7/13/2026 6:02 PM
D-1-GN-23-001549
Velva L. Price
District Clerk
Travis County
Victoria Benavides

CAUSE NO. D-1-GN-23-001549

THE TEXAS DEPARTMENT OF INSURANCE, *Plaintiff,*	§	IN THE DISTRICT COURT OF
v.	§	TRAVIS COUNTY, TEXAS
FRIDAY HEALTH INSURANCE COMPANY, INC. *Defendant.*	§	345th JUDICIAL DISTRICT

SPECIAL DEPUTY RECEIVER'S APPLICATION TO APPROVE SETTLEMENT AGREEMENT [US Renal Care, Inc.]

TO THE HONORABLE JUDGE OF SAID COURT:

Cantilo & Bennett, L.L.P., Special Deputy Receiver of Friday Health Insurance Company, Inc. (the "SDR" and "FHIC," respectively) files this *Application to Approve Settlement Agreement [US Renal Care, Inc.]* (the "Application"), and shows the following:

I. INTRODUCTION

1.1 The SDR seeks approval of a settlement in connection with its claims involving overpayments made by FHIC to US Renal Care, Inc. and its affiliates (collectively, "USRC"). The SDR seeks this Court's approval of the settlement under TEX. INS. CODE § 443.154(y) because it involves a claim exceeding $1 million. A true and correct copy of the Settlement Agreement (the "USRC Settlement Agreement") is attached as **Exhibit 1**. In summary, the USRC Settlement Agreement provides for USRC to pay the SDR $9.3 million, in three quarterly installments, in full and final settlement of all claims by the SDR against USRC; full releases by both the SDR and USRC; and the SDR to seek Receivership Court approval of the settlement.

II. BACKGROUND

2.1. On March 23, 2023, the Court entered an *Agreed Order Appointing Liquidator, Permanent Injunction, and Notice of Automatic Stay* appointing the Texas Commissioner of

Insurance as Liquidator of FHIC. Effective March 23, 2023, the Texas Commissioner of Insurance, as Liquidator, appointed CANTILO & BENNETT, L.L.P. as Special Deputy Receiver of FHIC.

III. JURISDICTION

3.1. This Court has jurisdiction over the subject matter of this Application and of the parties and property affected herein pursuant to TEX. INS. CODE § 443.005. The Court has personal jurisdiction over USRC because this is a civil proceeding arising under and related to a delinquency proceeding under Chapter 443 of the Texas Insurance Code (the "Code"), the transactions and occurrences which form the basis for the proceeding occurred, in whole or in part, in this state, because USRC falls under the Court's statutory personal jurisdiction set out in TEX. INS. CODE § 443.005(d) and TEX. CIV. PRAC. & REM. Code Chapter 17, alternatively, because USRC reside and/or conduct business in this state that is directly related to the subject matter of this proceeding, and because the exercise of jurisdiction comports to customary standards of fair play and substantial justice and complies with the protections of the Constitutions of the United States of America and the State of Texas.

3.2. The SDR is authorized to file this Application pursuant to TEX. INS. CODE § 443.154 (y). The subject matter of this Application has been referred to the Special Master appointed in this proceeding in accordance with the *Order of Reference to Master* entered on March 23, 2023.

IV. DISPUTE WITH USRC

4.1 Before receivership, FHIC and USRC entered into a Participating Provider Agreement (the "Network Agreement"). The Network Agreement is attached as **Exhibit 2**. Pursuant to the Network Agreement, FHIC agreed to pay USRC for certain medical services provided by USRC to FHIC insureds pursuant to the terms of the Network Agreement. The Network Agreement provided that FHIC would be entitled to recover from USRC in the event that

claims submitted by USRC were overpaid. FHIC eventually determined that it had overpaid USRC in the amount of $10.3 million and sought refund of the overpayments. USRC disputed the amount of the alleged overpayment as well as the SDR's right to recover those overpayments pursuant to the Network Agreement. After negotiation, and further review of the complex accounting for the overpayments, the parties agreed to the terms of the USRC Settlement Agreement.

V. THE USRC SETTLEMENT

5.1 The SDR moves the Court to approve the settlement with USRC. The USRC Settlement Agreement (**Exhibit 1**) requires Receivership Court approval of its terms, which includes payment by USRC of the total sum of $9.3 million to the SDR in three equal quarterly installments. This represents approximately 90% of the sum initially demanded by the SDR. This settlement would avoid the time and expense of arbitration as required under the Network Agreement. The settlement avoids the potential that certain defenses asserted by USRC would be successful in the arbitration.

VI. NOTICE

6.1 The SDR has served this Application to all known parties at interest and all individuals and entities identified by the SDR in the Certificate of Service by email, or such other method as is described in the Certificate of Service.

VII. OFFER OF PROOF AND VERIFICATION

7.1 This Application is verified by the affidavit and certification pursuant to TEX. INS. CODE § 443.017(b) by Susan Salch, Partner in Cantilo & Bennett, L.L.P., Special Deputy Receiver of Friday Health Insurance Company, Inc.

VIII. NOTICE

8.1 SDR has served this Application to all known parties in interest, including all affected guaranty associations, and all individuals and entities identified by the SDR in the

Certificate of Service by e-mail and, as noted, by mail or overnight delivery to certain government agencies.

PRAYER

WHEREFORE, PREMISES CONSIDERED, Cantilo & Bennett, L.L.P., Special Deputy Receiver of Friday Health Insurance Company, Inc., prays that the Court enter an order as follows:

1. Granting the Application;
2. Approving the USRC Settlement Agreement in the same or substantially similar format as **Exhibit 1**;
3. Authorizing the SDR to proceed with the performance of its duties under the USRC Settlement Agreement and to accept USRC's payment of $9.3 million as resolution of its claims against USRC;
4. Authorizing the SDR to take any action necessary to carry out the Order;
5. Finding that the Order constitutes a final judgment fully resolving all issues relating to the Application, provided that this Court shall retain jurisdiction to issue further orders pursuant to TEX. INS. CODE Chapter 443;
6. Finding that the Order shall not affect in any way, the Receiver's and the SDR's immunities from suit and shall not give rise to any right to sue or create any causes of action against the Receiver or the SDR;
7. Finding that the Permanent Injunction and the automatic stay under TEX. INS. CODE § 443.008 remain in effect;
8. Ordering that the SDR and USRC shall pay their own respective attorneys' fees and costs that have arisen, and may continue to arise, in connection with this Order and the USRC Settlement Agreement; and
9. Granting the SDR such other and further relief to which it may justly entitled.

Respectfully submitted,

/s/ Greg Pierce

Gregory A. Pierce
State Bar No. 15994250
P.O. Box 40
Austin, Texas 78767
Tel: (512) 474-2154
gpierce@gpiercelaw.com

Attorney for CANTILO & BENNETT, LLP,
Special Deputy Receiver of
Friday Health Insurance Company, Inc.

APPLICANT'S NOTICE OF SUBMISSION

Pursuant to the terms of the Agreed Order of Reference to Master entered by the District Court in this cause, the *Application to Approve Settlement Agreement [US Renal Care, Inc.]* is hereby set for written submission before the Special Master, Tom Collins, on **July 27, 2026**.

The Special Master has asked that the following rules be provided you:

1. Any objection must be filed with the Travis County District Clerk at least three (3) calendar days before the submission date.

2. A copy of any objection shall be served by e-mail by such date on:

   (a) The Special Master's Docket Clerk, at specialmasterclerk@tdi.texas.gov;
   (b) The undersigned counsel, Greg Pierce at gpierce@gpiercelaw.com; and
   (c) All interested parties, including those listed on the SDR's Certificate of Service.

3. The objecting party shall coordinate with the SDR's counsel and the Docket Clerk [(512) 676-6915)] to obtain an oral hearing setting for argument on the Application and Objection, and complete and attach an "Objecting Party's Notice of Oral Hearing" to the objection.

4. The written objection must specifically list all reasons for objection with supporting references to and discussion of statutory and case authorities. Reasons not stated in writing will not be considered orally.

5. **Please note that if an objection is not filed as described in the Notice of Submission, the Master may consider the Application without a hearing.**

6. **Failure to file timely a written objection before the Special Master constitutes a waiver of the right to object to the Special Master's recommendation to the District Court.**

7. Any Acknowledgment of Notice and Waiver to be filed by the Guaranty Association or other interested party should be filed at least three (3) calendar days before the submission or hearing date.

/s/ Greg Pierce
Gregory A. Pierce

CERTIFICATE OF SERVICE

I certify that on July 13, 2026, a true and correct copy of this *Application to Approve Settlement Agreement [US Renal Care, Inc.]* was served pursuant to the Order of Reference, the Texas Rules of Civil Procedure, and TEX. INS. CODE ANN. § 443.007 (d) on the following:

Via Email: specialmasterclerk@tdi.texas.gov
Tom Collins, Receivership Master
c/o Special Master's Clerk
RLO MC-FRD
PO Box 12030
Austin, TX 78711-2030

Via Email: Shawn.Martin@tdi.texas.gov
Shawn Martin
General Counsel Division
Office of Financial Counsel
TEXAS DEPARTMENT OF INSURANCE
PO Box 12030
Austin, TX 78711-2030

Via Email: John.Walker@tdi.texas.gov
John Walker
TEXAS DEPARTMENT OF INSURANCE
RLO MC-FRD
PO Box 12030
Austin, TX 78711-2030

Via Email: Vane.Hugo@tdi.texas.gov
Vane Hugo
TEXAS DEPARTMENT OF INSURANCE
RLO MC-FRD
PO Box 12030
Austin, TX 78711-2030

Via Email: David.Ashton@tdi.texas.gov
David Ashton
General Counsel Division
Office of Financial Counsel
TEXAS DEPARTMENT OF INSURANCE
PO Box 12030
Austin, TX 78711-2030

Via e-Service: Kimberly.Gdula@oag.texas.gov
Kimberly Gdula
Assistant Attorney General
General Litigation Division
OFFICE OF THE TEXAS ATTORNEY GENERAL
P.O. Box 12548, Mail Stop 01901
Austin, TX 78711-2548
Counsel for Texas Department of Insurance

Via e-Service: dprice@sp-legal.com
Via e-Service: cfrasier@sp-legal.com
Dan Price
Carrie Frasier, Legal Assistant
SHANLEY PRICE
5501A Balcones Drive, Suite 218
Austin, TX 78731
Counsel for the Texas Life and Health Insurance Guaranty Association

Via e-Service: bburner@mwlaw.com
Burnie Burner
MITCHELL, WILLIAMS, SELIG, GATES & WOODYARD, P.L.L.C.
500 W. 5th Street, Ste. 1150
Austin, TX 78701

Via First Class Mail
INTERNAL REVENUE SERVICE
Mail Stop 5027 Dal (AUSC)
1100 Commerce Street
Dallas, TX 75242-1012

Via Email: BPollock@mayerbrown.com
Bronwyn Pollock
MAYER BROWN LLP
333 Grand Ave., 47th Floor
Los Angeles, CA 90071
Counsel for AXA France Vie

Via Email: RHarrell@mayerbrown.com
Via Email: JDanford@mayerbrown.com
Robert Harrell
James Danford, Jr.
MAYER BROWN LLP
700 Louisiana St., Suite 3400
Houston, TX 77002
Counsel for AXA France Vie

Via Email: VSidhu@mayerbrown.com
Via Email: JToes@mayerbrown.com
Vikram Sidhu
Juliana Toes
MAYER BROWN LLP
1221 Avenue of the Americas
New York, NY 10020-10011
Counsel for AXA France Vie

Via Email: Brian.Hansen@hcahealthcare.com
Brian Hansen
HCA HEALTHCARE
One Park Plaza, Building 1-2E
Nashville, TN 37203

Via Email: mpcooley@reedsmith.com
Michael P. Cooley
REED SMITH LLP
2850 N. Harwood Street, Suite 1500
Dallas, TX 75201
Counsel for Molina Healthcare, Inc.

Via Email: dhollaway@houstonlaw.com
T. Daniel Hollaway
Hollaway PC – Attorneys at Law
19 Briar Hollow Lane, Suite 245
Houston, TX 77027
Counsel for Christus Health

Via Email: Kristen.Perry@faegredrinker.com
Kristen L. Perry
FAEGRE DRINKER BIDDLE & REATH LLP
1717 Main Street, Ste 5400
Dallas, TX 75201
Counsel for Quest Diagnostics Clinical Laboratories, Inc.

Via Email: MTurner@plevinturner.com
Miranda H. Turner
PLEVIN & TURNER LLP
1701 Pennsylvania Ave., N.W. Suite 200
Washington, DC 20006

Via Email: Amy_Condo@bcbsil.com
Amy Pinkerman Condo
HEALTH CARE SERVICE CORPORATION
300 E. Randolph Street
Chicago, IL 60601
Counsel for Health Care Service Corporation Blue Cross and Blue Shield of Illinois, Montana, New Mexico, Oklahoma and Texas

Via EMail:
Boubacar.Ba@CommunityHealthChoice.org
Boubacar Ba
Community Health Choice
4888 Loop Central Dr., #600
Houston, Texas 77081

/s/ Greg Pierce
Gregory A. Pierce

SPECIAL DEPUTY RECEIVER'S VERIFICATION AND CERTIFICATION PURSUANT TO TEX. INS.CODE ANN. §443.017(b)

AFFIDAVIT OF SUSAN E. SALCH

State of Texas

County of Travis

BEFORE ME, the undersigned authority appeared Susan E. Salch, who after being by me duly sworn, stated the following under oath:

1. "My name is Susan E. Salch. I am of sound mind, capable of making this affidavit, and am competent to testify to the matters contained in this affidavit.

2. I am a partner in CANTILO & BENNETT, L.L.P., the Special Deputy Receiver of Friday Health Insurance Company, Inc. (the "SDR" and "FHIC" respectively), I am duly authorized to make this Affidavit on behalf of the SDR.

3. I have reviewed the *Special Deputy Receiver's Application to Approve Settlement Agreement [US Renal Care, Inc.]* and the facts stated therein are true and correct based on my personal knowledge, my review of estate records and my consultation with the staff and subcontractors.

4. I certify that the exhibits, books, accounts, records, papers, correspondence, and/or other records and documents attached hereto were produced pursuant to TEX. INS. CODE § 443.017, are either true and correct copies of records of FHIC and were received from the custody of FHIC or found among its effects, or were created by and filed with the Receiver's office in connection with the receivership of this delinquent company, and are held by the Special Deputy Receiver in its official capacity."

By: Susan E. Salch
Susan E. Salch

SUBSCRIBED AND SWORN TO BEFORE ME on July 10, 2026, by Susan E. Salch, Special Deputy Receiver of Friday Health Insurance Company, Inc.

ROMAN FLORES
My Notary ID # 129762309
Expires March 26, 2030

Notary Public

EXHIBIT 1

Exhibit 1

SETTLEMENT AGREEMENT

This Settlement Agreement ("Agreement") is made effective as of _____, 2026, by and between CANTILO & BENNETT, L.L.P., as Special Deputy Receiver for Friday Health Insurance Company, Inc. and Friday Health Insurance Company, Inc. ("**SDR**" and "**FHIC**," respectively), and US Renal Care, Inc. and its affiliates, including but not limited to the entities listed on the attached **Exhibit A** (collectively, "**USRC**"). The SDR, FHIC, and USRC shall be collectively referred to as the "**Parties**."

