# TEACO
## PROVIDER NETWORK

_____

**PRIMARY CARE PROVIDER AGREEMENT**

**○ Individual Provider or ○ Provider Group**

**Contracting Entity Name: _____**

# TEACO PROVIDER NETWORK, LLC

# PRIMARY CARE PHYSICIAN AGREEMENT

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**TEACO PROVIDER NETWORK, L.L.C.**

**PRIMARY CARE PROVIDER AGREEMENT**

**THIS PROVIDER AGREEMENT** (the "Agreement") is made and entered into this first day [month/year]_____, between **TEACO Provider Network, L.L.C.**, a Texas LLC ("IPA"), and _____ ("Primary Care Provider," or "PCP") having his or her place of business at _____. IPA and Provider shall each be referred to as a "Party," and together as "the Parties".

## RECITALS

**WHEREAS**, IPA has entered or intends to enter into agreements with Health Care Services Plans, Non-Profit Hospital Services Plans, Federally Qualified Health Maintenance Organizations and other purchasers of Covered Services who are licensed to provide medical services in the State of Texas, Texas ("Plan(s)") for the provision of medical services to persons enrolled as Plan Members ("Plan Members") of Plans, and;

**WHEREAS**, PCP currently operates a medical practice at the following location(s) ("Office Site(s)"):

1. _____
2. _____
3. _____

For additional offices, please add attachment

**WHEREAS**, IPA and PCP desire to enter into a contract whereby the Provider agrees to provide Covered Services on behalf of IPA to Plan Members of Plans that contract with IPA,

## AGREEMENT

**NOW, THEREFORE**, in consideration of the mutual covenants contained herein and other good valuable consideration, the parties agree as follows:

## ARTICLE I - DEFINITIONS

The following terms shall have the following meanings for purposes of this Agreement:

1.1. “Acts and Regulations” means the Federal and Texas codes and regulations that govern the services to be provided under this Agreement, and more fully described in Article VII of this Agreement.

1.2. “Attachment(s)” means Attachments which are incorporated herein as if set forth in full.

1.3. “Authorization” means the approval by IPA for Plan Member to be hospitalized in a hospital or skilled nursing facility, to receive specialty care and covered ancillary services including durable medical equipment, home health care, care in ambulatory surgery facilities, and medical transportation services.

1.4. “Compensation” means the reimbursement paid by IPA under this Agreement for providing or arranging for the provision of Covered Medical Services to Plan Members.

1.5. “Coordination of Benefits (“COB”) and Third-Party Liability (“TPL”) means the determination of which of two or more benefit plans will apply, either as primary or secondary coverage, for the rendition of hospital, surgical or medical services to a Plan Member. Such coordination is intended to preclude the Plan Member from receiving an aggregate of more than one hundred percent (100%) of covered charges from all coverage. When the primary and secondary benefits are coordinated, determination of liability will be in accordance with the usual procedures employed by the Texas Department of Health Services (TDHS) and applicable state regulations.

1.6. “Copayment or Deductible” means those charges for professional services, which shall be collected directly by PCP from Plan Member as payment in addition to the Compensation, in accordance with the Plan Member’s Evidence of Coverage.

1.7. “Covered Health Care Services” means those Medically Necessary services and supplies set forth in Attachment A, including Covered Medical Services.

1.8. “Covered Medical Services” means those covered Health Care Services that are set forth in Attachment B, and are to be provided to Plan Members by PCP, within the scope of his/her licensure, pursuant to this Agreement.

1.9. “TDHS” means the Texas Department of Health Services.

1.10. “Emergency Services” means those Covered Health Care Services, provided inside or outside the Service Area, which are required on an immediate basis for an illness or injury in order to prevent loss of life, permanent impairment of bodily function, or other severe medical consequences in the judgment of IPA.

1.11. “Evidence of Coverage" means the document issued by a Plan to a Plan Member that describes the Plan Member’s Covered Medical Services in the Plan.

1.12. “Health Insurance Portability & Accountability Act of 1996” or “HIPAA” shall mean the regulations enacted by the Federal Government which provisions regulate (i) privacy, (ii) standard coding and, (iii) security, as they are relevant to the health care industry.

1.13. “Health Professional” means any nurse, physician extender (e.g., nurse practitioner, physician assistant) and other allied health professionals, including but not limited to health educator, laboratory technologist, audiologist, speech pathologist, psychologist, podiatrist, dentist, chiropractor, physical therapist, occupational therapist, clinical social worker, marriage, family and child counselor, optometrist or dispensing optician, who is licensed by the State of Texas and who provides certain covered Health Care Services to Plan Members through an agreement with Plan or IPA.

1.14. "IPA" or "Medical Group" means an Independent Physician Association or physician network organization established as a professional medical corporation for the primary purpose of delivering professional medical services by entering into written provider or employment agreements or other arrangements with physicians and Health Professionals, and that has entered into an arrangement with Plan to provide and make available certain Covered Medical Services and coordinate the provision of other Covered Health Care Services to Plan Members.

1.15. "Medical Director" means a Participating PCP who is authorized by IPA to be responsible for administering IPA medical affairs and for serving as IPA's medical liaison to contracting Plans.

1.16. "Medically Necessary" means those Covered Health Care Services provided by a Participating Provider that meets the following criteria:

a. Appropriate for the symptoms and diagnosis or treatment of condition, illness or injury; and
b. Provided for the diagnosis or the direct care and treatment of the condition, illness or injury; and
c. In accordance with the professional and technical standards of good medical practice required by Section III.6 herein and adopted by the Utilization Review Committee of IPA.

1.17. Network Physician" means (i) a physician who is duly licensed to practice medicine in the State of Texas; or (ii) a professional medical corporation or medical group partnership organized and in good standing under the laws of the State of Texas, which professional corporation or partnership will provide services through its physician shareholder(s), partners and/or employee(s) or independent contractors practicing in the area(s) set forth in Attachment E, and whose agreement with IPA includes responsibility for providing Covered Medical Services in his or her designated specialty.

1.18. "Network Providers" means the physician, hospitals, skilled nursing facilities, home health agencies, pharmacies, ambulance companies, laboratories, X-ray facilities, durable medical equipment suppliers and other licensed health care entities or professionals that or who provide Covered Health Care Services to Plan Members through an agreement with Plan, IPA, a PCP, a Plan Hospital, or another Network Provider.

1.19. "Non-Covered Services" means those health care services, which are not benefits under the Evidence of Coverage.

1.20. "Plan Hospital" means an institution licensed by the Texas State Department of Health Services ("TDHS") that is accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), is certified for participation under Medicare and Medicaid as an acute care hospital, and provides certain Covered Health Care Services to Plan Members through an agreement with Plan.

1.21. "Plan Member" means a person certified as eligible for coverage under the Benefits Agreement who has enrolled in the Plan.

1.22. "Primary Care Physician ("PCP") means (i) a Network Physician, chosen by or for a Plan Member, who is primarily responsible for providing initial care to the Plan Member, for maintaining the continuity of the Plan Member's care, and for providing or initiating referrals for Covered Health Care Services for the Plan Member, practicing in the area of general practice, family practice, pediatrics, internal medicine, primary care

obstetrics/gynecology, or primary care occupational medicine; or (ii) a professional medical corporation or medical group partnership organized and in good standing under the laws of the State of Texas, which professional corporation or partnership will provide services through its physician shareholder(s), partners and/or employee(s) or independent contractors.

1.23. "Protected Health Information (PHI)" or "Electronically Protected Health Information (EPHI)" shall mean any information, whether oral or recorded in any form or medium: (i) that relates to the past, present or future physical or mental condition of an individual; the provision of health care to an individual, or; the past, present or future payment for the provision of health care to an individual; and, (ii) that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual, as defined under the HIPAA regulations.

1.24. "Provider Manual" means the IPA Quality Management and Utilization Management Programs, Member Grievance Policy and Procedures, Encounter Data Reporting Requirements, and other operational and administrative Policies and Procedures as amended from time to time, provided herein as Attachment A, and which are incorporated in this Agreement by reference.

1.25. "Quality Management Program" means IPA's program as approved by Plan and directed by the IPA Medical Director: that is designed to assure the provision of quality Covered Health Care Services to Plan Members; to document that the quality of care provided is being reviewed; and to ensure that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated. The Quality Management Program is included in Attachment A.

1.26. "RBRVS" means Resource Based Relative Value Studies published by the American Medical Association.

1.27. "Referral" means the process by which the PCP directs a Plan Member to seek and obtain Covered Health Care Services from a Specialist Physician, health professional, a hospital or any other provider of Covered Health Care Services.

1.28. "Service Area" means, in general, those portions of Texas in which Plan is licensed to operate.

1.29. "Specialist Physician" means (i) a Network Physician, who is duly licensed to practice medicine in the State of Texas; or (ii) a professional medical corporation or medical group partnership organized and in good standing under the laws of the State of Texas, which professional corporation or partnership will provide services through its physician shareholder(s), partners and/or employee(s) or independent contractors practicing in the area(s), and whose agreement with IPA includes responsibility for providing Covered Medical Services in his or her designated specialty.

