THE STATE OF TEXAS )
:
COUNTY OF WINKLER )

On this the 12th day of May, 2014, the Commissioners' Court of Winkler County, Texas, met in Regular Term of Court at the Courthouse in Kermit, Texas, with the following members present, to-wit:

| | |
|---|---|
| Bonnie Leck | County Judge |
| Billy Stevens | Commissioner, Precinct No. 1 |
| Robbie Wolf | Commissioner, Precinct No. 2 |
| Randy Neal | Commissioner, Precinct No. 3 |
| Billy Ray Thompson | Commissioner, Precinct No. 4 |
| Shethelia Reed | County Clerk and Ex-Officio Clerk of Commissioners' Court |

constituting the entire Court, at which time the following among other proceedings were had:

At 9:00 o'clock A.M. Judge Leck called the meeting to order and asked for matters of business from the audience.

A motion was made by Commissioner Neal and seconded by Commissioner Stevens to approve Proclamation declaring May 18-24, 2014 as "2014 Emergency Medical Services Week" in Winkler County; which motion became an order of the Court upon the following vote:

Ayes: Commissioners Stevens, Wolf, Neal and Thompson
Noes: None

EMS DEDICATED. FOR LIFE.

# PROCLAMATION

## 2014 Emergency Medical Services Week

**WHEREAS,** emergency medical services is a vital public service; and

**WHEREAS,** the members of emergency medical services teams are ready to provide lifesaving care to those in need 24 hours a day, seven days a week; and

**WHEREAS,** access to quality emergency care dramatically improves the survival and recovery rate of those who experience sudden illness or injury; and

**WHEREAS,** the emergency medical services system consists of emergency physicians, emergency nurses, emergency medical technicians, paramedics, firefighters, first responders, educators, administrators and others ; and

**WHEREAS,** the members of emergency medical services teams, whether career or volunteer, engage in thousands of hours of specialized training and continuing education to enhance their lifesaving skills; and

**WHEREAS,** it is appropriate to recognize the value and the accomplishments of Emergency Medical Service practitioners by designating Emergency Medical Services Week.

**NOW, THEREFORE, WE, THE WINKLER COUNTY COMMISSIONERS' COURT** do hereby proclaim the week of May 18 – 24, 2014, as **Emergency Medical Services Week with the theme "EMS: Dedicated. For Life."** in Winkler County and call upon the people of Winkler County to observe this week with appropriate programs, ceremonies, and activities.

**THEREFORE, IN OFFICIAL RECOGNITION WHEREOF,** we, the undersigned do hereby affix our signatures this 12th day of May, 2014.

Bonnie Leck
Winkler County Judge

Billy J. Stevens
Commissioner, Precinct 1

Robbie Wolf
Commissioner, Precinct 2

Randy Neal
Commissioner, Precinct 3

Billy Ray Thompson
Commissioner, Precinct 4

ATTEST:

Shethelia Reed
Winkler County Clerk

At this time the Court heard presentation of Mary Burch, City of Kermit, regarding city's recycling project.

KERMIT
RECYCLING CENTER

802 W. HWY 302

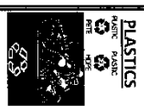
Please place items in the appropriate container and break down all cardboard boxes.

We also accept Pallets that measure 48"X40" at the recycle center.

RECYCLE

ALUMINUM

PLASTICS



PAPER

CARDBOARD

STOP


THANK YOU FOR DOING YOUR PART!!!

WITH THE OPENING OF KERMIT'S RECYCLE CENTER IT'S NOW EASIER FOR YOU TO HELP KEEP VALUABLE RESOURCES OUT OF THE LANDFILL!!


FOR MORE INFORMATION:

City of Kermit
City Hall
110 S Tornillo
Kermit, TX 79745
(432) 586-3468

Or Visit us at:
http://www.kermittexas.us/

CITY OF KERMIT'S

# GUIDE TO RECYCLING

**The City of Kermit**
**Citizens' Collection Station**

**Gate Fees**

Construction & Demolition Debris, Brush, Trees and Lawn Clippings

- **Residential Waste:** $14.50 per cubic yard (pickup bed full)
- **Outside (Non-City resident) / Commercial Waste:** $17.50 per cubic yard (pickup bed full)
- **Construction/Demolition Waste:** $22.00 per cubic yard (pick up bed full)
- **Tires:**
  - Whole Tires.
    7.15" X 18" tires or smaller: $3.00 per tire.
    Larger than 7.15" x 18" up to tractor size: $9.00 per tire
    Tractor Tires: $28.00 per tire
    Larger than tractor tire: $39.00 per tire.
  - Other Tire Fees.
    7.15" x 18" tires or smaller + rims: $8.00 per tire
    Larger than 7.15" x 18" up to tractor + rims: $15.00 per tire
    Tractor tires + rims: $33.00 per tire
    Larger than tractor tire + rims: $44.00 per tire.

**Exceptions to Fees:**
The citizens of the city shall be allowed to dispose of a pickup load or trailer load (not to exceed one cubic yard or pickup bed full) of yard waste per month. *Prior to being* allowed to dispose of such yard waste in the Citizens' Collection Station, free of any fees, said citizens shall present to the landfill gatekeeper your current paid water utility bill and a valid ID.

No-allowable waste items: Wet paint in cans, batteries, engine oil, transmission oil, radiator fluid, volatile liquids, asbestos infused materials and appliances containing Freon.

# PROP FACT Sheet

## Grasscycling

Grass clippings and other yard debris represent a large percentage of solid waste deposited in landfills. An analysis of the composition of residential waste in this part of North America showed that yard debris (leaves, prunings and grass clippings) accounted for nearly 20 percent of the total. In many communities, collection and composting of grass clippings is limited. The disposal of this waste material is expensive and takes up valuable landfill space.

The obvious solution to the clipping disposal problem is to recycle the grass - grasscycling. Grasscycling can be easily accomplished by returning the clippings to the lawn. If performed correctly, returning grass clippings should not detract from the appearance of the lawn or cause an accumulation of thatch. In fact, this practice will reduce the labor involved in bagging and also return essential nutrients to the soil.

Research at Penn State University has shown that over a three year period, the leaf clippings from Kentucky bluegrass contained between 55 to 59 percent of nitrogen (N) applied as fertilizer. When clippings are returned, a substantial amount of nitrogen and other nutrients can be used by the turf, significantly reducing fertilizer requirements.

Several tools and management practices can be used to make the recycling process more efficient. A few of the more effective practices are described below.

***Mowing Practices:***
For clippings to break down rapidly, the lawn should be mowed frequently enough so that large amounts of leaf residue do not remain on the surface of the turf. Weekly mowing is often not enough, especially during the peak period of leaf growth in the spring. As a rule of thumb, no more than one-third of the leaf tissue should be removed during the mowing operation. The turf should be mowed at the suggested height of cut for the predominant species present.

Some people are concerned that returning clippings to the lawn may result in thatch accumulation. Thatch is the tightly intermingled layer of partially decomposed stems and roots which develops between actively growing green vegetation and the soil surface. Because turf clippings are composed mostly of leaf tissue that decomposes rapidly, they do not contribute to thatch.

If the soil pH near the surface is low, populations of microorganisms, which decompose the clippings, may be reduced. To insure that adequate microbial decomposition occurs, maintain a soil pH between 6.3 and 7.0. Soil pH can be determined through a soil test available from your county cooperative extension office.

***Mulching Mowers:***
Mulching mowers are rotary mowers designed to keep the clippings circulating under the mower deck so the grass blades will be chopped into finer pieces. This hastens clipping decomposition and reduces the amount of residue on the lawn. Some of the newer mowers have special features that facilitate mulching, such as multiple rippled blades and dome shaped decks that allow better circulation of clippings. Lawn mower manufacturers also offer mulching kits - plates that block discharge and force the clippings back through the blades.

***Fertilization:***
A common problem with many lawns is over fertilization. Excessive fertilizer can produce a flush of growth, necessitating more frequent mowing. Chemical fertilizers are also a non-point source of water pollution as yard runoff carries the chemicals into the local watershed. For these reasons, if your turf grows in infertile soil try using organic fertilizers, such as top dressing with loose leaf compost.

***Irrigation:***
Excessive irrigation can increase leaf growth of turfgrasses, thereby increasing mowing frequency. This practice eventually will weaken the turf and may cause disease problems. A sufficient amount of water should be applied to insure that the entire root system will be moistened. If water runs off the lawn before soaking into the soil, turn off the sprinkler, allow the water to soak in, and continue irrigation. Frequent light watering encourages shallow rooting and germination of weed seeds.

***Special Considerations:***
Occasionally, periods of prolonged rainfall make mowing difficult or impossible. In such cases, the turf becomes overgrown and large clumps of grass may remain on the lawn following mowing. The clumps of grass can be removed after drying to facilitate dispersal, composted or removed, air-dried and used as mulch around trees, shrubs or gardens. If the turf has been treated with broadleaf herbicides, do not place clippings around trees, shrubs or garden plants.

If you would like to eliminate use of herbicides, do not cut your grass too low. Cutting your grass short encourages broadleaf weeds like dandelion and the two most common plantains because they have the opportunity to spread out and receive more sunlight. Cutting your grass higher than usual and hand picking weeds can reduce your weeds to a tolerable level while reducing the use of toxic chemicals on your lawn.

*This fact sheet was developed by the Professional Recyclers of Pennsylvania, P.O. Box 25, Bellwood, PA 16617. For more information, visit our website, www.proprecycles.org, or contact us by email at prop@proprecycles.org. Portions of this fact sheet were adapted from Recycling Turfgrass Clippings, a publication of the Penn State Cooperative Extension. Funding for this fact sheet was provided through a grant from the Department of Conservation and Natural Resources' Forest Lands Beautification Program. We do our part to close the recycling loop and print all our publications on recycled paper.*

## Kermit Front Curb Pickup Program

The City of Kermit Public Works department will be conducting a city-wide Front Curb Pickup Program at no additional charge to customers. All citizens must place items on the curb **and must call in to City Hall at 432-586-3468.** You will be placed on schedule and crews will come by to pick up those items.

**Items that will be picked up:**

- **Furniture and bulky household items** such as sinks, mattresses, hot water heaters, appliances, etc.
- **Tree limbs** must be cut into manageable sizes for 2 people to handle and no longer than 4'.
- **Carpet** must be cut in strips no more than 4', tightly rolled and tied.
- **Construction material such as drywall and lumber** less than 4' in length, but no more than approximately 50lbs of material.

**Items that will NOT be picked up:**

- **Regular household waste** should be disposed of in the alley dumpsters as usual.
- **Batteries**
- **Pressurized tanks**
- **Auto parts**
- **Liquids, oil or paint**
- **Refrigerant items** such as refrigerators not drained and A/C Units
- **Hazardous Materials**

**Procedure for Pickup:**

- Place materials on the front curb of the residence. (Items will not be picked up unless seen from the street and **placed** no more than 5' from the edge of the street).
- Please **DO NOT set** out pick up items **more than one week in advance** of your pick up date.
- The quantity of pick up material collected from one residence is limited to a reasonable amount. That equates to a pile no more than 10' L X 5' W X 4' H or about the size of a pickup bed.
- City crews will not pick up items too heavy for 2 people to safely handle, or items not properly prepared for collection.
- **Please recycle what you can!** Anchor Towing Service accepts junk vehicles (432) 251-9497
- **Do not mix with the materials to be picked up with regular household waste or small, loose items.** Regular household waste should still be bagged and placed in dumpsters. Loose bits and pieces will not be picked up.
- **Please be courteous.** Please prepare and place items out on the curb in an orderly way and according to the set rules and regulations. This will help the process run smoothly and ensure that your items are picked up saving you the time and effort it would take to haul it away yourself.

For any questions about the Front Curb Pickup Program please call City Hall at: (432) 586-3468 or log on to: www.kermittexas.us.

## Programa de Kermit de Recoger Basura Sobre su Banqueta

La Ciudad de Kermit estara conduciendo una limpieza extendida en el pueblo en un Programa de Recoger Basura sobre su Banqueta sin costo adicional para los residentes de la Ciudad de Kermit. Los residentes deben poner estos artículos sobre la banqueta junto el camino **y llamar a la oficina al 432-586-3468**. Personal de la Ciudad colectara estos artículos.

**Artículos que se colectaran:**

- **Muebles de casa y artículos de casa en mayoría** como lavabos, colchones, calentadores de agua, aparatos electricos, etc.
- **Ramas** seran cortadas a medidas manejables para dos personas (cuatro pies maximo).
- **Carpeta** sera cortara en pedasos no mas de cuatro pies de largo, en rollo y apretada.
- **Material de construction como madera y material de paredes** menos de cuatro pies de largo y no mas de 50 libras de material.

**Artículos que NO se colectaran:**

- **Basura de la casa** el contenedor de su callejon se usara para basura de casa como siempre.
- **Baterias**
- **Tanques Presurizados**
- **Partes de Auto**
- **Liquidos, aceites o tintes**
- **Artículos Refrigantes** como refrigeradores que contienen Freon y aparatos de aire frio.
- **Materiales peligrosos**

**Procedimiento para colecion de estos artículos:**

- Ponga artículos sobre la banqueta directamente en frente de su residencia (artículos no seran colecionados si no se ven del camino y puestos no mas de cinco (5) pies de la calle).
- Por favor de NO poner los artículos en la banqueta **mas de una semanda adelantada** de la fecha para levantarse.
- La cantidad de material que se colectara por residencia es limitada a una cantidad razonable igualada a un monton no mas de 10' Largo X 5'Ancho X 4' Alto o igual que la cama de una troca.
- Personal de la Ciudad no recojeran artículos muy pesados para dos personas o artículos no apropiados para colecion.
- **Por favor de reciclar lo que se pueda!** Anchor Towing Service aceptara vehiculos para desechar (432) 251-9497
- **Por favor de no mezclar materiales que seran recojidos con basura regular de su hogar, artículos chicos y sueltos.** Basura regular de casa sera enbolsada y desecha en el contenedor en su callejon. Artículos sueltos NO seran colecionados.
- **Por favor de ser amable.** Prepare artículos en la banqueta en una forma ordenada y conforme a las reglas. Nos ayudara con el proceso y asegurara que los artículos se recojan ahorrandole tiempo y el esfuerzo de que lo deseche usted mismo.

Si tiene preguntas llame a City Hall al: (432) 586-3468 o visitenos por internet en: www.kermittexas.us.

There was no financial information or monthly reports regarding Winkler County Memorial Hospital for the Court to consider at this time.

There were no line item transfer(s), budget amendment(s) or salary schedule change(s) regarding Winkler County Memorial Hospital for the Court to consider at this time.

A motion was made by Commissioner Neal and seconded by Commissioner Thompson to approve IGT payment in the approximate amount $200,000.00 from budgeted Winkler County Memorial Hospital funds; which motion became an order of the Court upon the following vote:

Ayes: Commissioners Stevens, Wolf, Neal and Thompson
Noes: None

A motion was made by Commissioner Neal and seconded by Commissioner Stevens to approve request of Roxanne Greer, Principal of Kermit

Elementary School, to use Pavilion in County Park in Kermit from 9:00 A.M. to 2:00 P.M. on Tuesday through Friday, May 20-23, 2014 and Tuesday through Thursday, May 27-29, 2014 for end-of-year school parties; which motion became an order of the Court upon the following vote:

Ayes: Commissioners Stevens, Wolf, Neal and Thompson
Noes: None

A motion was made by Commissioner Wolf and seconded by Commissioner Thompson to approve request of Wink Education in Action to use field at County Park in Wink for softball tournament on Saturday and Sunday, June 28-29, 2014 for benefit for Angel Martinez; which motion became an order of the Court upon the following vote:

Ayes: Commissioners Stevens, Wolf, Neal and Thompson
Noes: None

A motion was made by Commissioner Stevens and seconded by Commissioner Neal to approve request of Masonic Lodge to hold one-day tournament on Saturday, July 19, 2014 at Winkler County Golf Course as a fund raiser; which motion became an order of the Court upon the following vote:

Ayes: Commissioners Stevens, Wolf, Neal and Thompson
Noes: None

A motion was made by Commissioner Thompson and seconded by Commissioner Neal to approve request of Winkler County Senior Citizens Recreation Center to use van for out-of-county trip to Senior Celebration at Ector County Coliseum in Odessa, Texas on Thursday, May 15, 2014 leaving at 9:00 A.M.; which motion became an order of the Court upon the following vote:

Ayes: Commissioners Stevens, Wolf, Neal and Thompson
Noes: None

A motion was made by Commissioner Neal and seconded by Commissioner Thompson to approve Agreement for Transfer of Entitlements between Winkler County Airport and Federal Aviation Administration; which motion became an order of the Court upon the following vote:

Ayes: Commissioners Stevens, Wolf, Neal and Thompson
Noes: None

U.S. Department
of Transportation
**Federal Aviation**
**Administration**

**AGREEMENT FOR TRANSFER OF ENTITLEMENTS**

In accordance with section 47117(c)(2) of Title 49 U.S.C. (hereinafter called the "Act).

Wink-Winkler County Airport (INK)
*(Name of Transferor Sponsor)*

Hereby waives receipt of the following amount of funds apportioned to it for each fiscal year specified under section 47114(c)(1) of the Act.

| | Amount | Fiscal Year |
|---|---|---|
| $ | 150,000 | 2011 |
| TOTAL $ | 150,000 | |

On the condition that the Federal Aviation Administration makes the waived amount available to:

Texas Dept. Of Transportation
*(Name of Transferee Sponsor)*

for eligible projects under section 47104(a) Act. This waiver shall expire on earlier of 9-30- 14
*(date)* or when the availability of apportioned funds would lapse under section 47117(b) of the Act.

**FOR THE UNITED STATES OF AMERICA**
**FEDERAL AVIATION ADMINISTRATION**

*(Signature)*
David Fulton
*(Typed Name)*
Director, Aviation Division
*(Title)*
*(Date)*

**FOR Wink, Texas**

*(Signature)*
Bonnie Leck
*(Typed Name)*
Winkler County Judge
*(Title)*
*(Date)*

**CERTIFICATE OF SPONSOR'S ATTORNEY**

I, _____, acting as Attorney for the Sponsor do hereby certify:
That I have examined the foregoing Agreement and find that the Sponsor has been duly authorized to make such transfer and that the execution thereof is in all respects due and proper and in accordance with the laws of the State of _____ and the Act.
Dated at _____ this _____day of _____, _____.

**By:** _____
*(Signature of Sponsor's Attorney)*

FAA Form 5100-110 (10-89)

A motion was made by Commissioner Thompson and seconded by Commissioner Neal to approve request of Chief Adult Probation Officer to raise Adult Probation MasterCard limit to $5,000.00; which motion became an order of the Court upon the following vote:

Ayes: Judge Leck, Commissioners Neal and Thompson
Noes: Commissioners Stevens and Wolf

A motion was made by Commissioner Neal and seconded by Commissioner Thompson to approve request of Sheriff to repair weather damage to outside walls of Winkler County Law Enforcement Center in the approximate amount of $48,000.00 from contingency funds; which motion became an order of the Court upon the following vote:

Ayes: Commissioners Stevens, Wolf, Neal and Thompson
Noes: None

COLORWORKS CONSTRUCTION
Commercial & Residential Services
1301 Latta St Midland Tx. 79701
432-235-8371

Contract Agreement

This Independent Contract Agreement ("Agreement") is made and entered into as of the **April 29,2014** by and between Winkler County / County Jail 1300 Bellaire St Kermit Tx79745 ("Owner")Sergio Chavez ("Contractor"). Owner desires to retain Contractor as an independent contractor to perform home and/or commercial inspections for Owner. In consideration of the mutual promises contained herein, the parties agree as follows:

1. **TERM OF CONTRACT**

This Agreement will become effective upon its execution and will continue until terminated in accordance with the provisions of this Agreement.

2. **INDEPENDENT CONTRACTOR STATUS**

(a) **No Employment Relationship**

It is the express intention of the parties that Contractor is an independent contractor and not an employee, agent, joint venturer or partner of the Owner. Nothing in this Agreement shall in any way be interpreted or construed as creating or establishing the relationship of employer and employee between Owner Contractor or any employee or agent of the Contractor. Both parties acknowledge that Contractor is not an employee for state or federal tax purposes. As an independent contractor, Contractor is not entitled to any employee benefits of the Owner. Contractor shall retain the right to perform services for others during the term of this Agreement so long as these services (I) are not inconsistent or incompatible with Contractor's obligations under this Agreement; or (II) do not violate Section 4 of this Agreement.

(b) **No Authority to Bind Owner**

Contractor has no authority to act, to enter into any contract, or to incur any liability on behalf of the Owner.

3. **SERVICES TO BE PERFORMED BY CONTRACTOR**

**To prep and pressure wash complete wall surface.**

**To repair all stucco as needed.**

**To seal all repairs for better protection.**

**To seal all joints as well concrete .**

**To primer all repairs as needed for new coating .**

**To install (2) coats of elastomeric coating from Sherwing Williams.**



**All work will be done by spects of Sherwin Williams for warrantys and better protection.**

**All labor will be warranty for (3) years with a certified agreement.**

**Color Works will provide to customer spects and summitals by Sherwin Williams for there product being applied to exterior coating and warranty's.**

(a) **Availability and Description of Services**

Contractor agrees to be available at reasonable times upon reasonable request by the Owner during the term of this Agreement, and to perform the requested home and/or commercial inspections ("Services").

(b) **Work Product**

Contractor agrees that Owner shall own all data, compilations, analyses and reports generated by Contractor in connection with the Services. Ownership rights shall include, but are not limited to, all rights associated with publications, trade secrets, copyrights, trademarks and patents. Contractor shall treat such data, compilations, analyses and reports as Confidential Information (as defined below), subject to the protections of this Agreement.

(c) **Method of Performing Services**

Contractor will determine the method, details and means of performing the above-described services. Owner shall have no right to, and shall not, control the manner or determine the method of accomplishing Contractor's services. Contractor agrees to exercise the highest degree of professionalism and to utilize his/her expertise in providing such services.

4. **CONFIDENTIAL INFORMATION**

(a) **Definition of Confidential Information**

As used in this Agreement, the term "Confidential Information" shall mean all trade secrets or confidential or proprietary information of the Owner. By way of illustration and not limitation, "Confidential Information" shall include the Owner's research and development plans or projects, data and reports; computer materials such as programs, instructions, source and object code, and printouts; formulas; inventions, developments and discoveries; product testing information; business improvements, processes, marketing and selling ideas; business plans (whether pursued or not); budgets; unpublished financial statements; licenses; pricing, pricing strategy and cost data; information regarding the skills and compensation of employees of the Owner; the identities of the Owner's clients and potential clients, customers and potential customers (hereinafter referred to collectively as "Customers"); the particular preferences, likes, dislikes and needs of those Customers; Customer information regarding contact persons, pricing sales calls, timing, sales terms, and service plans; methods, practices, strategies, forecasts, know-how, and other marketing techniques; the identities of key accounts and potential key accounts; the identities of the Owner's suppliers and contractors, all information about those supplier and contractor relationships such as contact person(s), pricing and other terms; and, of appropriate, information concerning patient data of the Owner or its Customers.

(b) **Non-Use and Non-Disclosure of Confidential Information**



Contractor agrees that, except as required by judicial order or governmental laws or regulations, Contractor will not, during or subsequent to the term of this Agreement (i) use the Owner's Confidential Information for any purpose whatsoever other than the performance of Contractor's Services or (ii) disclose the Owner's Confidential Information to any third party. It is understood that the Owner's Confidential Information shall remain the sole property of the Owner. Contractor further agrees to take all reasonable precautions to prevent any unauthorized use or disclosure of the Owner's Confidential.

(c) **Injunctive Relief**

Contractor acknowledges that any remedy at law for the breach or threatened breach of this Section 4 would be inadequate to fully and properly protect Owner and, therefore, Contractor agrees that Owner shall be entitled to injunctive relief in addition to other available remedies, *provided, however*, that nothing contained herein shall be construed as prohibiting Owner from pursuing any other remedies available in law or in equity for such breach or threatened breach.

(d) **Return of Confidential Information**

Upon the termination of this Agreement or upon the Owner's earlier request, Contractor will return to the Owner any and all Owner property, including property containing Confidential Information that Contractor has in Contractor's possession or control.

(e) **Survival**

The provisions of this Section 4 shall survive expiration or termination of this Agreement.

5. **COMPENSATION**

(a) **Rate of Pay**

IN CONSIDERATION WHEREOF, the said Owner agrees to pay to the said Contractor the sum of: **48,000.00**

(b) **Invoices, Deposits and Payment of Compensation**

1. Owner agrees to pay Color Works Construction Upon work is being completed.
2. Owner agrees to pay 0% payment when contract signed by both parties.
3. Owner agrees to pay final payment upon all work is completed to customer satisfaction.

(c) **Expenses**

Contractor shall be responsible for all costs and expenses incident to the performance of Services for Owner, including but not limited to, all costs of equipment provided by Contractor and all fees, fines, licenses, bonds or taxes required of or imposed against Contractor. Owner shall be responsible for no expenses incurred by Contractor in performing Services for Owner

6 **OBLIGATIONS OF CONTRACTOR**



(a) **Tools and Instrumentalities**

Contractor will supply all tools and instrumentalities required to perform the Services.

(b) **State and Federal Taxes**

As an independent contractor, Contractor will pay all required state and federal taxes and making contributions to the government-sponsored benefit programs. In particular:

- Owner will not withhold FICA (Social Security) from Contractor's payments;
- Owner will not make state or federal unemployment insurance contributions on Contractor's behalf;
- Owner will not withhold state or federal income tax from payment to Contractor; and
- Owner will not obtain workers' compensation insurance on behalf of Contractor.

Owner will issue an Internal Revenue Service Form 1099 with respect to Contractor's fees. Contractor agrees to accept exclusive liability for complying with all applicable state and federal laws governing self-employed individuals including obligations such as payment of quarterly taxes, social security, disability and other contributions based on the fees paid to the Contractor under this Agreement. Contractor agrees to indemnify and hold Owner harmless to the extent Owner becomes obligated to pay any of the above taxes or incurs any similar liabilities.

(c) **Insurance Requirements**

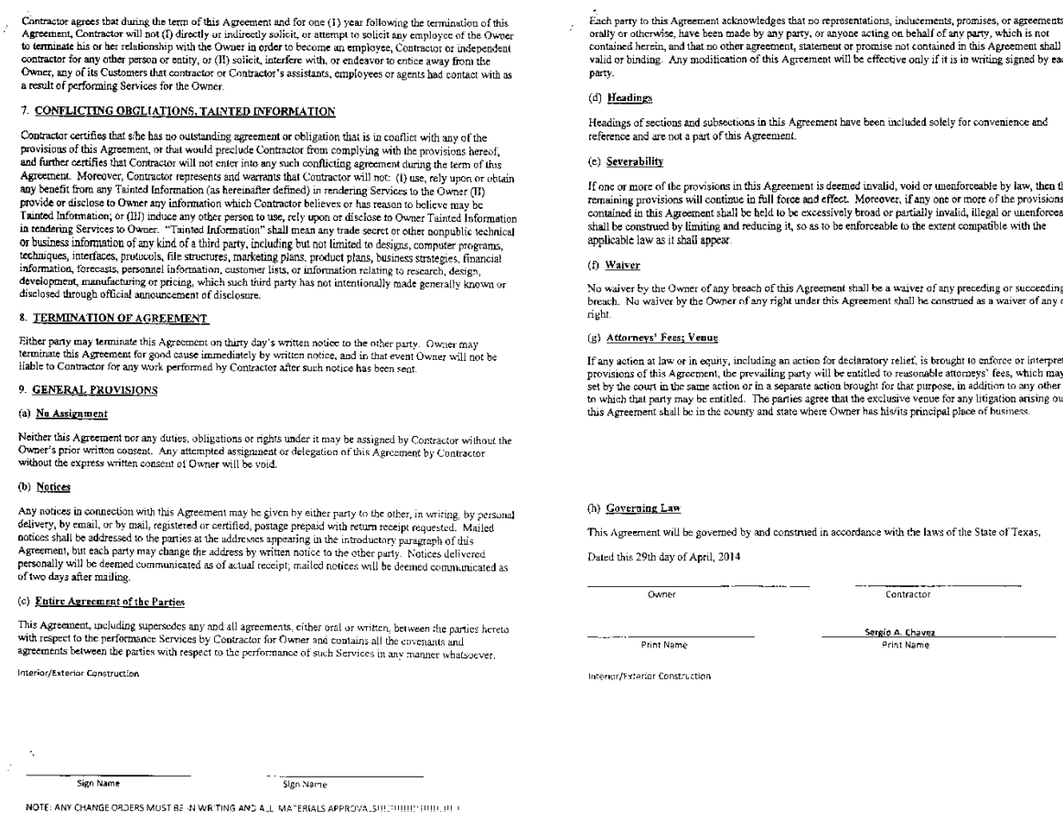
For the term of this Agreement, Contractor agrees to maintain a policy of insurance to cover: (a) claims under workers' compensation and state disability laws; (b) claims for damages for bodily injury, sickness, disease or death which arise out of any negligent act or omission of Contractor; and (c) claims for damages because of injury to or destruction of tangible or intangible property, including loss of use resulting there from, which arise out of any negligent act or omission of Contractor.