WHEREAS, FHIC was placed into receivership on March 23, 2023 in the action styled Cause No. D-1-GN-23-001549, *Texas Department of Insurance v. Friday Health Insurance Company, Inc.*, In the 345th Judicial District Court, Travis County, Texas (the "**FHIC Liquidation Proceeding**");

WHEREAS, the SDR, FHIC, and USRC have disputes regarding obligations owed under the Participating Provider Agreement Between Friday Health Plans Management Services Company, Inc. and US Renal Care, Inc. (Ancillary Provider Agreement) (the "Agreement");

WHEREAS, the Parties desire to resolve all disputes and claims between them, and to avoid the costs of litigation, and without any Party admitting the validity of any other Party's position, the Parties wish to settle these matters on the terms set forth here;

NOW, THEREFORE, in consideration of the mutual agreements set forth herein, and for other good and valuable consideration, the receipt and sufficiency of which are acknowledged, the Parties do agree as follows:

1.1 **Recitals**. The Parties hereby acknowledge and agree that each and all of the recitals set forth herein are true and correct and are incorporated by this reference and made a part hereof for all purposes.

1.2 **Settlement Payment.** USRC agrees to pay to the SDR, in full satisfaction of all obligations owed to the SDR and/or FHIC, the sum of $9,300,000 (the "Settlement Payment"). The Settlement Payment shall be made in three equal installments of $3,100,000, with the first installment due 30 days after notice is provided to FHIC of the entry of an order approving this Agreement by the court in the FHIC Liquidation Proceeding, the second installment due 90 days after the first installment, and the third installment due 90 days after the second installment.

1.3 **Releases by SDR and FHIC.** Upon payment of all three installments of the Settlement Payment, the SDR and FHIC release USRC, including all of USRC's current and former shareholders, officers, directors, employees, agents, attorneys, affiliates, and representatives (including their respective predecessors, successors, assigns, heirs, executors and administrators), from any and all claims, rights, demands, losses, expenses, costs, liabilities, actions, causes of action, suits or compensation of any nature, whether based in tort, contract, equity or any other theory of recovery that FHIC and/or the SDR ever had, now has, or might have in

the future based upon anything from the beginning of the world to the date and time of this agreement.

1.4 **Releases by USRC**. Upon payment of all installments of the Settlement Payment, USRC releases FHIC and the SDR, including all employees, attorneys, agents, affiliates and representatives (including their respective predecessors, successors, assigns, heirs, executors, and administrators) from any and all claims, rights, demands, losses, expenses, costs, liabilities, actions, causes of action, suits or compensation of any nature, whether based in tort, contract, equity or any other theory of recovery that USRC ever had, now has, or might have in the future based upon anything from the beginning of the world to the date and time of this agreement.

1.5 **Effectiveness.** The Parties to this Agreement recognize that it will become effective only after approval by the court in the FHIC Liquidation Proceeding. The SDR agrees to seek approval in the FHIC Liquidation Proceeding. This Agreement is binding upon the Parties, subject only to approval of the Court in the FHIC Liquidation Proceeding. In the event that the Court in the FHIC Liquidation Proceeding denies approval of this Agreement, this Agreement shall be null and void, and no statements made by the Parties in this Agreement, any motion for approval of the Agreement, at any hearing regarding an application to approve the Agreement, or in negotiations for settlement of the disputes that are the subject of this Agreement, may be used for any purpose whatsoever by the Parties.

1.6 **Binding.** Upon approval by the Court in the FHIC Liquidation Proceeding, this Agreement is binding upon and inures to the benefit of the respective Parties hereto and their respective successors and assigns.

1.7 **Authorization.** Each Party represents and warrants that it is authorized to execute this Agreement, and that the person signing this Agreement on its behalf is authorized to execute this Agreement on its behalf.

1.8 **All Terms.** The provisions of this Agreement comprise all of the terms, conditions, agreements, and representations of the Parties respecting their agreement, as set forth herein. This Agreement may not be altered or amended or waived except by written agreement executed by all Parties. All Parties agree that the terms of this Agreement have in no way been changed, modified or expanded by any oral agreements or representations entered into or made by any party prior to or at the execution of this Agreement.

1.9 **Construction.** The Parties acknowledge that each of them has had the opportunity to engage counsel of his or its own choice and has been offered an opportunity to review this Agreement with chosen counsel. The Parties further acknowledge that they have, through their respective counsel or otherwise, participated or had the opportunity to participate in the preparation of this Agreement, and it is understood that no provision will be construed more strictly against any Party.

1.10 **Governing Law.** The Parties agree that this Agreement shall be governed by the laws of the State of Texas.

1.11 **No Admission.** The Parties agree that this Agreement represents a compromise of disputed claims, the liability for which each party hereto has expressly denied. The execution of this Agreement by any party hereto shall not be deemed an admission of liability or fault on the part of any person or entity executing this Agreement.

1.12 **Counterparts.** This Agreement may be executed in one or more original or facsimile counterparts each of which shall be deemed an original, but also which together will constitute one and the same instrument. Further, facsimile copies or electronic signatures shall be treated as originals for all purposes.

1.13 **Notices**. All notices to the SDR and/or FHIC relating to this Agreement shall be made by email to Greg Pierce at gpierce@gpiercelaw.com.

All notices to USRC shall be made by mail and email to:

Alison Andersen
ArentFox Schiff LLP
1717 K Street, NW
Washington, DC 20006
alison.andersen@afslaw.com

with a copy to:

Legal Department, US Renal Care
Attn: Samantha Samoylo, Esq.
5851 Legacy Circle, Suite 900
Plano, TX 75024
samantha.samoylo@usrenalcare.com

Each Party may update its notice address in the future by written notice.

1.14 **Miscellaneous.** It is further agreed as follows:

1.14.1 **Captions.** The captions and headings used in this Agreement are for convenience only and do not in any way affect, limit, amplify or modify the terms and provisions hereof.

1.14.2 **Attorneys' Fees.** If any legal action, arbitration or other proceeding is commenced to enforce or interpret any provision of this Agreement, the prevailing party shall be entitled to an award of its actual fees and expenses, including, without limitation, attorneys' fees and disbursements (including

fees on appeal) expert witness fees and disbursements. The term "prevailing party" shall include a party who receives substantially the relief desired whether by settlement, dismissal, summary judgment, judgment or otherwise.

1.14.3 **Exhibits.** All of the Exhibits shall be deemed incorporated herein by reference and made a part hereof for all purposes.

1.14.4 **Further Assurances.** From time to time after the date of this Agreement, and without further consideration, the Parties agree to work cooperatively to do all such other acts and things, all in accordance with applicable law, as may be reasonably necessary or appropriate to more fully and effectively carry out the purposes and intent of this Agreement.

1.14.5 **Closing Costs.** All costs and expenses of the Parties' performance of their respective obligations hereunder shall be borne by the party incurring such cost or expense.

IN WITNESS WHEREOF, the Parties have executed this Agreement effective as of _____, 2026.

Date: _____

CANTILO & BENNETT, L.L.P.,
SPECIAL DEPUTY RECEIVER FOR
FRIDAY HEALTH INSURANCE COMPANY, INC.,
ON BEHALF OF ITSELF AND FRIDAY HEALTH
INSURANCE COMPANY, INC.

By: _____
Its: _____

Date: _____

US RENAL CARE, INC., ON BEHALF OF ITSELF AND ITS AFFILIATES, INCLUDING BUT NOT LIMITED TO THE ENTITIES LISTED ON EXHIBIT A

By: _____
Thomas L. Weinberg
Executive Vice President & General Counsel
U.S. Renal Care, Inc.

Exhibit A

DSI Chinatown Hemodialysis, LLC
Liberty Dialysis - McKinney
Liberty Dialysis - Mesquite, LLC
Liberty Dialysis - Plano Dexter
MDC 14 Partners, LLCLiberty Dialysis
U.S. Renal Care Delta Dialysis
U.S. Renal Care Edinburg Dialysis
U.S. Renal Care Glenwater Dialysis
U.S. Renal Care Harlingen Dialysis
U.S. Renal Care Kingwood Dialysis
U.S. Renal Care Laredo South Dialysis
U.S. Renal Care McAllen Dialysis
U.S. Renal Care Mid Valley Weslaco Dialysis
U.S. Renal Care Mission Dialysis
U.S. Renal Care North Dallas Dialysis
U.S. Renal Care North El Paso Dialysis
U.S. Renal Care Rowlett Dialysis
US Renal Care Conway Dialysis
US Renal Care Datapoint Dialysis
US Renal Care East El Paso Dialysis
US Renal Care Meadows Place Dialysis
US Renal Care Premier Dialysis
US Renal Care Richardson Dialysis
US Renal Care San Benito Dialysis
US Renal Care South El Paso Dialysis
US Renal Care Space City Dialysis
US Renal Care Tarrant Dialysis Arlington
US Renal Care Tarrant Dialysis West Fork Dialysis
US Renal Care Valley McAllen Dialysis
US Renal Care Webster Dialysis
US Renal Care West University Dialysis
USRC East Dallas LLC
USRC West Grand Prairie, LLC
WAXLD LLC Liberty Dialysis

Exhibit A

EXHIBIT 2

Participating Provider Agreement
Between
Friday Health Plans Management Services Company, Inc.
And
US Renal Care, Inc.
(Ancillary Provider Agreement)

This Participating Provider Agreement ("**Agreement**") is made and entered into as of the 1st day of December 2020 ("**Effective Date**") by and between **Friday Health Plans Management Services Company, Inc.** ("**Health Plan**") for the benefit of itself and its Affiliates, and **US Renal Care, Inc.** ("**Provider**"), hereinafter referred to collectively as "**Parties**" or individually as a "**Party**".

WHEREAS, Health Plan is an insurance company, health maintenance organization and/or third party administrator that issues or administers Benefit Plans, as herein defined;

WHEREAS, Health Plan requires the services of physicians, health care facilities and other health care providers to provide health care services to persons enrolled in Benefit Plans;

WHEREAS, Health Plan desires to have Provider be a Participating Provider and to provide health care services to Covered Persons, as defined herein, in accordance with the terms of this Agreement; and

WHEREAS, Provider desires to become a Participating Provider and provide health care services to Covered Persons, in accordance with the terms of this Agreement.

NOW, THEREFORE, in consideration of the premises and the mutual promises and covenants herein contained and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties agree as follows:

1. DEFINITIONS

1.1 **Affiliate** means an entity that controls, is controlled by, or is under common ownership or control with, another entity.

1.2 **Affiliated Provider** means any health care provider that is employed by or contracted with Provider to provide Covered Services or, if Provider is a group of health care providers, is a member of the group. Affiliated Providers are listed on the Affiliated Provider Data Sheet attached hereto as Exhibit A, as may be amended from time to time.

1.3 **Benefit Plan** means any health insurance policy, health maintenance or HMO contract, self-funded health plan, or any other health plan issued or administered by Health Plan or a Health Plan Affiliate.

1.4 **Claim** means a written request to Health Plan for payment for Covered Services.

Exhibit 2

1.5 **Clean Claim** means, unless otherwise required by Law, a claim for Covered Services submitted by Provider for payment that: (i) is submitted for payment of Covered Services, (ii) includes each of the data elements specified in the Provider Manual and Exhibit C (Fee Schedule) for the applicable type of Claim; (iii) is accurate, complete and requires no additional information for payment; (iv) has no defect, impropriety, or particular circumstance requiring special treatment preventing payment; (v) has a corresponding authorization for services, if required under the applicable Benefit Plan; and (vi) does not involve coordination of benefits; and (vii) complies with applicable Law.

1.6 **Control** means the possession, directly or indirectly, of the power to direct or cause the direction of the management or policies of such person, whether through the ownership of voting securities, by contract or otherwise.

1.7 **Cost Sharing Amount** means a payment obligation, such as a copayment, coinsurance or deductible, for Covered Services that is the financial responsibility of the Covered Person as set forth in the applicable Benefit Plan.

1.8 **Covered Person** means a person entitled to receive benefits pursuant to a Benefit Plan.

1.9. Covered Services means Medically Necessary health care services or supplies provided to a Covered Person for which benefits are provided under the applicable Benefit Plan

1.10 **Emergency Medical Condition** means, unless otherwise required by Law, the sudden and unexpected onset of a medical condition that manifests itself by acute symptoms of such severity, including severe pain, that a prudent layperson would reasonably believe requires immediate medical attention or surgical care to avoid serious physical impairment or loss of life.

1.11 **Emergency Services** means health care services including medical transportation services that are needed to evaluate, treat or stabilize an Emergency Medical Condition.

1.12 **Experimental Services.** Any service or supply that is determined to be investigational or experimental under the terms of the applicable Benefit Plan.

1.13 **Governmental Authority** means any United States federal, state or local governmental body, or political subdivision thereof, or any authority, agency or commission entitled to exercise any administrative, executive, judicial, legislative, policy, regulatory or taxing authority or power, including but not limited to, a State department of insurance, the U.S. Department of Health and Human Services, the Centers for Medicaid and Medicare Services, the Office of the Inspector General and the Comptroller General.

1.14 **HIPAA** means the Health Insurance Portability and Accountability Act of 1996, Pub. Law 104 – 191, and its implementing regulations.

1.15 **Law** means all federal, state, and local laws, statutes, ordinances, regulations, rules, executive orders, supervisory requirements, directives, circulars, interpretive letters and other official releases of or by any government, or any authority, department or agency thereof, including but not limited to CMS and any State department of insurance, with jurisdiction over Health Plan or a Benefit Plan.

1.16 **License** means a State or Federal license, certification or registration that is required to perform certain health care services. The term includes a DEA number.

1.17 **Medically Necessary** means, unless otherwise required by applicable Law or defined in the applicable Benefit Plan, any service provided by a health care provider for the prevention, diagnosis, or treatment of an illness, injury, disease or its symptoms and that is: (1) provided in accordance with generally accepted current medical standards; (2) clinically appropriate in type, frequency, extent, site, duration, intensity, and clinical effectiveness for the patient's illness, injury, or disease; (3) not primarily for the convenience of the patient, physician, or other individual; (4) not more costly than an alternative service which is at least as likely to produce equivalent therapeutic or diagnostic results for the patient's illness, injury, or disease; and (5) that are not Experimental Services.

1.18 **Non-Covered Services** means health care services or supplies that are not Covered Services.

1.19 **Participating Provider** means a health care provider, including a physician, physician group, hospital or other person or entity that is duly licensed or certified to provide health care services, that has directly or indirectly entered into an agreement with Health Plan to provide Covered Services.

1.20 **Payor** means the entity that is responsible for payment of Covered Services rendered to Covered Persons under a Benefit Plan, including but not limited to Health Plan or any Benefit Plan offered or administered by Health Plan or a Health Plan Affiliate.

1.21 **Preventable Adverse Event** means events identified by the National Quality Forum guidelines or the Centers for Medicare and Medicaid Services as never events, serious reportable events, or hospital-acquired conditions.

1.22 **Provider Manual** means the provider participation manual or manuals as developed and amended by Health Plan from time to time, that describes rules, standards, programs, policies and procedures for Participating Providers.

