

COMMUNITY FIRST HEALTH PLANS, INC.

ANCILLARY PROVIDER AGREEMENT

AGREEMENT BETWEEN CFHP AND ANCILLARY PROVIDER

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ANCILLARY PROVIDER AGREEMENT

This Ancillary Provider Agreement ("Agreement") is made and entered into as of the First day of _____, _____ by and between _____ (Provider"), and **Community First Health Plans, Inc. ("CFHP")** identified in Addendum A to this Agreement.

RECITALS

- A. Provider is a corporation or other public or private entity that is licensed or otherwise legally permitted to provide Contracted Services with the State(s).
- B. CFHP is a Texas non-profit corporation which has the legal authority to enter into this Agreement, and to perform the obligations of CFHP hereunder with respect to the Benefit Programs identified on Addendum A.
- C. CFHP desires to enter into this Agreement to arrange for Provider to render Contracted Services to Beneficiaries of the various Benefit Programs identified on Addendum A.
- D. Provider desires to enter into this Agreement to render Contracted Services to Beneficiaries of the various Benefit Programs identified on Addendum A.

AGREEMENT

NOW, THEREFORE, in consideration of the above recitals and the covenants contained herein, the parties hereby agree as follows:

1. DEFINITIONS

Many words and terms are capitalized throughout this Agreement to indicate that they are defined as set forth in this Article I.

- 1.1 Beneficiary:** A person who is eligible to receive Covered Medical Services under a Benefit Program included in this Agreement. May also be referred to as Member.
- 1.2 Benefit Program:** CFHP's performance of its obligations to provide, arrange or administer health care, provider networks, administrative or other related services pursuant to a written agreement between a public or private employer or other entity and CFHP. The Benefit Programs covered under this agreement are listed on Addendum A hereto, as amended from time to time.
- 1.3 Benefit Program Requirements:** The rules, procedures, policies, protocols and other conditions to be followed by Participating Providers and Beneficiaries with respect to providing Covered Medical Services under a particular Benefit Program.
- 1.4 Capitation Compensation:** Compensation made by CFHP or Payor for a specified period of time, usually on a monthly basis (unless otherwise set forth in applicable Addenda), per Member (Beneficiary), as indicated in the applicable Addenda to this Agreement, compensation is for each Member who has selected or been assigned to Provider. May appear as Cap.

- 1.5 Contracted Services:** All Covered Medical Services and supplies listed on Addendum C, except Excluded Services, to be rendered by Provider to a Beneficiary in accordance with this Agreement.
- 1.6 Coordination of Benefits:** The allocation of financial responsibility between two or more Payors of health care services, each with a legal duty to pay for or provide Covered Medical Services to a Beneficiary at the same time.
- 1.7 Copayment:** That portion of the cost of Covered Medical Services that a Beneficiary is obligated to pay under a particular Benefit Program, including a deductible and co-insurance. A Copayment may be either a fixed dollar amount or a percentage of the applicable Participating Provider contract rate. CFHP will advise Participating Providers of the amounts or methods by which Copayments may be determined.
- 1.8 Covered Medical Services:** The Medically Necessary health care services and supplies that are to be provided pursuant to a Benefit Program.
- 1.9 Emergency:** The sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including sever pain, such that the absence of immediate medical attention could reasonably be expected to result in: (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part. A medical emergency continues as long as the Beneficiary is unable to be transferred to the appropriate CFHP Facility because the nature of the illness or injury involved and/or the distance to the Facility would make the transfer medically unreasonable.
- 1.10 Excluded Services:** Those health care services and supplies which are determined not to be Medically Necessary, or which otherwise are not Covered Medical Services under the applicable Benefit Program.
- 1.11 Facility(ies):** The hospitals, health care facility(ies) and other service locations operated by Provider at which Contracted Services are to be provided under this Agreement. Provider's hospitals, health care facilities and other service locations are listed on Exhibit 1 to Addendum A of this Agreement, as amended from time to time.
- 1.12 Medically Necessary:** Those Covered Medical Services which are determined under the applicable Utilization Management Program to be:
- (a) Appropriate and necessary for the symptoms diagnosis or treatment of a medical condition; and
 - (b) Provided for the diagnosis or direct care and treatment of a medical condition; and
 - (c) Within standards of good medical practice within the organized medical community of the treating provider; and
 - (d) Not primarily for the convenience of the Beneficiary or the treating provider; and
 - (e) Consistent with the medical policy, the Utilization Management Program and Quality management Program requirements and the Benefit Program Requirements applicable to the Benefit Program under which the Covered Medical Services are rendered; and

- (f) The most appropriate and cost effective service or supply consistent with generally accepted medical standards of care. For inpatient stays, this means that acute care as an inpatient is necessary due to the kind of services the Beneficiary is receiving or the severity of the Beneficiary's condition, and that safe, cost effective and adequate care cannot be received as an outpatient or in a less intensified medical setting.
- 1.13 Member.** A person who is eligible to receive Covered Medical Services under a Benefit Program included in this Agreement. May also be referred to as Beneficiary.
- 1.14 Participating Provider:** A hospital, physician, physician organization or association other health care practitioner or other organization which has a direct or indirect contractual relationship with CFHP, a Payor or another Participating Provider to provide certain Covered Medical Services.
- 1.15 Payor:** CFHP, or any other public or private entity which provides, administers, funds, insures or is responsible for paying Participating Providers for Covered Medical services rendered to Beneficiaries under a Benefit Program covered under this Agreement.
- 1.16 Primary Care Provider(PCP):** The Provider who is a Participating Provider and who is responsible pursuant to the applicable Benefit Program for coordinating and managing the delivery of Covered Medical Services to Beneficiaries selecting or assigned to such Provider.
- 1.17 Pre Authorization:** The written approval by CFHP, an Affiliate, a Payor, or other permitted person or entity, prior to admitting a Beneficiary to a hospital, or to providing certain other Covered Medical Services to a Beneficiary, which approval is required under the Utilization Management Program of the applicable Benefit Program.
- 1.18 Quality Management Program:** The functions, including, but not limited to, Credentialing and certification of providers, review and audit of medical and other records, outcome rate reviews, peer review and provider appeals and grievance procedures performed or required by CFHP, a Payor, or any other permitted person or entity, to review the quality of Covered Medical Services rendered to beneficiaries.
- 1.19 Referral:** The written approval, usually from the Beneficiary's PCP and usually for a specified number of visits, treatments, or period of time, required under a Utilization Management Program for a Beneficiary to receive Covered Medical Services from a physician (usually a specialist) or other health care professional or organization. Referral to a non-Participating Provider generally requires Prior Authorization.
- 1.20 Stabilized:** The term stabilized means, with respect to an Emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition.
- 1.21 State:** The State of Texas in which Provider is to provide Contracted Services under this Agreement.
- 1.22 Utilization Management Program:** The functions, including, but not limited to Pre Authorization, Referral and prospective, concurrent and retrospective review, performed or required by CFHP, a Payor, or any other permitted person or entity, to review and

determine whether medical services or supplies which have been or will be provided to Beneficiaries are covered under a Benefit Program and meet the criteria as Medically Necessary.

2. PERFORMANCE PROVISIONS

2.1 Representations and Warranties. Provider represents and warrants that Provider:

- (a) is licensed by the State(s), or otherwise legally permitted under the laws of the State(s), to operate and provide Contracted Services;
- (b) provides Contracted Services in compliance with all applicable local, State, and federal laws, rules, regulations and professionals standards of care;
- (c) is certified to participate in Medicare under Title XVIII of the Social Security Act, and in Medicaid under Title XIX of the Social Security Act or other applicable State law pertaining to Title XIX of the Social Security Act;
- (d) shall maintain such licensure, compliance and certification throughout the term of this Agreement.

2.2 Provision of Services. Provider agrees to provide Contracted Services to Beneficiaries of the Benefit Programs covered under this Agreement, in accordance with:

- (a) The terms and conditions of this Agreement;
- (b) All laws, rules and regulations applicable to Provider, CFHP, and Payors;
- (c) The Utilization Management Program, Quality Management Program, Benefit Program Requirements and grievance, appeals and other policies and procedures of the particular Benefit Program under which the Covered Medical Services are rendered;
- (d) The same manner, and with the same availability, as services are rendered to other patients.
- (e) When a Beneficiary presents themselves for Emergency care services, Provider agrees to perform any medical screening evaluation or other evaluation required by State or federal law which is needed to determine if an Emergency medical condition exists. If Provider determines that an Emergency medical condition does **not** exist Provider agrees to instruct Beneficiary to contact their PCP to obtain an appropriate level of care. However, if an Emergency medical condition is determined to exist Provider agrees to provide Emergency care services to the covered Beneficiary. Furthermore, once Beneficiary is considered to be Stabilized, Provider agrees to contact CFHP or Payor for the approval and coordination of post stabilization services. CFHP or its appointed representative(s) will approve or deny coverage of post stabilization care within the time frame appropriate to the circumstances but in no case to exceed one (1) hour. After Provider treats a covered Beneficiary for Emergency services, Provider agrees to contact CFHP or Payor within twenty-four (24) hours of providing Emergency services or on the next working day.

