; (b) notify Company that surgery has been recommended; and (c) notify Company of the facility that has been recommend for the surgery.

For the purpose of providing quality care to Members, Provider shall furnish to other physicians and providers treating a Member all relevant medical information, including treatments and diagnostic tests, related to such Member."

2.11 Product Participation

The third paragraph of Section 2.11 Product Participation, shall be deleted and replaced with the following:

"Company may sell, lease, transfer information or otherwise convey to third parties the benefits of this Agreement, including, but not limited to, the applicable **Service and Rate Schedule(s).**

Company may contract with a third party entity to provide access to the Company's rights and responsibilities under this Agreement. On the request of Provider Company will provide information necessary to determine whether a particular third party has been authorized to access Provider's health care services and contractual discounts."

4.1.1 Provider Obligation to Submit Claims

The following sentence shall be added after the fifth sentence in Section 4.1.1 Provider Obligation to Submit Claims:

"This time limit for billing is ninety-five (95) days for Medicaid and CHIP plans. Except for Medicaid and CHIP plans, this requirement will be waived in the event Provider provides notice to Company, along with appropriate evidence, of extraordinary circumstances outside the control of Provider that resulted in the delayed submission."

The eighth (now tenth) sentence of Section 4.1.1 Obligation to Submit Claim, shall be deleted and replaced with the following:

"Except as otherwise required under applicable Federal, or state law or regulation, or a Plan, if Provider does not bill Company, Payer or plan sponsors or dispute any payment timely as provided in this Section 4.1.1, Provider's claim for payment will be deemed waived and Provider will not seek payment from Payer, Company or Members."

4.1.2 Company Obligation to Pay Covered Services

Section 4.1.2 Company Obligation to Pay Covered Services shall be deleted and replaced with the following:

"Subject to applicable law and the terms of each applicable **Product Addendum**, and except for applicable Member copayments, coinsurance and deductibles, Company agrees: (a) when it is the Payer, to pay Provider for Covered Services rendered to Members; and (b) when it is not the Payer, to notify Payers to forward payment for Covered Services rendered to the applicable Members, according to the rates set forth in the applicable **Service and Rate Schedule**, Company will reimburse Provider within forty-five (45) days of actual receipt by Company/Payer of a Clean Claim. Provider will utilize online explanation of benefits, electronic remittance of advice and electronic funds transfer in lieu of receiving paper equivalents.

Except for capitated services, in the event Company fails to pay Clean Claims within forty-five (45) days (or such time as permitted by applicable law or regulation) of receipt, Company shall pay a penalty as required by applicable law or regulation. In relation to Full Risk Plans, if applicable law or regulation does not require a penalty for Company's failure to pay a clean claim within the time period required by applicable law or regulation, then Provider shall not be entitled to billed charges or any penalty. Provider shall not be entitled to billed charges or any penalty for claims submitted in relation to Payer or plan sponsor Plans. (Plan sponsor Plans are not Full Risk Plans.) The receipt date for claims will be determined in accordance with applicable law or regulation.

Except as otherwise required under applicable Federal, or state law or regulation, or a Plan, if Company pays a claim and afterwards either –

4.1.2.1 Company discovers a possible underpayment to Provider within the time period for Provider to dispute payments stated in Section 4.1.1, or

4.1.2.2 Provider discovers a possible underpayment to Provider and gives prompt notice to Company within the time period for Provider to dispute payments stated in Section 4.1.1 above,

then Company shall review the claim within forty-five (45) days of Company's discovery or Provider's notice, and shall pay any eligible unpaid portion of the claim. In relation to Full Risk Plans, if applicable law or regulation does not require a penalty for Company's failure to pay a clean claim within the time period required by applicable law or regulation, then Provider shall not be entitled to billed charges or any penalty for a possible underpayment. Provider shall not be entitled to billed charges or any penalty for possible underpayment for claims submitted in relation to Payer or plan sponsor Plans. (Plan sponsor Plans are not Full Risk Plans.)

When required, Company shall comply with all applicable statutes and rules pertaining to prompt payment of clean claims, including Texas Insurance Code Sections 1301.101-1301.109, Sections 1301.131-1301.138, Sections 843.336–843.353, and 28 Texas Administrative Code Sections 21.2801-21.2826, with respect to payment to a Participating Provider for Covered Services that are rendered to Members. In accordance with Texas Insurance Code Sections 843.323, 1301.0641 and 28 Texas Administrative Code Section 3.3703 (22), Company'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 not a clean claim.

In accordance with applicable law and regulation, including but not limited to Texas Insurance Code Section 1301.136 and Sec. 843.321:

(1) Provider may request a description and copy of the coding guidelines, including any underlying bundling, recoding, or other payment process and fee schedules applicable to specific procedures that the Provider will receive under the contract;
(2) Company or Company's agent will provide the coding guidelines and fee schedules not later than the 30th day after the date the Company receives the request;
(3) Company or Company's agent will provide notice of changes to the coding guidelines and fee schedules that will result in a change of payment to Provider not later than the 90th day before the date the changes take effect and will not make retroactive revisions to the coding guidelines and fee schedules;
(4) The contract may be terminated by Provider on or before the 30th day after the date Provider receives information requested under this subsection without penalty or discrimination in participation in other health care products or plans;
(5) Provider shall only use or disclose the information for the purpose of practice management, billing activities, and other business operations; and disclose the information to a governmental agency involved in the regulation of health care or insurance;
(6) Company shall, on request of Provider, provide the name, edition, and model version of the software that Company uses to determine bundling and unbundling of claims.

Provider shall use information technology as required under Texas Insurance Code Chapter 1661 beginning no later than September 1, 2013, unless Provider has received a waiver of any requirement for the use of information technology from Company as permitted by Texas Insurance Code Section 1661.055(c).

While Company may remit payment for claims on behalf of Payers who are not Company Affiliates, Provider and Company acknowledge that Company has no legal responsibility for the payment of such claims for Covered Services rendered to a Payer's Members; provided, however, that Company agrees to use commercially reasonable efforts to assist Provider as appropriate in collecting any such payments. Where there is a Payer or plan sponsor, Company shall have no obligation to pay Provider in the event the Payer or plan sponsor or Member fails to pay

Provider.

Company or its designee may perform pre-payment reviews of certain claims. This review may include, but not be limited to, a request for itemized bills or more specific detail with respect to claims contracted on a percentage of charges basis. Provider acknowledges that, as a result of the review, payment may be denied for, among other things, duplicate charges, errors in billing or categorization of capital equipment. Except as otherwise required under applicable Federal, or state law or regulation, or a Plan, Company and/or its designees may, from time to time, notify Provider or Group Providers of overpayments, and Provider agrees to return any such overpayment or payment made in error (e.g., a duplicate payment or payment for services rendered to a patient who was not a Member) within forty-five (45) days. In the event Provider fails to return overpayments within forty-five (45) days of receipt, upon written notice from Company of such event, Provider shall pay a contracted penalty of 1.0% per month simple interest on the eligible, unrepaid portion of such overpayment, beginning on the forty-sixth (46th) day after receipt of notice of such overpayment(s). If the overpayment request is mailed, the Provider's receipt date will be the fifth (5th) calendar day following the postmark date. Company shall not be entitled to collect any other penalty, charge or fee, for Provider's failure to return overpayment of claims under any Full Risk Plans. Company shall not be entitled to the contracted penalty for overpayments submitted in relation to Payer or plan sponsor Plans.

In the event Company is unable to secure the return of any such payment within such reasonable time, Company reserves the right to offset such payment against any other monies due to Provider under this Agreement provided that Provider has been provided with at least ten (10) days prior written notice and Provider has otherwise failed to return such payment. Company agrees to make all reasonable efforts to recover such overpayments from Provider before it offsets overpayments against any other monies due to Provider.

To the extent, if any, that the compensation under certain Plans is in the form of capitation payments or a diagnosis/case-based rate methodology, Provider acknowledges the financial risks to Provider of this arrangement and has made an independent analysis of the adequacy of this arrangement. Provider, therefore, agrees and covenants not to bring any action asserting the inadequacy of these arrangements or that Provider was in any way improperly induced by Company to accept the rate of payment, including, but not limited to, causes of actions for damages, rescission or termination alleging fraud or negligent misrepresentation or improper inducement. Company may propose changes in the capitation rate or the Service and Rates Schedule upon ninety (90) days written notice to Provider. If Provider is compensated in the form of capitation payments, said payments shall begin and selection of a Primary Care Provider by a member shall be in accordance with applicable state law. If capitation applies, Company will comply with the requirements described in Texas Insurance Code Sections 843.315 and 843.316."

4.1.4 Utilization Management

Subsection (e) in Section 4.1.4 Utilization Management, shall be deleted and replaced with the following:
(e) to the extent required by the terms of the applicable Plan, Provider who are Primary Care Providers shall refer or admit Members only to Participating Providers for Covered Services, unless such Covered Services are not available from a Participating Provider, and shall furnish such Participating Providers with complete information on treatment procedures and diagnostic tests performed prior to such referral or admission."