1.23 **Quality Management Program** means the program relating to the quality of Covered Services and includes Health Plan's provider credentialing and re-credentialing program.

1.24 **Term** means the Initial Term together with any Renewal Term.

1.25 **Utilization Management Policies and Procedures** means either the utilization management policies and procedures established and administered by Health Plan or any utilization management program required by a Payor.

2. PROVIDER RESPONSIBILITIES

2.1 **Provision of Health Care Services.** Provider shall provide Covered Services for which Provider is qualified and customarily furnishes to the general public in accordance with the standards of good medical practice and in accordance with the terms of this Agreement. Provider shall provide Covered Services through the last day this Agreement is in effect. Provider shall participate in all Benefit Plans identified in Exhibit D—Participation Election Attachment.

2.2 **Qualifications and Credentialing.** At all times during the term of this Agreement, Provider and all Affiliated Providers, as applicable, shall:

(a) Be duly licensed, certified, or registered to perform health care services and in good standing under applicable Law;

(b) Satisfy and comply with credentialing criteria developed, adopted, and amended from time to time, by Health Plan and included in the Provider Manual or otherwise made available to Provider;

(c) Provide Covered Services with the same standard of care, skill, and diligence customarily used by health care professionals in the community in which such services are rendered and in accordance with nationally accepted standards of care; and

(d) Provide Covered Services in the same manner in accordance with the same standards, and with no less availability as offered to individuals who are not Covered Persons.

2.3 **Access to Services.** Provider shall make necessary and appropriate arrangements to ensure the availability of Covered Services during its standard business operating hours, consistent with operating hours and availability of similar type providers as Provider. Provider shall maintain appointment hours that are convenient to serve Covered Persons and appointment access, appointment wait times, and telephone answering standards that meet the requirements set forth in the Provider Manual.

2.4 **Emergency Services.** Prior authorization is not required prior to providing Emergency Services. If a Covered Person requires non-Emergency Services that arise out of the Emergency Medical Condition screening assessment, Provider shall request and receive prior authorization for such non-Emergency

Services prior to providing or arranging for the provision of such non-Emergency Services. Provider acknowledges and agrees that payment may be reduced, in whole or in part, for failure to comply with prior authorization requirements, and Provider shall not bill Health Plan or the Covered Person for any such reduction in payment.

2.5 Verification of Covered Person Status. Provider shall undertake reasonable business efforts to establish a person's status as a Covered Person prior to rendering health care services. In an Emergency or if Provider is unable to establish a person's status prior to rendering health care services, Provider shall establish the person's status as soon as reasonably practical in accordance with applicable Health Plan procedures. Health Plan shall communicate to Provider in a timely manner all material modifications to then-current coverage verification procedures. Provider acknowledges that eligibility information is subject to change retroactively: (i) if Health Plan does not receive proper and timely notification regarding termination of a Covered Person's coverage; (ii) as a result of a final decision about a Covered Person's continuation of coverage pursuant to Law; or (iii) if eligibility information is later proven to be false.

2.6 Third Party Liability. Provider shall collect information from Covered Persons to identify any individual, entity, or program that is or may be liable to pay all or part of the cost for Covered Services including, but not limited to, liability insurance, automobile insurance, workers compensation, government programs or other health insurance coverage.

2.7 Health Plan Compliance. Provider shall cooperate with Health Plan to meet any requirements imposed on Health Plan by Law and shall cooperate with and assist Health Plan in complying with the requirements of NCQA, URAC, The Joint Commission, or other accrediting bodies.

2.8 Cooperation with Reporting. Provider agrees to cooperate with Health Plan and to assist it to timely comply with all reporting requirements of applicable Law, including requirements to provide information on encounters, patterns of utilization, the availability, accessibility, and acceptability of services, and Covered Person health status. Provider shall certify the accuracy of its records as required by a Health Plan or applicable Law. Provider agrees to allow Health Plan to use Provider performance data.

2.9 Provider Locations. Provider agrees to provide Covered Services at those locations identified in Exhibit B, as may be amended from time to time upon written notice to Health Plan. Provider shall ensure that facilities in which Covered Persons shall be received, screened, and treated, meet applicable State and local fire, safety, and sanitation codes. Provider agrees to notify Health Plan regarding the addition or deletion of any locations at least thirty (30) days prior to the date that Provider intends to make such addition or deletion effective. Until Health Plan approves the addition of a Provider location in writing, which shall not be unreasonably withheld, Health Plan has no

obligation to reimburse Provider for any health care services provided at said location.

2.10 Affiliated Providers. Provider may engage services of health care providers as Affiliated Providers as appropriate in maintaining accepted professional standards of medical care and to meet Provider's obligations under this Agreement. Provider shall require Affiliated Providers to comply with all provisions of this Agreement, including but not limited to, Section 4.3 (Prohibition on Balance Billing) and Section 4.4 (Hold Harmless). If Provider is a group of health care providers, Provider shall obtain the written agreement of each of the health care providers to be personally bound by the terms of this Agreement. Provider shall indemnify Payor, or a Group Health Plan accessing this Agreement, and Covered Persons for any failure of any Affiliated Provider to comply with the terms of this Agreement. Affiliated Providers as of the Effective Date are listed in Exhibit A, which shall be updated by Provider on a monthly basis. Provider shall provide Health Plan with thirty (30) days advance written notice if an Affiliated Provider is terminated or shall cease to provide Covered Services under this Agreement. Notwithstanding the foregoing, in the event that Provider's relationship with an Affiliated Provider is terminated for cause and Provider cannot provide such thirty (30) days advance notice, Provider shall notify Health Plan in writing of such termination as soon as possible but no later than five (5) days after learning of such termination. Provider shall be solely responsible for submitting Claims and providing payment on such Claims to Affiliated Providers. In the event any Affiliated Provider already has a contract with Health Plan, payment for Covered Services performed by the Affiliated Provider shall be governed by the terms of this Agreement beginning on the first day of the month following the date the provider is, or should have been, listed on Exhibit A as an Affiliated Provider.

2.11 On-Call Physicians. All on-call physicians must satisfy Health Plan credentialing criteria, and all financial arrangements for on-call services are between Provider and the on-call physician and are not the responsibility of Health Plan.

2.12 Excluded Persons. Provider shall not employ or contract with any health care provider to perform Covered Services on behalf of Provider who has been debarred or excluded from any State or Federal health care program. Provider shall review the U.S. Department of Health and Human Services Office of Inspector General exclusion database and verify that all health care providers employed or contracted by Provider to perform Covered Services on behalf of Provider are in good standing.

2.13 Compliance with Provider Manual. Provider shall abide by and comply with the programs, procedures, policies and reporting contained in the Provider Manual including but not limited to, the Utilization Management Policies and Procedures, the Quality Management Program, care management programs and performance measures. Notwithstanding the foregoing, the following shall

not be modified, altered or amended by any change or adoption of new rules, policies or procedures in the Provider Manual the rates set forth in Exhibit C, Fee Schedule (the "**Allowed Amount**").

2.14 Referrals. Provider shall use its best efforts when medically appropriate to refer Covered Persons to Participating Providers.

2.15 Prior Authorization. Provider shall cooperate with, participate in, and observe the protocols of the Utilization Management Policies and Procedures, including obtaining any requirements to obtain prior authorization for services as set forth in the Provider Manual. Provider has the sole responsibility for obtaining any necessary prior authorization for Covered Services ordered by Affiliated Providers. Provider acknowledges and agrees that payment may be reduced for failure to comply with Utilization Management Policies and Procedures requirements, and Provider shall not bill Health Plan or the Covered Person for any such reduction in payment.

2.16 Complaints. Provider shall cooperate with Health Plan to resolve complaints of Covered Persons promptly. Provider acknowledges the importance to Health Plan of providing responses to Covered Persons' complaints in a timely fashion and agrees to respond to a complaint within ten (10) calendar days.

2.17 Assignment of Benefits. Provider shall obtain a signed assignment of benefits authorizing payment for Covered Services to be made directly to Provider.

2.18 Cost-Effective Care. Within the dictates of good medical practice and applicable Law, Provider shall provide Covered Services in the most cost-effective setting and manner.

2.19 Nondiscrimination. Provider shall render care and treat Covered Persons with respect and dignity and give consideration for the privacy of all Covered Persons. Provider shall treat Covered Persons in all respects no less favorably than Provider treats all other patients. Provider shall not discriminate against Covered Persons based upon race, religion, national origin, color, sex, gender, marital status, sexual orientation, age, health status, disability, or source of payment.

2.20 Advance Directives. Provider acknowledges that each Covered Person has the right to accept or refuse treatment and execute advance directives pursuant to applicable Law. Provider shall (i) document in the medical records whether or not the Covered Person has executed an advance directive and/or a health care proxy, and if so, maintain a copy; (ii) not condition the provision of care or otherwise discriminate against Covered Person based on whether or not Covered Person has an advance directive; and (iii) take any other steps reasonably available to determine if the Covered Person has an advance directive.

2.21 Compliance with Law. Provider shall comply with all Laws applicable to the Benefit Plans and the provision of Covered Services pursuant to this Agreement.

2.22 Notices to Health Plan. Provider agrees to immediately notify Health Plan, in writing, if any of the circumstances occur.

(a) The revocation, suspension or other restriction on a License of Provider or an Affiliated Provider.

(b) Provider or an Affiliated Provider loses privileges at any hospital or facility for cause or agrees to the termination of privileges in lieu of an investigation or administrative action.

(c) The filing of a malpractice action in which Provider or an Affiliated Provider has been named as a defendant.

(d) The commission or omission by Provider or an Affiliated Provider of any act or any misconduct or allegation of misconduct for which the Provider's or health care provider's License may be subject to revocation or suspension whether or not actually revoked or suspended.

(e) A criminal indictment for any act or omission by Provider or an Affiliated Provider.

(f) Provider or an Affiliated Provider is otherwise disciplined by any licensing, regulatory, professional entity or any professional organization with jurisdiction.

(g) Filing of voluntary of involuntary bankruptcy of Provider or Provider being placed in receivership.

(h) Provider or an Affiliated Provider becomes subject to an exclusion from or the loss of good standing in the Medicaid or Medicare program.

(i) The initiation of an investigation by a State or Federal law enforcement agency against Provider or an Affiliated Provider.

2.23 Insurance Coverages. Provider shall purchase and maintain insurance with insurance companies reasonably acceptable to Health Plan, at Provider's expense, for comprehensive general liability insurance and for professional liability insurance each in an amount no less than one million dollars ($1,000,000) for each occurrence and three million dollars ($3,000,000) in the annual aggregate. Provider's professional liability insurance shall be occurrence coverage or claims made coverage with an extended period reporting option that is no shorter than three (3) years under such terms and

conditions as may be reasonably required by Health Plan. Upon request, Provider shall provide Health Plan with satisfactory evidence of the insurance coverages. Provider shall provide Health Plan with prior notification of any cancellation, non-renewal, or other material change in any such insurance coverage within ten (10) days of such cancellation, non-renewal or other material change.

2.24 Health Plan Access to Covered Persons. When a Covered Person's medical condition permits, Provider agrees to allow Health Plan access to the Covered Person or a person acting on behalf of the Covered Person to discuss benefits, discharge planning, follow up care and other pertinent Health Plan processes or requirements.

2.25 Work Stoppage. In the event of a work stoppage at Provider, Provider agrees to provide immediate notification to Health Plan and to work with Health Plan to provide continuity of care to Covered Persons.

3. HEALTH PLAN RESPONSIBILITIES

3.1 Benefit Plans. Health Plan shall offer or administer Benefit Plans in compliance with applicable Law.

3.2 Identification of Covered Persons. Health Plan shall offer a means to identify Covered Persons and Cost Sharing Amounts either by issuing an identification card to the Covered Person or by a telephonic, paper, or electronic means. For each Benefit Plan, Health Plan shall disclose whether Health Plan or a Payor other than Health Plan is the issuer of the Benefit Plan. Provider acknowledges and agrees that possession of such identification card or ability to access eligibility information telephonically or electronically, in and of itself, does not qualify the holder thereof as a Covered Person, nor does the lack thereof mean that the person is not a Covered Person.

3.3 Payment of Claims. Health Plan shall receive, process, and facilitate timely payment of Claims in accordance with the procedures as set forth in the Provider Manual and the terms of this Agreement.

3.4 Provider Directory. Health Plan shall maintain and provide to Covered Persons a listing of Participating Providers.

3.5 Health Plan Programs. Health Plan shall maintain a Quality Management Program, Utilization Management Policies and Procedures, and other programs, policies or procedures for the purpose of administering the Benefit Plans. Information related to all such programs shall be included in the Provider Manual or otherwise available to Provider.

3.6 Credentialing. Health Plan reserves the right to refuse or terminate the participation status of any Affiliated Provider. Health Plan shall use commercially reasonable best efforts to credential Provider within ninety (90)

days and in accordance with its standard credentialing policy upon receipt of Provider required documentation and shall not unreasonably withhold Provider from adding additional locations in all areas that Health Plan is licensed for business to the Agreement after its effective date.

3.7 Provider Manual. Health Plan shall maintain a Provider Manual which shall be available to Provider and Affiliated Providers in an electronic format.

3.8 Insurance Coverage. Health Plan shall carry and maintain commercial or self-insurance for professional and general comprehensive liability. Upon request, Health Plan shall deliver reasonable evidence of such coverage to Provider.

3.9 Customer Service. Health Plan shall provide inquiry services for Covered Persons, Provider, Affiliated Providers, and the general public.

4. COMPENSATION

4.1 Payment for Services. Provider shall be compensated by Payor for Covered Services at the lesser of the Provider's usual and customary billed charges or the rates set forth in Exhibit C, Fee Schedule (the "**Allowed Amount**"), less applicable Cost Sharing Amounts, and subject to any offsets for any payment(s) received by Provider from other sources resulting from coordination of benefits, subrogation, or other procedures.

(a) Provider agrees that payments shall be subject to reduction or denial based on Preventable Adverse Events.

(b) Provider agrees to permit rebundling to the primary procedure those services considered part of, incidental to, or inclusive of the primary procedure and to allow other adjustments for inappropriate billing or coding.

(c) In the event Health Plan receives less than ninety (90%) of claims electronically from Provider for a period of more than thirty (30) consecutive days, Health Plan may adjust provider's Allowed Amount, at Health Plan's discretion, in order for Health Plan to offset any processing expense resulting from receiving paper claims.

(d) Provider may not bill Health Plan or Covered Persons any additional charge for Covered Services being provided outside of normal business hours.

4.2 Payors other than Health Plan. Provider acknowledges that when Health Plan provides administrative and network access services to other Affiliates as listed in Exhibit E, (i) the Affiliate that issues the Benefit Plan is solely responsible for funding payment of claims for Covered Services pursuant to

the applicable Benefit Plan, and (ii) while Health Plan may remit payment for Claims on behalf of such Affiliate, Health Plan has no legal responsibility for the payment of such Claims for Covered Services.

4.3 Network Lease and Repricing. This Agreement is intended to serve only the Affiliates that are identified on Exhibit E. The Agreement and its terms, including rates, are confidential to the Parties and shall not be leased or accessed by any other Payor or Health Plan Participant unless such Payor and Health Plan Participant are included on Exhibit E. Payors, Health Plan Participants or Affiliates may be added to Exhibit E with the mutual written agreement by the Parties.

