

Sample Company Name, Inc.
ANCILLARY AGREEMENT

This Agreement is entered into and effective as of the date shown on the signature page ("Effective Date"), by and between Sample Company Name, Inc. a Texas non-profit 501(c)(4) corporation licensed by the Texas Department of Insurance as a health maintenance organization in the State of Texas and its Affiliates

ABC Center

1.1 Accreditation Organization. Any organization, including but not limited to, URAC, the National Committee for Quality Assurance ("NCQA") or the Joint Commission, engaged in accrediting or certifying Community or any Participating Provider.

1.2 Affiliate. A corporation, partnership or other legal entity (including without limitation any Payor) directly or indirectly owned or controlled by, or which owns or controls, or which is under common ownership or control with Community.

1.3 Benefit Plan/Program. A certificate of coverage, summary plan description, or other document or program under which Community or other Payor undertakes to provide, arrange for, pay for, or reimburse any part of the cost of health care services for eligible Members. Community may also enter into administrative agreements with other Payors, governmental, public or private employers, or other entities to provide administrative services related to providing coverage for, or pay for or reimbursing for the cost of health care services for eligible employees or other persons. Benefit Plan/Program will include information and data for other Community covered administrative services.

1.4 Bill Charges. The usual and customary charges or prices that a Provider would ordinarily charge regardless of expected payment source.

1.5 Capitation. A method of compensating a Provider for arranging for or providing a defined set of covered health care services to certain enrollees for a specified period that is based on a predetermined payment per enrollee for the specified period, without regard to the quantity of services actually provided.

1.6 CMS. The federal agency, Center for Medicare and Medicaid Services, responsible for administering the Medicare, Medicaid, and Children Health Insurance Programs.

1.7 Clean Claim. An electronic claim or paper claim for payment for services that meets the Texas

~~Health Care Payment Accessibility and Transparency Requirements Act's~~

1.8 Beneficiary Information. The name, addresses, phone numbers, and other information furnished by Beneficiary Information, Providers and Health Plans; required by providing Covered Member with a particular benefit. Provider, generally defined in Beneficiary's Provider Manual.

1.9 Beneficiary. A member of Member Group, generally referred to as payee(s), is an account identified in Member's Benefit Plan/Program, paid by a Provider as a Beneficiary for Covered Services by Member.

1.10 Beneficiary's Representative. An individual or individual's representative, including a health plan administrator, who is authorized by the Member to act on the Member's behalf in connection with the Member's health plan/program, and authorized by the provider to act on the Member's behalf covered by plan.

1.11 Beneficiary's Representative. The individual or person representing member with a health plan/program, authorized to act on the Member's behalf to pay for payee(s) Covered Services to a Provider of the member.

1.12 Beneficiary's Representative. The health plan/program paid by payee(s), generally, is a payee for which a member is authorized to receive services from Beneficiary or other payee, provided to the benefit of the Member's health plan/program.

1.13 Beneficiary's Representative. A member of Member Group, generally referred to as payee(s) or payee(s), is an account identified in Member's Benefit Plan/Program, paid by a Provider as a Beneficiary for Covered Services. Beneficiary may apply to a member's health plan/program.

1.14 Beneficiary's Representative. An individual, generally, is a payee for which a member is authorized to receive services from Beneficiary or other payee, provided to the benefit of the Member's health plan/program. Beneficiary may apply to a member's health plan/program.

1.15 Beneficiary's Representative. The health plan/program provided to a member, generally, is a payee for which a member is authorized to receive services from Beneficiary or other payee, provided to the benefit of the Member's health plan/program. Beneficiary may apply to a member's health plan/program.

1.16 Beneficiary's Representative. A member of Member Group, generally, is a payee for which a member is authorized to receive services from Beneficiary or other payee, provided to the benefit of the Member's health plan/program.

1.17 Beneficiary's Representative. A member of Member Group, generally, is a payee for which a member is authorized to receive services from Beneficiary or other payee, provided to the benefit of the Member's health plan/program.

1.18 Beneficiary's Representative. The health plan/program provided to a member, generally, is a payee for which a member is authorized to receive services from Beneficiary or other payee, provided to the benefit of the Member's health plan/program.

1.19 Beneficiary's Representative. The health plan/program provided to a member, generally, is a payee for which a member is authorized to receive services from Beneficiary or other payee, provided to the benefit of the Member's health plan/program.

1.20 Medically Necessary/Medical Necessity. Those Covered Services that Community determines under the applicable Utilization Management Program to be: (i) appropriate and necessary for the symptoms, diagnosis, treatment of a medical condition, or the diagnosis, treatment, or management of a disease, injury, or condition.

or another Payor to provide certain Covered Services.

1.25 Payor. Community, or any other public or private entity (including, but not limited to, the federal government, the State, employers, insurance carriers, self-funded plans, associations, trust funds, and health maintenance organizations), which provides, administers, funds, insures, or is responsible for paying Participating Physicians or Participating Providers for Covered Services rendered to Members.

1. All "examples" of persons or things, which have a Psychology, which is known or otherwise ascribed to in their own nature by this Science, depending, but not limited by: (1) an altogether neglected time, and, consequently, occasional repetition, or non-repetition, of the same thing, repeated or other repetition of

organization; a person who is wholly owned or controlled by a provider, or by a group of providers, who are licensed or otherwise authorized to provide the same health care service; or a person who is wholly owned or controlled by one or more hospitals and physicians, including a physician-hospital organization.

4.26 Provider Model: The Community Program

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Participating Primary Care Physicians of the participating Primary Care Health Organization are of excellent, having met a minimum standard and meet a Participating Primary Care Physician or Physician Assistant Primary Care Physician (PCP) designation. Community and its subsidiary assign the Member. Upon automatic assignment of a Participating Primary Care Physician or Participating Primary Care Provider, the Member may change to another Participating Primary Care Physician or Participating Primary Care Provider.

4.27 Member Status: Community Provider understands that no guarantee and a Provider by Community as to the number of Members and number of Community Benefit Plans Programs. Community does not expect

2.5 Regulatory Compliance. Community agrees that it shall comply with all applicable requirements of State and federal authorities, all municipal ordinances and regulations, and all State and federal statutes and regulations now or hereafter in force and effect which bear upon the subject matter of this Agreement.

SECTION 3 – OBLIGATIONS OF PROVIDER

3.1 Changes in Contracted Provider Information. Contracted Provider shall provide Community thirty (30) calendar days advanced written notice of any of the following changes, as applicable to Contracted Provider or any Healthcare Professional rendering services under the terms of this Agreement:

- a. termination of any Healthcare Professional from Contracted Provider's office;
- b. the addition of any Healthcare Professional to Contracted Provider's office;
- c. the addition of another Covered Service after the Effective Date of this Agreement to be provided to Members by Contracted Provider and;
- d. the discontinuation of delivery of any Covered Service currently offered as of the Effective Date of this Agreement, which thereby results in Members having to receive such Covered

or Covered Services to Member by Contracted Provider or that may be required for Community to meet Community's obligations defined in this Agreement.

Contracted Provider acknowledges that the addition of any Healthcare Professional shall be subject to

compensation for said Covered Services. For a situation involving Emergency Services, Contracted Provider agrees to ensure that Community or Payor is notified as soon as possible, but no later than twenty-four (24) hours after the provision of Covered Services or the ordering of the other Covered Services, or on the next business day.

3.11 Referral to Non-Participating Providers. Referral to a non-Participating Physician or non-Participating Provider requires Prior Authorization.

3.12 Certification and Regulatory Compliances. Contracted Provider and its Healthcare Professionals shall, at all times during the term of this Agreement, satisfy all State and federal certifications, regulations, or licensure requirements and shall render Covered Services under this Agreement in compliance with all applicable statutes, regulations, standards, rules, and directives of State, federal, and other governmental and regulatory bodies having jurisdiction over Contracted Provider. Evidence of such licensing, if applicable, shall be submitted to Community upon request. Contracted Provider agrees to give immediate notice to Community in the case of a disciplinary action, modification, limitation, suspension or revocation, or initiation of any proceeding that could result in a disciplinary action, modification, limitation, suspension or revocation, of such licensure.

3.13 Non-Participating Provider. Contracted Provider agrees to notify Community within twenty-four (24) hours if Contracted Provider has knowledge that a non-Participating Provider is rendering Covered Services to a Member in a situation involving Emergency Services.

3.14 New or Additional Benefit Plans/Programs. Contracted Provider acknowledges that Community may administer and/or offer new or additional Benefit Plans/Programs, and Contracted Provider, if requested by Community, agrees to negotiate with Community in good faith to amend this Agreement to include such new or additional Benefit Plans/Programs.

3.15 Payment of Applicable Taxes. Subject to the provisions of Section 5.10 ("No Surcharges") hereof, Contracted Provider shall be solely responsible for the payment of any sales, use, or other applicable taxes on the sale or delivery of medical services.