4.2 Coordination of Benefits

The following shall be added to the beginning of Section 4.2 Coordination of Benefits:

"Provider shall retain in its records updated information for a Member concerning other health benefit plan coverage and to provide the information to Company on the form described by applicable law or regulation, and if a form is not described by applicable law or regulation, in the manner specified by Company."

4.3.1 Permitted Billing of Members

The following shall be added after the second sentence of Section 4.3.1 Permitted Billing of Members:

"As required by Texas Insurance Code Section 1661.005, if Provider receives an overpayment from a Member Provider must refund the amount of the overpayment to Member no later than the thirtieth (30th) day after the date Provider determines that an overpayment has been made."

4.3.2 Holding Members Harmless

The last sentence of Section 4.3.2 Holding Members Harmless, following shall be deleted and replaced with the following:

"Any modifications, additions, deletions to the provisions of this clause shall become effective on a date no earlier than ninety (90) days after notice to Provider of any such modification, addition, or deletion to the provisions of this clause, and no earlier than fifteen (15) days after the Commissioner of Insurance has received written notice of such proposed changes."

5.1 Policies

The fifth sentence in Section 5.1 Policies, shall be deleted and replaced with the following:

"If Provider objects to the Material Change, Provider shall provide written notice to Company within thirty (30) days following receipt thereof, and in the event that Provider reasonably believes that a Material Change is likely to have a material adverse financial impact upon Provider's practice, Provider shall specify in writing the specific bases demonstrating a likely material adverse financial impact on Provider's practice. Provider may then request that the Parties negotiate in good faith an appropriate amendment to this Agreement. If the parties are unable to negotiate any such amendment not more than thirty (30) days after receipt of a Material Change and Provider provides notice of termination of this Agreement not more than thirty (30) calendar days after receipt of a Material Change, then this Agreement shall terminate coincident with the effective date of the Material Change."

The following shall be added to the end of Section 5.1 Policies:

"In addition, Provider shall participate in Company's preventive care program or implement an effective preventive care program consistent with Company's criteria and policies, for which Provider shall be compensated in accordance with the rates set forth in the **Service and Rate Schedule**."

5.2 Notices and Reporting

The following shall be added to the end of Section 5.2 Notices and Reporting:

"If Provider and/or Group Providers provide facility-based Provider Services at a facility that is a preferred provider for Company, Provider and/or Group Providers shall give notice to such facility as soon as reasonably practicable that Provider and/or Group Providers is also a preferred provider for Company.

In accordance with 28 Texas Administration Code Section 3.3703 (28), except for instances of emergency care as defined under TX Insurance Code §1301.155(a), when scheduling surgery Provider shall: (a) notify the Member of the possibility that out-of-network providers may provide treatment and that the Member can contact Company for more information; and (b) notify Company that surgery has been scheduled."

5.3.2 Access to Information and Records

Subparagraph (c) in Section 5.3.2 Access to Information and Records, shall be deleted and replaced with the following:

"(c) consistent with the consents and authorizations required by Section 2.12 hereof, Company, Payers and their agents or designees shall have access to medical records for the purpose of assessing quality of care, conducting medical evaluations and audits, including pre-payment review, and performing utilization management functions

and as required by Texas law, Company shall conduct quality assessment through a panel of at least three (3) Participating Providers;".

6.0 Termination

The following shall be added under the heading of Section 6.0 Termination:

"Prior to termination initiated by Company and in accordance with applicable State law, Company shall provide a written explanation of the reason(s) for termination, and upon request before the effective date, Provider shall be entitled to a review by an advisory panel."

6.1 Term

The following shall be added to the end of Section 6.1 Term:

"Notices of renewal may be sent to Provider. In the event Provider has not responded or objects within sixty (60) days of receipt of such notice, the Agreement shall automatically renew."

6.2 Termination without Cause

Section 6.2 Termination without Cause, shall be deleted and replaced with the following:

"This Agreement may be terminated by either Party with at least one hundred and twenty (120) days prior written notice to the other Party, or non-renewed by either Party as of the anniversary date of the Effective Date with at least one hundred and twenty (120) days written notice to the other Party prior to such anniversary date; and in accordance with such procedures as are applicable at the time of such termination. No termination of this Agreement pursuant to this Section 6.2 shall be effective during the Initial Term of this Agreement. Company may also terminate the participation of one or more individual Group Providers by providing Group and the individual Group Provider with at least ninety (90) days written notice prior to the date of termination.

Notwithstanding the foregoing, a Provider with fewer than five (5) individual Group Providers rendering Provider Services to Members may terminate this Agreement at any time, upon at least ninety (90) days prior written notice to Company."

6.5.1 Upon Termination

The following shall be added after the first sentence of Section 6.5.1 Upon Termination:

"Company shall reimburse Provider for Covered Services to any Member of special circumstance, such as a person who has a disability, acute condition, or life-threatening illness or is past the twenty-fourth week of pregnancy. "Special circumstances" means a condition such that Provider reasonably believes that discontinuing care by the Provider could cause harm to the patient. The special circumstance shall be identified by the Provider, who must request that the Member be permitted to continue treatment under the Provider's care and agree not to seek payment from the patient of any amounts for which the Member would not be responsible if the Provider were still a Participating Provider. This subsection does not extend the obligation of Company to reimburse the terminated Provider for ongoing treatment of a Member beyond the 90th day after the effective date of termination, or beyond nine months in the case of a Member who at the time of the termination has been diagnosed with a terminal illness, except that the obligation to reimburse a Member who at the time of the termination is past the 24th week of pregnancy, extends through delivery of the child, immediate postpartum care, and the follow-up checkup within the first six weeks of delivery. Provider shall comply with Texas Insurance Code Sections 1301.152 - 1301.154."

6.5.3 Obligation to Cooperate

The following shall be added to the end of Section 6.5.3 Obligation to Cooperate:

"Upon notice of expiration or termination of this Agreement or of a Plan, Provider, upon the direction of Company and in accordance with applicable state law, shall provide reasonable advance notice of the impending termination to Members currently under the treatment of Provider."

7.1 Independent Contractor Status/Relationship

The following shall be added after the third sentence of Section 7.1 Independent Contractor Status/Relationship:

"In particular, medical necessity decisions are for compensation purposes only, and do not direct or limit the advice or care which Provider and/or Group Providers can or should provide in Provider's sole medical judgment."

The fourth (now fifth) sentence of Section 7.1 Independent Contractor Status/Relationship, shall be deleted and replaced with the following:

"Notwithstanding anything else in this section or this Agreement to the contrary, nothing shall require Provider and/or Group Providers to indemnify and hold harmless Company (including for costs and counsel fees) from any and all claims, liabilities and third party causes of action arising out of the Company's administration of Plans."

8.1 Member Grievance Dispute Resolution

The following shall be added at the end of Section 8.1 Member Grievance Dispute Resolution:

"As required by State law, Provider shall post a notice to Members on the process for resolving complaints with Company including the Department of Insurance toll-free telephone number for filing complaints. Company shall not terminate or refuse to renew this Agreement or otherwise retaliate against Provider because Provider reasonably filed a complaint or an appeal on behalf of a Member."

9.0 Miscellaneous

Section 9.11 Delegation shall be added to the Agreement as follows:

"9.11 Delegation.
To the extent Company delegates certain functions to Provider, such delegation shall be governed by a separate delegation agreement which shall be subject to the applicable requirements of Texas Insurance Code, Chapter 1272."

COMMERCIAL HEALTH PRODUCT ADDENDUM

1. Description. The term Commercial Health Product includes, but is not limited to, the health products, benefit plans, programs, and networks described below (each referred to in this Addendum as a "Product"). Nothing in this Addendum requires Company to include Provider in any specific Product and Provider's participation may be terminated by Company from one or more Products with ninety (90) days' prior written notice to Provider, without affecting participation in any other Products.

   Commercial Health Products – Commercial health Products offered, administered and/or serviced by Company, including, but not limited to, Federal Employee Health Benefit Programs (FEHB) and other Office of Personnel Management (OPM) Products, and self-funded Products administered and/or serviced by Company. Examples of Commercial Health Products include, but are not limited to: *HMO, QPOS, Elect Choice, Managed Choice POS, Aetna Choice POS II, Aetna Select, Open Access Student MC, Aetna Signature Administrators®, joint claims administration, Passport to Healthcare®, PPO, and National Advantage.*

   Note: Many member ID cards include the National Advantage logo (NAP) in conjunction with other Commercial Health Products. In those circumstances, the rate applicable to the other Product (not NAP) on the ID card will apply.

2. Other Terms and Conditions. All terms not otherwise defined in this Commercial Health Product Addendum shall have the meanings set forth in the Signature Sheet and General Terms and Conditions to the Agreement. Except as specifically set forth otherwise herein, all terms and conditions set forth in the Signature Sheet and General Terms and Conditions, and where applicable, any State Compliance Addendum(s), shall be incorporated into this Commercial Health Product Addendum.