(d) **Indemnities**

Contractor will indemnify Owner and hold it harmless from and against, and at Owner's option defend against, all claims, damages, losses and expenses as they are accrued, including court costs and reasonable fees and expenses of attorneys, expert witnesses and other professionals, arising out of or resulting from:

(I) any action by a third party against Owner that is based on any claim that any of Contractor's Services or their results, or Owner's use of their results, infringe a patent, copyright or other proprietary right or incorporates any misappropriated trade secrets;
(II) any action by a third party that is based on any negligent act or omission or willful conduct of Contractor or employees or contractors of Contractor and which results in: (I) any bodily injury, sickness, disease or death, (II) any injury or destruction to tangible or intangible property (including computer programs and data) or any loss of use resulting there from, or (iii) any violation of any statute, ordinance, or regulation; and
(III) Any determination by a court or agency that Contractor is not an independent contractor.

(e) **Solicitation of Employees, Customers**



Contractor agrees that during the term of this Agreement and for one (1) year following the termination of this Agreement, Contractor will not (I) directly or indirectly solicit, or attempt to solicit any employee of the Owner to terminate his or her relationship with the Owner in order to become an employee, Contractor or independent contractor for any other person or entity, or (II) solicit, interfere with, or endeavor to entice away from the Owner, any of its Customers that contractor or Contractor's assistants, employees or agents had contact with as a result of performing Services for the Owner.

7. **CONFLICTING OBGLIATIONS, TAINTED INFORMATION**

Contractor certifies that s/he has no outstanding agreement or obligation that is in conflict with any of the provisions of this Agreement, or that would preclude Contractor from complying with the provisions hereof, and further certifies that Contractor will not enter into any such conflicting agreement during the term of this Agreement. Moreover, Contractor represents and warrants that Contractor will not: (I) use, rely upon or obtain any benefit from any Tainted Information (as hereinafter defined) in rendering Services to the Owner (II) provide or disclose to Owner any information which Contractor believes or has reason to believe may be Tainted Information; or (III) induce any other person to use, rely upon or disclose to Owner Tainted Information in rendering Services to Owner. "Tainted Information" shall mean any trade secret or other nonpublic technical or business information of any kind of a third party, including but not limited to designs, computer programs, techniques, interfaces, protocols, file structures, marketing plans, product plans, business strategies, financial information, forecasts, personnel information, customer lists, or information relating to research, design, development, manufacturing or pricing, which such third party has not intentionally made generally known or disclosed through official announcement of disclosure.

8. **TERMINATION OF AGREEMENT**

Either party may terminate this Agreement on thirty day's written notice to the other party. Owner may terminate this Agreement for good cause immediately by written notice, and in that event Owner will not be liable to Contractor for any work performed by Contractor after such notice has been sent.

9. **GENERAL PROVISIONS**

(a) **No Assignment**

Neither this Agreement nor any duties, obligations or rights under it may be assigned by Contractor without the Owner's prior written consent. Any attempted assignment or delegation of this Agreement by Contractor without the express written consent of Owner will be void.

(b) **Notices**

Any notices in connection with this Agreement may be given by either party to the other, in writing, by personal delivery, by email, or by mail, registered or certified, postage prepaid with return receipt requested. Mailed notices shall be addressed to the parties at the addresses appearing in the introductory paragraph of this Agreement, but each party may change the address by written notice to the other party. Notices delivered personally will be deemed communicated as of actual receipt; mailed notices will be deemed communicated as of two days after mailing.

(c) **Entire Agreement of the Parties**

This Agreement, including supersedes any and all agreements, either oral or written, between the parties hereto with respect to the performance Services by Contractor for Owner and contains all the covenants and agreements between the parties with respect to the performance of such Services in any manner whatsoever.

Interior/Exterior Construction

Sign Name

Sign Name

NOTE: ANY CHANGE ORDERS MUST BE IN WRITING AND ALL MATERIALS APPROVAL SHEETS

Interior/Exterior Construction

Each party to this Agreement acknowledges that no representations, inducements, promises, or agreements, orally or otherwise, have been made by any party, or anyone acting on behalf of any party, which is not contained herein, and that no other agreement, statement or promise not contained in this Agreement shall be valid or binding. Any modification of this Agreement will be effective only if it is in writing signed by each party.

(d) **Headings**

Headings of sections and subsections in this Agreement have been included solely for convenience and reference and are not a part of this Agreement.

(e) **Severability**

If one or more of the provisions in this Agreement is deemed invalid, void or unenforceable by law, then the remaining provisions will continue in full force and effect. Moreover, if any one or more of the provisions contained in this Agreement shall be held to be excessively broad or partially invalid, illegal or unenforceable, it shall be construed by limiting and reducing it, so as to be enforceable to the extent compatible with the applicable law as it shall appear.

(f) **Waiver**

No waiver by the Owner of any breach of this Agreement shall be a waiver of any preceding or succeeding breach. No waiver by the Owner of any right under this Agreement shall be construed as a waiver of any other right.

(g) **Attorneys' Fees; Venue**

If any action at law or in equity, including an action for declaratory relief, is brought to enforce or interpret the provisions of this Agreement, the prevailing party will be entitled to reasonable attorneys' fees, which may be set by the court in the same action or in a separate action brought for that purpose, in addition to any other relief to which that party may be entitled. The parties agree that the exclusive venue for any litigation arising out of this Agreement shall be in the county and state where Owner has his/its principal place of business.

(h) **Governing Law**

This Agreement will be governed by and construed in accordance with the laws of the State of Texas.

Dated this 29th day of April, 2014

Owner

Contractor

Print Name

Sergio A. Chavez
Print Name

Interior/Exterior Construction

A motion was made by Commissioner Stevens and seconded by Commissioner Thompson to replace Steve Taliaferro, former County Attorney, with Thomas Duckworth, Jr., County Attorney, on signature card at West Texas State Bank; which motion became an order of the Court upon the following vote:

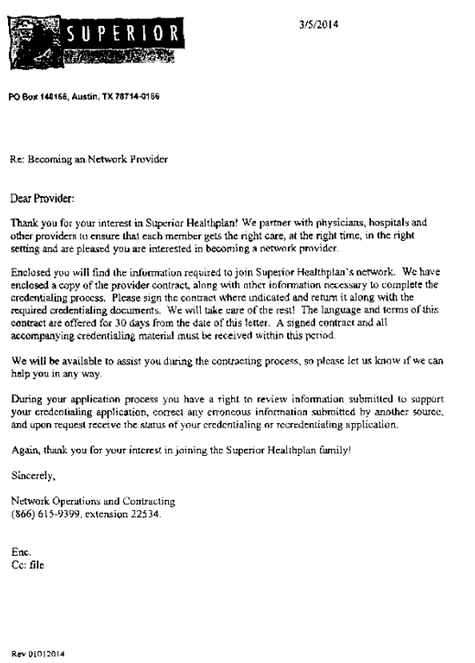
Ayes: Commissioners Stevens, Wolf, Neal and Thompson
Noes: None

A motion was made by Commissioner Neal and seconded by Commissioner Thompson to deny claim of Concord Medical Group, Inc.'s Claim Against Winkler County Memorial Hospital in the amount of $24,000.00; which motion became an order of the Court upon the following vote:

Ayes: Commissioners Stevens, Wolf, Neal and Thompson
Noes: None

A motion was made by Commissioner Thompson and seconded by Commissioner Neal to approve Participating Provider Agreement between Winkler County and Superior HealthPlan, Inc. to provide home meal delivery service for the term beginning September 01, 2014 for a one-year term, automatically renewing each year; which motion became an order of the Court upon the following vote:

Ayes: Commissioners Stevens, Wolf, Neal and Thompson
Noes: None



SUPERIOR

3/5/2014

PO Box 140166, Austin, TX 78714-0166

Re: Becoming an Network Provider

Dear Provider:

Thank you for your interest in Superior Healthplan! We partner with physicians, hospitals and other providers to ensure that each member gets the right care, at the right time, in the right setting and are pleased you are interested in becoming a network provider.

Enclosed you will find the information required to join Superior Healthplan's network. We have enclosed a copy of the provider contract, along with other information necessary to complete the credentialing process. Please sign the contract where indicated and return it along with the required credentialing documents. We will take care of the rest! The language and terms of this contract are offered for 30 days from the date of this letter. A signed contract and all accompanying credentialing material must be received within this period.

We will be available to assist you during the contracting process, so please let us know if we can help you in any way.

During your application process you have a right to review information submitted to support your credentialing application, correct any erroneous information submitted by another source, and upon request receive the status of your credentialing or recredentialing application.

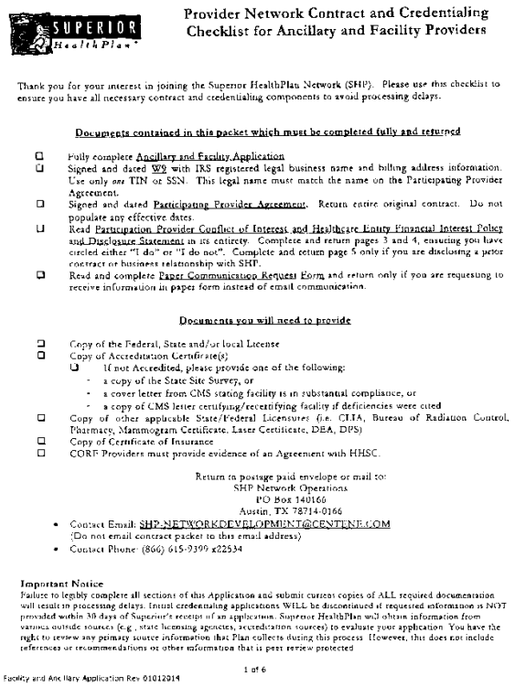
Again, thank you for your interest in joining the Superior Healthplan family!

Sincerely,

Network Operations and Contracting
(866) 615-9399, extension 22534.

Enc.
Cc: file

Rev 01012014



SUPERIOR HealthPlan

**Provider Network Contract and Credentialing Checklist for Ancillary and Facility Providers**

Thank you for your interest in joining the Superior HealthPlan Network (SHP). Please use this checklist to ensure you have all necessary contract and credentialing components to avoid processing delays.

**Documents contained in this packet which must be completed fully and returned**

- ☐ Fully complete Ancillary and Facility Application
- ☐ Signed and dated W9 with IRS registered legal business name and billing address information. Use only one TIN or SSN. This legal name must match the name on the Participating Provider Agreement.
- ☐ Signed and dated Participating Provider Agreement. Return entire original contract. Do not populate any effective dates.
- ☐ Read Participation Provider Conflict of Interest and Healthcare Entity Financial Interest Policy and Disclosure Statement in its entirety. Complete and return pages 3 and 4, ensuring you have circled either "I do" or "I do not". Complete and return page 5 only if you are disclosing a prior contract or business relationship with SHP.
- ☐ Read and complete Paper Communication Request Form and return only if you are requesting to receive information in paper form instead of email communication.

**Documents you will need to provide**

- ☐ Copy of the Federal, State and/or local License
- ☐ Copy of Accreditation Certificate(s)
  - ☐ If not Accredited, please provide one of the following:
    - a copy of the State Site Survey, or
    - a cover letter from CMS stating facility is in substantial compliance, or
    - a copy of CMS letter certifying/recertifying facility of deficiencies were cited
- ☐ Copy of other applicable State/Federal Licensures (i.e. CLIA, Bureau of Radiation Control, Pharmacy, Mammogram Certificate, Laser Certificate, DEA, DPS)
- ☐ Copy of Certificate of Insurance
- ☐ CORF Providers must provide evidence of an Agreement with HHSC.

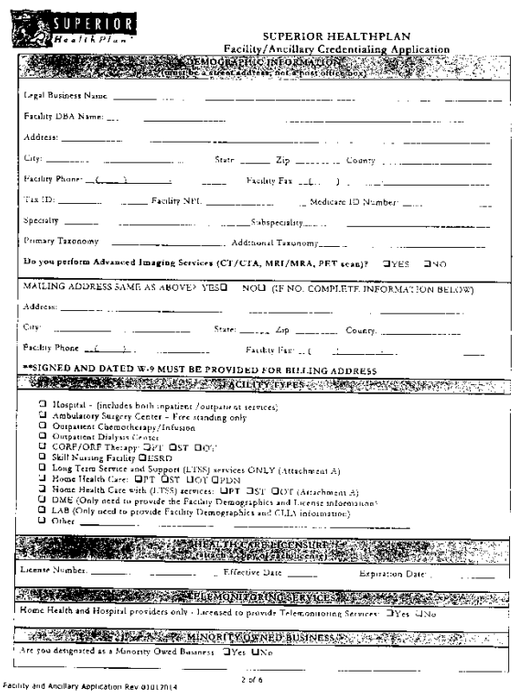
Return to postage paid envelope or mail to:
SHP Network Operations
PO Box 140166
Austin, TX 78714-0166

- Contact Email: SHP-NETWORKDEVELOPMENT@CENTENE.COM
  (Do not email contract packet to this email address)
- Contact Phone: (866) 615-9399 x22534

**Important Notice**
Failure to legibly complete all sections of this Application and submit current copies of ALL required documentation will result in processing delays. Initial credentialing applications WILL be discontinued if requested information is NOT provided within 30 days of Superior's receipt of an application. Superior HealthPlan will obtain information from various outside sources (e.g., state licensing agencies, accreditation sources) to evaluate your application. You have the right to review any primary source information that Plan collects during this process. However, this does not include references or recommendations or other information that is peer review protected

1 of 6

Facility and Ancillary Application Rev 01012014



SUPERIOR HealthPlan

**SUPERIOR HEALTHPLAN**
**Facility/Ancillary Credentialing Application**

DEMOGRAPHIC INFORMATION
(complete a street address not a post office box)

Legal Business Name: _____
Facility DBA Name: _____
Address: _____
City: _____ State: _____ Zip: _____ County: _____
Facility Phone: (___) _____ Facility Fax: (___) _____
Tax ID: _____ Facility NPI: _____ Medicare ID Number: _____
Specialty: _____ Subspecialty: _____
Primary Taxonomy: _____ Additional Taxonomy: _____
**Do you perform Advanced Imaging Services (CT/CTA, MRI/MRA, PET scan)?** ☐YES ☐NO

MAILING ADDRESS SAME AS ABOVE? YES☐ NO☐ (IF NO, COMPLETE INFORMATION BELOW)
Address: _____
City: _____ State: _____ Zip: _____ County: _____
Facility Phone: (___) _____ Facility Fax: (___) _____
****SIGNED AND DATED W-9 MUST BE PROVIDED FOR BILLING ADDRESS**

FACILITY TYPES

- ☐ Hospital - (includes both inpatient /outpatient services)
- ☐ Ambulatory Surgery Center – Free standing only
- ☐ Outpatient Chemotherapy/Infusion
- ☐ Outpatient Dialysis Center
- ☐ CORF/ORF Therapy: ☐PT ☐ST ☐OT
- ☐ Skill Nursing Facility ☐ESRD
- ☐ Long Term Service and Support (LTSS) services ONLY (Attachment A)
- ☐ Home Health Care: ☐PT ☐ST ☐OT ☐PDN
- ☐ Home Health Care with (LTSS) services: ☐PT ☐ST ☐OT (Attachment A)
- ☐ DME (Only need to provide the Facility Demographics and License information)
- ☐ LAB (Only need to provide Facility Demographics and CLIA information)
- ☐ Other _____

MEDICAL FACILITY LICENSURE
(Attach a copy of the License)

License Number: _____ Effective Date: _____ Expiration Date: _____

TELEMONITORING SERVICES

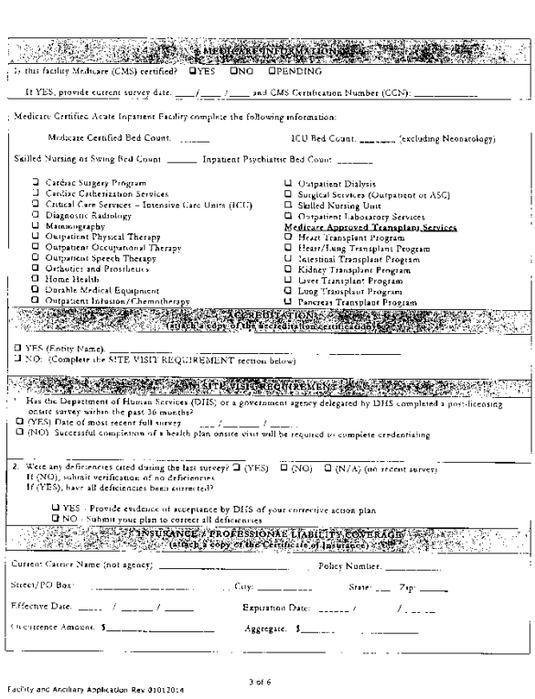
Home Health and Hospital providers only - Licensed to provide Telemonitoring Services: ☐Yes ☐No

MINORITY OWNED BUSINESS

Are you designated as a Minority Owned Business: ☐Yes ☐No

2 of 6

Facility and Ancillary Application Rev 01012014



MEDICARE CERTIFICATION

Is this facility Medicare (CMS) certified? ☐YES ☐NO ☐PENDING

If YES, provide current survey date: ___/___/___ and CMS Certification Number (CCN): _____

Medicare Certified Acute Inpatient Facility complete the following information:

Medicare Certified Bed Count: _____ ICU Bed Count: _____ (excluding Neonatology)

Skilled Nursing or Swing Bed Count: _____ Inpatient Psychiatric Bed Count: _____

- ☐ Cardiac Surgery Program
- ☐ Cardiac Catheterization Services
- ☐ Critical Care Services – Intensive Care Units (ICU)
- ☐ Diagnostic Radiology
- ☐ Mammography
- ☐ Outpatient Physical Therapy
- ☐ Outpatient Occupational Therapy
- ☐ Outpatient Speech Therapy
- ☐ Orthotics and Prosthetics
- ☐ Home Health
- ☐ Durable Medical Equipment
- ☐ Outpatient Infusion/Chemotherapy
- ☐ Outpatient Dialysis
- ☐ Surgical Services (Outpatient or ASC)
- ☐ Skilled Nursing Unit
- ☐ Outpatient Laboratory Services

**Medicare Approved Transplant Services**

- ☐ Heart Transplant Program
- ☐ Heart/Lung Transplant Program
- ☐ Intestinal Transplant Program
- ☐ Kidney Transplant Program
- ☐ Liver Transplant Program
- ☐ Lung Transplant Program
- ☐ Pancreas Transplant Program

ACCREDITATION
(Attach a copy of the accreditation certificate)

☐ YES (Entity Name): _____
☐ NO: (Complete the SITE VISIT REQUIREMENT section below)

SITE VISIT REQUIREMENT

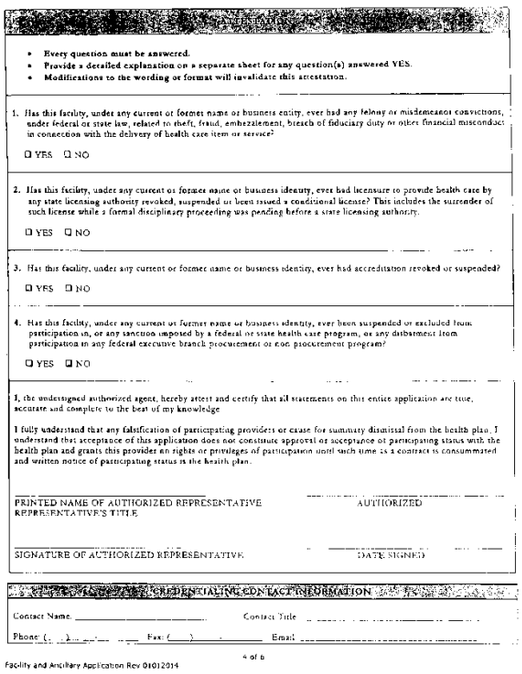
1. Has the Department of Human Services (DHS), or a government agency delegated by DHS completed a post-licensing onsite survey within the past 36 months?
   ☐ (YES) Date of most recent full survey: ___/___/___
   ☐ (NO) Successful completion of a health plan onsite visit will be required to complete credentialing
2. Were any deficiencies cited during the last survey? ☐ (YES) ☐ (NO) ☐ (N/A) (no recent survey)
   If (NO), submit verification of no deficiencies
   If (YES), have all deficiencies been corrected?
   - ☐ YES - Provide evidence of acceptance by DHS of your corrective action plan
   - ☐ NO - Submit your plan to correct all deficiencies

INSURANCE / PROFESSIONAL LIABILITY COVERAGE
(attach a copy of the Certificate of Insurance)

Current Carrier Name (not agency): _____ Policy Number: _____
Street/PO Box: _____ City: _____ State: ___ Zip: _____
Effective Date: ___/___/___ Expiration Date: ___/___/___
Occurrence Amount: $_____ Aggregate: $_____

3 of 6

Facility and Ancillary Application Rev 01012014



- **Every question must be answered.**
- **Provide a detailed explanation on a separate sheet for any question(s) answered YES.**
- **Modifications to the wording or format will invalidate this attestation.**

1. Has this facility, under any current or former name or business entity, ever had any felony or misdemeanor convictions, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty or other financial misconduct in connection with the delivery of health care item or service?

☐ YES ☐ NO

2. Has this facility, under any current or former name or business identity, ever had licensure to provide health care by any state licensing authority revoked, suspended or been issued a conditional license? This includes the surrender of such license while a formal disciplinary proceeding was pending before a state licensing authority.

☐ YES ☐ NO

3. Has this facility, under any current or former name or business identity, ever had accreditation revoked or suspended?

☐ YES ☐ NO

4. Has this facility, under any current or former name or business identity, ever been suspended or excluded from participation in, or any sanction imposed by a federal or state health care program, or any debarment from participation in any federal executive branch procurement or non-procurement program?

☐ YES ☐ NO

I, the undersigned authorized agent, hereby attest and certify that all statements on this entire application are true, accurate and complete to the best of my knowledge.

I fully understand that any falsification of participating providers or cause for summary dismissal from the health plan. I understand that acceptance of this application does not constitute approval or acceptance of participating status with the health plan and grants this provider an rights or privileges of participation until such time as a contract is consummated and written notice of participating status in the health plan.

PRINTED NAME OF AUTHORIZED REPRESENTATIVE / REPRESENTATIVE'S TITLE

AUTHORIZED

SIGNATURE OF AUTHORIZED REPRESENTATIVE

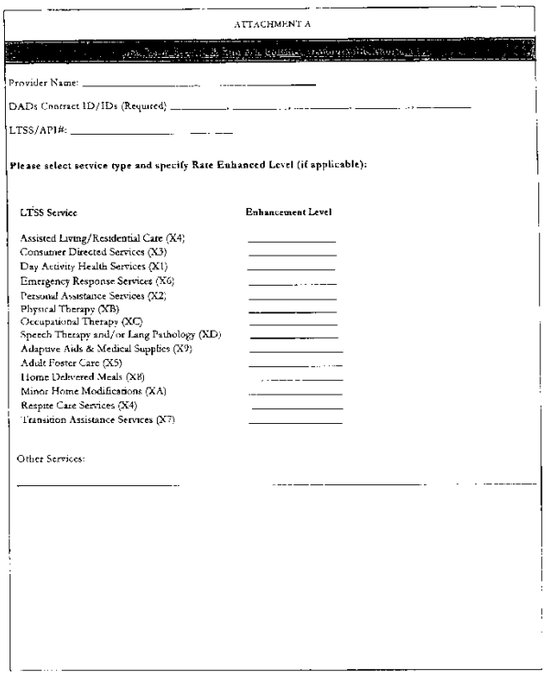
DATE SIGNED

CREDENTIALING CONTACT INFORMATION

Contact Name: _____ Contact Title _____

Phone: (___) ___-____ Fax: (___) ___-____ Email: _____





ATTACHMENT A

Provider Name: _____

DADs Contract ID/IDs (Required) _____

LTSS/API#: _____

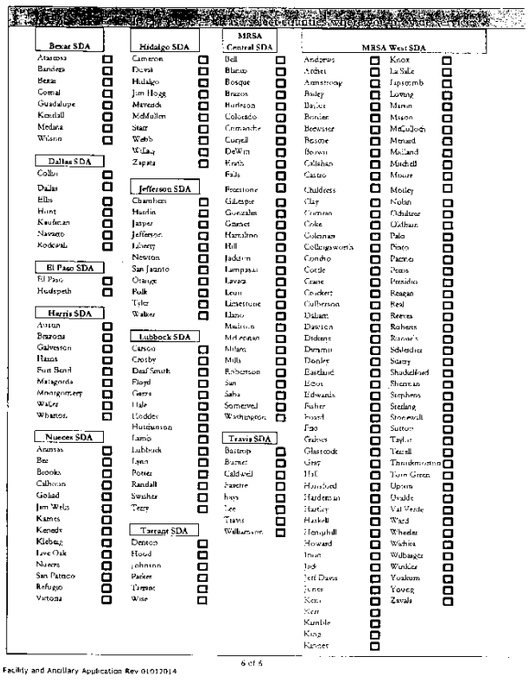
**Please select service type and specify Rate Enhanced Level (if applicable):**

| LTSS Service | Enhancement Level |
|---|---|
| Assisted Living/Residential Care (X4) | |
| Consumer Directed Services (X3) | |
| Day Activity Health Services (X1) | |
| Emergency Response Services (X6) | |
| Personal Assistance Services (X2) | |
| Physical Therapy (XB) | |
| Occupational Therapy (XC) | |
| Speech Therapy and/or Lang Pathology (XD) | |
| Adaptive Aids & Medical Supplies (X9) | |
| Adult Foster Care (X5) | |
| Home Delivered Meals (X8) | |
| Minor Home Modifications (XA) | |
| Respite Care Services (X4) | |
| Transition Assistance Services (X7) | |

Other Services:

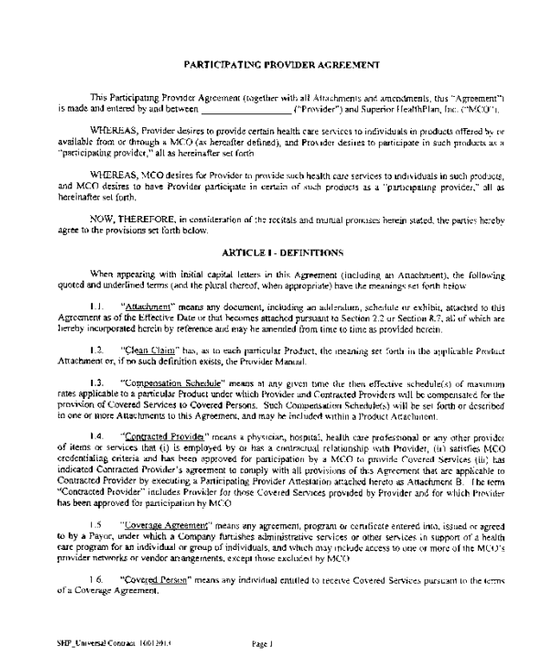
_____





| Bexar SDA | | Hidalgo SDA | | MRSA Central SDA | | MRSA West SDA | | | |
|---|---|---|---|---|---|---|---|---|---|
| Atascosa | ☐ | Cameron | ☐ | Bell | ☐ | Andrews | ☐ | Knox | ☐ |
| Bandera | ☐ | Duval | ☐ | Blanco | ☐ | Archer | ☐ | La Salle | ☐ |
| Bexar | ☐ | Hidalgo | ☐ | Bosque | ☐ | Armstrong | ☐ | Lipscomb | ☐ |
| Comal | ☐ | Jim Hogg | ☐ | Brazos | ☐ | Bailey | ☐ | Loving | ☐ |
| Guadalupe | ☐ | Maverick | ☐ | Burleson | ☐ | Baylor | ☐ | Marion | ☐ |
| Kendall | ☐ | McMullen | ☐ | Coleman | ☐ | Borden | ☐ | Mason | ☐ |
| Medina | ☐ | Starr | ☐ | Comanche | ☐ | Brewster | ☐ | McCulloch | ☐ |
| Wilson | ☐ | Webb | ☐ | Coryell | ☐ | Briscoe | ☐ | Menard | ☐ |
| | | Willacy | ☐ | DeWitt | ☐ | Brown | ☐ | Midland | ☐ |
| Dallas SDA | | Zapata | ☐ | Erath | ☐ | Callahan | ☐ | Mitchell | ☐ |
| Collin | ☐ | | | Falls | ☐ | Castro | ☐ | Moore | ☐ |
| Dallas | ☐ | Jefferson SDA | | Freestone | ☐ | Childress | ☐ | Motley | ☐ |
| Ellis | ☐ | Chambers | ☐ | Gillespie | ☐ | Clay | ☐ | Nolan | ☐ |
| Hunt | ☐ | Hardin | ☐ | Gonzales | ☐ | Coleman | ☐ | Oldham | ☐ |
| Kaufman | ☐ | Jasper | ☐ | Grimes | ☐ | Cooke | ☐ | Parmer | ☐ |
| Navarro | ☐ | Jefferson | ☐ | Hamilton | ☐ | Coleman | ☐ | Pale | ☐ |
| Rockwall | ☐ | Liberty | ☐ | Hill | ☐ | Collingsworth | ☐ | Pecos | ☐ |
| | | Newton | ☐ | Jackson | ☐ | Concho | ☐ | Potter | ☐ |
| El Paso SDA | | San Jacinto | ☐ | Lampasas | ☐ | Cottle | ☐ | Presidio | ☐ |
| El Paso | ☐ | Orange | ☐ | Lavaca | ☐ | Crane | ☐ | Reagan | ☐ |
| Hudspeth | ☐ | Polk | ☐ | Leon | ☐ | Crockett | ☐ | Real | ☐ |
| | | Tyler | ☐ | Limestone | ☐ | Culberson | ☐ | Reeves | ☐ |
| Harris SDA | | Walker | ☐ | Llano | ☐ | Dallam | ☐ | Roberts | ☐ |
| Austin | ☐ | | | Madison | ☐ | Dawson | ☐ | Runnels | ☐ |
| Brazoria | ☐ | Lubbock SDA | | Mclennan | ☐ | Dickens | ☐ | Schleicher | ☐ |
| Galveston | ☐ | Carson | ☐ | Milam | ☐ | Dimmit | ☐ | Shackelford | ☐ |
| Hanis | ☐ | Crosby | ☐ | Mills | ☐ | Donley | ☐ | Stanton | ☐ |
| Fort Bend | ☐ | Dad Smith | ☐ | Robertson | ☐ | Eastland | ☐ | Stephens | ☐ |
| Matagorda | ☐ | Floyd | ☐ | San | ☐ | Ector | ☐ | Sterling | ☐ |
| Montgomery | ☐ | Garza | ☐ | Saba | ☐ | Edwards | ☐ | Stonewall | ☐ |
| Waller | ☐ | Hale | ☐ | Somervel | ☐ | Fisher | ☐ | Sutton | ☐ |
| Wharton | ☐ | Hockley | ☐ | Washington | ☐ | Foard | ☐ | Taylor | ☐ |
| | | Huntington | ☐ | | | Fisher | ☐ | Terrell | ☐ |
| Nueces SDA | | Lamb | ☐ | Travis SDA | | Gaines | ☐ | Throckmorton | ☐ |
| Aransas | ☐ | Lubbock | ☐ | Bastrop | ☐ | Glasscock | ☐ | Tom Green | ☐ |
| Bee | ☐ | Lynn | ☐ | Burnet | ☐ | Gray | ☐ | Upton | ☐ |
| Brooks | ☐ | Potter | ☐ | Caldwell | ☐ | Hall | ☐ | Ozalde | ☐ |
| Calhoun | ☐ | Randall | ☐ | Fayette | ☐ | Howard | ☐ | Val Verde | ☐ |
| Goliad | ☐ | Swisher | ☐ | Ivey | ☐ | Hardeman | ☐ | Ward | ☐ |
| Jim Wells | ☐ | Terry | ☐ | Lee | ☐ | Harker | ☐ | Wheeler | ☐ |
| Kames | ☐ | | | Travis | ☐ | Haskell | ☐ | Wichita | ☐ |
| Kennedy | ☐ | Tarrant SDA | | Williamson | ☐ | Hemphill | ☐ | Wilbarger | ☐ |
| Kleberg | ☐ | Denton | ☐ | | | Howard | ☐ | Winkler | ☐ |
| Live Oak | ☐ | Hood | ☐ | | | Irion | ☐ | Yoakum | ☐ |
| Nueces | ☐ | Johnson | ☐ | | | Jack | ☐ | Young | ☐ |
| San Patricio | ☐ | Parker | ☐ | | | Jeff Davis | ☐ | Zavala | ☐ |
| Refugio | ☐ | Tarrant | ☐ | | | Jones | ☐ | | |
| Victoria | ☐ | Wise | ☐ | | | Kent | ☐ | | |
| | | | | | | Kerr | ☐ | | |
| | | | | | | Kimble | ☐ | | |
| | | | | | | King | ☐ | | |
| | | | | | | Kinney | ☐ | | |





**PARTICIPATING PROVIDER AGREEMENT**

This Participating Provider Agreement (together with all Attachments and amendments, this "Agreement") is made and entered by and between _____ ("Provider") and Superior HealthPlan, Inc. ("MCO").