1.30. "Utilization Management Program" means the program approved by IPA and designed to review and manage the appropriate utilization of Covered Health Care Services provided to Plan Members. A summary of the Utilization Management Program is included in Attachment A.

## ARTICLE II - IPA COVERED SERVICES AND RESPONSIBILITIES

2.1. IPA shall perform the administrative operations, enrollment, member services, marketing, quality and utilization management, credentialing, and regulatory compliance and reporting functions appropriate and necessary for the administration of IPA and Agreement(s) with Plan(s).

2.2. IPA has entered into agreement(s) with Plan(s) pursuant to which IPA is obligated to provide or arrange for the provision of Covered Health Care Services to Plan Members through agreements with PCPs, Specialists and other ancillary providers. IPA's Agreements with PCPs, Specialists and other ancillary providers shall not terminate IPA's obligations to any Plan(s) pursuant to the Agreement(s).

2.3. IPA will notify Provider not less than thirty (30) days in advance of the effective date of any new Plan contract and will provide Provider with a summary of terms and conditions. Unless IPA receives written notice from Provider rejecting such agreement within such 30-day period, PCP shall be deemed to have accepted such Agreement or amendment. Rejection of a Plan agreement or of amendments to an existing agreement shall not terminate PCP's obligations under this Agreement with respect to Covered Health Care Services to be provided to Plan Members of other Plans under Plan agreements previously or subsequently accepted by Provider. However, rejection of more than two (2) Plan agreements in any twelve (12) month period by PCP could result, in IPA's sole discretion, in termination of this Agreement.

2.4. IPA may, upon request by Plan, assist Plan to assign Plan Member to PCP to provide and make available Covered Health Care Services to the Plan Member.

2.5. Plan shall provide identification cards or other materials for Plan Members, to enable PCP to identify Plan Members who are eligible to receive covered Medical Services from or through PCP. IPA shall verify Plan Member eligibility and the scope of Covered Medical Services the Plan Member is eligible to be provided by PCP upon request from PCP.

2.6. IPA shall compensate PCP for Covered Medical Services, in accordance with provisions of Attachment C.

2.7. IPA shall monitor the quality of health care provided to Plan Members in accordance with the Provider Services Manual and all applicable legal requirements.

2.8. IPA shall monitor and evaluate accessibility of care and address problems that develop, that shall include, but not be limited to, waiting time and appointments; and conduct at least an annual review of PCP's standards of accessibility and availability and compliance with these standards.

2.9. IPA shall notify PCP of any change to regulations that may affect the normal operations and Business Associate Agreement, as incorporated into this Agreement, of the PCP pertaining to the HIPAA regulations and enforcement and shall make any amendment to this Agreement from time-to-time subsequent to newly promulgated provisions.

## ARTICLE III - PCP RESPONSIBILITIES

3.1. PCP agrees to provide Covered Medical Services to Plan Members of each Plan contracting with IPA who have selected PCP (as defined in Section 1.22) as their PCP.

Covered Medical Services shall be performed at one of the Office Sites or at a Primary Hospital. PCP shall not render Covered Medical Services at any location other than an Office Site or Primary Hospital unless such location has been approved by IPA's Board of Directors. If there is more than one (1) Office Site and PCP ceases to operate its medical practice at one or more, but less than all, of the Office Sites, this Agreement shall continue in full force and effect with reference to the remaining Office Site(s). If there is only one (1) Office Site listed in this Agreement and PCP ceases to operate its medical practice at said Office Site, then IPA, in its sole and absolute discretion, may immediately terminate this Agreement as provided in Section XV.3.

3.2. PCP shall provide to Plan Members those PCP Covered Medical Services set forth in Attachment B and shall coordinate the provision of other Covered Health Care Services to Plan Members.

3.3. Except in an Emergency, PCP shall not refer a Plan Member to any non-PCP physician or other provider of health care services without first securing the IPA's authorization. PCP shall comply with Referral Procedures (included in the Provider Manual) in effect at the time of referral and shall not directly or indirectly engage in self-referral or any other method of referral not specifically authorized by the Referral Procedures. IPA may, in addition to any other right or remedy under this Agreement, retain from any amount owed to PCP, an amount equal to the amount of money paid by IPA to the non-participating referred physician.

3.4. PCP shall admit Plan Members only to a contracted Hospital unless an appropriate bed or service is unavailable. PCP may not admit a Plan Member to a Plan Hospital (or any hospital) on a non-emergency basis without first receiving the prior authorization of the IPA Medical Director or his/her designated agent. PCP shall devote the time, attention and energy necessary for the competent and effective performance of PCP's duties hereunder to Plan Members.

3.5. PCP shall provide Covered Medical Services to Plan Members with the standard of care customarily used in the community in which such services are rendered.

3.6. PCP shall provide or arrange the provision of Covered Medical Services to Plan Members in the same manner and in accordance with the same standards, and with the same time availability as he or she provides or arranges for provision of Covered Medical Services and other services and supplies to all of his or her other recipients of Covered Medical Services consistent with existing medical ethical/legal requirements for providing continuity of care to the patient. PCP shall not discriminate against any Plan Member on the basis of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, age or mental or physical handicap.

3.7. If PCP is for any reason, from time to time, unable to provide Covered Medical Services when and as needed, PCP may secure services of a qualified covering physician who shall render such Covered Medical Services otherwise required of PCP, provided, however, that the covering Physician so furnished must be a physician approved by IPA to provide Covered Medical Services to Plan Members. PCP shall ensure that each covering physician: (1) looks solely to IPA for compensation; (2) will accept IPA's peer review procedures; (3) will not directly bill Plan Members for Covered Medical Services under any circumstance; (4) will, prior to all elective hospitalizations or any Plan Member referrals to other health care providers, obtain authorization in accordance with the IPA's Utilization Management Program; and (5) will comply with the terms hereof.

3.8. Subject to the provisions of this Article III, PCP will determine the method, details, and means of performing Covered Medical Services pursuant to this Agreement.

3.9. PCP shall cooperate and consult with a Plan Member's Specialist Physician(s) in the PCP's monitoring, coordination and management of the Plan Member's overall health care.

3.10. PCP may, at PCP's sole cost and expense, employ such professional assistants or employees as PCP deems necessary to perform Covered Medical Services in PCP's office. IPA may not control, direct, or supervise PCP's assistants or employees in the performance of Covered Medical Services.

3.11. Nothing in this Agreement shall be construed to restrict PCP from entering into other contracts or agreements to provide health care services to other health care delivery plans, patients, or employer groups. IPA and PCP acknowledge and agree that PCP does not render professional medical services exclusively on behalf of IPA or Plans and that PCP may perform such services on behalf of himself or for another individual, group, organization, or governmental agency, subject to the following limitations:

a. PCP may provide professional medical services to persons or entities other than IPA provided that such activities do not hinder or conflict with PCP's ability to perform his or her duties and obligations under this Agreement.

b. All professional medical services rendered by PCP on behalf of himself or herself, or for another individual, group, organization, or governmental agency, shall be rendered exclusively outside the scope of this Agreement. In rendering such outside services, PCP shall neither represent nor imply in any way to the recipient thereof that such services are being rendered by or on behalf of IPA.

c. All professional medical services rendered by PCP outside the scope of this Agreement shall not be covered by IPA's policy of professional liability insurance. Furthermore, PCP shall defend, indemnify and shall further hold harmless IPA, its agents, against any and all claims, damages, losses and expenses, including costs and attorneys' fees, incurred by reason of liability imposed upon IPA for damages sustained by any person or persons because of the alleged negligence or the medical malpractice of PCP while rendering services outside the scope of this Agreement.

d. PCP shall be responsible for providing his or her own professional liability insurance coverage for any professional medical services rendered within or outside the scope of this Agreement.

3.12. PCP shall comply with IPA's credentialing and re-credentialing policies and procedures and the credentialing and re-credentialing policies and procedures of any Plan contracting with IPA.

3.13. PCP agrees to cooperate with all applicable federal, state or municipal statutes, ordinances, or regulations, all applicable rules and regulations of the Medical Board of Texas and the ethical standards of the American and Texas Medical Associations.

3.14. PCP agrees to cooperate with administrative policies and procedures which IPA may adopt (as described in the Provider Manual), and abide by claims processing, authorization, Utilization Management, Quality Management, appeal, peer review, and audit, policies and procedures of IPA, and to comply with final determinations rendered

pursuant to such policies and procedures. PCP may appeal adverse determinations in accordance with procedures established by IPA.