- 2.3 Locations and Hours.** Provider shall maintain such locations, equipment, supplies, patient service personnel and health and other personnel as may be necessary to provide Contracted Services under this Agreement. Provider shall provide Contracted Services under this Agreement. Provider shall provide Contracted Services under this Agreement during normal business hours, and shall be available, when required by applicable law or regulation, to provide Covered Services on an Emergency basis twenty-four (24) hours a day, seven (7) days a week.
- 2.4 Non-Discrimination.** Provider shall not discriminate against any Beneficiary in the provision of Contracted Services hereunder, whether on the basis of the Beneficiary's sex, race, color, religion, ancestry, national origin, disability, health status, source of payment, utilization of medical or mental health services or supplies or other unlawful basis including, without limitation, the filing by such Beneficiary of any complaint, grievance or legal action against Provider, CFHP, or a Payor. Pursuant to Texas Administrative Code 11.1500(b), CFHP is prohibited from retaliating against any Provider who has reasonably filed a complaint on behalf of a Beneficiary, or has appealed a decision made by CFHP.
- 2.5 Subcontracting.** Provider shall not subcontract for the performance of Contracted Services under this agreement without the prior written consent of CFHP. Every subcontract between Provider and a subcontractor shall comply with all applicable local, State and federal laws, be consistent with the terms and conditions of this Agreement, and be terminable with respect to Beneficiaries by Provider upon request of CFHP. Each such subcontract may require the prior approval of one or more local, State, or federal regulatory agencies, and shall not become effective until all such required approvals have been obtained. Provider agrees to be solely responsible to pay any subcontractor permitted under this Agreement, and shall hold, and ensure that subcontractors hold, CFHP, Payors and Beneficiaries harmless from and against any and all claims which may be made by such subcontractors in connection with Contracted Services rendered to Beneficiaries under any such subcontract.
- 2.6 Utilization Management Requirements.** Provider agrees to participate in, cooperate with and comply with all decisions rendered in connection with CFHP's or a Payor's Utilization Review and Management Program. Provider also agrees to provide such records and other information as may be required or requested under such Utilization Management Program.
- 2.7 Pre Authorization and Referrals.** Unless a particular Benefit Program or Utilization Management Program contains no such requirement, and except in an Emergency, Provider agrees not to seek payment from CFHP or a Payor for Contracted Services rendered to a Beneficiary unless Pre-Authorization or a Referral was obtained for the rendering of such services. Such Pre-Authorization or Referral may be issued by CFHP, the applicable Payor, or a Participating Provider.

In the event that Medically Necessary Covered Medical Services are not available through a Participating Provider(s), CFHP will, upon request of Participating Provider and within a reasonable time period, allow Referral(s) to a Non-Participating Provider and make arrangements to fully compensate such Non-Participating Provider at a mutually agreed upon rate. Furthermore, CFHP agrees that prior to denying any Referral(s) to a Non-Participating Provider for Medically Necessary Covered Medical Services, CFHP will provide for a review by a specialist of the same or similar specialty as the type of Provider to whom such Referral is requested.

- 2.8 Quality Management Program.** Provider shall be solely responsible for the quality of Contracted Services rendered to Beneficiaries. The quality of Contracted Services rendered to Beneficiaries shall be monitored under the Quality Management Program applicable to the particular Benefit Program. Provider agrees to participate in, cooperate with and comply with all decisions rendered by CFHP or a Payor in connection with a Quality Management Program. Provider also agrees to provide such records, review data and other information as may be required or requested under a Quality Management Program, including outcome reporting in accordance with, but not limited to, the Health Plan Employer Data and Information Set (HEDIS), Version 2.0, or its successor. In the event that the standard or quality of care furnished by provider is found to be unacceptable under any Quality Management Program, CFHP shall give written notice to Provider to correct the specified deficiencies within the time period specified in the notice. Provider shall correct such deficiencies within that time period.
- 2.9 Notice of Adverse Action.** Provider shall notify CFHP in writing, within five (5) days of receiving any written or oral notice of any adverse action, including, without limitation, any malpractice suit or arbitration action, or other suit or arbitration action naming or otherwise involving Provider, CFHP or any Payor, and of any other event, occurrence or situation which might materially interfere with, modify or alter performance of any of Provider's duties or obligations under this Agreement. Provider shall forward to CFHP any written complaint or grievance of a Beneficiary against Provider, CFHP or any Payor within twenty-four (24) hours of receipt thereof. Provider shall maintain a written record of any Beneficiary complaint and provide such record to CFHP promptly upon request. Provider also shall notify CFHP promptly of any action against any license, certification under Title XVIII or Title XIX or other applicable statute of the Social Security Act or other State law, and of any material change in the ownership or business operations of Provider.
- 2.10 Professional Liability Insurance.** Provider shall maintain professional liability insurance in an amount equal to the greater of the highest amount required by law, or one million dollars (\$1,000,000) per claim and three million dollars (\$3,000,000) in the aggregate of all claims per policy year. Provider agrees to provide CFHP with written evidence, acceptable to CFHP, of such insurance coverage within three (3) days of such request by CFHP. Provider also agrees to notify or to ensure that its insurance carriers notify CFHP at least thirty (30) days prior to any proposed termination, cancellation or material modification of any policy for all or any portion of the coverage provided for above.
- 2.11 Use of Name.** Neither CFHP nor Provider shall use each other's trademarks, name, or symbols without permission; provided, however, that Provider agrees that CFHP and Benefit Plans may use Provider's and each Group Provider's name, office address, telephone number, and specialty, and a factual description of the practice in directories and other promotional materials.
- 2.12 Non-Solicitation.** Neither Provider, nor any employee, agent or contractor of Provider shall solicit or attempt to convince or otherwise persuade any Beneficiary to discontinue participation in any CFHP, Affiliate or Payor Benefit Program with respect to which Provider provides Contracted Services under this Agreement.
- 2.13 Encounter Reporting.** For Beneficiaries for which Provider receives Capitation Compensation under this Agreement, Provider shall provide CFHP with such information as CFHP or a Payor may require, via personal computer diskette, magnetic tape or electronic transmission in standard HCFA 1500 format and hard copy, for each encounter

with a Beneficiary during a calendar month. Such electronic encounter information and hard copy materials shall be complete, accurate and provided to CFHP by the fifteenth (15) day of the month following the month in which the encounter occurred. Additionally, Provider shall promptly provide CFHP with all corrections to and revisions of such encounter data. If Provider fails to provide such encounter data by the time required above, CFHP may withhold up to two and one-half percent (2-1/2%) of Provider's subsequent Capitation Compensation until the required information is provided.

2.14 New or Additional Benefit Programs. Provider acknowledges that CFHP may develop new or additional Benefit Programs in Provider's geographic area(s), and Provider agrees to negotiate with CFHP in good faith to amend this agreement to include such new or additional Benefit Programs as requested by CFHP.

2.15 Payment of Applicable Taxes. Provider shall be solely responsible for the collection and payment of any sales, use or other applicable taxes on the sale or delivery of medical services.

3. COMPENSATION

3.1 Compensation Rates. Provider shall accept as payment in full for Contracted Services and all other services (including payment for any and all sales, use or other applicable taxes on the sale or delivery of medical services) rendered under this Agreement to Beneficiaries the amounts payable by CFHP or a Payor as set forth in the applicable Addendum to this Agreement, less Copayment amounts payable by Beneficiaries in accordance with the applicable Benefit Program.

3.2 Billing and Payment

(a) **Billing.** Unless a Provider is compensated on a Capitation Compensation basis, Provider shall submit to CFHP, via CFHP's electronic claims submission program, clean, complete and accurate claims for Contracted Services rendered to a Beneficiary(ies), within ninety five (95) calendar days after such services are rendered. Where CFHP is the secondary payor under Coordination of benefits, such ninety-five (95) day period shall commence once the primary payor has made payment on or has denied the claim. Neither CFHP nor any Payor shall be under any obligation to pay Provider on any claim not timely submitted. Provider shall not seek payment from any Beneficiary in the event CFHP or a Payor fails to pay Provider for a claim not timely submitted.

(b) **Payment.** Unless the claim is disputed, CFHP or a Payor shall make payment on each of Provider's clean, complete, accurate and timely submitted claims for Contracted Services rendered to a Beneficiary, within forty-five (45) working days of receipt of each such claim or within such other period of time as set forth in the applicable Benefit Program Addendum to this Agreement, or as required by State Occupationally Ill/Injured or Workers' Compensation law, if applicable. Pursuant to Texas Administrative Code 11.1603(1 and 2), if Provider is compensated on a Capitation basis, CFHP will compensate Provider within ninety (90) days of Beneficiary's selection or assignment, calculated from the date of enrollment, or if Beneficiary selection does not occur, CFHP will reserve Capitation Compensation until such Beneficiary selection or assignment is made. When CFHP is responsible for the Beneficiary assignment and such Beneficiary does not select a PCP, CFHP will use its best efforts to assign Beneficiary to a PCP who is located

in a zip code nearest to the Beneficiary's residence or place of employment; thus resulting in fair and equitable distribution of Beneficiaries to PCPs.

- 3.3 Eligibility.** Except in an Emergency, Provider shall verify the eligibility of Beneficiaries before providing Contracted Services. When required by the applicable Utilization Management Program, Provider shall verify the eligibility of Beneficiaries before providing Provider Risk Services. CFHP shall make a good faith effort to confirm the eligibility of any Beneficiary when such is in question.
- 3.4 Reconciliation of Eligibility.** When Provider is compensated on a Capitation Compensation basis, CFHP shall provide Provider with a monthly list of Beneficiaries for whom Provider is responsible for providing Provider Risk Services during such month. CFHP will use its best efforts to discourage retroactive cancellation or addition of Beneficiaries to a benefit Program. However, in the event CFHP allows such adjustments, CFHP shall retroactively adjust Provider's Capitation Compensation as necessary, provided that the retroactive addition or cancellation period shall not exceed ninety (90) days. In cases where a Beneficiary has utilized a non-Participating Provider, and an appeal of the denial of such utilization by CFHP or Provider has been approved in favor of the Beneficiary by a governmental agency or its agent, after such ninety (90) day period, CFHP may disenroll such Beneficiary and retroactively adjust Provider's Capitation Compensation accordingly. In the event of allowable retroactive additions, Provider agrees to be responsible for all Provider Risk Services rendered to the Beneficiary from beginning of the retroactive period. In the event of retroactive cancellations, Provider may bill the Beneficiary for all Provider Risk Services received by the Beneficiary from the date such Beneficiary was no longer covered under the applicable Benefit Program.
- 3.5 Collection of Copayments.** Provider shall use its best efforts to collect all Copayments due from Beneficiaries, and shall not "waive" or fail to pursue collection of Copayments from Beneficiaries, without the prior written consent of CFHP.
- 3.6 No Surcharges.** Provider shall not charge the Beneficiary any fees or surcharges for Contracted Services rendered pursuant to this Agreement (except to the extent of authorized Copayments). In addition, Provider shall not collect a sales, use or other applicable tax from Beneficiaries for the sale or delivery of medical services. If CFHP or any Payor receives notice of any additional charge, Provider shall fully cooperate with CFHP or such Payor to investigate such allegations, and shall promptly refund any payment deemed improper by CFHP or a Payor to the party who made the payment.
- 3.7 Beneficiary Held Harmless.** Provider agrees that in no event, including, but not limited to, non-payment by CFHP or a Payor, the insolvency of CFHP or a Payor, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against Beneficiaries or persons other than CFHP or a Payor acting on their behalf for Contracted Services provided pursuant to this Agreement. This provision shall not prohibit collection of supplemental charges or Copayments on CFHP's or a Payor's behalf made in accordance with the terms of the applicable Benefit Program. Provider further agrees that (a) this provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of Beneficiaries; and (b) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Beneficiaries or persons acting on their behalf. Any modification, addition, or deletion of or to the provisions of this clause shall be effective on a date no earlier than fifteen (15) days after the State

regulatory agency has received written notice of such proposed change and has approved such change.