WHEREAS, Provider desires to provide certain health care services to individuals in products offered by or available from or through a MCO (as hereafter defined), and Provider desires to participate in such products as a "participating provider," all as hereinafter set forth

WHEREAS, MCO desires for Provider to provide such health care services to individuals in such products, and MCO desires to have Provider participate in certain of such products as a "participating provider," all as hereinafter set forth.

NOW, THEREFORE, in consideration of the recitals and mutual promises herein stated, the parties hereby agree to the provisions set forth below.

**ARTICLE I - DEFINITIONS**

When appearing with initial capital letters in this Agreement (including an Attachment), the following quoted and underlined terms (and the plural thereof, when appropriate) have the meanings set forth below

1.1. "Attachment" means any document, including an addendum, schedule or exhibit, attached to this Agreement as of the Effective Date or that becomes attached pursuant to Section 2.2 or Section 8.7, all of which are hereby incorporated herein by reference and may be amended from time to time as provided herein.

1.2. "Clean Claim" has, as to each particular Product, the meaning set forth in the applicable Product Attachment or, if no such definition exists, the Provider Manual.

1.3. "Compensation Schedule" means at any given time the then effective schedule(s) of maximum rates applicable to a particular Product under which Provider and Contracted Providers will be compensated for the provision of Covered Services to Covered Persons. Such Compensation Schedule(s) will be set forth or described in one or more Attachments to this Agreement, and may be included within a Product Attachment.

1.4. "Contracted Provider" means a physician, hospital, health care professional or any other provider of items or services that (i) is employed by or has a contractual relationship with Provider, (ii) satisfies MCO credentialing criteria and has been approved for participation by a MCO to provide Covered Services (iii) has indicated Contracted Provider's agreement to comply with all provisions of this Agreement that are applicable to Contracted Provider by executing a Participating Provider Attestation attached hereto as Attachment B. The term "Contracted Provider" includes Provider for those Covered Services provided by Provider and for which Provider has been approved for participation by MCO

1.5. "Coverage Agreement" means any agreement, program or certificate entered into, issued or agreed to by a Payor, under which a Company furnishes administrative services or other services in support of a health care program for an individual or group of individuals, and which may include access to one or more of the MCO's provider networks or vendor arrangements, except those excluded by MCO

1.6. "Covered Person" means any individual entitled to receive Covered Services pursuant to the terms of a Coverage Agreement.

1.7. "Covered Services" means those services and items for which benefits are available and payable under the applicable Coverage Agreement and which are determined, if applicable, to be medically necessary under the applicable Coverage Agreement.

1.8. "Managed Care Organization" or "MCO" means (collectively or individually, as appropriate in the context) MCO and its affiliates, except those specifically excluded by MCO.

1.9. "Participating Provider" means, with respect to a particular Product, any physician, hospital, ancillary, or other health care provider that has contracted, directly or indirectly, with MCO to provide Covered Services to Covered Persons, and that is designated by the MCO as a "participating provider" in such Product.

1.10. "Payor" means the entity (including a MCO) that bears direct financial responsibility for paying from its own funds, without reimbursement from another entity, the cost of Covered Services rendered to Covered Persons under a Coverage Agreement and, if such entity is not a MCO, such entity contracts, directly or indirectly, with a MCO for the provision of certain administrative or other services with respect to such Coverage Agreement.

1.11. "Payor Contract" means the contract with a Payor, pursuant to which a MCO furnishes administrative services or other services in support of the Coverage Agreements entered into, issued or agreed to by a Payor, which services may include access to one or more of the MCO's provider networks or vendor arrangements, except those excluded by MCO. The term "Payor Contract" includes a MCO's or other Payor's contract with a governmental authority (also referred to herein as a "Governmental Contract") under which the MCO or Payor arranges for the provision of Covered Services to eligible individuals.

1.12. "Product" means any program or health benefit arrangement designated as a "product" by a MCO (e.g., PPO Product, HMO Product, Medicaid Product, Medicare Product, Payor-specific Product, etc.) that is now or hereafter offered by or available from or through MCO (and includes the Coverage Agreements that access, or are issued or entered into in connection with such product, except those excluded by MCO) that provides Covered Persons in such product with incentives or access to Participating Providers in such product.

1.13. "Product Attachment" means an Attachment setting forth certain requirements, terms and conditions specific to one or more Products, including certain provisions that must be included in a provider agreement under the laws of the State, which may be alternatives to, or in addition to, the requirements, terms and conditions set forth in this Agreement or the Provider Manual.

1.14. "Provider Manual" means the manuals, requirements, policies and procedures adopted by MCO to be followed by Participating Providers, including, without limitation, those relating to utilization management, quality management, grievances and appeals, and Product-specific, Payor-specific and State-specific requirements, as the same may be amended from time to time by the MCO.

1.15. "Regulatory Requirements" means all applicable statutes, regulations, regulatory guidance, judicial or administrative rulings, requirements of Governmental Contracts and standards and requirements of any accrediting or certifying organization, including, but not limited to, the requirements set forth in a Product Attachment.

1.16. "State" is defined as the state identified in the applicable Attachment

## ARTICLE II – PRODUCTS AND SERVICES

2.1. Contracted Providers. Provider shall, and shall cause each Contracted Provider, to comply with and abide by the agreements, representations, warranties, acknowledgements, certifications, terms and conditions of this Agreement (including the provisions of Attachment A that are applicable to Provider, the Contracted Provider, or their services, and the other Attachments), and the Provider Manual, and fulfill all of the duties, responsibilities and obligations imposed on Provider and Contracted Providers under this Agreement (including each Attachment), and the Provider Manual.



2.2. Participation in Products. Subject to the other provisions of this Agreement, each Contracted Provider may be identified as a "Participating Provider" in each Product identified in a Product Attachment designated on the signature page of this Agreement.

2.2.1. If MCO desires to add one or more Contracted Providers to an additional Product, the MCO will provide advance written notice (electronic or paper) thereof to Provider, along with the applicable Product Attachment and the new Compensation Schedule, if any. The applicable Contracted Providers will not be designated as Participating Providers in such additional Product if Provider opts out of such additional Product by giving the MCO written notice of its decision to opt-out within thirty (30) days of the MCO's giving of written notice. If Provider timely provides such opt-out notice, the applicable Contracted Providers will not constitute "Participating Providers" in such Product. If Provider does not timely provide such opt-out notice, then each applicable Contracted Provider shall be a Participating Provider in such additional Product on the terms and conditions set forth in this Agreement and the applicable Product Attachment.

2.2.2. A Contracted Provider may only identify itself as a Participating Provider for those Products in which the Contracted Provider actually participates as provided in this Agreement. Provider acknowledges that MCO or Payor may have, develop or contract to develop various Products or provider networks that have a variety of provider panels, program components and other requirements. No MCO or Payor warrants or guarantees that any Contracted Provider: (i) will participate in all or a minimum number of provider panels, (ii) will be utilized by a minimum number of Covered Persons, or (iii) will indefinitely remain a Participating Provider or member of the provider panel for a particular network or Product.

2.2.3. Attached hereto as C and/or D is the initial list of the Contracted Providers participating under this Agreement as of the Effective Date. Provider shall provide MCO on an annual basis or more often upon request with a list containing the names, office telephone numbers, tax identification numbers, hospital affiliations, specialties and board status (if applicable), addresses, State license number, and National Provider Identifier of Contracted Providers and such other information as mutually agreed upon by the parties, and shall provide the MCO with a list of modifications to such list at least thirty (30) days prior to the effective date of such changes, when possible. Provider shall provide such lists in a manner and format mutually acceptable to the parties.

2.2.4. Provider shall, at all times during the term of this Agreement, require all of its providers to participate (or be eligible and willing to participate) under this Agreement as "Contracted Providers." Subject to MCO's approval, Provider may add new providers to this Agreement as "Contracted Providers." In such case, Provider shall use best efforts to notify the MCO, in writing, of the prospective addition at least sixty (60) days in advance. Each such new provider may become a "Contracted Provider" once he, she or it meets the requirements contained elsewhere in this Agreement. Provider shall maintain written agreements with each of its Contracted Providers (other than Provider) that require the Contracted Providers to comply with the terms and conditions of this Agreement and that address and comply with the Regulatory Requirements.

2.3. Covered Services. Each Contracted Provider shall provide Covered Services described or referenced in the applicable Product Attachment(s) to Covered Persons in those Products in which the Contracted Provider is a Participating Provider, in accordance with this Agreement. Each Contracted Provider shall provide Covered Services to Covered Persons with the same degree of care and skill as customarily provided to patients who are not Covered Persons, within the scope of the Contracted Provider's license and in accordance with generally accepted standards of the Contracted Provider's practice and in accordance with the provisions of this Agreement, the Provider Manual, and Regulatory Requirements. Each Contracted Provider shall direct or refer Covered Persons to Participating Providers, unless otherwise authorized by MCO or Payor.

2.4. Provider Manual; Policies and Procedures. Provider and Contracted Providers shall at all times cooperate and comply with the requirements, policies, programs and procedures ("Policies") of MCO and Payor, which generally will be described in the Provider Manual and include, but are not limited to, the following: credentialing criteria and requirements; policies and procedures requiring notification for certain Covered Services; medical management programs including those components relating to quality improvement, utilization



management, disease management, and case management, and on-site reviews; grievance and appeal procedures; coordination of benefits and third party liability policies; and carve-out and third party vendor programs. The failure to comply with such Policies could result in a denial or reduction of payment to the Provider or Contracted Provider or a denial or reduction of the Covered Person's benefits. Such Policies do not in any way affect or remove the obligation of Contracted Providers to render care. MCO shall make the Provider Manual available to Provider and Contracted Providers via one or more designated websites or alternative means. Upon Provider's reasonable request, MCO shall provide Provider with a copy of the Provider Manual. In the event of a material change to the Provider Manual, MCO will use reasonable efforts to notify Provider in advance of such change. Such notice may be given by MCO through a periodic provider newsletter, an update to the on-line Provider Manual, or any other written method (electronic or paper).

2.5. Credentialing Criteria. Provider and each Contracted Provider agrees as follows: (a) that it is currently, and for the duration of this Agreement shall remain: (i) in compliance with all applicable Regulatory Requirements, including licensing laws; (ii) if applicable, accredited by The Joint Commission or the American Osteopathic Association; and (iii) a Medicare-certified provider under the federal Medicare program and a Medicaid participating provider under applicable federal and State laws; and (b) that all employees of Provider or the Contracted Provider will perform their duties in accordance with all Regulatory Requirements, as well as applicable national, State and local standards of professional ethics and practice. No Contracted Provider shall provide Covered Services to Covered Persons or identify itself as a Participating Provider unless and until the Contracted Provider has been notified, in writing, by the MCO that such Contracted Provider has successfully completed the MCO's credentialing process.

2.6. Eligibility Determinations. Provider or the Contracted Provider shall verify whether an individual seeking Covered Services is a Covered Person. MCO will make available to Provider and Contracted Providers a method, whereby Provider and Contracted Providers can obtain, in a timely manner, general information about eligibility and coverage. The MCO does not guarantee that persons identified as "Covered Persons" are eligible for benefits. If MCO, Payor or its delegate determines that an individual was not eligible for Covered Services at the time the services were rendered, such services shall not be eligible for payment under this Agreement.

2.7. Treatment Decisions. No MCO or Payor is liable for, nor will it exercise control over, the manner or method by which a Contracted Provider provides items or services under this Agreement. Provider and Contracted Providers understand that determinations of a MCO or Payor that certain items or services are not Covered Services or have not been provided or billed in accordance with the requirements of this Agreement or the Provider Manual are administrative decisions only. Such decisions do not absolve the Contracted Provider of its responsibility to exercise independent judgment in treatment decisions relating to Covered Persons. Nothing in this Agreement (i) is intended to interfere with Contracted Provider's relationship with Covered Persons, or (ii) prohibits or restricts a Contracted Provider from disclosing to any Covered Person any information that the Contracted Provider deems appropriate regarding health care quality or medical treatment decisions or alternatives.

2.8. Carve-Out Vendors. Provider acknowledges that MCO may, during the term of this Agreement, carve-out certain Covered Services from its general provider contracts, including this Agreement, for one or more Products as the Company deems necessary or appropriate. Provider and Contracted Providers shall cooperate with and, when medically appropriate, utilize all third party vendors designated by MCO for those Covered Services identified by MCO from time to time for a particular Product.

2.9. Disparagement Prohibition. Provider, each Contracted Provider and the officers of MCO shall not disparage the other during the term of this Agreement or in connection with any expiration, termination or non-renewal of this Agreement. Neither Provider nor Contracted Provider shall interfere with MCO's direct or indirect contractual relationships including, but not limited to, those with Covered Persons or other Participating Providers. Nothing in this provision should be construed as limiting the ability of either party or a Contracted Provider to inform Covered Persons that this Agreement has been terminated or otherwise expired or, with respect to Provider, to promote Provider to the general public or to post information regarding other health plans consistent with Provider's usual procedures, provided that no such promotion or advertisement is specifically directed at one or more Covered Persons. In addition, nothing in this provision should be construed as limiting MCO's ability to use



and disclose information and data obtained from or about Provider or Contracted Provider, including this Agreement, to the extent determined reasonably necessary or appropriate by MCO in connection with its efforts to comply with Regulatory Requirements and to communicate with regulatory authorities.

2.10. Nondiscrimination. Provider and each Contracted Provider will provide Covered Services to Covered Persons without discrimination on account of race, sex, sexual orientation, age, color, religion, national origin, place of residence, health status, type of Payor, source of payment (e.g., Medicaid generally or a State-specific health care program), physical or mental disability or veteran status, and will ensure that its facilities are accessible as required by Title III of the Americans With Disabilities Act of 1991. Provider and Contracted Providers recognize that, as a governmental contractor, MCO or Payor may be subject to various federal laws, executive orders and regulations regarding equal opportunity and affirmative action, which also may be applicable to subcontractors, and Provider and each Contracted Provider agree to comply with such requirements.

2.11. Notice of Certain Events. Provider shall give written notice to MCO of: (i) any event of which notice must be given to a licensing or accreditation agency or board; (ii) any change in the status of Provider's or the Contracted Provider's license; (iii) termination, suspension, exclusion or voluntary withdrawal of Provider or the Contracted Provider from any state or federal health care program, including but not limited to Medicaid; or (iv) any lawsuit or claim filed or asserted against Provider or the Contracted Provider alleging professional malpractice involving a Covered Person. In any instance described in subsection (i)-(iii) above, Provider must notify MCO in writing within ten (10) days, and in any such instance described in subsection (iv) above, Provider must notify MCO in writing within thirty (30) days, from the date it first obtains knowledge of the same.

2.12. Use of Name. Provider and each Contracted Provider hereby authorize each MCO to use their respective names, telephone numbers, addresses, specialties, certifications, hospital affiliations (if any), and other descriptive characteristics of their facilities, practices and services for the purpose of identifying the Contracted Providers as "Participating Providers" in the applicable Products. Provider and Contracted Providers may only use the name of the applicable Companies for purposes of identifying the Products in which they participate, and may not use the registered trademark or service mark of a MCO without the MCO's prior written consent.

2.13. Compliance with Regulatory Requirements and Payor Contracts. Provider, each Contracted Provider and MCO agree to carry out their respective obligations under this Agreement and the Provider Manual in accordance with all applicable Regulatory Requirements, including, but not limited to, the requirements of the Health Insurance Portability and Accountability Act, as amended, and any regulations promulgated thereunder. If, due to Provider's or Contracted Provider's noncompliance with applicable Regulatory Requirements or this Agreement, sanctions or penalties are imposed on MCO , the MCO may, in its sole discretion, offset such amounts against any amounts due Provider or Contracted Providers from any Company or require Provider or the Contracted Provider to reimburse the MCO for such amounts.

## ARTICLE III – CLAIMS SUBMISSION, PROCESSING, AND COMPENSATION

3.1. Claims or Encounter Submission. As provided in the Provider Manual, Contracted Providers shall submit to the MCO or its delegate claims for payment for Covered Services rendered to Covered Persons. Contracted Provider shall submit encounter data to the MCO or its delegate in a timely fashion, which must contain statistical and descriptive medical and patient data and identifying information, if and as required in the Provider Manual. Payor or its delegate reserves the right to deny payment to the Contracted Provider if the Contracted Provider fails to submit claims for payment or encounters in accordance with the Provider Manual.

3.2. Compensation. The compensation for Covered Services provided to a Covered Person ("Compensation Amount") will be the appropriate amount under the applicable Compensation Schedule in effect on the date of service for the Product in which the Covered Person participates. Subject to the terms of this Agreement and the Provider Manual, Provider and Contracted Providers shall accept the Compensation Amount as payment in full for the provision of Covered Services hereunder. The applicable Payor shall pay or arrange for payment of each Clean Claim received from a Contracted Provider for Covered Services provided to a Covered

Person in accordance with the applicable Compensation Amount less any applicable copayments, cost-sharing or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement.

3.3. Financial Incentives. The parties acknowledge and agree that nothing in this Agreement shall be construed to create any financial incentive for Provider or a Contracted Provider to withhold Covered Services.

3.4. Hold Harmless. Provider and each Contracted Provider agree that in no event, including but not limited to non-payment by a Payor, a Payor's insolvency, or breach of this Agreement, shall Provider or a Contracted Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Covered Person for Covered Services provided under this Agreement. This provision shall not prohibit collection of any applicable copayments, cost-sharing or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement. This provision survives termination or expiration of this Agreement for any reason, will be construed for the benefit of Covered Persons, and supersedes any oral or written agreement entered into between Provider or a Contracted Provider and a Covered Person.

3.5. Recovery Rights. Payor will provide written or electronic notice to Provider or Contracted Provider before using an offset as a means to recover an overpayment or payment made in error, and will not implement the offset or other recoupment action if, within forty five (45) days after the date of notice, Provider or Contracted Provider refunds the overpayment or payment made in error, or initiates an appeal. The written or electronic notice shall explain the reason and calculation of the overpayment or payment made in error. Appeals shall be made pursuant to procedures outlined in the Provider Manual. Provider and Contracted Providers agree that all recoupment and any offset rights under this Agreement will constitute lawful rights of recoupment and that such rights will not be subject to any requirement of prior or other approval from any court or other government authority that may now have or hereafter have jurisdiction over Provider or a Contracted Provider. The written or electronic notice prior to use of an offset and the appeal rights described above shall not apply in situations where the State has determined that a Covered Person was ineligible and the State recoups premium from Payor based on that Covered Person's ineligibility. Payor may recoup related payments made to Provider or Contracted Provider for an ineligible Covered Person.

## ARTICLE IV – RECORDS AND INSPECTIONS

4.1. Records. Each Contracted Provider shall maintain medical, financial and administrative records related to items or services provided to Covered Persons, including but not limited to a complete and accurate permanent medical record for each such Covered Person, in such form and detail as are required by applicable Regulatory Requirements and consistent with generally accepted medical standards.

4.2. Access. Provider and each Contracted Provider shall provide access to their respective books and records to each of the following, including any delegate or duly authorized agent thereof, subject to applicable Regulatory Requirements: (i) the applicable MCO and Payors, during regular business hours and upon prior notice; (ii) government agencies, to the extent such access is necessary to comply with Regulatory Requirements; and (iii) accreditation organizations. Provider and each Contracted Provider shall provide copies of such records at no expense to any of the foregoing that may make such request. Each Contracted Provider also shall obtain any authorization or consent that may be required from a Covered Person in order to release medical records and information to MCO or Payor or any of their delegates. Provider and each Contracted Provider shall cooperate in and allow on-site inspections of their facilities and records by any MCO, Payor, their delegates, any authorized government officials, and accreditation organizations. Provider and each Contracted Provider shall compile information necessary for the expeditious completion of such on-site inspection in a timely manner.

4.3. Record Transfer. Subject to applicable Regulatory Requirements, Provider and each Contracted Provider shall cooperate in the timely transfer of Covered Persons' medical records to any other health care provider, at no charge and when required.



## ARTICLE V – INSURANCE AND INDEMNIFICATION

5.1. Insurance. During the term of this Agreement Provider and each Contracted Provider shall maintain policies of general and professional liability insurance and other insurance that are necessary to insure Provider and such Contracted Provider, respectively; their respective employees; and any other person providing services hereunder on behalf of Provider or such Contracted Provider, as applicable, against any claim(s) of personal injuries or death alleged or caused by their performance under this Agreement. Such insurance shall include, but not be limited to, any "tail" or prior acts coverage necessary to avoid any gap in coverage. Insurance shall be through a licensed carrier, and in a minimum amount of one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) in the aggregate (for Hospital Providers) or in a minimum amount of one hundred thousand dollars ($100,000) per occurrence and three hundred thousand dollars ($300,000) in the aggregate (for all other Providers), unless a lesser amount is accepted by MCO or where State law mandates otherwise. Provider and each Contracted Provider will provide MCO with at least fifteen (15) days notice of such cancellation, non-renewal, lapse, or adverse material modification of such coverage. Upon MCO's request, Provider and each Contracted Provider will furnish MCO with evidence of such insurance.

5.2. Indemnification by Provider and Contracted Provider. Provider and each Contracted Provider shall indemnify and hold harmless (and at MCO's request defend) each Company and Payor and all of their respective officers, directors, agents and employees from and against any and all third party claims for any loss, damages, liability, costs, or expenses (including reasonable attorney's fees) arising from or relating to any negligence, wrongful act or omission, or breach of this Agreement by Provider, a Contracted Provider, or any of their respective officers, directors, agents or employees.

5.3. Indemnification by MCO. MCO agrees to indemnify and hold harmless (and at Provider's request defend) Provider, Contracted Providers, and their officers, directors, agents and employees from and against any and all third party claims for any loss, damages, liability, costs, or expenses (including reasonable attorney's fees) arising from or relating to any negligence, wrongful act or omission or breach of this Agreement by MCO or its directors, officers, agents or employees.

## ARTICLE VI – DISPUTE RESOLUTION

6.1. Informal Dispute Resolution. Except as provided below or superseded by applicable Regulatory Requirements, any dispute between the parties (or involving a Contracted Provider) with respect to or involving the performance under, termination of, or interpretation of this Agreement, or any other claim or cause of action, whether sounding in tort, contract or under statute (a "Dispute") shall first be addressed by exhausting the applicable procedures in the Provider Manual pertaining to claims payment, credentialing, utilization management, or other programs. If, at the conclusion of these applicable procedures, the matter is not resolved to each of the parties' satisfaction, or if there are no applicable procedures in the Provider Manual, then the parties agree that they shall engage in a period of good faith negotiations between designated representatives of the parties who have authority to settle the Dispute, which negotiations may be initiated by either party upon written request to the other, provided such request takes place within one year of the date on which the requesting party first had, or reasonably should have had, knowledge of the event(s) giving rise to the Dispute. If the matter has not been resolved within sixty (60) days of such request, either party may, as its sole and exclusive forum for the litigation of the Dispute or any part thereof, initiate arbitration pursuant to Section 6.2 below by providing written notice to the other party.

6.2. Arbitration. Either party wishing to pursue the Dispute as provided in Section 6.1 shall submit it to binding arbitration conducted in accordance with the Commercial Arbitration Rules of the American Arbitration Association ("AAA"). In no event may any arbitration be initiated more than one (1) year following, as applicable, the end of the sixty (60) day negotiation period set forth in Section 6.1, or the date of notice of termination. Arbitration proceedings shall be conducted by an arbitrator chosen from the National Healthcare Panel at a mutually agreed upon location within the State. The arbitrator shall not award any punitive or exemplary damages of any kind, shall not vary or ignore the provisions of this Agreement, and shall be bound by controlling law. The parties and the Contracted Providers, on behalf of themselves and those that they may now or hereafter represent,



agree to and do hereby waive any right to pursue, on a class basis, any Dispute. Each party shall bear its own costs and attorneys' fees related to the arbitration except that the AAA's Administrative Fees, all Arbitrator Compensation and travel and other expenses, and all costs of any proof produced at the direct request of the arbitrator shall be borne equally by the parties, and the arbitrator shall not have the authority to order otherwise. The existence of a Dispute or arbitration proceeding shall not in and of itself constitute cause for termination of this Agreement. Except as hereafter provided, during an arbitration proceeding, each party shall continue to perform its obligations under this Agreement pending the decision of the arbitrator. Nothing herein shall bar a party from seeking emergency injunctive relief to preclude any actual or perceived breach of this Agreement, although such party shall be obligated to file and pursue arbitration at the earliest reasonable opportunity. Judgment on the award rendered may be entered in any court having jurisdiction thereof. Nothing contained in this Article VI shall limit a party's right to terminate this Agreement with or without cause in accordance with Section 7.2.

## ARTICLE VII – TERM AND TERMINATION

7.1. Term. This Agreement is effective as of the effective date designated by MCO on the signature page of this Agreement ("Effective Date"), and will remain in effect for an initial term of one (1) year(s), after which it will automatically renew for terms of one (1) year each, unless this Agreement is sooner terminated as provided in this Agreement or either party gives the other party written notice of non-renewal of this Agreement not less than ninety (90) days prior to the renewal date of this Agreement. In addition, either party may elect to not renew a Contracted Provider's participation as a Participating Provider in a particular Product, effective as of the renewal date of this Agreement, by giving the others written notice of such non-renewal not less than ninety (90) days prior to the renewal date of this Agreement, in such event, Provider shall immediately notify the affected Contracted Provider of such non-renewal.

7.2. Termination. This Agreement, or the participation of Provider or a Contracted Provider as a Participating Provider in one or more Products, may be terminated or suspended as set forth below.