3. Termination. In the event this Commercial Health Product Addendum is terminated or assigned, such termination or assignment shall not constitute termination or assignment of any other Product Addendum that Provider has entered into with Company pursuant to the Agreement.

MEDICARE ADVANTAGE PRODUCT ADDENDUM

Without limiting any obligation of Provider under the Agreement, Provider agrees to the requirements set forth in this Addendum. Capitalized terms not otherwise defined herein, including within Schedule 1 attached hereto, shall have the meanings ascribed to them in the Agreement.

1. DESCRIPTION. The Medicare Advantage Product includes the Medicare Advantage plan(s) offered by Company to Medicare beneficiaries under a contract with the Centers for Medicare and Medicaid Services ("CMS") pursuant to Part C of Title XVIII of the Social Security Act ("Medicare Plans"). From time to time Company and/or Payers may designate only certain Participating Providers to take part in the provider delivery network for a particular Product benefit plan(s).

2. PAYMENT.

A. In consideration of Provider's agreement to perform Covered Services in accordance with the Agreement, Provider shall be paid for Covered Services performed according to the terms of the applicable Service and Rate Schedule.

B. Company shall not pay any amounts beyond the amounts set forth in the applicable Service & Rate Schedule, including but not limited to any incentive payments that may be payable under traditional Medicare, except as expressly required by the Agreement or applicable law. Further, the Parties acknowledge and agree that payments under the Medicare program to providers, suppliers, and Medicare Advantage organizations may be adjusted as the result of legislation, regulation, executive order or other federal mandate ("Medicare Payment Adjustment"). Furthermore, any such Medicare Payment Adjustment could result in an increase or decrease in Medicare payments. In accordance with the terms of this Agreement, the Parties agree that, in the event of a Medicare Payment Adjustment, Company's payment to Provider will be adjusted in accordance with the Medicare Payment Adjustment. Company shall adjust payments under this Agreement for Covered Services rendered by Provider on and after the effective date of the Medicare Payment Adjustment, and shall continue to adjust payments to Provider until the earlier of (i) the Medicare Payment Adjustment is discontinued or (ii) is replaced by a subsequent Medicare Payment Adjustment.

C. Pursuant to Section 5.M. of this Addendum, Provider certifies that the diagnosis codes submitted to Company for Medicare Members that Company is required to submit to CMS will be accurate, complete and truthful ("Certification"). Provider acknowledges and agrees that Company may impose a penalty on Provider not to exceed five thousand dollars ($5,000) for each instance that Provider submits a diagnosis code to Company for a Medicare Member that does not comply with this Certification because the diagnosis code was not submitted in the format described in 42 C.F.R. § 422.310 or any subsequent or additional federal regulations. For purposes of this Section, "diagnosis code" shall mean an International Classification of Diseases-9th Edition-Clinical Modification (ICD-9-CM) code or its successor.

D. Federal laws and regulations limit the timeframe within which CMS may recover overpayments made to physicians, providers, and suppliers who submit claims to Medicare contractors (such as fiscal intermediaries, regional home health intermediaries, carriers, Medicare Administrative Contractors, and Durable Medical Equipment Medicare Administrative Contractors) for services provided or supplied to Medicare beneficiaries enrolled in Original Medicare ("Medicare Statute of Limitations"). If Company makes an overpayment or payment in error to Provider for Medicare Members, Company shall have the right to initiate overpayment recovery efforts within the same timeframe available to CMS under the Medicare Statute of Limitations; provided that no time limit shall apply to initiation of overpayment recovery efforts based on Company's reasonable suspicion of fraud or other intentional misconduct.

3. ASSIGNMENT. In addition to all other rights of Company under the Agreement, the Agreement (including, but not limited to, as it relates to the line(s) of business described in this Addendum) may be assigned by Company, at

any time and from time to time, in whole or in part, to any other affiliate or successor in interest. At Company's option, the Agreement shall survive, without any other change in its terms, as a distinct, separate agreement with Company for those products/lines of business designated by Company and in duplicate form as a separate, distinct participating provider agreement with the applicable affiliate(s)/successor(s) for the products/lines of business assigned to such entity(ies). In the event of any assignment under this paragraph, Company shall provide advance written notice to Provider. In the event of a conflict between this paragraph and any other provision of the Agreement, the terms of this paragraph shall supersede and prevail.

4. EFFECT OF TERMINATION. In the event this Addendum is terminated for any reason, such termination shall not constitute termination of any of Company's other products, plans or programs.

5. PROVIDER OBLIGATIONS.

A. Provider represents and warrants that all provisions of Section 5, Provider Obligations, and Schedule 1, attached hereto and incorporated into this Addendum, shall apply equally to any employee, temporary employee, partner, or other individual practitioner that performs services under this Medicare Addendum to the Agreement, including but not limited to those employees, temporary employees, partners, or other individual practitioners who perform services under this Agreement in Provider's offices on behalf of Provider for which Provider bills such services under this Agreement. Provider shall take all steps necessary to cause such individuals described in this section to comply with this Addendum, including Schedule 1, and all applicable laws, regulations and CMS instructions. Provider represents and warrants that Provider has the authority to bind such individuals, and shall provide written evidence of the same upon request. Provider also represents and warrants that all provisions of this Addendum, including Schedule 1, shall apply equally to any of Provider's Downstream Entities, as defined by CMS and as set forth in Schedule 1 to this Addendum. Provider shall include in Provider's contracts with Downstream Entities all of the contractual and legal obligations required by Company in order for the Downstream Entity and Company to comply with applicable laws, regulations and CMS instructions. Provider shall take all steps necessary to cause its Downstream Entities to comply with this Addendum, including Schedule 1, and all applicable laws, regulations and CMS instructions. To the extent CMS requires additional provisions to be included in such subcontracts, Provider shall amend its contracts with its Downstream Entities accordingly.

B. Provider agrees to provide to Company's Medicare Members the health care services for which Provider is licensed and customarily provides in accordance with accepted medical and surgical standards in the community. Provider shall make such Covered Services available and accessible to Company's Medicare Members, including telephone access to Provider, on a twenty-four (24) hours, seven (7) days per week basis. Provider agrees to provide to Company those services, as described in the Agreement, that support Company's Medicare Plans, including but not limited to the health care services described in this Section ("Medicare Services"). Provider acknowledges and agrees that Company may monitor the performance of Provider to confirm Provider's compliance with applicable laws, regulations and CMS instructions.

C. Provider agrees that all Medicare Services performed by Provider under the Agreement will be consistent and comply with Company's obligations as a Medicare Advantage Organization under Company's contracts with CMS. Upon request, Provider shall immediately provide to Company any information that is required by Company to meet its reporting obligations to CMS, including without limitation, physician incentive plan information, if applicable.

D. Provider agrees to cooperate with and participate in internal and external review procedures necessary to allow Company to process Medicare appeals and grievances in accordance with Medicare laws, regulations and CMS instructions.

E. **Compliance Program and Anti-Fraud Initiatives**. Provider shall (and shall cause its Downstream Entities to) institute, operate, and maintain an effective compliance program to detect, correct and prevent the incidence of non-compliance with CMS requirements and the incidence of fraud, waste and abuse (FWA) relating to the operation of Company's Medicare Program. Such compliance program shall be appropriate to Provider's or Downstream Entity's organization and operations and shall include:

(1) written compliance policies and standards of conduct that are comparable to Aetna's compliance policies/Aetna Code of Conduct and articulate the entity's commitment to comply with federal and state laws, ethical behavior and compliance program operations. Provider will disseminate either Aetna's compliance policies/Aetna Code of Conduct or comparable versions to Provider's employees, officers, and Downstream Entities within ninety (90) days of hire/contracting, when updates are made, and annually thereafter;

(2) reporting mechanisms communicated to Provider's employees and Downstream Entities for their use in adhering to the expectation that Provider, its employees and its Downstream Entities report potential non-compliance or FWA issues (internally and to Company, as applicable) and understand their obligation to report. Provider must publicize the reporting methods to Provider employees and Downstream Entities along with a no-tolerance policy for retaliation or retribution for good faith reporting;

(3) completion of CMS' Medicare Learning Network® "Medicare Parts C and D Fraud, Waste, and Abuse Training and Medicare Parts C and D General Compliance Training" by Provider employees, officers, and Downstream Entities initially within ninety (90) days of hire/contracting and at least annually thereafter, unless exempt from such training under relevant CMS regulations. Training may be completed in one of two ways: (1) by completing the general compliance and FWA training modules located on the CMS Medicare Learning Network; or (2) by downloading, viewing or printing the content of the then current CMS standardized training modules from the CMS website to incorporate into Provider's and/or Downstream Entity's organization's existing compliance training materials/systems. The CMS training content may not be changed but Provider and/or its Downstream Entities may add to it to cover topics specific to its organization;

(4) processes to oversee and ensure that Provider and Provider's Downstream Entities maintain compliance with processes to oversee and ensure that: (1) Provider and Provider's Downstream Entities maintain compliance with CMS compliance program requirements, and (2) Provider's Downstream Entities perform Medicare Services consistent with this Agreement and the agreement between Provider and such Downstream Entities. Provider's oversight under this Agreement shall include: (1) imposition of disciplinary actions, as needed, to ensure employee compliance with CMS compliance program requirements, and (2) implementation of corrective actions (up to and including contract termination), as needed, with respect to its Downstream Entities to ensure Downstream Entity compliance with applicable CMS requirements, including the CMS compliance program requirements, this Agreement and Provider's contract with the Downstream Entity; and

(5) retention of evidence showing that Provider and Provider's Downstream Entities complied with the requirements set forth in this Section 5(E) of this Addendum. Such evidence must be maintained for at least the period of time specified in Section 5(I) of this Addendum and shall be made available to Company and CMS, upon request. Provider shall complete attestations in the form and manner requested by Company to confirm its compliance with this section on an annual basis.