4.4 Health Plan shall enter into agreements with Affiliates, Payors and Health Plan Participants that bind them to pay the rates set forth in this Agreement. Those agreements shall prohibit Affiliates, Payors and Health Plan Participants from opting out of or otherwise attempting to avoid the obligation to pay the rates set forth in this Agreement. To the extent Health Plan fails to bind Affiliates, Payors and Health Plan Participants or Affiliates, Payors and Health Plan Participants fail or refuse to pay the rates set forth in this Agreement, Health Plan shall be liable to pay Provider the rates set forth in this Agreement for services provided.

4.5 **Prohibition on Balance Billing.** Provider agrees to accept the Allowed Amount, as stated in Attachment C, Fee Schedule, attached to the Agreement as payment in full, for Covered Services in all circumstances. In no event shall Provider bill a Covered Person or any other person or entity for payment of the difference between the Allowed Amount and Provider's usual and customary billed charges.

4.6 **Hold Harmless.** Provider shall not under any circumstances bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, engage in any collection activities against, or have any recourse against Covered Persons for amounts due under this Agreement by Health Plan. This prohibition applies to, but is not limited to, any delay in payment or any amounts not paid by an Affiliate, Payor or Health Plan Participant due to: (i) an Affiliate's, Payor's or Health Plan Participant's insolvency; (ii) Provider's breach of this Agreement; (iii) Provider's failure to comply with the requirements of the Utilization Management Policies and Procedures; (iv) failure to file a timely Claim or appeal; or (v) the application of coding and bundling rules. This provision shall not prohibit Provider's collection of applicable Cost Sharing Amounts nor prohibit Provider from billing Covered Persons for Non-Covered Services in compliance with the terms of this Agreement. This section supersedes any oral or written agreement to the contrary now existing or hereafter entered into between Provider and a Covered Person or persons acting on the Covered Person's behalf.

4.7 **Non-Covered Services.** Provider may bill Covered Persons for Non-Covered Services only if: (i) the Covered Person was advised in writing prior to the

service or supply being rendered that the specific service or supply may not be a Covered Service, and (ii) the Covered Person agreed in writing to pay for such service or supply after being so advised. Provider acknowledges that denial, partial denial, or adjustment of payment to Provider based on failure to comply with applicable Utilization Management Policies and Procedures, failure to timely submit a Claim, or the application of coding and bundling rules does not render the service or supply a Non-Covered Service and are not grounds for billing Covered Persons. Any Provider charges to Covered Persons for services or supplies permitted to be billed in accordance with this section shall not exceed the Allowed Amount that would have been payable under this Agreement if the services or supplies were Covered Services.

4.8 No Guarantee on Volume of Patients. Provider acknowledges that Health Plan does not warrant or guarantee that Provider will be utilized by any particular number of Covered Persons.

5. SUBMISSION OF CLAIMS

5.1 Claim Forms. Provider shall submit Claims to Health Plan in accordance with the procedures identified in the Provider Manual. The claim must be submitted on a standard CMS 1500, UB-04 or successor forms, and shall include all information necessary to verify and substantiate the provision of and charges for Covered Services. All Claims shall include appropriate coding based on the most current established clinical edit rules, including the proper use and combination of billing codes, and shall be consistent with the Provider Manual. Electronic claims submission will be preferred over hard copy formats.

5.2 Timeliness of Submission. Provider acknowledges that payment is contingent on providing Health Plan with all information necessary for Health Plan to determine its payment liability, including submission of a Clean Claim. Provider shall use best efforts to submit Clean Claims within ninety (90) days from the date of discharge or the date of the service, as applicable, but in no event more than one hundred twenty (120) days. Claims submitted more than one hundred twenty (120) days following the date of discharge or the date of the service, as applicable, shall be denied payment; provided, however, that when coordinating benefits if Health Plan is the secondary payor the one hundred twenty (120) day period will not begin until Provider receives notification of the primary payor's responsibility.

5.3 Payment of Claim. Health Plan will take reasonable business efforts to pay Clean Claims or facilitate payment of Clean Claims from an Affiliate, Payor or Health Plan Participant other than Health Plan, within the lesser of: (i) thirty (30) days for Clean Claims submitted electronically and forty-five (45) days for Clean Claims submitted by other means, or (ii) the period required by applicable Law. To the extent required by applicable Law, interest will be paid on Clean Claims that are not paid timely.

5.4 Cost Sharing Amounts. Provider shall collect Cost Sharing Amounts. Provider shall make reasonable efforts to verify Cost Sharing Amounts prior to billing any Covered Person. Provider may waive payment of Cost Sharing Amounts only in accordance with Provider's established financial hardship policy, which shall apply the same hardship standards to all persons. Provider shall provide Health Plan with its financial hardship policy upon request.

5.5 Coordination of Benefits. Provider agrees to cooperate in coordination of benefits with Health Plan. Provider will use its best effort to determine primary and secondary responsibility for payment of each Claim. When allowed under its policies and procedures and applicable Law, in all cases involving coordination of benefits Health Plan shall pay Provider the lesser of: (i) the amount due under this Agreement, or (ii) the amount due under this Agreement less the amount paid or payable by the other payor(s). In no event will Health Plan pay more than the Allowed Amount.

5.6 Overpayments/Underpayments.

Overpayments: Except for an overpayment caused by miscoding, claim submission error or suspected fraud/abuse, Health Plan may recover a refund due to an overpayment only if Health Plan notifies Provider in writing not later than twelve (12) months after the date of the explanation of benefits or completion of an audit; provided, however, that claims related to coordination of benefits or a government funded plan may be adjusted within thirty-six (36) months of the date of service or as permitted under applicable Law (see State Compliance Attachments attached to this Agreement). If Provider has not made arrangements to repay or otherwise appeal Health Plan's notice within forty-five (45) days of Health Plan's notice of overpayment or within thirty (30) days of notice of completion of an audit, Health Plan may offset the amount of the overpayment against future payments owing to Provider for any reason. If Provider disagrees with Health Plan's request for recovery of overpayment or refund, Provider may appeal the request in writing as provided for in Health Plan's notice of its intent to recover the overpayment.

Underpayments/erroneous payments: PROVIDER may submit a written request for reconsideration of a claims payment within ninety (90) days from receipt of applicable claims payment or notice of denial from PLAN. PROVIDER's failure to submit a request for reconsideration as specified herein shall result in the request being denied, and no further action may be taken by PROVIDER.

5.7 Preventable Adverse Events. Notwithstanding any provision in this Agreement to the contrary, Provider shall neither bill, nor seek to collect from, nor accept any payment from, Health Plan or Covered Persons for a Preventable Adverse Event. If Provider receives any payment from a Payor or Covered Person for a Preventable Adverse Event, Provider shall refund such payment to the person or entity making the payment within thirty (30) days of becoming aware of such receipt. Furthermore, Provider shall cooperate with

Health Plan, to the extent reasonable, in any Health Plan initiative designed to help analyze or reduce such Preventable Adverse Events.

5.8 **Non-Covered Persons.** If it is determined that an individual was not a Covered Person, Provider may directly bill the individual for health care services provided. If Health Plan determines that the individual was not eligible for coverage after payment by Health Plan has already occurred, Health Plan will request such amounts in writing from Provider and Provider will issue such refund within thirty (30) days as long as there is no dispute to the amount requested by Health Plan. Health Plan retains the right to offset amounts owed Provider under this Agreement if such refund is not received by Health Plan under the above timeframe..

5.9 **Audits.** Health Plan may conduct audits of Claims paid to Provider for a period of up to twelve (12) months from the original date of payment or such other period as may be permitted under applicable Law. If Health Plan suspects fraud or abuse Health Plan may audit claims at any time. In the event the audit identifies an improper use or combination of billing codes or a lack of supporting medical records, certain billed services or supplies may be denied. All services or supplies denied in accordance with this provision are subject to the hold harmless provisions set forth in this Agreement.

6. DATA AND RECORDS

6.1 **Data Exchange.** The Parties desire to work towards future data and system interoperability to bridge inpatient and outpatient care delivery through exchange of clinical data that supports coordination of care for Covered Persons. To that end, both Parties will mutually agree to all aspects of the data exchange, which may include use of national and state standards, following all security, HIPAA, and compliance requirements for data sharing and exchange, and agree to adapt to changes in the standards and compliance as they advance. The Parties agree that data exchange may include labs, pharmacy, radiology claims and electronic medical record data elements to the extent mutually agreed upon by the Parties, and to the extent that such information is reasonably available to the providing Party in the normal course of business. The specific data required to support inpatient and outpatient care delivery will be agreed upon by the Parties and may include technology pilots, new technology and data exchange with bio medical devices. The Parties agree to establish and adhere to a mutually agreed upon data exchange service level agreement that defines the data elements, technology, communication processes, standards, security, privacy, metrics and performance levels, how changes will be managed, resolution of dispute in the exchange of data and interoperability between systems for patient care, and a process between the Parties for allocating the costs of the foregoing data initiatives.

6.2 **Confidentiality of Medical Records and other Protected Health Information**. Health Plan and Provider agree that medical records of Covered Persons and any other records containing individually identifiable information

with respect to Covered Persons shall be treated as confidential. Provider and Health Plan shall comply with all applicable Laws regarding the privacy and security of such records including, but not limited to, HIPAA. Provider shall be responsible for obtaining consent to or authorization from Covered Persons for the disclosure of such information to the extent such consent or authorization is required by applicable Law.

6.3 Record Maintenance. Provider agrees to prepare and maintain accurate, complete, detailed and current medical, billing, financial, administrative, and other records and information related to the provision of Covered Services. Such records shall be maintained in accordance with accepted medical practice and in compliance with all Health Plan policies, applicable Laws, including patient privacy and security standards.

6.4 Retention Period. Provider shall retain all records related to the provision and billing of Covered Services for the longer of: (i) ten (10) years from the date of the last service provided to the Covered Person, or (ii) the period required under applicable Law. Provider agrees to provide Health Plan with all data necessary to comply with reporting requirements related to the Benefit Plans including but not limited to information related to applicable medical loss ratio requirements and risk adjustment programs.

6.5 Access to Records. Except as prohibited by Law, Provider shall, promptly , but in no event later than thirty (30) days from receipt of a request and without charge, permit access (both on-site and electronic), inspection, audits and copying by Health Plan, accrediting agencies, and any Governmental Authority with jurisdiction over a Benefit Plan, to clinical and billing data, information, and medical records obtained, created or maintained by Provider related to Covered Persons for any period during which they are a Covered Person. Provider shall share a Covered Person's medical records and clinical information and shall forward same in a timely manner to other health care providers treating the Covered Person at no cost to Health Plan, other treating providers or the Covered Person.

6.6 Confidentiality of Proprietary Information. As a result of this Agreement, Provider may obtain access to certain non-public trade secrets or other confidential and proprietary information of Health Plan or Affiliates of Health Plan (herein, "**Proprietary Information**"). Provider shall hold such Proprietary Information including the terms and conditions of this Agreement, in confidence and shall not use or disclose such Proprietary Information, either by publication or otherwise, to any person without the prior written consent of Health Plan, except as may be required by Law or as may be required for Provider to fulfill its rights and obligations set forth in this Agreement. Nothing in this provision shall be construed to prohibit communications necessary or appropriate for the delivery of Covered Services, communications regarding coverage and coverage appeal rights, or any other communications expressly protected under applicable.

6.7 **Use of Name, Trademarks and Service Marks.** During the term of this Agreement, Health Plan may use Provider's name and other identifying and descriptive information in provider directories and other Health Plan marketing materials in all formats, including, but not limited to, electronic media. Provider may identify itself as a Participating Provider but shall not otherwise use or refer to Health Plan's name, symbol, or service mark without Health Plan's express prior written consent. Except as otherwise provided in this Agreement, each Party reserves the exclusive right to the control and the use of its name and all symbols, trademarks, or service marks presently existing or later established.

7. RELATIONSHIP OF THE PARTIES

7.1 **Independent Contractors.** For purposes of this Agreement, Health Plan and Provider are and will act at all times as independent contractors. Nothing in this Agreement shall be construed, or be deemed to create, a relationship of employer or employee or principal and agent, or any relationship other than that of independent entities contracting with each other for the purposes of effectuating this Agreement. In no way shall Health Plan be construed to be a provider of health care services or responsible for the provision of health care services. Provider shall be solely responsible to the Covered Person for treatment and medical care with respect to the provision of Covered Services.

7.2 **Medical Independence.** Provider and Health Plan agree that Provider shall maintain a health care/patient relationship with each Covered Person whom the Provider treats. Provider shall comply with the terms and conditions of this Agreement and be solely responsible for the provision and quality of health care services provided to Covered Persons. Provider and Health Plan agree that nothing in this Agreement shall limit or otherwise restrict the Provider's medical judgment and ultimate responsibility for patient care in the provision of Covered Services. Nothing herein is intended to create any right for Health Plan to intervene in the medical decision-making regarding the Covered Person.

8. TERM AND TERMINATION

8.1 **Term.** The term of this Agreement shall be for one (1) year commencing on the Effective Date and shall continue for one (1) year renewal terms, each a "Renewal Term" thereafter unless terminated pursuant to the terms of this Agreement.

8.2 **Termination Without Cause.** Either Party may terminate this Agreement by giving at least ninety (90) days' prior written notice of termination to the other Party.

8.3 **Termination for Cause.** Either Party may terminate this Agreement for cause in the following circumstances: (i) upon written notice to the other Party if either Party becomes insolvent; or (ii) upon written notice in the event of a

material breach of this Agreement by the other Party not remedied within thirty (30) days after notice thereof from the terminating Party.

8.4 Immediate Termination. Health Plan may terminate this Agreement immediately and with notice (or upon such notice required by applicable Law, if any), or terminate participation of an Affiliated Provider, if any of any of the following with regard Provider or an Affiliated Provider: (i) Health Plan credentialing is revoked or suspended; (ii) general or professional liability insurance is canceled, substantially modified, or non-renewed; (iii) Health Plan determines that there has been a material misrepresentation or false statement; (iv) a finding of unlawful activity relating to professional practice, or financial misconduct including, but not limited to, offering or soliciting remuneration for referrals or billing for services that were not provided as claimed; (v) the subject of a suspension, termination, withdrawal, expiration, revocation or non-renewal of any License; (vi) the subject of an indictment, arrest or conviction of a felony, or subject to any indictment, arrest or conviction of a criminal charge related to or in any way impairing it's License; or (vii) excluded from either Medicare or Medicaid; (viii) continued participation in the Health Plan is determined by Health Plan to threaten the health, safety or welfare of any Covered Person. Such an automatic termination shall be effective as of the date of such occurrence.

8.5 Termination of Affiliated Provider. Health Plan may terminate an Affiliated Provider's participation under this Agreement upon thirty (30) days' prior written notice to Provider.

8.6 Obligations upon Termination. Upon termination of this Agreement, unless termination was due to quality of care issues or as otherwise directed by Health Plan, Provider shall continue to provide Covered Services pursuant to this Agreement to Covered Persons who are receiving care from Provider at the time of such termination until the latest of the following: (i) the conclusion of such treatment; or (ii) the period of time required by applicable Law. During such period the terms and conditions of this Agreement, including but not limited to, Article 4 shall continue to apply to Covered Services rendered by Provider.