- 3.8 Liability for Excluded Services.** Neither a Beneficiary, nor CFHP nor any Payor shall be liable to pay Provider for any Contracted Service rendered by Provider to a Beneficiary which is determined under a Utilization Management Program not to be Medically Necessary. Prior to the provision of any Excluded Services to a Beneficiary, Provider shall obtain written confirmation from such Beneficiary that he/she has been informed in writing of the services to be provided, that the services to be provided are not covered under the Beneficiary's Benefit Program, that neither CFHP nor a Payor will pay for or be liable for such services, that Beneficiary requests that Provider render the excluded Services, and that such Beneficiary will be financially liable for such services.
- 3.9 Coordination of Benefits.** Provider agrees to conduct Coordination of Benefits in accordance with the policies and procedures established by CFHP or a Payor for the applicable Benefit Program. Provider shall not bill Beneficiaries for any portion of Contracted Services not paid by the primary carrier when CFHP or Payor is the secondary carrier, but shall instead look to CFHP or Payor for such payment. When a Beneficiary has coverage which is primary through another carrier, then CFHP's or a Payor's compensation to Provider shall be limited to the difference between the amount paid by the primary payor and the contract rates, including Copayments, contained in the applicable Addendum to this Agreement. When Provider is compensated on a Capitated Compensation basis, Provider shall not be entitled to conduct Coordination of Benefits.
- 3.10 Third Party Recoveries.** When CFHP or a Payor has compensated Provider, directly or indirectly, for Contracted Services, then CFHP or a Payor retains the right to recover from applicable third party carriers covering a Beneficiary, including self-insured plans, and to retain all such recoveries. Provider agrees to provide CFHP with such information as CFHP may require to pursue recoveries from such third party sources, and to promptly remit to CFHP or a Payor any monies Provider may receive from or with respect to such sources of recovery.
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4. TERMS AND TERMINATION

- 4.1 Term.** The term of this Agreement shall commence on the date set forth on the first page of this Agreement and shall continue for a period of [one (1) year] thereafter. This Agreement shall automatically renew for successive [one (1) year] periods, unless one party notifies the other in writing of its intent not to renew this Agreement, at least sixty (60) days prior to the next scheduled renewal date. The renewal date of the term of this Agreement shall remain the same for all Benefit Programs covered hereunder, even if this Agreement becomes effective with respect to a particular Benefit Program after the initial or any renewal date of this Agreement, due to licensure, contract award or other reason. Regardless of the effective date or any renewal date of this Agreement, Provider shall not begin providing Contracted Services to Beneficiaries and CFHP shall have no obligation to pay for such services until the completion of CFHP's or a Payor's Credentialing and certification processes.
- 4.2 Immediate Termination.** CFHP may terminate this Agreement immediately upon notice to Provider, in the event of (a) Provider's violation of any applicable law, rule or regulation; (b) Provider's failure to maintain the professional liability insurance coverage

specified hereunder; (c) Provider's failure to comply with the terms, conditions or determinations of any Utilization Management Program or Quality Management Program or other Benefit Program Requirements; (d) Provider's breach of section 2.1(a), 2.1(d), 2.6, 2.8, 2.10, 2.15, 3.1, 3.6 or 3.7 hereof; or (e) CFHP's determination that the health, safety or welfare of any Beneficiary may be in jeopardy if this Agreement is not terminated.

- 4.3 Termination Due to Material Breach.** In the event that either Provider or CFHP fails to cure a material breach of this Agreement with thirty (30) days of receipt of written notice to cure from the other, the noticing party may terminate this Agreement, effective as of the expiration of said thirty (30) day period. If the breach is cured within such thirty (30) day period, or if the breach is one which cannot reasonably be corrected within thirty (30) days, and the noticed party makes substantial and diligent progress toward correction during such thirty (30) day period, this Agreement shall remain in full force and effect.
- 4.4 Right of Partial Termination.** Provider may only terminate this Agreement in its entirety in accordance with Section 4.3. CFHP may terminate this Agreement, with respect to one or more Benefit Programs as CFHP indicates in the notice of termination to Provider. This agreement shall remain in full force and effect with respect to all other Beneficiaries and Benefit Programs.
- 4.5 Effect of Termination.** Furthermore and pursuant to Texas Administrative Code 11.1103, in the event of termination of this Agreement (except for reasons of medical competence or professional behavior) pursuant to Section 6.11 CFHP will permit, upon request of treating Provider for such Provider to continue rendering those services which are Medically Necessary in accordance with the dictates of medical prudence to Beneficiaries with special circumstances for a period up to ninety (90) days from effective date of termination. Special circumstance include, but are not limited to: (a) persons with disabilities, (b) persons with acute conditions, (c) persons with life threatening illnesses, or (d) persons past the twenty fourth (24th) week of pregnancy. In turn Provider agrees not to seek compensation for Covered Medical Services from Beneficiary of any amount for which the Beneficiary would not be responsible for if the Provider were still a Participating Provider under this Agreement. CFHP will compensate Provider for such Covered Medical Services at the contractual compensation rate effective with Provider at the time of termination of this Agreement.

In the event that a dispute develops regarding the necessity for continued treatment both Provider and CFHP agree to resolve such issues in accordance with Section 6.4 (Dispute Resolution) of this Agreement.

- 4.6 Termination Standards.** Pursuant to Texas Administrative Code 11.1601, in the event this Agreement is terminated by CFHP as set forth in Section 4.1, 4.2, 4.3, 4.4 or 4.5, CFHP will make available to Provider any reason(s) for such termination. Provider may, upon request and prior to the effective date of such said termination, request to appeal CFHP's termination decision. Termination appeals must be submitted in accordance with Section 6.11, within thirty (30) days of Provider's receipt of termination notice. CFHP's Quality Management Committee will review all such Provider termination appeals. When a Quality Management Committee review is requested, CFHP will insure that at least one member of Committee is of the same or similar specialty as Provider requesting review. CFHP will also make available to Provider, upon request, a copy of recommendations of the Quality Management Committee and CFHP's determination for such termination.

In the event that CFHP conducts or uses economic profiling of Provider as a reason(s) for termination of Provider, CFHP will make such economic profiling information and standards of measurement available to Provider, upon request.

5. RECORDS, REPORTS AND REGULATORY REQUIREMENTS

5.1 Encounter Forms. Provider shall submit Encounter Forms to CFHP in accordance with Section 2.18 ("Encounter Reporting").

5.2 Maintenance of Records

5.2.1 Administrative Records. Provider shall maintain such financial, administrative, and other records as may be necessary for compliance by CFHP, other Payors, and Benefit Plans with all applicable local, State, and federal laws, rules, and regulations. Provider agrees to maintain the confidentiality of all information related to fees, charges, expenses, and utilization derived from, through, or provided by CFHP and/or the Benefit Plan.

5.2.2 Medical Records. Provider shall maintain a complete medical record for each Beneficiary for which it provides contracted Services which includes the recording of Provider's services and such other records as may be required by law. Such records shall be maintained in accordance with the requirements established by CFHP and in accordance with all applicable local, State, and federal laws, rules, and regulations. 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.

5.2.3 Records for Benefit Plan. In accordance with State and federal regulations regarding Benefit Plan Medicare Beneficiaries, Provider agrees to maintain complete and accurate fiscal, medical, and social records in such format as necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under this Agreement. These records shall be retained for a period of at least five (5) years after the starting date of the applicable retention period or until the resolution of any ongoing audit occurs.

5.3 Access to Records. The records referred to in Section 5.2 above shall be and remain the property of Provider and shall not be removed or transferred from Provider except in accordance with applicable local, State, and federal laws, rules, and regulations. Subject to applicable State or federal confidentiality laws and pursuant to written authorization by Beneficiaries, CFHP and any Payor shall have access to Provider's office during normal business hours on request, to inspect, review, and make copies of such records. When requested by CFHP, Payors, or authorized representatives of local, State or federal regulatory agencies, Provider shall provide copies of any such records for which Provider shall charge no more than Ten Cents (\$0.10) per page. In no event, however, shall Provider charge for records requested for payment of a claim. Notwithstanding the foregoing, but subject to applicable local, State, or federal laws, rules or regulations, in the event of (i) termination of this Agreement, (ii) the selection by a Beneficiary of another Participating Provider in accordance with Benefit Plan procedures, or (iii) the approval by the Benefit Plan of Provider's request to transfer a Beneficiary to another Provider, Provider agrees to transfer copies of Beneficiary's medical records, x-rays, or other data

to the Benefit Plan when requested to do so by the Benefit Plan or the Beneficiary, at no charge to the Beneficiary or the Benefit Plan. Additionally, Provider agrees to permit CFHP and any Payor, or their designated representatives, and the designated representatives of local, State, and federal regulatory agencies having jurisdiction over CFHP, Payor, or any Benefit Plan, to conduct site evaluations and inspections of Provider's offices and service locations as may be needed to assure quality of care rendered to Beneficiaries.