3.15. PCP shall ensure that each of its employed or contracted Network Physician maintains a current license to practice medicine in the State of Texas, and authorization to practice and administer controlled substances. PCP shall notify IPA promptly of any modification, suspension, or revocation of PCP's license or authorization to prescribe or to administer controlled substances. If at any time during the term of this Agreement, PCP's license (or the license of PCP's physician employee(s) or contractor(s)) to practice medicine in the State of Texas, or authorization to prescribe and administer controlled substances, is modified, suspended or revoked, this Agreement shall, at the option of IPA, terminate immediately and become null and void and of no further force or effect, except as otherwise provided herein, without regard to whether or not such suspension, condition or revocation has been finally adjudicated. PCP shall also ensure that PCP maintains appropriate privileges on the medical staff of at least one Plan Hospital. If PCP does not have staff privileges at a Plan Hospital, PCP may make arrangement with IPA for admission of Plan Member by another IPA Provider. PCP shall further notify the IPA promptly concerning any reaction, suspension, denial, impairment, revocation, termination, or non-renewal of any PCP Plan Physician's medical staff privileges at any hospital. If PCP's medical staff privileges are thus affected, IPA shall have the option to immediately terminate this Agreement, whereupon it shall become null and void and of no further force or effect, except as otherwise provided herein, without regard to whether or not such restriction, suspension, denial, impairment, revocation, termination, or non-renewal has been finally adjudicated. PCP has provided IPA a copy of the following certification and qualification for PCP and other Network Providers (including physicians and physician extenders) working in the same offices as Providers:

a. PCP's and Network Provider's effective Texas license to provide the medical services required herein;

b. PCP's and Network Provider's current certification issued by the United States Drug Enforcement Administration (DEA);

c. PCP's and Network Provider's current Board Certification or Board Eligibility certificate, where applicable;

d. PCP's and Network Provider's current malpractice insurance certificate, where applicable;

e. List of required continuing medical education completed by PCP and Network Provider during the past two (2) years; and

f. Certificate of Residency.

3.16. IPA must approve PCP's Provider Application before PCP can render services hereunder to any Plan Member. Prior to rendering such services, PCP shall require each of its Network Providers to complete the Participating Provider Application, and submit the completed Application to IPA for approval. Upon IPA's requests, PCP shall furnish IPA with additional evidence indicating that all PCP and Network Provider licenses, certificates and qualifications are then existing, valid and in full force and effect. PCP shall notify IPA in writing no less than thirty (30) days in advance of any addition or deletion of Network Providers working with PCP.

3.17. PCP shall ensure that the Network Providers employed by or under contract with PCP shall be appropriately licensed to provide health care services in the State of Texas, have met and continue to meet all applicable federal, state or municipal statutes, ordinances or regulations, and Plan standards of care and shall submit evidence of such licensure to IPA upon request.

3.18. PCP shall make available Covered Medical Services twenty-four (24) hours a day / seven (7) days a week, three hundred sixty-five (365) days a year. PCP shall provide Emergency Services when Medically Necessary and shall not be required to obtain prior authorization for emergency services from IPA. PCP shall notify IPA no later than the following business day after a Plan Member requires Emergency Services.

3.19. PCP shall appoint a Coordinator who shall assume the day to day Covered Services of PCP'S performance under this Agreement.

a. Ensure that care is provided to Plan Members by qualified personnel;

b. Ensure that care provided meets IPA standards for acceptable care;

c. Assist in implementation of medical policy; and

d. Participate in resolving medically related grievances.

3.20. PCP shall comply with drug formularies and policies regarding the prescription of generic or lowest cost alternative brand name pharmaceutical proposed by Plan and/or IPA, subject to generally accepted medical and surgical practices and standards prevailing in the professional community. If for medical reasons, PCP believes a generic equivalent should not be dispensed or a non-formulary pharmaceutical should be prescribed to Plan Member, PCP agrees to obtain prior authorization from Plan or the Medical Director of IPA or his/her agent (according to Plan Policy and Procedure).

3.21. PCP understands that contracting Plans will place certain obligations upon IPA regarding the quality of care received by Plan Members and that contracting Plans in certain instances will have the right to oversee and review the quality of care administered to Plan Members. PCP agrees to cooperate with contracting Plan Medical Directors in the Medical Director's review of the quality of care administered to Plan Members.

3.22. PCP will supply all necessary office personnel, equipment, instruments and supplies required to perform Covered Medical Services and that are usual and customary for a medical practice in PCP's specialty in the community.

3.23. During the entire term of this Agreement, PCP shall maintain his/her professional competence and skills commensurate with the medical standards of the community, and as required by the law, by attending and participating in the approved continuing education courses.

3.24. PCP agrees to ensure that each of its Network Physicians complies with the obligations of PCP hereunder including, without limitation, the obligations of Articles V, VI, VII and VIII and Section 11.3.

3.25. If PCP is a professional corporation (or medical group partnership), PCP shall obligate, in writing, each of its physician shareholder(s) of partners and/or employee(s) who is to perform services hereunder to comply with all of the obligations of PCP hereunder.

3.26. By executing this Agreement, PCP appoints IPA as PCP's attorney-in-fact, and acknowledges that PCP shall be bound by all IPA Agreements with Plans.

3.27. Unless otherwise agreed by the Governing Board of IPA, PCP agrees to coordinate with IPA for proper determination of Coordination of Benefits and Third-Party Liability and to bill and collect from other payers those charges for which the other partners are responsible. PCP shall report all collections received in accordance with this section to IPA.

3.28. PCP shall maintain all licenses required by law to operate its facilities and all certifications necessary for PCP to participate in Medicare and Medicaid programs. PCP agrees to notify IPA promptly in the event any action is taken against any such license or certification.

3.29. PCP agrees to abide with all terms and conditions set forth in any and all regulations promulgated by all Federal agencies affecting HMO participation in the Medicare Risk program and promulgated by all Federal and State agencies affecting HMO participation in the Medicaid Program. This shall include adherence to the enforceable provisions as set forth in the HIPAA of 1996. The Governing Body of the IPA shall develop and promulgate standards against which individual PCP performance shall be measured, and with which PCP must conform, to qualify as Medicare-Risk Program provider and as a Medicaid Program provider. Such standards shall include utilization, quality of care, patient service and performance to such standards as determined from time to time by the Governing Body.

## ARTICLE IV - QUALITY MANAGEMENT PROGRAM

4.0 A Quality Management Program shall be established to review the quality of PCP Covered Medical Services furnished by PCP to Plan Members, as described in Attachment A. Such program will be established by IPA, in its sole and absolute discretion, and will be in addition to any quality assurance program required by the conditions or provisions of a contracting Plan agreement. PCP shall comply with and, subject to PCP's right of appeal, shall be bound by such Quality Management Program, and if requested shall serve on the Quality Assurance Committee of such program, without compensation, in accordance with the procedures established by IPA and contracting Plans. PCP shall implement any reasonable change required by IPA regarding any PCP procedure or a problem identified by IPA's Quality Management Program. Failure to comply with the requirements of this Article IV may be deemed by IPA to be a material breach of this Agreement and may, at IPA's option, be grounds for immediate termination of this Agreement by IPA. PCP agrees that decisions of IPA designated Quality Assurance Committee may be used to deny PCP payment hereunder for those Covered Medical Services provided to a Plan Member that are determined to be medically unnecessary, medically inappropriate or of poor medical quality.

## ARTICLE V - UTILIZATION MANAGEMENT PROGRAM

5.1. PCP will abide and cooperate with IPA and/or payer with the utilization review, quality assurance/improvement, peer review and other provider requirements and procedures established by IPA and/or Payer, including but not limited to precertification of admissions and procedures, referral processes, concurrent & retrospective review and

discharge planning of inpatient admissions, claims review, peer review, reporting of clinical encounter data as IPA or Payer from time to time notifies PCP.

5.2. PCP will abide and cooperate with IPA to provide all patient encounter data, including utilization and other data, required to enable IPA to meet all governmental regulatory requirements imposed payer.

5.3. Failure to comply with the requirement of this Article V may be deemed by the IPA to be a material breach of this Agreement and may, at IPA's option, be grounds for immediate termination of this Agreement by IPA. PCP agrees that decisions of the IPA and or payer designated Utilization Review Committee may be used to deny PCP payment for those PCP Covered Medical Services provided to a Plan Member that are determined to be medically unnecessary or for which PCP failed to receive prior written consent to treat a Plan Member.

## ARTICLE VI - REGULATORY COMPLIANCE

6.1. This Agreement is subject to all requirements imposed by federal and state law, and municipal and county ordinances, as amended, and all regulations issued pursuant thereto. This includes the provisions of Sections 160 – 164 of the HIPAA of 1996 pertaining to privacy, PHI/EPHI and security, collectively called "Acts and Regulations", and any provision required to be in this Agreement by any of the above State and Federal Acts and Regulations, as amended, shall bind the parties whether or not provided in this Agreement.

6.2. PCP agrees to permit IPA, Plan(s), the Texas State Department of Health Services ("TDHS"), the United States Department of Health and Human Services ("DHHS"), and the Comptroller General of the United, or their authorized representatives, to inspect, examine or copy, at all reasonable times upon demand, all facilities, books, records and papers relating to the provision of PCP Covered Services rendered by or through PCP under this Agreement, the cost thereof, and the amount of any payments received therefore from Plan Members, or from others on such Plan Members' behalf.

6.3. PCP agrees to maintain, in a form in accordance with the general standards applicable to such book or record keeping at PCP's place of business or at such other mutually agreeable location in Texas, the books, records and other papers provided for herein for at least ten (10) years from the date of the close of the Plan's fiscal year in which this Agreement is in effect, and that such obligation shall not terminate upon termination of this Agreement, whether by rescission or otherwise.