7.2.1. Upon Notice. This Agreement may be terminated by either party giving the other party at least ninety (90) days prior written notice of such termination. The participation of any Contracted Provider as a Participating Provider in a Product may be terminated by either party giving the other party at least ninety (90) days prior written notice of such termination; in such event, Provider shall immediately notify the affected Contracted Provider of such termination.

7.2.2. With Cause. This Agreement, or the participation of any Contracted Provider as a Participating Provider in one or more Products under this Agreement, may be terminated by either party giving at least sixty (60) days prior written notice of termination to the other party if such other party (or the applicable Contracted Provider) is in breach of any material term or condition of this Agreement and such other party (or the Contracted Provider) fails to cure the breach within the thirty (30) day period immediately following the giving of written notice of such breach. Any notice given pursuant to this Section 7.2.2 must describe the specific breach. In the case of a termination of a Contracted Provider, Provider shall immediately notify the affected Contracted Provider of such termination.

7.2.3. Suspension of Participation. Unless expressly prohibited by applicable Regulatory Requirements, MCO has the right to immediately suspend or terminate the participation of a Contracted Provider in any or all Products by giving written notice thereof to Provider when (i) based upon available information, the continued participation of the Contracted Provider appears to constitute an immediate threat or risk to the health, safety or welfare of Covered Persons, or (ii) the Contracted Provider's fraud, malfeasance or non-compliance with Regulatory Requirements is reasonably suspected. Provider shall immediately notify the affected Contracted Provider of such suspension. During such suspension, the Contracted Provider shall, as directed by MCO, discontinue the provision of all or a particular Covered Service to Covered Persons. During the term of any suspension, the Contracted Provider shall notify Covered Persons that his or her status as a Participating Provider has been suspended. Such suspension will continue until the Contracted Provider's participation is reinstated or terminated.



7.2.4. Insolvency. This Agreement may be terminated immediately by a party giving written notice thereof to the other party if the other party is insolvent or has bankruptcy proceedings initiated against it.

7.2.5. Credentialing. The status of a Contracted Provider as a Participating Provider in one or more Products may be terminated immediately by MCO giving written notice thereof to Provider if the Contracted Provider fails to adhere to MCO's credentialing criteria, including, but not limited to, if the Contracted Provider (1) loses, relinquishes, or has materially affected its license to provide Covered Services in the State, (2) fails to comply with the insurance requirements set forth in this Agreement, or (3) is convicted of a criminal offense related to involvement in any state or federal health care program or has been terminated, suspended, barred, voluntarily withdrawn as part of a settlement agreement, or otherwise excluded from any state or federal health care program. Provider shall immediately notify the affected Contracted Provider of such termination.

7.3. Effect of Termination. After the effective date of termination of this Agreement or a Contracted Provider's participation in a Product, this Agreement shall remain in effect for purposes of those obligations and rights arising prior to the effective date of termination. Upon such a termination, each affected Contracted Provider (including Provider, if applicable) shall (i) continue to provide Covered Services to Covered Persons in the applicable Product(s) during the longer of the ninety (90) day period following the date of such termination or such other period as may be required under any Regulatory Requirements, and, if requested by MCO, each affected Contracted Provider (including Provider, if applicable) shall continue to provide, as a Participating Provider, Covered Services to Covered Persons until such Covered Persons are assigned or transferred to another Participating Provider in the applicable Product(s), and (ii) continue to comply with and abide by all of the applicable terms and conditions of this Agreement, including, but not limited to, Section 3.4 (Hold Harmless) hereof, in connection with the provision of such Covered Services during such continuation period. During such continuation period, each affected Contracted Provider (including Provider, if applicable) will be compensated in accordance with this Agreement and shall accept such compensation as payment in full.

7.4. Survival of Obligations. All provisions hereof that by their nature are to be performed or complied with following the expiration or termination of this Agreement, including without limitation Sections 2.8, 2.10, 3.2, 3.4, 3.5, 4.2, 5.2, 5.3, 6.2, 7.3, and 7.4 and Article VIII, survive the expiration or termination of this Agreement.

## ARTICLE VIII – MISCELLANEOUS

8.1. Relationship of Parties. The relationship among the parties is that of independent contractors. None of the provisions of this Agreement will be construed as creating any agency, partnership, joint venture, employee-employer, or other relationship.

8.2. Conflicts Between Certain Documents. If there is any conflict between this Agreement and the Provider Manual, this Agreement will control. In the event of any conflict between this Agreement and any Product Attachment, the Product Attachment will control as to such Product.

8.3. Assignment. This Agreement is intended to secure the services of and be personal to Provider and may not be assigned, sublet, delegated or transferred by Provider without MCO's prior written consent. MCO shall have the right, exercisable in its sole discretion, to assign or transfer all or any portion of its rights or to delegate all or any portion of its interests under this Agreement or any Attachment to an Affiliate, successor of MCO, or purchaser of the assets or stock of MCO, or the line of business or business unit primarily responsible for carrying out MCO's obligations under this Agreement.

8.4. Headings. The headings of the sections of this Agreement are inserted merely for the purpose of convenience and do not limit, define, or extend the specific terms of the section so designated.

8.5. Governing Law. The interpretation of this Agreement and the rights and obligations of the parties hereto will be governed by and construed in accordance with applicable federal and State laws.

8.6. Third Party Beneficiary. This Agreement is entered into by the parties signing it for their benefit and the benefit of each Company. Except as specifically provided in Section 3.4 hereof, no Covered Person or third party, other than MCO, will be considered a third party beneficiary of this Agreement.

8.7. Amendment. Except as otherwise provided in this Agreement, this Agreement may be amended only by written agreement of duly authorized representatives of the parties.

8.7.1. MCO may amend this Agreement by giving Provider written notice of the amendment to the extent such amendment is deemed necessary or appropriate by MCO to comply with any Regulatory Requirements. Any such amendment will be deemed accepted by Provider upon the giving of such notice.

8.7.2. MCO may amend this Agreement by giving Provider written notice (electronic or paper) of the proposed amendment. Unless Provider notifies MCO in writing of its objection to such amendment to the base agreement or any of its attachments during the thirty (30) day period following the giving of such notice by MCO, Provider shall be deemed to have accepted the amendment. If Provider objects to any proposed amendment, MCO may exclude one or more of the Contracted Providers from being Participating Providers in the applicable Product or Products (or any component program of, or Coverage Agreement in connection with, such Product or Products).

8.8. Entire Agreement. All prior or concurrent agreements, promises, negotiations or representations either oral or written, between the MCO and Provider relating to a subject matter of this Agreement, which are not expressly set forth in this Agreement, are of no force or effect.

8.9. Severability. The invalidity or unenforceability of any terms or provisions hereof will in no way affect the validity or enforceability of any other terms or provisions.

8.10. Waiver. The waiver by either party of the violation of any provision or obligation of this Agreement will not constitute the waiver of any subsequent violation of the same or other provision or obligation.

8.11. Notices. Except as otherwise provided in this Agreement, any notice required or permitted to be given hereunder is deemed to have been given when such written notice has been personally delivered or deposited in the United States mail, postage paid, or delivered by a service that provides written receipt of delivery, addressed as follows:

| To MCO at: | To Provider at: |
|---|---|
| Attn. President | Attn: |
| Superior HealthPlan, Inc. | _____ |
| 2100 South IH-35, Suite 202 | |
| Austin, TX 78704 | |

or to such other address as such party may designate in writing.

8.12. Force Majeure. Neither party shall be liable or deemed to be in default for any delay or failure to perform any act under this Agreement resulting, directly or indirectly, from acts of God, civil or military authority, acts of public enemy, war, accidents, fires, explosions, earthquake, flood, strikes or other work stoppages by either party's employees, or any other similar cause beyond the reasonable control of such party.

8.13. Proprietary Information. Neither party shall disclose to a third party the substance of this Agreement, or any information of a confidential nature acquired from the other party during the course of this Agreement, except to agents of such party as necessary for such party's performance under this Agreement, or as



required by a Payor Contract or applicable Regulatory Requirements. Provider acknowledges and agrees that all information relating to a Company's programs, policies, protocols and procedures is proprietary information and Provider shall not disclose such information to any person or entity without MCO's express written consent.

8.14. Authority. The individuals whose signatures are set forth below represent and warrant that they are duly empowered to execute this Agreement. Provider represents and warrants that it has all legal authority to contract on behalf of and to bind all Contracted Providers to the terms of the Agreement with MCO.

* * * * *



**THIS AGREEMENT CONTAINS A BINDING ARBITRATION PROVISION THAT MAY BE ENFORCED BY THE PARTIES.**

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the date set forth beneath their respective signatures.

| | |
|---|---|
| **Superior HealthPlan, Inc.** | _____ (Legibly Print Name of Provider) |
| Signature: _____ | Signature: _____ |
| Print Name: Michael Diel | Print Name: _____ |
| Title: SVP Network Development and Contracting | Title: _____ |
| Date: _____ | Date: _____ |
| | Tax Identification Number: _____ |

| **To be completed by MCO only:** |
|---|
| Effective Date of Agreement: |

| Included in Agreement | Attachment/Exhibit |
|---|---|
| X | Attachment – Contracted Provider – Specific Provisions |
| X | Attachment – State Mandated Provisions |
| X | Attachment – Participating Provider Attestation |
| X | Attachment – Participating Facility/Provider Listing |
| X | Attachment – STAR, STAR+PLUS, CHIP, CHIP Perinate Product Attachment |
| X | Attachment – Medicaid Comprehensive Healthcare Program for Foster Care Product Attachment |
| X | Attachment – Compensation Schedule - STAR, STAR+PLUS, CHIP, CHIP Perinate, STAR Health |
| X | Attachment – Medicare Advantage Product Attachment |
| X | Exhibit of Attachment – Compensation Schedule – Medicare Advantage |
| X | Attachment – Commercial Exchange Product Attachment |
| X | Exhibit of Attachment – Commercial Exchange Regulatory Requirements |
| X | Exhibit of Attachment – Compensation Schedule – Commercial Exchange |

| **To be complete by MCO only:** | |
|---|---|
| **Provider Product Participation** | **Effective Date of Agreement** |
| CHIP and CHIP Perinate | |
| STAR | |
| STAR+PLUS | |
| Foster Care (STAR Health) | |
| Medicare Advantage | |
| Commercial Exchange | |



**ATTACHMENT A**
**CONTRACTED PROVIDER-SPECIFIC PROVISIONS**

Provider and Contracted Providers shall comply with the applicable provisions of this Exhibit.

1. Hospitals. If Provider or a Contracted Provider is a hospital ("Hospital"), the following provisions apply.

1.1 24 Hour Coverage. Each Hospital shall be available to provide Covered Services to Covered Persons twenty-four (24) hours per day, seven (7) days per week.

1.2 Emergency Care. Each Hospital shall provide Emergency Care (as hereafter defined) in accordance with Regulatory Requirements. The Contracted Provider shall notify Company's medical management department of any emergency room admissions by electronic file sent within twenty-four (24) hours or by the next business day of such admission. "Emergency Care" (or derivative thereof) has, as to each particular Product, the meaning set forth in the applicable Coverage Agreement or Product Attachment. If there is no definition in such documents, "Emergency Care" means inpatient and/or outpatient Covered Services furnished by a qualified provider that are needed to evaluate or stabilize an Emergency Medical Condition. "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

1.3 Staff Privileges. Each Hospital shall assist in granting staff privileges or other appropriate access to Company's Participating Providers who are qualified medical or osteopathic physicians, provided they meet the reasonable standards of practice and credentialing standards established by the Hospital's medical staff and bylaws, rules, and regulations.

1.4 Discharge Planning. Each Hospital agrees to cooperate with Company's system for the coordinated discharge planning of Covered Persons, including the planning of any necessary continuing care.

1.5 Credentialing Criteria. Each Hospital shall (a) currently, and for the duration of this Agreement, remain accredited by the Joint Commission or American Osteopathic Association, as applicable, and (b) ensure that all employees of Hospital perform their duties in accordance with all applicable local, State and federal licensing requirements and standards of professional ethics and practice.

1.6 Cancellation of Product Orders. A Hospital that offers delivery services for Covered Services and products, such as durable medical equipment (DME), limited home health supplies (LHHS), or outpatient drugs or biological products must reduce, cancel, or stop delivery if the Covered Person or the Covered Person's authorized representative submits an oral or written request. The Hospital must maintain records documenting the request.

2. Practitioners. If Provider or Contracted Provider is a physician or other health care practitioner (including physician extenders) ("Practitioner"), the following provisions apply.

2.1 Contracted Professional Qualifications. At all times during the term of this Agreement, Practitioner shall, as applicable, maintain medical staff membership and admitting privileges with at least one hospital that is a Participating Provider ("Participating Hospital") with respect to each Product in which the Practitioner participates. Upon Company's request, Practitioner shall furnish evidence of the foregoing to Company. If Practitioner does not have such admitting privileges, Provider or the Practitioner shall provide Company with a written statement from another Participating Provider who has such admitting privileges, in good standing, certifying that such individual agrees to assume responsibility for providing inpatient Covered Services to Covered Persons who are patients of the applicable Practitioner.

2.2 Acceptance of New Patients. To the extent that Practitioner is accepting new patients, such Practitioner must also accept new patients who are Covered Persons with respect to the Products in which such Practitioner participates. Practitioner shall notify Company in writing forty-five (45) days prior to such Practitioner's decision to no longer accept Covered Persons with respect to a particular Product. In no event will an established patient of any Practitioner be considered a new patient.

2.3 Preferred Drug List/Drug Formulary. If applicable to the Covered Person's coverage, Practitioners shall abide by MCO's formulary or preferred drug list when prescribing medications for Covered Persons.

2.4 Cancellation of Product Orders. A Provider and each Contracted Provider that offers delivery services for Covered Services and products, such as durable medical equipment (DME), limited home health supplies (LHHS), or outpatient drugs or biological products must reduce, cancel, or stop delivery if the Covered Person or the Covered Person's authorized representative submits an oral or written request. The Provider and Contracted Provider must maintain records documenting the request.

3. Ancillary Providers. If Provider or Contracted Provider is an ancillary provider (including but not limited to a home health agency, durable medical equipment provider, sleep center, pharmacy, ambulatory surgery center, nursing facility, laboratory or urgent care center)("Ancillary Provider"), the following provisions apply.

3.1 Acceptance of New Patients. To the extent that Ancillary Provider is accepting new patients, such Ancillary Provider must also accept new patients who are Covered Persons with respect to the Products in which such Ancillary Provider participates. Ancillary Provider shall notify Company in writing forty-five (45) days prior to such Ancillary Provider's decision to no longer accept Covered Persons with respect to a particular Product. In no event will an established patient of any Ancillary Provider be considered a new patient.

3.2 Cancellation of Product Orders. A Provider and each Contracted Provider that offers delivery services for Covered Services and products, such as durable medical equipment (DME), limited home health supplies (LHHS), or outpatient drugs or biological products must reduce, cancel, or stop delivery if the Covered Person or the Covered Person's authorized representative submits an oral or written request. The Provider and Contracted Provider must maintain records documenting the request.

4. FQHC. If Provider or a Contracted Provider is a federally qualified health center ("FQHC"), the following provision applies.

4.1 FQHC Insurance. To the extent FQHC's employees are deemed to be federal employees qualified for protection under the Federal Tort Claims Act ("FTCA") and MCO has been provided with documentation of such status issued by the U.S. Department of Health and Human Services (such status to be referred to as "FTCA Coverage"), Section 5.1 of this Agreement will not apply to those Contracted Providers with FTCA Coverage. FQHC shall provide evidence of such FTCA Coverage to MCO at any time upon request. FQHC shall promptly notify MCO if, any time during the term of this Agreement any Contracted Provider is no longer eligible for, or if FQHC becomes aware of any fact or circumstance that would jeopardize, FTCA Coverage. Section 5.1 of this Agreement will apply in a Contracted Provider immediately upon such Contracted Provider's loss of FTCA Coverage for any reason.



**ATTACHMENT B**
**STATE-MANDATED PROVISIONS**

MCO and Provider shall comply with the following provisions, which are required by State law to be included in this Agreement, as such provisions may be amended from time to time by the State.

1. As used in this Agreement, the term "State" refers to the State of Texas.

2. No Retaliation. MCO shall not terminate, refuse to renew this Agreement or take any retaliatory action against Provider as a result of any complaints filed by Provider on behalf of a Covered Person or policyholder, against MCO or due to an appeal of a decision made by MCO.

3. No Indemnification. MCO shall not interpret any provision of this Agreement to require Provider to indemnify MCO for any tort liability resulting from the acts or omissions of MCO.

4. Posting of Complaint Notice. Provider shall post in its office a notice to Covered Persons regarding the process for resolving complaints with MCO. Such notices must include the Texas Department of Insurance's toll-free number for filing complaints.

5. Compliance with Prompt Payment Regulations. Payor will make payments for Covered Service(s) provided by Provider to Medicaid Covered Persons within thirty (30) days of its receipt of Clean Claims submitted in accordance with the requirements of this Agreement, subject to coordination of benefits rules and eligibility verification. Payor shall comply with the applicable requirements of TEX. INS. CODE chapter 843 and 28 TEX. ADMIN. CODE §§ 21.2801 *et.seq.* relating to the prompt payment of Clean Claims.

6. Special Rules Relating to Capitation Reimbursement. In the event that any of the Product Attachments provide for Capitation Reimbursement based on a Covered Person's PCP selection, Payor will begin making payments calculated from that date of the Covered Person's enrollment which shall be no later than sixty (60) days following the date the Covered Person selected or has been assigned to a PCP. If no such selection or assignment has been made within such sixty (60) day period, the applicable Capitation Reimbursement shall be held by Payor in reserve until such time as there is a selection and retroactive payments can be made. MCO shall notify the PCP of his or her selection by a Covered Person within thirty (30) business days of the selection or assignment.

Payor will make Capitation Reimbursement payments to PCP on or before the fifteen (15th) working day of the month in which services are provided.

7. Covered Person Hold Harmless. Provider shall look only to the applicable Payor and agree to hold Covered Persons harmless for compensation for all Covered Services provided to Covered Persons during the term of this Agreement. Under no circumstances, including but not limited to, nonpayment by Payor, Payor insolvency, or breach of this Agreement or an Attachment, shall Provider bill, charge, collect a deposit from, or seek compensation, remuneration, or reimbursement from, or have any recourse against, Medicare, Medicaid, Covered Persons or persons (other than Payor) acting on the Covered Persons' behalf (including but not limited to the applicable participating employer group or Payor) for Covered Services provided pursuant to this Agreement. This provision shall not prohibit collection of Copayments on Payor's behalf made in accordance with the terms of the applicable MCO Coverage Plan, nor does this provision affect the right of Provider to collect fees for services provided to Covered Persons which do not constitute Covered Services (unless Payor denied payment on the basis of lack of Medical Necessity or Provider's failure to comply with the terms and conditions of this Agreement or any Attachment) or for which Covered Person has specifically otherwise assumed financial responsibility, in writing, prior to the time that services were rendered. Provider further agrees that this section shall: (i) survive the termination of this Agreement or any Attachment, regardless of the reason for termination; (ii) supersede any oral or written agreement now existing or hereafter entered into between Provider and a Covered Person, persons acting on the Covered Persons' behalf (other than MCO), and the participating employer, Payor, or group



contract holder; and (iii) be construed to be for the benefit of Covered Persons, persons acting on the Covered Person's behalf (other than MCO), and the participating employer, Payor, or group contract holder. Any modifications, additions, or deletions to this provision shall be effective no earlier than fifteen (15) days after the Texas Commissioner of Insurance has received written notice of such changes

8. Pre-termination Review. Prior to the termination of this Agreement by MCO, MCO shall provide a written explanation to Provider of the reasons for termination. Prior to the effective date of the termination and to the extent required by the laws and regulations applicable to health maintenance organizations, Provider may request a review of MCO's proposed termination, to be held within a period not to exceed sixty (60) days of Provider's request. At Provider's request, the review shall be conducted on an expedited basis. Such review shall be conducted by the physicians, including at least one primary care physician, if available, appointed to serve on MCO's Quality Improvement Committee. MCO shall consider, but shall not be bound by, the decision reached by the advisory review panel. Upon Provider's request, MCO shall provide Provider with a copy of this decision and of MCO's determination with respect to termination of this Agreement. This review shall not be required for termination under circumstances involving "Imminent Harm" as follows: (i) imminent harm to a Covered Person's health, (ii) fraud or misfeasance, or (iii) action by a state medical or other physician licensing board or other government agency that effectively impairs the ability of a Provider to practice medicine. MCO shall not notify Covered Persons of the termination until the earlier of the effective date of termination or the date that the advisory review panel makes its recommendations except in situations involving Imminent Harm.

9. Continuity of Treatment. Unless this Agreement terminates for reasons of medical competence or professional behavior, termination shall not release Payor of its obligation to compensate Provider for the continued care and treatment of any Covered Person who is under Special Circumstances (as defined below). As used in this section, "Special Circumstances" shall mean a Covered Person who has a disability, an acute condition, a life-threatening illness, who is past the twenty-fourth (24th) week of pregnancy, or who has a condition that Provider reasonably believes could cause harm to the Covered Person if such care or treatment is discontinued. To be reimbursed for providing continued care and treatment under this section, Provider must identify the Covered Person's Special Circumstances to MCO, 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 this Agreement were not terminated. Compensation to Provider shall be in accordance with the fee schedule in effect as of the termination date. Treatment of Special Circumstances as described herein shall be governed by the dictates of medical prudence and Medical Necessity. The requirements of this section shall not extend beyond ninety (90) days from the effective date of termination, or beyond nine (9) months in the case of a Covered Person who at the time of the termination has been diagnosed with a terminal illness, provided, however, the obligation of the Payor for reimbursement to a Covered Person shall, for a pregnant Covered Person who at the time of termination is past the twenty-fourth (24th) week of pregnancy, extend through delivery of the child, immediate postpartum care, and the follow-up check-up within the first six (6) weeks of delivery. In addition to the foregoing, termination shall not release Provider or MCO/Payor from liability to others with respect to services rendered to Covered Persons, monies paid, or other actions through the date of termination, nor shall it relieve Provider of his or her obligation not to bill Covered Persons for Covered Services. This section shall survive termination of this Agreement for any reason.

10. Disclosure of Claims Processing Information. Upon Provider's request, MCO shall provide information to assist Provider in determining that he or she is being compensated in accordance with this Agreement. The information shall provide a level of detail sufficient to enable a reasonable person with sufficient training, experience and competence in claims processing to determine the payment to be made to Provider for Covered Services rendered pursuant to this Agreement. The information shall include a summary and explanation of the payment and reimbursement methodologies that MCO will use to pay Clean Claims submitted by Provider, including, but not limited to, fee schedules, coding methodologies, bundling processes, downcoding policies, descriptions of any other applicable policy or procedure used by MCO that may affect payment to Provider, and any addenda, schedules, exhibits or policies used by MCO in carrying



out the payment of Clean Claims submitted by Provider. If source information outside the control of MCO, such as State Medicaid or federal Medicare fee schedules, is the basis for fee computation under this Agreement, MCO shall identify such source and explain the procedures by which Provider may readily access the source electronically, telephonically, or as otherwise agree to be the parties. In complying with this section, MCO shall not be required to provide specific information that would violate any applicable copyright law or licensing agreement. In such circumstances, MCO shall provide a summary of the information withheld, which will allow a reasonable and sufficiently trained and experienced person to determine the payments to be made under this Agreement. MCO may provide the information by any reasonable method, including by email, computer disks, paper copies, or access to an electronic database, and shall provide the information within thirty (30) days after MCO receives the Provider's request. MCO shall provide Provider with ninety (90) days prior written notice of any amendments, revisions, or substitutions of the information required to be provided by MCO under this section.

Provider is prohibited by law and by this Agreement from using or disclosing the information provided to MCO pursuant to this section for any purpose other than Provider's practice management, billing activities, other business operations, or communications with a governmental agency involved in the regulation of health care or insurance. Provider may not use the information provided by MCO to knowingly submit a claim for payment that does not accurately represent the level, type or amount of services that were actually provided to a Covered Person or to misrepresent any aspect of the services. Provider may not rely upon information provided by MCO pursuant to this section about a service as a representation that a Covered Person is covered for that service under the terms of the Covered Person's MCO Coverage Plan.

Upon receiving information under this section, Provider may terminate this Agreement on or before the 30th day after the date Provider received the information without penalty or discrimination in participation in other health care products or plans. Reasonable advance notice must be given to Covered Persons being treated by Provider prior to the termination.

11. Records relating to Other Insurance. Provider shall retain in Provider's records updated information concerning a Covered Person's other health benefit plan coverage.

**ATTACHMENT C**
**PARTICIPATING PROVIDER ATTESTATION**

WHEREAS, Superior HealthPlan, Inc. ("MCO"), has executed an agreement with _____, ____ ("Provider") dated _____, pursuant to which Contracted Provider has agreed to provide Covered Services to Covered Persons through the Participating Provider Agreement (the "Agreement"); and

WHEREAS, Provider has requested that the undersigned Contracted Provider serve as a provider under the Agreement and Contracted Provider so desires to participate; and

WHEREAS, as a condition of such participation and Provider's designation as a "Contracted Provider" under this Agreement, Contracted Provider must satisfy MCO's credentialing criteria and execute this Attestation acknowledging his/her agreement to comply with, and be bound by, the terms and conditions of the Agreement that are applicable to Contracted Providers.

NOW THEREFORE, Contracted Provider hereby agrees as follows:

1. Contracted Provider agrees to provide Covered Services to Covered Persons in accordance with the requirements of the Agreement that are applicable to Contracted Providers so long as Contracted Provider qualifies as a Contracted Provider.

2. Contracted Provider understands and agrees that his/her initial and continued participation as a Contracted Provider under the Agreement is contingent upon meeting and complying with MCO's credentialing standards and otherwise complying with the terms and conditions of the Agreement.

3. Contracted Provider acknowledges that MCO expressly reserves the right to reject, suspend, and/or terminate his/her participation under the Agreement for breaching or otherwise failing to: (i) comply with the term of the Agreement or any Attachment thereto; (ii) meet MCO's credentialing requirements; or (iii) comply with the Provider Manual.

4. This Attestation shall be effective as of _____ ____.

Contracted Provider

Signature: _____

Print Name: _____

Specialty: _____

Date: _____

NPI: _____



**ATTACHMENT D**
**PARTICIPATING FACILITY/PROVIDER LISTING**

**[TO BE INSERTED]**



**ATTACHMENT E**
**STAR, STAR+PLUS, CHIP and CHIP Perinate PRODUCT ATTACHMENT**

This Attachment is incorporated into the Participating Provider Agreement (the "Agreement") entered into by and between parties set forth above with the effective date set forth above.

Provider has entered into the Agreement with MCO. This Attachment is intended to supplement the Agreement by setting forth the Medicaid-specific and CHIP-specific requirements with which Provider must comply in order to participate in the STAR, STAR+PLUS, CHIP and/or CHIP Perinatal programs, as those terms are defined below.

**ARTICLE I**
**DEFINITIONS**

The following terms, and any terms defined in the Agreement, shall have the specified meanings when capitalized in this Attachment:

1.1. ***"CHIP"*** means the Children's Health Insurance Program as authorized under Title XXI of the federal Social Security Act and Texas Senate Bill 445, codified as Chapter 62, Texas Health & Safety Code.

1.2. ***"CHIP Perinate"*** is an individual CHIP Perinatal Program beneficiary who is identified prior to birth and is enrolled to receive Covered Services from MCO pursuant to the terms of the CHIP Perinatal Contract.

1.3. ***"CHIP Perinatal Contract"*** means the agreements then in effect between MCO and the State of Texas, as revised or replaced from time to time, pertaining to the provision of Covered Services by MCO to its Covered Persons who are beneficiaries of the State CHIP Perinatal Program and who enroll to receive care through MCO.

1.4. ***"CHIP Perinate Newborn"*** means a CHIP Perinate who has been born alive.

1.5. ***"CHIP Perinatal Program"*** means the State of Texas program in which HHSC contracts with health maintenance organizations to provide, arrange for, and coordinate Covered Services for enrolled CHIP Perinate and CHIP Perinate Newborn members

1.6. ***"Clean Claim"*** means a claim submitted by a Participating Health Care Provider for medical care or health care services rendered to a Covered Person, with all documentation reasonably necessary for MCO to process the claim.

1.7. ***"Covered Person"*** is an individual STAR, STAR+PLUS, CHIP, or CHIP Perinatal beneficiary who is eligible and has enrolled to receive Covered Services from MCO pursuant to the terms of the STAR, STAR+PLUS, CHIP or CHIP Perinatal Contract. An ***"Assigned Covered Person"*** is a Covered Person who has chosen Provider to serve as his or her Primary Care Physician (or ***"PCP"***).

1.8. ***"Emergency Care"*** means health care services provided in a hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in: (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part; (4) serious disfigurement; or (5) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

1.9. ***"HHSC"*** means the Texas Health and Human Services Commission.



1.10. ***"Primary Care Provider" or "PCP"*** means a physician or provider who has agreed with the MCO to be responsible for providing initial and primary care to patients, maintaining the continuity of patient care, and initiating referral for care.

1.11. ***"STAR"*** (which stands for State of Texas Access Reform) is the program in Texas that provides managed care services for beneficiaries of the State Medicaid program.