9. INDEMNIFICATION AND LIMITATION OF LIABILITY

9.1 Indemnification by Provider. Provider agrees to indemnify, defend, and hold harmless Health Plan and their respective officers, employees, and agents from and against any and all liability, loss, claim, damage or expense, including defense costs and legal fees, incurred in connection with claims for damages of any nature whatsoever, including but not limited to, bodily injury, death, personal injury, or property damage arising from Provider's or an Affiliated Provider's delivery of health care services or Provider's or an Affiliated Provider's performance or failure to perform Provider's obligations under this Agreement.

9.2 Indemnification by Health Plan. Health Plan agrees to indemnify, defend, and hold harmless Provider and, if Provider is an entity, its officers, employees, and agents from and against any and all liability, loss, claim, damage or expense, including defense costs and legal fees, incurred in connection with claims for damages of any nature whatsoever, arising from Health Plan's performance or failure to perform its obligations under this Agreement.

9.3 Limitation. In no event shall either of the Parties hereto be liable for any amounts representing loss of revenues, loss of profits, loss of business, the multiple portion of any multiplied damage award, or incidental, indirect, consequential, special, or punitive damages, whether arising in contract, tort (including negligence), or otherwise, regardless of whether or not foreseeable. Further, in no event shall Health Plan be liable to Provider for any extra contractual damages relating to any claim or cause of action assigned to Provider by any person or entity.

9.4 Notification of Action. Each Party will promptly, but in no event later than ten (10) days, notify the other Party in writing of any complaint to or from any State insurance department, any other State or Federal regulatory agency, or of any litigation (or threat of litigation) of which that Party becomes aware that relates to any matter covered by this Agreement. Each Party will promptly, but in no event later than ten (10) days, forward to the other Party all summonses, complaints, and notices of claims received by that Party.

9.5 Responsibility for Acts and Medical Decisions of Provider. Nothing in this Agreement shall be construed as making Health Plan legally liable to any Covered Person or other third Party for the acts or omissions of Provider, including without limitation, the acts or omissions of Provider relating to the medical care provided or the professional medical judgment of Provider. Provider shall not be deemed to be an employee, agent (ostensible or otherwise), or representative of Health Plan for any purpose. Provider acknowledges and agrees that Health Plan shall not be liable under any circumstances for any act or omission of Provider relating to the medical care provided by, or the professional medical judgment of, Provider.

9.6 Period of Limitations. Unless otherwise provided for in this Agreement, neither Party shall commence any action at law or equity, against the other to recover on any legal or equitable claim arising out of this Agreement more than two (2) years after the events which gave rise to such claim, unless compliance with this Section would compel a Party to violate the terms of the Health Benefit Plan. The deadline for initiating an action shall not be tolled by the appeal process or any other administrative process.

10. DISPUTE RESOLUTION

10.1 Dispute Resolution Process. For all disputes between the Parties arising with respect to the performance or interpretation of this Agreement, or the relationship created pursuant to this Agreement, the Parties shall attempt to

resolve the dispute through good faith negotiations. If any such dispute is not resolved to the Parties' mutual satisfaction within thirty (30) days, then the Parties agree that such dispute shall be submitted to non-binding mediation by a mediator mutually acceptable to the Parties. In the event the dispute is not resolved through mediation, at the conclusion of the mediation either Party may initiate arbitration proceedings pursuant to Section 10.2 (Arbitration) by providing written notice to the other Party. Notwithstanding the foregoing and subject to a Health Plan's grievance and appeal procedures, disputes involving overpayments, underpayments, non-payment, and/or erroneous payments (whether in whole or in part) must be submitted for arbitration within six (6) months of the date of the original payment, or, in the case of non-payment, within six (6) months of the date the payment would have been due under the terms of this Agreement. Failure to submit the matter to arbitration within the applicable time frame waives the aggrieved Party's right to pursue arbitration or any other legal or equitable resolution of the aggrieved Party's claim.

10.2 Arbitration. The Parties agree that any disputes not settled pursuant to the process set forth in Section 10.1 (Dispute Resolution Procedure) shall be submitted to final and binding arbitration under the American Health Lawyers Association Alternative Dispute Resolution Services Rules of Procedure for Arbitration (the "AHLA Rules") and determined and settled by a panel of three (3) arbitrators selected in accordance with the AHLA Rules. Denver, County, Colorado, or other location identified is a state compliance attachment, if any, shall be the sole, proper venue of any arbitration. The arbitrators may construe or interpret, but shall not vary or ignore, the terms of this Agreement. The costs of the arbitration shall be borne equally by both Parties, provided that each Party shall bear the fees and costs of attorneys or other persons representing the interests of such Party. The Parties expressly intend (i) that any dispute arising under this Agreement will be resolved as between them alone, so that no other dispute with any third party(ies) may be consolidated or joined with the arbitration proceeding, and (ii) this Agreement prohibits the arbitrator from consolidating the claims of others into one proceeding, to the maximum extent permitted by law. For the avoidance of doubt, this means that an arbitrator does not have the authority to fashion a proceeding as a class or collective action or to award relief to a group of persons in one proceeding, to the maximum extent permitted by law. The arbitrators may not award extra-contractual damages, including exemplary or punitive damages, and may not require one Party to pay another Party's costs, fees, attorneys' fees, or expenses. The award of the arbitrators will be binding on each Party and not appealable.

10.3 Legal Fees and Costs. In the event of a dispute between the Parties, each Party is solely responsible for its own costs and expenses, including court costs and attorneys' fees, and all other expenses associated with resolving the dispute.

11. MISCELLANEOUS

11.1 Amendment. This Agreement may not be modified or amended except by a written instrument executed by duly authorized representatives of both Parties; provided, however, that this Agreement shall be deemed to be automatically amended as required to conform with any applicable Law promulgated at any time. Health Plan may unilaterally amend this Agreement if it reasonably determines that a written amendment is required to comply with Law. Health Plan agrees to provide Provider with written notice of any such amendment in advance or as soon as reasonably practicable thereafter. Notwithstanding the foregoing, Health Plan may amend this Agreement, other than compensation schedules, at any time upon thirty (30) days prior written notice to Provider. If Provider provides written notice within the thirty (30) day notice period that it objects to such amendment, then Provider shall have the right to terminate this Agreement upon sixty (60) days written notice to Health Plan. During the sixty (60) day termination notice period, the amendment shall not take effect. If Health Plan withdraws the amendment upon Provider's objection or during the termination notice period, the amendment and the termination shall not take effect, and the Agreement shall remain in place without the amendment.

11.2 Assignment. This Agreement shall be binding upon and inure to the benefit of the respective legal successors and assignees of the Parties; provided, however, that neither this Agreement nor any rights or obligations hereunder may be assigned, either by operation of law or otherwise, or transferred in whole or in part, without the prior written consent of the other Party, except that Health Plan retains the right to assign, either by operation of law or otherwise, or transfer in whole in or in part, this Agreement to an Affiliate of Health Plan, or to delegate any rights or obligations under this Agreement to a designee.

11.3 Authority to Execute Agreement. Each Party represents and warrants that it has full power and authority to enter into this Agreement and the person signing this Agreement on behalf of either Party has been duly authorized and empowered to enter into this Agreement.

11.4 Change in Control. Provider shall notify Health Plan at least thirty (30) days prior to undergoing a change in Control or selling all or substantially all of its assets.

11.5 Cooperation. Each Party shall cooperate with the other Party in the performance of its respective activities contemplated by this Agreement in order that the obligations and responsibilities under this Agreement may be accomplished in a proper, timely and efficient manner.

11.6 Counterparts. This Agreement may be executed in multiple counterparts, each of which shall be deemed to be an original and all of which taken together shall constitute a single instrument. The Parties agree and stipulate that the original of this document, including the signature page, may be scanned and stored in a computer database or similar device, and that any printout that

accurately reproduces the original may be used for any purpose just as if it were the original, including proof of the content of the original writing.

11.7 Direct Communications with Regulators. Provider shall not communicate with a Governmental Authority regarding any issue related to this Agreement, including but not limited to payment of claims, unless Provider has exhausted the applicable dispute resolution or claim appeal process set forth in this Agreement or the Provider Manual, provided, however that the Provider is not prohibited from reporting fraud, waste or abuse or to respond to an audit or other inquiry by a Governmental Authority. For the avoidance of doubt, Provider is not prohibited by this Agreement from communicating with representatives of a Governmental Authority about matters unrelated to this Agreement or the Benefit Plans.

11.8 Entire Agreement. This Agreement, including any exhibit, state compliance attachment or other attachment, addendum or amendment, constitutes the entire understanding between the Parties and supersedes all prior oral or written agreements between them with respect to the matter provided for herein.

11.9 Force Majeure. Either Party shall be excused from any inability to meet its obligations under this Agreement due to extraordinary circumstances beyond its reasonable control occasioned by war, acts of government, labor disputes, acts of terrorism, fire, flood, earthquake, extreme weather or other acts of nature provided that the effected party gives prompt written notice to the other party within two (2) business days of discovery, or as soon as practicable, of any of the foregoing events or conditions, including a description of the date of the occurrence and the anticipated duration. Any Party giving such notice must use its best efforts to minimize potential adverse effects to the other party, and the other Party shall be entitled to take any necessary measures or actions, including temporarily subcontracting the obligations of the noticing Party until fulfillment of the obligations of the Agreement can be resumed for the balance of the Term.

11.10 Governing Law. This Agreement shall be governed by and construed in accordance with the laws of state in which Provider is located, without regard to conflict of law provisions, unless such State laws are otherwise preempted by Federal law. However, coverage issued specific to a Benefit Plan are governed by the State laws where the Benefit Plan is issued, unless such State laws are otherwise preempted by Federal law.

11.11 No Third-Party Beneficiaries. This Agreement is not a third-party beneficiary contract and shall not in any respect whatsoever increase the right of Covered Persons or any other third party with respect to Provider or Health Plan or create any rights or remedies on behalf of a Covered Person against Provider or Health Plan.

11.12 Non-Exclusivity. None of the provisions of this Agreement shall prevent Provider or Health Plan from participating in or contracting with any provider, preferred provider organization, network, health maintenance organization, insurance company or any other health care delivery or insurance program.

11.13 Notices. Any notice required to be given pursuant to this Agreement shall be in writing and shall be delivered by nationally recognized overnight courier or by hand unless otherwise specified in this Agreement or specifically agreed to by the Parties in writing. Notice shall be sent to the address set forth on the signature page or such other address as the Parties may indicate by using the notice procedure to inform the other Party. Notice shall be effective upon the date of delivery.

11.14 Offshoring. Provider shall not contract with an offshore entity related to services under this Agreement without the prior written consent of Health Plan. Upon the request of Health Plan, Provider shall provide a written attestation of compliance for each such offshore entity in a format acceptable to Health Plan.

11.15 Rules of Construction. The headings used in this Agreement are provided for ease of reference only and are not intended to substantively alter the meaning of the provisions hereof. The use of masculine pronouns is intended to have both masculine and feminine meanings. If there is any inconsistency between any provision in this Agreement and any exhibit, attachment, addendum or amendment thereto, the terms of the exhibit, attachment, addendum or amendment shall take precedence unless specifically stated otherwise.

11.16 Severability. In case any one or more of the provisions of this Agreement shall be invalid, illegal, or unenforceable in any respect, the remaining provisions shall be construed liberally in order to effectuate the purposes hereof, and the validity, legality and enforceability of the remaining provisions shall not in any way be affected or impaired thereby. If one or more provisions of this Agreement are invalid, illegal or unenforceable and an amendment to this Agreement is necessary to maintain its integrity, Parties shall make commercially reasonable efforts to negotiate an amendment to this Agreement, exhibit, attachment or addendum which could reasonably be construed not to contravene such statute, regulation or interpretation.

11.17 Survival. All provisions of this Agreement that contemplate performance or observance subsequent to any termination or expiration of this Agreement or are required to survive to give the Parties the benefit accorded through this Agreement shall survive any termination or expiration of this Agreement and continue in full force and effect. For the avoidance of doubt, Articles 4, 5, 6, 9, and 10 survive termination or expiration if this Agreement.

11.18 Waiver. Neither the waiver of either Party of a breach or any of the provisions of this Agreement, nor the failure of either Party, on one or more occasion, to enforce any of the provisions of this Agreement, shall thereafter be construed

as a waiver of any subsequent breach of any of the provisions of this Agreement.

11.19 Compliance. The parties shall comply with the applicable State Compliance Attachments attached hereto and incorporated into this Agreement.

11.20 Agreement Governs. In the event of a conflict or inconsistency between this Agreement and any exhibit, attachments, plan program, policy, manual or any other document affecting this Agreement, the provisions of this Agreement shall control.

SIGNATURES ON FOLLOWING PAGE

IN WITNESS WHEREOF, the Parties have executed this Agreement as of the dates listed below.

Health Plan		**Provider**	
By:		By:	Nancy Gill Digitally signed by Nancy Gill Date: 2020.10.05 13:00:06 -05'00'
Printed:	David Pinkert	Printed:	Nancy Gill
Title	President	Title	VP, Managed Care
Date:	01.11.2021	Date:	10/5/2020
		Tax ID:	See Attached Exhibit B

Health Plan address for any notices:

Friday Health Plans
700 Main St, #100
Alamosa, CO 81101
Attn: Network Development/Provider Relations

Provider address for any notices:

5851 Legacy Cir. Ste 900
Plano, TX 75024
Attn: VP Managed Care

Exhibit A – Affiliated Provider Data Sheet

Exhibit B – List of Provider Locations

Exhibit C – Fee Schedule

Exhibit D – Participation Election Attachment—Required for Texas

Exhibit E - Affiliated Plans

State Compliance Attachment for Colorado

State Compliance Attachment for New Mexico

State Compliance Attachment for Texas

Exhibit A – AFFILIATED PROVIDER DATA SHEET

The following list shall set forth those Affiliated Providers who shall provide Covered Services under this Agreement. Provider shall provide Health Plan written notification thirty (30) days prior to any changes in this Exhibit. Nonetheless in absence of said written notification, in the event an Affiliated Provider bills under Provider's tax identification number, said Affiliated Provider is bound by the terms of this Agreement.

See Attached Roster

Please provide information for each provider

- CAQH Number
- Name
- Address
- E-mail address
- Telephone and facsimile numbers
- Professional license numbers
- Medicare/Medicaid ID numbers/TIN
- Federal tax ID numbers
- Completed W-9 form
- National Provider Identifier (NPI) numbers
- Provider Taxonomy Codes
- Area of medical specialty
- Age restrictions (if any)
- Area hospitals with admitting privileges (where applicable)
- Whether Providers are employed or subcontracted with Contracted Provider using the designation "E" for employed or "C" for subcontracted.
- For a subcontracted Provider, whether its Provider(s) is/are employed or contracted with the subcontracted Provider using the designation "E" for employed or "C" for contracted.
- Office contact person
- Office hours
- Billing office
- Billing office address
- Billing office telephone and facsimile numbers
- Billing office email address
- Billing office contact person

Exhibit B- LIST OF PROVIDER LOCATIONS

The following list sets forth Provider's entities governed under this Agreement. Provider shall provide Health Plan written notification thirty (30) days prior to any changes in this Exhibit. However, in absence of said written notification, in the event Covered Services are billed under Provider's tax identification number, said services shall be paid by the terms of this Agreement.