3.16 Adherence to Community Protocols. Contracted Provider shall comply with all Community Protocols without limitation, notification and Prior Authorizations as may be required for (i) medical services, hospital admissions, and elective outpatient diagnostic or procedural Covered Services; (ii) concurrent and retrospective review; and (iii) Referral procedures; provided, however, in no event shall such policies and procedures be less than the standard of care for the provision of medical services to patients in the geographic area where medical services

3.17 Electronic Connectivity. Contracted Provider agrees to communicate with Community electronically according to standard HIPAA transactions, including, but not limited to, verification of eligibility, claims status check, electronic claims submission, electronic payment remittance advice, and electronic funds transfer. In the event of a system(s) failure or a catastrophic event that substantially interferes with the Contracted Provider's business operations, Contracted Provider may submit paper claims to Community at the address in the signature block below with "Attention to Technical Support Manager" for the days during which a substantial interference with business operations occurs as a result of the catastrophic event or systems failure. Contracted Provider shall provide written notice of Contracted Provider's intent to submit non-electronic claims to Community within five (5) calendar days of the catastrophic event or systems failure. Contracted Provider may request that Community waive this requirement to communicate electronically under circumstances in which so stated in

3.18 Credentialing of Contracted Provider and/or Healthcare Professional. Contracted Provider shall submit to Community a credentials application, as modified from time to time by Community, TDI or other regulatory entity (as applicable), the current form of which will be provided by Community upon request. Contracted Provider shall be responsible for completing the credentials application in its entirety for Contracted Provider and every Healthcare Professional, including Covered Services Providers, in and over all the Agreement, including all Contracted Provider or Healthcare Professional, under Covered Services to a Member with Contracted Provider's or Healthcare Professional's credentials applications have been accepted and approved in writing by Community provided, however, this Agreement may be amended prior to acceptance by Community of all Healthcare Professional's credentials.

2.10. **Access to Energy.** **Confidential Presentations to Special Governmental and Non-Profit Organizations** concerning the use of integrated energy systems at home and abroad regulatory agencies (including the U.S. Environmental Protection Agency) and other interested parties. To be held in a confidential setting.

concerns are addressed and discussed. Information on community development programs, loans, grants or capital projects is also provided to enhance quality of life considered to be relevant. In the event the City of Phoenix is represented under this, the following provisions shall, upon request, provide and make available the staff the number of the staff, address, and probable telephone number of the person or persons to whom the City of Phoenix or its staff are authorized to provide information. All information on such staff shall be made available to a community resident who has the permission of Phoenix's Mayor and its City Manager. The City of Phoenix shall not be held liable for any information that is provided under this.

7. Continued Reporting Policy. Continued provision and protection in the United States of information necessary to the full extent by all Members of the program for consulting completely with, including the United Department of the reports of the information contained in the records.

1. Laboratory Curriculum. The Chemical Process students attend laboratory sessions. Curriculum is currently with all components of the Chemical Laboratory Improvement Act (CLIA) and implementing Chemical Process system is further under development at University. The Chemical Process is split into two parts: Process Fundamentals and Process Design. Process Fundamentals is a course that covers the basics of process design, including the design of distillation, absorption, extraction, and other unit operations. Process Design is a course that covers the design of chemical processes, including the design of reactors, heat exchangers, and other unit operations. The Chemical Process students attend laboratory sessions. Curriculum is currently with all components of the Chemical Laboratory Improvement Act (CLIA) and implementing Chemical Process system is further under development at University. The Chemical Process is split into two parts: Process Fundamentals and Process Design. Process Fundamentals is a course that covers the basics of process design, including the design of distillation, absorption, extraction, and other unit operations. Process Design is a course that covers the design of chemical processes, including the design of reactors, heat exchangers, and other unit operations.

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the "Unauthorized" Document (Proprietary), and any and all products and services provided by the Bureau. Consequently, you own the right-to-use the New Province District & Co. sales document that was written by the Bureau and after the "Unauthorized" Document is no longer used by the Bureau. We agree to delete all copies of and destroy all rights or responsibilities of Proprietor under the Agreement. Therefore, the Bureau and its affiliates acknowledge to the Agreement for execution of Section 4.2.13.

SECTION 4- EXAMINATION, 30. MAR. 6, APPROX 13 50H-1350H

Informational Privacy. Government Provider shall retain the e-records of her (its) users, or any other recipient by law authorized to obtain such records, information, and other records or may be for access by Government and with other agencies local, State, and Federal law, crime, and Government Provider shall retain such records or information available to Government, Federal and their agents, and appropriate agencies for law enforcement purposes, including agency records and the records, information, and other records.

4.2 Medical Records. Contracted Provider shall maintain a complete medical record for each Member for which Contracted Provider or Healthcare Professional renders Covered Services hereunder. Such medical records shall include the recording of a Contracted Provider's services and such other records as may be required by law. Such records shall be maintained in accordance with all applicable present and future local, State, and federal laws, rules, and regulations and shall be safeguarded against loss, destruction, and unauthorized use. All medical records shall be treated as confidential so as to comply with all State and federal laws, rules, and regulations regarding the confidentiality of patient records. Contracted Provider shall retain such medical records for a period of ten (10) years following termination of this Agreement or as mandated by any applicable State or federal law.

4.3 Member Consent to Release of Medical Record Information. Contracted Provider will obtain Member consent required in order to authorize Contracted Provider to provide access to the requested information or records as contemplated in this Section 4 of this Agreement, including copies of the Contracted Provider's medical records relating to the care provided to Member.

4.4 Access to Records. The records referred to in Section 4.2 above shall be and remain the property

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Following the effective date published by the appropriate coding entity or government agency. Should Contracted Provider submit claims using retired or replaced codes, Contracted Provider understands and agrees that Payor may deny such claims until appropriately coded and resubmitted.

5.2 Adjudication of Claims. In circumstances in which Contracted Provider is not paid Capitation, Payor will adjudicate all Clean Claims submitted by Contracted Provider within forty-five (45) calendar days for claims received by Contracted Provider via non-electronic submission, and within thirty (30) calendar days for claims



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3.6. Payor Policy/Policy Manual/Policy. Payor shall utilize CMS state Medicaid policy and nationally recognized claims and payment processing policies, procedures, and guidelines which may include claim and code audit and edit determinations and other claims logic as may be implemented by Payor. Upon request by Contracted Provider, Payor shall forward to Contracted Provider a description and copy of Payor's coding guidelines, including any underlying bundling, modeling, or other payment process and its schedules of benefits for the Contracted Provider's services. Contracted Provider shall submit such policies

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5.4 **Unilateral Dispute.** Should Contracted Provider request reconsideration of or dispute a denial or payments made by Payor under this Agreement, Contracted Provider must notify Payor in writing of dispute within nine hundred and eighty (100) calendar days of the date of the original claim adjudication. Contracted Provider acknowledges that Payor may consider Contracted Provider's failure to adhere to such

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23. Do you have any other comments? I am a member of the Veterans' Group, and I am a member of the American Legion.

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5.7 **Benefit Plan/Program Participation and Compensation Rates.** The parties agree that Exhibit B shall outline: (1) the Benefit Plan(s)/Program(s) in which Provider participates; and (2) the applicable compensation to Provider for each Benefit Plan/Program. Contracted Provider agrees to participation in such Benefit Plan(s)/Program(s) and agrees to receive compensation for Covered Services for such Benefit Plan(s)/Program(s) as described in the applicable Exhibit B.

For the term of this Agreement, Contracted Provider shall accept as payment in full for Covered Services and all other services rendered to Members under this Agreement, less any applicable Member Expense, the agreed-compensation set forth in Exhibit B, attached hereto and incorporated by reference into this Agreement. If Exhibit B outlines Contracted Provider's compensation based on Capitation for any programs in which Contracted Provider and Healthcare Professionals participate, such Capitation shall include any Member Expense. Payer shall begin payment of specified amounts to Provider, computed from the date of enrollment, not later than the stated (50th) calendar day after the day the Member selects or is assigned a PCP.

5.8 **Schedule of Benefits and Determination of Covered Services.** Upon request, Community will provide or make available to Contracted Provider with a summary of Covered Services its cash applicable Benefit Plan/Program. Payer shall be solely responsible for the determination of the extent of Member's coverage. Any action by Payer pursuant to a Member's Benefit Plan/Program, or Contracted Provider or Healthcare Professionals or Payer proposed or Utilization Management Program in no way releases Contracted Provider or Healthcare Professionals of the responsibility to provide appropriate care to Members.

5.9 **Member Hold Harmless.** Contracted Provider agrees that in no event, including but not limited to, non-payment by Payer, the ineffectiveness of Payer or breach of this Agreement, shall Contracted Provider bill, charge, collect a deposit from, seek compensation, reimbursement, or reimbursement from, or have any other accounts against any Members or persons other than Payer acting on the Member's behalf for services provided under this Agreement. This section shall not protect collection of Member Expenses made in accordance with the terms of the applicable Benefit Plan/Program. Contracted Provider shall agree that the terms of this section shall be binding on the Member, its estate, executor, administrator, heirs, assigns, personal representatives, and all other persons claiming through or by or for the Member.