1.12. ***"STAR+PLUS"*** is the Medicaid managed care program in Texas that provides and coordinates preventive, primary, acute and long term care to adult persons with disabilities and elderly persons age 65 and over who qualify for Medicaid through SSI/MAO.

1.13. ***"STAR, STAR+PLUS and CHIP Contracts" or "State Contracts"*** means the agreements then in effect between MCO and the State, as revised or replaced from time to time, including, but not limited to, the STAR, STAR+PLUS and CHIP Contracts awarded to MCO pursuant to the STAR, STAR+PLUS and CHIP programs as implemented by the State. It also includes the CHIP Perinatal Contract(s).

1.14. ***"State Agency"*** means the State agency which administers the STAR, STAR+PLUS and CHIP (including CHIP Perinatal) managed care programs, as implemented from time to time.

**ARTICLE II**
**COMPLIANCE WITH STATE AGENCY REQUIREMENTS**

2.1. Provider agrees to provide the Texas Health and Human Services Commission ("**HHSC**"): (a) all information required under the State Contracts, including but not limited to the reporting requirements and other information related to the Provider's performance of its obligations under the Agreement; and (b) any information in its possession sufficient to permit HHSC to comply with the federal Balanced Budget Act of 1997 or other federal or State laws, rules, and regulations. All information must be provided in accordance with the timelines, definitions, formats and instructions specified by HHSC.

2.2. Upon receipt of a record review request from the Health and Human Services Commission Office of Inspector General (OIG) or another state or federal agency authorized to conduct compliance, regulatory, or program integrity functions, Provider must provide, at no cost to the requesting state or federal agency, the records request within three (3) business days of the request. If the OIG or another state or federal agency representative reasonably believes that the requested records are about to be altered or destroyed or that the request may be completed at the time of the request and/or in less than 24 hours, Provider must provide the records requested at the time of the request and/or in less than 24 hours. The request for record review includes, but is not limited to clinical medical or dental Member records; other records pertaining to the Member; any other records of services provided to Medicaid or other health and human services program recipients and payments made for those services; documents related to diagnosis, treatment, service, lab results, charting, billing records, invoices, documentation of delivery items, equipment, or supplies; radiographs and study models related to orthodontia services; business and accounting records with backup support documentation; statistical documentation; computer records and data; and/or contracts with providers and subcontractors. Failure to produce the records or make the records available for the purpose of reviewing, examining and securing custody of the records may result in OIG imposing sanctions against Provider as described in Title 1 Tex. Admin Code, Chapter 371 Subchapter G.

2.3. Updates to Contact Information. Provider must inform both the MCO and HHSC's administrative services contractor of any changes to Provider's address, telephone number, group affiliation, etc.

2.4. Provider must comply with the requirements of state and federal laws, rules and regulations relating to advance directives.

2.5. Provider agrees to provide the following entities or their designees with prompt, reasonable, and adequate access to the Agreement and any records, books, documents, and papers that are related to the Agreement and/or the Provider's performance of its responsibilities under the State Contracts:

a) MCO program Personnel from HHSC or its designee;
b) The U.S. Department of Health and Human Services or its designee;
c) The Office of Inspector General;
d) The Texas Medicaid Fraud Control Unit of the Texas Attorney General's Office or its designee;
e) Any independent verification and validation contractor, audit firm, or quality assurance contractor acting on behalf of HHSC;
f) A state or federal law enforcement agency;
g) A special or general investigating committee of the Texas Legislature or its designee,
h) The U.S. Comptroller General or its designee;
i) The Office of the State Auditor of Texas or its designee, and
j) Any other state or federal entity identified by HHSC, or any other entity engaged by HHSC.

2.6. Provider must provide access wherever it maintains such records, books, documents, and papers and Provider must provide such access in reasonable comfort and provide any furnishings, equipment, and other conveniences deemed reasonably necessary to fulfill the purposes described herein. Requests for access may be for, but are not limited to, the following purposes: examination; audit; investigation; contract administration; the making of copies, excerpts or transcripts; or any other purpose HHSC deems necessary for contract enforcement or to perform its regulatory functions.

2.7. Provider understands and agrees that the acceptance of funds under this contract acts as acceptance of the authority of the State Auditor's Office ("SAO"), or any successor agency, to conduct an investigation in connection with those funds. Provider further agrees to cooperate fully with the SAO or its successor in the conduct of the audit or investigation, including providing all records requested at no cost.

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

2.9. If Provider provides inpatient psychiatric services to a Covered Person, Provider must schedule the Covered Person for outpatient follow-up and/or continuing treatment prior to discharge. The outpatient treatment must occur within seven (7) days from the date of discharge. Behavioral Health Service Providers must contact Covered Persons who have missed appointments within 24 hours to reschedule such appointments.

2.10. In order to submit a Clean Claim, Provider must provide the information set forth under Clean Claims in the Participating Health Care Provider Manual.

2.11. MCO will provide the Provider at least ninety (90) days notice prior to implementing a change in the claims guidelines set forth in the Participating Health Care Provider Manual, unless the change is required by statute or regulation in a shorter timeframe.

2.12. The Participating Health Care Provider Manual includes information concerning which entity/entities Provider must submit claims to for processing and/or adjudication. MCO must notify Provider in writing of any changes in the list of claims processing or adjudication entities at least thirty (30) days prior to the effective date of change. If MCO is unable to provide thirty (30) days notice, MCO must give Provider a thirty (30)-day extension on their claims filing deadline to ensure claims are routed to the correct processing center.

2.13. Provider acknowledges and agrees that program violations arising out of performance of the Agreement are subject to administrative enforcement by the Texas Health and Human Services Commission Office of Inspector General (OIG) as specified in Title 1 Tex. Admin. Code, Chapter 371 Subchapter G.



2.14. The Participating Health Care Provider Manual includes information concerning the complaint and appeal process that applies to Participating Health Care Providers.

2.15. Provider understands and agrees that HHSC reserves the right and retains the authority to make reasonable inquiry and to conduct investigations into Provider and Covered Person complaints.

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

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

2.18. Provider shall protect the confidentiality of Covered Person Protected Health Information (PHI), including patient records. Provider must comply with all applicable Federal and State laws, including the HIPAA Privacy and Security Rule governing the use and disclosure of protected health information.

2.19. Provider shall not transfer an identifiable Covered Person record, including a patient record, to another entity or person without written consent from the Covered Person or someone authorized to act on his or her behalf; however, Provider understands and agrees that HHSC may ask it to transfer a Covered Person's record to another agency if HHSC determines that the transfer is necessary to protect either the confidentiality of the record or the health and welfare of the Covered Person.

2.20. Provider must cooperate and coordinate with local ECI programs to comply with federal and state requirements relating to the development, review and evaluation of Individual Family Service Plans ("*IFSP*"). Provider understands and agrees that any Medically Necessary health and behavioral health services contained in an IFSP must be provided to the Covered Person in the amount, duration, scope and setting established in the IFSP.

2.21. If a Covered Person requests contraceptive services or family planning services, Provider must also provide the Covered Person counseling and education about family planning and available family planning services.

2.22. Provider cannot require parental consent for Covered Persons who are minors to receive family planning services.

2.23. Provider must comply with state and federal laws and regulations governing Covered Person confidentiality (including minors) when providing information on family planning services to Covered Persons.

2.24. Provider understands and agrees to the following:

(a) HHSC Office of Inspector General ("**OIG**") and/or the Texas Medicaid Fraud Control Unit must be allowed to conduct private interviews of Provider, Provider's employees, agents, contractors, and patients;
(b) requests for information from such entities must be complied with, in the form and language requested;
(c) Provider and Provider's employees, agents, and contractors must cooperate fully with such entities in making themselves available in person for interviews, consultation, grand jury proceedings, pre-trial conference, hearings, trials and in any other process, including investigations at the Provider's own expense; and
(d) Compliance with these requirements will be at Provider's own expense.

2.25. Provider understands and agrees to the following:



(a) Provider is subject to all state and federal laws and regulations relating to fraud, abuse or waste in health care or dental care and the Medicaid and/or CHIP Programs, as applicable;
(b) Provider must cooperate and assist HHSC and any state or federal agency that is charged with the duty of identifying, investigating, sanctioning or prosecuting suspected fraud, abuse or waste;
(c) Provider must provide originals and/or copies of any and all information, allow access to premises, and provide records to the Office of Inspector General, HHSC, the Centers for Medicare and Medicaid Services ("**CMS**"), the U.S. Department of Health and Human Services, FBI, Texas Department of Insurance ("**TDI**"), the Texas Attorney General's Medicaid Fraud Control Unit or other unit of state or federal government, upon request, and free-of-charge;
(d) If Provider places required records in another legal entity's records, such as a hospital, Provider is responsible for obtaining a copy of these records for use by the above-named entities or their representatives; and
(e) Provider must report any suspected fraud or abuse including any suspected fraud and abuse committed by the MCO or a Covered Person to the HHSC Office of Inspector General.

2.26 Provider understands and agrees that if Provider receives annual Medicaid payments of at least $5 million (cumulative, from all sources), Provider must:

(a) Establish written policies for all employees, managers, officers, contractors, subcontractors, and agents of Provider. The policies must provide detailed information about the False Claims Act, administrative remedies for false claims and statements, any state laws about civil or criminal penalties for false claims, and whistleblower protections under such laws, as described in Section 1902(a)(68)(A).
(b) Include as part of such written policies detailed provisions regarding the Provider's policies and procedures for detecting and preventing Fraud, Waste, and Abuse.
(c) Include in any employee handbook a specific discussion of the laws described in Section 1902(a)(68)(A), the rights of employees to be protected as whistleblowers, and Provider's policies and procedures for detecting and preventing Fraud, Waste, and Abuse.

2.27. Provider understands and agrees that it is subject to all state and federal laws, rules, regulations, waivers, policies and guidelines, and court-ordered consent decrees, settlement agreements, or other court orders that apply to the Agreement; MCO's contract(s) with HHSC; the Medicaid and CHIP Programs; and, all persons or entities receiving state and federal funds. Provider understands and agrees that any violation by a provider of a state or federal law relating to the delivery of services pursuant to this Agreement, or any violation of MCO's contract(s) with HHSC could result in liability for money damages, and/or civil or criminal penalties and sanctions under state and/or federal law.

2.28 Provider understands and agrees that the following laws, rules, and regulations, and all amendments or modifications thereto, apply to the Agreement:
(i) environmental protection laws:
(a) Pro-Children Act of 1994 (20 U.S.C. §6081 et seq.) regarding the provision of a smoke-free workplace and promoting the non-use of all tobacco products;
(b) National Environmental Policy Act of 1969 (42 U.S.C. §4321 et seq.) and Executive Order 11514 ("Protection and Enhancement of Environmental Quality") relating to the institution of environmental quality control measures;
(c) Clean Air Act and Water Pollution Control Act regulations (Executive Order 11738, "Providing for Administration of the Clean Air Act and Federal Water Pollution Control Act with Respect to Federal Contracts, Grants, and Loans");



(d) State Clean Air Implementation Plan (42 U.S.C. §7401 et seq.) regarding conformity of federal actions to State Implementation Plans under §176(c) of the Clean Air Act; and
(e) Safe Drinking Water Act of 1974 (21 U.S.C. §349; 42 U.S.C. §300f to 300j-9) relating to the protection of underground sources of drinking water.

(ii) state and federal anti-discrimination laws:
(a) Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d et seq.) and as applicable 45 C.F.R. Part 80 or 7 C.F.R. Part 15;
(b) Section 504 of the Rehabilitation Act of 1973(29 U.S.C. § 794);
(c) Americans with Disabilities Act of 1990 (42 U.S. Code § 12101 et seq.),
(d) Age Discrimination Act of 1975 (42 U.S.C. §§ 6101-6107);
(e) Title IX of the Education Amendments of 1972 (20 U.S.C. §§ 1681-1688);
(f) Food Stamp Act of 1977 (7 U.S.C. § 200 et seq.);
(g) Executive Order 13279, and its implementing regulations at 45 C.F.R. Part 87 or 7 C.F.R. Part 16); and
(h) the HHS agency's administrative rules, as set forth in the Texas Administrative Code, to the extent applicable to this Agreement

(iii) the Immigration and Nationality Act (8 U.S.C. §1101 et seq.) and all subsequent immigration laws and amendments;
(iv) the Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**") (Public Law 104-191); and,
(v) the Health Information Technology Act for Economic and Clinical Health Act (HITECH Act) at 42 U.S.C. § 17931 et seq.

2.29. In the event MCO becomes insolvent or ceases operations, Provider understands and agrees that its sole recourse against MCO will be through MCO's bankruptcy, conservatorship, or receivership estate. Provider understands and agrees that Covered Persons may not be held liable for MCO's debts in the event of the entity's insolvency.

2.30. Provider understands and agrees that the HHSC does not assume liability for the actions of, or judgments rendered against, MCO, its employees, agents or subcontractors. Further, Provider understands and agrees that there is no right of subrogation, contribution, or indemnification against HHSC for any duty owed to Provider by MCO or any judgment rendered against MCO. HHSC's liability to Provider, if any, will be governed by the Texas Tort Claims Act, as amended or modified (Tex. Civ. Pract. & Rem. Code §101.001 et seq.).

2.31. Provider agrees to comply with HHSC's marketing policies and procedures, as set forth in the HHSC/MCO Managed Care Contract (which includes HHSC's Uniform Managed Care Manual).

2.32. Provider is prohibited from engaging in direct marketing to Covered Persons that is designed to increase enrollment in a particular health plan. This prohibition does not constrain Provider from engaging in permissible marketing activities consistent with broad outreach objectives and application assistance.

2.33. MCO will initiate and maintain any action necessary to stop a Provider or a Provider's employee, agent, assign, trustee, or successor-in-interest from maintaining an action against HHSC, an HHS Agency, or any Covered Person to collect payment from HHSC, an HHS Agency, or any Covered Person, excluding payment for non-covered services. This provision does not restrict a CHIP Network Provider from collecting allowable copayment and deductible amounts from CHIP Covered Persons.

2.34. Provider must be licensed in the State of Texas to provide the Covered Services for which the MCO is contracting with Provider, and not be under sanction or exclusion from the Medicaid Program. If Provider is serving Medicaid Covered Persons, he/she must be enrolled as a Medicaid provider and have a Texas

Provider Identification Number ("*TPI#*"). Effective May 23, 2007, Provider (those serving both Medicaid and CHIP Covered Persons) must also have a National Provider Identification Number (NPI) (see 45 C.F.R. Part 162, Subpart D).

2.35. MCO is prohibited from imposing restrictions upon Provider's free communication with a Covered Person about the Covered Person's medical conditions, treatment options, MCO referral policies, and other MCO policies, including financial incentives or arrangements and all managed care plans with whom the Provider contracts.

2.36. Provider is prohibited from billing or collecting any amount from a Medicaid Covered Person for Covered Services provided pursuant to this Attachment. Federal and State laws provide severe penalties for any provider who attempts to bill or collect any payment from a Medicaid recipient for a Covered Service.

2.37. If Provider is a PCP, Provider's services must be accessible to Covered Persons 24 hours per day, 7 days per week, and Provider must have acceptable after-hours telephone availability.

2.38. While performing the services described in the Agreement, Provider agrees to comply with applicable state laws, rules, and regulations and HHSC's requests regarding personal and professional conduct generally applicable to the service locations, and otherwise conduct themselves in a businesslike and professional manner.

2.39. Provider agrees to comply with the MCO's QAPI Program requirements.

2.40. MCO must follow the procedures outlined in Section 843.306 of the Texas Insurance Code if terminating the Agreement with Provider. At least ninety (90) days before the effective date of the proposed termination of this Agreement, MCO must provide a written explanation to Provider of the reasons for termination. MCO may immediately terminate this Agreement in a case involving **(a)** imminent harm to patient health; (b) an action by a state medical or dental board, another medical or dental licensing board, or another licensing board or government agency that effectively impairs Provider's ability to practice medicine, dentistry, or another profession; or (c) fraud or malfeasance.

Not later than thirty (30) days following receipt of the termination notice, Provider may request a review of the MCO's proposed termination by an advisory review panel, except in a case in which there is imminent harm to patient health, an action against a license, or fraud or malfeasance. The advisory review panel must be composed of physicians and providers, including at least one representative in Provider's specialty, if available, appointed to serve on the standing quality assurance committee or utilization review committee of MCO. The decision of the advisory review panel must be considered by MCO but is not binding on MCO. Within 60 days following receipt of Provider's request for review and before the effective date of the termination, the advisory review panel must make its formal recommendation, and the MCO must communicate the MCO's decision to Provider. MCO must provide to Provider, on request, a copy of the recommendation of the advisory review panel and MCO's determination.

2.41. Provider may not offer or give any thing of value to an officer or employee of HHSC or the State of Texas in violation of state law. A "thing of value" means any item of tangible or intangible property that has a monetary value of more than $50.00 and includes, but is not limited to, cash, food, lodging, entertainment and charitable contributions. The term does not include contributions to public office holders or candidates for public office that are paid and reported in accordance with state and/or federal law. MCO may terminate the Agreement at any time for violation of this requirement.

2.42. Provider understands and agrees that it may not interfere with or place any liens upon the state's right or MCO's right, acting as the state's agent, to recovery from third party resources.

2.43. Texas Health Steps providers must send all Texas Health Steps newborn screens to the Texas Department of State Health Services ("*DSHS*"), formerly the Texas Department of Health, Bureau of Laboratories or a



DSHS-certified laboratory. Such providers must include detailed identifying information for all screened newborn Covered Persons and each Covered Person's mother to allow HHSC to link the screens performed at the hospital with screens performed at the two-week follow-up.

2.44. Provider must coordinate with the local TB control program to ensure that all Covered Persons with confirmed or suspected TB have a contact investigation and receive Directly Observed Therapy ("DOT"). Provider must report to the DSHS or the local TB control program any member who is non-compliant, drug resistant, or who is or may be posing a public health threat.

2.45. Provider must coordinate with the Women, Infants, and Children ("*WIC*") Special Supplemental Nutrition Program to provide medical information necessary for WIC eligibility determinations, such as height, weight, hematocrit or hemoglobin

2.46. If Provider is a PCP, Provider must provide preventive care (1) to children under age 21 in accordance with AAP recommendations for CHIP Covered Persons and CHIP Perinatal Newborns, and the Texas Health Steps periodicity schedule found in the Texas Health Steps Manual for Medicaid Covered Persons, and (2) to adults in accordance with the U.S. Preventative Task Force requirements.

2.47. If Provider is a PCP, Provider must assess the medical and behavioral health needs of Covered Persons for referral to specialty care providers and provide referrals as needed. PCPs must coordinate Covered Persons' care with specialty care providers after referral. PCPs must serve as a medical home to Covered Persons.

2.48 Provider must inform Covered Persons of the costs for non-covered services prior to rendering such services and obtain a signed Private Pay form from such Covered Persons

2.49. Provider understands and agrees that HHSC is not liable or responsible for payment for Covered Services rendered pursuant to this Agreement.

2.50. Termination of Provider Contracts. Unless prohibited or limited by applicable law, as soon as possible and at least 30 days prior to the effective date of the MCO's termination of this Agreement, MCO must provide written notice to (i) Provider that it will no longer be a part of the Participating Health Care Provider Network; (ii) the HHSC Administrative Services Contractor; and, (iii) affected Covered Persons. Affected Covered Persons include all Covered Persons in a PCP's panel and all Covered Persons who have been receiving ongoing care from the terminated Provider, where ongoing care is defined as two or more visits for home based or office-based care in the past 12 months.

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

2.52. Provider shall not charge: (i) cost-sharing or deductibles to CHIP Covered Persons of Native American Tribes or Alaskan Natives; (ii) co-payments or deductibles to a CHIP Covered Person with an fD card that indicates the Covered Person has met his or her cost-sharing obligation for the balance of their term of coverage; and (iii) co-payments for well-child or well-baby visits or immunizations.

2.53. Co-payments are the only amounts that Provider may collect from CHIP Covered Persons except for costs associated with unauthorized non-emergency services provided to a CHIP Covered Person by out-of-network providers for non-covered services.

2.54. Payment of Clean Claims. All provider claims shall be processed within 30 days from the date of claim receipt by the MCO. All provider claims that are Clean Claims shall be adjudicated (finalized as paid or denied) within thirty (30) days from the date of claim receipt. MCO shall offer Provider the option of submitting and receiving claims information through electronic data interchange ("EDI") that allows for automated processing and adjudication of claims. EDI processing must be offered as an alternative to the



filing of paper claims. Electronic claims must use HIPAA-compliant electronic formats. MCO shall pay Provider interest at a rate of 1.5% per month (18% per annum), calculated daily, for the full period in which the Clean Claim remains unadjudicated beyond the 30-day claims processing deadline

2.55. MCO shall not pay any claim submitted by Provider if Provider has been excluded or suspended from the Medicare, Medicaid, or CHIP programs for fraud and abuse. MCO shall not pay any claim submitted by Provider if Provider is on payment hold under the authority of HHSC or its authorized agent(s), or has pending accounts receivable with HHSC.

2.56. MCO must adjudicate all appealed claims to a paid or denied status within 30 days of receipt of the appealed claim.

2.57 MCO may deny a claim for failure to file timely if a provider does not submit the claim to the MCO within 95 days of the date of service. If Provider files with the wrong health plan, or with the HHSC Administrative Services Contractor, and produces documentation verifying the initial timely claims filing within 95 days of the date of service, MCO shall process the claim without denying for failure to timely file. MCO shall send a remittance and status report or other remittance written communication that includes detailed information for each adjudicated, denied deficient, and pended deficient claim to allow Provider to easily identify the claim number, date of service, type of service, claim codes, Covered Person's name, and Covered Person ID number. MCO shall finalize all claims, including appealed claims, within 24 months of the date of service.

2.58. MCO shall inform Provider about the information required to submit a claim at least 30 days prior to the operational start date of the State Contract(s). Such claims submission requirements, including claims coding and processing guidelines, are found in MCO's Participating Health Care Provider Manual, which is a part of this Agreement.

2.59 Provider shall comply with the HIPAA confidentiality provisions of Section 2.18 of the Agreement.

2.60 Provider shall comply with the professional liability insurance provisions of Section 5.1 of the Agreement

2.61 Provider acknowledges and agrees that the Participating Health Care Provider Manual is incorporated into the Agreement by Section 2.4 of the Agreement.

2.62. Provider understands that CHIP Perinate Newborns are eligible for 12 months continuous enrollment, beginning with the month of enrollment as a CHIP Perinate. A CHIP Perinate Newborn will maintain coverage in his or her CHIP Perinatal health plan.

2.63 Provider understands that when a Covered Person enrolls in MCO's CHIP Perinatal Plan, all traditional CHIP members in the Covered Person's household will be disenrolled from their current health plans and prospectively enrolled in MCO's traditional CHIP Plan. All members of the household must remain in MCO's CHIP Plan through the end of the Covered Person's enrollment period.

2.64 Provider agrees to provide CHIP Perinatal Covered Services to Covered Persons as set forth in the HHSC Uniform Managed Care Contract Terms and Conditions, Attachment 10-2.2, and any corresponding guidelines published by HHSC.

2.65 Providers must comply with the requirements of Texas Government Code §531.024161, regarding the submission of claims involving supervised providers.

2.66 For STAR+PLUS Covered Persons, all Home and Community Support Services Agency providers, adult day care providers, and residential care facility providers must notify MCO if a Covered Person experiences any of the following:



i) a significant change in the Covered Person's physical or mental condition or environment;
ii) hospitalization;
iii) an emergency room visit; or
iv) two or more missed appointments.

## ARTICLE III
## ADDITIONAL STATE REQUIREMENTS

Provider acknowledges and agrees that, following the effective date of this Attachment, the State Agency may require that new or modified provisions be included in this Attachment. In such event, MCO shall notify Provider in writing of the new or modified provisions to be incorporated into this Attachment, and Provider shall comply with such provisions as of the compliance effective date established by the State.

**ATTACHMENT F**
**MEDICAID COMPREHENSIVE HEALTHCARE PROGRAM FOR FOSTER CARE PRODUCT ATTACHMENT**

This Attachment is incorporated into the Participating Provider Agreement (the "Agreement") entered into by and between parties set forth above with the effective date set forth above.

Pursuant to the requirements of the Medicaid Comprehensive Healthcare Program for Foster Care ("CHPFC"), as defined below, Provider must comply with the Medicaid-specific provisions and with the CHPFC requirements set forth in Article II of this Attachment in order to participate in the Medicaid Comprehensive Healthcare Program for Foster Care.

**ARTICLE I**
**DEFINITIONS**

The following terms, and any terms defined in the Agreement, shall have the specified meanings when capitalized in this Attachment:

1.1 "***Administrative Services Contractor***" (or "***ASC***") means an entity performing Medicaid managed care administrative services functions, including enrollment or claims payment functions, under contract with HHSC.

1.2 "***Caregiver***" means the DFPS-authorized caretaker for a Foster Care Covered Person, including the Foster Care Covered Person's foster parent(s), relative(s), or 24-hour child-care facility staff.

1.3 "***Clean Claim***" means a claim submitted by a Participating Health Care Provider for medical care or health care services rendered to an FC Covered Person, with documentation reasonably necessary for MCO to process the claim. MCO may not require a Participating Health Care Provider to submit documentation that conflicts with the requirements of Texas Administrative Code, Title 28, Part 1, Chapter 21, Subchapters C and T.

1.4 "***Covered Services***" means health care services SHPN (as defined below) must arrange to provide to FC Covered Persons, including all services required by the Foster Care Program Contract, state and federal law, and all value-added services negotiated by SHPN and HHSC. Covered Services include, without limitation, acute care, behavioral health services, dental services, vision services, and court-ordered medical services.

1.5 "***DFPS***" means the Texas Department of Family and Protective Services or its successor agency.

1.6 "***Emergency Behavioral Health Condition***" means any condition, without regard to the nature or cause of the condition, which in the opinion of a prudent layperson possessing an average knowledge of health and medicine: (1) requires immediate intervention and/or medical attention without which FC Covered Persons would present an immediate danger to themselves or others, or (2) that renders FC Covered Persons incapable of controlling, knowing or understanding the consequences of their actions.

1.7 "***Emergency Care***" means health care services provided in a hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in: (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part; (4) serious disfigurement; or (5) in the case of a pregnant woman, serious jeopardy to the health of the fetus



1.8 "***Emergency Medical Condition***" means a medical condition manifesting itself by acute symptoms of recent onset and sufficient severity (including severe pain), such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical care could result in:

(a) placing the patient's health in serious jeopardy;
(b) serious impairment to bodily functions;
(c) serious dysfunction of any bodily organ or part;
(d) serious disfigurement; or
(e) serious jeopardy to the health of a pregnant woman or her unborn child.

1.9 "***Emergency Services***" means covered inpatient and outpatient services furnished by a provider that is qualified to furnish such services under the Foster Care Program Contract and that are needed to evaluate or stabilize an Emergency Medical Condition and/or an Emergency Behavioral Health Condition, including post-stabilization care services.

1.10 "***Foster Care Covered Person***" or "***FC Covered Person***" is an individual included within the definition of "Target Population" and enrolled under the CHPFC.

1.11 "***Foster Care Program Contract***" means the agreement between Superior HealthPlan Network ("***SHPN***") and the State of Texas, as revised or replaced from time to time, pertaining to the provision of services by SHPN to FC Covered Persons who are beneficiaries of the State's Medicaid Comprehensive Healthcare Program for Foster Care.

1.12 "***Health Care Service Plan***" means an individualized plan developed with and for FC Covered Persons with special health care needs. The Health Care Service Plan includes, but is not limited to, the following:

(a) the FC Covered Person's history;
(b) summary of current medical and social needs and concerns;
(c) short and long term needs and goals;
(d) a treatment plan to address the FC Covered Person's physical, psychological, and emotional health care problems and needs including a list of services required, their frequency, and a description of who will provide such services.

The Health Care Service Plan should incorporate as a component of the plan the Individual Family Service Plan (IFSP) for FC Covered Persons in the Early Childhood Intervention ("***ECI***") Program.

1.13 "***Health Passport***" means an electronic health record used to document information regarding medical services provided to an FC Covered Person.

1.14 "***HHSC***" refers to the Texas Health and Human Services Commission, which is the State agency responsible for the administration of the CHPFC.

1.15 "***Medicaid Comprehensive Healthcare Program for Foster Care***" (or "***CHPFC***") is the statewide program designed to provide comprehensive medical and behavioral health Medicaid services to members of the Target Population through a managed care provider network.

1.16 "***Medical Consenter***" means the person who may consent to medical care for the FC Covered Person under Chapter 266 of the Texas Family Code.

1.17 "***Medically Necessary***" means:

Non-behavioral health related Health care services that are



(a) reasonable and necessary to prevent illnesses or medical conditions, or provide early screening, interventions, and/or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a handicap, cause illness or infirmity of an FC Covered Person, or endanger life;
(b) provided at appropriate facilities and at the appropriate levels of care for the treatment of an FC Covered Person's health conditions;
(c) consistent with health care practice guidelines and standards that are endorsed by professionally recognized health care organizations or governmental agencies;
(d) consistent with the diagnosis of the conditions;
(e) no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;
(f) are not experimental or investigative; and
(g) are not primarily for the convenience of the FC Covered Person or Provider; and

Behavioral health services that are:

(a) are reasonable and necessary for the diagnosis or treatment of a mental health or chemical dependency disorder, or to improve, maintain, or prevent deterioration of functioning resulting from such a disorder;
(b) are in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care;
(c) are furnished in the most appropriate and least restrictive setting in which services can be safely provided;
(d) are the most appropriate level or supply of service that can safely be provided;
(e) could not be omitted without adversely affecting the FC Covered Person's mental and/or physical health or the quality of care rendered;
(f) are not experimental or investigative; and
(g) are not primarily for the convenience of the FC Covered Person or Provider.