F. **Federal Fund Obligations**. Provider understands and agrees that payments received by Company for the Medicare Plans from CMS pursuant to the Medicare Plan's contract with CMS are Federal funds. As a result, Provider, by entering into this Agreement and the terms of this Addendum, is subject to laws

applicable to individuals/entities receiving Federal funds, including but not limited to, Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 C.F.R. part 84, the Age Discrimination Act of 1975 as implemented by regulations at 45 C.F.R. part 91, the Rehabilitation Act of 1973, and the Americans with Disabilities Act.

G. **Continuation of Services**. In the event Company's Medicare Advantage contract for the Medicare Plans with CMS terminates or Company becomes insolvent, Provider shall continue to provide Covered Services to Medicare Members who are hospitalized through the date of discharge. Provider is prohibited by law from billing Medicare Advantage Members for such Covered Services. This provision shall survive the termination of the Agreement in whole or in part, regardless of the reason for termination, including the insolvency of Company, and shall supersede any oral or written agreement between Provider and a Medicare Member.

H. **Policies, Programs & Procedures.** Provider agrees to comply with Company's policies and procedures (which Company shall provide to Provider upon request) which operationalize many of the requirements of the Agreement, this Addendum, and the Medicare Advantage Program. Provider agrees to comply with Company's quality improvement, administrative processes and procedures, utilization review, peer review, grievance procedures, credentialing and recredentialing procedures, and any other policies Company may implement, including amendments made to the above mentioned policies, procedures and programs from time to time. In the event that a Company policy or procedure conflicts with a provision in the Agreement, then the language in the Agreement (including all amendments, exhibits, and attachments thereto) shall govern.

I. **Maintenance of Records.** Provider shall preserve records applicable to Medicare Members or to Company's participation in the Medicare Program, for the longer of: (i) the period of time required by State and Federal law, or (ii) ten (10) years. In addition, to the extent applicable to Provider, Provider, on behalf of itself and any Downstream Entities with whom Provider has contracted, agrees to comply with 42 C.F.R. §422.2480(c) and to maintain all records, if any, containing data used by Company to calculate Medicare medical loss ratios ("MLRs") for Company's Medicare Plans and/or evidence needed by Company and/or federal governmental authorities with jurisdiction to validate MLRs (collectively, "MLR Records") for a minimum of ten (10) years from the date such MLRs were reported by Company to CMS.

J. **Contracts with Excluded Entities.** Provider understands and agrees that no person or entity that provides Medicare Services, directly or indirectly, for Company's Medicare Plans, may be an individual or entity excluded from participation in Medicare under Section 1128 or 1128A of the Social Security Act. Provider hereby certifies that no such excluded person or entity will be employed by or utilized by Provider or by any of Provider's Downstream Entities to directly or indirectly perform Medicare Services under this Agreement. Provider agrees to review the Department of Health and Human Services ("HHS") Office of Inspector General List of Excluded Individuals and Entities and the General Services Administration System for Awards Management (collectively, "Exclusion Lists") to ensure that no persons or entities employed by or utilized by Provider or by any of Provider's Downstream Entities are included on such Exclusion Lists. Provider agrees to review the Exclusion Lists prior to initially hiring, appointing or contracting with any new employee, temporary employee or Downstream Entity and at least once per month thereafter to confirm that such persons and entities are not included on such Exclusion Lists. Provider agrees that if any such person or entity utilized by Provider to directly or indirectly to perform Medicare services under this Agreement appears on an Exclusion List and/or is excluded from participation in any federally-funded health program, Provider will immediately remove the employee, temporary employee or Downstream Entity from any work related directly or indirectly to Company's Medicare Plans, and take all corrective actions required under applicable laws, rules or regulations. In the event Provider or any employee, temporary employee or Downstream Entity of Provider that directly or indirectly performs Medicare Services under this Agreement is listed in an Exclusion List after the Effective Date of this Addendum, Company shall have the right, in its sole discretion and judgment, to terminate Provider's participation in Company's Medicare Plans in accordance with the Agreement or to

disqualify any such person or entity on the Exclusion List from providing any part of the Medicare Services.

K. **Offshore Services.** Provider is prohibited from performing on its own or through any Downstream Entity any services for Company's Medicare Plans while physically located outside of one of the fifty United States or one of the United States Territories (i.e., American Samoa, Guam, Northern Marianas, Puerto Rico, and Virgin Islands)("Offshore Services"), unless Company, in its sole discretion and judgment, agrees in advance and in writing to the provision of such Offshore Services by Provider or its Downstream Entity. Provider further agrees that Company has the right to audit Provider or Provider's Downstream Entity prior to the provision of its Offshore Services for Medicare Plans. Additionally, Provider acknowledges and agrees that Offshore Services that involve Medicare Member protected health information (PHI) are subject to CMS reporting within thirty (30) days of: (1) performing, or contracting with a Downstream Entity to perform, Offshore Services, and (2) any time Provider changes the Offshore Services that it or its Downstream Entity will perform.

L. **Submission of Encounter Data**. Provider hereby acknowledges that Company is required to provide CMS and other federal and state regulatory agencies and accrediting organizations with encounter data as requested by such agencies and organizations. Such data may include medical records and all other data necessary to characterize each encounter between Provider and a Medicare Member. Provider agrees to cooperate with Company and to provide Company with all such information in such form and manner as requested by Company. Provider agrees to immediately notify Company if any encounter data that Provider submitted to Company for Medicare Members is inaccurate, incomplete or erroneous, and cooperate with Company to correct erroneous encounter data to ensure Company's compliance with Medicare laws, rules and regulations and CMS instructions.

M. **Certification of Data.** Provider recognizes that as a Medicare Advantage organization, Company is required to certify the accuracy, completeness and truthfulness of data that CMS requests. Such data include encounter data, payment data, and any other information provided to Company by its contracted providers and Downstream Entities. To the extent that Provider generates and/or compiles and provides to Company (either on its own or through its Downstream Entities) any data that Company, in turn, submits to CMS, Provider certifies, to the best of its knowledge and belief, that such data is accurate, complete and truthful. Upon request, Provider shall make such certification in the form and manner prescribed by Company.

N. **Medicare Member Complaints.** Provider agrees to cooperate with Company in resolving any Medicare Member complaints related to coverage for the provision of Covered Services. Company will notify Provider as necessary concerning all Medicare Member complaints involving Provider. Provider shall, in accordance with the Provider's regular procedures, investigate such complaints and respond to Company in the required time. Provider shall use best efforts to resolve complaints in a fair and equitable manner.

O. **Enrollment as Medicare Provider.** To the extent that Provider prescribes drugs covered under Medicare Part D to Medicare Members who have Medicare prescription drug ("MA-PD") coverage offered by Company, Provider agrees to comply with the requirements set forth in 42 C.F.R. § 423.120(c)(6), including, but not limited to, the requirement that Provider be enrolled in Medicare in an approved status in order for its prescriptions to be covered under Medicare Part D.

P. **Home Infusion Drugs.** The following provisions shall only apply to Provider if Provider dispenses to a Medicare Member home infusion drugs that are covered under Medicare Part D and the Medicare Member has MA-PD coverage offered by Company ("Home Infusion Drug"):

(1) With respect to Home Infusion Drugs, Company will pay clean claims (as defined in 42 C.F.R. § 423.520(b)) submitted by Provider on behalf of Medicare Members within 14 days for electronic claims and within 30 days for claims submitted otherwise. 42 C.F.R. § 423.505(i)(3)(vi).

(2) Home Infusion Drugs will be reimbursed (as applicable) in accordance with a fee schedule, or the third-party pricing source (e.g., Medi-Span) otherwise agreed upon as set forth in this Agreement or Provider's agreement with Company's Pharmacy Benefit Manager ("PBM"). 42 C.F.R. § 423.505(i)(3)(viii)(B).

(3) If a prescription drug pricing standard is used for reimbursement of Home Infusion Drugs, updates to such a standard will occur not less frequently than once every 7 days beginning with an initial update on January 1 of each year, to accurately reflect the market price of acquiring the Home Infusion Drug. 42 CFR § 423.505(i)(3)(viii)(A).