5.10 **Assignment of Claims.** Contracted Provider shall assign to Payer all claims for payment for Covered Services rendered to Members under this Agreement, and the Member shall be deemed to have assigned to Payer all such claims. Payer shall be deemed to have assigned to Contracted Provider all such claims for payment for Covered Services rendered to Members under this Agreement, and the Member shall be deemed to have assigned to Contracted Provider all such claims for payment for Covered Services rendered to Members under this Agreement.

5.11 **Assignment of Claims.** Contracted Provider shall assign to Payer all claims for payment for Covered Services rendered to Members under this Agreement, and the Member shall be deemed to have assigned to Payer all such claims. Payer shall be deemed to have assigned to Contracted Provider all such claims for payment for Covered Services rendered to Members under this Agreement, and the Member shall be deemed to have assigned to Contracted Provider all such claims for payment for Covered Services rendered to Members under this Agreement.

5.12 **Member Signature Required for Services.** Prior to the provision of any Covered Services to a Member, Contracted Provider or Healthcare Professionals shall obtain written authorization with Member's signature indicating that (a) Member has been informed of the benefits to be provided; (b) the benefits to be provided are not covered by Member's health plan or other coverage; (c) Member understands and agrees to accept the terms of this Agreement; and (d) Contracted Provider or Healthcare Professionals agrees to provide the Covered Services; and (e) Member will be deemed to have accepted the terms of this Agreement.

5.13 **Assignment of Benefits.** Payer and the Covered Services provided to each Member shall be subject to assignment to Payer or Provider, and Payer shall be deemed to have assigned to Payer all such claims for payment for Covered Services rendered to Members under this Agreement. Contracted Provider and Healthcare Professionals shall agree to Member's written assignment of benefits, covering other health benefit plan coverage that is provided by Payer. Contracted Provider and Healthcare Professionals who obtain a claim for particular health care services to which they are not Payer shall provide written notice to Payer of the date of the Member of the date when Payer will be the owner of the claim. Payer will immediately process for Covered Services in accordance with the terms of the Member's Benefit Plan/Program and applicable rules and federal laws, rules,

and regulations. If a Member has coverage from more than one payment source, Payor will coordinate benefits with such other payment source in accordance with the Member's Benefit Plan/Program. Contracted Provider agrees to share information obtained or documentation required by Payor to facilitate Payor's coordination of such other benefits. If Contracted Provider has knowledge of an alternative primary Payor, Contracted Provider shall bill such other Payor(s) with the primary liability based on such information prior to submitting claims for the same services to Payor. If Payor is a secondary Payor, and pays a portion of a claim that should have been paid by the primary Payor, Payor may recover the overpayment only from the Payor that is primarily responsible for that amount. If the portion of the claim overpaid by Payor was also paid by the primary Payor, Payor may recover the amount of the overpayment from Contracted Provider or Healthcare Professional that received the payment. To the extent permitted by law, if Payor is not Member's primary Payor, payment for Covered Services from Payor shall be no more than the difference between the amount paid by the primary Payor(s) and the applicable rate under this Agreement, less any applicable Member Expense. Payor may share information with another Payor to the extent necessary to coordinate appropriate payment obligations on a specific claim.

5.13 Failure to Obtain Prior Authorization or Referral. For any Covered Services rendered to, prescribed, or authorized for Members by Contracted Provider in a non-emergent situation for which Payor requires Prior Authorization in advance of the delivery of service, which Prior Authorization was not obtained by Contracted Provider in advance, Contracted Provider acknowledges that Payor will deny Provider's claim for said Covered Services. Contracted Provider agrees that in no event will Member be financially responsible for payments arising for such services, except for applicable Member Expenses as may be required under a Benefit Plan/Program.

5.14 Services Locations/New Services. This Agreement applies to Covered Services rendered at Contracted Provider's service locations set forth in Exhibit A. In the event Contracted Provider begins providing services at other locations, new types of facilities, or other places accessible to the public, including, but not limited to, mobile units, temporary facilities, or other locations, Contracted Provider shall notify Payor in writing of such locations, new types of facilities, or other places accessible to the public, including, but not limited to, mobile units, temporary facilities, or other locations, at least 30 days prior to the start of such services.

under this Agreement, and shall be subject to the terms and conditions of any other policy, plan, or contract. It is agreed that all Covered Services subject to this Agreement will be rendered in accordance with the terms and conditions of the Agreement of Contracting.

Contracted Provider agrees to comply with all applicable laws, regulations, and policies, including, but not limited to, the terms and conditions of the Agreement of Contracting, which shall be the primary source of the terms and conditions of the Agreement of Contracting.

QUALITY MANAGEMENT AND QUALITY IMPROVEMENT PROGRAMS

SECTION 6

6.1 Quality Improvement Program. Contracted Provider shall participate in, cooperate with, and be subject to all applicable laws, regulations, and policies, including, but not limited to, the terms and conditions of the Agreement of Contracting, and shall be subject to all applicable laws, regulations, and policies, including, but not limited to, the terms and conditions of the Agreement of Contracting.

6.1 Quality Improvement Program. Contracted Provider shall participate in, cooperate with, and be subject to all applicable laws, regulations, and policies, including, but not limited to, the terms and conditions of the Agreement of Contracting, and shall be subject to all applicable laws, regulations, and policies, including, but not limited to, the terms and conditions of the Agreement of Contracting.

6.2 Quality Improvement Program. Contracted Provider shall be solely responsible for the quality of services rendered to Members. The quality of Covered Services rendered to Members shall be jointly improved. Applicable to the particular Benefit Plan/Program, Contracted Provider shall (i) cooperate with, and comply with all applicable laws, regulations, and policies, including, but not limited to, the terms and conditions of the Agreement of Contracting, and (ii) comply with all applicable laws, regulations, and policies, including, but not limited to, the terms and conditions of the Agreement of Contracting.

6.2 Quality Improvement Program. Contracted Provider shall be solely responsible for the quality of services rendered to Members. The quality of Covered Services rendered to Members shall be jointly improved. Applicable to the particular Benefit Plan/Program, Contracted Provider shall (i) cooperate with, and comply with all applicable laws, regulations, and policies, including, but not limited to, the terms and conditions of the Agreement of Contracting, and (ii) comply with all applicable laws, regulations, and policies, including, but not limited to, the terms and conditions of the Agreement of Contracting.

standard or quality of care furnished by a Contracted Provider is found to be unacceptable under any Quality Improvement Program, Community shall give written notice to Contracted Provider and/or Healthcare Professional to correct the specified deficiencies within the time period specified in the notice. Such Contracted Provider shall correct such deficiencies within that time period. Contracted Provider shall perform such quality management in accordance with the performance standards and criteria of Community.

6.3 Limitation. In no event, however, shall the requirements of such Utilization Management Program or Quality Improvement Program be less than the standard of care for the provision of medical services to patients in the geographic area where medical services are being provided by Contracted Providers under this Agreement. Further, nothing in this Agreement shall be construed to authorize Community or any of Community's officers or employees to exercise any control over the practice of medicine by Contracted Providers or the manner in which Providers provide medical services.

SECTION 7 – INSURANCE, INDEMNIFICATION & RELEASE

7.1 Professional and General Liability. Contracted Provider agrees to purchase and maintain

acceptable to Community, but in no event shall professional liability insurance be less than One Hundred Thousand Dollars (\$100,000) for each person and Three Hundred Thousand Dollars (\$300,000) for each single occurrence for

odily injury or death and One Hundred Thousand Dollars (\$100,000) for each single occurrence for injury to or destruction of property, unless a lesser amount is determined sufficient by Community in writing. Such professional liability coverage shall include the coverage of the same limits as stated above for any "claims-made" policy as necessary to continue coverage until any applicable statute of limitations has expired. Contracted Provider shall require of Contracted Provider's professional liability insurance carrier that Community be named as a party entitled to thirty (30) calendar days' prior written notice of an intent to cancel or terminate such insurance. Upon execution of this Agreement, Contracted Provider shall provide to Community written proof from Contracted Provider's carrier(s) of the coverage required under this Section.

agree to keep confidential any information regarding the other's business activities that is not otherwise available to the general public, unless prior written consent for disclosure is obtained from the other party.

9.3 Proprietary Information. All information and materials provided by Community to Contracted Provider shall remain proprietary to Community including, but not limited to, contracts, fee schedules, reimbursement rates and methodology, handbooks, and any other operations manuals. Contracted Provider shall not disclose any of such information or materials or use them except as may be required to perform Contracted Provider's obligations hereunder.

9.4 Survival of Obligations. The obligations of the parties under this Section 9 shall survive termination of this Agreement.