See Attached Roster

Exhibit C- FEE SCHEDULE

Reimbursement - Unless otherwise specified in the Agreement, Health Plan shall reimburse Provider as per the fees as set forth below, for Covered Services rendered to Commercial Covered Persons:

Colorado/Texas/New Mexico—Commercial Reimbursement

Procedure	Rev Code	CPT Code	Colorado	Texas	New Mexico
Hemodialysis	821	90999	$1,100	$1,100	$1,550
Hemo/Training	821	90993	$1,100	$1,100	$1,550
Home Hemodialysis	821	90999	$1,100	$1,100	$1,550
Home Hemo Training	821	90999	$1,100	$1,100	$1,550
Incenter AKI	821	G0491/90999	$1,100	$1,100	$1,550
Ultrafiltration	881	90999	$1,100	$1,100	$1,550
CAPD/AKI	841	G0491/90945	$471	$471	$670
CAPD/Training	841cce	90993	$1,100	$1,100	$1,550
CCPD/AKI	851	G049190945	$471	$471	$670
CCPD/Training	851	90993	$1,100	$1,100	$1,550
Parsabiv	636	J0606 (0.1 mg)	$3.47	$3.47	$3.47
Sensipar	636	J0604 (1 mg)	$0.95	$0.95	$0.95

In accordance with CMS guidance for bundled outpatient dialysis services, the above rates are based on a global all-inclusive rate per treatment for the service specified unless otherwise stated herein, shall include all related ESRD lab, ESRD pharmaceuticals and other ESRD services provided during the treatment. For non-ESRD Related services that may be provided and not included in the global all-inclusive per treatment rate, such services shall be reimbursed by Health Plan at fifty percent (50%) of Provider's standard billed charges.

In the event a new procedure or drug (a "New Technology) which requires that Provider incur material additional expense, then the parties agree to conduct good faith negotiations, with regard to additional reimbursement rate for reimbursement for such new Technology. Provider shall provide written notice to Health Plan of the existence of such New Technology, and the parties shall attempt to negotiate a separate appropriate reimbursement within thirty (30) days following such notice, New Technology shall be reimbursed at fifty (50%) percent of Provider's standard billed charges effective thirty (30) days following such notice from Provider and such rate will remain in effect until the contract is amended and a new rate is established for New Technology.

The rates established in this Agreement may not be discounted, reduced, limited, modified, rendered inapplicable, voided, or avoided in any way, unless agreed to in writing by all parties to this Agreement. The Parties agree that nothing in any plan document, policy document, certificate of insurance, or any benefit plan or program provision shall have the effect of reducing the reimbursement specified in this Agreement and further agree that this Agreement shall control reimbursement to Provider.

Provider shall accept such reimbursement as payment in full for those Covered Services provided to Covered Persons. Reimbursement shall not exceed billed charges.

LIMIT ON CHARGE MASTER INCREASE

For the purposes of this Agreement, Provider is limited to an annual aggregate increase to its charge master not to exceed three percent (3.0%). In the event Provider's annual aggregate charge master increase exceeds three percent (3.0%), the reimbursement percentage for Covered Services reimbursed on the basis of a percent of billed charges shall be reduced accordingly to ensure Health Plan's costs do not exceed three percent (3.0%). The reimbursement percentage for billed charges shall be reduced accordingly as per the following formula:

Current percentage rate (% of charges) x (1+CDM increase % limiter) / 1 + overall % charge increase) =New Percentage Rate

Provider shall provide Health Plan written notice of any increase in Provider's charge master within sixty (60) days prior to the effective date of such increase. Health Plan may also request from Provider and Provider shall furnish to Health Plan in an electronic format acceptable to Health Plan, Provider's prior year charge master with effective date(s) and current year charge master with effective dates(s). Charge master files will contain industry standard coding and rates. Health Plan agrees this information is confidential and will be used only for the purpose of validating Provider's charge master increase.

Remainder of Page Intentionally Left Blank

Exhibit D

PARTICIPATION ELECTION ATTACHMENT

In accordance with applicable state laws, by entering into this Agreement, Provider acknowledges that Provider consents to participate all Benefit Plans offered by Health Plan in the State in which Provider renders Covered Services.

Notwithstanding the foregoing, if Provider renders Covered Services in the State of Texas, pursuant to applicable requirements in Texas Insurance Code Chapter 1458, Provider or Facility ("Provider") agrees to participate in the Health Plan Benefit Plan(s) selected below, whether Benefit Plan is funded by Payor and administered by Health Plan or is a Benefit Plan offered directly by Health Plan:

BENEFIT PLANS	Check Benefit Plans in which Participating Provider elects to participate	Participating Provider signature required on each line to indicate Benefit Plan is included in this Agreement and Participating Provider has received a Fee Schedule (or reference to same) applicable to participation in the line of business
Commercial PPO - Preferred Provider benefit plans covering individuals and groups	X	Nancy Gill Digitally signed by Nancy Gill Date: 2020.10.05 12:58:38 -05'00'
Commercial EPO - Exclusive Provider benefit plans covering individuals and groups	X	Nancy Gill Digitally signed by Nancy Gill Date: 2020.10.05 12:59:15 -05'00'
Medicare Advantage or similar plans	N/A	

Exhibit E – Plan Affiliation List

- Friday Health Plans of Colorado
- Friday Health Plans of New Mexico
- Friday Health Plans of Texas

STATE COMPLIANCE ATTACHMENT FOR COLORADO

Health Plan and Provider or Facility (each referred to herein as "**Provider**") agree that the provisions in this State Compliance Attachment for Colorado (this "**Attachment**") are incorporated into the Participating Provider Agreement or the Participating Facility Agreement, as applicable (the "**Agreement**") solely for the purpose of ensuring compliance with Colorado laws, rules and regulations, and not as an expansion or restriction of rights and obligations under the Agreement when Colorado laws, rules and regulations do not apply. Unless otherwise specifically stated herein, the provisions of this Attachment are applicable only to Benefit Plans that are subject to state insurance statutes and regulations as either a health insurance policy or HMO contract, whether issued or administered by Health Plan, affiliates of Health Plan (references to Health Plan herein also include affiliates of Health Plan), or another Payor that is licensed as an insurer or HMO in Colorado (hereinafter referred to in this Attachment, subject to the insurer or HMO license requirement limitation, as "**Payor**"). The provisions of this Attachment do not apply to a self-funded Benefit Plan for which Health Plan provides administrative services or in any circumstance not required by law, including but not limited to Medicare Advantage plans issued or administered by Health Plan. In the event of any conflict between the terms of this Attachment and the terms of the Agreement, the terms of this Attachment shall control but only to the extent required by Law. Capitalized terms used in this Attachment shall have the meanings as defined in the Agreement, except as otherwise specifically provided in this Attachment, and are intended to be used in a manner consistent with any definition set forth in applicable state Law. In the event any terms of this Attachment are in conflict with the Colorado statutes or regulations as amended or revised, such terms are amended to conform to such statutes and regulations, and, in such an event, Health Plan shall provide notice of the change by any reasonable means..

1. Hold Harmless

   Provider shall not under any circumstances bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, engage in any collection activities against, or have any recourse against Covered Persons for amounts due under this Agreement by Health Plan. This prohibition applies to, but is not limited to, any delay in payment or any amounts not paid by a Payor due to: (a) Payor's insolvency; (b) Provider's breach of this Agreement; (c) Provider's failure to comply with the requirements of the Utilization Management Policies and Procedures; (d) failure to file a timely Claim or appeal; or (e) the application of coding and bundling rules. This provision shall not prohibit Provider's collection of applicable Cost Sharing Amounts nor prohibit Provider from billing Covered Persons for Non-Covered Services in compliance with the terms of this Agreement. This paragraph supersedes any oral or written agreement to the contrary now existing or hereafter entered into between Provider and a Covered Person or persons acting on the Covered Person's behalf.

2. Health Plan Policies & Programs.

   Health Plan shall maintain a Quality Management Program (which includes credentialing, quality assessment and quality improvement programs), Utilization Management Policies and Procedures (which include utilization review, prior authorization and referral processes), grievance procedures for Participating Providers and for Covered Persons, and other programs, policies or procedures for the purpose of administering the Benefit Plans including, but not limited to, payments systems, verification of eligibility, data reporting, confidentiality requirements and compliance standards for federal and state programs (collectively the "**Health Plan Policies**"). Information related to the Health Plan Policies shall be included in the Provider Manual or otherwise made available to Provider. Provider shall abide by and comply with the Health Plan Policies**.** Provider acknowledges and agrees that payment for Covered Services may be reduced for failure to comply with the Utilization Management Policies and Procedures and Provider shall not bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against, a Covered Person, or person acting on behalf of the Covered Person, for any such reduction in payment.

3. Assignment.
Provider may not assign or delegate this Agreement nor any rights or responsibilities hereunder without the prior written consent of Health Plan. Any subcontracts entered into by Provider related to services provided under the Agreement shall be in writing and shall require the subcontractor to comply with the Agreement and the applicable provisions of Colo. Rev. Stat. Ann. § 10-16-701 et seq.

4. Nondiscrimination**.**
Provider shall not discriminate against Covered Persons based upon race, religion, ethnicity, color, sex, gender, marital status, sexual orientation, age, health status, disability, or source of payment, including participation in a publicly financed program.

5. Dispute Resolution.
For all disputes between the Parties arising with respect to the performance or interpretation of the Agreement, or the relationship created pursuant to this Agreement, the Parties shall attempt to resolve the dispute through good faith negotiations. If any such dispute is not resolved to the Parties' mutual satisfaction within thirty (30) days, then the Parties agree that such dispute shall be submitted to non-binding mediation by a mediator mutually acceptable to the Parties. In the event the dispute is not resolved through mediation, at the conclusion of the mediation either Party may initiate arbitration proceedings pursuant to Section 10.2 of the Agreement by providing written notice to the other Party. Notwithstanding the foregoing and subject to the applicable grievance and appeal procedures, disputes involving overpayments, underpayments, non-payment, and/or erroneous payments (whether in whole or in part) must be submitted for arbitration within six (6) months of the date of the original payment, or, in the case of non-payment, within six (6) months of the date the payment would have been due under the terms of this Agreement. Failure to submit the matter to arbitration within the applicable time frame waives the aggrieved Party's right to pursue arbitration or any other legal or equitable resolution of the aggrieved Party's claim.

6. Prompt Payment of Clean Claims.
Health Plan will take reasonable business efforts to notify the Provider that a submitted claim is not a Clean Claim or to pay Clean Claims within thirty (30) days for claims submitted electronically, and forty-five (45) days for claims submitted by other means. For Clean Claims that are not paid timely, Health Plan shall pay interest as required by Colo. Rev. Stat. Ann. § 10-16-106.5 (4) & (5), and any regulations promulgated thereunder.

7. Overpayments.
Except for an overpayment caused by miscoding, claim submission error or suspected fraud/abuse, Health Plan may recover a refund due to an overpayment only if Health Plan notifies Provider in writing not later than twelve (12) months after the date of the explanation of benefits or completion of an audit; provided, however, that claims related to coordination of benefits or a government funded plan may be adjusted within thirty-six (36) months of the date of service. If Provider has not made arrangements to repay or otherwise appeal Health Plan's notice within forty-five (45) days of Health Plan's notice of overpayment or within thirty (30) days of notice of completion of an audit, Health Plan may offset the amount of the overpayment against future payments owing to Provider for any reason. If Provider disagrees with Health Plan's request for recovery of overpayment or refund, Provider may appeal the request in writing as provided for in Health Plan's notice of its intent to recover the overpayment.

8. Notice of Termination.

Either Party may terminate this Agreement without cause by giving at least ninety (90) days' prior written notice of termination to the other Party. Health Plan shall make a good faith effort to provide written notice of termination within fifteen (15) working days after receipt of or issuance of a notice of termination to all Covered Persons that are patients seen on a regular basis by Provider, regardless of whether the termination was for cause or without cause. Where a contract termination involves a primary care provider ("**PCP**"), all Covered Persons that are patients of that PCP shall also be notified. Within five (5) working days after the date that Provider either gives or receives notice of termination, Provider shall supply Health Plan with a list of those patients of Provider that are Covered Persons. Health Plan shall supply Provider with a list of Provider's patients that are Covered Persons.

9. Obligations upon Termination**.**

Upon termination of the Agreement, unless the termination was due to medical competence or professional behavior, Provider shall continue, for a transitional period determined by Health Plan and communicated to Provider, to provide Covered Services to a Covered Person who is undergoing an ongoing course of treatment. The transitional period shall be a period of time that is sufficient to permit coordinated transition planning consistent with the Covered Person's condition and needs relating to continuity of care. Unless otherwise agreed to by Health Plan, the transition period shall last until the earlier of ninety (90) days, the date the course of treatment is completed or the date that care is successfully transitioned to a Participating Provider; provided, however that for a Covered Person in the second or third trimester of pregnancy, the transition period shall continue through post-partum care period. During any such transition period the terms and conditions of this Agreement, including but not limited to Article 4, shall continue to apply to Covered Services rendered by Provider.

10. No Adverse Action or Financial Disincentive.

Health Plan shall not take an adverse action against Provider or provide financial incentives or subject the provider to financial disincentives for any of the following reasons.

(a) The number of referrals made to a Participating Provider for Covered Services so long as Provider adheres to the Health Plan's Utilization Review Policies and Procedures;
(b) Based solely on a patient satisfaction survey or other method of obtaining patient feedback relating to the patient's satisfaction with pain treatment;
(c) Provider, in good faith, reports to state or federal authorities any act or practice by Health Plan that jeopardizes patient health or welfare;
(d) Provider discusses the financial incentives or financial arrangements between Provider and Health Plan;
(e) In the case of a primary care provider, for making a standing referral of a Covered Person to a specialist;
(f) Provider expresses disagreement with a Health Plan's decision to deny or limit benefits to a Covered Person;
(g) Provider assists the Covered Person to seek reconsideration of Health Plan's decision;
(h) Provider communicates with a public official or other person concerning public policy issues related to health care items or services;
(i) Provider files a complaint, makes a report, or comments to an appropriate governmental body regarding actions, policies, or practices of Health Plan that Provider believes might negatively affect the quality of, or access to, patient care;
(j) Provider provides testimony, evidence, opinion, or any other public activity in any forum concerning a violation or possible violation of applicable Law;
(k) Provider reports what the provider believes to be a violation of Law to an appropriate Governmental Authority; or

(l) Provider participates in any investigation into a violation or possible violation of any applicable Law.

12. Right to Disagree.

The Parties agree that neither Party shall be prohibited from protesting or expressing disagreement with a medical decision, medical policy, or medical practice of Health Plan or Provider. Health Plan shall not terminate the Agreement because Provider expresses disagreement with a decision by Health Plan, or an entity representing or working for Health Plan, to deny or limit benefits to a Covered Person or because Provider discusses with a current or prospective Covered Person any aspect of the Covered Person's medical condition, any proposed treatments or treatment alternatives, whether covered by the Benefit Plan or not, policy provisions or any health plan, or Provider's personal recommendation regarding selection of a health plan based upon Provider's personal knowledge of the health needs of such persons.