- 5.4 Continuing Obligation.** The obligations of Provider under this Article 5 shall not be terminated upon termination of this Agreement, whether by rescission or otherwise. After termination of this Agreement, CFHP and Payors shall continue to have access to Provider's records as necessary to fulfill the requirements of this Agreement and to comply with all applicable laws, rules, and regulations.
- 5.5 Regulatory Compliance.** Provider agrees to comply with all applicable local, State, and Federal laws, rules and regulations, now or hereafter in effect, to the extent that they directly or indirectly affect Provider, CFHP, or any Payor, and bear upon the subject matter of this Agreement.

6. GENERAL PROVISIONS

- 6.1 Amendments.** All amendments to this Agreement or any of its Addenda proposed by Provider must be agreed to in writing by CFHP in advance of the effective date thereof. Any amendment to this Agreement, including any of its Addendum, proposed by CFHP shall be effective twenty (20) days after CFHP has given written notice to Provider of the amendment, and Provider has failed within that time period to notify CFHP in writing of Provider's rejection of the requested amendment. Amendments required because of legislative, regulatory or legal requirements do not require the consent of Provider or CFHP and will be effective immediately on the effective date thereof. Any amendment to this Agreement requiring prior approval of or notice to any federal or State regulatory agency shall not become effective until all necessary approvals have been granted or all required notice periods have expired. CFHP and Provider shall amend this Agreement from time to time, to include additional Affiliates, Benefit Programs and Payors.
- 6.2 Assignment.** Neither this Agreement, nor any of Provider's rights or obligations hereunder, is assignable by Provider without the prior written consent of CFHP.
- 6.3 Confidentiality.** CFHP and Provider agree to hold all confidential or proprietary information or trade secrets of each other in trust and confidence and agree that such information shall be used only for the purposes contemplated herein, and not for any other purpose. Specifically, Provider, as well as CFHP and Payors shall keep strictly confidential all compensation arrangements set forth in this Agreement and its Addenda, except as otherwise required by law.
- 6.4 Dispute Resolution.** Provider and CFHP agree to meet and confer in good faith to resolve any problems or disputes that may arise under this Agreement. Negotiation shall be a condition precedent to the filing of any arbitration demand by either party, and no arbitration demand may be filed until the exhaustion of CFHP's internal appeal procedures. In the event arbitration between provider and CFHP becomes necessary, either party making a written demand for arbitration on the other party shall initiate such

arbitration. Such arbitration shall be conducted under rules the same as or consistent with the rules of the American Arbitration Association, but need not necessarily be conducted by that Organization, except where applicable federal or State law requires otherwise. The parties expressly agree to be bound by the decision of the arbitrator(s). During the arbitration, each party shall bear its own attorneys' fees. Upon an award of the arbitrator, the prevailing party shall be entitled to recover its share of arbitration costs expended, and all its other costs, including its attorneys' fees. In the event the arbitrator fails to render an award within thirty (30) days after submission of the matter for decision, or such longer times as the parties may stipulate, then either party may elect to have all further arbitration proceedings terminated and the matter submitted for judicial resolution. The court shall then award all reasonable costs and fees incurred during the arbitration to the prevailing party. All disputes and controversies arising under or related to this Agreement may be arbitrated other than disputes relating to compensation rates as set out in Section 3.1 hereof.

- 6.5 Entire Agreement.** This Agreement supersedes any and all other agreements, either oral or written, between the parties with respect to the subject matter hereof, and no other agreement, statement or promise relating to the subject matter of this Agreement shall be valid or binding.
- 6.6 Governing Law.** This Agreement shall be governed by and construed and enforced in accordance with the laws of the State, except to the extent such laws conflict with or are preempted by any federal law, in which case such federal law shall govern. Federal law shall also govern with respect to Benefit Programs of governmental Payors.
- 6.7 Hold Harmless.** Neither Provider nor CFHP (nor any of their respective agents or employees) shall be liable to the other for any act or omission of the other Party. Provider and CFHP each agree to indemnify and hold the other harmless from and against any and all liabilities, losses, damages, claims and expenses of any kind, including costs and attorneys' fees, incurred by the indemnified party and arising from or in connection with the indemnifying party's performance of, or failure to perform its duties and obligations under this Agreement.
- 6.8 Non-Exclusive Contract.** This Agreement is non-exclusive and shall not prohibit Provider or CFHP from entering into agreements with other health care providers or purchasers of health care services.
- 6.9 No Notice to Beneficiaries.** Provider and CFHP reserve the right to amend this Agreement and any of its provisions, to waive any rights granted to either party hereunder, and to terminate this Agreement without notice to or consent of any Beneficiary.
- 6.10 No Third Party Beneficiary.** 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 Beneficiary. Nothing contained herein shall operate (or be construed to operate) in any manner whatsoever to increase the rights of any such Beneficiary or the duties or responsibilities of Provider or CFHP with respect to such Beneficiaries.
- 6.11 Notice.** Any notice required or desired to be given under this Agreement shall be in writing and shall be sent by certified mail, return receipt requested, postage prepaid, or overnight courier, or facsimile, addressed as follows:

CFHP: Patrina Fowler

Vice-President/COO
Community First Health Plans, Inc.
12238 Silicon Dr., Ste. 100
San Antonio, TX 78249

Provider:

Notices given hereunder shall be deemed given upon documented receipt. The addresses to which notices are to be sent may be changed by written notice given in accordance with this Section.

- 6.12 Regulation.** CFHP is subject to the requirements of various local, State, and federal laws, rules, and regulations. Any provision required to be in this Agreement by any of the above shall bind Provider and CFHP whether or not provided herein.
- 6.13 Severability.** If any provision of this Agreement is rendered invalid or unenforceable by any local, State or federal law, rule or regulation, or declared null and void by any court of competent jurisdiction, the remainder of this Agreement shall remain in full force and effect.
- 6.14 Status as Independent Entities.** None of the provisions of this Agreement is intended to create or shall be deemed or construed to create any relationship between Provider and CFHP other than that of independent entities contracting with each other solely for the purpose of effecting the provisions of this Agreement. Neither Provider nor CFHP, nor any of their respective agents, employees, or representatives shall be construed to be the agent, employee or representative of the other.
- 6.15 Addenda.** Each Addendum to this Agreement is made a part of this Agreement as though set forth fully herein. Any provision of an Addendum that is in conflict with any provision of this Agreement shall take precedence and supersede the conflicting provision of this Agreement.
- 6.16 Regulatory Approval.** If CFHP has not been licensed to provide, or provide services in connection with, a particular Benefit Program, or has not received all required regulatory approvals for use of this Agreement with respect to a particular Benefit Program prior to the execution of this Agreement, this Agreement shall be deemed to be a binding letter of intent with respect to such Benefit Program. In such event, this Agreement shall become effective with respect to any such Benefit Program on the date that the required licensure and regulatory approvals are obtained. If CFHP is unable to obtain such licensure or regulatory approvals after due diligence, CFHP shall notify Provider and both parties shall be released from any liability under this Agreement with respect to the Benefit Program in question in the applicable State; provided however, that if such licensure or regulatory approval is conditioned upon amendment of this Agreement, then this Agreement shall be amended automatically pursuant to Section 6.1 hereof.

IN WITNESS WHEREOF, the parties have executed this Agreement to be effective as of the date first written above.

(Provider)

Community First Health Plans, Inc.

Signature

Patrina Fowler, Vice-President/COO

Title

Date

Date

Federal Tax Identification Number

ADDENDUM A

BENEFIT PROGRAMS, CREDENTIALS APPLICATION and SERVICE AREA

I. BENEFIT PROGRAMS

CFHP’s Benefit Programs included within and covered by this Agreement, are indicated by the mark "X" below. This Agreement applies only Benefit Programs where a check mark appears in either the "Fee for Service".

Benefit Programs	ADDENDUM	FEE FOR SERVICE
HMO Standard	B	
Government Sponsored (STAR Program Medicaid Managed Care)	D	
CHIP (Children's Health Insurance Program)	E	
University Family Care Plan	F	
Business Associate Addendum	G	

II. CREDENTIALS APPLICATION

The CFHP Provider Credentials Applications is included herein as Exhibit 1 to this Addendum A. Provider shall be responsible for completing the Credentials Application in its entirety.

III. SERVICE AREA includes the following Texas counties:

HMO/ASO

Atascosa
Bexar
Comal
Guadalupe
Kendall
Medina

STAR

Atascosa
Bexar
Comal
Guadalupe
Kendall
Medina

CHIP

Atascosa
Bexar
Comal
Guadalupe
Kendall
Medina

Optional Service Area

Bandera

ADDENDUM B

TO ANCILLARY PROVIDER AGREEMENT

HMO STANDARD BENEFIT PROGRAM

Provider understands and agrees that the obligations of CFHP set forth on this Addendum are the obligations of Community First Health Plans, Inc., and not the obligations of any other Affiliate.

- 1. Fee-For-Service Contracted Services.** Provider shall render Contracted Services to Beneficiaries of CFHP's Benefit Programs covered under this Addendum on a fee-for-service basis. As compensation for providing such Contracted Services, Provider shall be paid in accordance with the rates set forth on Exhibit 1 of this Addendum. Such compensation shall be paid subject to the billing requirements set forth in Section 3.2 of the Agreement, excepting that CFHP shall pay Provider within forty-five (45) working days of receipt of CFHP of a complete and accurate claim for Contracted Services rendered to a Beneficiary.

- 2. Capitation; Provider Risk Services.**
 - 2.1 Compensation to Provider for Provider Risk Services.** Provider shall render Contracted Services to each Beneficiary assigned to Provider. As compensation for providing Contracted Services, CFHP shall pay Provider the Capitation Compensation as set forth in Exhibit 2 of this Addendum for each Beneficiary eligible to receive such services from Provider during a particular month. Such payments shall be made by CFHP on or before the fifteenth (15th) day of such month. CFHP's payment shall be subject to the provisions of Sections 2.13 and 3.3 of the Agreement.