9.5 HIPAA Provisions. Contracted Provider and Community are Covered Entities. Therefore, Contracted Community and Provider agree to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191 (codified at 45 C.F.R. Parts 160 and 164), as amended ("HIPAA"); privacy and security regulations promulgated by the United States Department of Health and Human Services ("DHHS"); Title XIII, Subtitle D of the American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, as amended ("HITECH Act"); provisions regarding Confidentiality of Alcohol and Drug Abuse Patient Records (codified at 42 C.F.R. Part 2), as amended; and TEX. HEALTH & SAFETY CODE ANN. §§ 81.046, as amended, 181.001 et seq., as amended, 241.151 et seq., as amended, and 611.001 et seq., as amended (collectively referred to herein as the "Privacy and Security Requirements").

SECTION 10 – TERM AND TERMINATION

10.1 Term. Unless otherwise agreed upon by the parties, this Agreement shall commence on the Effective Date as indicated on the signature page of this Agreement, and shall continue for an initial term of one (1) year. The Agreement shall automatically renew for periods of one (1) year, unless either party terminates the Agreement as allowed in any of the following circumstances:

a. either party terminates the Agreement as allowed herein; or

upon written notice to Contracted Provider in the event of any of the following: (i) suspension, revocation, condition, or other action by the state or federal government, or any agency thereof, that affects the ability of Contracted Provider to provide services;

Professionals breach of Section 5.9 ("Member Hold Harmless"); (v) determination by a government agency or any judicial or administrative review body that Contracted Provider or its Healthcare Professionals have engaged in or are engaging in fraud; (vi) failure by Contracted Provider or its Healthcare Professionals to maintain the general and/or professional liability insurance coverage requirements of this Agreement; (vii) Community's reasonable determination that termination of Agreement or Contracted Provider or its Healthcare Professionals is necessary for health and safety of Member(s); or (viii) any other grounds that are not in bad faith.

10.5 Pre-Termination Review. Upon request of Contracted Provider, prior to terminating this Agreement, Community shall provide a written explanation to Contracted Provider of the reason or reasons for termination. On request and before the effective date of the termination, but within a period not to exceed sixty (60) calendar days, Contracted Provider shall be entitled to a review of Community's proposed termination by an advisory review panel appointed by Community, except in a case in which there is imminent harm to patient health, as determined solely by Community, or an action by a state medical or dental board, other medical or dental licensing board, or other licensing board or other government agency, that effectively impairs Contracted Provider's ability to practice medicine, dentistry, or another profession, or in a case of fraud or malfeasance, as determined solely by Community. The advisory review panel shall be composed of physicians and providers, including at least one representative in Contracted Provider's specialty or a similar specialty, if available, appointed to serve on the standing Quality Improvement Committee or Utilization Review Committee of Community. The decision of the advisory review panel must be considered but is not binding on Community. Community shall provide to Contracted Provider, on request, a copy of the recommendation of the advisory review panel and Community's determination. Contracted Provider

It is important to note that the model is not intended to be used for the purpose of predicting the outcome of a specific case, but rather to provide a general overview of the factors that may influence the outcome of a case.

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After chapter 6 summarizes the methods "recommended" by the FBI, *The Southern Way* is concerned with the question of the degree of a filmmaker's responsibility for a depiction of violence. The book's introduction introduces the reader to

whether, modification of them. Give definition of the Agreement for my name. Not necessarily, we've signed one at County High and elsewhere, and may be a good idea to have a second definition for a contract not to be signed. (b)(7)(D)

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information or opinions regarding the provisions, terms, requirements or services of the Benefit Plan/Program as they relate to the medical needs of the patient.

11.4 **Non-Exclusivity.** This Agreement shall not be an exclusive agreement between Community and Contracted Provider. Nothing herein shall be construed to restrict the rights of Contracted Provider (and any Healthcare Professionals) or Community to participate in other preferred provider plans, health maintenance organizations, or other managed care systems.

11.5 Entire Agreement. This Agreement, the Community Protocols, and the Exhibits constitute the sole and only agreement of the parties with respect to the subject matter hereof and supersedes any and all prior agreements or understandings, either oral or in writing, between the parties hereto with respect to the subject matter hereof, and no other agreement, understanding, or promise relating to the subject matter of this Agreement that is not embodied in this document by reference hereto shall be valid or binding. ~~Respectfully, however, the Community Services provided hereunder shall be provided in accordance with the laws and regulations of the particular State/Province.~~

14.1 **Assignment.** The Parties to this Agreement recognize that the use of either party's confidential information in violation of the other party's rights, including its right to privacy, under this Agreement, constitutes a breach of the right to privacy. Therefore, the assignment of the Agreement to any third party, in whole or in part, is prohibited.

*1.3 Stressors and Coping. Subject to the provisions of Section 5.11 below (Assignment), the Agreement shall be binding on the Party, its successors, administrators, legal representatives, executors, and assigns in the event of the Party's death.

[illegible]

ALL: Please. Please make sure for any adoption-related information, go to the local adoption agency in your area or contact the National Adoption Center, 1000 Connecticut Avenue, NW, Washington, DC 20036.

11.43 **Assignment.** This Agreement may be assigned by the student signatory of the portion herein relating to his Contracting upon written notice to the other Party. No assignment is effective until the assignment has been filed. Assignments are prohibited, voidable or otherwise imposed by any change in status or degree. Law or contract law shall be controlling. Irrevocable and shall remain in effect until the contract is terminated.

[illegible][illegible]

shall not impair or waive any such right or remedy. Every right and remedy given by this Agreement to the parties may be exercised from time to time and as often as appropriate.

11.14 No Third-Party Member. Except as set forth in Section 5.9 hereof ("Member Hold Harmless"), or as may be required by law, nothing in this Agreement is intended to, or shall be deemed or construed to, create any rights or remedies in any third party, including a Member. Nothing contained herein shall operate (or be construed to operate) in any manner whatsoever to increase the rights of any such Member or the duties or responsibilities of Provider or Community with respect to such Members.

11.15 Regulations. Community is subject to the requirements of various local, State, and federal laws, rules, and regulations. Any provision required to be

11.21 Costs Associated with this Agreement. Except as otherwise provided herein, each party shall bear the costs of its own legal, accounting, and other services necessary to comply with its duties and obligations under this Agreement.

11.22 No Waiver of Rights. The failure of either party to insist upon the strict observation or performance of any provision of this Agreement or to exercise any right or remedy shall not impair or waive any such right or remedy. Every right and remedy given by this Agreement to the parties may be exercised from time to time and as often as appropriate.

11.23 Impossibility of Performance. Neither Contracted Provider nor Community shall be deemed to be in default of this Agreement if prevented from performing for reasons beyond its control including, without limitation, governmental laws, rules and regulations, acts of God, war, and strikes. In such cases, the parties shall negotiate in good faith with the goal and intent of preserving this Agreement and the respective rights and obligations of the parties.

11.24 No Personal Liability. Nothing in this agreement is construed as creating any personal liability on the part of any officer, director, employee, or agent or any public body that may be a party to this Agreement, and the parties expressly agree that the execution of this Agreement does not create any personal liability on the part of any officer, director, employee, or agent of Community.

11.25 Use of Name. Neither Community nor Contracted Provider shall use each other's trademarks, name, or symbols without the prior written consent of the other; provided, however, Contracted Provider agrees that Community and Benefit Plans/Programs may use Provider's and each Healthcare Professional's name, office address, telephone number, and specialty, and a factual description of the practice in directories and other promotional materials.

IN WITNESS WHEREOF, the parties have and caused this Agreement to be effective on the later day and year written below by execution on behalf of **Community Health Choice, Inc.** by a duly authorized representative of **Community Health Choice, Inc.**, and by execution on behalf of Contracted Provider and Healthcare Professional by a duly authorized representative.

Sample Company Name, Inc
1400 South Loop West, Suite 125
Houston, TX 77054
Phone: 713-295-2294
Facsimile: 713-295-7058



Community Signature

Ian Smith

Printed Name

Director - Contracting

Title

Date

8/30/19

TO BE COMPLETED BY COMMUNITY ONLY:

Effective Date: SEP 01 2019

ABC Center
1400 Airport Ave Bldg D
Rosenberg, TX 77471
Phone: 281-239-1445
Facsimile: 281-239-088



Contracted Provider Signature

George Clone

Printed Name

Title

Date

123456789

TIN

112345678

NPI

EXHIBIT A

CONTRACTED PROVIDER DEMOGRAPHICS & LIST OF HEALTHCARE PROFESSIONALS

Complete list of each service location where Contracted Provider will render Covered Services, including all of the following data elements listed below.