13. Cost Sharing Amounts**.**

Provider shall collect Cost Sharing Amounts. Provider shall make reasonable efforts to verify Cost Sharing Amounts prior to billing any Covered Person. Provider may waive payment of Cost Sharing Amounts only in accordance with Provider's established financial hardship policy, which shall apply the same hardship standards to all persons. Provider shall provide Health Plan with its financial hardship policy upon request.

14. Non-Covered Services**.**

Provider may bill Covered Persons for Non-Covered Services only if: (a) the Covered Person was advised in writing prior to the service or supply being rendered that the specific service or supply may not be a Covered Service, and (b) the Covered Person agreed in writing to pay for such service or supply after being so advised. Provider acknowledges that denial, partial denial, or adjustment of payment to Provider based on failure to comply with applicable Utilization Management Policies and Procedures, failure to timely submit a Claim, or the application of coding and bundling rules does not render the service or supply a Non-Covered Service and are not grounds for billing Covered Persons. Any Provider charges to Covered Persons for services or supplies permitted to be billed in accordance with this paragraph shall not exceed the Allowed Amount that would have been payable under this Agreement if the services or supplies were Covered Services.

15. Preauthorization.

Health Plan and Provider agree that the sole responsibility for obtaining any necessary required preauthorization for particular services, treatments, or procedures rests with Provider, not with the Covered Person. A Covered Person may receive a standing referral for Medically Necessary treatment to a specialist or specialized treatment center participating in Health Plan's network or participating in a subdivision or subgrouping of Health Plan's network if the subdivision or subgrouping demonstrates network adequacy pursuant to Colo. Rev. Stat. § 10-16-704. The PCP for the Covered Person, in consultation with the specialist and Covered Person, shall determine that the Covered Person needs ongoing care from the specialist in order to make the standing referral. A time period for the standing referral of up to one year, or a longer period of time if authorized by Health Plan, or any entity that contracts with Health Plan, shall be determined by the PCP in consultation with the specialist or specialized treatment center. The specialist or specialized treatment center shall refer the Covered Person back to the PCP for primary care. To be reimbursed by Health Plan treatment provided by the specialist shall be for a Covered Person and must comply with provisions contained in the Covered Person's Benefit Plan. The PCP shall record the reason, diagnosis, or treatment plan necessitating the standing referral.

16. Dentists.

If Provider is a dentist licensed to practice in Colorado, the amount that Provider may charge for Non-Covered Services is not prescribed by the Agreement.

17. Termination of Affiliated Provider**.**
Either Party may terminate an Affiliated Provider's participation under the Agreement upon sixty (60) days' prior written notice to the other Party.

18. Medical Records.
Provider shall share a Covered Person's medical records and clinical information with other Health Care Providers who are treating or who have treated the Covered Person, to facilitate the continuity of Health Care Services, consistent with applicable Law and shall forward same in a timely manner to at no cost to Health Plan to monitor and evaluate the quality of care, to conduct evaluations and audits, and to determine on a concurrent or retrospective basis the medical necessity and appropriateness of health care services.

19. Amendment.
(a) For purposes of this paragraph, "**Material Change**" means a change to the Agreement that decreases Provider's payment or compensation, changes the administrative procedures in a way that may reasonably be expected to significantly increase Provider's administrative expense, or adds a new category of coverage. The term does not include:
(i) A decrease in payment or compensation resulting solely from a change in a published fee schedule upon which the payment or compensation is based and the date of applicability is clearly identified in the Agreement;
(ii) A decrease in payment or compensation that was anticipated under the terms of the Agreement, if the amount and date of applicability of the decrease is clearly identified in the Agreement;
(iii) An administrative change that may significantly increase the provider's administrative expense, the specific applicability of which is clearly identified in the Agreement;
(iv) Changes to an existing prior authorization, precertification, notification, or referral program that do not substantially increase Provider's administrative expense; or
(v) Changes to an edit program or to specific edits.
(b) Health Plan shall give Provider ninety (90) days prior written notice of a Material Change to the Agreement. Such notice shall be conspicuously titled: "Notice Of Material Change." The Material Change will take effect on the date specified in the written notice unless Provider objects, in writing, to the Material Change within fifteen (15) days of receipt of such Material Change notice. If Provider objects to the Material Change and the Parties are unable to resolve the objection, either Party may terminate the Agreement upon sixty (60) days prior written notice, such termination to take effect on the Material Change effective date. Notwithstanding the foregoing, in the event, such Material Change is the addition of a new category of coverage and Provider objects, such addition shall not be effective as to Provider and the objection shall not be a basis upon which either Party terminates the Agreement.
(c) For a change that is administrative only and is not a Material Change, the change shall be effective upon at least fifteen (15) days' notice to the Provider.

20. Third Party Access to Agreement.
Provider acknowledges and expressly authorizes that Health Plan may contract with third parties to provide access to Health Plan's rights and responsibilities under the Agreement. Health Plan shall notify any such third party of where claims should be sent and where inquiries should be directed and shall require any such third party to comply with all applicable terms of the Agreement.

21. New Patients.

For purposes of this paragraph, "**New Patient**" means person who has not received services from Provider in the immediately preceding three (3) years. A patient shall not become a New Patient solely by changing health insurance coverage. Upon sixty (60) days' prior written notice, Provider may decline to accept New Patients who are Covered Persons. Provider shall state in the written notice the reason or reasons for this action and shall act uniformly without regard to any factor related to health status and shall not discriminate against any person, as stated in paragraph 4 above.

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STATE COMPLIANCE ATTACHMENT FOR NEW MEXICO

Health Plan and Provider or Facility (each referred to herein as "**Provider**") agree that the provisions in this State Compliance Attachment for New Mexico (this "**Attachment**") are incorporated into the Participating Provider Agreement or the Participating Facility Agreement, as applicable (the "**Agreement**") solely for the purpose of ensuring compliance with New Mexico laws, rules and regulations, and not as an expansion or restriction of rights and obligations under the Agreement when New Mexico laws, rules and regulations do not apply. Unless otherwise specifically stated herein, the provisions of this Attachment are applicable only to Benefit Plans that are subject to state insurance statutes and regulations as either a health insurance policy or HMO contract, whether issued or administered by Health Plan, affiliates of Health Plan (references to Health Plan herein also include affiliates of Health Plan), or another Payor that is licensed as an insurer or HMO in New Mexico (hereinafter referred to in this Attachment, subject to the insurer or HMO license requirement limitation, as "**Payor**"). The provisions of this Attachment do not apply to a self-funded Benefit Plan for which Health Plan provides administrative services or in any circumstance not required by law, including but not limited to Medicare Advantage plans issued or administered by Health Plan. In the event of any conflict between the terms of this Attachment and the terms of the Agreement, the terms of this Attachment shall control but only to the extent required by Law. Capitalized terms used in this Attachment shall have the meanings as defined in the Agreement, except as otherwise specifically provided in this Attachment, and are intended to be used in a manner consistent with any definition set forth in applicable state Law. In the event any terms of this Attachment are in conflict with the New Mexico statutes or regulations as amended or revised, such terms are amended to conform to such statutes and regulations.

1. Hold Harmless

   Provider agrees that in no event, including but not limited to nonpayment by Health Plan, insolvency of Health Plan, or breach of the Agreement, shall Provider bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against, a Covered Person, or person acting on behalf of the Covered Person, for health care services provided pursuant to the Agreement. This does not prohibit Provider from collecting coinsurance, deductibles, or copayments as specifically provided in a Benefit Plan, or fees for Non-Covered Services pursuant to Section 4.5 of the Agreement, nor from any recourse against Health Plan or its successor. This provision shall survive the termination of the Agreement regardless of the reason for the termination including the insolvency of Health Plan.

2. Health Plan Policies & Programs.

   Health Plan shall maintain a Quality Management Program (which includes credentialing and recredentialing standards and processes), Utilization Management Policies and Procedures (which include utilization review, prior authorization and referral processes), a health care provider grievance procedure, and other programs, policies or procedures for the purpose of administering the Benefit Plans including, but not limited to, payments systems, confidentiality requirements and compliance standards for federal and state programs (collectively the "**Health Plan Policies**"). Information related to the Health Plan Policies shall be included in the Provider Manual or otherwise made available to Provider. Provider shall abide by and comply with the Health Plan Policies**.** Provider acknowledges

and agrees that payment for Covered Services may be reduced for failure to comply with the Utilization Management Policies and Procedures and Provider shall not bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against, a Covered Person, or person acting on behalf of the Covered Person, for any such reduction in payment.

3. Medical Records.

Medical records of Covered Persons and any other records containing individually identifiable information with respect to Covered Persons shall be treated as confidential. Provider and Health Plan shall comply with all applicable Laws regarding the privacy and security of such medical records including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Provider shall be responsible for obtaining consent or authorization from Covered Persons for the disclosure of such information to the extent such consent or authorization is required by applicable Law. Except as prohibited by applicable Law, Provider shall, promptly, but in no event later than thirty (30) days from receipt of a request, and without charge, permit access (both on-site and electronic), inspection, audits and copying by Health Plan, accrediting agencies, and any Governmental Authority with jurisdiction over a Benefit Plan, to clinical and billing data, information, and medical records obtained, created or maintained by Provider related to Covered Persons for any period during which they are a Covered Person. Provider shall share a Covered Person's medical records and clinical information and shall forward same in a timely manner to at no cost to Health Plan to monitor and evaluate the quality of care, to conduct evaluations and audits, and to determine on a concurrent or retrospective basis the medical necessity and appropriateness of health care services.

4. Assignment.

Provider may not assign or delegate this Agreement nor any rights or responsibilities hereunder without the prior written consent of Health Plan.

5. Professional Liability Insurance.

Provider shall purchase and maintain insurance with insurance companies reasonably acceptable to Health Plan, at Provider's expense, for comprehensive general liability insurance and for professional liability insurance each in an amount no less than two million dollars ($2,000,000) for each occurrence and two million dollars ($2,000,000) in the annual aggregate. Provider's professional liability insurance shall be occurrence coverage or claims made coverage with an extended period reporting option that is no shorter than three (3) years under such terms and conditions as may be reasonably required by Health Plan. Upon request, Provider shall provide Health Plan with satisfactory evidence of the insurance coverages. Provider shall provide Health Plan with prior notification of any cancellation, non-renewal, or other material change in any such insurance coverage within ten (10) days of such cancellation, non-renewal or other material change.

6. Nondiscrimination**.**

Provider shall render care and treat Covered Persons with respect and dignity and give consideration for the privacy of all Covered Persons. Provider shall treat Covered Persons in all respects no less favorably than Provider treats all other patients. Provider shall not

discriminate against Covered Persons based upon race, religion, ethnicity, color, sex, gender, marital status, sexual orientation, age, health status, disability, or source of payment.

7. Language Assistance Services.
As required by applicable Law, Health Plan shall provide and shall make available to Provider, at no cost to Provider, interpreters for limited English proficient (LEP) Covered Persons and interpretative services for Covered Persons who qualify under the Americans with Disabilities Act (ADA).

8. Access to Services.
Provider shall make necessary and appropriate arrangements to ensure the availability of Covered Services twenty-four (24) hours per day and seven (7) days per week. Provider shall maintain appointment hours that are convenient to serve Covered Persons and appointment access, appointment wait times, and telephone answering standards that meet the requirements set forth in the Provider Manual.

9. Dispute Resolution.
For all disputes between the Parties arising with respect to the performance or interpretation of the Agreement, or the relationship created pursuant to this Agreement, the Parties shall attempt to resolve the dispute through good faith negotiations. If any such dispute is not resolved to the Parties' mutual satisfaction within thirty (30) days, then the Parties agree that such dispute shall be submitted to non-binding mediation by a mediator mutually acceptable to the Parties. In the event the dispute is not resolved through mediation, at the conclusion of the mediation either Party may initiate arbitration proceedings pursuant to Section 10.2 of the Agreement by providing written notice to the other Party. Notwithstanding the foregoing and subject to the applicable grievance and appeal procedures, disputes involving overpayments, underpayments, non-payment, and/or erroneous payments (whether in whole or in part) must be submitted for arbitration within six (6) months of the date of the original payment, or, in the case of non-payment, within six (6) months of the date the payment would have been due under the terms of this Agreement. Failure to submit the matter to arbitration within the applicable time frame waives the aggrieved Party's right to pursue arbitration or any other legal or equitable resolution of the aggrieved Party's claim.

10. Prompt Payment of Clean Claims.
Health Plan will take reasonable business efforts to notify the Provider that a submitted claim is not a Clean Claim or to pay Clean Claims within thirty (30) days for claims submitted electronically, and forty-five (45) days for claims submitted by other means. For Clean Claims that are not paid timely, Health Plan shall pay interest as required by N.M. Admin. Code § 13.10.22.12(O).

11. Overpayments.
Except for an overpayment caused by miscoding, claim submission error or suspected fraud/abuse, Health Plan may recover a refund due to an overpayment only if Health Plan notifies Provider in writing not later eighteen (18) months after the overpayment or

completion of an audit. If Provider has not made arrangements to repay or otherwise appeal Health Plan's notice within forty-five (45) days of Health Plan's notice of overpayment or within thirty (30) days of notice of completion of an audit, Health Plan may offset the amount of the overpayment against future payments owing to Provider for any reason. If Provider disagrees with Health Plan's request for recovery of overpayment or refund, Provider may appeal the request in writing as provided for in Health Plan's notice of its intent to recover the overpayment.

12. Notice of Termination.
Provider shall give Health Plan at least sixty (60) days advance written notice of termination of the Agreement. Health Plan shall give Provider at least thirty (30) days advance written notice of termination of the Agreement; except that no advance written notice of termination of the Agreement is required if Health Plan has a good faith and reasonable belief that further care by Provider would result in imminent and significant harm to Covered Persons; provided, however, that such a termination is subject to a fair hearing under Health Plan's health care provider grievance procedure.

13. Obligations upon Termination**.**
Upon termination of the Agreement, unless the termination was due to medical competence or professional behavior, Provider shall continue, for a transitional period determined by Health Plan and communicated to Provider, to provide Covered Services to a Covered Person who is undergoing an ongoing course of treatment. The transitional period shall be a period of time that is sufficient to permit coordinated transition planning consistent with the Covered Person's condition and needs relating to continuity of care. The transition period shall not, in any event, be less than thirty (30) days. For a Covered Person in the third trimester of pregnancy, the transition period shall continue through post-partum care directly related to the delivery. During any such transition period the terms and conditions of this Agreement, including but not limited to Article 4, shall continue to apply to Covered Services rendered by Provider.

14. Financial Incentive.
The provisions of the Agreement and this Attachment are in no way intended to be a financial incentive or payment which directly or indirectly acts as an inducement for Provider to limit Medically Necessary services.

15. Relationship with Covered Persons.
The Parties acknowledge and agree that Provider shall observe, protect and promote the rights of Covered Persons as patients and that nothing contained in this Agreement is intended to interfere with or hinder: (a) communications between Provider and Covered Persons regarding a Covered Person's health care, including the discussion of treatment options regardless of Health Plan's position on or coverage of any treatment options; (b) a Provider from advocating on behalf of a Covered Person within the utilization review or grievance and appeal processes; or (c) a Provider from using disparaging language or making disparaging comments when referring to Health Plan.