(4) In accordance 42 C.F.R.§ 423.120(c)(3), Provider agrees to submit claims for Home Infusion Drugs to Company or its PBM whenever the Medicare Member's ID card is presented or is on file at the Provider, unless the Medicare Member expressly requests that the claim not be submitted to Company or its PBM.

(5) Provider must submit claims for Home Infusion Drugs in real time by means of point of service claims adjudication systems in compliance with CMS standards. 42 C.F.R. § 423.505(b)(17).

(6) Provider must provide Medicare Members with access to the negotiated prices (as defined in 42 C.F.R. § 423.100) for Home Infusion Drugs to Members. 42 C.F.R. § 423.104(g)(1).

(7) Provider must charge/apply the correct cost-sharing amount to the Medicare Member for Home Infusion Drugs. 42 C.F.R. § 423.104.

(8) At the time of purchase by a Medicare Member, Provider must inform the Medicare Member of any differential between the price of the Home Infusion Drug being dispensed and the price of the lowest priced generic version of that Home Infusion Drug available from Provider, unless the Home Infusion Drug being dispensed is the lowest priced generic version of that Home Infusion Drug. 42 C.F.R. § 423.132.

(9) Provider agrees to ensure that the professional services and ancillary supplies necessary for Home Infusion Drugs are in place before dispensing Home Infusion Drugs to a Medicare Member in his/her place of residence. 42 C.F.R. § 423.120(a)(4)(iii).

(10) Provider agrees to provide delivery of Home Infusion Drugs within 24 hours of a Medicare Member's discharge from an acute setting, or later if so prescribed. 42 C.F.R. § 423.120(a)(4)(iv).

(11) Provider shall submit to Company (not PBM) claims for equipment, supplies, and professional services associated with Home Infusion Drugs dispensed by Provider to a Medicare Member that are covered under Medicare Part C.

Q. **Marketing.** Consistent with Federal laws, regulations, and agency requirements applicable to the Medicare Advantage program, Provider shall not: (1) engage in any marketing or sales activities that could mislead or confuse Medicare beneficiaries, or (2) market or advertise non-health care related products to Medicare Members or prospective Medicare Members. Further, Provider shall at all times comply with the then current Medicare Marketing Guidelines.

R. **Non-Covered Services.** Provider shall not hold a Medicare Advantage Member financially responsible for payment of a service not covered under the Member's Plan ("Non-covered Service") unless the Medicare Member has received a pre-service organization determination notice of denial from Company before such services are rendered. Provider acknowledges and agrees that if Provider renders Non-covered Services to a Medicare Member who has not received a pre-service organization determination notice of denial from

Company, the Provider must hold the Medicare Member harmless for the Non-covered Services and cannot charge the Medicare Member any amount beyond the normal cost-sharing amounts (i.e., copayments, coinsurance, and/or deductibles). With respect to those Non-covered Services that are clearly listed as exclusions in the Medicare Member's Evidence of Coverage or other similar Plan document, a pre-service organization determination is not required in order for Provider to hold the Medicare Member financially liable for such Non-covered Services.

6. COMPANY OBLIGATIONS.

A. Fee Schedule. Company shall arrange for Provider to be compensated for health care services rendered to Medicare Members in accordance with Section 2 of this Addendum.

B. Prompt Pay. In accordance with 42 C.F.R. § 422.520(b)(1), Company shall make best efforts to pay clean claims submitted by Provider for Covered Services provided to Medicare Members within thirty (30) calendar days of receipt. For purposes of this Addendum, the term "clean claim" shall have the meaning assigned in 42 C.F.R. §422.500.

7. GENERAL PROVISIONS

A. Termination. This Addendum may be terminated on its own without respect to the remainder of the Agreement with or without cause by either Party in accordance with the termination provisions of the underlying Agreement. This Addendum shall terminate automatically in the event that the underlying Agreement is terminated in accordance with the termination provisions of the Agreement.

B. Governing Law. This Addendum shall be governed by Federal laws, regulations, and agency requirements applicable to the Medicare Advantage Program. In the event that changes to the governing laws, regulations, or agency requirements applicable to the Medicare Advantage Program occur, the new law, regulation or agency requirement shall supersede to the extent required by any such later required changes.

C. All other terms and provisions of the Agreement not amended hereby shall remain in full force and effect, without modification. In the event of any inconsistency between the terms of this Addendum and the Agreement, the terms of this Addendum shall govern and control.

D. Survival. All provisions of this Addendum which by their nature should survive termination of Provider's provision of Medicare Services under this Agreement or termination of the Agreement as a whole, shall survive termination.

Schedule 1

Medicare Required Provisions

CMS requires that specific terms and conditions be incorporated into the Agreement between a Medicare Advantage Organization or First Tier Entity and a First Tier Entity or Downstream Entity to comply with the Medicare laws, regulations, and CMS instructions, including, but not limited to, the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 ("MMA"); and

Except as provided herein, all other provisions of the Agreement between Company and Provider (referred to in this Schedule 1 as "FDR") not inconsistent herein shall remain in full force and effect. This Addendum shall supersede and replace any inconsistent provisions to such Agreement; to ensure compliance with required CMS provisions, and shall continue concurrently with the term of such Agreement.

NOW, THEREFORE, the parties agree as follows:

A. Definitions:

1. Centers for Medicare and Medicaid Services ("CMS"): the agency within the Department of Health and Human Services that administers the Medicare program.

2. Completion of Audit: completion of audit by the Department of Health and Human Services, the Government Accountability Office, or their designees of a Medicare Advantage Organization, Medicare Advantage Organization contractor or related entity.

3. Downstream Entity: any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit, below the level of the arrangement between an MA organization (or applicant) and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

4. Final Contract Period: the final term of the contract between CMS and the Medicare Advantage Organization.

5. First Tier Entity: any party that enters into a written arrangement, acceptable to CMS, with an MA organization or applicant to provide administrative services or health care services for a Medicare eligible individual under the MA program.

6. Medicare Advantage ("MA"): an alternative to the traditional Medicare program in which private plans run by health insurance companies provide health care benefits that eligible beneficiaries would otherwise receive directly from the Medicare program.

7. Medicare Advantage Organization ("MA organization"): a public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the MA contract requirements.

8. Member or Enrollee: a Medicare Advantage eligible individual who has enrolled in or elected coverage through a Medicare Advantage Organization.

9. Provider: (1) any individual who is engaged in the delivery of health care services in a State and is licensed or certified by the State to engage in that activity in the State; and (2) any entity that is engaged in the delivery of health care services in a State and is licensed or certified to deliver those services if such licensing or certification is required by State law or regulation.

10. Related entity: any entity that is related to the MA organization by common ownership or control and (1) performs some of the MA organization's management functions under contract or delegation; (2) furnishes services to Medicare enrollees under an oral or written agreement; or (3) leases real property or sells materials to the MA organization at a cost of more than $2,500 during a contract period.

B. Required Provisions:

FDR agrees to the following:

1. HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any pertinent information for any particular contract period, including, but not limited to, any books, contracts, computer or other electronic systems (including medical records and documentation of the first tier, downstream, and entities related to CMS' contract with Company's Affiliates included in this Agreement, (hereinafter, "MA organization") through 10 years from the final date of the final contract period of the contract entered into between CMS and the MA organization or from the date of completion of any audit, whichever is later. [42 C.F.R. §§ 422.504(i)(2)(i) and (ii)] and [42 CFR §423.505]

2. HHS, the Comptroller General, or their designees have the right to audit, evaluate, collect, and inspect any records under paragraph 1 of this amendment directly from any First Tier Entity, Downstream Entity, or Related Entity. For records subject to review under paragraph 1, except in exceptional circumstances, CMS will provide notification to the MA organization that a direct request for information has been initiated. [42 C.F.R. §§ 422.504(i)(2)(ii) and (iii)]

3. FDR will comply with the confidentiality and enrollee record accuracy requirements, including: (1) abiding by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information, (2) ensuring that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas, (3) maintaining the records and information in an accurate and timely manner, and (4) ensuring timely access by enrollees to the records and information that pertain to them. [42 C.F.R. §§ 422.504(a)(13) and 422.118] and [42 CFR §423.136]

4. Enrollees will not be held liable for payment of any fees that are the legal obligation of the MA organization. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)] and [42 CFR §423.505(i)(3)(i)]

5. For all enrollees eligible for both Medicare and Medicaid, enrollees will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Providers will be informed of Medicare and Medicaid benefits and rules for enrollees eligible for Medicare and Medicaid. FDR may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under title XIX if the individual were not enrolled in such a plan. Providers will: (1) accept the MA plan payment as payment in full, or (2) bill the appropriate State source. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]

6. Any services or other activity performed in accordance with a contract or written agreement by FDR are consistent and comply with the MA organization's contractual obligations. [42 C.F.R. § 422.504(i)(3)(iii)] and [42 CFR §423.505(i)(3)(iii)]

7. Contracts or other written agreements between the MA organization and providers or between first tier and downstream entities must contain a prompt payment provision, the terms of which are developed and agreed to by the contracting parties. The MA organization is obligated to pay contracted providers under the terms of the contract between the MA Organization/Physician and the provider. [42 C.F.R. §§ 422.520(b)(1) and (2)]

See Section 6.b of the Addendum to which this Schedule 1 is attached.