6.4. PCP agrees to maintain, provide to IPA, and, upon request, make available to the THDS and Plan, copies of all subcontract for the provision of PCP Covered Services and to ensure that all such subcontracts are in writing, comply with the Act and the Regulations and require that the subcontractors:

a. Make all applicable books and records available at all reasonable times for inspection, examination, or copying by IPA and Plan.

b. Retain such books and records for a term of at least ten years from the close of Plan fiscal year in which the subcontract is in effect.

c. IPA agrees to notify Plan(s) in the event this Agreement is amended or terminated. PCP further agrees to notify IPA and Plan in the event any agreement with a

subcontractor for the provision of PCP Covered Services is amended or terminated.

6.5. PCP agrees to hold harmless Plan Members in the event IPA cannot or will not pay for Covered Medical Services provided to Plan Members hereunder due to the failure of Plan to pay IPA for such services.

## ARTICLE VII - ACCESS to, and CONFIDENTIALITY of, MEDICAL RECORDS

7.1. PCP shall maintain for each Plan Member receiving PCP Covered Medical Services pursuant to this Agreement, a single standard medical record in such form and containing such information as may be required by applicable federal and state laws and HIPAA regulations. The medical record shall contain, at a minimum, medical charts, prescription orders, diagnosis for which medications were administered or prescribed, documentation of orders for laboratory, EKG, hearing, vision, and other tests and the results of such tests and other documentation sufficient to disclose the quality, quantity, appropriateness and timeless of PCP Covered Medical Services performed or ordered under this Agreement. Each Plan Member's medical record shall be legible and maintained in detail, consistent with good medical and professional practice, permitting effective internal and external peer review and/or medical audit and facilitates an adequate system of follow-up.

7.2. PCP shall safeguard the confidentiality of Plan Member information according to applicable federal and state laws and HIPAA regulations, and shall take the usual precautions to prevent the unauthorized disclosure of PHI.

7.3. Duly authorized representatives of IPA, Plans, and federal, state and local governments as well as HIPAA enforcement agency, shall have access to Plan Members' records and shall be allowed to make notes and copies, subject to all applicable state and federal laws and regulations relating to the confidentiality of patient medical records.

7.4. Consistent with state laws relating to the confidentiality of patient medical records, PCP shall make the medical records of Plan Members available to other Plan Providers to assure continuity of care for Plan Members.

7.5. PCP shall ensure that all employed or contracting physicians and Health Professionals comply with the records maintenance, PHI, access and confidentiality provisions of this Agreement, as though each such professional was the PCP for the purpose of this Agreement.

7.6. PCP hereby authorizes IPA to release any and all information, records, summaries of records and statistical reports specific to PCP (including, but not limited to, physician utilization profiles pertinent to PCP's use of PCP Covered Medical Services, professional qualifications and credentialing information) to Plans without receiving PCP's prior written consent. PCP hereby releases IPA, its employees and/or its authorized agents from any and all liability and expense that is incurred by PCP due to any action taken by IPA.

## ARTICLE VIII - ADVERTISING AND PUBLICITY

8.0. IPA and PCP each reserves the right to use and control the use of its name and all symbols, trademarks and service marks presently existing or later established by it. Neither IPA nor

PCP shall use the other party's name, symbols, trademarks or service marks in advertising or promotional materials or otherwise (with the exception of the use of PCP's employee or contracting physician's name, address, phone number, type of practice and willingness to accept new patients in standard provider listings developed by Plan(s)) without the prior written consent of that party, and shall cease any such usage immediately upon written notice of the party or on termination of this Agreement, whichever is sooner.

## ARTICLE IX - RELATIONSHIP OF THE PARTIES

9.1. No provision of this Agreement is intended to create, nor shall any be deemed or construed to create, any relationship between IPA and PCP (or any Network Physician or Health Professional) other than that of independent entities contracting with each other hereunder solely for the purpose of effecting the provisions of this Agreement. Neither IPA nor PCP, nor any of their respective partners, contractors, employees, agents or representatives shall be construed to be the contractors, partners, employees, agents or representatives of the other. As independent contracting parties, IPA and PCP maintain separate and independent management, and each has full, unrestricted authority and responsibility regarding its organization and structure. PCP understands and agrees that:

a. IPA will not withhold on behalf of PCP any sum for income tax, unemployment insurance, social security or other withholding pursuant to any law or requirement of any governmental body relating to PCP, including contributions to government mandated employment-related insurance and similar programs, or make available to PCP any benefits afforded to employees of IPA, except as required by law;

b. All of such payments, withholdings and benefits, if any, are the sole responsibility of PCP; and

c. In the event of any claim by any person or entity including any governmental agency, for any of the items described in Section 10.1 (a), PCP agrees, on demand, to indemnify, defend, and hold IPA and its representatives, successors-in-interest, assigns, agents, and employees, and each of them, free and harmless from and against any and all debts, liabilities, obligations, losses, damages, costs or expenses (including but not limited to attorneys' fees), liens, or encumbrances accruing, based upon or arising out of any such claim with respect to any of the items discussed in Section 10.1(a), including any interest or penalty obligation related thereto.

9.2. Nothing in this Agreement, express or implied, is intended or shall be construed to confer upon any person, firm or corporation other than the parties hereto and their respective successors or assignees, any remedy or claim under or by reason of this Agreement or any term, covenant or condition hereof, as third party beneficiaries or otherwise, and all of the parties hereto and their successors and assigns.

## ARTICLE X - LIABILITY, INDEMNITY AND INSURANCE

10.1. Neither IPA nor PCP, nor any of their respective agents or employees, shall be liable to third parties for any act or omission of the other party.

10.2. PCP agrees to indemnify, defend and hold harmless IPA, Plan and Plan members, and their agents, contractors and employees from any and all liability, loss, damage, cause of action, claim and expense of any kind, including costs and attorneys' fees, that result from the negligent or willful performance or nonperformance by the indemnifying party or its agents, contractors, or employees of the duties and obligations of such other party under this Agreement.

10.3. PCP, at its sole expense, agrees to maintain a policy or policies of professional liability insurance of not less than two hundred thousand dollars ($200,000) per claim and six hundred thousand dollars annual aggregate ($600,000) to insure PCP and its agents, servants and employees against any and all loss, liability or damage arising from its duties and obligations under this Agreement. In addition, PCP, at its sole expense, agrees to maintain a policy or policies of insurance covering PCP's principal place of business to insure PCP against any and all loss, liability or damage committed or arising out of the alleged condition of said premises, or the furniture, fixtures, appliances or equipment located therein, together with standard liability protection against any loss, liability or damage as a result of the operation of a motor vehicle for business purposes by PCP, or PCP's agents, servants or employees. PCP further agrees to purchase such other available insurance as shall be necessary to insure PCP and its agents, servants or employees against any and all damages arising from its duties and obligations under this Agreement. All such policies shall be purchased from licensed insurance companies admitted to do business in the State of Texas. PCP shall make IPA an additional named insured on such policies. PCP shall also provide, at its sole cost and expense, Workers' Compensation benefits for its agents, servants and employees as required by Texas law.

10.4. PCP shall provide IPA with written evidence that the policies of insurance required under Section 10.3 are in full force and effect, and are valid and existing in accordance with the provisions of this Agreement.

10.5. If the professional liability insurance procured by PCP pursuant to Section 10.3 is on a "claims made" rather than "occurrence" form, PCP upon termination of this Agreement, shall either obtain extended reporting malpractice insurance coverage ("tail" coverage) in a form acceptable to IPA with liability limits equal to those most recently in effect prior to the date of termination, or enter into such other arrangements as shall reasonably assure IPA of the maintenance of coverage applicable to the claims arising during the period in which this Agreement was in effect for a period of not less than seven (7) years after the date of termination.

10.6. PCP shall advise IPA of each professional liability claim filed against PCP and/or a PCP agent, servant, or employee and each settlement of a professional liability claim entered into by PCP and/or a PCP agent, servant or employee within fifteen (15) days following said filing or settlement.

## ARTICLE XII - PLAN MEMBER COMPLAINTS AND DISPUTES

11.1. If PCP receives any complaint regarding PCP in connection with Agreement, PCP agrees to notify IPA within five (5) working days of all details of such complaint. In the event that IPA receives any complaint regarding PCP, IPA will notify PCP within five (5) working days of receipt thereof.

11.2. A Plan Member Grievance Policy and Procedure has been established by IPA and contracting Plans in their sole absolute discretion. PCP agrees to cooperate with IPA in the investigation and resolution of Plan Member complaints and grievances under the Plan Member Grievance Policy and Procedure, included in Attachment A, as amended from time to time.

11.3. In the event any complaint or grievance of a Plan Member cannot be settled through the initial procedures described in Attachment A, the matter may be submitted to Plan or administrative department or agency. PCP agrees to cooperate and, when necessary, participate in any such administrative hearing proceedings. The administrative hearing results shall be final and binding on all parties.

## ARTICLE XII - DISPUTE RESOLUTION

12.1. IPA and PCP agree to meet and confer to resolve any dispute that may arise under this Agreement. PCP may submit disputes to IPA at the address and telephone number provided in Section 18.2 of this Agreement. IPA shall attempt to respond to all disputes within thirty (30) days of receipt, except in urgent cases in which IPA will respond as soon as possible. If both parties agree, the dispute may be submitted to voluntary mediation or any other dispute settlement technique as the parties may mutually agree upon at such time. If any such dispute cannot be resolved, PCP and IPA agree to submit such dispute to binding arbitration.