 - 2.2 Qualification Process for Capitation Compensation.** CFHP shall have the right to its option to review and assess Provider's financial ability and administrative capacity to perform its obligations hereunder, including the managed care and other functions delegated to Provider by CFHP, prior to implementing Capitation Compensation to Provider. Such review and assessment may include, but is not limited to, Provider's general operations and administration, claims processing adjudication, information systems capability and capacity, and financial viability and reporting, Utilization Management Program, Quality Management Program, and Group Provider Credentialing program. If CFHP determines that Provider does not meet CFHP's minimum requirements for Capitation Compensation, then the implementation of such prospective payment methodology shall be deferred until Provider remedies the deficiency (ies). Provider shall in the meantime be compensation for Contracted Services on a fee for service basis in accordance with rates set forth on Exhibit 1 of this Addendum. CFHP, at its sole discretion, may implement Capitation Compensation on a provisional basis subject to appropriate monitoring and evaluation of Provider to assess ongoing viability and capacity.

2.3 Access to Financial Records. In that Provider will be compensated on other than a fee for service basis CFHP also shall have access to all financial records relating to the financial condition of Provider. Provider agrees to submit such reports and financial information as is necessary for CFHP to comply with regulatory requirements to monitor the financial viability of Capitated Providers.

2.4 Encounter Data. Provider shall provide CFHP with all encounter information under Section 2.13 of the Agreement.

3. Contracted Services Reciprocity. When a Beneficiary not assigned to Provider under a Capitation Compensation arrangement receives Contracted services from Provider, then Provider shall accept compensation therefore at the rates set forth in Exhibit 1 of this Addendum.

4. Report of Reinsurance Claims. Provider shall report potential reinsurance claims in accordance with CFHP's reinsurance guidelines. CFHP shall provide Provider with such guidelines, from time to time.

IN WITNESS WHEREOF, the undersigned have executed this Addendum, effective on the date of the underlying agreement.

(Provider)

Community First Health Plans, Inc.

Signature

Patrina Fowler, Vice-President/COO

Title

Date

Date

Federal Tax Identification Number

**EXHIBIT 1 TO ADDENDUM B
FEE FOR SERVICE COMPENSATION SCHEDULE
HMO BENEFIT PROGRAMS**

Provider shall accept the following fee-for-service rates as payment in full from Community First Health Plans, Inc. for covered services provided to CFHP/HMO Members, less any applicable Co-pays, Deductibles or Coinsurance:

Fee Schedule.

1. Provider shall accept as payment in full from CFHP for Covered Services the lesser of CFHP's current Commercial Fee Schedule or Provider's billed charges, less applicable co-payments, deductibles or coinsurance amounts due from Member.
2. For those Covered Services for which an allowable has not been determined, Provider shall be reimbursed at (1) the lesser of CFHP's usual and customary rate; or (2) the interim rate established by CFHP based on a rate analysis completed at the time the claims is received; Once CFHP establishes a reimbursement rate, all future claims will be paid at that rate.

ADDENDUM C
Contracted Services

Laboratory Services

**ADDENDUM D
TO ANCILLARY PROVIDER AGREEMENT
MEDICAID BENEFIT PROGRAM
(GOVERNMENT SPONSORED)**

This addendum is hereby made part of the Ancillary Provider Agreement between **Community First Health Plans, Inc.** (hereinafter referred to as CFHP), and _____ hereinafter referred to as Provider).

The parties hereby agree as follows:

That Section 1.13 (Definitions) is hereby amended to include a CFHP/Medicaid Member within the definition of a Member. CFHP/Medicaid Member means a Member who is entitled to Texas Medicaid services and benefits through CFHP based upon the member's status as a participant in the Aid to Families with Dependent Children (AFDC) program and/or AFDC-related programs.

That Section 1.22 (Definitions) is hereby amended to add the following: Medicaid means a program of prepaid health care offered by CFHP in accordance with Title XIX of the Federal Social Security Act and Chapter 32 of the Texas Human Resources Code or as otherwise allowed by the Texas Department of Health (TDH) and HCFA and any waivers attendant thereto.

That Section 2.16 (Participating Providers) is hereby amended to add the following: Prior to the provision of any non-covered services to a CFHP/Medicaid Member, Provider shall obtain written confirmation from such Member that he/she has been informed in writing that CFHP will not pay for or be liable for said services; and that such Member will be financially liable to Provider.

That Section 2.6 (Utilization Management Requirements) is hereby amended to include and clarify that the parties acknowledge and agree that the Texas Department of Health (TDH), or such other duly authorized agency or entity, has final authority over all aspects of the provision of services to CFHP/Medicaid Members, including but not limited to determination of benefits and/or eligibility; termination of coverage under CFHP; and structure and operation of the Grievance System utilized by CFHP for said Membership. In addition, the parties acknowledge that CFHP/Medicaid Members may choose to resolve a grievance directly through the Texas Department of Human Services Fair Hearing process at any time.

That Section 3.7 (Beneficiary Held Harmless) is hereby substituted with the following section:

- (a) Provider agrees that in the event of CFHP's insolvency or other cessation of operations, Provider will continue benefits to CFHP/Medicaid Members through the period for which premium has been paid, including CFHP/Medicaid Members who are in an inpatient facility.
- (b) Provider hereby agrees that in no event, including, but not limited to non-payment by CFHP, CFHP's insolvency or breach of this agreement, shall Provider bill, charge, collect a deposit from, or have any recourse against Member or person (other than CFHP) acting on their behalf for services provided pursuant to this agreement. This provision shall not prohibit the collection of charges for services

rendered by Provider but not covered under the HMO evidence of coverage document.

- (c) Provider agrees to hold harmless the State of Texas, all state officers and employees, and all Members in the event of nonpayment by CFHP to the Provider. Provider further agrees to indemnify and hold harmless the State and its agents, officers and employees against all injuries, death, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against the State or its agents, officers or employees, through the intentional conduct, negligence or omission of the Provider, any shareholder, partner or any other individual or entity holding an equitable interest in the Provider its agents, officers, employees or contractors.
- (d) Provider further agrees that (1) this provision shall survive the termination of the agreement regardless of the cause giving rise to the termination and shall be construed to be for the benefit of CFHP's Member, and that (2) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and the Member or persons acting on their behalf, insofar as such contrary agreement relates to liability for payment for continuation of covered medical services provided under the terms and conditions of the provision.
- (e) Any modification, addition, or deletion to provisions of this section shall become effective on a date no earlier than 15 days after approval by the Texas Department of Health.

That Section 5.3 (Access to Records) is hereby amended to provide that Provider further agrees to provide such agency or entity, duly designated by Texas Department of Health, access to and/or copies of the medical records of CFHP/Medicaid Members at CFHP's request, as may be needed to assure the quality and/or utilization of services rendered to such Members.

STAR Program Compensation Schedule.

Fee Schedule. Provider shall accept as payment in full from CFHP for Covered Medical Services the following fee-for-service arrangement:

- One hundred percent (100%) of the current State of Texas Medicaid Fee Schedule, less any applicable Copayments.
- For those Covered Services for which an allowable has not been determined, Provider shall be reimbursed at (1) the lesser of CFHP's usual and customary rate; or (2) the interim rate established by CFHP based on a rate analysis completed at the time the claims is received; Once CFHP establishes a reimbursement rate, all future claims will be paid at that rate.

Revisions based on State's Adjustments to Fee Schedule. Any adjustments to the Medicaid Fee Schedule, as established by the State of Texas, will be effective the first of the following month in which CFHP receives official written notification from the State of Texas or its contracted claims processor for fee-for-service Medicaid.

Revisions to the Terms of the Contract Between CFHP and HHSC. Should the terms of the contract between CFHP and HHSC be altered by HHSC or as the legislative, regulatory or legal requirements including but not limited to a reduction in premiums from

appropriation or state agency decision, CFHP will provide written notice to Provider and the Agreement will be adjusted accordingly.

IN WITNESS WHEREOF, the undersigned have executed this Addendum, effective on the date of the underlying agreement.

(Provider)

Community First Health Plans, Inc.

Signature

Patrina Fowler, Vice-President/COO

Title

Date

Date

Federal Tax Identification Number

**FIRST AMENDMENT TO
ADDENDUM D TO ANCILLARY PROVIDER AGREEMENT
MEDICAID BENEFIT PROGRAM
(GOVERNMENT SPONSORED)**

WHEREAS **Community First Health Plans, Inc.** (hereinafter referred to as CFHP) and _____ hereinafter referred to as Participating Provider) entered into an Addendum to Ancillary Provider Agreement (hereinafter referred to as Addendum); and

WHEREAS, the Parties thereto have mutually agreed to amend the Addendum.

NOW THEREFORE, it is mutually agreed by and between the Parties hereto as follows:

- (1) **That Section 2.4 (Non-Discrimination)** is hereby clarified to include that Participating Provider further agrees to comply with Title VI of the Civil Rights Act of 1964 (Public Law), Section 504 of the Rehabilitation Act of 1973 (Public Law), The Americans with Disabilities Act of 1990 (Public Law 101-336), and all amendments to each, and all requirements imposed by the regulations issued pursuant to these acts.
- (2) **That Section 3.7 (Beneficiary Held Harmless)**; subsection (e) "Any modification, addition, or deletion to provisions of this section shall become effective on a date no earlier than 15 days after approval by the Texas Department of Health"; shall be replaced with the following subsection:
 - (e) Any modification, addition, or deletion to provisions of this section shall become effective on a date no earlier than 30 days after approval of the Texas Department of Health.
- (3) **That Section 5.2 (Maintenance of Records)** is hereby amended to include that Participating Provider further agrees to comply with Texas Health and Safety Code Section 85.113 (relating to workplace and confidentiality guidelines regarding AIDS and HIV).
- (4) **That Section 5.5 (Regulatory Compliance)** is hereby amended to include that Participating Provider further agrees to comply with regulations of the United States Department of Labor recited in 20 Code of Federal Regulations, Part 741 and the Federal Rehabilitation Act of 1973.

IN WITNESS WHEREOF, the undersigned have executed this Addendum, effective on the date of the underlying agreement.

(Provider)

Community First Health Plans, Inc.

Signature

Patrina Fowler, Vice-President/COO

Title

Date

Date

**CHIP AMENDMENT TO
ANCILLARY PROVIDER AGREEMENT
BETWEEN
COMMUNITY FIRST HEALTH PLANS, INC.
AND**

WHEREAS, **Community First Health Plans, Inc.** (“CFHP”) and _____ (“Provider”) entered into that certain Ancillary Provider Agreement (“Agreement”), effective _____, _____.