1.18 "***Primary Care Provider***" (or "***PCP***") means a physician or provider who has agreed with the MCO to provider a medical home to Foster Care Covered Persons and who is responsible for providing initial and primary care to patients, maintaining the continuity of patient care, and initiating referral for care.

1.19 "***PCP Team***" means a Covered Person's PCP, other Providers, and the Covered Person's Medical Consenter, who agree to function as an interdisciplinary team. If requested by the Covered Person's Medical Consenter, the Covered Person's Caregiver may be included in the PCP Team. The PCP Team may also include an FC Covered Person's DFPS caseworker and SHPN Service Coordinator.

1.20 "***Service Manager(s)***" perform the functions of Service Management.

1.21 "***State Medicaid Agency***" means the State agency which administers the State Medicaid managed care program, as implemented from time to time.

1.22 "***Substitute Care***" means the placement of a child or young adult who is in the conservatorship of DFPS in care outside the child's or young adult's home. The term includes foster care, institutional care, adoption or placement with a relative of the child or young adult.

1.23 "***Target Population***" means children and young adults in Substitute Care and/or one of the following categories: (1) DFPS conservatorship, (2) emancipated minors and young adults age 18-22 who voluntarily agree to continue in a foster care placement, or (3) young adults who have exited foster care and are participating in the foster care youth transitional Medicaid program.

1.24 "***Texas Health Steps***" is the name adopted by the state of Texas for the federally mandated EPSDT program. It includes the State's Comprehensive Care Program extension to EPSDT, which adds benefits to



the federal EPSDT requirements contained in 42 U.S.C. §1396d(r), and defined and codified at 42 C.F.R. §§440.40 and 441.56-62. HHSC's rules are contained in 25 T.A.C., Chapter 33 (relating to EPSDT).

**ARTICLE II**
**COMPLIANCE WITH STATE MEDICAID AGENCY AND CHPFC REQUIREMENTS**

2.1 Provider agrees to provide the Texas Health and Human Services Commission ("***HHSC***"): (a) all information required under the Foster Care Program Contract, including but not limited to the reporting requirements and other information related to the Provider's performance of its obligations under the Agreement; and (b) any information in its possession sufficient to permit HHSC to comply with the federal Balanced Budget Act of 1997 or other federal or State laws, rules, and regulations. All information must be provided in accordance with the timelines, definitions, formats and instructions specified by HHSC.

2.2 Upon receipt of a record review request from the Health and Human Services Commission Office of Inspector General (OIG) or another state or federal agency authorized to conduct compliance, regulatory, or program integrity functions, Provider must provide, at no cost to the requesting state or federal agency, the records request within three (3) business days of the request. If the OIG or another state or federal agency representative reasonably believes that the requested records are about to be altered or destroyed or that the request may be completed at the time of the request and/or in less than 24 hours, Provider must provide the records requested at the time of the request and/or in less than 24 hours. The request for record review includes, but is not limited to clinical medical or dental Member records, other records pertaining to the Member; any other records of services provided to Medicaid or other health and human services program recipients and payments made for those services; documents related to diagnosis, treatment, service, lab results, charting; billing records, invoices, documentation of delivery items, equipment, or supplies; radiographs and study models related to orthodontia services; business and accounting records with backup support documentation; statistical documentation; computer records and data, and/or contracts with providers and subcontractors. Failure to produce the records or make the records available for the purpose of reviewing, examining and securing custody of the records may result in OIG imposing sanctions against Provider as described in Title 1 Tex. Admin. Code, Chapter 371 Subchapter G.

2.3 Updates to Contact Information. Provider must inform both SHPN and HHSC's administrative services contractor of any changes to Provider's address, telephone number, group affiliation, etc.

2.4 Provider must comply with the requirements of state and federal laws, rules and regulations relating to advance directives.

2.5 Provider agrees to provide the following entities or their designees with prompt, reasonable, and adequate access to the Agreement and any records, books, documents, and papers that are related to the Agreement and/or the Provider's performance of its responsibilities under the Foster Care Program Contract:

(a) SHPN program Personnel from HHSC or its designee;
(b) The U.S. Department of Health and Human Services or its designee;
(c) The Office of Inspector General;
(d) The Texas Medicaid Fraud Control Unit of the Texas Attorney General's Office or its designee;
(e) Any independent verification and validation contractor, audit firm, or quality assurance contractor acting on behalf of HHSC;
(f) A state or federal law enforcement agency;
(g) A special or general investigation committee of the Texas Legislature or its designee;
(h) The U.S. Comptroller General or its designee;
(i) The Office of the State Auditor of Texas or its designee; and
(j) Any other state or federal entity identified by HHSC, or any other entity engaged by HHSC

2.6 Provider must provide access wherever it maintains such records, books, documents, and papers and Provider must provide such access in reasonable comfort and provide any furnishings, equipment, and other conveniences deemed reasonably necessary to fulfill the purposes described herein. Requests for access may be for, but are not limited to, the following purposes: examination; audit; investigation; contract administration; the making of copies, excerpts or transcripts; or any other purpose HHSC deems necessary for contract enforcement or to perform its regulatory functions.

2.7 Provider understands and agrees that the acceptance of funds under this contract acts as acceptance of the authority of the State Auditor's Office ("*SAO*"), or any successor agency, to conduct an investigation in connection with those funds. Provider further agrees to cooperate fully with the SAO or its successor in the conduct of the audit or investigation, including providing all records requested at no cost.

2.8 If Provider provides inpatient psychiatric services to an FC Covered Person, Provider must schedule the FC Covered Person for outpatient follow-up and/or continuing treatment prior to discharge. The outpatient treatment must occur within seven (7) days from the date of discharge. Behavioral Health Service Providers must contact FC Covered Persons who have missed appointments within 24 hours to reschedule such appointments.

2.9 In order to submit a Clean Claim, Provider must provide the information set forth under Clean Claims in the Participating Health Care Provider Manual.

2.10 MCO will provide the Provider at least ninety (90) days notice prior to implementing a change in the claims guidelines set forth in the Participating Health Care Provider Manual, unless the change is required by statute or regulation in a shorter timeframe.

2.11 The Participating Health Care Provider Manual includes information concerning which entity/entities Provider must submit claims to for processing and/or adjudication. MCO must notify Provider in writing of any changes in the list of claims processing or adjudication entities at least thirty (30) days prior to the effective date of change. If MCO is unable to provide thirty (30) days notice, MCO must give Provider a thirty (30)-day extension on their claims filing deadline to ensure claims are routed to the correct processing center.

2.12 Provider acknowledges and agrees that program violations arising out of performance of the Agreement are subject to administrative enforcement by the Texas Health and Human Services Commission Office of Inspector General (OIG) as specified in Title 1 Tex. Admin. Code, Chapter 371 Subchapter G.

2.13 The Participating Health Care Provider Manual includes information concerning the complaint and appeal process that applies to Participating Health Care Providers.

2.14 Provider understands and agrees that HHSC reserves the right and retains the authority to make reasonable inquiry and to conduct investigations into Provider and FC Covered Person complaints.

2.15 Provider must treat all information that is obtained through the performance of the services included in this Attachment as confidential information to the extent that confidential treatment is provided under state and federal laws, rules, and regulations. This includes, but is not limited to, information relating to applicants or recipients of the Medicaid, CHIP, and Foster Care Programs.

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

2.17 Provider shall not transfer an identifiable Foster Care Covered Person record, including a patient record, to another entity or person without written consent from the Covered Person or someone authorized to act on his or her behalf; however, Provider understands and agrees that HHSC may ask it to transfer a Covered



Person's record to another agency if HHSC determines that the transfer is necessary to protect either the confidentiality of the record or the health and welfare of the Foster Care Covered Person.

2.18 Provider must cooperate and coordinate with local ECI programs to comply with federal and state requirements relating to the development, review and evaluation of Individual Family Service Plans ("IFSP"). Provider understands and agrees that any Medically Necessary health and behavioral health services contained in an IFSP must be provided to the FC Covered Person in the amount, duration, scope and setting established in the IFSP.

2.19 If an FC Covered Person requests contraceptive services or family planning services, Provider must also provide the FC Covered Person counseling and education about family planning and available family planning services.

2.20 Provider cannot require parental consent for FC Covered Persons who are minors to receive family planning services.

2.21 Provider must comply with state and federal laws and regulations governing FC Covered Person confidentiality (including minors) when providing information on family planning services to FC Covered Persons.

2.22 Provider understands and agrees to the following:

(a) HHSC Office of Inspector General ("*OIG*") and/or the Texas Medicaid Fraud Control Unit must be allowed to conduct private interviews of Provider, Provider's employees, agents, contractors, and patients;
(b) requests for information from such entities must be complied with, in the form and language requested;
(c) Provider and Provider's employees, agents, and contractors must cooperate fully with such entities in making themselves available in person for interviews, consultation, grand jury proceedings, pre-trial conference, hearings, trials and in any other process, including investigations at the Provider's own expense; and
(d) Compliance with these requirements will be at Provider's own expense.

2.23 Provider understands and agrees to the following:

(a) Provider is subject to all state and federal laws and regulations relating to fraud, abuse or waste in health care or dental care and the Medicaid and/or CHIP Programs, as applicable;
(b) Provider must cooperate and assist HHSC and any state or federal agency that is charged with the duty of identifying, investigating, sanctioning or prosecuting suspected fraud, abuse or waste; Provider must provide originals and/or copies of any and all information, allow access to premises, and provide records to the Office of Inspector General, HHSC, the Centers for Medicare and Medicaid Services ("*CMS*"), the U.S. Department of Health and Human Services, FBI, Texas Department of Insurance ("*TDI*"), the Texas Attorney General's Medicaid Fraud Control Unit or other unit of state or federal government, upon request, and free-of-charge.
(c) If Provider places request records in another legal entity's records, such as a hospital, Provider is responsible for obtaining a copy of these records for use by the above-named entities or their representatives; and
(d) Provider must report any suspected fraud or abuse including any suspected fraud and abuse committed by the MCO or an FC Covered Person to the HHSC Office of Inspector General.

2.24 Provider understands and agrees that if Provider receives annual Medicaid payments of at least $5 million (cumulative, from all sources), Provider must:



(a) Establish written policies for all employees, managers, officers, contractors, subcontractors, and agents of Provider. The policies must provide detailed information about the False Claims Act, administrative remedies for false claims and statements, any state laws about civil or criminal penalties for false claims, and whistleblower protections under such laws, as described in Section 1902(a)(68)(A).
(b) Include as part of such written policies detailed provisions regarding the Provider's policies and procedures for detecting and preventing Fraud, Waste, and Abuse.
(c) Include in any employee handbook a specific discussion of the laws described in Section 1902(a)(68)(A), the rights of employees to be protected as whistleblowers, and Provider's policies and procedures for detecting and preventing Fraud, Waste, and Abuse.

2.25 Provider understands and agrees that it is subject to all state and federal laws, rules, regulations, waivers, policies and guidelines, and court-ordered consent decrees, settlement agreements, or other court orders that apply to the Agreement, MCO's and SHPN's contract(s) with HHSC, the Medicaid, CHIP and FC Programs, and, all persons or entities receiving state and federal funds. Provider understands and agrees that any violation by a provider of a state or federal law relating to the delivery of services pursuant to this Agreement, or any violation of MCO's or SHPN's contract(s) with HHSC could result in liability for money damages, and/or civil or criminal penalties and sanctions under state and/or federal law.

2.26 Provider understands and agrees that the following laws, rules, and regulations, and all amendments or modifications thereto, apply to the Agreement:
(i) environmental protection laws:

(a) Pro-Children Act of 1994 (20 U.S.C. §6081 et seq.) regarding the provision of a smoke-free workplace and promoting the non-use of all tobacco products;
(b) National Environmental Policy Act of 1969 (42 U.S.C. §4321 et seq.) and Executive Order 11514 (*"Protection and Enhancement of Environmental Quality"*) relating to the institution of environmental quality control measures;
(c) Clean Air Act and Water Pollution Control Act regulations (Executive Order 11738, "Providing for Administration of the Clean Air Act and Federal Water Pollution Control Act with Respect to Federal Contracts, Grants, and Loans");
(d) State Clean Air Implementation Plan (42 U.S.C. §740 et seq.) regarding conformity of federal actions to State Implementation Plans under §176(c) of the Clean Air Act; and
(e) Safe Drinking Water Act of 1974 (21 U.S.C. §349; 42 U.S.C. §300f to 300j-9) relating to the protection of underground sources of drinking water.

(ii) state and federal anti-discrimination laws:

(a) Title VI of the Civil Rights Act of 1964, Executive Order 11246 (42 U.S.C. § 2000d et seq.) and as applicable 45 C.F.R. Part 80 or 7 C.F.R. Part 15 (29 U.S.C. § 794);
(b) Section 504 of the Rehabilitation Act of 1973 (42 U.S. Code § 12101 et seq.);
(c) Americans with Disabilities Act of 1990 (42 U.S.C. §§ 6101-6107);
(d) Age Discrimination Act of 1975 (42 U.S.C. §§ 6101-6107);
(e) Title IX of the Education Amendments of 1972 (20 U.S.C. §§ 1681-1688);
(f) Food Stamp Act of 1977 (7 U.S.C. § 200 et seq.);
(g) Executive Order 13279, and its implementing regulations at 45 C.F.R. Part 87 or 7 C.F.R. Part 16), and
(h) the HHS agency's administrative rules, as set forth in the Texas Administrative Code, to the extent applicable to this Agreement.

(iii) the Immigration and Nationality Act (8 U.S.C. §1101 et seq.) and all subsequent immigration laws and amendments;



(iv) the Health Insurance Portability and Accountability Act of 1996 ("*HIPAA*") (Public Law 104-191); and

(v) the Health Information Technology Act for Economic and Clinical Health Act (HITECH Act) at 42 U.S.C. § 17931 et seq.

2.27 In the event MCO becomes insolvent or ceases operations, Provider understands and agrees that its sole recourse against MCO will be through MCO's bankruptcy, conservatorship, or receivership estate. Provider understands and agrees that FC Covered Persons may not be held liable for MCO's debts in the event of the entity's insolvency.

2.28 Provider understands and agrees that the HHSC does not assume liability for the actions of, or judgments rendered against, MCO, its employees, agents or subcontractors. Further, Provider understands and agrees that there is no right of subrogation, contribution, or indemnification against HHSC for any duty owed to Provider by MCO or any judgment rendered against MCO. HHSC's liability to Provider, if any, will be governed by the Texas Tort Claims Act, as amended or modified (Tex. Civ. Pract. & Rem. Code §101.001 et seq.).

2.29 Provider agrees to comply with HHSC's marketing policies and procedures, as set forth in the HHSC/MCO Managed Care Contract (which includes HHSC's Uniform Managed Care Manual).

2.30 Provider is prohibited from engaging in direct marketing to FC Covered Persons that is designed to increase enrollment in a particular health plan. This prohibition does not constrain Provider from engaging in permissible marketing activities consistent with broad outreach objectives and application assistance.

2.31 MCO will initiate and maintain any action necessary to stop a Provider or a Provider's employee, agent, assign, trustee, or successor-in-interest from maintaining an action against HHSC, an HHS Agency, or any FC Covered Person to collect payment from HHSC, an HHS Agency, or any FC Covered Person, excluding payment for non-covered services.

2.32 Provider must be licensed in the State of Texas to provide the Covered Services for which the MCO is contracting with Provider, and not be under sanction or exclusion from the Medicaid Program. Provider must be enrolled as a Medicaid provider and have a Texas Provider Identification Number ("*TPIN*"). Effective May 23, 2007, Provider must also have a National Provider Identification Number (NPI) (see 45 C.F.R. Part 162, Subpart D). However, Provider and other Participating Health Care Providers are not required to serve Medicaid populations that are not included in the CHPFC.

2.33 MCO is prohibited from imposing restrictions upon Provider's free communication with an FC Covered Person about the FC Covered Person's medical conditions, treatment options, MCO referral policies, and other MCO policies, including financial incentives or arrangements and all managed care plans with whom the Provider contracts.

2.34 Provider is prohibited from billing or collecting any amount from an FC Covered Person for Covered Services provided pursuant to this Attachment. Federal and State laws provide severe penalties for any provider who attempts to bill or collect any payment from an FC Covered Person for a Covered Service.

2.35 If Provider is a PCP, Provider's services must be accessible to FC Covered Persons 24 hours per day, 7 days per week, and Provider must have acceptable after-hours telephone availability.

2.36 While performing the services described in the Agreement, Provider agrees to comply with applicable state laws, rules, and regulations and HHSC's requests regarding personal and professional conduct generally applicable to the service locations, and otherwise conduct themselves in a businesslike and professional manner.

2.37 Provider agrees to comply with the MCO's QAPI Program requirements.

2.38 MCO must follow the procedures outlined in Section §43.306 of the Texas Insurance Code if terminating the Agreement with Provider. At least ninety (90) days before the effective date of the proposed termination of this Agreement, MCO must provide a written explanation to Provider of the reasons for termination. MCO may immediately terminate this Agreement in a case involving (a) imminent harm to patient health; (b) an action by a state medical or dental board, another medical or dental licensing board, or another licensing board or government agency that effectively impairs Provider's ability to practice medicine, dentistry, or another profession; or (c) fraud or malfeasance.

2.39 Not later than thirty (30) days following receipt of the termination notice, Provider may request a review of the MCO's proposed termination by an advisory review panel, except in a case in which there is imminent harm to patient health, an action against a license, or fraud or malfeasance. The advisory review panel must be composed of physicians and providers, including at least one representative in Provider's specialty, if available, appointed to serve on the standing quality assurance committee or utilization review committee of MCO. The decision of the advisory review panel must be considered by MCO but is not binding on MCO. Within 60 days following receipt of Provider's request for review and before the effective date of the termination, the advisory review panel must make its formal recommendation, and the MCO must communicate the MCO's decision to Provider. MCO must provide to Provider, on request, a copy of the recommendation of the advisory review panel and MCO's determination.

2.40 Provider may not offer or give any thing of value to an officer or employee of HHSC or the State of Texas in violation of state law. A "thing of value" means any item of tangible or intangible property that has a monetary value of more than $50.00 and includes, but is not limited to, cash, food, lodging, entertainment and charitable contributions. The term does not include contributions to public office holders or candidates for public office that are paid and reported in accordance with state and/or federal law. MCO may terminate the Agreement at any time for violation of this requirement.

2.41 Provider understands and agrees that it may not interfere with or place any liens upon the state's right or MCO's right, acting as the state's agent, to recovery from third party resources.

2.42 Texas Health Steps providers must send all Texas Health Steps newborn screens to the Texas Department of State Health Services (*"DSHS"*), formerly the Texas Department of Health, Bureau of Laboratories or a DSHS-certified laboratory. Such providers must include detailed identifying information for all screened newborn FC Covered Persons and each FC Covered Person's mother to allow HHSC to link the screens performed at the hospital with screens performed at the two-week follow-up.

2.43 Provider must coordinate with the local TB control program to ensure that all FC Covered Persons with confirmed or suspected TB have a contact investigation and receive Directly Observed Therapy (*"DOT"*). Provider must report to the DSHS or the local TB control program any member who is non-compliant, drug resistant, or who is or may be posing a public health threat.

2.44 Provider must coordinate with the Women, Infants, and Children (*"WIC"*) Special Supplemental Nutrition Program to provide medical information necessary for WIC eligibility determinations, such as height, weight, hematocrit or hemoglobin.

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

2.46 If Provider is a behavioral health provider, Provider must: (1) submit to the MCO for inclusion into the Health Passport treatment plans and referrals to other providers; (2) document the outcome measurement scores in the Health Passport; (3) function as a member of the PCP Team by coordinating with the PCP and Service Manager as appropriate; and (4) testify in court as needed for child protection litigation.



2.47 If Provider is a PCP, Provider must provide preventive care (1) to children under age 21 in accordance with AAP recommendations for CHIP Covered Persons and CHIP Perinatal Newborns; and the Texas Health Steps Manual for Medicaid and FC Covered Persons, and (2) to adults in accordance with the U.S. Preventative Task Force requirements.

2.48 Provider must comply with medical consent requirements in Texas Family Code §266.004 that require the FC Covered Person's Medical Consentee to consent to the provision of medical care. Provider does not need the medical consent of the FC Covered Person's Medical Consentee to provide Emergency Services for a FC Covered Person that has an Emergency Medical Condition. Provider must notify the Medical Consentee about the provision of Emergency Services no later than the second business day after providing Emergency Services, as required by Texas Family Code §266.009. The notification must be documented in the FC Covered Person's Health Passport.

2.49 If Provider is a PCP, Provider must comply with the following to participate in the CHPFC:

(a) Either be enrolled as a Texas Health Steps provider or refer FC Covered Persons due for a Texas Health Steps checkup to a Texas Health Steps provider;

(b) Refer FC Covered Persons for follow-up assessments or interventions clinically indicated as a result of the Texas Health Steps checkup, including the developmental and behavioral components of the screening; and

(c) Submit information from the Texas Health Steps forms and documents to the Health Passport.

2.50 If Provider is a PCP, Provider must assess the medical and behavioral health needs of FC Covered Persons for referral to specialty care providers and provide referrals as needed. FC Covered Persons can access behavioral health treatment without prior approval from the PCP. PCPs must coordinate FC Covered Persons' care with specialty care providers after referral. PCPs must serve as a medical home to Covered Persons.

2.51 If Provider is a behavioral health provider, Provider must provide a monthly summary form, to be provided by MCO. The following information must be included in the monthly summary form for the Health Passport:

(a) Primary and secondary (if present) diagnosis.
(b) Assessment information, including results of a mental status exam
(c) Brief narrative summary of the Member's clinical visits/progress
(d) Scores on each outcome rating form(s).
(e) Referrals to other providers or community resources.
(f) Health Care Service Plans and referrals to providers.
(g) Evaluations of each Covered Person's progress at intake, monthly, and at termination of the Health Care Service Plan, or as significant changes are made in the treatment plan.
(h) Any other relevant care information

2.52 Provider is prohibited from billing or collecting any amount from an FC Covered Person for Covered Services covered by the Foster Care Program Contract. Provider must inform FC Covered Persons of the costs for non-covered services prior to rendering such services and obtain a signed private pay form from such FC Covered Persons.

2.53 Provider understands and agrees that HHSC is not liable or responsible for payment for Covered Services rendered pursuant to this Agreement.



2.54 Termination of Provider Contracts. Unless prohibited or limited by applicable law, as soon as possible and at least 30 days prior to the effective date of the MCO's termination of this Agreement, MCO must provide written notice to (i) Provider that it will no longer be a part of the Participating Health Care Provider Network; (ii) the HHSC Administrative Services Contractor; and, (iii) affected FC Covered Persons. Affected FC Covered Persons include all FC Covered Persons in a PCP's panel and all FC Covered Persons who have been receiving ongoing care from the terminated Provider, where ongoing care is defined as two or more visits for home-based or office-based care in the past 12 months.

2.55 Provider must testify in court as needed for child protection litigation relating to FC Covered Persons.

2.56 Health Passports. MCO and the FC Covered Person's Providers, as appropriate, will be responsible for updating each FC Covered Person's Health Passport with the required medical information. Provider shall submit all applicable information for the Health Passport either (i) by inputting data directly into the Health Passport at the point of service through a web-based interface or (ii) submitting the required information to MCO for entry into the Health Passport.

2.57 If Provider is a PCP, Provider must use the Texas Health Steps behavioral health forms, at a minimum, for the detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders. FC Covered Persons must be screened for behavioral health problems, including possible substance abuse or chemical dependency. Provider must submit completed Texas Health Steps screening and evaluation results to the MCO to include in the Health Passport.

2.58 Provider must comply with the *"Psychiatropic Medication Utilization Parameters for Foster Children"* found at http://www.dfps.state.tx.us/Child_Protection/Medical_Services/guide-psychotropic.asp, as amended or modified from time to time.

2.59 Payment of Clean Claims. All provider claims shall be processed within 30 days from the date of claim receipt by the MCO. All provider claims that are Clean Claims shall be adjudicated (finalized as paid or denied) within thirty (30) days from the date of claim receipt. MCO shall offer Provider the option of submitting and receiving claims information through electronic data interchange (*"EDI"*) that allows for automated processing and adjudication of claims. EDI processing must be offered as an alternative to the filing of paper claims. Electronic claims must use HIPAA-compliant electronic formats. MCO shall pay Provider interest at a rate of 1.5% per month (18% per annum), calculated daily, for the full period in which the Clean Claim remains unadjudicated beyond the 30-day claims processing deadline.

2.60 MCO shall not pay any claim submitted by Provider if Provider has been excluded or suspended from the Medicare, Medicaid, or CHIP programs for fraud and abuse. MCO shall not pay any claim submitted by Provider if Provider is on payment hold under the authority of HHSC or its authorized agent(s), or has pending accounts receivable with HHSC.

2.61 MCO must adjudicate all appealed claims to a paid or denied status within 30 days of receipt of the appealed claim.

2.62 MCO may deny a claim for failure to file timely if a provider does not submit the claim to the MCO within 95 days of the date of service. If Provider files with the wrong health plan, or with the HHSC Administrative Services Contractor, and produces documentation verifying the initial timely claims filing within 95 days of the date of service, MCO shall process the claim without denying for failure to timely file. MCO shall send a remittance and status report or other remittance written communication that includes detailed information for each adjudicated, denied deficient, and pended deficient claim to allow Provider to easily identify the claim number, date of service, type of service, claim codes, FC Covered Person's name, and FC Covered Person ID number. MCO shall finalize all claims, including appealed claims, within 24 months of the date of service.



2.63 MCO shall inform Provider about the information required to submit a claim at least 30 days prior to the operational start date of the CHPFC. Such claims submission requirements, including claims coding and processing guidelines, are found in MCO's Participating Health Care Provider Manual, which is a part of this Agreement.

2.64 Provider shall comply with the HIPAA confidentiality provisions of Section 2.18 of the Agreement.

2.65 Provider shall comply with the professional liability insurance provisions of Section 5.1 of the Agreement.

2.66 Provider acknowledges and agrees that the Participating Health Care Provider Manual is incorporated into the Agreement by Section 2.4 of the Agreement.

2.67 Providers must comply with the requirements of Texas Government Code §531.024161, regarding the submission of claims involving supervised providers.

**ATTACHMENT G**

**LTSS ANCILLARY COMPENSATION SCHEDULE**

**STAR+PLUS**

For Long Term Supports and Services Covered Services provided to Covered Persons, Payor shall pay Provider one hundred percent (100%) of the State Medicaid fee schedule, not to exceed one hundred percent (100%) of Medicare in effect on the date of service.

***Additional Provisions:***

1. Medicaid Fee Schedule. Payor utilizes the current Texas Medicaid Fee Schedule as published at: http://public.tmhp.com/FeeSchedules/Default.aspx for the provider's specialty.

2. Code Change Updates. Updates to billing-related codes (e.g., CPT, HCPCS, ICD-9, DRG, and revenue codes) shall become effective on the date ("Code Change Effective Date") that is the later of: (i) the first day of the month following thirty (30) days after publication by the governmental agency having authority over the applicable product of such governmental agency's acceptance of such code updates; or (ii) the effective date of such code updates, as determined by such governmental agency. Claims processed prior to the Code Change Effective Date shall not be reprocessed to reflect any such code updates.

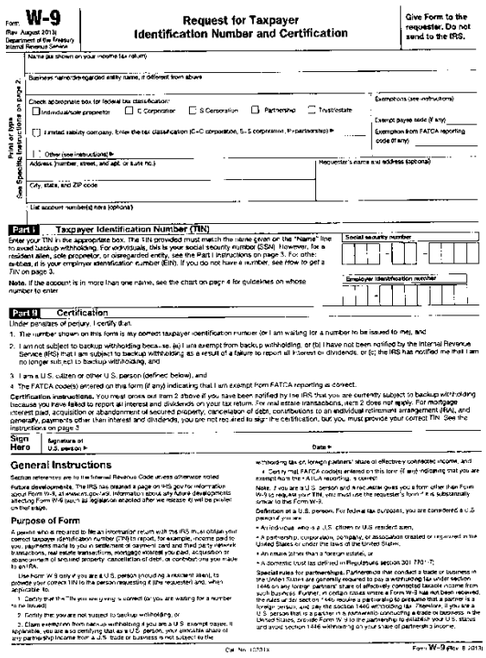
3. Fee Schedule Updates. Updates to the State Medicaid fee schedule shall become effective on the date ("Fee Change Effective Date") that is the later of: (i) the first day of the month following thirty (30) days after publication by the governmental agency having authority over the applicable product of such governmental agency's acceptance of such fee schedule updates; or (ii) the effective date of such fee schedule updates, as determined by such governmental agency. Claims processed prior to the Fee Change Effective Date shall not be reprocessed to reflect any updates to the fee schedule.