12.2. In the event arbitration between IPA and PCP becomes necessary, either party making a written demand for arbitration on the other party shall initiate such arbitration. Such arbitration shall be conducted under the CMS/Commercial Rules of the American Arbitration (AAA) using mutually selected attorney arbitration in Houston, Texas, unless the parties mutually agree to have such proceeding in some other locale. Judgment upon the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof. The arbitrator(s) may in such proceeding award attorneys' fees and costs to the prevailing party.

12.3. Any grievance related to claims settlement practices shall be deferred to the Claims Settlement Practices & Dispute Resolution Mechanism and timelines policy ("Policy") as provided for in Attachment A (Provider Manual) to this Agreement. Provider shall submit such formal disputes and grievances in the medium(s) and to the address (es) as identified in the Policy.

## ARTICLE XIII - UNFORESEEN CIRCUMSTANCES

13.1. For so long as any natural disaster, war, riot, civil insurrection, epidemic, other emergency or other event not within the control of PCP results in the facilities or personnel of PCP being unavailable to provide or arrange for the provision of Covered Medical Services, PCP shall only be required to make a good faith effort to provide such services, taking into account the impact of the event.

## ARTICLE XIV - TERM AND TERMINATION OF AGREEMENT

14.1. The initial term of this Agreement shall commence on the date of signed Agreement between IPA and PCP, and shall continue for a period of one year. Thereafter, the Agreement will be automatically renewed for successive one-year terms, without the necessity of notice of action by either party; provided, however, that this Agreement may be terminated as provided below.

14.2. This Agreement may be terminated without cause by either party giving the other party ninety (90) days prior written notice of such termination.

14.3. For-cause termination may be effected for breach of this Agreement or default in the performance of any provision herein, if such breach or default is not corrected to the reasonable satisfaction of the non-breaching/non-defaulting party within thirty (30) days of receipt of written notice from the non-breaching/non-defaulting party specifying the breach or default. Such notice shall clearly state the effective date of such termination. All terms and provisions of this Agreement shall remain in effect until the effective date of termination. Notwithstanding the above, this Agreement may be immediately terminated for cause in the event of the following circumstances:

a. PCP's license to provide services in the State of Texas is modified, suspended or revoked; or

b. PCP's certificate issued by the United States Drug Enforcement Agency ("DEA") authorizing PCP to prescribe and administer controlled substances is modified, suspended or revoked; or

c. PCP's medical staff privileges at any hospital are restricted, suspended, denied, impaired, revoked, terminated or not renewed; or

d. PCP fails to maintain insurance in at least the minimum amount specified in Section 10.3 of this Agreement; or

e. PCP fails to comply with IPA Quality Management Program, as specified in Article V of this Agreement; or

f. PCP fails to comply with IPA Utilization Management Program, as specified in Section 6.1 of this Agreement; or

g. There is only one (1) Office Site listed in this Agreement and PCP ceases to operate its medical practice at said Office Site; or

h. IPA, or Plan, determines that the health, safety or welfare of Plan Members is jeopardized by the PCP by continuing to provide Covered Health Care Services under this Agreement.

14.4. In the event of termination of this Agreement, upon request, PCP shall make available to IPA, or its designated representative, at no charge, any or all records, whether medical or financial, related to the PCP's performance under this Agreement.

14.5. Upon termination of this Agreement, PCP shall continue to provide PCP Covered Medical Services to Plan Members, who are receiving PCP Covered Medical Services at the time of termination, who retain eligibility under the terms and conditions of their Benefits Agreement, or by operation of law until the PCP Covered Medical Services being rendered

to the Plan Members are completed, or until IPA makes reasonable and medically appropriate arrangements for the provision of such services by another Network Provider, and notifies PCP that such arrangements have been made. PCP shall continue to provide PCP Covered Medical Services under such circumstances at the compensation rates then in effect for this Agreement.

14.6. Notwithstanding any other provision of this Agreement, in the event that a contracting Plan notifies IPA that said Plan wishes to remove PCP or any PCP employee or contractor from the Plan roster of participating physicians/providers, IPA shall have the right to terminate PCP, and/or such PCP's employees or contractors participation in said Plan.

## ARTICLE XV - TRADE SECRETS AND NON- SOLICITATION

15.1. PCP agrees to keep confidential and to not disclose the professional business practices, trade secrets or privileged information of IPA, and to keep such knowledge confidential in PCP's dealings with any medical group, clinic, hospital, health care facility, IPA, or other medical practice for which PCP may either work or have contact with during the term of this Agreement (and subsequent term of this Agreement) and for a period of three (3) years after this Agreement terminates. Further, PCP agrees that it shall not use or disclose to any person or entity (except for the benefit of IPA) information obtained by PCP during the period of its relationship with IPA as to Plans, contracts (including managed care contracts), medical records, business methods, financial statements, or any other trade secrets, confidential or proprietary information with respect to IPA, including but not limited to, information concerning customers, third-party Payers, patients or patient groups of IPA with whom the PCP dealt or of whom PCP became aware during the term of this Agreement.

15.2. During the term of this Agreement (and any subsequent term of this Agreement) and for a period of three (3) years after the effective date of termination of this Agreement, PCP shall not directly or indirectly engage in the practice of solicitation of Plan Members or any employer of said Plan Members without IPA's prior written consent. For purposes of this Agreement, solicitation shall mean any action by PCP that IPA may reasonably interpret to be designed to persuade a Plan Member to discontinue his or her relationship with IPA, to disenroll from a Plan contracted with IPA, or to encourage a Plan Member to receive health care from PCP on a fee-for-service basis. A breach of this Section 15.2 during any term of this Agreement shall be grounds for immediate termination of this Agreement.

## ARTICLE XVI - HIPAA REQUIREMENTS

16.1. The parties acknowledge that:

a. Pursuant to this Agreement, they will use or disclose Protected Health Information which includes Electronic Protected Health Information ("PHI", "EPHI" or "IIHI") that is subject to protection under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and certain regulations, including the Security Rule found at Title 45, Code of Federal Regulations (CFR), Sections 160 through 164 ("HIPAA Regulations"), and is not limited to, subsequent amendments;

b. Plans and IPA are Covered Entities as that term is defined in the HIPAA Regulations, and Participating Provider creates or receives PHI/EPHI or IIHI from or on behalf of Plans and IPA and are, therefore, Business Associates, as defined in the HIPAA Regulations;

c. Pursuant to§164.504(e) of the HIPAA Regulations, as it may be amended from time-to-time, Business Associates of IPA must agree in writing to certain mandatory provisions regarding the use and disclosure of PHI/EPHI or IIHI;

16.2. Definitions pertaining to this Article XVII are as follows. Unless otherwise provided herein, capitalized terms are ascribed the same meaning as set forth in the HIPAA Regulations.

d. "Business Associate" shall have the meaning given to such term under the HIPAA Regulations, including, but not limited to, Title 45 CFR Section 160.103

e. "Designated Record Set" shall have the meaning given to such term under the Privacy Rule, including, but not limited to, Section 164.501.

f. "Individually Identifiable Health Information" or "IIHI" shall mean information as it relates to the individual's health, healthcare, or payment for healthcare in any form, written, spoken, faxed and electronic and, such that is defined in a standard transaction as stipulated by HIPAA that can serve to identify an individual;

g. "Parties" shall mean IPA and PCP.

h. "Privacy Rule" and "Security Rule" shall mean the HIPAA Regulation that is codified at Title 45 CFR Parts 160 to 164, as it pertains to use and disclosure.

i. "Protected Health Information" or "Electronic Protected Health Information" ("PHI" or "EPHI) means any information, whether oral or recorded in any form or medium: (i) that relates to the past, present or future physical or mental condition of an individual; the provision of health care to an individual, or; the past, present or future payment for the provision of health care to an individual; and, (ii) that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual, and shall have the meaning given to such term under HIPAA and the HIPAA Regulations, including, but not limited to, Title 45 CFR Section 164.501. For the purpose of this Addendum, the acronym PHI and/or EPHI may also refer to IIHI.

j. "Treatment, Payment or Operational purposes" or "TPO" shall pertain to the related performance of reasonable industry standard management and administration within the organization.

16.3. Scope of Use and Disclosure of PHI/EPHI OR IIHI. Except as otherwise limited in this Amendment:

k. PCP shall use and disclose PHI solely to provide the services, or to perform the functions, described in the Agreement, provided that such use or disclosure would not violate the HIPAA Regulations if so used or disclosed by PCP and recipient entities;

l. PCP may use or disclose PHI or IIHI for the TPO of PCP or to provide Data Aggregation services to IPA and Health Plan;

m. PCP may use or disclose certain PHI provided the protected individual gives written consent and/or authorization that is limited to the scope and purpose of such use or disclosure.