WHEREAS, CFHP participates in the Texas Children’s Health Insurance Program (“CHIP”) by contracting with entities designated by the State for the purpose of providing Covered Medical Services to CHIP Members; and

WHEREAS, Provider desires to participate in CHIP through this Agreement; and

WHEREAS, CFHP and Provider mutually agree to amend the Agreement as set forth in this Amendment, effective _____, _____ and

WHEREAS, the terms contained in this Amendment are as defined in the Agreement; and

NOW, THEREFORE, in consideration of the promises and mutual covenants herein contained and other good and valuable consideration, the sufficiency of which is hereby acknowledged, it is mutually covenanted and agreed by and between CFHP and Provider that the Agreement is amended as follows:

Article 1 of the Agreement is hereby amended by inserting item numbers 1.26 through 1.31 as follows:

- 1.26 Children’s Health Insurance Program (CHIP). The health insurance program that is authorized and funded pursuant to Title XXI, Social Security Act (42 U.S.C. §§ 1397aa-1397jj) and Senate Bill 445, 76th Texas Legislature, and is administered by the Texas Health and Human Services Commission.
- 1.27 CHIP Member. A person who has met CHIP eligibility criteria, and is enrolled in a CHIP health plan.
- 1.28 Coverage Year. The 12 months from the first date that a CHIP Member is covered by a CHIP health plan, or the appropriate period for pregnant CHIP Members in accordance with Section 11.01(c) of the agreement between CFHP and HHSC for CHIP.
- 1.29 Covered Services. Those health care services that CFHP must arrange to provide to CHIP Members as set out in the CHIP RFP.
- 1.30 Deductible. The amount a CHIP Member is required to pay in each Coverage Year for CHIP Covered Services before benefits become payable by CFHP.
- 1.31 Health and Human Services Commission (HHSC). The administrative agency within the executive department of Texas state government established under chapter 531, Texas Government Code, and authorized to administer CHIP under chapter 62, Texas Health and Safety Code or its designee, including, but not limited to, the Texas Department of Health.

The following Addendum E

Children's Health Insurance Program is hereby added to the Agreement:

1. Provider understands and agrees that CFHP has the sole responsibility for payment of Covered Services rendered by Provider under this Agreement, and in the event that CFHP becomes insolvent or ceases operations, Provider's sole recourse is against CFHP through CFHP's bankruptcy, conservatorship, or receivership estate.

Provider agrees that in the event of CFHP's or HHSC's insolvency or other cessation of operations, Provider will continue benefits to CHIP Members through the period for which premium has been paid, including CHIP members who are in an inpatient facility.

Provider hereby agrees that in no event, including, but not limited to non-payment by CFHP or HHSC, CFHP's or HHSC's insolvency or breach of this Agreement, shall Provider bill, charge, collect a deposit from, or have any recourse against a CHIP Member or another party (other than CFHP or HHSC) acting on their behalf for Covered Services provided pursuant to this Agreement. This provision shall not prohibit the collection of charges for Excluded Services rendered by Provider.

Provider agrees to hold harmless the State of Texas, all State officers and employees, and all CHIP Members in the event of nonpayment by CFHP or HHSC to the Provider. Provider further agrees to indemnify and hold harmless the State and its agents, officers and employees against all injuries, death, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against the State or its agents, officers or employees, through the intentional conduct, negligence or omission of Provider, any shareholder, partner or any other individual or entity holding an equitable interest in the Provider its agents, officers, employees or contractors.

Provider further agrees that (1) this provision shall survive the termination of the Agreement regardless of the cause giving rise to the termination and shall be construed to be for the benefit of CHIP Members, and that (2) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and the CHIP Member or persons acting on their behalf, insofar as such contrary agreement relates to liability for payment for continuation of Covered Services provided under the terms and conditions of the provision.

Any modification, addition, or deletion of or to the provisions of this Section 1 shall be effective on a date no earlier than fifteen (15) days after the State regulatory agency has received written notice of such proposed change and has approved such change.

2. If Provider initiates any action to collect payment from HHSC or any CHIP Member over and above allowable Copayments or Deductibles, excluding payment for Excluded Services, CFHP will initiate and maintain such necessary action to stop Provider or his or her employees, agents, assigns, trustees, or successors in interest from maintaining that action against HHSC or any CHIP Member.
3. Provider and CFHP acknowledge that HHSC maintains the right to review this Agreement and any arrangement between Provider and CFHP.
4. CFHP will defend, indemnify and hold harmless CHIP Members and HHSC against any and all claims, costs, damages, or expenses (including attorneys' fees) of any type or

nature arising from the failure, inability, or refusal of CFHP to pay Provider for Covered Services.

5. Unless prohibited or limited by applicable law, at least 30 days prior to the effective date of CFHP's termination of the Agreement without cause, CFHP will notify the CHIP administrative contractor and will notify any affected CHIP Members in writing. Upon a termination of the Agreement with cause, CFHP will notify the CHIP administrative contractor in writing on the next working day and will notify affected CHIP Members in writing. If Provider initiates termination of the Agreement, CFHP will notify the CHIP administrative contractor and will make reasonable efforts to notify affected CHIP Members in writing.
6. Provider is prohibited from engaging in direct marketing to CHIP Members that is designed to increase enrollment in a particular health plan. Such prohibition does not prevent Provider from engaging in permissible marketing activities consistent with broad outreach objectives and application assistance.
7. A Provider incentive plan, if any, contained in the Agreement will meet requirements of the Texas Insurance Code and the Texas Administrative Code.
8. Provider is subject to all state and federal laws, rules, and regulations that apply to all persons or entities receiving state and federal funds, including provisions of the Clean Air Act and the Federal Water Pollution Control Act, as amended, found at 42 C.F.R. 7401, *et seq.* and 33 U.S.C. 1251, *et seq.*, respectively; the exclusion, debarment, and suspension provisions of Section 1128(a) or (b) of the Social Security Act (42 USC §1320 a-7), or Executive Order 12549; the provisions of the Byrd Anti-Lobbying Amendment, found at 31 U.S.C. 1352, relating to use of federal funds for lobbying for or obtaining federal contracts; Health and Safety Code, Chapter 85, Subchapter E, relating to the Duties of State Agencies and State Contractors for the confidentiality of AIDS and HIV-related medical information and an anti-discrimination policy of employees and CHIP Members with communicable diseases; confidentiality provisions relating to CHIP Member information; Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990, and all requirements imposed by the regulations implementing these acts and all amendments to the laws and regulations; the provisions of Executive Order 11246, as amended by 11375, relating to Equal Employment Opportunity; section 9-7.06 of article IX of the General Appropriations Act of 1999 regarding "Buy Texas"; Texas Family Code §231.006 regarding child support payments; and chapter 552 of the Texas Government Code regarding the release of public information.
9. Provider is subject to all state and federal laws and regulations relating to fraud and abuse in health care and CHIP. Provider must cooperate and assist HHSC and any state or federal agency in identifying, investigating, sanctioning, or prosecuting suspected fraud and abuse. Provider must provide originals and /or copies of all records and information requested and allow access to premises and provide records to HHSC or its authorized agent(s), HCFA, and the U.S. Department of Health and Human Services (DHHS), FBI, TDI, or other unit of state government. Provider must provide all copies of records free of charge.

10. Provider is responsible for collecting, at the time of the service, any applicable CHIP Copayments or Deductibles, given the limitations on those Copayments and Deductibles as set out in section 11.06 of the agreement between CFHP and HHSC.
11. Provider is responsible for creating and keeping medical records in compliance with the medical records standards contained in the Standards for Quality Improvement Programs in Appendix F of the agreement between CFHP and HHSC. All medical records must be kept for at least five years, except for records of rural health clinics, which must be kept for a period of six years from the date of service.

IN WITNESS WHEREOF, the undersigned have executed this Addendum, effective on the date of the underlying agreement.

(Provider)

Community First Health Plans, Inc.

Signature

Patrina Fowler, Vice-President/COO

Title

Date

Date

Federal Tax Identification Number

EXHIBIT 1 TO THE CHIP AMENDMENT

FEE FOR SERVICE COMPENSATION SCHEDULE

Provider shall accept the following fee-for-service rates as payment in full from Community First Health Plans, Inc. for covered services provided to CFHP/CHIP Members, less any applicable Copays, Deductibles or Coinsurance:

1. **Fee Schedule.** Provider shall accept as payment in full from CFHP for Covered Services:
 - ♦ One hundred percent (100%) of the current CFHP CHIP Fee Schedule, less any applicable Copayments.
 - ♦ For those Covered Services for which an allowable has not been determined, Provider shall be reimbursed at (1) the lesser of CFHP's usual and customary rate; or (2) the interim rate established by CFHP based on a rate analysis completed at the time the claims is received; Once CFHP establishes a reimbursement rate, all future claims will be paid at that rate.
2. **Revisions based on State's Adjustments to Fee Schedule.** Any adjustments to the CHIP Fee Schedule, as established by the State of Texas, will be effective the first of the following month in which CFHP receives official written notification from the State of Texas or its contracted claims processor for fee-for-service Medicaid.
3. **Revisions to the Terms of the Contract Between CFHP and HHSC.** Should the terms of the contract between CFHP and HHSC be altered by HHSC or as the legislative, regulatory or legal requirements including but not limited to a reduction in premiums from appropriation or state agency decision, CFHP will provide written notice to Provider and the Agreement will be adjusted accordingly.

**ADDENDUM F
TO ANCILLARY PROVIDER AGREEMENT
UNIVERSITY FAMILY CARE PLAN (UFCP)
BENEFIT PROGRAM**

Provider understands and agrees that the obligations of CFHP set forth on this Addendum are the obligations of Community First Health Plans, Inc., and not the obligations of any other Affiliate.