4. Payment under this Exhibit. All payments under this Exhibit are subject to the terms and conditions set forth in the Agreement and the Provider Manual

***Definitions:***

1. Allowable Charges mean those Provider billed charges for services that qualify as Covered Services.





Form **W-9** (Rev. August 2013) Department of the Treasury Internal Revenue Service

**Request for Taxpayer Identification Number and Certification**

**Give Form to the requester. Do not send to the IRS.**

Print or type (See Specific Instructions on page 2.)

Name (as shown on your income tax return)

Business name/disregarded entity name, if different from above

Check appropriate box for federal tax classification: ☐ Individual/sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶

☐ Other (see instructions) ▶

Exemptions (see instructions)

Exempt payee code (if any)

Exemption from FATCA reporting code (if any)

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

**Part I** Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

**Note.** If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number

Employer identification number

**Part II** Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below), and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

**Certification instructions.** You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

**Sign Here** Signature of U.S. person ▶ Date ▶

**General Instructions**

Section references are to the Internal Revenue Code unless otherwise noted.

**Future developments.** The IRS has created a page on IRS.gov for information about Form W-9, at www.irs.gov/w9. Information about any future developments affecting Form W-9 (such as legislation enacted after we release it) will be posted on that page.

**Purpose of Form**

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, payments made to you in settlement of payment card and third party network transactions, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contribution you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA codes entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct.

**Note.** If you are a U.S. person and it has not been given you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

**Definition of a U.S. person.** For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

**Special rules for partnerships.** Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.





In the cases below, the following person must give Form W-9 to the partnership for purposes of withholding on its U.S. status and allocable share of net income from the partnership conducting a trade or business in the United States.

- In the case of a disregarded entity with a U.S. owner, the U.S. owner of the disregarded entity and not the entity,
- In the case of a grantor trust with a U.S. grantor or other U.S. owner, generally, the U.S. grantor or other U.S. owner of the grantor trust and not the trust, and
- In the case of a U.S. trust (other than a grantor trust), the U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

**Foreign person.** If you are a foreign person or the U.S. branch of a foreign bank that has elected to be treated as a U.S. person, do not use Form W-9. Instead, use the appropriate Form W-8 or Form 8233 (see Publication 515, *Withholding of Tax on Nonresident Aliens and Foreign Entities*).

**Nonresident alien who becomes a resident alien.** Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

**Example.** Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity, give the requester the appropriate completed Form W-8 or Form 8233.

**What is backup withholding?** Persons making certain payments to you must under certain conditions withhold and pay to the IRS a percentage of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, payments made in settlement of payment card and third party network transactions, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

**Payments you receive will be subject to backup withholding if:**

1. You do not furnish your TIN to the requester,
2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),
3. The IRS tells the requester that you furnished an incorrect TIN,
4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or
5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See *General Instructions* on page 3 and the separate Instructions for the Requester of Form W-9 for more information.

Also see *Special rules for partnerships* on page 1.

**What is FATCA reporting?** The Foreign Account Tax Compliance Act (FATCA) requires a participating foreign financial institution to report all United States account holders that are specified United States persons. Certain payees are exempt from FATCA reporting. See *Exemption from FATCA reporting code* on page 3 and the Instructions for the Requester of Form W-9 for more information.

**Updating Your Information**

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account, for example, if the grantor of a grantor trust dies.

**Penalties**

**Failure to furnish TIN.** If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

**Civil penalty for false information with respect to withholding.** If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

**Criminal penalty for falsifying information.** Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

**Misuse of TINs.** If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

**Specific Instructions**

**Name**

If you are an individual, you must generally enter the name shown on your income tax return. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the change, please enter your first name, the last name shown on your social security card, and your new last name.

If the account is in more than one name, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

**Sole proprietor.** Enter your individual name as shown on your income tax return on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name/disregarded entity name" line.

**Partnership, C Corporation, or S Corporation.** Enter the entity's name on the "Name" line and any business, trade, or "doing business as (DBA) name" on the "Business name/disregarded entity name" line.

**Disregarded entity.** For U.S. federal tax purposes, an entity that is disregarded as an entity separate from its owner is treated as a "disregarded entity." See Regulations section 301.7701-2(c)(2)(iii). Enter the owner's name on the "Name" line. The name of the entity entered on the "Name" line should never be a disregarded entity. The name to be entered on the "Name" line must be the name shown on the income tax return on which the income should be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a single owner that is a U.S. person, the U.S. owner's name is required to be provided on the "Name" line. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on the "Business name/disregarded entity name" line. If the owner of the disregarded entity is a foreign person, the owner must complete an appropriate Form W-8 instead of a Form W-9. This is the case even if the foreign person has a U.S. TIN.

**Note.** Check the appropriate box for the U.S. federal tax classification of the person whose name is entered on the "Name" line (Individual/sole proprietor, Partnership, C Corporation, S Corporation, Trust/estate).

**Limited Liability Company (LLC).** If the person identified on the "Name" line is an LLC, check the "Limited liability company" box only and enter the appropriate code for the LLC in the space provided. If the LLC is treated as a partnership for federal tax purposes, check the "Limited liability company" box and enter "P" in the space provided. If the LLC has filed Form 8832 or 2553 to be taxed as a corporation, enter "C" for C corporation or "S" for S corporation. If the LLC is disregarded as an entity separate from its owner under Regulation section 301.7701-3 (except for employment and excise tax), do not check the LLC box unless the owner of the LLC (required to be identified on the "Name" line) is another LLC that is not disregarded for U.S. federal tax purposes. If the LLC is disregarded as an entity separate from its owner, enter the appropriate tax classification of the owner identified on the "Name" line.

**Other entities.** Enter your business name as shown on required U.S. federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or "doing business as (DBA)" name on the "Business name/disregarded entity name" line.

**Exemptions**

If you are exempt from backup withholding and/or FATCA reporting, enter in the Exemptions box, any code(s) that may apply to you. See *Exempt payee code* and *Exemption from FATCA reporting code* on page 3.



**Exempt payee code.** Generally, individuals (including sole proprietors) are not exempt from backup withholding. For partnerships, see exempt from backup withholding for certain payments, such as interest and dividends. Corporations are not exempt from backup withholding for payments made in settlement of payment card or third party network transactions.

Note. If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

The following codes identify payees that are exempt from backup withholding.

1—An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2)

2—The United States or any of its agencies or instrumentalities

3—A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities

4—A foreign government or any of its political subdivisions, agencies, or instrumentalities

5—A corporation

6—A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States

7—A futures commission merchant registered with the Commodity Futures Trading Commission

8—A real estate investment trust

9—An entity registered at all times during the tax year under the Investment Company Act of 1940

10—A common fund operated by a bank under section 584(a)

11—A financial institution

12—A middleman known in the investment community or a nominee or custodian

13—A trust exempt from tax under section 664 or described in section 4947

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 13.

| IF the payment is for . . . | THEN the payment is exempt for . . . |
|---|---|
| Interest and dividend payments | All exempt payees except for 7 |
| Broker transactions | Exempt payees 1 through 4 and 6 through 11 and all C corporations. S corporations must not enter an exempt code for payments other than gross proceeds reportable on Form 1099-B. |
| Barter exchange transactions and patronage dividends | Exempt payees 1 through 4 |
| Payments over $600 required to be reported and direct sales over $5,000[1] | Generally, exempt payees 1 through 5[2] |
| Payments made in settlement of payment card or third party network transactions | Exempt payees 1 through 4 |

[1] See Form 1099-MISC, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney, and payments for services paid by a federal executive agency.

**Exemption from FATCA reporting code.** The following codes identify payees that are exempt from reporting under FATCA. These codes apply to persons submitting this form for accounts maintained outside of the United States by certain foreign financial institutions. Therefore, if you are only submitting this form for an account you hold in the United States, you may leave this field blank. Consult with the person requesting this form if you are uncertain if the financial institution is subject to these requirements.

A—An organization exempt from tax under section 501(a) or any individual retirement plan as defined in section 7701(a)(37)

B—The United States or any of its agencies or instrumentalities

C—A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities

D—A corporation the stock of which is regularly traded on one or more established securities markets, as described in Reg. section 1.1472-1(c)(1)(i)

E—A corporation that is a member of the same expanded affiliated group as a corporation described in Reg. section 1.1472-1(c)(1)(i)

F—A dealer in securities, commodities, or derivative financial instruments (including notional principal contracts, futures, forwards, and options) that is registered as such under the laws of the United States or any state

G—A real estate investment trust

H—A regulated investment company as defined in section 851 or an entity registered at all times during the tax year under the Investment Company Act of 1940

I—A common trust fund as defined in section 584(a)

J—A bank as defined in section 581

K—A broker

L—A trust exempt from tax under section 664 or described in section 4947(a)(1)

M—A tax exempt trust under a section 403(b) plan or section 457(g) plan

**Part I. Taxpayer Identification Number (TIN)**

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-member LLC that is disregarded as an entity separate from its owner (see *Limited liability company (LLC)* on page 2), enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note. See the chart on page 4 for further clarification of name and TIN combinations.

**How to get a TIN.** If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local Social Security Administration office or get this form online at www.ssa.gov. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at www.irs.gov/businesses and clicking on Employer Identification Number (EIN) under Starting a Business. You can get Forms W-7 and SS-4 from the IRS by visiting IRS.gov or by calling 1-800-TAX-FORM (1-800-829-3676).

If you were asked to complete Form W-9 but do not have a TIN, apply for a TIN and write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note. Writing "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

**Caution.** A disregarded U.S. entity that has a foreign owner must use the appropriate Form W-8.

**Part II. Certification**

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if item 1, 4, or 5 below indicates otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on the "Name" line must sign. Exempt payees, see *Exempt payee code* earlier.

**Signature requirements.** Complete the certification as indicated in items 1 through 5 below.

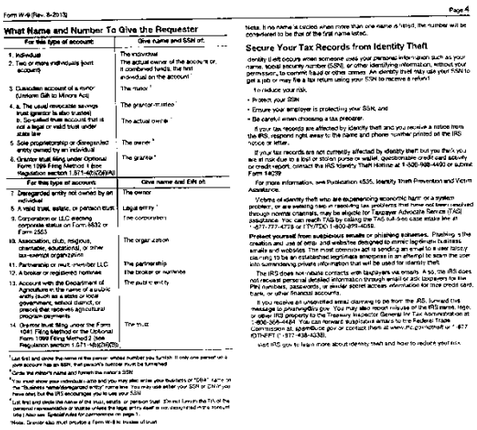
1. **Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983.** You must give your correct TIN, but you do not have to sign the certification.

2. **Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983.** You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you do not have to sign the certification before signing the form.

3. **Real estate transactions.** You must sign the certification. You may cross out item 2 of the certification.

4. **Other payments.** You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments made in settlement of payment card and third party network transactions, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. **Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions.** You must give your correct TIN, but you do not have to sign the certification.



Form W-9 (Rev. 8-2013) Page 4

**What Name and Number To Give the Requester**

| For this type of account: | Give name and SSN of: |
|---|---|
| 1. Individual | The individual |
| 2. Two or more individuals (joint account) | The actual owner of the account or, if combined funds, the first individual on the account[1] |
| 3. Custodian account of a minor (Uniform Gift to Minors Act) | The minor[2] |
| 4. a. The usual revocable savings trust (grantor is also trustee) | The grantor-trustee[1] |
| b. So-called trust account that is not a legal or valid trust under state law | The actual owner[1] |
| 5. Sole proprietorship or disregarded entity owned by an individual | The owner[3] |
| 6. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulation section 1.671-4(b)(2)(i)(A)) | The grantor[4] |
| **For this type of account:** | **Give name and EIN of:** |
| 7. Disregarded entity not owned by an individual | The owner |
| 8. A valid trust, estate, or pension trust | Legal entity[5] |
| 9. Corporation or LLC electing corporate status on Form 8832 or Form 2553 | The corporation |
| 10. Association, club, religious, charitable, educational, or other tax-exempt organization | The organization |
| 11. Partnership or multi-member LLC | The partnership |
| 12. A broker or registered nominee | The broker or nominee |
| 13. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments | The public entity |
| 14. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulation section 1.671-4(b)(2)(i)(B)) | The trust |

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name and you may also enter your business or "DBA" name on the "Business name/disregarded entity" name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

[4] List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see Special rules for partnerships on page 1.

*Note. Grantor also must provide a Form W-9 to trustee of trust.*

**Note.** If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

**Secure Your Tax Records from Identity Theft**

Identity theft occurs when someone uses your personal information such as your name, social security number (SSN), or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Publication 4535, Identity Theft Prevention and Victim Assistance.

Victims of identity theft who are experiencing economic harm or a system problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes. Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to phishing@irs.gov. You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at: spam@uce.gov or contact them at www.ftc.gov/idtheft or 1-877-IDTHEFT (1-877-438-4338).

Visit IRS.gov to learn more about identity theft and how to reduce your risk.

**Privacy Act Notice**

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.

SUPERIOR HEALTHPLAN, INC.
PARTICIPATING PROVIDER CONFLICT OF INTEREST
AND HEALTH CARE ENTITY FINANCIAL INTEREST POLICY
AND
DISCLOSURE STATEMENTS

It is the policy of Superior HealthPlan, Inc. (Superior) that no provider participating in Superior's network shall use his or her position as a contracted provider, or knowledge gained in such position, in such a way that creates conflicts of interest (COI) with Superior, its parent company, an affiliate, subsidiary, or related corporation. The term COI refers to any situation or position in which personal interests (of the provider or a "related party"[1]) conflict with organizational interests, affecting an individual's ability to make impartial decisions. Training and education are provided to promote COI awareness among all of Superior's providers. Superior also offers numerous avenues for providers to ask questions and receive information about identifying and disclosing COI.

Providers are responsible for disclosing actual, potential, or perceived COI on this form at the time they apply to join or to be recredentialed to remain in Superior's network. They are also responsible for promptly disclosing COI that may arise later, after they have joined Superior's network.

**Process for Disclosing Actual, Potential, or Perceived Conflicts Of Interest**

1. All questions about, and disclosures of, COI should be directed to the Provider's local Superior Provider Services Representative.
2. Identify COI by consulting with the Superior's Provider Services staff or referring to the examples listed in Attachment A to this Policy.
3. Disclose actual, potential, or perceived COI before taking any action that may appear to be influenced by the conflict.
4. Avoid participating in the activity in question until Superior determines whether a COI exists.
5. If a Conflict of Interest is determined to be real, Superior's Compliance Director will document and report the decision to the provider involved.

[1] A "related party" is defined as a provider's spouse, parents, step parents, children, step children, siblings, step-siblings, nieces/nephews, aunts/uncles, grandparents, grandchildren, in-laws, same or opposite sex domestic partner.



**Health Care Entity Financial Interest Disclosures**

It is also the policy of Superior HealthPlan, Inc. that all providers participating in its network shall disclose to Superior any and all Financial Interests, including "Controlling Interests,"[2] such providers or any of their related parties may have in a "Health Care Entity."

For purposes of this policy and the disclosure required herein, a "Health Care Entity" is defined to mean any provider of health care services, in whatever form that provider may be organized (to include but not be limited to a corporation, a partnership, a professional association, a limited liability company, or a professional corporation) and no matter what type of services the provider may provide or be licensed to provide (to include but not be limited to, therapy services, hospital services, pharmacy services, laboratory services, radiology services, physician services, home health services, etc).

Providers are responsible for disclosing any such Financial Interest on this form at the time they apply to join or to be recredentialed to remain in Superior's network. They are also responsible for promptly disclosing any such Financial Interest that may arise later, after they have joined Superior's network.

Providers who have questions about whether an interest or relationship they have with a Health Care Entity or other provider constitutes a Financial Interest that should be disclosed to Superior should contact their local Provider Services Representative to discuss.

**Examples of Health Care Entity Financial Interests that should be disclosed pursuant to this policy include**

1. A physician applying to join or being recredentialed in Superior's network owns an interest in a pharmacy;
2. The spouse of a provider joining or being recredentialed in Superior's network owns a therapy services company;
3. A provider joining or being recredentialed in Superior's network owns an interest in a hospital or owns a company that leases facility space to a hospital; or
4. A physician being contracted/credentialed or recredentialed by Superior has a Financial Interest in a Health Care Entity that provides a "Designated Health Service" (clinical laboratory services; physical, occupational, or speech pathology services, radiation therapy services and supplies; radiology and certain other imaging services; durable medical equipment services and supplies, prosthetics and orthotics services, and prosthetic devices and supplies; parenteral and enteral nutrients, equipment and supplies; home health services; outpatient prescription drug services inpatient and outpatient hospital services, and/or nuclear medicine).

[2] A "Financial Interest" refers to any ownership interest you have in any corporation (whether for profit or nonprofit), limited liability company, partnership or other business organization other than beneficial ownership in a publicly traded company of less than 5%. A "Controlling Interest" shall include an interest by which you have the power to vote for the election of directors, managers or other management of a person or entity or the power to direct or cause the direction of the management or policies of a person or entity. A "Financial Interest" also refers to a financial arrangement you may have with the Health Care Entity, such as an employment agreement, services contract, consulting arrangement, lease or equipment sharing agreement.



**Conflict of Interest Disclosure Statement**

I, _____, hereby declare that I (or a related party) do/do not (circle one) have an actual, potential, or perceived Conflict of Interest that I wish to disclose to Superior HealthPlan, Inc.

Such disclosure shall include, at a minimum, the legal name of the entity involved, its business address, its federal tax ID number, its principal line(s) of business, and the provider's ownership interest (by percentage) and/or management role (including title) with the entity.

If I circled "do" above, the following is a summary of my disclosure, including all material facts and the above-listed items or information (use additional paper as necessary):

Legal name of the entity involved: _____

Business address: _____

_____

Federal tax ID number: _____

Provider's ownership interest (e.g., type and percentage): _____

_____

Entity's principal line(s) of business: _____

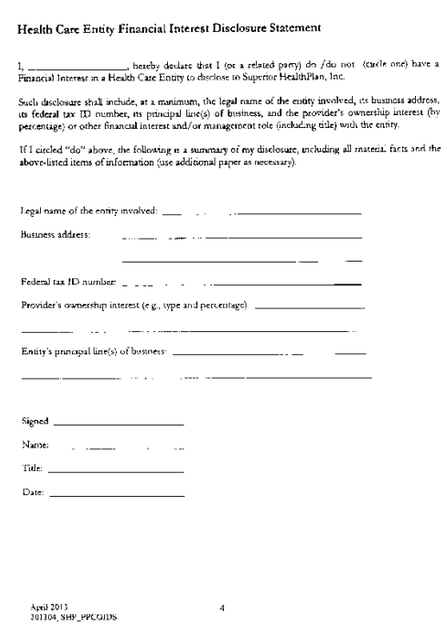
_____

Signed: _____

Name: _____

Title: _____

Date: _____



**Health Care Entity Financial Interest Disclosure Statement**

I, _____, hereby declare that I (or a related party) do /do not (circle one) have a Financial Interest in a Health Care Entity to disclose to Superior HealthPlan, Inc.

Such disclosure shall include, at a maximum, the legal name of the entity involved, its business address, its federal tax ID number, its principal line(s) of business, and the provider's ownership interest (by percentage) or other financial interest and/or management role (including title) with the entity.

If I circled "do" above, the following is a summary of my disclosure, including all material facts and the above-listed items of information (use additional paper as necessary).

Legal name of the entity involved: _____

Business address: _____

_____

Federal tax ID number: _____

Provider's ownership interest (e.g., type and percentage) _____

_____

Entity's principal line(s) of business: _____

_____

Signed _____

Name: _____

Title: _____

Date: _____

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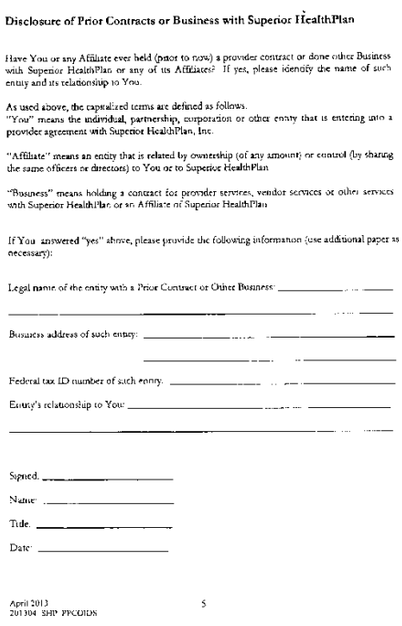

**Disclosure of Prior Contracts or Business with Superior HealthPlan**

Have You or any Affiliate ever held (prior to now) a provider contract or done other Business with Superior HealthPlan or any of its Affiliates? If yes, please identify the name of such entity and its relationship to You.

As used above, the capitalized terms are defined as follows.
"You" means the individual, partnership, corporation or other entity that is entering into a provider agreement with Superior HealthPlan, Inc.

"Affiliate" means an entity that is related by ownership (of any amount) or control (by sharing the same officers or directors) to You or to Superior HealthPlan

"Business" means holding a contract for provider services, vendor services or other services with Superior HealthPlan or an Affiliate of Superior HealthPlan

If You answered "yes" above, please provide the following information (use additional paper as necessary):

Legal name of the entity with a Prior Contract or Other Business: _____

_____

Business address of such entity: _____

_____

Federal tax ID number of such entity: _____

Entity's relationship to You: _____

_____

Signed: _____

Name: _____

Title: _____

Date: _____

April 2013
201304_SHP_PPCGIDS

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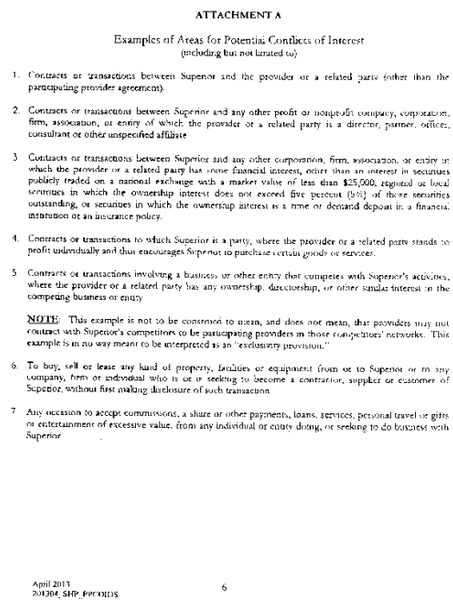


**ATTACHMENT A**

Examples of Areas for Potential Conflicts of Interest
(including but not limited to)

1. Contracts or transactions between Superior and the provider or a related party (other than the participating provider agreement).

2. Contracts or transactions between Superior and any other profit or nonprofit company, corporation, firm, association, or entity of which the provider or a related party is a director, partner, officer, consultant or other unspecified affiliate

3. Contracts or transactions between Superior and any other corporation, firm, association, or entity in which the provider or a related party has some financial interest, other than an interest in securities publicly traded on a national exchange with a market value of less than $25,000, required or local securities in which the ownership interest does not exceed five percent (5%) of those securities outstanding, or securities in which the ownership interest is a time or demand deposit in a financial institution or an insurance policy.

4. Contracts or transactions to which Superior is a party, where the provider or a related party stands to profit individually and thus encourages Superior to purchase certain goods or services.

5. Contracts or transactions involving a business or other entity that competes with Superior's activities, where the provider or a related party has any ownership, directorship, or other similar interest in the competing business or entity.

   **NOTE**: This example is not to be construed to mean, and does not mean, that providers may not contract with Superior's competitors to be participating providers in those competitors' networks. This example is in no way meant to be interpreted as an "exclusivity provision."

6. To buy, sell or lease any kind of property, facilities or equipment from or to Superior or to any company, firm or individual who is or is seeking to become a contractor, supplier or customer of Superior, without first making disclosure of such transaction.

7. Any occasion to accept commissions, a share or other payments, loans, services, personal travel or gifts or entertainment of excessive value, from any individual or entity doing, or seeking to do business with Superior.

April 2013
201304_SHP_PPCGIDS

6

A motion was made by Commissioner Wolf and seconded by Commissioner Stevens to table approving Road Policy and Specifications for Winkler County; which motion became an order of the Court upon the following vote:

Ayes: Commissioners Stevens, Wolf, Neal and Thompson
Noes: None

A motion was made by Commissioner Thompson and seconded by Commissioner Neal to approve IBM maintenance contract for RS/6000 Server 9111 Model 520 SN 850BD between Winkler County and Tyler Technologies, Inc. for the period of July 27, 2014 through July 26, 2015 and payment in the amount of $2,187.77 from budgeted funds; which motion became an order of the Court upon the following vote:

Ayes: Commissioners Stevens, Wolf, Neal and Thompson
Noes: None

tyler technologies

5101 Tennyson Parkway
Plano, Texas 75024

P: 972.713.3770
F: 972.713.3777

www.tylertech.com

5/6/2014

Dear Jeanna Willhelm,

Our records indicate that IBM hardware maintenance for Winkler County is coming up for renewal.

IBM Service Elite Hardware Maintenance for R5/6000 Server 9113 Model 520 s/n 850BD

| [illegible] | [illegible] | [illegible] | [illegible] |
|---|---|---|---|
| 7/26 | 07/19/14 | 12 Months | $ 2,187.77 |

Please indicate your decision to renew or discontinue IBM maintenance below and return this letter to Tim.Schauer@tylertech.com

☑ Renew IBM hardware maintenance through Tyler Technologies.
I understand that I must submit this letter as well as the attached Purchase Agreement to renew through Tyler Technologies

☐ Do not renew IBM hardware maintenance through Tyler Technologies
I plan to renew maintenance directly with IBM.

☐ Do not renew IBM hardware maintenance.
I understand that IBM's hourly rates for support, replacement parts, and/or labor will apply in the event of a hardware failure.

**Failure to return this document to Tyler Technologies by the renewal notice deadline assumes you wish to discontinue your IBM hardware maintenance through Tyler Technologies.**

Authorized Signature _____ Date May 12, 2014

Printed Name Bonnie Leck Title Winkler County Judge

Questions? Please contact me at the number below or you can email our Support Operations team at PLA-SupportOps@tylertech.com.

Sincerely,

Tim Schauer
Sr. Support Analyst, Operations
972.713.3770

tyler technologies

**Winkler County**

May 6, 2014

| Purchase Agreement | Price |
|---|---|
| IBM Service Elite Hardware Maintenance for R5/6000 Server 9111 Model 520 s/n 85CBD | $2,187.77 |
| Renewal Term: <Renewal Term> | |
| **Total:** | **$2,187.77** |

Tyler Technologies
Prepared by: Tim Schauer
5101 Tennyson Parkway
Plano, Texas 75024

Winkler County
*Bill To (please print)* *PO Number*

*Authorized Signature* *Date* 5/12/14

**To Authorize This Purchase Agreement**
1) Review Items for Accuracy
2) Complete 'Bill To' Information
3) Note any Special Instructions
4) Attach Your Purchase Order (if applicable, not required)
5) Sign and return to Betsy.Veneziano@tylertech.com

*Special Invoicing Instructions*

Prices valid for up to 30 days from date of issue.

jeabna.willhelm@co.winkler.tx.us
*Email Address*

Page 1 of 1

## IBM ServicesAssistant Solution Summary

For Information purposes only with End User Reference prices - Final prices will be those in effect when the contract is signed

| **Customer Information** | |
|---|---|
| Customer Name: ARROW ENTERPRISE COMPU | Signing Customer Number: 06394132 |
| Customer Type | COMMERCIAL CUSTOMER |
| **Business Partner Information** | |
| BP Name: ARROW ENTERPRISE COMPU | BP Number: 06561734 |
| **Contract Information** | |
| Contract Start Date | 07/27/2014 |
| Standard Contract Term Stop Date | 07/26/2015 |
| Non-Standard Contract Term Stop Date | |
| Proposal Reference Date | 07/27/2014 |
| Charge Period Start Date | 07/27/2014 |

| **General Information** | | | |
|---|---|---|---|
| Solution Summary ID | A352DF | Status | Priced |
| Channel Indicator | I | Created By | ARBRANC |
| Pricing structure | Remarketer | Created On | 05/02/2014 |
| Description | Peak - Winkler County Renewal old A059KN new A352DF | Last Updated By | ARBRANC |
| Associated contract number | | Last Updated On | 05/02/2014 |
| Fiscal Period | | | |
| Type of Discount(s) Applied | | | |
| [1] Accumulated Adjustment Invoicing Option | N | | |

**Summary Section**

**Summary for 12 MONTH TERM,PREPAY, 1 LVL**

| Customer No. | Customer Name and Address | One Time Charge | Maintenance | Services | Totals |
|---|---|---|---|---|---|
| 08700545 | ARROW ENTERPRISE COMPUTING SO WINKLER COUNTY TAX OFF 100 E WINKLER KERMIT TX 79745-6019 | $ 0.00 | $ 2,187.77 | $ 0.00 | $ 2,187.77 |
| | Totals Inclusive of MES | $ 0.00 | $ 2,187.77 | $ 0.00 | $ 2,187.77 |

**Details for Maintenance Machine List - 12 MONTH TERM,PREPAY, 1 LVL**

Charges shown below are for the first Pricing option in the Summary Section. They exclude taxes.
The details include charges for the entire prepay term.
Installation Customer Number: 08700545 City, State: KERMIT TX 79745-6019

| Description | Type | Model / Feature | Serial Number | Charge Start Date[5] | Charge Stop Date[5] | Qty | Type of Svc[2] | Maint Svc[3] | Code[4] | Charges |
|---|---|---|---|---|---|---|---|---|---|---|
| ESERVER P5 520 | 9111 | 520 | 0000850BD | | | 1 | B | 1 | H | $ 2,187.77 |
| 1WAY 1.5GHZ PWR PRC,CNGL3 C | | 5231 | | | | 1 | | | | |
| 36/72GB 4MM INT.TAPE DRIVE | | 6258 | | | | 1 | | | | |
| ULTRA320 SCSI 4-PACK | | 6574 | | | | 1 | | | | |
| | | | | | | | | | Subtotal without MES | $ 2,187.77 |
| | | | | | | | | | Subtotal with MES | $ 2,187.77 |
| **Recurring Maintenance Grand Total Without MES** | | | | | | | | | | $ 2,187.77 |
| **Recurring Maintenance Grand Total With MES** | | | | | | | | | | $ 2,187.77 |

**Legends**

[1] Change adjustments related to inventory and Service changes will be accumulated and invoiced with your next standard invoicing cycle (may be sooner for annual or semiannual payment plans)

[2] TYPE OF REPAIR SERVICE:
A) On-Site Repair/Exchange Services, Monday through Friday (excluding holidays), 8am to 5pm, next business day
B) On-Site Repair/Exchange Services, 7 days a week, 24hrs/day.
C) On-Site Repair/Exchange Services, Monday through Friday (excluding holidays), 8am to 5pm, 4 hour response objective
This type of repair Service includes a response objective and is not a guarantee
D) On-Site Repair/Exchange Services, 7 days a week, 24hrs/day 2 hour response objective
This type of repair Service includes a response objective and is not a guarantee
X) EasyServe (Remote delivered services)

[3] MAINTENANCE SERVICES:
1) Maintenance of IBM Machines
2) Maintenance of Non-IBM Machines
3) Warranty Service Upgrade
13) Maintenance of non-IBM Machines during the Manufacturer's Warranty Period
16) IBM Maintenance Services - First Line Maintenance for Wincor Nixdorf ATMs
18) Post Installation Coverage (PIC) Service Upgrade for selected Non-IBM Machines

[4] CODES:
A (C) indicates a Machine that will have usage charges billed separately.
An (E) indicates a Machine that has been announced as withdrawn from generally available Maintenance Service.
An (F) indicates an assumptive Product included in the total Charge Period Price that has a manually inserted serial number and configuration provided by the customer.
An (H) identifies a Machine on an existing ServiceElite/ServiceSuite/ServiceElect CHIS contract with duplicate Maintenance Service coverage.
A (K) indicates assumptive Products included in the total Charge Period Price that are based on the customer provided configuration.
An (M) indicates a Miscellaneous Equipment Specification (MES) on order is not installed and applicable pricing is not included.
An (N) indicates that the Product is a non-GSA Schedule item.
An (O) indicates a one time charge.
A (P) indicates a Machine or Service with coverage on a non-CHIS contract.
An (R) indicates the usage charge rate (feet, hours, or impressions) for a Machine under a usage plan.
An (S) indicates a manual order installation date change.
A (U) indicates Usage Charges which are measured in either feet, hours or impressions.
A (W) indicates a Machine under warranty.
An (X) indicates On-Order Products which are shown for planning purposes only.
An (Y) indicates On-Order MES Products which are shown for planning purposes only. Those charges are included in the related Machine.