Contracted Provider Name, Address, City, State, Zip, Telephone Number, Fax Number, E-mail Address, Website

123

123

ABC Center

www.abccenter.com

12-3456789

1234567890

12C83M

001122334

123 Maple Street, Springfield,

123-456-7890/123-456-7890

123

123 Maple Street, Springfield,

123-456-7890/123-456-7890

123 Maple Street, Springfield,

123-456-7890/123-456-7890

123 Maple Street, Springfield,

123-456-7890/123-456-7890

123

Practice or Business Location Address: / City / State/ ZIP: Phone: / Fax:	456 Oak Avenue, Coppell, TX 77423 123-456-7890/123-456-7890
Hours of operation	Mon – Fri: 8:00AM – 5:00PM
Language(s) spoken	English, Spanish

Practice or Business Location Address: / City / State/ ZIP: Phone: / Fax:	456 Oak Avenue, Coppell, TX 78934 123-456-7890/123-456-7890
Hours of operation	Mon – Fri: 8:00AM – 5:00PM
Language(s) spoken	English, Spanish

Practice or Business Location Address: / City / State/ ZIP: Phone: / Fax:	456 Oak Avenue, Coppell, TX 77488 123-456-7890/123-456-7890
Hours of operation	Mon – Fri: 8:00AM – 5:00PM
Language(s) spoken	English, Spanish

Practice or Business Location Address: / City / State/ ZIP: Phone: / Fax:	456 Oak Avenue, Coppell, TX 77471 123-456-7890/123-456-7890
Hours of operation	24 Hours – 7 days a week
Language(s) spoken	English, Spanish

Practice or Business Location Address: / City / State/ ZIP: Phone: / Fax:	456 Oak Avenue, Coppell, TX 77479 123-456-7890/123-456-7890
Hours of operation	Mon – Fri: 8:00AM – 5:00PM
Language(s) spoken	English, Spanish

Practice or Business Location Address: / City / State/ ZIP: Phone: / Fax:	456 Oak Avenue, Coppell, TX 77478 123-456-7890/123-456-7890
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456 Oak Avenue, Coppell,
123-456-7890/123-456-7890

456 Oak Avenue, Coppell,
123-456-7890/123-456-7890

Hours of operation	Mon – Fri: 8:00AM – 5:00PM
Language(s) spoken	English, Spanish



Practice or Business Location Address: / City / State/ ZIP: Phone: / Fax:	123 Maple Street, Springfield, 123-456-7890/123-456-7890 TX 77471
Hours of operation	Mon – Fri: 8:00AM – 5:00PM
Language(s) spoken	English, Spanish

Physician or Mid-Level Practitioner Last Name, First Name, MI and Degree	SEE ROSTER
Specialty / Type of Service	SEE ROSTER
Individual NPI Number	SEE ROSTER
Medicare Participation Number	SEE ROSTER
Medicaid Number	SEE ROSTER
Individual THSteps TPI	SEE ROSTER
Practice or Business Location Address: City / State/ ZIP: Phone: Fax:	SEE ROSTER
Hours of operation	SEE ROSTER
Language(s) spoken	SEE ROSTER

Facility active provider roster of healthcare professionals to be submitted by Texana Center including all data elements above.

EXHIBIT B-1 COMPENSATION

Applicable Benefit Plan(s):	☒ CHIP ☐ CHIP Perinatal ☒ STAR ☒ STAR PLUS	☐ Does not participate in CHIP ☒ Does not participate in CHIP/P ☐ Does not participate in STAR ☐ Does not participate in STAR PLUS
Provider Type:	☒ Local Mental Health Authority (LMHA) ☐ Chemical Dependency (CD) Treatment Facility ☒ Early Childhood Intervention (ECI) Provider ☒ Mental Health Targeted Case Management ☐ Non- Local Mental Health Authority (LMHA)	
Services:	☒ Behavioral Health Services ☒ Mental Health Targeted Case Management ☒ Mental Health Rehabilitative Services	

Physician/Provider agrees to participate in the Benefit Plan/Program described in this Exhibit and authorizes, through its signature below, the transfer of all payment/reimbursement terms and obligations under the Agreement to Payors as set forth in this Agreement.

 Physician/Provider

 Date

99212	Office / outpatient visit for evaluation and management; established patient	\$ 75.14	MD / DO
99213	Office / outpatient visit for evaluation and management; established patient	\$ 75.14	MD / DO
99214	Office / outpatient visit for evaluation and management; established patient	\$ 110.91	MD / DO
99215	Office / outpatient visit for evaluation and management; established patient	\$ 149.57	MD / DO

Compensation Notes:

- Community shall process Clean Claims based on the then current Texas Medicaid Fee Schedule as applicable to services rendered and according to Texas Medicaid reimbursement methodology.
- if applicable, Physician/Provider agrees to only bill for and Community shall be obligated to only pay for clinical laboratory services for

 Physician/Provider

EXHIBIT B-2 COMPENSATION

Applicable

MAINTENANCE

- ☐ Chemical Dependency (CD) Treatment Facility
- ☐ Early Childhood Intervention (ECI) Provider
- ☐ Mental Health Targeted Case Management
- ☐ Non-Targeted Case Management

subject to allowed costs that Community may apply as a result of Physician/Provider's non-compliance with any applicable credentialing, billing, Prior Authorization, Referral, or Utilization Management guidelines, or other Community Protocols referenced in this Agreement. Physician/Provider shall accept as payment in full for Covered Services and all other services rendered to Members under this Agreement, the lesser of Physician/Provider's Billed Charges or the agreed compensation set forth in this Exhibit, less any applicable Member Expense.

- All Covered Services except those listed below, one hundred fifteen percent (115%) of the then current Texas Medicaid Fee Schedule.

Applied Behavior Analysis (ABA) Services and Rates

Procedure Code	Description	Rate Per Unit (15 minutes)
97151	Behavior identification assessment, administered by a physician or other qualified healthcare professional, each 15 minutes of the physician's or other QHP's time face-to-face with patient and/or guardian(s) administering assessments and discussing findings and recommendations, and non face-to-face analyzing past data, scoring/ interpreting the assessment, and preparing the report/treatment plan	\$40.00
97152	Behavior identification supporting assessment, administered by one technician under the	\$15.50

Procedure Code	Description	Rate Per Unit (15 minutes)
97154	Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other QHP, face-to-face with 2 or more patients, each 15 minutes	\$ 11.00
97155	Adaptive behavior treatment, with protocol modification, administered by physician or other QHP, which includes simultaneous direction of technician, face-to-face with one patient, each 15 minutes	\$ 30.00
97156	Family adaptive behavior treatment guidance administered by physician or other QHP (with or without the patient present), face-to-face with guardians(s)/caregiver(s), each 15 minutes	\$ 30.00
97157	Multiple-family group adaptive behavior treatment guidance administered by physician or other qualified healthcare professional (without the patient present) face-to-face with multiple sets of guardians(s)/ caregiver(s)	\$ 22.00
97158	Group adaptive behavior treatment with protocol modifications, administered by a physician or other QHP, face to face with multiple patients, each 15 minutes	\$ 22.00
0373T	Adaptive behavior treatment with protocol modification, each 15 minutes of technician's time face-to-face with a patient requiring the following components: *administered by the physician or other qualified healthcare professional who is on site, * with the assistance of two or more technicians, *for a patient who exhibits destructive behavior, *completed in an environment that is customized to a patient's behavior	\$ 45.00
H0032	Mental health service plan development by a non-physician	\$ 25.00

Compensation Notes:

- Community shall process Clean Claims based on the Texas Medicaid Fee Schedule as applicable to services rendered and according to Texas Medicaid reimbursement methodology.
- If applicable, Physician/Provider agrees to only bill for and Community shall be obligated to only pay for clinical laboratory services for which Physician/Provider holds a valid CLIA certification.
- If Physician/Provider bills for a Covered Service for which no reimbursement is defined by any of the methods listed above, Community shall compensate Physician/Provider according to thirty percent (30%) of Physician/Provider's Billed Charges.

Physician/Provider Signature:  Date: 8-28-19

EXHIBIT B-3 COMPENSATION

Applicable:	☒ Do Not Participate (N-P) ☒ Do Participate (P)
By: <u>Dr. [Redacted]</u>	
Reviewed by:	☐ Local Mental Health Authority (LMA) ☐ Chemical Dependency (CD) Treatment Facility ☐ Early Childhood Intervention (ECI) Provider ☐ Mental Health Targeted Case Management ☐ Non-Local Mental Health Authority (NLA)
Service:	☐ Behavioral Health Services ☐ Mental Health Targeted Case Management ☐ Mental Health Rehabilitation Services

(Physician/Provider does not participate above program.)

Physician/Provider Signature: _____

[Signature]

Date: 8-28-19

Sample Company Name, Inc

This Addendum may be updated and amended unilaterally at any time in order to comply with any local, state, or federal laws, rules, or regulations. If Community has delegated administrative functions to any Subcontractor under the Agreement

that the terms of the White-Backed will govern up until:

SECTION 1 - INTRODUCTION

Many words and terms are capitalized throughout this Addendum to indicate that they are defined in Section 1. Capitalized terms used without definition should be understood to have the same meaning as such in the Agreement unless indicated to the contrary in the White-Backed or under "Common Law."

For purposes of this Addendum, the term "Provider" means participating Provider as defined in the Agreement. The term "Contractor" indicates any Subcontractor designated as a provider by Community under the Agreement or otherwise (including or otherwise for purposes of General Services).