16.4. Obligations of PCP. In connection with its use and disclosure of PHI/EPHI and IIHI, PCP shall:

n. Not use or disclose PHI or IIHI other than as permitted or required by the Agreement or as Required By Law;

o. Use reasonable and appropriate safeguards to prevent use or disclosure of the PHI other than as provided for by this Article XVII;

p. Mitigate, to the extent practicable, any harmful effect that is known to PCP of a use or disclosure of PHI by PCP in violation of the requirements of this Article XVII;

q. Report to IPA any use or disclosure of the PHI or IIHI not provided for by this Article XVII of which PCP becomes aware;

r. Require contractors or agents to whom PCP provides PHI or IIHI created or received by PCP on behalf of IPA to agree to the same restrictions and conditions that apply to PCP with respect to such PHI under this Article XVII;

s. Provide access, at the request of IPA to PHI or IIHI in a Designated Record Set, to IPA or, as agreed by PCP, to an Individual in order to meet the requirements under §164.524 of the HIPAA Regulations;

t. Make any amendment(s) to PHI or IIHI in a Designated Record Set that the IPA directs or agrees to, pursuant to §164.526 of the HIPAA Regulations at the request of IPA in the time and manner proscribed;

u. Make internal practices, books, and records, including policies and procedures and PHI or IIHI, relating to the use and disclosure of PHI or IIHI created or received by PCP on behalf of IPA, available to the IPA, Health Plan, the HSS Office for Civil Rights or its delegated HIPAA enforcement agency, if requested, in a time and manner designated by the regulatory agency, for the purpose of determining the parties' compliance with the HIPAA Regulations;

v. Maintain for a period of ten (10) years an accounting of all disclosures of PHI or IIHI that are required to be maintained under §164.528 of the HIPAA Regulations. Such accounting will include the date of the disclosure, the name of the recipient, a description of PHI or IIHI disclosed and the purpose of the disclosure. This interval requirement of this section shall survive the terms of Article XVI;

w. Provide to IPA, in a timely manner, information collected in accordance with this Section 17.4, to permit IPA to respond to a request by an oversight entity for an accounting of disclosures of PHI or IIHI in accordance with §164.528 of the HIPAA Regulations;

x. Make reasonable efforts to implement any restriction to the use or disclosure of PHI or IIHI that IPA has agreed to pursuant to 17.5.

y. With respect to EPHI, implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity,

and availability of the EPHI that Provider creates, receives, maintains, or transmits on behalf of IPA as required by 45 CFR Part 164, Subpart C.

z. With respect to EPHI, ensure that any agent, including a subcontractor, to whom Provider provides EPHI, agrees to implement reasonable and appropriate safeguards to protect the EPHI.

aa. With respect to EPHI, report to IPA any Security Incident of which Provider becomes aware.

16.5. Obligations of IPA:

bb. Use appropriate safeguards to maintain and ensure the confidentiality, privacy and security of PHI/EPHI or IIHI transmitted to IPA pursuant to this Agreement, in accordance with the standards and requirements of the Privacy Rule, until such PHI or IIHI is received by PCP;

cc. Provide PCP with the notice of privacy practices that Health Plan and IPA produces in accordance with §164.520 of the HIPAA Regulations;

dd. Promptly notifies PCP of any change in, or revocation of, permission by Individual to use or disclose PHI/EPHI or IIHI, to the extent that such changes may affect PCP's use or disclosure of PHI;

ee. Promptly notify PCP of any restriction to the use or disclosure of PHI that IPA has agreed to in accordance with §164.522 of the HIPAA Regulations, to the extent that such restriction may affect PCP's use or disclosure of PHI;

ff. Not request PCP to use or disclose PHI/EPHI or IIHI in any manner that would not be permissible under the HIPAA Regulations if done, by IPA, unless such disclosure is necessary for the purposes of Data Aggregation or TPO activities of PCP under the Agreement.

16.6. IPA shall notify PCP of any change to regulations that may affect normal operations and shall make any amendment to this Agreement from time to time, as required by newly promulgated provisions.

## ARTICLE XVII - GENERAL PROVISIONS

17.1. Assignment: This Agreement shall be binding upon, and shall inure to the benefit of, the parties to it, and their respective heirs, legal representatives, successors and assigns. Notwithstanding the foregoing, PCP shall not assign this Agreement without first obtaining the written consent of IPA. Assignment or delegation of this Agreement shall be void unless prior written approval of such or delegation is obtained from IPA.

17.2. Notices: Any notice required to be given pursuant to this Agreement shall be made in writing and shall be sent personally delivered or by certified mail, return receipt requested, postage prepaid, to the other party as follows:

IPA: TEACO PROVIDER NETWORK, L.L.C.
8278 Bellaire Blvd Suite A
Houston, TX 77036
Attn: Administrator

○ PCP ○ Group: _____

_____

_____

_____

Attn: _____

Notice delivered personally shall be deemed communicated upon actual receipt. Mailed notices shall be deemed communicated as of the date shown as date of delivery upon the United States Postal Service return thereof or, should such notice be unclaimed by the recipient thereof, three (3) days after mailing. Either party may at the time change its address for notification purposes by mailing or delivering a notice as required herein above stating the change and setting forth the new address. The new address shall be effective on the tenth (10th) day following the date such notice is received, unless a subsequent date of effectiveness is specified in said notice.

17.3. Documentation: IPA shall provide PCP with a copy of any document required by a contracting Plan that has been approved by IPA's Board of Directors and that requires the signature of PCP and/or a PCP employee or subcontractor. If PCP does not obtain the requisite signatures and return said document within fifteen (15) calendar days of document receipt, said document shall be deemed executed by PCP and/or the PCP employees or subcontractor.

17.4. Severability: If any provision of this Agreement is held by a court of competent jurisdiction or applicable state or federal law and their implementing regulations to be invalid, void or unenforceable, the remaining provisions shall nevertheless continue in full force and effect, subject to Section 17.5

17.5. Effect and Severable Provision: In the event that a provision of this Agreement is rendered invalid or unenforceable or declared null and void, as provided in Section 17.4 above, and its removal has the effect of materially altering the obligations of either party in such manner as, in the judgment of the party affected, (a) will cause serious financial hardship to such party; or (b) will cause such party to act in violation of its corporate articles or bylaws, the party so affected shall have the right to terminate this Agreement upon thirty (30) days' prior written notice to the other party. The provisions of Article XVI shall apply to such termination.

17.6. Confidentiality: The terms of this Agreement and in particular the provisions regarding compensation, are confidential and shall not be disclosed by PCP except as necessary to the performance of this Agreement or as required by law.

17.7. Waiver: The waiver of any provision, or of the breach of any provision, of this Agreement must be set forth specifically in writing and signed by waiving party. Any such waiver shall not operate or be deemed to be a waiver of any prior or future breach of such provision or of any other provision.

17.8. Entire Agreement: This Agreement, together with the Attachments, supersedes any and all agreements, promises, negotiations or representations, either written or oral, between

the parties hereto with respect to the subject matter contained herein and contains all of the covenants and agreements between the parties with respect to the rendering of Covered Medical Services by PCP. Each party to this Agreement acknowledges that no representations, inducements, promises, or agreements, oral or otherwise, have been made by either party, or anyone acting on behalf of either party, that are not embodied herein, and that no other agreement, statement, or promise not contained in this Agreement shall be valid or binding. Except as otherwise provided herein, any effective modification must be in writing and signed by the party to be charged.

17.9. Amendment: This Agreement may only be amended by the mutual written consent of the parties. Additionally, this Agreement may be amended by IPA at any time to comply with any agreement entered into between IPA and a Plan or to comply with any applicable federal or state law regulation or other governmental requirement.

17.10. Attorney's Fees: In the event that either PCP or IPA institutes any action, suit, or arbitration proceeding to enforce the provisions of this Agreement, the prevailing party shall be entitled to recover costs and reasonable attorney's fees from the other party.

17.11. Headings: The headings of articles and sections contained in this Agreement are for reference purposes only and shall not affect in any way the meaning or interpretation of this Agreement.

17.12. Conflict of Interest: PCP warrants that no part of the total Agreement Compensation provided herein shall be paid directly or indirectly to any officer or employee of the Plan as wages, compensation, or gifts in exchange for acting as an officer, agent, employee, subcontractor, or consultant to PCP in connection with any service contemplated or performed relative to this Agreement. PCP certifies that no member of or delegate of Congress, the General Accounting Office, DHHS (including the Health Care Financing Administration), or any other Federal agency has or will benefit financially or materially from this Agreement.

17.13. Governing Law: This Agreement shall be governed by and construed and enforced in accordance with the laws of the State of Texas.

The signatory represents that he/she is an individual, authorized to bind the applicable party.

| Company: | ○ Provider or ○ Provider Group |
|---|---|
| TEACO Provider Network L.L.C.<br>Contracting Entity Name | _____<br>Contracting Entity Name |
| _____<br>Signature | _____<br>Signature |
| _____<br>Print Name/Title | _____<br>Print Name/Title |
| _____<br>Title | _____<br>Title |
| _____<br>Date | _____<br>Billing NPI |
| | _____<br>Tax ID |
| | _____<br>Date |

## EXHIBIT I - IPA BILLING & PAYMENT REQUIREMENTS

IPA will enter into contracts with various Payers for services provided by PCP. The Payer Agreement will detail the procedure for payment to be made to PCP and PCP will accept to agree to payer procedure for billing & payment of covered medical services. PCP agree to accept as payment in full for Covered Medical Services which PCP provides, the compensation specified in the appropriate payment schedule for the Payer Plan covering the Covered Individuals to whom the Approved Covered Medical Services were provided. Payer shall have no obligation to pay for Covered Medical Services determined by it not to be Approved Covered Medical Services.