- 1. Fee-For-Service Contracted Services.** Provider shall render Contracted Services to Beneficiaries of CFHP's Benefit Programs covered under this Addendum on a fee-for-service basis. As compensation for providing such Contracted Services, Provider shall be paid in accordance with the rates set forth on Exhibit 1 of this Addendum. Such compensation shall be paid subject to the billing requirements set forth in Section 3.2 of the Agreement, excepting that CFHP shall pay Provider within forty-five (45) working days of receipt of CFHP of a complete and accurate claim for Contracted Services rendered to a Beneficiary.

- 2. Capitation; Provider Risk Services.**
 - 2.1 Compensation to Provider for Provider Risk Services.** Provider shall render Contracted Services to each Beneficiary assigned to Provider. As compensation for providing Contracted Services, CFHP shall pay Provider the Capitation Compensation as set forth in Exhibit 2 of this Addendum for each Beneficiary eligible to receive such services from Provider during a particular month. Such payments shall be made by CFHP on or before the fifteenth (15th) day of such month. CFHP's payment shall be subject to the provisions of Sections 2.13 and 3.3 of the Agreement.

 - 2.2 Qualification Process for Capitation Compensation.** CFHP shall have the right to its option to review and assess Provider's financial ability and administrative capacity to perform its obligations hereunder, including the managed care and other functions delegated to Provider by CFHP, prior to implementing Capitation Compensation to Provider. Such review and assessment may include, but is not limited to, Provider's general operations and administration, claims processing adjudication, information systems capability and capacity, and financial viability and reporting, Utilization Management Program, Quality Management Program, and Group Provider Credentialing program. If CFHP determines that Provider does not meet CFHP's minimum requirements for Capitation Compensation, then the implementation of such prospective payment methodology shall be deferred until Provider remedies the deficiency (ies). Provider shall in the meantime be compensated for Contracted Services on a fee for service basis in accordance with rates set forth on Exhibit 1 of this Addendum. CFHP, at its sole discretion, may implement Capitation Compensation on a provisional basis subject to appropriate monitoring and evaluation of Provider to assess ongoing viability and capacity.

 - 2.3 Access to Financial Records.** In that Provider will be compensated on other than a fee for service basis CFHP also shall have access to all financial records relating to the financial condition of Provider. Provider agrees to submit such reports and financial information as is necessary for

CFHP to comply with regulatory requirements to monitor the financial viability of Capitated Providers.

2.4 Encounter Data. Provider shall provide CFHP with all encounter information under Section 2.13 of the Agreement.

3. Contracted Services Reciprocity. When a Beneficiary not assigned to Provider under a Capitation Compensation arrangement receives Contracted services from Provider, then Provider shall accept compensation therefore at the rates set forth in Exhibit 1 of this Addendum.

4. Report of Reinsurance Claims. Provider shall report potential reinsurance claims in accordance with CFHP's reinsurance guidelines. CFHP shall provide Provider with such guidelines, from time to time.

IN WITNESS WHEREOF, the undersigned have executed this Addendum, effective on the date of the underlying agreement.

(Provider)

Community First Health Plans, Inc.

Signature

Patrina Fowler, Vice-President/COO

Title

Date

Date

**EXHIBIT 1 TO ADDENDUM F
FEE FOR SERVICE COMPENSATION SCHEDULE
UFCP BENEFIT PROGRAMS**

Fee Schedule.

1. Provider shall accept as payment in full from CFHP for Covered Services the lesser of CFHP's current Commercial Fee Schedule or Provider's billed charges, less applicable co-payments, deductibles or coinsurance amounts due from Member.
2. For those Covered Services for which an allowable has not been determined, Provider shall be reimbursed at (1) the lesser of CFHP's usual and customary rate; or (2) the interim rate established by CFHP based on a rate analysis completed at the time the claims is received; Once CFHP establishes a reimbursement rate, all future claims will be paid at that rate.

ADDENDUM G
BUSINESS ASSOCIATE ADDENDUM

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Part I

PREAMBLE

- A. **Effective Date:** The effective date of this Business Associate Addendum (“Addendum”) is the same as the effective date of the underlying Agreement.
- B. **Parties:** The parties to this Addendum are **Community First Health Plans, Inc.**, a Texas health maintenance organization (“Community First”), and _____ (“Business Associate”). Community First and Business Associate agree that there shall be no third party beneficiaries to the underlying Agreement or this Addendum, including but not limited to individuals whose protected health information is created, received, used, and/or disclosed by Business Associate in its role as business associate.
- C. **Purpose:** The parties intend that this Addendum comply with the business associate contract requirements set forth in the Standards for Privacy and Security of Individually Identifiable Health Information, 45 C.F.R. Parts 160 and 164 (“HIPAA Privacy and Security Rule”), The Health Information Technology for Economic and Clinical Health (“HITECH”) Act, and applicable state law requirements regarding the privacy of protected health information.
- D. In connection with the Business Associate’s creation, receipt, use, and/or disclosure of protected health information (defined below), the parties agree as follows.

Part II

GENERAL TERMINOLOGY

- A. The following terms shall have the same meaning in this Addendum as is set forth in the HIPAA Privacy and Security Rule: business associate, data aggregation, designated record set, individual, Notice of Privacy Practices, required by law, use, individually identifiable health information, health information, disclose or disclosure, administrative safeguards, physical safeguards, technical safeguards, facility, confidentiality, availability, security, security incident, and Secretary. Protected health information (“PHI”) shall have the same meaning as the term “protected health information” in 45 C.F.R. § 164.501. Electronic Protected Health Information (“ePHI”) shall mean PHI in electronic media as that term is defined in 45 C.F.R. § 162.103. Unless otherwise indicated in this Addendum, both PHI and ePHI will be referred to collectively as PHI.
- B. In the event of an inconsistency between the provisions of this Addendum and the mandatory terms of the HIPAA Privacy and Security Rule or HITECH , as may be expressly amended from time to time by the U.S. Department of Health and Human Services (“HHS”) or as a result of interpretations by HHS, a court, or another regulatory agency with authority over the parties, the interpretation of HHS, such court, or regulatory agency shall prevail. In the event of a conflict among the interpretations of these entities, the conflict shall be resolved in accordance with rules of precedence.

- C. Where provisions of this Addendum are different from those mandated by the HIPAA Privacy and Security Rule or HITECH, but are nonetheless permitted by the Rule, the provisions of the Addendum shall control.

Part III

PERMITTED USES AND DISCLOSURES BY BUSINESS ASSOCIATE

- A. Except as otherwise provided in this Addendum, Business Associate may use or disclose PHI on behalf of, or to provide services to, Community First for those functions, activities, and/or services relating to mining of pharmacy data activities if such use or disclosure of PHI would not violate the HIPAA Privacy and Security Rule or HITECH if done by Community First.
- B. As part of providing functions, activities, and/or services to Community First as identified in Part III.A., Business Associate may disclose information, including PHI, to other business associates of Community First and may use and disclose information, including PHI, received from other business associates of Community First as if this information was received from, or originated with, Community First as long as all such Business Associates have executed an Addendum or Agreement providing reasonable assurances that they will comply with the provisions of this Addendum.
- C. Business Associate agrees not to use or further disclose PHI, and to ensure that its directors, officers, employees, contractors, and agents, do not use or further disclose PHI other than as permitted or required by this Addendum or as required by law. Except as otherwise limited in this Addendum, Business Associate may use PHI for the proper management and administration of Business Associate's business or to carry out the legal responsibilities of Business Associate.
- D. Except as otherwise limited in this Addendum, Business Associate may use PHI to provide data aggregation services to Community First as permitted by 42 C.F.R. § 164.504(e)(2)(i)(B).
- E. If the use or disclosure of PHI in this Agreement is based upon an individual's specific consent or authorization and the individual revokes such consent or authorization in writing, or the effective date of such authorization has expired, or the consent or authorization is found to be defective in any manner that renders it invalid, Business Associate agrees that, upon notice of such revocation or invalidity, Business Associate will cease the use and disclosure of any such individual's PHI except where an exception under the HIPAA Privacy and Security Rule expressly applies. Any prior use or disclosure undertaken by Business Associate in reliance on such consent or authorization will not be affected.
- F. If Business Associate becomes aware of any use or disclosure of PHI that is not provided for in this Addendum, Business Associate will report that use or disclosure to Community First as soon as reasonably possible.
- G. Business Associate acknowledges that should Community First or one of its Business Associates Use or Disclose PHI improperly in violation of this Addendum ("Improper Use/Disclosure"), Community First is required to take reasonable steps to mitigate harmful effects of the Improper Use/Disclosure. Should Business Associate or an agent of Business Associate make an Improper Use/Disclosure, Business Associate shall notify Community First immediately and consult with Community First on the steps necessary to mitigate the harmful effects of such Disclosure, which steps may include:

1. Identifying the source(s) of the Improper Use/Disclosure and taking appropriate corrective action;
 2. Contacting the recipient of the information that was disclosed by the Improper Use/Disclosure and instructing such recipient to either destroy or return the information and to make no further use or disclosure of such information;
 3. Notifying the individual whose PHI was the subject of the Improper Act; and/or
 4. Reviewing, and correcting where appropriate, any policy or procedure of Business Associate that directly caused or contributed to the Improper Use/Disclosure.
- H.** Upon receiving a written request from Community First or an individual whose PHI is in Business Associate's possession, Business Associate shall provide the individual access to his or her PHI in a designated record set in accordance with 45 C.F.R. § 164.524. Business Associate may require the individual to pay certain fees, as delineated in 45 C.F.R. § 164.524(c)(4), for it to provide copies or summaries of PHI.
- I.** Upon receiving written notification from Community First that it has directed or agreed, pursuant to 45 C.F.R. § 164.526, to amend PHI in a designated record set, Business Associate agrees to make available such PHI for amendment and incorporate any such amendments to such PHI as directed by Community First.
- J.** Upon receiving written notification from Community First that it has agreed, pursuant to 45 CFR §164.522, to honor an individual's reasonable request for confidential communications to the individual (e.g., by using alternative means or sending information to an alternative location), Business Associate shall cooperate with Community First in processing and honoring such requests for confidential communications and will disclose information to the individual only through the alternative means or location agreed to by Community First.
- K.** Upon receiving written notification from Community First that it has agreed, pursuant to 45 CFR §164.522, to honor an individual's request that Community First restrict, in a manner that exceeds restrictions required by law, uses and disclosures of PHI to carry out payment or health care operations or to disclose PHI to a relative, personal friend or other person identified by the individual and involved in the care of the person or payment of the person's health care, Business Associate shall cooperate with Community First in processing and honoring such requests for restrictions and shall comply with any restriction agreed to by Community First of which Business Associate has notice.
- L.** Business Associate agrees, at the written request of Community First, to make available to Community First the information required to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528.
- M.** For the purpose of Community First or the Secretary determining Community First's compliance with the HIPAA Privacy and Security Rule, Business Associate shall make available to Community First or the Secretary the Business Associate's internal practices, books, and records relating to the use and disclosure of PHI. No legal privilege, if any, will be deemed to have been waived by Business Associate by virtue of disclosure under this provision of the Addendum.