STATE COMPLIANCE ATTACHMENT FOR TEXAS

Health Plan and Provider or Facility (each referred to herein as "Provider") agree that the provisions in this State Compliance Attachment for Texas (this "Attachment") are incorporated into the Participating Provider Agreement or the Participating Facility Agreement, as applicable (the "Agreement") solely for the purpose of ensuring compliance with Texas laws, rules and regulations, and not as an expansion or restriction of rights and obligations under the Agreement when Texas laws, rules and regulations do not apply. Unless otherwise specifically stated herein, the provisions of this Attachment are applicable only to Benefit Plans that are subject to state insurance statutes and regulations as either a health insurance policy or HMO contract, whether issued or administered by Health Plan, affiliates of Health Plan (references to Health Plan herein also include affiliates of Health Plan), or another Payor that is licensed as an insurer or HMO in Texas (hereinafter referred to in this Attachment, subject to the insurer or HMO license requirement limitation, as "Payor"). The provisions of this Attachment do not apply to a self-funded Benefit Plan for which Health Plan provides administrative services or in any circumstance not required by law, including but not limited to Medicare Advantage plans issued or administered by Health Plan. In the event of any conflict between the terms of this Attachment and the terms of the Agreement, the terms of this Attachment shall control but only to the extent required by Law. In the event any terms of this Attachment are in conflict with the Texas statutes or regulations as amended or revised, such terms are amended to conform to such statutes and regulations. Capitalized terms used in this Attachment shall have the meanings as defined in the Agreement, except as otherwise specifically provided in this Attachment.

1. Covered Person Billing

   Provider shall not bill a Covered Person for unnecessary care if a physician or practitioner panel has determined the care was unnecessary. Provider shall bill Covered Persons at Provider's contracted rate as specified in the fee schedule and shall not pursue collection from a Covered Person using Provider's full billed charge rate for services. Provider may collect from a Covered Person in connection with any Non-Covered Service and/or Cost Sharing Amounts in accordance with the terms of the applicable Covered Person's Benefit Plan and the Agreement.

2. Continuity of Care

   (a) For a Covered Person who has a Special Circumstance, as defined herein, the termination of this Agreement or termination of an Affiliated Provider, except for reason of medical competence or professional behavior, does not release Provider from the generally recognized obligation to treat such Covered Person and cooperate in arranging for appropriate referrals and does not release Health Plan or Payor(s)from the obligation to reimburse Provider at the Allowed Amount, until:

      (1) the 90th day after the effective date of the termination; or

      (2) if the insured has been diagnosed as having a terminal illness at the time of the termination, the expiration of the nine-month period after the effective date of the termination; or

(3) if an insured is past the 24th week of pregnancy at the time of termination, delivery of the child, immediate postpartum care, and the follow-up checkup within the six-week period after delivery.

(b) "Special circumstances" means a condition for which the treating health care provider reasonably believes that discontinuing care by the treating health care provider could cause harm to the Covered Person. Examples of a special circumstance include a person with a disability, acute condition, or life-threatening illness or a person who is past the 24th week of pregnancy.

(c) Special circumstance shall be identified by Provider. Provider must request that the Covered Person be permitted to continue treatment under Provider's care and agree not to seek payment from the Covered Person of any amounts for which the Covered Person would not be responsible if the Agreement had not terminated.

(d) Any dispute between Health Plan and Provider regarding the necessity of continued treatment shall be subject to the Dispute Resolution Process set forth in the Agreement.

3. Notice to Covered Person in the Event of Termination

Reasonable advance notice will be given to a Covered Person of the termination from the Participating Provider network of any Provider who is currently treating a Covered Person. If Provider voluntarily terminates this Agreement, Provider, with Health Plan's assistance, shall provide Covered Persons under Provider's care with reasonable notice. If Health Plan terminates this Agreement, Health Plan will notify Covered Persons on the later of the effective date of the termination or when the Advisory Panel (described below) makes a formal recommendation. If Provider is terminated for reasons related to imminent harm, Health Plan will notify Covered Persons immediately.

4. Covered Person Complaint Process

Provider shall post in Provider's facility or location a notice to Covered Persons on the process for resolving complaints with Health Plan. The notice shall include the Texas Department of Insurance's toll-free telephone number for filing complaints.

Health Plan shall not engage in any retaliatory action, including termination or refusal to renew a contract, against the Provider because the Provider has, on behalf of a Covered Person, reasonably filed a complaint against Health Plan or has appealed a decision of Health Plan.

5. Disclosure of Payment Information

Consistent with Texas Department of Insurance regulatory requirements at Title 28 Texas Administrative Code § 3.3703(a)(20), Provider may request a description and copy of the coding guidelines, including any underlying bundling, recoding or other payment process and fee schedules applicable to the compensation to be paid to Provider as set forth in the Agreement. . Health Plan will provide the coding guidelines not later than thirty (30) days after receipt of the request. Health Plan will provide notice of changes to the coding guidelines and fee schedule that will result in a change of payment not later than the ninetieth (90th) day before the date the change takes effect. Provider may terminate this Agreement in accordance with termination provisions of the Agreement on or before the

thirtieth (30th) day after Provider receives information requested without penalty or discrimination in participation in other health care products or plans.

6. Financial Incentive

The provisions of the Agreement and this Attachment are in no way intended to be a financial incentive or payment which directly or indirectly acts as an inducement for Provider to limit Medically Necessary services.

7. Communications with Covered Persons

The Parties acknowledge and agree that nothing contained in this Agreement is intended to interfere with or hinder communications between Provider and Covered Persons regarding a Covered Person's health care, including: the Covered Person's medical condition and/or treatment options; information or opinions regarding the terms, requirements, or services of the Benefit Plan as they relate to the medical needs of the Covered Person; or, the termination of Provider's contract with Health Plan or the fact that Provider will otherwise no longer be providing medical care or health care services under the Benefit Plan.

8. Economic Profiling

Upon request of Provider, Health Plan will make available Provider's economic profile, if any, including the standards by which the Provider is measured. If Health Plan uses an economic profile, Health Plan will recognize the characteristics of Provider's practice that may account for variations from expected costs.

9. Prompt Payment

Health Plan shall pay claims from Provider in accordance with this Agreement and shall comply with all applicable statutory and regulatory requirements pertaining to prompt payment of clean claims with respect to payment to Provider, including but not limited to Tex. Ins. Code Ann. § 1301.101 through § 1301.110 and Tex. Ins. Code Ann. § 1301.137.

10. Termination of Participation

At least ninety (90) days prior to the effective date of Health Plan's termination of the Agreement, Health Plan shall provide a written explanation to Provider of the reason(s) for termination and shall provide notice of Provider's right to request a review from an Advisory Panel, as described below, prior to termination. Health Plan will comply with all regulations promulgated by the Texas Department of Insurance applicable to the review of a decision to terminate the Agreement. Exceptions to this provision are: (i) cases of imminent harm to patient health; (ii) action against license to practice; or (iii) fraud or malfeasance pursuant to the Texas Insurance Code, in which cases termination may be immediate.

11. Advisory Panel Review

Provider, upon written request and before the effective date of termination, will be entitled to an advisory panel review of such termination. The advisory panel will be appointed by Health Plan and will be comprised of three (3) Participating Providers, including at least one representative in Provider's specialty. Health Plan shall abide by the requirements set forth in Texas state regulations concerning the advisory panel. This provision shall not

apply in cases where there is: (i) imminent or the threat of imminent harm to a Covered Person's health, safety or welfare; (ii) action taken by a state medical, other professional licensing board, or other governmental agency that effectively impairs the individual Participating Provider's ability to practice their profession; or (iii) fraud or other malfeasance. The decision of the advisory panel must be considered but is not binding upon Health Plan. Health Plan shall provide Provider, upon written request, a copy of the recommendation of the advisory panel and Health Plan's final determination.

12. Submission of Claims

If applicable, Provider shall submit claims within ninety-five (95) days after the date services are rendered, and further agrees and acknowledges that Health Plan and/or Payor is not obligated to pay claims which are submitted ninety-five (95) days after the date services are rendered. Provider shall not resubmit any claim until, at a minimum, the forty-sixth (46th) date or the thirty-first (31st) day if filed electronically, after the date the original claim was received.

In the event there is a systems failure or a catastrophic event that substantially interferes with the business operations of Provider, Provider may submit non-electronic claims in accordance with the requirements of §21.3701 of Title 28 of the Texas Administrative Code by providing written notice of Provider's intent to submit non-electronic claims to Health Plan within 5 calendar days of the catastrophic event or systems failure.

13. Overpayment

Provider agrees that Health Plan may recover a refund due to an overpayment or completion of an audit if Health Plan notifies Provider in writing not later than one hundred and eighty (180) days after the overpayment or completion of the audit. If Provider has not made arrangements to repay or otherwise appeal Health Plan's notice within forty-five (45) days of Health Plan's notice of overpayment or within thirty (30) days of notice of completion of audit, Health Plan and/or Payor will offset the amount of the overpayment against future payments owing to Provider for any reason. If Provider disagrees with Health Plan's request for recovery of overpayment or refund, Provider may appeal the request in writing as provided for in Health Plan's notice of its intent to recover the overpayment.

14. Coordination of Benefit Information

Provider shall collect and maintain primary payor information in the Covered Person's medical or billing records and shall provide such information to Health Plan, upon request, so that Health Plan can coordinate benefits according to the Covered Person's health benefits contract and the Agreement.

15. Overpayments from Covered Persons

Provider agrees to comply with all applicable requirements of Tex. Ins. Code § 1661.005 relating to refunds of overpayments from Covered Persons within 30 days of determining that an overpayment has been made.

16. Claims Submission

Provider shall use best efforts to submit all claims and clinical data to Health Plan and/or Payors or their designees by electronic means available and accepted as industry standards

that are mutually agreeable and which may include claims clearinghouses or electronic data interface companies used by Health Plan.

17. Sale, Lease or Other Transfer of Agreement Rights

Provider acknowledges and agrees that Health Plan may contract with third parties to provide access to Health Plan's rights and responsibilities under their Agreement.

18. Right to Request Information

Provider has the right to request information necessary to determine whether a specific third party has been authorized access to the Provider's health services and contractual discounts.

19. Compliance with Agreement Terms by Third Parties

Third parties to the Agreement shall be required to comply with all applicable terms, limitations and conditions of the Agreement.

20. Notification of Third Parties and Approval

Provider acknowledges notice of and expressly authorizes the transfer of all payment/reimbursement terms and obligations under the Agreement to Benefit Plans offered by Affiliates of Health Plan.

21. Additional Third Parties

Provider will receive notification of additional third parties prior to any transfer of payment/reimbursement terms and obligations to such additional third parties. Notice will be provided via email communication or through other means as determined by Health Plan in accordance with applicable law. Failure of Provider to respond to the transfer shall constitute express approval of Provider for the transfer.

23. Specific Referrals

Provider acknowledges that Covered Persons may have coverage limitations or exclusions related to services received from providers who are not Participating Providers. Except in the case of emergency care or as necessary to avoid interruption or delay of Medically Necessary care, Provider agrees to use its best efforts to admit, refer, and cooperate with the transfer of Covered Persons for Covered Services only to Participating Providers.

For a provider other than an institutional provider, upon referring a Covered Person to a provider that is not a Participating Provider, Provider shall disclose to the Covered Person:

(a) that the provider to whom the insured is being referred might not be a Participating Provider; and

(b) if applicable, that Provider has an ownership interest in the facility to which the insured is being referred.

24. Surgery Referrals

(a) If Provider is not an institutional provider, except for instances of Emergency Care, Provider shall, upon referring a Covered Person to a facility for surgery:

(1) notify the Covered Person of the possibility that out-of-network providers may provide treatment and that the insured can contact Health Plan for more

information;

(2) notify Health Plan that surgery has been recommended; and

(3) notify Health Plan of the specific facility that has been recommended for the surgery.

(b) If Provider is a facility, except for instances of Emergency Care, Provider shall, upon scheduling surgery:

(1) notify the Covered Person of the possibility that out-of-network providers may provide treatment and that the Covered Person can contact Health Plan for more information; and

(2) notify Health Plan that surgery has been scheduled.

Automated Certificate of eService

This automated certificate of service was created by the efiling system. The filer served this document via email generated by the efiling system on the date and to the persons listed below. The rules governing certificates of service have not changed. Filers must still provide a certificate of service that complies with all applicable rules.

Greg Pierce on behalf of Greg Pierce
Bar No. 15994250
gpierce@gpiercelaw.com
Envelope ID: 117287838
Filing Code Description: Motion (No Fee)
Filing Description: SPECIAL DEPUTY RECEIVER'S APPLICATION TO APPROVE SETTLEMENT AGREEMENT
Status as of 7/15/2026 3:28 PM CST

Case Contacts

Name	BarNumber	Email	TimestampSubmitted	Status
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James Danford	24105775	jdanford@mayerbrown.com	7/13/2026 6:02:07 PM	SENT
Patricia Muniz		pmuniz@inquestresources.com	7/13/2026 6:02:07 PM	SENT
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Marty Campbell		mcampbell@mayerbrown.com	7/13/2026 6:02:07 PM	SENT
Robert Harrell		rharrell@mayerbrown.com	7/13/2026 6:02:07 PM	SENT

Associated Case Party: FRIDAY HEALTH INSURANCE COMPANY, INC

Name	BarNumber	Email	TimestampSubmitted	Status
Melvin Burner	3425700	bburner@mwlaw.com	7/13/2026 6:02:07 PM	SENT

Associated Case Party: TEXAS DEPARTMENT OF INSURANCE

Name	BarNumber	Email	TimestampSubmitted	Status
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Special Master Clerk		specialmasterclerk@tdi.texas.gov	7/13/2026 6:02:07 PM	SENT
Vane Hugo		Vane.Hugo@tdi.texas.gov	7/13/2026 6:02:07 PM	SENT
John Walker		John.Walker@tdi.texas.gov	7/13/2026 6:02:07 PM	SENT

Automated Certificate of eService

This automated certificate of service was created by the efiling system. The filer served this document via email generated by the efiling system on the date and to the persons listed below. The rules governing certificates of service have not changed. Filers must still provide a certificate of service that complies with all applicable rules.

Greg Pierce on behalf of Greg Pierce
Bar No. 15994250
gpierce@gpiercelaw.com
Envelope ID: 117287838
Filing Code Description: Motion (No Fee)
Filing Description: SPECIAL DEPUTY RECEIVER'S APPLICATION TO APPROVE SETTLEMENT AGREEMENT
Status as of 7/15/2026 3:28 PM CST

Associated Case Party: TEXAS DEPARTMENT OF INSURANCE

John Walker		John.Walker@tdi.texas.gov	7/13/2026 6:02:07 PM	SENT
David Ashton		David.Ashton@tdi.texas.gov	7/13/2026 6:02:07 PM	SENT

Associated Case Party: TEXAS LIFE AND HEALTH INSURANCE

Name	BarNumber	Email	TimestampSubmitted	Status
Daniel Price	24041725	dprice@sp-legal.com	7/13/2026 6:02:07 PM	SENT

Associated Case Party: QUEST DIAGNOSTIC CLINICAL LABORATORIES, INC.

Name	BarNumber	Email	TimestampSubmitted	Status
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