[5] Charges Start/Stop dates shown are those that differ from the Contract period Start/End Dates

A motion was made by Commissioner Thompson and seconded by Commissioner Neal to approve Contract and Agreement by and between Hays County Juvenile Board and Winkler County for secure Long-Term and Short-Term

Residential Service of Juvenile Offenders for the term of May 12, 2014 through May 11, 2015; which motion became an order of the Court upon the following vote:

Ayes: Commissioners Stevens, Wolf, Neal and Thompson
Noes: None

**STATE OF TEXAS** §
§
**COUNTY OF HAYS** §

**CONTRACT AND AGREEMENT FOR SECURE LONG-TERM AND SHORT-TERM RESIDENTIAL SERVICE OF JUVENILE OFFENDERS**

This Contract and Agreement is made and entered into by and between **HAYS COUNTY JUVENILE BOARD,** hereinafter referred to as the Service Provider, and the County of **WINKLER,** hereinafter referred to as the placing County, acting by and through its duly authorized representative, as indicated by their signatures below, to be effective from and after the *1st day of September, 2013, through the 31st day of August, 2014* pursuant to its provisions.

**WITNESSETH:**

Whereas, Hays County Juvenile Center has been duly inspected and certified as being suitable for the treatment and detention of children: and,

Whereas, the placing County, in order to carry out and conduct its juvenile program in accordance with the Texas Juvenile Court Act (Texas Family Code) has need of the use of detention facilities to house and maintain children of juvenile age, referred for an act of delinquency or an act indicating a need for supervision, during pre-trial and pre-dispositional status or in the post-dispositional treatment prescribed by the Court; and

Whereas, Service Provider desires to make the facility available to the placing County for such use and purposes and the Service Provider desires to contract for the use of said facility;

NOW, THEREFORE, the parties agree as follows:

**I. TERMINATION**

The term of this contract shall be for a period of twelve (12) months from the effective date; however if either party hereto feels in its judgment that the contract cannot be successfully continued, and desires to terminate the contract, then the party so desiring to terminate may do so by notifying the other party in writing, by certified mail or personal delivery to its principal office, of its intention to terminate the contract thirty (30) calendar days from the date of Notice of Termination is received by the other party. At 12:00 o'clock midnight thirty (30) calendar days thereafter, this contract shall terminate, become null and void and be of no further force of effort. Such termination shall not affect or diminish the placing County's responsibility for payment of any amounts due and owing at the time of termination of the contract. After receipt of notice of termination, the placing County shall remove all children placed in the facility on or before the termination date.

**II. COMPENSATION, BILLING, AND PAYMENT**

The placing County agrees to pay Service Provider the sum of $100.00 per day for each space utilized in Detention services. The placing County agrees to pay Service Provider the sum of $105.00 per day for each space utilized in the Boot Camp (B/C)/Academy/General Offender programs. The placing County agrees to pay Service Provider the sum of $140.00 per day for each space utilized in the Juvenile Intensive Treatment Program (JITP) and the Sex Offender Residential Treatment program (SORT). The daily cost being based on the projected actual cost of care for children in the facility. **Payment shall be made monthly in accordance with Texas Government Code, Chapter 2251, Payment for Goods and Services. The Service Provider may at its discretion, or upon recommendation of the Hays County Auditor's Office, impose interest on payments that become overdue in accordance with §2251.025, Texas Government Code.**

In addition to the rate agreed upon between the two parties, the placing County shall either make arrangements to pay, or reimburse the Service Provider for expenditures made, for medical care and dental care for children placed if: (1) the medical care or dental care is not covered by Medicaid or the funding source, and (2) the expenditures are approved by the placing County in writing prior to the expenditures being incurred.

If emergency examination, treatment and/or hospitalization outside the facility is required for a child placed in the facility, the Administrator of the facility is authorized to secure such examination, treatment or hospitalization at the expense of the County. The County agrees to indemnify and hold harmless Service Provider, their representatives, agents and employees from any and all liability for charges for reasonable and necessary medical treatment, examination, and/or hospitalization. The Administrator, or designee, shall notify the appropriate County and parent/guardian of such an emergency within twenty-four (24) hours of its occurrence.

**III. PLACEMENT OBJECTIVE**

Service Provider agrees to provide a space, if available, at the time that the placing County requests the space. Service Provider will provide a copy of the visitation/phone contact schedule with this contract and the placing County shall provide a copy to a resident's parent/guardian/legal custodian.

Service Provider will provide room and board, twenty-four hour per day, seven day a week supervision; routine medical examination and treatment within the facility (emergency examination, treatment, or hospitalization outside the facility with prior written approval of the placing County, if feasible); TEA approved educational programming; recreation facilities; and counseling to each child placed within the facility. The objective of the placement with the Service Provider is to protect the well-being of the child, and in long-term to enhance the child's functional abilities in a residential care setting and achieve the goals of the child's Individual Treatment Plan and Child/Family Case Plan.

**IV. ADMISSION AND DISCHARGE**



Prior to transporting a child to the facility for short term-placement, the official authorizing the placement shall call the facility to insure that space is available. Placement of children from any County may be denied if space limitations require. Children referred for long-term placement shall complete the referral process for acceptance prior to placement.

Each child placed in the facility shall be placed therein under proper order of the Juvenile Court, and the Administrator shall be furnished a copy of said order and will arrive with appropriate pre- and post-adjudication paperwork as stipulated by Texas Juvenile Justice Department standards.

Each child placed therein shall be required to follow the rules and regulations of conduct as fixed and determined by the Administrator and staff of the facility.

If a child is accepted by the facility from any County and such child thereafter is found to be, in the sole judgment of the Administrator, mentally unfit, dangerous, or unmanageable or whose mental or physical condition would or might endanger the other occupants of the facility, then the Administrator shall notify the placing County of such conditions. Such child shall be immediately removed from the facility. It will be the responsibility of the placing County to provide for the transportation for the removal of the child.

The Service Provider must provide at least (10) calendar days notice before discharging a child except when the child is a danger to self or others.

Service Provider agrees that the facility will accept any child qualified hereunder, without regard to such child's religion, race, creed, color, sex, or national origin.

It is further understood and agreed by the parties hereto that children placed in the facility may be granted furloughs with parents, guardians, custodians, or other responsible adults only with prior written approval of the placing County or appropriate Juvenile Court.

It is further understood and agreed by the parties hereto that children placed in the care of the facility shall not be discharged there from without:

(a) Receipt of the Order signed by the Judges having juvenile jurisdiction of the placing County, duly certified by the clerk of said Court, or
(b) Prior written authorization of the Juvenile Probation Department who originally detained the child.

It is further understood and agreed by the parties hereto that children placed in pre adjudication care in the facility shall be removed therefrom by the appropriate authorities from the placing County, or its agents, servants or employees at the expiration of the period authorized by the Court Order issued by the Judge of the appropriate Juvenile Court unless a new Order has been issued authorizing the continued detention, and a copy of such Order has been delivered to the



detention facility, or unless a waiver of a detention hearing has been executed and a signed copy of the waiver delivered to the facility.

It is further understood and agreed by the parties hereto that nothing in this contract shall be construed to permit the placing County, its agents, servants, or employees in any way to manage, control, direct or instruct Service Provider, its servants or employees in any manner respecting of their work, duties or function pertaining to the maintenance and operation of the facility. However, it is also understood that the Juvenile Court of the placing County shall control the conditions and terms of detention supervision as to a particular child pursuant to Texas Family Code Section 51.12.

**V. SERVICES TO BE PROVIDED**

The Service Provider shall provide the following services to each child placed by the placing County to the extent that such services are permitted within the Service Provider's standards and consistent with the child's Individual Treatment Plan.

- Basic residential child care services, including food and snacks, room, clothing, personal hygiene items, haircuts, local transportation & school supplies.
- Educational and vocational activities
- Recreational activities.
- Special treatment services, including behavior management, diagnostic services, psychological counseling, and psychiatric consultation.
- Medically necessary health services.
- Other services described in this Contract.

The Service Provider shall provide all services in a manner which safeguards the health, welfare, and safety of the children to the maximum extent possible, and in the least restrictive setting possible.

Residential care shall be provided by professional staff that posses the required qualifications for performing designated job functions. The Service Provider shall verify and disclose, or cause its employees and volunteers to verify and disclose, criminal history and any current criminal indictment for an offense against the person, an offense against the family, an offense involving public indecency under the Texas Penal Code as amended, or an offense under the Texas Controlled Substances Act, Chapter 481 of the Texas Health and Safety Code or comparable provisions in another state. This verification and disclosure shall be required for all staff having direct contact with the placing County children.

**VI. INDIVIDUAL TREATMENT PLAN**

Each child placed in long-term shall have a written Individualized Treatment Plan (ITP) developed in concert with the child and mutually agreed upon by the Service Provider staff, any psychologist and/or psychiatrist working with the child, as applicable, and/or appropriate placing

county personnel within thirty (30) days of placement. The ITP shall complement the Child/Family Case Plan supplied by the placing County.

The ITP shall be reviewed jointly by all parties at intervals specified by Texas Juvenile Justice Department standards, to assess the child's progress with modifications of the ITP being made when indicated. Either the Service Provider or the placing County may request a review at any time.

The ITP may contain, but not be limited to the following: the reasons why the placement will benefit the child; specify behavioral goals and objectives being sought for the child; state how the goals and objectives are to be achieved during the child's placement with the Service Provider; and state how the parent(s), guardian(s), and where possible, grandparents(s) or other extended family members will be involved in the ITP to assist in preventing or controlling the child's alleged delinquent behavior or alleged conduct indicating a need for supervision as defined in the Texas Family Code.

The Service Provider shall provide the placing County with a written report of the child's progress toward or achievement of goal's/objectives contained in the ITP on a monthly basis.

These reports are to include, but not be limited to, the following information:

(a) Behavior in program
(b) Progress in treatment.
(c) Progress in school.
(d) Peer and staff relationships.
(e) Family relationships.
(f) Aftercare goals.

## VII. PERFORMANCE MEASURES

**Goals**

The Individual Treatment Plan for each child shall contain specific behavior goals and services that are appropriate to the child and that enable the child to develop to his/her fullest potential. This development will be through provision of a safe, drug-free environment in which counseling services are utilized as tools for educational, emotional and behavioral catharsis.

**Outputs**

The Service Provider shall provide the placing County, within ten (10) working days, information which outlines the services provided to clients. These output measures may include, but are not limited to:

- Average length of stay of children in each program.



- Average daily population of children in each program.
- Average number of counseling hours provided each child daily, weekly or monthly.
- Average number of educational hours provided each child daily, weekly or monthly.
- Specific types of milieu implemented by the Service Provider.

**Measurable Outcomes**

The Service Provider agrees to furnish the placing County the annual indicators which express the effectiveness of the Service Provider in providing public benefit. Evaluation of the contract by the placing County may be performed by using the following outcome measures:

- 80% of youth successfully completing the program.
- 80% of youth report improved family communication/functioning while in placement.
- 80% of youth will demonstrate progress in a majority of goals outlined in the ITP and encompassing the nine domains of the Child/Family Case Plan.
- 85% of youth will earn at least ½ educational credits in core subject(s)

**Sanctions**

If the Service Provider fails to achieve the defined goals, outputs, and outcomes, set out by the placing County or if the Service Provider fails to comply with the terms of this contract, the placing County may, at its discretion, take any one or more of the following sanctions:

- Cease placement of children at the facility.
- Remove children previously placed by the County.
- Require the Service Provider to take specific corrective actions in order to comply with the terms and conditions of the contract.
- Suspend the contract in part or in whole until such time as the Service Provider is in compliance with all of the terms of the contract.
- Terminate the contract.
- Exercise any other rights or remedies which may be available to the County, at law or in equity.

## VIII. RECORDS AND RECORDS RETENTION

Service Provider will keep a record of all services provided to the placing County under this agreement and provide all information, records, papers, reports, and other documents regarding any aspect of the services furnished as may be requested by the placing County. Service Provider will make these records and all other materials which relate in any way to the services provided, available for inspection, audit, and examination by the County, the Comptroller General of the United State,



the U.S. Department of Justice, the Texas Juvenile Justice Department, and the State of Texas and/or their duly authorized representatives.

Service Provider will maintain the records (as referenced above) for three (3) years after the final payment, or until any audit of the program, has been made and all questions arising therefrom have been resolved, whichever is later

This Agreement shall be construed under and in accordance with the laws of the State of Texas

Service Provider will provide certification of eligibility to receive State funds as required by Texas Family Code Section 231.006.

Service Provider shall adhere to all applicable state and federal laws and regulations pertinent to the Service Provider's provision of services to the placing County.

## IX. EXAMINATION AND ACCESS TO FACILITY

The placing County reserves the right to perform periodic on site monitoring of the Service Provider's compliance with the terms of this Contract, and the adequacy and timeliness of the Service Provider's performance under this Contract.

The Service Provider shall establish a method to ensure the confidentiality of records and other information relating to the child according to applicable federal and state law, rules and regulations, and applicable professional ethical standards. This provision shall not limit the placing County's right of access to the child's case records or other information relating to children served under this Contract

## X. INDEMNITY, HOLD HARMLESS, AND CLAIMS

The Service Provider shall indemnify, save and hold harmless the placing County, its officers, agents, and employees from all suits, actions, losses, damages, claims, or liability of any character, type, or description, including without limiting the generality of the foregoing all expenses of litigation, court costs, and attorney's fees for injury or of the foregoing all expenses of litigation, court costs, and attorney's fees for injury or death to any person, or injury to property, received or sustained by any person or persons or property, arising out of, or occasioned by, directly or indirectly, the acts of omissions of the Service Provider, its agents, servants, employees, consultants, or invitees, in the execution or performance of this Contract.

In the event that any claim, suit, or other action is made or brought by any person, firm, corporation, or other entity against the Service Provider or County, the Service Provider shall give written notice to the placing County of any such claim, demand, suit or other action within three (3) working days after being notified of such claim, demand, suit or other action of the threat thereof.



## XI. INSURANCE

The Service Provider shall have, and shall require all subcontractors providing services under this Contract to have insurance throughout the term of this agreement covering, among other matters that the placing County shall desire, any and all damages and/or claims that might arise out of the placement of county children. Such insurance shall include, but not be limited to, breach of confidentiality.

## XII. COMPLIANCE WITH LAWS, REGULATIONS AND STANDARDS

The Service Provider shall comply with all federal, state, county, and city laws, rules, ordinances, regulations and standards applicable to the provision of services described herein and the performance of all obligations undertaken pursuant to this Contract.

The Service Provider shall not discriminate against any employee or applicant for employment based on race, color, religion, sex (gender), national origin, age or handicapping condition. The Service Provider will take affirmative action to ensure that applicants are employed, and that the employees are treated during employment without regard to their race, religion, color, sex, national origin, age or handicapping condition.

The Service Provider shall comply with minimum standards as put forth by the Texas Juvenile Justice Department at all times.

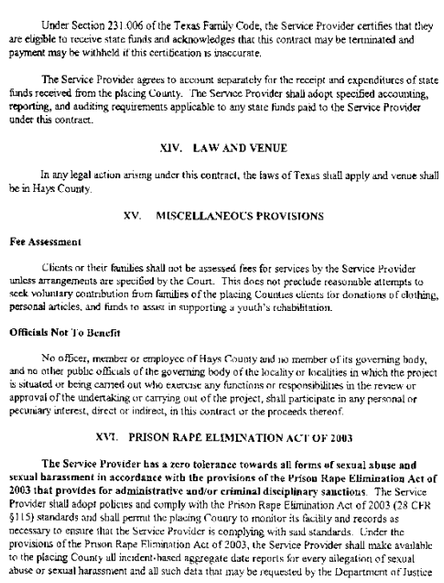
The Service Provider shall ensure that suspected or alleged cases of child abuse, neglect or exploitation are immediately reported to the placing County and to the appropriate authorities as required by law and in conformity with the procedures detailed in Chapter 261 of the Texas Family Code. The Service Provider shall ensure that its employees are properly trained in the reporting requirements and procedures of Chapter 261 of the Texas Family Code.

## XIII. ACKNOWLEDGEMENTS AND ASSURANCES

The Service Provider acknowledges and agrees that the placing County is under no obligation to place any child or children with the Service Provider and this Contract shall not be so construed.

The Service Provider acknowledges and agrees that the placing County may, at its discretion, remove any child placed pursuant to this Contract, at any time. The placing County will notify Service Provider in a timely manner prior to the removal of a child except in instances where in the placing County's judgement such notification may result in risk to the child's health, safety or welfare.

The parties acknowledge and agree that the Service Provider is under no obligation to accept a child who is deemed by Service Provider to be inappropriate for placement with the Service Provider



Under Section 231.006 of the Texas Family Code, the Service Provider certifies that they are eligible to receive state funds and acknowledges that this contract may be terminated and payment may be withheld if this certification is inaccurate.

The Service Provider agrees to account separately for the receipt and expenditures of state funds received from the placing County. The Service Provider shall adopt specified accounting, reporting, and auditing requirements applicable to any state funds paid to the Service Provider under this contract.

**XIV. LAW AND VENUE**

In any legal action arising under this contract, the laws of Texas shall apply and venue shall be in Hays County.

**XV. MISCELLANEOUS PROVISIONS**

**Fee Assessment**

Clients or their families shall not be assessed fees for services by the Service Provider unless arrangements are specified by the Court. This does not preclude reasonable attempts to seek voluntary contribution from families of the placing Counties clients for donations of clothing, personal articles, and funds to assist in supporting a youth's rehabilitation.

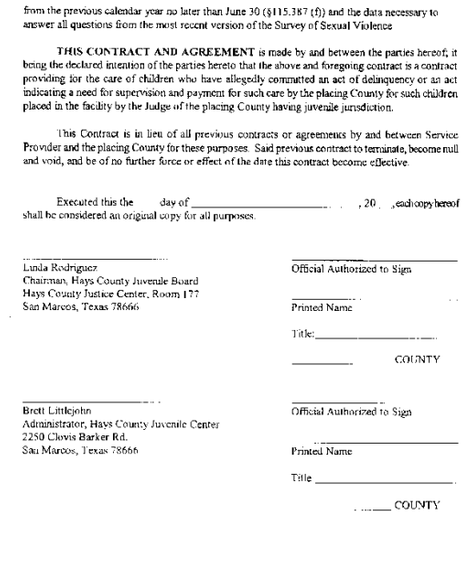
**Officials Not To Benefit**

No officer, member or employee of Hays County and no member of its governing body, and no other public officials of the governing body of the locality or localities in which the project is situated or being carried out who exercise any functions or responsibilities in the review or approval of the undertaking or carrying out of the project, shall participate in any personal or pecuniary interest, direct or indirect, in this contract or the proceeds thereof.

**XVI. PRISON RAPE ELIMINATION ACT OF 2003**

**The Service Provider has a zero tolerance towards all forms of sexual abuse and sexual harassment in accordance with the provisions of the Prison Rape Elimination Act of 2003 that provides for administrative and/or criminal disciplinary sanctions**. The Service Provider shall adopt policies and comply with the Prison Rape Elimination Act of 2003 (28 CFR §115) standards and shall permit the placing County to monitor its facility and records as necessary to ensure that the Service Provider is complying with said standards. Under the provisions of the Prison Rape Elimination Act of 2003, the Service Provider shall make available to the placing County all incident-based aggregate date reports for every allegation of sexual abuse or sexual harassment and all such data that may be requested by the Department of Justice

-9-



from the previous calendar year no later than June 30 (§115.387 (f)) and the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence

**THIS CONTRACT AND AGREEMENT** is made by and between the parties hereof; it being the declared intention of the parties hereto that the above and foregoing contract is a contract providing for the care of children who have allegedly committed an act of delinquency or an act indicating a need for supervision and payment for such care by the placing County for such children placed in the facility by the Judge of the placing County having juvenile jurisdiction.

This Contract is in lieu of all previous contracts or agreements by and between Service Provider and the placing County for these purposes. Said previous contract to terminate, become null and void, and be of no further force or effect of the date this contract become effective.

Executed this the day of , 20 , such copy hereof shall be considered an original copy for all purposes.

Linda Rodriguez
Chairman, Hays County Juvenile Board
Hays County Justice Center, Room 177
San Marcos, Texas 78666

Official Authorized to Sign

Printed Name

Title:

COUNTY

Brett Littlejohn
Administrator, Hays County Juvenile Center
2250 Clovis Barker Rd.
San Marcos, Texas 78666

Official Authorized to Sign

Printed Name

Title

COUNTY

-10-

A motion was made by Commissioner Neal and seconded by Commissioner Wolf to approve payment in the amount of $3,200.00 to Kidd's Cropdusting, Inc. for herbicide application at Winkler County Airport from budgeted funds, one-half (1/2) to be reimbursed from RAMP grant; which motion became an order of the Court upon the following vote:

Ayes: Commissioners Stevens, Wolf, Neal and Thompson
Noes: None

A motion was made by Commissioner Neal and seconded by Commissioner Thompson to approve payment in the total amount of $780.00 to Total Office Solution of West Texas for contract base charge for maintenance of the following machines for the period of April 01, 2014 through March 31, 2015 from budgeted funds:

1. Extension Office – Xerox/CopyCentre C20 – $300.00; and
2. Winkler County Law Enforcement Center – Xerox/WorkCentre Pro 5330/PHXF - $480.00

which motion became an order of the Court upon the following vote:

Ayes: Commissioners Stevens, Wolf, Neal and Thompson
Noes: None

A motion was made by Commissioner Neal and seconded by Commissioner Thompson to approve payment in the amount of $3,240.00 to Diamond A Ranch for caliche for County Roads 404, 403 and 103 from budgeted lateral road funds; which motion became an order of the Court upon the following vote:

Ayes: Commissioners Stevens, Wolf, Neal and Thompson
Noes: None

A motion was made by Commissioner Wolf and seconded by Commissioner Stevens to approve payment in the amount of $4,075.00 to Ramirez Builders and Remodeling, LLC for material and labor to construct picnic table at County Park in Wink from budgeted committed funds; which motion became an order of the Court upon the following vote:

Ayes: Commissioners Stevens, Wolf, Neal and Thompson
Noes: None

A motion was made by Commissioner Neal and seconded by Commissioner Thompson to approve park project claims against the County and pay as per list of vouchers submitted; which motion became an order of the Court upon the following vote:

Ayes: Commissioners Stevens, Wolf, Neal and Thompson
Noes: None

A motion was made by Commissioner Neal and seconded by Commissioner Thompson to approve payroll; which motion became an order of the Court upon the following vote:

Ayes: Commissioners Stevens, Wolf, Neal and Thompson
Noes: None

There were no line item adjustment(s) for the Court to consider at this time.

A motion was made by Commissioner Neal and seconded by Commissioner Thompson to approve the following budget amendment(s):

**WINKLER COUNTY**
**BUDGET AMMENDMENTS**
**MAY 12, 2014**

| | | | |
|---|---|---|---|
| **MEDICAL** | | | |
| 10-104-209 | TOBACCO SETTLEMENT FUNDS | $ | 94,002.21 |
| 10-600-085 | DEDICATED RESERVES | $ | 94,002.21 |
| TO RECORD REVENUE & EXPENSE FOR TOBACCO SETTLEMENT FUNDS | | | |
| | | | |
| **NON DESIGNATED** | | | |
| 10-104-231 | OTHER GOVERNMENTAL | $ | 93,279.00 |
| 10-230-080 | CAPITAL EXPENDITURES | $ | 93,279.00 |
| TO RECORD REVENUE & EXPENSE FOR CITY OF KERMIT PORTION OF AMBULANCE | | | |

which motion became an order of the Court upon the following vote:

Ayes: Commissioners Stevens, Wolf, Neal and Thompson
Noes: None

A motion was made by Commissioner Neal and seconded by Commissioner Thompson to receive the following Monthly Reports from County Officials of fees earned and collected for the month of April, 2014;

MONTHLY REPORTS

For the Month of April 2014

| | Date Received | Amount |
|---|---|---|
| Tommy Duckworth, Co Attorney Fee 5-5-14 $75.00 Hot Check 5-5-14 | Ø | $75.00 |
| Bonnie Leck, County Judge | | |
| Minerva Soltero, Tax Assessor | 5-9-14 | $2378.75 |
| Shethelia Reed, County Clerk | 5-5-14 | $27,717.03 |
| Glenda Mixon, JP Precinct #2 | 4-30-14 | $340.00 |
| Sherry Terry, District Clerk | 5-6-14 | $1934.52 |
| DeLynn Trammell, JP Precinct #1 | 5-2-14 | $ 11,332.00 |
| George Keely, Sheriff | 4-30-14 | $4714.21 |
| Eric DeAnda, Probation | | |
| Billy Stevens, Commissioner Precinct #1 | | |
| Robbie Wolf, Commissioner Precinct #2 | | |
| Randy Neal, Commissioner Precinct #3 | | |
| Billy Ray Thompson, Commissioner Precinct #4 | | |
| Jeanna Willhelm, Auditor Investment | | |
| Eulonda Everest, Treasurer | | |
| Lee Wilson, Constable Pct # 2 | | |
| Richard Crow, Constable Pct #1 | 5-2-14 | Ø |

which motion became an order of the Court upon the following vote:

Ayes: Commissioners Stevens, Wolf, Neal and Thompson
Noes: None

A motion was made by Commissioner Thompson and seconded by Commissioner Stevens to examine and approve bills over $500.00 and place in line for payment; which motion became an order of the Court upon the following vote:

Ayes: Commissioners Stevens, Wolf, Neal and Thompson
Noes: None

A motion was made by Commissioner Neal and seconded by Commissioner Thompson to approve claims against the County and pay as per list of vouchers submitted; which motion became an order of the Court upon the following vote:

Ayes: Commissioners Stevens, Wolf, Neal and Thompson
Noes: None

A motion was made by Commissioner Neal and seconded by Commissioner Thompson to adjourn the meeting; which motion became an order of the Court upon the following vote:

Ayes: Commissioners Stevens, Wolf, Neal and Thompson
Noes: None

MINUTES approved the_____day of_____, 20_____.

_____

COUNTY CLERK