8. FDR and any related entity, contractor or subcontractor will comply with all applicable Federal and Medicare laws, regulations, and CMS instructions. [42 C.F.R. §§ 422.504(i)(4)(v)] and [42 CFR §423.505(i)(4)(iv)]

9. If any of the MA organization's activities or responsibilities under its contract with CMS are delegated to any first tier, downstream and related entity:

   (i) The delegated activities and reporting responsibilities are specified as follows:

   None delegated.

[42 C.F.R. §§ 422.504(i)(4) and (5)]

In the event of a conflict between the terms and conditions above and the terms of a related agreement, the terms above control.

Service and Pay to (Remittance) Location Form

Listed below is each participating provider* with the corresponding physical service location, pay to (remittance) address and telephone numbers:

***Upon written notice from Provider, Company may agree to add new or relocating facilities, locations or providers to existing Agreement upon completion of applicable credentialing and satisfaction of all other requirements of Company. Other demographic information may be revised upon written notice from Provider.**

Provider Name: Hidalgo County Health and Human Services Department

Service Location Name		**Pay to (Remittance) Name**	
Pulmonary Clinic		Electronic Pay to (Remittance) Name *(as it appears on the submission)*	
Street	1304 S. 25th Ave	Address	1304 S. 25th Ave
Suite #		Suite #	
City	Edinburg	City	Edinburg
State, Zip	Texas, 78542	State, Zip	Texas, 78542
Phone #	956-387-0118	Phone #	956-383-6221
Fax #	956-318-2870	Fax #	956-318-2421
Email Address		Email Address	
Tax ID #	746000717	NPI: 1932146636	NPI Type: 2

Company Use Only: **PIN # 5185799** **PVN #** _____

Service Location Name		**Pay to (Remittance) Name**	
Edinburg Clinic		Electronic Pay to (Remittance) Name *(as it appears on the submission)*	
Street	3105 E. Richardson	Address	1304 S. 25th Ave
Suite #		Suite #	
City	Edinburg	City	Edinburg
State, Zip	Texas, 78539	State, Zip	Texas, 78542
Phone #	956-318-2040	Phone #	956-383-6221
Fax #	956-316-3491	Fax #	956-318-2421
Email Address		Email Address	
Tax ID #	746000717	NPI: 1932146636	NPI Type: 2

Company Use Only: **PIN #** _____ **PVN #** _____

Service and Pay to (Remittance) Location Form

Listed below is each participating provider* with the corresponding physical service location, pay to (remittance) address and telephone numbers:

***Upon written notice from Provider, Company may agree to add new or relocating facilities, locations or providers to existing Agreement upon completion of applicable credentialing and satisfaction of all other requirements of Company. Other demographic information may be revised upon written notice from Provider.**

Provider Name: Hidalgo County Health and Human Services Department

Service Location Name		**Pay to (Remittance) Name**	
Elsa Clinic		Electronic Pay to (Remittance) Name *(as it appears on the submission)*	
Street	708 Edinburg St.	Address	1304 S. 25th Ave
Suite #		Suite #	
City	Elsa	City	Edinburg
State, Zip	Texas, 78543	State, Zip	Texas, 78542
Phone #	956-262-1141	Phone #	956-383-6221
Fax #	956-262-7842	Fax #	956-318-2421
Email Address		Email Address	
Tax ID #	746000717	NPI: 1932146636	NPI Type: 2

Company Use Only: **PIN #** _____ **PVN #** _____

Service Location Name		**Pay to (Remittance) Name**	
Hidalgo Clinic		Electronic Pay to (Remittance) Name *(as it appears on the submission)*	
Street	702 E. Texano	Address	1304 S. 25th Ave
Suite #		Suite #	
City	Hidalgo	City	Edinburg
State, Zip	Texas, 78557	State, Zip	Texas, 78542
Phone #	956-843-7463	Phone #	956-383-6221
Fax #	956-843-6672	Fax #	956-318-2421
Email Address		Email Address	
Tax ID #	746000717	NPI: 1932146636	NPI Type: 2

Company Use Only: **PIN #** _____ **PVN #** _____

Service and Pay to (Remittance) Location Form

Listed below is each participating provider* with the corresponding physical service location, pay to (remittance) address and telephone numbers:

***Upon written notice from Provider, Company may agree to add new or relocating facilities, locations or providers to existing Agreement upon completion of applicable credentialing and satisfaction of all other requirements of Company. Other demographic information may be revised upon written notice from Provider.**

Provider Name: Hidalgo County Health and Human Services Department

Service Location Name		**Pay to (Remittance) Name**	
Mission Clinic		Electronic Pay to (Remittance) Name *(as it appears on the submission)*	
Street	211 N. Schuerbach Rd	Address	1304 S. 25th Ave
Suite #	1	Suite #	
City	Mission	City	Edinburg
State, Zip	Texas, 78572	State, Zip	Texas, 78542
Phone #	956-585-2461	Phone #	956-383-6221
Fax #	956-581-7144	Fax #	956-318-2421
Email Address		Email Address	
Tax ID #	746000717	NPI: 1932146636	NPI Type: 2

Company Use Only: **PIN #** _____ **PVN #** _____

Service Location Name		**Pay to (Remittance) Name**	
Pharr Clinic		Electronic Pay to (Remittance) Name *(as it appears on the submission)*	
Street	300 W. Hall Acres	Address	1304 S. 25th Ave
Suite #	B	Suite #	
City	Pharr	City	Edinburg
State, Zip	Texas, 78577	State, Zip	Texas, 78542
Phone #	956-787-1531	Phone #	956-383-6221
Fax #	956-783-6310	Fax #	956-318-2421
Email Address		Email Address	
Tax ID #	746000717	NPI: 1932146636	NPI Type: 2

Company Use Only: **PIN #** _____ **PVN #** _____

Service and Pay to (Remittance) Location Form

Listed below is each participating provider* with the corresponding physical service location, pay to (remittance) address and telephone numbers:

***Upon written notice from Provider, Company may agree to add new or relocating facilities, locations or providers to existing Agreement upon completion of applicable credentialing and satisfaction of all other requirements of Company. Other demographic information may be revised upon written notice from Provider.**

Provider Name: Hidalgo County Health and Human Services Department

Service Location Name		**Pay to (Remittance) Name**	
McAllen Clinic		Electronic Pay to (Remittance) Name *(as it appears on the submission)*	
Street	300 E. Hackberry	Address	1304 S. 25th Ave
Suite #		Suite #	
City	McAllen	City	Edinburg
State, Zip	Texas, 78501	State, Zip	Texas, 78542
Phone #	956-682-6155	Phone #	956-383-6221
Fax #	956-618-5979	Fax #	956-318-2421
Email Address		Email Address	
Tax ID #	746000717	NPI: 1932146636	NPI Type: 2

Company Use Only: **PIN #** _____ **PVN #** _____

Service Location Name		**Pay to (Remittance) Name**	
Weslaco Clinic		Electronic Pay to (Remittance) Name *(as it appears on the submission)*	
Street	1901 N. Bridge Ave	Address	1304 S. 25th Ave
Suite #		Suite #	
City	Weslaco	City	Edinburg
State, Zip	Texas, 78596	State, Zip	Texas, 78542
Phone #	956-968-7542	Phone #	956-383-6221
Fax #	956-968-0085	Fax #	956-318-2421
Email Address		Email Address	
Tax ID #	746000717	NPI: 1932146636	NPI Type: 2

Company Use Only: **PIN #** _____ **PVN #** _____

MULTI-SPECIALTY PHYSICIAN
SERVICES AND RATE SCHEDULE

RATE:

Payment Details:

For Gatekeeper and Non-Gatekeeper products:

Service	Billing Codes	Rates
All Services not otherwise identified		100% of Aetna Market Fee Schedule

For Government Programs products:

Service	Billing Codes	Rates
All Services not otherwise identified		100% of Aetna Medicare Market Fee Schedule Rest of Texas

Government Programs does not include Medicaid Programs or Children's Health Insurance Programs.

SERVICES:

Specialist will provide services that are within the scope of and appropriate to the Specialist's license and certification to practice. Moreover, Specialist agrees, with respect to all chronic biotherapies administered in Specialist's office to Members, to order the necessary specialty medications from a Participating specialty pharmacy provider. With respect to Members diagnosed with either Crohn's Disease or Immunodeficiency Syndrome or Infused Medications for Psoriasis and needing specialty medications for their conditions, Specialist shall in accordance with a Member's plan and unless prohibited by law, coordinate with Member's Participating specialty pharmacy provider to transition the drug and service authorization, drug distribution, clinical oversight and billing management of the specialty medications treating these conditions to the participating specialty pharmacy.