1.1 **As a term, "Contractor" may, primary may, and other related term provided under the structure of a population base including being consistently used herein.**

1.2 **Administrative Health Services** - General Services by the structure of general, organized, or structured department, system.

1.3 **General Services** - Health Care Services Contractor may provide to providers, including, but not limited to, any services required by the state contract, state and federal law, and accepted patient population may that under the state contract.

1.4 **2019 State Health Insurance Program as of 2019** - The health insurance program established and funded pursuant to the 2019 Health Insurance Act (HIA 2019) (HIA 2019) and established by Texas Health and Human Services Department (THHSD).

1.5 **2019 Program** - The state of Texas program established in 2019 pursuant to the 2019 Health Insurance Act (HIA 2019) and established by Texas Health and Human Services Department (THHSD).

1.6 **2019 Program** - The state of Texas program established in 2019 pursuant to the 2019 Health Insurance Act (HIA 2019) and established by Texas Health and Human Services Department (THHSD). The state of Texas program established in 2019 pursuant to the 2019 Health Insurance Act (HIA 2019) and established by Texas Health and Human Services Department (THHSD).

1.7 **Contracting** - As used in this Addendum 1.7 is a term defined by statute or provider for medical services as defined in the state contract, state and federal law, and accepted patient population may that under the state contract. As used in this Addendum 1.7 is a term defined by statute or provider for medical services as defined in the state contract, state and federal law, and accepted patient population may that under the state contract.

1.8 **Contracting** - As used in this Addendum 1.8 is a term defined by statute or provider for medical services as defined in the state contract, state and federal law, and accepted patient population may that under the state contract.

1.9 **Contracting** - As used in this Addendum 1.9 is a term defined by statute or provider for medical services as defined in the state contract, state and federal law, and accepted patient population may that under the state contract.

1.10 **Contracting** - As used in this Addendum 1.10 is a term defined by statute or provider for medical services as defined in the state contract, state and federal law, and accepted patient population may that under the state contract.

- (b) the Subcontract is considered by HHSC to be for a key type of service or function, including Administrative Services (including, but not limited to, third party administrator, Network administration, and claims processing); delegated Networks (including, but not limited to, behavioral health, dental, pharmacy, and vision); management services (including management agreements with parent); reinsurance; Disease Management; pharmacy benefit management ("PBM") or pharmacy administrative services; call lines (including nurse and medical consultation); or
- (c) any other Subcontract that exceeds, or is reasonably expected to exceed, the lesser of:
 - a. \$500,000 per year, or
 - b. 1% of Company's annual Revenues under the State Contract.
- (d) Any Subcontracts between Company and a single entity that are split into separate agreements by time period, Program, or SDA, etc., will be consolidated for the purpose of this definition. For the purposes of the Agreement, Material Subcontracts do not include contracts with any non-Affiliates for any of the following, regardless of the value of the contract: utilities (e.g., water, electricity, telephone, Internet, trash), mail/shipping, office space, maintenance, security, or computer hardware.

1.10 Medicaid. The medical assistance entitlement program authorized and funded pursuant to Title XIX, Social Security Act (42 U.S.C. § 1396, *et seq.*) and administered by HHSC.

1.11 Medical Home. A patient-centered medical home as described in Texas Government Code § 533.0029(a).

1.12 Primary Care Physician or Primary Care Provider ("PCP"). A physician or provider who has agreed with Community to provide a Medical Home to Members and who is responsible for providing initial and primary care to patients, maintaining the continuity of patient care, and initiating referral for care.

1.13 State Contract. The HHSC Uniform Managed Care Contract ("UMCC") for Medicaid, CHIP and STAR+PLUS Contract(s) where applicable.

1.14 Subcontractor. Any entity with a Material Subcontract with Community.

1.15 Texas Health Steps or THSteps. The name adopted by the State of Texas for the federally mandated Early and Periodic Screening, Diagnosis and Treatment ("EPSDT") program. It includes the State's Comprehensive Care Program extension to EPSDT, which adds benefits to the federal EPSDT requirements contained in 42 U.S.C. § 1396c, and defined and codified at 42 C.F.R. §§ 440.40 and 441.66-62. HHSC's rules are contained in 25 T.A.C., Chapter 33 (relating to Early and Periodic Screening, Diagnosis and Treatment).

SECTION 2 – OBLIGATIONS OF COMMUNITY

2.1 Community will initiate and maintain any action necessary to stop Provider or employee, agent, assign, trustee, or successor-in-interest from maintaining an action against HHSC, an HHS Agency, or any Member to collect payment from HHSC, an HHS Agency, or any Member, excluding payment for non-covered services. This provision does not restrict a CHIP Provider from collecting allowable copayment and deductible amounts from CHIP Members. Additionally, this provision does not restrict a CHIP Dental Provider from collecting payment for services that exceed a CHIP Member's benefit cap.

SECTION 3 – OBLIGATIONS OF PROVIDER

3.1 Provider acknowledges that HHSC does not assume liability for the actions of, or judgments rendered against, Community, its employees, agents or subcontractors or sub-contractors. Further, Provider understands and agrees that HHSC and its employees, agents or subcontractors will not defend HHSC for any claims or judgments rendered against Community. HHSC's liability to Provider, if any, will be governed by the Texas Tort Claims Act, as amended or modified (TEX. CIV. PRAC. & REM. CODE § 101.001, *et seq.*).

3.2 Pharmacy. If prior authorization for a medication is not immediately available, a 72-hour emergency supply may be dispensed when the pharmacist on duty recommends it as clinically appropriate and when the medication is needed without delay. Please consult the Vendor Drug Program Pharmacy Provider Procedures Manual, the Texas Medicaid Provider Procedures Manual, and Community's Provider Manual (page 48) for information regarding reimbursement for 72-hour emergency supplies of prescription claims. It is important that pharmacies understand the 72-hour emergency supply policy and procedure to assist Medicaid clients.

3.3 Access to Records.

a. Provider agrees to provide at no cost to HHSC: all information required under Community's managed care contract with HHSC, including, but not limited to, the reporting requirements and other information related to Provider's

performance of its obligations under that contract; and any information in its possession sufficient to permit HHSC to comply with the federal Balanced Budget Act of 1997 or other federal or state laws, rules and regulations. All information must be provided in accordance with the timelines, definitions, formats and instructions specified by HHSC.

b. Provider agrees that upon receipt of a record review request from HHSC's Office of Inspector General ("OIG"), Special Investigative Units (SIUs) or another state or federal agency authorized to conduct compliance, regulatory, or program integrity functions, Provider shall provide, at no cost to requesting agency, the records requested within 3 business days of the request. If the OIG, SIUs or another state or federal agency representative believes that the requested records are about to be altered or destroyed or that the request may be completed at the time of the request and/or in

[illegible]

Provider must provide names whenever a listing is not available under the name, address, and phone. Provider must provide such names in reasonable number and provide any additional information that will assist in identifying the person. Information to include may be the last, first and middle names, date of birth, sex, telephone, address, occupation, ethnic background, last listing of name, occupation or description, or any other purpose to aid the person concerned in identifying the person or persons. See section 201.10.

4. Further investigation and review of the membership of the various life agencies; with an emphasis on the welfare of the World People's Union (WPU), of the Movement's groups, in order to be consistent in accordance with their goals. Further review again is required by the WPU or the members to the extent of the study as mentioned, having a review of people involved at the end.

10. The following information was obtained from the records of the Department of the Interior, Bureau of Land Management, regarding the land owned by the United States in the State of Alaska, and is hereby incorporated by reference into this report. The information is as follows: The total land owned by the United States in the State of Alaska is 1,182,000,000 acres. The land is divided into three categories: (1) National Forest Land, (2) National Monument Land, and (3) National Preserve Land. The total land owned by the United States in the State of Alaska is 1,182,000,000 acres. The land is divided into three categories: (1) National Forest Land, (2) National Monument Land, and (3) National Preserve Land.

[illegible][illegible]

4.4 Salinity Tolerances of the 70 Species and Implications for the Florida Bay Project

[illegible]

{“IFSP”). Provider understands and agrees that any Medically Necessary Health and Behavioral Health Services contained in IFSP must be provided to the Member in the amount, type, and manner specified in the IFSP.

confirmed or suspected TB have a contact investigation and receive Directly Observed Therapy (DOT). The Network Providers must report to the Texas Department of State Health Services (DSHS) or the local TB control program any Member who is non-compliant, drug resistant, or who is or may be posing a public health threat.

3.11 Lead Screening. Provider agrees to (1) report all blood lead results to the Childhood Lead Poisoning Program (if not performed at the DSHS state laboratory) and (2) follow up on suspected or confirmed cases of Childhood Lead exposure with the Childhood Lead Poisoning Prevention Program, and follow the Centers for Disease Control and Prevention guidelines for testing children for lead and following up care for children with elevated lead levels based on [Environmental Health Guidance Report 103](#) ([provider reference link](#)).