Part IV
SAFEGUARDS TO SECURE PHI

- A.** Business Associate agrees to, and assures Community First that it will, use appropriate safeguards to prevent the use or disclosure of PHI other than as provided for by this Addendum or as required by law. Specifically, Business Associate agrees to:
1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of the Community First and to allow Community First to review such safeguards upon request; and
 2. Secure ePHI (including data in motion, data at rest, data in use and data disposed), created by Community First, or accessed, maintained, retained, modified, recorded, stored, destroyed, or otherwise held, used, or disclosed by Business Associate on behalf of Community First, by encrypting such ePHI in accordance with the Department of Health and Human Services Guidance at <http://www.hhs.gov/ocr/privacy> (“HHS Guidance”) and the National Institute of Standards and Technologies (“NIST”) at <http://www.csrc.nist.gov/> to ensure that such information is unusable, unreadable, or indecipherable to unauthorized individuals. Business Associate understands and agrees that ePHI is encrypted as specified in the HIPAA Security Rule by the use of an algorithmic process to transform data into a form in which there is a low probability of assigning meaning without use of a confidential process or key and such confidential process or key that might enable decryption has not been breached. To avoid a breach of the confidential process or key, these decryption tools shall be stored by Business Associate on a device or at a location separate from the data that are used to encrypt or decrypt.

Part V
BREACH NOTIFICATION

- A.** Business Associate agrees to report to Community First any security incident involving PHI of which it becomes aware.
- B.** In the event that Business Associate uses a method other than encryption or an encryption algorithm that is not specified in the Guidance or NIST Standards and Technologies to secure the ePHI as referenced in Part IV, Section A.2. of this Addendum, such ePHI shall be considered to be “unsecured” in accordance with HITECH. If unsecured ePHI is breached, Business Associate agrees to assume full responsibility, including all costs and expenses, incurred to assess the risk of harm caused by the breach and to provide notification to the individuals whose PHI was breached, the media and HHS as required by HITECH.
- C.** For the purposes of this Part V, a breach occurs when there is an unauthorized acquisition, access, use or disclosure of unsecured PHI/ePHI which compromises the security or privacy of the PHI/ePHI. A breach compromises the security or privacy of PHI/ePHI if it poses a significant risk of financial, reputational, or other harm to the individual whose PHI/ePHI was compromised. Business Associate agrees to:
1. Implement a system to detect breaches of PHI/ePHI within Business Associate’s business; maintain written documentation with respect to all suspected and confirmed breaches for six (6) years; provide access to such documentation to Community First upon request; and to submit documentation on breaches to

HHS as required by HITECH on an annual basis; to develop breach notification policies and procedures; to train workforce members on, and have sanctions for failure to comply with, these policies and procedures; to allow workforce members to file complaints regarding these policies and procedures or a failure to comply with them, and refrain from intimidating or retaliatory acts towards its workforce members;

2. Notify Community First on the first day that a breach is known to Business Associate, or by exercising reasonable diligence, would have been known to Business Associate;
 3. Provide Community First, to the extent possible, with the identity of each individual whose unsecured PHI/ePHI has been, or is reasonably believed to have been, breached;
 4. Conduct a risk assessment, as instructed by and in collaboration with Community First, to determine whether the privacy or security of individuals' PHI/ePHI was compromised as a result of the breach and to provide Community First the results of the assessment and any other available information, in writing, that is required to evaluate what information shall be included in notification of the breach;
 5. Provide Community First any supplemental information relevant to the assessment and/or determination of whether the breach compromises the security and privacy of the PHI/ePHI, even if that information becomes available after notification;
 6. In consultation with Community First, implement mutually agreed upon action(s) to mitigate any harm to individuals whose PHI/ePHI has been breached;
 7. Upon agreement by Community First that a breach compromises the privacy and security of PHI/ePHI, send notification to individuals whose PHI/ePHI has been compromised, the media and HHS as required by HITECH, as soon as possible, without reasonable delay but no later than sixty (60) calendar days after the date the breach was discovered by Business Associate, on the form and in the manner approved by Community First. Business Associate shall maintain documentation of all notifications and risk assessments;
 8. In those instances where Community First determines that a breach does not compromise the privacy and security of PHI/ePHI, Business Associate shall maintain documentation of the reason for this conclusion for six (6) years from the date of the determination unless a longer retention period is required by state or federal law. Such documentation shall include the application of any exceptions to the breach notification requirements provided in HITECH.
- D.** In the event Business Associate, as of September 23, 2009, uses a method of encryption or an encryption algorithm in compliance with the HIPAA Security Rule, and as specified in the HHS Guidance and NIST Standards and Technologies to secure ePHI under this Addendum, and subsequently discovers a breach of encrypted information, Business Associate is not required to provide the breach notification in the Part V, Section C.7. above. Business Associate must, however, comply with the provisions of Part III of this Agreement that relate to unauthorized use and disclosures of PHI, including Part III, Sections F, G, K, and M.

**Part VI
DESTRUCTION OF PHI/EPHI**

Business Associate shall destroy all paper, film, or other hard copy media by shredding or destruction, and destroy electronic media by clearing, purging or destruction consistent with NIST Special Publication 800-88, Guidelines for Media Sanitization, such that the PHI cannot be retrieved.

**Part VII
SUBCONTRACTORS**

- A.** Business Associate agrees [and shall provide that its directors, officers, employees, subcontractors, and agents, agree] not to disclose PHI to any other person (other than members of their respective workforce as specified in Section B of this Part VII), unless disclosure is required by law or authorized by the person whose PHI is to be disclosed. Any such disclosure other than as specifically permitted in the immediately preceding sentences shall be made only if such disclosee has previously signed a written agreement that:
1. Binds the disclosee to the provisions of this Addendum pertaining to PHI, for the express benefit of Community First and, if disclosee is other Community First, the disclosee;
 2. Contains reasonable assurances from disclosee that the PHI will be held confidential as provided in this Addendum, and only disclosed as required by law for the purposes for which it was disclosed to disclosee; and
 3. Obligates disclosee to immediately notify Community First of any breaches of the confidentiality or security of the PHI, to the extent disclosee has obtained knowledge of such breach.
- B.** Business Associate shall not disclose PHI to any member of its workforce and shall provide that its subcontractors and agents do not disclose PHI to any member of their respective workforces, unless Business Associate or such subcontractor or agent has advised such person of Business Associates' obligations under this Addendum, and of the consequences for such person and for Business Associate or such subcontractor or agent of violating them. Business Associate shall take and shall provide that each of its subcontractors and agents take appropriate disciplinary action against any member of its respective workforce who uses or discloses PHI in contravention of this Agreement.

**Part VIII
OBLIGATIONS OF COMMUNITY FIRST**

- A.** Community First shall provide Business Associate with the Notice of Privacy Practices that Community First produces in accordance with 45 C.F.R. § 164.520, as well as any changes to such Notice. The Notice of Privacy Practices currently in effect for the insurance or benefit products being provided or administered through Community First is attached to the Agreement as Exhibit B.
- B.** Community First shall provide Business Associate with any changes in, or revocation of, permission by any individual to use or disclose his/her PHI if such changes affect

Business Associate's permitted or required uses and disclosures. Community First shall notify Business Associate in writing of such change made by an individual.

- C. Community First shall notify Business Associate, of any restriction to the use or disclosure of PHI that Community First has agreed to in accordance with 45 C.F.R. § 164.522.

**Part IX
INDEMNIFICATION**

Business Associate hereby agrees to indemnify and hold harmless Community First and its officers, directors, employees, and agents, from and against any and all claims, actions or proceedings of any kind and any losses, costs, damages, liabilities or expenses (including, but not limited to, attorneys' fees at all levels of trial and appeal) incurred by, imposed upon or asserted against any separate party and its officers, directors, employees, and agents, resulting from or in connection with (i) the negligent acts or omissions of any party, or any of its shareholders, officers, directors, employees, contractors, or agents, (ii) any misrepresentation or breach of any warranty made by Business Associate under this Agreement, or (iii) the breach of any covenant, agreement, or obligation of Business Associate under this Agreement or applicable law.

**Part X
MISCELLANEOUS**

- A. Upon termination of this Agreement, Business Associate agrees, at Community First's option, to either return or destroy all PHI received from Community First that Business Associate maintains in any form. Business Associate also agrees to comply with federal and state laws as they may be amended from time to time governing the maintenance or retention of PHI. If the return or destruction of PHI is not feasible, Business Associate agrees to extend the protections of this Agreement to the information and limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
- B. If it is believed that Business Associate breached any provision in this Addendum, Community First may, at its option:
 - 1. Access and audit the records of Business Associate related to Business Associate's use and disclosure of PHI;
 - 2. Require Business Associate to submit to monitoring and reporting, and such other conditions as Community First may determine are necessary, to ensure compliance with this Addendum, including mitigation of harmful effects of an Improper Use/Disclosure under Section III.J of this Agreement;
 - 3. Require any action or inaction necessary of Business Associate to remedy the breach and comply with the HIPAA Privacy and Security Rules and, if such steps were unsuccessful;
 - 4. Terminate this Agreement; or
 - 5. Report the infraction to the Secretary.

IN WITNESS WHEREOF, the undersigned have executed this Addendum.

Provider

Community First Health Plans, Inc.

Signature

Patrina Fowler, Vice-President/COO

Title

Date

Date