RATE TERMS AND CONDITIONS:

Definitions

"**Aetna Market Fee Schedule**" (AMFS) – A fee schedule that is based upon the contracted location where services are performed. Company may periodically update this fee schedule.

"Aetna Medicare Market Fee Schedule Rest of Texas" - A fee schedule created and maintained by Company for use in reimbursing covered services to Members under Company's Medicare Plans. The fee schedule includes rates as determined by the Centers for Medicare and Medicaid Services (CMS) using the Resource Based Relative Value Scale (RBRVS), the Clinical Laboratory Fee Schedule (CLAB), the Durable Medical Equipment, Prosthetics, Orthotics and Supplies Fee Schedule including PEN (DMEPOS), Anesthesia, and Average Sales price including immunizations (ASP). The rates contained in this schedule are set at varying percentages of Medicare's (CMS) amounts including but not limited to OPPS rates as published in the first quarter annually for the applicable CMS locality. Except for the categories listed above (i.e. CLAB, DMEPOS, Anesthesia and ASP), the schedule does not provide fees for any codes for which RBRVS does not provide relative values. ASP rates for immunizations and drugs are updated quarterly. Company plans to update the schedule within 60 days of the final rates and/or codes being published by CMS. Until updates are complete, the procedure will be paid according to the standards,

reimbursement and coding set for the prior period. Claims will be processed in accordance with Company guidelines.

"Gatekeeper products" – For purposes of this Service and Rate Schedule, Gatekeeper products refer to Commercial Health Products offered, administered and/or serviced by Company which encourage or promote the use of a Primary Care Physician, regardless of whether (i) selection of a Primary Care Physician is mandatory or voluntary under the terms of the Plan; or (ii) an individual Member has selected a Primary Care Physician. Examples of Gated Commercial Health Products include, but are not limited to: HMO, QPOS, Elect Choice, Managed Choice POS, Aetna Choice POS II, Aetna Select, Open Access Student MC. In some circumstances, certain Commercial Health Products (e.g., FEHB plans) may be available on both a "Gatekeeper" and "Non-Gatekeeper" basis.

"Non-Gatekeeper products" – For purposes of this Service and Rate Schedule, Non-Gatekeeper products refer to Commercial Health Products offered, administered and/or serviced by Company which do not allow for the designation and/or use of a Primary Care Physician in the administration of the product. Examples of Non-Gated Commercial Health Products include, but are not limited to: PPO, Passport to Healthcare® and National Advantage. In some circumstances, certain Commercial Health Products (e.g., FEHB plans) may be available on both a "Gatekeeper" and "Non-Gatekeeper" basis.

"Service Groupings" – A grouping of codes (e.g., HCPCS, CPT4, ICD-9 (ICD-10 or successor standard)) that are considered similar services and are contracted at one rate under the Services and Rate Schedule.

General

a) Rates are inclusive of any applicable Member Copayment, Coinsurance, Deductible and any applicable tax including but not limited to sales tax. For procedures and/or services not specifically listed above, Provider agrees to accept then current AMFS as payment in full. Company will pay the lesser of the contracted rate or eligible billed charges.

b) Unless required by law, payment for services of Mid-level Practitioners (Nurse Practitioners, Certified Nurse Midwives, Physician Assistants and Registered Nurses) may be less than Physician services based on Company's then current payment policy.

c) Payment for services of Clinical Psychologists, Psychiatric Nurses and any other Licensed Master Level Practitioner (Clinical Social Workers, Licensed Professional Counselors, Marriage/Family Therapists, Psychological Examiner, Drug and Alcohol Counselor, Pastoral Counselor) may be less than Company's then current payment methodology for Behavioral Health physician services.

d) Except where prohibited by applicable law and notwithstanding Section 6.3 of the Agreement, Company may, at its sole discretion, upon thirty (30) days prior written notice to Provider, reduce the rates for Covered Services by twenty percent (20%) should Provider fail to refer Members to Participating Providers in the absence of either: 1) sound clinical reasons; 2) advance approval of Company; 3) the existence of an Emergency Services or exigent circumstances; or 4) if applicable, the Member's request for referral to an out of network provider after notice and informed consent of the patient has been documented, in writing, as set forth in referral section of the Agreement. If Company imposes a reduction to the rates, Provider may request, no more than once every six (6) months, for Company to re-evaluate Provider's use of Participating Providers. If Company determines that Provider has consistently referred Members to Participating Providers for all Covered Services for the preceding six (6) month period, Company will eliminate the reduction within sixty (60) days after Company's determination.

e) Unless prohibited by applicable law, Company may, at its sole discretion, upon thirty (30) days prior written notice to Provider reduce the rates for Covered Services by ten percent (10%) for a three (3) month period

should Provider fail to provide timely notice of change in Provider information to Company as required and set forth in the Agreement, e.g., changes in notice address, location, staff and demographics.

Billing

f) Specialist must designate the codes set forth in this Rate Schedule when billing.

g) The Parties acknowledge and agree that payments under the Medicare program to providers, suppliers, and Medicare Advantage organizations may be adjusted as the result of legislation, regulation, executive order or other federal mandate ("Medicare Payment Adjustment"). Furthermore, any such Medicare Payment Adjustment could result in an increase or decrease in Medicare payments. In accordance with the terms of this Agreement, the Parties agree that, in the event of a Medicare Payment Adjustment, Company's payment to Provider will be adjusted in accordance with the Medicare Payment Adjustment. Company shall adjust payments under this Agreement for Covered Services rendered by Provider on and after the effective date of the Medicare Payment Adjustment, and shall continue to adjustment payments to Provider for until the earlier of (i) the Medicare Payment Adjustment is discontinued or (ii) is replaced by a subsequent Medicare Payment Adjustment.

Coding

h) Company utilizes nationally recognized coding structures including, but not limited to, Revenue Codes as described by the Uniform Billing Code, AMA Current Procedural Terminology (CPT4), CMS Common Procedure Coding System (HCPCS), Diagnosis Related Groups (DRG), ICD-9 (ICD-10 or successor standard) Diagnosis and Procedure codes, National Drug Codes (NDC) and the American Society of Anesthesiologists (ASA) relative values for the basic coding, and description for the services provided. As changes are made to nationally recognized codes, Company will update internal systems to accommodate new and/or changes to existing codes. Such updates may include assignment and/or reassignment to Service Groupings for new and/or existing codes. Such changes will only be made when there is no material change in the procedure itself. Until updates are complete, the procedure will be paid according to the standards and coding set for the prior period. Unless otherwise specified, the reimbursement for new, replacement, reassigned, or modified code(s) will be paid on the same basis or at a comparable rate as set forth within this Schedule.

Company will comply and utilize nationally recognized coding structures as directed under applicable Federal laws and regulations, including, without limitation, the Health Insurance Portability and Accountability Act (HIPAA).

PROVIDER
SERVICES AND RATE SCHEDULE

RATE:

Payment Details:

For Gatekeeper and Non-Gatekeeper products:

Service	Billing Codes	Rates
All Services not otherwise identified		85% of Aetna Market Fee Schedule

For Government Programs products:

Service	Billing Codes	Rates
All Services not otherwise identified		85% of Aetna Medicare Market Fee Schedule Rest of Texas

Government Programs does not include Medicaid Programs or Children's Health Insurance Programs.

SERVICES:

Provider will provide services that are within the scope of and appropriate to the Provider's license and certification to practice.

RATE TERMS AND CONDITIONS:

Definitions

"**Aetna Market Fee Schedule**" (AMFS) – A fee schedule that is based upon the contracted location where services are performed. Company may periodically update this fee schedule.

"Aetna Medicare Market Fee Schedule Rest of Texas" - A fee schedule created and maintained by Company for use in reimbursing covered services to Members under Company's Medicare Plans. The fee schedule includes rates as determined by the Centers for Medicare and Medicaid Services (CMS) using the Resource Based Relative Value Scale (RBRVS), the Clinical Laboratory Fee Schedule (CLAB), the Durable Medical Equipment, Prosthetics, Orthotics and Supplies Fee Schedule including PEN (DMEPOS), Anesthesia, and Average Sales price including immunizations (ASP). The rates contained in this schedule are set at varying percentages of Medicare's (CMS) amounts including but not limited to OPPS rates as published in the first quarter annually for the applicable CMS locality. Except for the categories listed above (i.e. CLAB, DMEPOS, Anesthesia and ASP), the schedule does not provide fees for any codes for which RBRVS does not provide relative values. ASP rates for immunizations and drugs are updated quarterly. Company plans to update the schedule within 60 days of the final rates and/or codes being published by CMS. Until updates are complete, the procedure will be paid according to the standards, reimbursement and coding set for the prior period. Claims will be processed in accordance with Company guidelines.