PCP agrees that in no event, including, but not limited to, non-payment by a Payer, insolvency of Payer or IPA and/or a breach of this Agreement or the Payer Agreement, shall PCP charge, seek compensation from or have any recourse against IPA or Covered Individuals or persons (other than the Payer) acting on a Covered Individual's behalf for Covered Medical Services provided pursuant to this Agreement; excepting only, however, when the terms of a Payer Plan (in accordance with law) permit expressly such recovery against a Covered Individual or such other party.

PCP agree that this Section shall survive termination of this Agreement for any reason and shall be construed for the benefit of Covered Individuals. PCP will make every effort to submit all claims for Covered Medical Services rendered to Covered Individuals by PCP within the period of time permitted under the Payer Agreement. PCP acknowledge that the failure to submit claims within the time required by the applicable Payer Plan may result in their disallowance for purposes of payment unless such failure was with good cause as may be permitted under the Payer Plan.

Unless otherwise specified in writing by IPA, PCP specifically acknowledge and agree that the Payer shall have the full and final responsibility and liability for payment of claims and that IPA is not responsible for, does not guarantee, or assume liability for payment of any claim. PCP agree that all final claims decisions will be the responsibility of the Payer.

# EXHIBIT II – MEDICARE ADVANTAGE PROGRAM

## Downstream Medicare Advantage Provider Contract Addendum

This revised ICE Downstream Provider Contract Addendum ("Addendum") is hereby incorporated into the Agreement between TEACO PROVIDER NETWORK, L.L.C. ("First Tier Entity") and _____ ("Downstream Provider") and is intended to add contract language required by the Centers for Medicare and Medicaid Services, ("CMS") for participation in the Medicare Advantage ("MA") Program.

**WHEREAS**, CMS requires that specific terms and conditions be incorporated into subcontracts between a First Tier Entity and a Downstream Provider to comply with the provisions of the Medicare Prescription Drug, Improvement and Modernization Act of 2003. (Pub. L. 108-73) (MMA).

**WHEREAS**, Downstream Provider desires to provide services to Medicare beneficiaries who enroll in the Medicare Advantage Program; and

**WHEREAS**, First Tier Entity desires that Downstream Provider provide services to Medicare beneficiaries who enroll in the Medicare Advantage Program; and

**WHEREAS**, Downstream Provider agrees to comply with the terms and conditions specified by CMS in the form of this Addendum to the Agreement between Downstream Provider and First Tier Entity;

***NOW, THEREFORE***, the parties agree as follows:

II.1. DEFINITIONS

a. "Agreement" means the agreement between the First Tier Entity and Downstream Provider that specifies the contractual relationship between the First Tier Entity and Downstream Provider for the provision of services to Enrollees.

b. "Downstream Provider" means an entity or individual that is contracted by a First Tier Entity to provide services to Enrollees. A Downstream Provider includes, but is not limited to physicians, ancillary providers, and other health care providers.

c. "First Tier Entity" means the entity which contracts with a Medicare Advantage Organization, (MAO) to provide services to Enrollees. A First Tier Entity includes but is not limited to medical group, individual practice association ("IPA"), or hospital.

d. "Centers for Medicare and Medicaid Services" ("CMS") means the agency within the Department of Health and Human Services that administers the Medicare Program.

e. "Completion of Audit" means Completion of Audit by CMS of an MAO, MAO subcontractors or related entities.

f. "Final Contract Period" means Final Contract Period between CMS and the MAO with whom the First Tier Entity has entered into an Agreement.

g. "Industry Collaboration Effort" ("ICE") is a collaboration of health plans, providers and industry associations working on health care issues.

h. "Medicare Advantage Organization" ("MAO") means a Health Plan that has entered into an agreement with the CMS to provide services to Medicare beneficiaries under the Medicare Advantage Program.

i. "Medicare Advantage" ("MA") means the program offered by the federal government in which Medicare beneficiaries have several options to receive health care services.

j. "Member" means an individual who has enrolled in or elected coverage through an MAO. A Member is also known as an Enrollee.

II.2. OPL 77 REQUIRED PROVISIONS

Operational Policy Letter (OPL) 98.077 (revised) requires the Downstream Provider to comply with the following requirements:

a. Downstream Provider agrees to give the Department of Health and Human Services (HHS), and the General Accounting Office (GAO) or their designees the right to audit, evaluate, inspect books, contracts, medical records, patient care documentation, other records of subcontractors, or related entities for (10) years, or for periods exceeding ten (10) years, from the end of the Final Contract Period or Completion of Audit, whichever is later for reasons specified in the federal regulation, for Members enrolled in a MAO. 42 CFR 422.504 (e)(2)(3)(4)(i)(2).

b. Downstream Provider agrees to comply with all confidentiality and Member record accuracy requirements. 42 CFRs 422.118 and 422.504. (a)(13).

c. Downstream Provider agrees to hold harmless and protect Members from incurring financial liabilities that are the legal obligation of the MAO or First Tier Entity. In no event, including but not limited to, nonpayment or breach of an agreement by the MAO, First Tier Entity, or other intermediary, or the insolvency of the MAO, First Tier Entity, or other intermediary, shall Downstream Provider bill, charge, collect a deposit from or receive other compensation or remuneration from a Member. Downstream Provider shall not take any recourse against the Member, or a person acting on behalf of the Member, for services provided. This provision does not prohibit collection of applicable coinsurance, deductibles, or co-payments, as specified in the MAO Evidence of Coverage. This provision also does not prohibit collection of fees for non-covered services, provided the Member was informed in advance of the cost and elected to have non-covered services rendered. 42 CFRs 422.504(g)(1) and (i)(3)(i).

d. Downstream Provider agrees to perform, if applicable, the functions that are delegated consistent with the First Tier Entity requirements, MAO requirements, and federal regulation. Downstream Provider also agrees to comply with any applicable delegation requirements and regulations between the MAO and First Tier Entity. 42 CFRs 422.504(i)(3)(iii) and 422.504(i)(4).

e. First Tier Entity agrees to pay Downstream Provider promptly according to CMS standards and comply with all payment provisions of law. 42 CFR 422.520(b).

f. Downstream Provider agrees to comply with CMS reporting requirements as specified in Sec 422.257(c)(d)(1)(4)(encounter data) and Sec 422.516(a)(6)(b) and Sec 422.500(3)(ii) (informational data). 42 CFR 422.504(a)(8).

g. Downstream Provider agrees to comply with CMS accountability provisions, including but not limited to the requirement to comply with Medicare laws, regulations, and CMS instructions, which are more fully documented in the MAO's policies and procedures. 42 CFRs 422.504(i)(3)(ii)(A) and 422.504(i)(4)(v).

h. Except as provided in this Addendum, all other provisions of the Agreement between Provider and First Tier Entity not inconsistent herein shall remain in full force and effect. This Addendum shall remain in force as a separate but integral addition to such Agreement to ensure compliance with required CMS provisions, and shall continue concurrently with the term of such Agreement.

## ATTACHMENT A - PROVIDER GROUP PHYSICIANS

I certify that I am a physician employee or otherwise contractually obligated to Provider Group to provide covered medical services to members of payer contracting with Provider. I agree to be bound by the terms and conditions of this Agreement for, and on behalf of, Provider.

| Print Name/Title | Signature | NPI | Date |
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Physician Assistants/Nurse Practitioners (PA/NP Applications must also be reviewed by a credentialing panel.)

| Print Name/Title | Signature | NPI | Date |
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## ATTACHMENT B - PROVIDER MANUAL

[The Provider Manual will be distributed at the Provider Orientation upon completion of the contracting and credentialing process]

## ATTACHMENT C - TAXPAYER IDENTIFICATION NUMBER AND CERTIFICATION

**(IRS FORM W-9 ATTACHED)**

Each Contracting Entity is required to complete a W-9 form and indicate the appropriate TIN, regardless of operations as Sole Proprietorship, Partnership, Corporation or Medical Group.

# ATTACHMENT D - CMS MEDICARE ADVANTAGE REGULATORY REQUIREMENTS

| Code of Regulations § | Description of Requirement. |
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| Exhibit 422.504(e)(2); 422.504(e)(3); 422.504(i)(2)(ii); 422.504(e)(4) | Provider grants Contracted Health Plan ("Plan"), DHHS, CMS, GAO and their respective designees the right to audit etc. for 10 years or periods exceeding 10 years or completion of an audit, whichever is later. |
| Exhibit 422.504(a)(3)(iii); 422.118 | Provider agrees to comply with all confidentiality and enrollee record accuracy requirements. |
| Exhibit 422.504(g)(1)(I) | Provider agrees that Enrollees will not be liable for payment of moneys owed by Plan or Provider. Provider agrees, and will require its Participating Providers to agree, not to, under any circumstances bill, charge, collect a deposit from, seek compensation from, seek remuneration from, seek reimbursement from, impose a Surcharge on, bring a collection action at law or in equity against, or have any recourse against an Enrollee or persons acting on behalf of Enrollee (other than Plan), except to the extent that Co-payments are specified in Plan's agreement with CMS or for Non-covered Services. |
| Exhibit 422.504(i)(3)(iii); 422.504(i)(4). | Provider shall specify the delegation requirements in a written delegation agreement, in manner consistent with federal regulations. |
| Exhibit 422.520(b). | The financially responsible party shall pay all clean claims for Covered Services, including Covered Services rendered by non-contracted but authorized providers, within the shorter of: the time period required by law; the time period required by Plan's agreement with CMS; or the time period required by subcontract with the provider. The term "complete claim" shall have the meaning given the term in the Medicare regulations (currently at 42 CFR §422.500). |
| Exhibit 422.516 and 422.310, 422.504(a)(8) | Provider shall comply with reporting requirements by providing Plan at its request with information (while safeguarding confidentiality) with respect to: the cost of care; patterns of utilization; availability, accessibility and acceptability of services; developments in the health status of the members assigned to Provider; fiscal soundness of Provider's operation; significant business transactions; loans to subcontractors and related entities; risk adjustment data; and other data and information as reasonably requested by CMS. |

| **Code of Regulations §** | **Description of Requirement.**<br>**Subcontractors and Sub-subcontractors must:** |
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| Exhibit 422.504(i)(3)(ii) & (4). | Provider agrees that to the extent that any of Plan's activities or responsibilities under its contract with CMS are delegated to Provider or by Provider to other parties, the following requirements apply to any related entity, contractor, subcontractor, or provider: (a) Written arrangements must specify delegated activities and reporting responsibilities. (b) Written arrangements must either provide for revocation of the delegation activities and reporting requirements or specify other remedies in instances where CMS or the Plan determine that such parties have not performed satisfactorily. (c) Written arrangements must specify that the performance of the parties is monitored by the Plan on an ongoing basis. (d) Written arrangements must specify that either: (i) The credentials of medical professionals affiliated with the party or parties will be either reviewed by the Plan; or (ii) The credentialing process will be reviewed and approved by the Plan and the Plan must audit the credentialing process on an ongoing basis. (e) All contracts or written arrangements must specify that the related entity, contractor, or subcontractor must comply with all applicable Medicare laws, regulations, and CMS instructions. If the Plan delegates selection of the providers, contractors, or subcontractor to another organization, the Plan's written arrangements with that organization must state that the CMS-contracting Plan retains the right to approve, suspend, or terminate any such arrangement. |
| Exhibit 422.504(i)(4)(v). | Provider shall comply with applicable Medicare laws, regulations, guidelines and CMS instructions and contractually require contractors and subcontractors to do the same. |
| Exhibit 422.504(g)(2)(i); 422.504(g)(2)(ii); 422.504(g)(3) | To provide for continuation of enrollee health care benefits, Provider agrees, and will require its contracted or subcontracted Providers, if any, to agree that, notwithstanding any termination of this Agreement or Plan's agreement with CMS, to continue the provision of Covered Services: (i) For all enrollees, for the duration of the contract period for which payments have been made; and (ii) For enrollees who are hospitalized on the date this Agreement or the Plan's agreement with CMS terminates, or, in the event of an insolvency, through date of discharge; and, (iii) For any longer period required by state or federal law, or otherwise specified in this Agreement. |
| Exhibit 422.110(a) | Provider shall not discriminate against members based on health status, which includes but is not limited to: physical or mental condition, claims experience; utilization of services; medical history; genetic information; evidence of insurability; and disability. |
| Exhibit 422.112(b); 422.113; 422.100(b) | If capitated for emergency medical services, Provider shall pay for emergency and urgently needed care consistent with Medicare regulations. |
| Exhibit 422.100(b)(1)(iii) | If capitated for emergency medical services and/or renal dialysis services, Provider shall pay for renal dialysis for those temporarily out of service area, in accordance with Medicare regulations. |
| Exhibit 422.100(g)(1). | Provider understands that Members have a right to direct access to mammography screening and influenza vaccinations, without authorization from the PCP or from Plan. |
| Exhibit 422.100(g)(2) | Provider understands that in Plan's Medicare Advantage Program there are no copayments for influenza and pneumococcal vaccines. |

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| Exhibit 422.112(a)(1) | Provider agrees to notify Plan in advance of the loss of any contractors or subcontractors and to advise Plan how that gap in the network will be filled. The Plan's network must be sufficient at all times to provide access to covered services. |
| Exhibit 422.112(a)(3) | Members have the right to direct access to in-network women's health specialist for routine and preventive services, without prior authorization from Plan or PCP. |
| Exhibit 422.204; 422.504(i)(4). | A Provider Agreement and any subcontract entered into by Provider may be suspended or terminated or any delegated activity may be revoked, or other remedies may apply, in instances where CMS or the MA organization determine that Provider or one of its Participating Providers, if any, have not performed satisfactorily. |
| Exhibit . 422.112(a)(7) | If Provider is a physician, physician network (IPA, medical group or clinic), hospital or skilled nursing facility, Provider must make Covered Services available 24 hrs/day, 7 days/week. |
| Exhibit 422.80(a), (b), (c) | If Provider is asked to assist Plan with any marketing functions, or to distribute marketing or membership materials in the waiting room, Provider shall adhere to CMS marketing provisions. |
| Exhibit 422.112(a)(8) | Provider shall ensure services are provided in culturally competent manner to all enrollees, including those with limited English proficiency or reading skills and diverse cultural and ethnic backgrounds. |
| Exhibit 422.112(b)(5). | If Provider is a primary care physician or physician network, Provider must conduct a health assessment of all new enrollees assigned to Provider within 90 days of the effective date of enrollment or verify that Plan has already done so. |
| Exhibit 422.128(b)(1)(ii)(E) | Provider shall document in a prominent place in medical record if individual has executed Advance Directive. |
| Exhibit 422.504(a)(3)(iii) | Provider shall provide Covered Services in a manner consistent with professionally-recognized standards of health care. |
| Exhibit 422.208 | Provider understands that all payment and incentive arrangements between the Plan and its providers and Provider and any first tier, & downstream contractors and subcontractors must be specified in the written contract(s) with those entities. |
| Exhibit 422.504(h)(1) | Provider understands that the moneys used to pay Provider under this Agreement are in whole or in part federal funds. Provider shall also comply with all laws and regulations governing the use of federal funds, including but not limited to criminal laws, anti-kickback laws, the False Claims Act, the Civil Rights Act, the Americans with Disabilities Act and the Age Discrimination. |
| Exhibit 422.64(a): 422.504(a)(4): 422.504(f)(2) | Provider agrees to disclose to Plan, who will disclose to CMS, all information necessary to: (1) administer & evaluate the program; and (2) establish and facilitate a process for current and prospective beneficiaries to exercise choice in obtaining Medicare services. |
| Exhibit 422.111(e) | Provider shall make good faith effort to notify Plan of the termination of a provider contract or subcontract, at least 75 days prior to the proposed termination date, so that Plan may notify affected members within the time period required by Federal and/or State law. |

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| Exhibit 422.502(a)(8); 422.502(1)(2) & (3) | By submitting claims or encounter data to Plan, Provider will be deemed to have certified the completeness and truthfulness of the claim or data. Plan will be relying to its detriment on that certification when it submits the data to CMS and certifies to that agency the completeness and truthfulness of the aggregated encounter data. |
| Exhibit 422.202(b); 422.504(a)(5) | Upon request, Provider shall consult with Plan as Plan develops or amends its medical and quality management policies. Provider shall comply with all applicable Plan policies and procedures, including but not limited to those on medical and quality management. |
| Exhibit 422.504(f)(2)(iv)(A), (B) & (C) | Provider understands that Plan must disclose to CMS certain quality and performance indicators relating to the provision of Plan benefits, including but not limited to Member satisfaction levels, outcomes, compliance with Applicable Requirements, number and type of grievance appeals, dis-enrollment rates for Medicare beneficiaries enrolled in Plan for the previous two years. Performance levels can affect the rate of payment from CMS and Plan's ability to retain its agreement with CMS. Provider shall cooperate with Plan in its efforts to achieve acceptable performance levels and shall take corrective action necessary to raise unacceptable performance levels. |
| Exhibit 422.204(c)(1) | Plan will notify Provider in writing of the reason for any denial, suspension & termination of the Agreement. Provider shall notify its subcontracting providers, if any, in writing of the reason for any denial, suspension & termination of their subcontracts. |
| Exhibit 422.204(c)(4) | To promote continuity of care and adequate notice to Members, Provider shall provide at least sixty (60) days' notice to its subcontracting providers, if any, before terminating any subcontract without cause. |
| Exhibit 422.752(a)(8) | Provider shall not employ or contract with, or allow its subcontractors, if any, to employ or contract with, individuals excluded from participation in Medicare under section 1128 or 1128A of the SSA or other federal program. Provider shall notify Plan immediately if it, or any of its employees or subcontractors have been debarred from any federal program. |
| Exhibit 422.562(a) | Provider shall cooperate with Plan's grievance and appeals committee and shall adhere to appeals/grievance procedures and decisions. |