3.12 Waiting Times for Appointments. Provider must provide:

- Emergency services upon Member presentation at the service delivery site, including at non-network and out-of-area facilities where applicable;
 - Treatment for an Urgent condition, including urgent specialty care, within 24 hours before notification;
 - Routine primary care within 14 days;
 - Specialty routine care within 21 days;
 - Urgent specialty care within 14 days (this requirement does not apply to CRP Pediatric Members);
 - Non-urgent specialty care within 30 days (this requirement applies to STAR Health only);
 - Preventive care within 14 days, except for high-risk pregnancies or other Members in the high-risk group, for whom an appointment must be placed within 8 days, or immediately, if an emergency service return is indicated; and
 - Preventive health services including annual adult well checks for Members 21 years of age or older must be placed within 14 days before notification.
- Preventive health services for Members less than 6 months of age must be provided within 14 days. Preventive health services for Members 6 months through age 30 must be provided within 30 days. CRP Members should receive preventive care in accordance with the American Academy of Pediatrics (AAP) periodically schedule. STAR Health Members should receive preventive care in accordance with the Texas Health Steps preventive schedule.

In addition, CRP must make referrals for specialty care promptly based on the urgency of the condition.

12345

Sample Company Name
P.O. Box 123456

	Coppell, TX 77230-1404
Certified Mail	Sample Company Name 123 Maple Street, Springfield, Coppell, TX 77054

Provider may call 123-456-7890 for all claims inquiries.

Community will notify Provider in writing of any changes in the list of claims processing and adjudication entities at least 30 days prior to the effective date of change. If Community is unable to provide 30 days' notice, Community will give Provider a 30-day extension on its claims filing deadline to ensure claims are routed to the correct processing center.

4.3 Corrected Claims. A Corrected Claim is a claim that has already been adjudicated, whether paid or denied. Provider must submit a Corrected Claim if the original claim adjudicated needs to be changed. A Corrected Claim could be a result of:

- Errors were found involving diagnosis, procedure, date or modifier.
- Claims contained missing, incorrect, or incomplete data according to our claims submission requirements.
- Services were missed in an original claim.

Community shall not be responsible for a Provider's selection of a processing center, or for the accuracy or completeness of claims submitted by a Provider, and the release of claims is based on the signature provider's notification of the required or services. The member and associated network provider identifier numbers of the encounter will remain confidential. Community shall not be responsible for the development, submission, or processing of a claim that is not required or needed as required by the plan. Community shall not be responsible for the development, submission, or processing of a claim that is not required or needed as required by the plan. Community shall not be responsible for the development, submission, or processing of a claim that is not required or needed as required by the plan.

- 4.3 Adjudication of Claims.** Community shall adjudicate (process as paid or denied electronically) Clean Claims by:
- healthcare services within 60 days from the date the claim is received by the HMO;
 - primary services no later than 30 days of receipt if submitted electronically, or 21 days of receipt if submitted non-electronically; and
 - Community will pay Maximum Allowed Amount (AMA) on all clean claims that are not adjudicated within 60 days.

Community must withhold all or part of payment for any claim submitted by a Provider for any of the following reasons:

- excluded or suspended from the Medicaid, Medicaid, or CHIP programs for Fraud, Abuse, or Waste;
- any payment held under the authority of a state or its authorized agency;
- with debts, delinquencies, or pending payments due to HMO, or the state or federal government;
- for medical services provided on or after September 1, 2018, if submitted by a Hospital that does not have a national level of care designation from HHSO;
- for medical services provided on or after September 1, 2018, if submitted by a Hospital that does not have a national level of care designation from HHSO.

In compliance with Texas Health and Safety Code § 245.004, the provisions on payment withheld in items (d) and (e) above do not apply to emergency services that must be provided or reimbursed under state or federal law.

Community shall not be responsible for a Provider's selection of a processing center, or for the accuracy or completeness of claims submitted by a Provider, and the release of claims is based on the signature provider's notification of the required or services. The member and associated network provider identifier numbers of the encounter will remain confidential. Community shall not be responsible for the development, submission, or processing of a claim that is not required or needed as required by the plan. Community shall not be responsible for the development, submission, or processing of a claim that is not required or needed as required by the plan. Community shall not be responsible for the development, submission, or processing of a claim that is not required or needed as required by the plan.

If an exception to the 2-year limitation applies, then Community may recoup related payments from providers.

If an additional payment is due to Provider as a result of an audit, Community must make the payment no later than 30 days after it completes the audit. If the audit indicates that Community is due a refund from Provider, except for retroactive changes to a Member's Medicaid eligibility, Community must send Provider written notice of the basis and specific reasons for the recovery no later than 30 days after it completes the audit. If the provider disagrees with Community's request, Community must give Provider an opportunity to appeal, and may not attempt to recover the payment until the provider has exhausted all appeal rights.

4.7 Co-payments and Deductibles. Co-payments are the only amounts that Provider may collect from CHIP Members, except for costs associated with unauthorized non-emergency services provided to a Member by out-of-network providers for non-covered services.

Provider is responsible for collecting at the time of service any applicable CHIP co-payments or deductibles in accordance with CHIP cost-sharing limitations.

Providers shall not charge: (a) cost-sharing or deductibles to CHIP Members of Native American Tribes or Alaskan Natives; (b) co-payments or deductibles to the CHIP Member with an ID card that indicates the Member has met his or her cost-sharing obligation for the balance of their term of coverage; (c) co-payments for well-child or well-baby visits or immunizations; or (d) co-payments for routine preventive and diagnostic dental services (CHIP Dental).

4.8 Liability for Payment of Services. Provider understands and agrees that HHSC is not liable or responsible for payment for Covered Services rendered pursuant to the Agreement. In no event, including, but not limited to, nonpayment by Community, Community's insolvency or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Member or persons other than Community acting on their behalf for Covered Services provided pursuant to this Agreement. Provider further understands and agrees that Community's Members may not be held liable for Community's debts in the event of Community's

[illegible]

6.8 What Party Resources. Further acknowledge and agree that it may not interact with or place any bets upon the Website, right or ownership rights, including on the Website, except in connection with bona-fide transactions, and that since from the date of registration for, use, access, or other financial related payment made by Government, individuals, firms, companies, or projects is subject to "What Party Resources". 2019 may attempt obtaining information of any nature by Government. This will include, in all, all details provided on a basis of any confidential agency or individual's effort.

a. 40. Example of Non-Conserved Resources. Provide a list of three instances of the need for non-conserved resources either in production or in consumption. Provide a brief explanation of each. (10 points)

53. *Abstracts of the Proceedings of the 1994 Annual Meeting of the American Psychological Association, Washington, DC, August 12-16, 1994.* American Psychological Association, Washington, DC, 1994.

[illegible]

effectiveness was based on the assumption of an equal follow-up period. In the event, patients were randomly selected from the database and matched on age, sex, and ethnicity. Upcoming scheduled follow-up visits were used to ensure that patients were followed for the same duration.

SECTION 5 – DISPUTE RESOLUTION

5.1 Complaints and Appeals. Community's complaint and appeal processes applicable to Provider under the terms of this Agreement are set forth in the Provider Manual. Specifically, a Provider may file a complaint at any time with Community. Send Complaints to:

Sample Company Name

Attn: Services Improvement Team

123 Maple Street, Springfield,

Houston, TX 77054

Fax: 123.456.7890

Email: ServiceImprovement@companyname.org

Complaints may also be submitted online at the Community Web site <https://www.companyname.org> Community shall acknowledge all written complaints within five business days. If a Provider's complaint is oral, Community's acknowledgement letter shall include a one-page Complaint Form. Community shall acknowledge, investigate and resolve all complaints no later than the 30th calendar day after the date Community receives written complaint or one-page complaint form from the complainant. Community will retain all Provider complaint documentation, including fax cover sheets, emails to and from Community, and a telephone log of communication related to the complaint. Provider understands and agrees that HHSC reserves the right and retains the authority to make reasonable inquiry and to conduct investigations into Provider and Member complaints.

5.2 Claim Appeals. An appealed claim is a claim that has been previously adjudicated as a Clean Claim and the Provider is appealing the disposition through written notification to Community. Provider must request Claim Appeals within 120 days from the date of remittance of the Explanation of Payment (EOP).

SECTION 6 – CONFIDENTIALITY

6.1 Provider agrees to treat all information that is obtained through the performance of the services included in this Agreement as confidential information to the extent that confidential treatment is provided under state and federal laws, rules and regulations. This includes, but is not limited to, information relating to applicants or recipients of HHSC Programs.

6.2 Provider agrees it shall not use information obtained through the performance of this Agreement in any manner except as is necessary for the proper discharge of obligations and securing of rights under this contract.

6.3 Provider agrees to protect the confidentiality of Member Protected Health Information ("PHI"), including patient records. Provider must comply with all applicable federal and state laws, including the HIPAA Privacy and Security Rule

SECTION 7 – ASSIGNMENT

7.1 Provider hereby agrees and agrees to the following:

7.1.1 Provider shall not assign, subcontract, or otherwise transfer its obligations under this Agreement to any third party without the prior written consent of Community. Any assignment, subcontract, or transfer of Provider's obligations under this Agreement shall be null and void and any such assignment, subcontract, or transfer shall be deemed to be a breach of this Agreement. Provider shall be responsible for ensuring that any assignment, subcontract, or transfer of its obligations under this Agreement complies with all applicable laws, rules, and regulations, including the HIPAA Privacy and Security Rule.

7.1.2 Provider shall not assign, subcontract, or otherwise transfer its obligations under this Agreement to any third party without the prior written consent of Community. Any assignment, subcontract, or transfer of Provider's obligations under this Agreement shall be null and void and any such assignment, subcontract, or transfer shall be deemed to be a breach of this Agreement.

7.1.3 Provider shall not assign, subcontract, or otherwise transfer its obligations under this Agreement to any third party without the prior written consent of Community. Any assignment, subcontract, or transfer of Provider's obligations under this Agreement shall be null and void and any such assignment, subcontract, or transfer shall be deemed to be a breach of this Agreement.

7.1.4 Provider shall not assign, subcontract, or otherwise transfer its obligations under this Agreement to any third party without the prior written consent of Community. Any assignment, subcontract, or transfer of Provider's obligations under this Agreement shall be null and void and any such assignment, subcontract, or transfer shall be deemed to be a breach of this Agreement.

- (5) If the Provider places required records in another legal entity's records, such as a hospital, the Network Provider is responsible for obtaining a copy of these records for use by the above-named entities or their representatives.
- (6) Network Providers must report any suspected fraud or abuse including any suspected fraud and abuse committed by the MCO or a Member, to the HHSO Office of Inspector General.

SECTION 8 – INSURANCE

8.1 Provider shall maintain, during the term of the Provider contract, Professional Liability Insurance of at least \$100,000 per occurrence and \$300,000 in the aggregate, or, where applicable, the limits required by the hospital at which Provider has admitting privileges.

8.2 Subsection 8.1 does not apply if Provider is a state or federal unit of government, or a municipality, that is required to comply with, and is subject to, the provisions of the Texas and/or Federal Tort Claims Act.

SECTION 9 – LAWS, RULES AND REGULATIONS

9.1 Liability for Violation of Applicable Laws. Provider understands and agrees that it is subject to all state and federal laws, rules, regulations, waivers, policies and guidelines, and court-ordered consent decrees, settlement agreements or other court orders that apply to this Agreement and Community's managed care contract with HHSC, the Community Program, and all persons or entities receiving state and federal funds. Provider understands and agrees that any violation by a provider of a state or federal law relating to the delivery of services pursuant to this Provider Agreement, or any violation of Community's contract with HHSC could result in liability for money damages, and/or civil or criminal penalties and sanctions under state and/or federal law.

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9.3 Marketing. Provider agrees to comply with state and federal laws, rules and regulations governing marketing. Provider agrees to comply with HHSC's marketing policies and procedures, as set forth in HHSC's Uniform Managed Care Manual. Provider is prohibited from engaging in direct marketing to Members that is designed to increase enrollment in a particular health plan. The prohibition should not constrain Provider from engaging in permissible marketing activities consistent with broad outreach objectives and application assistance.

9.4. Member Protections. Provider must inform Community of any reports of abuse, neglect or exploitation made regarding a Member. This includes self-reports and reports made by others that Provider becomes aware of.

SECTION 10 – MEMBER COMMUNICATIONS

10.1 Nothing contained in this Agreement is intended to interfere with or hinder communications between Provider and Member regarding a patient's medical condition and/or treatment options; Community's referral policies, and other Community policies, including financial incentives or arrangements and all managed care plans with whom the Provider contracts.

SECTION 11 – PRIMARY CARE PHYSICIANS AND PRIMARY CARE PROVIDERS

11.1 Accessibility. If Provider is a PCP, it must be accessible to Members 24 hours per day, 7 days per week.

11.2 Preventative Care. If Provider is a PCP, it must provide preventative care to children under age 21 in accordance with AAP recommendations for CHIP Members and CHIP Perinatal Newborns; the THSteps periodicity schedule published in the THSteps

11.3 For each primary care physician or other provider who is a member of the Provider's network, the Provider shall ensure that the member is notified of the member's right to request a second opinion from a provider who is not a member of the Provider's network. The Provider shall ensure that the member is notified of the member's right to request a second opinion from a provider who is not a member of the Provider's network. The Provider shall ensure that the member is notified of the member's right to request a second opinion from a provider who is not a member of the Provider's network.

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11.5 For each primary care physician or other provider who is a member of the Provider's network, the Provider shall ensure that the member is notified of the member's right to request a second opinion from a provider who is not a member of the Provider's network. The Provider shall ensure that the member is notified of the member's right to request a second opinion from a provider who is not a member of the Provider's network. The Provider shall ensure that the member is notified of the member's right to request a second opinion from a provider who is not a member of the Provider's network.

11.6 For each primary care physician or other provider who is a member of the Provider's network, the Provider shall ensure that the member is notified of the member's right to request a second opinion from a provider who is not a member of the Provider's network. The Provider shall ensure that the member is notified of the member's right to request a second opinion from a provider who is not a member of the Provider's network. The Provider shall ensure that the member is notified of the member's right to request a second opinion from a provider who is not a member of the Provider's network.

SECTION 13 – BEHAVIORAL HEALTH

13.1 If Provider is a PCP, it must have screening and evaluation procedures for detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders.

13.2 Providers who provide inpatient psychiatric services to a Member must schedule the Member for outpatient follow-up and/or continuing treatment prior to discharge. The outpatient treatment must occur within 7 days from the date of discharge. Behavioral Health providers must contact Members who have missed appointments within 24 hours to reschedule appointments.

13.3 All behavioral and physical health providers (including PCPs, OB/GYNs, internists, and other relevant provider types) must share amongst each other clinical information regarding Members with co-occurring behavioral and physical health conditions, to the extent allowed by federal law.

ADDITIONAL PROVISIONS SPECIFIC TO MEDICAID

1. Durable Medical Equipment. Please consult the Texas Medicaid Provider Procedures Manual, Durable Medical Equipment (DME) and Comprehensive Care Program (CCP) sections, and Community's Provider Manual (Pharmacy and Benefits sections) for information regarding the scope of coverage of durable medical equipment (DME) and other products commonly found in a pharmacy. For qualified children, this includes medically necessary over-the-counter drugs, diapers, disposable/expendable medical supplies, and some nutritional products. It also includes medically necessary nebulizers, ostomy supplies or bed pans, and other supplies and equipment for all qualified Members. Community encourages your pharmacy's participation in providing these items to Medicaid clients.
2. Family Planning. If a Member requests contraceptive services or family planning services, Provider must provide Member counseling and education about family planning and available family planning services. Provider shall not require parental consent for Members who are minors to receive family planning services. Provider must comply with state and federal laws and regulations governing Member confidentiality (including minors) when providing information on family planning services to Members.
4. Provider Fraud and Abuse Policy. If Provider receives annual Medicaid payments of at least \$5 million dollars (cumulative, from all sources), Provider must:
 - a. Establish written policies for all employees, managers, officers, contractors, subcontractors and agents of Provider. The policies must provide detailed information about the False Claims Act, administrative remedies for false claims and statements, any state laws about civil or criminal penalties for false claims, and whistleblower protections under such laws, as described in Section 1902(a)(68)(A) of the Social Security Act.

Referral and Coordination of Care. If Provider is a PCP, it must assess the medical needs and behavioral health needs of Members for referral to specialty care providers and provide referrals as needed; coordinate Members' care with specialty care providers after referral; and serve as a Medical Home to Members.

6. Payment for Services. Provider is prohibited from billing or collecting from a Medicaid Member for health care services provided pursuant to the Agreement. Federal and state laws provide severe penalties for any provider to bill or collect any payment from a Medicaid recipient for a Covered Service.
7. Mental Health. Provider must comply with 25 Tex. Adm. Code, Part 1, Chapter 415, Subchapter F, "Interventions in Mental Health Services," when providing mental health rehabilitation services and mental health targeted case management.
8. Electronic Visit Verification. Network Providers using the EVV system must maintain compliance with HHSC minimum standards detailed in UCM, Chapter 8.7, Section IX.

9. Service Coordination. All Home and Community Support Services Agency (HCSA) providers, adult day care providers, and residential care facility providers must notify the MCO if a Member experiences any of the following: a) a significant change in the Member's physical or mental condition or environment; b) hospitalization; c) an emergency room visit; or d) two or more missed appointments.

10. Waiting Times for Appointments. In addition to the requirements in 3.12 of this Addendum, Community Long-Term Services and Supports for Members must be initiated within 7 days from the start date on the Individual Service Plan or the eligibility effective date for non-waiver LTSS unless the referring provider, Member, or STAR+PLUS Handbook states otherwise.

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