"Gatekeeper products" – For purposes of this Service and Rate Schedule, Gatekeeper products refer to Commercial Health Products offered, administered and/or serviced by Company which encourage or promote the

use of a Primary Care Physician, regardless of whether (i) selection of a Primary Care Physician is mandatory or voluntary under the terms of the Plan; or (ii) an individual Member has selected a Primary Care Physician. Examples of Gated Commercial Health Products include, but are not limited to: HMO, QPOS, Elect Choice, Managed Choice POS, Aetna Choice POS II, Aetna Select, Open Access Student MC. In some circumstances, certain Commercial Health Products (e.g., FEHB plans) may be available on both a "Gatekeeper" and "Non-Gatekeeper" basis.

"Non-Gatekeeper products" – For purposes of this Service and Rate Schedule, Non-Gatekeeper products refer to Commercial Health Products offered, administered and/or serviced by Company which do not allow for the designation and/or use of a Primary Care Physician in the administration of the product. Examples of Non-Gated Commercial Health Products include, but are not limited to: PPO, Passport to Healthcare® and National Advantage. In some circumstances, certain Commercial Health Products (e.g., FEHB plans) may be available on both a "Gatekeeper" and "Non-Gatekeeper" basis.

"Service Groupings" – A grouping of codes (e.g., HCPCS, CPT4, ICD-9 (ICD-10 or successor standard)) that are considered similar services and are contracted at one rate under the Services and Rate Schedule.

General

a) Rates are inclusive of any applicable Member Copayment, Coinsurance, Deductible and any applicable tax including but not limited to sales tax. For procedures and/or services not specifically listed above, Provider agrees to accept then current AMFS as payment in full. Company will pay the lesser of the contracted rate or eligible billed charges.

b) Unless required by law, payment for services of Mid-level Practitioners (Nurse Practitioners, Certified Nurse Midwives, Physician Assistants and Registered Nurses) may be less than Physician services based on Company's then current payment policy.

c) Payment for services of Clinical Psychologists, Psychiatric Nurses and any other Licensed Master Level Practitioner (Clinical Social Workers, Licensed Professional Counselors, Marriage/Family Therapists, Psychological Examiner, Drug and Alcohol Counselor, Pastoral Counselor) may be less than Company's then current payment methodology for Behavioral Health physician services.

d) Unless prohibited by applicable law, Company may, at its sole discretion, upon thirty (30) days prior written notice to Provider reduce the rates for Covered Service by ten percent (10%) for three (3) month period should Provider fail to provide timely notice of change in Provider information to Company as required and set forth in the Agreement, e.g., changes in notice address, location, staff and demographics.

Billing

e) Provider must designate the codes set forth in this Rate Schedule when billing.

f) The Parties acknowledge and agree that payments under the Medicare program to providers, suppliers, and Medicare Advantage organizations may be adjusted as the result of legislation, regulation, executive order or other federal mandate ("Medicare Payment Adjustment"). Furthermore, any such Medicare Payment Adjustment could result in an increase or decrease in Medicare payments. In accordance with the terms of this Agreement, the Parties agree that, in the event of a Medicare Payment Adjustment, Company's payment to Provider will be adjusted in accordance with the Medicare Payment Adjustment. Company shall adjust payments under this Agreement for Covered Services rendered by Provider on and after the effective date of the Medicare Payment Adjustment, and shall continue to adjustment payments to Provider for until the earlier of (i) the Medicare Payment Adjustment is discontinued or (ii) is replaced by a subsequent Medicare Payment Adjustment.

Coding

g) Company utilizes nationally recognized coding structures including, but not limited to, Revenue Codes as described by the Uniform Billing Code, AMA Current Procedural Terminology (CPT4), CMS Common Procedure Coding System (HCPCS), Diagnosis Related Groups (DRG), ICD-9 (ICD-10 or successor standard) Diagnosis and Procedure codes, National Drug Codes (NDC) and the American Society of Anesthesiologists (ASA) relative values for the basic coding, and description for the services provided. As changes are made to nationally recognized codes, Company will update internal systems to accommodate new and/or changes to existing codes. Such updates may include assignment and/or reassignment to Service Groupings for new and/or existing codes. Such changes will only be made when there is no material change in the procedure itself. Until updates are complete, the procedure will be paid according to the standards and coding set for the prior period. Unless otherwise specified, the reimbursement for new, replacement, reassigned, or modified code(s) will be paid on the same basis or at a comparable rate as set forth within this Schedule.

Company will comply and utilize nationally recognized coding structures as directed under applicable Federal laws and regulations, including, without limitation, the Health Insurance Portability and Accountability Act (HIPAA).

Hidalgo County Health & Human Services Dept.

Memo

To: Monica Badillo, Commissioner's Court Coordinator

From: Mike Escaname, CFO

CC: Eddie Olivarez, Chief Administrative Officer

Date: July 6, 2017

Re: **AI-59774 / AETNA Provider Agreement**

Hello Monica,

I'd appreciate if you can arrange to have the Provider Agreement from AETNA attested by The Honorable Arturo Guajardo.

Judge Garcia has already signed this document electronically; so, no need to send it to him.

We received the electronically signed copy from AETNA this week.

Let Mr. Olivarez or me know if you have any questions.

Thank you.

APPROVED BY
COMMISSIONERS' COURT
ON: 5-16-17 MB

AI-59774 **Purchasing Department 20. G. 2.**

CC - REGULAR

Meeting Date: 05/16/2017

Submitted For: Marty Salazar, PURCHASING DEPT.

Submitted By: Marty Salazar, PURCHASING DEPT.

Department: PURCHASING DEPT.

Information

CAPTION

Request by Hidalgo County Health & Human Services Dept. to complete a Provider Agreement /Product Participation and Signature Sheet with acceptance and approval by Commissioners Court with authority to have the document executed and subject to legal review and no obligation of compliance with form 1295.

BACKGROUND

Fiscal Impact

CALENDAR YEAR: **ACCT. #:**

FUNDS AVAILABLE Y/N?: **MATCHING FUNDS Y/N?:**

BUDGETARY IMPACT:

The fiscal impact of this Agreement is to have HCDHHS to get reimbursements on administering vaccines to eligible County participants.

Attachments

Agreement

email-Aetna

legal approval

Form Review

Inbox	Reviewed By	Date
Purchasing - Internal	Marty Salazar	05/12/2017 02:56 PM
Budget & Management	Veronica Ortiz	05/12/2017 02:59 PM
Ivan Cantu	Ivan Cantu	05/12/2017 04:44 PM
Final Approval	Monica Badillo	05/12/2017 05:46 PM
Form Started By: Marty Salazar		Started On: 05/09/2017 05:17 PM
Final Approval Date: 05/12/2017		

email request frm Pct 4-WA2-L&G
legals approval-Appraisal Haus
WA2-L&G Engineering-(Geo Tech Svcs)-Milo Ponce Park-Pct 4

F. Public Defenders

1. **AI-59578** a. Requesting exemption from competitive procurement requirements under the Texas Local Government Code, Section 262.024(a)(7)(a) proprietary software;

On motion by COMMISSIONER PCT. 1, DAVID FUENTES, seconded by COMMISSIONER PCT. 2, EDUARDO "EDDIE" CANTU, the Court made a UNANIMOUS vote of approval.

Vote: 3 - 0 – Unanimously

b. Requesting approval of agreement for "On-line Research Services" with Lexis Nexis for the Public Defenders and subject to form 1295.

On motion by COMMISSIONER PCT. 1, DAVID FUENTES, seconded by COMMISSIONER PCT. 2, EDUARDO "EDDIE" CANTU, the Court made a UNANIMOUS vote of approval.

Vote: 3 - 0 – Unanimously
Attachments:
Form 1295
Agreement
Legal Approval

G. Health & Human Services Dept.

1. **AI-59691** Approval of "First Amendment" to Service Contract E-16-392-11-01 between Hidalgo County Health & Human Services Department and Network Sciences, Inc., for the provision of Software Services for Indigent Health Care System [as permitted under the terms of the contract] with compliance with HB 1295 when and if applicable.

On motion by COMMISSIONER PCT. 1, DAVID FUENTES, seconded by COMMISSIONER PCT. 2, EDUARDO "EDDIE" CANTU, the Court made a UNANIMOUS vote of approval.

Vote: 3 - 0 – Unanimously
Attachments:
DA-Review of Amendment
1295
Amendment-Network Sciences
E-16-392-Network Sciences

2. **AI-59774** Request by Hidalgo County Health & Human Services Dept. to complete a Provider Agreement /Product Participation and Signature Sheet with acceptance and approval by Commissioners Court with authority to have the document executed and subject to legal review and no obligation of compliance with form 1295.

Commissioner David Fuentes abstain from voting on this item.

Commissioner Palacios joined the meeting.

On motion by COMMISSIONER PCT. 2, EDUARDO "EDDIE" CANTU, seconded by COMMISSIONER PCT. 4, JOSEPH PALACIOS, the Court made a UNANIMOUS vote of approval.

Vote: 3 - 0 -Unanimously
Attachments: