Texas Professional Healthcare Alliance

Administrative Service Center • Post Office Box 503 • Stilwell, Kansas 66085
Fax 832-201-0199 • request@texaspha.com • www.texaspha.com

PRESIDENT
Kenneth Klingensmith

BOARD MEMBERS
Kenneth Klingensmith
Denise Perfetta
Laura Klingensmith

ADMINISTRATION
Mimi Schmidt

Dear Prospective Member,

Thank you for your interest in joining Texas Professional Healthcare Alliance (TXPHA). The IPA accepts into membership physicians (MD/DO) and allows professional healthcare providers to join as participating providers in the network (DPM, ARNP, OD, DC, PT, SLP, OT, etc.). All mid-level providers must have a collaborating/supervising provider who is/or will be an active member of the IPA

There are various reasons physicians and other healthcare providers desire to affiliate with the IPA being they wish to access managed care affiliations held by the IPA through our messenger model arrangements, to seek out expense reduction initiatives through group purchasing or to seek out patient support programs designed to help patients of the practice. Attached is a document outlining some considerations in joining the IPA as well as a roster of our current contracts.

The IPA does NOT require a copy of a Texas Standard credentialing application. They only document needed is a W-9 for the Tax Id provider is enrolling under. All other documents will be retrieved from the Universal Provider Datasource of CAQH. We do need your assigned CAQH ID number, and please ensure a current attestation is on file with CAQH. Your profile should provide access to Texas Professional Healthcare Alliance and all carriers. Documents requested by CAQH should be on file and current and not expired. If you are not enrolled with CAQH, you can create an account at http://proview.caqh.org/.

TXPHA operates solely off dues paid and is not subsidized by any other source of revenue. There is a onetime payment of $336 needed to accompany the application.

After enrollment is approved, you will be invoiced annually on your anniversary date for $336. In order to assure you maintain your in-network status with your opted plans, we recommend that you complete the ACH form. This will allow us to automatically bill your credit card upon your anniversary date for the $336 only. Any other charges that may arise will not be automatically invoiced.

To get started, we need your:
(1) signed agreement **(2) payment of $336** **(3) Copy of W-9**
(4) Signed ACH form **(5) CAQH # ___________________**

Thank you again for your interest. If you have any questions concerning the credentialing process or benefits in joining the IPA, please contact Denise Perfetta, Provider Services Representative at request@texaspha.com.

Sincerely,

Kenneth E. Klingensmith
President

Thank you for your continued Membership. With a signature below Texas Professional Healthcare Alliance is authorized to debit the designated banking or credit account $385 once a year for your annual dues/Re-Credentialing fees upon the anniversary of your membership to the IPA.

Provider Full Name: ____________________

CREDIT CARD PURCHASE AUTHORIZATION

Cardholders Name (as it appears on credit card)________________________________

Full Provider Name from Invoice: ____

Zip Code: ____

Email for Payment Receipt: ____

Credit Card Number: ____

Expiration Date: _______________________

ACH TRANSFER AUTHORIZATION

Bank Name: ____

Address: ____

City: _____________________ State: __________________ Zip: ______________

ACH Routing Number: ____

Account Number: ____

_____ Checking _____ Savings ______ Modified Lock Box ___Other: ______________

AUTHORIZATION

Name: ____

Signature: _____________________________ Date: _____________________________

TEXAS PROFESSIONAL HEALTHCARE ALLIANCE

CONSIDERATIONS FOR JOINING
TEXAS PROFESSIONAL HEALTHCARE ALLIANCE, INC.

Hospital Affiliation

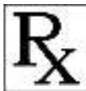
Use any hospital of your choice. NO specific hospital affiliation required for participation

Physicians Helping Physicians

IPA governed by practicing physicians under no hospital influence regarding direction and decisions of the IPA.

Managed Care Affiliations

Access to over 30 manage care contracts having over 65 products



Patient Prescription Support

FREE prescription card for each of your self pay patients; your patients can save up to 65% on generic medications.

Paperless Credentialing

Credentialing is delegated to the IPA by our managed care affiliations so you need only be credentialed with us ONCE to have access to all affiliations you decide to participate. Then once every 3 years to maintain participation.
CAQH Universal Datasource is used for paperless credentialing which saves time for your staff.

EMR/PM Solution

The IPA has partnered with Health Associate and their Healthcare Consulting division to assist is making your system work smarter, not harder for your facility. Their Consultancy has a shared ambition to generate long term results, more revenue and outperform the competition.

Revenue Care Management

A financial healthcare company providing revenue cycle and practice management services, support and expertise to members of the IPA. Products and services support members of the IPA in the generation of revenue helping independent practices remain independent and define a financial path of sustainability.

Office Supplies

Stephens guarantees a 40% savings off retail for our members on medical and office supplies aggregately over one year period

Patient Collections

Save 10% and have on extra fees with this TMA endorsed collection company.

Social Media Monitoring

A specific program for TXPHA members to monitor, manage and increase online reviews – utilizing five easy tools.

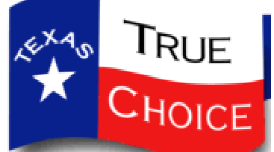
Medical Waste Disposal

Gamma is handles waste transportation and disposal service as well as medical records storage and shredding. Offers OSHA training and compliance inspections.

Merchant Services

Have lower transaction fees on this merchant card program that accepts all healthcare savings and flexible spending account. Complete suite of billing & Payment services

Managed Care Plans and Networks available to TXPHA Membership



AGREEMENT BETWEEN
TEXAS PROFESSIONAL HEALTHCARE ALLIANCE, INC.
AND
PHYSICIAN

This Agreement is made and entered into and is to be effective the date indicated on the signature page of the agreement, the “Effective Date”, by and between Texas Professional Healthcare Alliance, Inc., a Texas non-profit corporation (hereinafter referred to as “IPA”) and provider of services listed on the signature page of the agreement, (hereinafter referred to as “Physician”).

WHEREAS, IPA is a Texas non-profit corporation and has as its primary purpose the promotion of cost effective and quality healthcare through the arranging of healthcare services to the public;

WHEREAS, IPA desires to create a panel of healthcare providers who will agree to comply with the quality assurance and utilization management mechanisms established or agreed to by IPA and who will participate in and comply with the policies and procedures which may be adopted from time-to-time by IPA and Payers;

WHEREAS, Physician is a duly licensed physician in the State of Texas, whose license is without limitation or restriction and who desires to participate in provider panels established by IPA subject to this Agreement;

WHEREAS, IPA will offer to certain employers, managed care plans, organizations and other third party payers the opportunity to utilize the services of a healthcare provider panel; and

WHEREAS, Physician desires to enter into an agreement with IPA to participate in certain healthcare provider panels established by IPA by rendering Covered Services as set forth in this Agreement.

NOW THEREFORE, in consideration of the promises and mutual covenants herein contained and other good and valuable consideration, it is mutually agreed by and between the parties hereto as follows:

1. DEFINITIONS

1.1 Clean Claims means a request for payment for Covered Services submitted by a Participating Provider or his/her designee on a CMS 1500 form (or successor form), or the electronic equivalent of this form when billing claims electronically, that contains all of the elements consistent with claims processing rules described under 28 TAC 21.2801 through 21.2816 “Submission of Clean Claims” of the Texas Department of Insurance as they may, from time to time, be revised.

1.2 Covered Persons mean those employees or members and their dependents and/or other persons who are covered by a purchased program, health benefit plan policy, or product which is underwritten, provided, or administered by a Payer which contracts with IPA.

1.3 Covered Services means services provided to a Covered Person for which a Payer is obligated to pay or reimburse pursuant to the benefit plan, policy, or product with is underwritten, provided, or administered by a Payer.

1.4 Emergency Care means emergency services as defined in the applicable Payer agreement and consistent with applicable state and federal law.

1.5 Participating Provider means a physician, hospital, or licensed health professional, practitioner, ancillary care provider or facility which has entered into a written agreement (directly or indirectly through a physician or professional association, provider organization, or other entity) with IPA to participate in certain healthcare provider panels established by IPA subject to the terms of such agreement. Physicians will sometimes be referred to separately as “Participating Physicians.”

1.6 Payer means any entity including but not limited to any employer, patient, union group, association, managed care plan, insurer, health maintenance organization, preferred provider

organization, federal, state, or other government Payer, or any other third party Payer (or any third party administrator contracting on behalf of any such entity) which provides a health benefit plan and/or agrees to pay for the healthcare services of Covered Persons and which has contracted with IPA to arrange for Covered Services.

1.7 Payer Agreement means the contract between a Payer and IPA.

1.8 Payer Plan means a program agreed upon pursuant to a Payer Agreement by IPA and a Payer that includes a panel of Participating Providers selected by IPA and/or Payer to provide Covered Services.

2. DUTIES AND OBLIGATIONS OF IPA

2.1 Marketing of Panels. IPA will market provider network panels consisting of certain Participating Providers to various third party payers. IPA may present cost, quality, and performance data regarding its Participating Providers to such third party payers.

2.2 Notice of Payer Agreements. IPA shall notify Physician at least thirty (30) days in advance of the effective date when possible of any Payer Agreement providing a Payer Plan in which Physician is obligated to participating pursuant to Section 4.1 of this Agreement. IPA will provide in its notice the name of the Payer, reimbursement schedule, and any other information that IPA is obligated to provide under this Agreement or is deemed relevant by IPA. Each such notice shall become separate exhibit to this Agreement by reference.

2.3 Utilization Management and Quality Improvement Plan. IPA shall provide Physician a copy of any utilization management and quality improvement plan adopted or administered by IPA, and any modifications thereto, applicable to Physician.

2.4 Medical Records. IPA shall maintain any medical records to which it has access under this Agreement in confidence and in accordance with applicable laws and regulations, including the Texas Health and Safety Code, Ch. 181, Subchapters A & B and regulations promulgated pursuant, thereto, regulating Medical Record Privacy in Texas and the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the regulations promulgated thereunder upon the effective date of April 14, 2003 and any revision to date by HIPAA.

2.5 Physician-Patient Relationship. IPA agrees that it will not intervene in any way or manner with the rendition of services by Physician, it being understood and agreed that, except to the extent provided in Section 3.2 of this Agreement, the relationship between physician and patient will be maintained.

2.6 Practice Expense Control. The IPA will identify and evaluate vendors of services whom will offer a reduced fee to Physician for the purchase of services necessary in the operations of Physician practice or as requested by the membership. Upon completion of the IPA vendor evaluation process and approval by the Board of Directors, the IPA shall provide Physician name, address, phone number and fax number information to approved vendors who execute a vendor agreement with the IPA.

2.7 Payer Negotiations and Compliance with Contracting Policies. IPA and Physician will fully comply with the IPA Contracting Policies, including Physician's entering into a separate agreement regarding the "Standing Offer Messenger Model" which is incorporated by this reference. Consistent with such policies and agreements, IPA shall notify Physician at least thirty (30) days in advance of the effective date of any Payer Agreement providing a Payer Plan in which Physician may wish to participate pursuant to Section 4.1 of this Agreement. In negotiating and executing agreements with Payers, IPA shall make its best effort to ensure that Payer will:

a. Pay claims for Covered Services within thirty (30) days of receipt of a completed and uncontested claim.

b. Pay claims for Covered Services that were approved based on the eligibility verification process agreed to by Payer and adhered to by Participating Physician, even if that eligibility verification is later found to be mistaken.

c. Subject to Paragraph 10.5, pay Participating Physician his or her normal charges for services provided to Covered Persons beginning no later than thirty days following termination of this Agreement.

3. DUTIES AND OBLIGATIONS OF PHYSICIAN

3.1 Services. Physician agrees to make available and provide Covered Services to Covered Persons pursuant to the terms of any Payer Agreement accepted by Physician in accordance with Section 4.1 of this Agreement in the same manner, in accordance with the same standards, and within the same time availability as offered to all of Physician's other patients.

3.2 Compliance with IPA and Payer Plan Standards, Policies, Procedures, Programs, Rules, and Regulations. Physician shall follow and adhere to all IPA standards, policies, procedures, programs, rules and regulations (including, but not limited to, any IPA utilization management and quality assurance programs); any or all that IPA may amend in its own discretion from time-to-time. Further, Physician agrees to be bound by all of the standards, policies, rules, and regulations adopted or utilized by IPA and/or Payers from time-to-time in connection with Payer Plans. Copies of any standards, policies, procedures, programs, rules and regulations relevant to specific Payer Plans and applicable to Physician shall be made available for examination by Physician upon request.

3.3 Compliance with IPA Participation Criteria. Physician warrants and represents that he or she currently complies with the IPA participation criteria set forth within the credentialing policy and procedures and hereby incorporated by reference and made part of this Agreement. Physician understands that Physician's continued right to be a Participating Provider is conditioned upon Physician's continued compliance with IPA Credentialing Criteria.

3.4 Compliance with Utilization Management and Quality Improvement Program. Physician warrants and represents that he or she currently complies with the Utilization Management and Quality Improvement Program of IPA and/or any Payer as set forth in Exhibit B which is attached and herby incorporated by reference and made part of this Agreement. Physician understands that Physician's continued right to be a Participating Provider is conditioned upon Physician's continued compliance with the Utilization Management and Quality Improvement Program of IPA and/or Payer, as appropriate.

3.5 Provider Panels. Physician acknowledges that IPA may develop or contract with a Payer and organizations to develop Payer Plans or other programs that have a variety of provider panels, program components and other requirements necessary to meet the Payer's particular needs. IPA cannot warrant or guarantee (1) that Physician will participate in a minimum number of provider panels or Payer Plans, or (2) that, as a Participating Provider, Physician will be utilized by a minimum number of Covered Persons within any Payer Plan, or (3) that Physician will indefinitely remain a member of the provider panel or Payer Plan.

3.6 Referrals. Consistent with sound medical practice and in accordance with accepted community professional standards for rendering quality medical care, Physician agrees to use his or her best effort to make referrals of Covered Persons to the Participating Physicians and other Participating Providers in the relevant Payer Plan.

3.7 Practice Location and Access. Physician must at all times maintain his or her primary office within IPA's service area as defined by IPA.

3.8 Non-Disclosure. Physician shall not disclose the terms of this Agreement or any Payer Agreement or Payer Plan, including but not limited to any fee schedule or reimbursement arrangements without the prior written consent of IPA. This paragraph shall survive the termination of this Agreement.

3.9 Reporting Changes of Physician Information. Physician shall notify IPA in writing at least thirty (30) calendar days prior to any change in Physician's business address, business telephone number, office hours, tax identification number, malpractice insurance carrier or coverage, State of Texas license number, or Drug Enforcement Agency registration number.

3.10 IPA Rosters. Physician shall permit IPA to designate and make public reference to Physician as a Participating Provider. Physician shall not use the name or trademark of IPA or any Payer unless first approved in writing by IPA. Physician agrees that IPA and Payer may use his or her name, address, telephone number, and a description of specialty in any roster of Participating Providers published by IPA or Payer. The roster may be inspected by, and is intended for the use of, prospective and existing Covered Persons as well as for marketing purposes.

3.11 Non-Discrimination. Physician agrees not to discriminate against any Covered person because of race, physical handicap, color, religion, sex, or national origin.

3.12 Dues and Assessments. Physician agrees to pay, in a timely manner, such dues and assessments as may be imposed, from time to time, by IPA in order to reimburse in part IPA's administrative and marketing costs.

3.13 Reporting Duty. Physician agrees to report to IPA within ten (10) calendar days whenever he or she becomes aware of any of the following:

a. Commencement of any disciplinary or peer review action (including the initiation of an investigation and/or any determination to take adverse action) against Physician by the Texas State Board of Medical Examiners or any other governmental or regulatory entity, medical society, peer review organization, managed care plan, hospital, or other healthcare entity or provider;

b. Any cancellation or material modification of Physician's professional liability coverage;

c. Any malpractice claim against Physician; or

d. Any criminal action filed or brought against Physician.

Any information that Physician discloses to IPA in accordance with this Seciton 3.11 shall be confidential information of Physician and shall not be disclosed by IPA to third parties without the prior written consent of Physician unless otherwise required by law or IPA policies and procedures. The disclosure of such information by Physician to IPA shall not constitute a waiver of the confidentiality of, or any privilege applicable to, such information.

4. ACCEPTANCE OF PAYER PLANS

4.1 Contractual Authority.

a. Fee-for-Service Messenger Model. IPA shall have the authority on behalf of Physician to enter into Payer Agreements for the provision of Covered Services by Physician to Covered Persons, subject to the provisions set forth below. Physician will provide services to Covered Persons of those Payor Plans which provide for reimbursement arrangements for physician services that have been offered and agreed to by the Physician. Network will provide Physician with pertinent information regarding any Payor Plan and written summaries (ballots) of the terms of each Payor Plan and made by reference part of Agreement. Unless IPA and Network receives timely written notice from Physician agreeing to participate in such Payor Plan, Physician will be deemed to have rejected participation in that particular Payor Plan. If Physician provides notice to Network to opt in to such Payor Plan, Physician will be deemed to have agreed to provide Covered Services to the Covered Persons of such Payor Plan pursuant

to this Agreement and the Payor Agreement. Rejection of a Payor Plan will not terminate Physicians obligations under this Agreement with respect to Covered Services to be provided to Covered Persons of other Payors under Payor Agreements previously or subsequently accepted by Physician.

b. Capitated Contracts. For certain Payors, Physician may be asked to accept capitation, a percentage of premiums, global fee or some other remuneration arrangement inconsistent with traditional fee for service arrangements. In such case, Physician will receive a written summary of the remuneration terms and other pertinent contract terms and will be given the opportunity to accept the terms of that arrangement by written amendment to this Agreement signed by both Physician and Network. Under capitated contracts, Physician agrees that IPA has the right to bind Physician to participate in Payer Plans which are consistent with the provisions of this Agreement.

c. Notices. For any Payer Plan, the IPA will furnish Physician with the reimbursement schedule and/or any other pertinent information applicable to such Payer Plan. Physician shall have seven (7) days from receipt of such information to notify IPA in writing of his or her decision not to participate in this Payer Plan. Unless IPA receives timely written notice from Physician accepting such Payer Plan, Physician shall be deemed to have rejected such Payer Plan. Rejection of a Payer Plan shall not terminate Physician's obligations under this Agreement with respect to Covered Services to be provided to Covered Persons of other Payers under Payer Agreements previously or subsequently accepted by Physician.

4.2 Contract Compliance. Physician agrees to comply with all operational and procedural rules and regulations promulgated by those Payers whose Payer Plan Physician has accepted under this Agreement.

4.3 Payor Agreement Facilitation. In the event that a Payer requests to enter into a contract directly with Provider rather than through IPA, and to the extent requested by the Payer and agreed upon by IPA, Physician shall deal directly with such payors and the IPA shall have no further obligations. Nothing in this Section (or elsewhere in this Agreement) shall be construed to prohibit or limit Provider from negotiating or contracting directly with any Payer.

5. PHYSICIAN CHARGES, REIMBURSEMENT PROCEDURE AND BILLINGS

5.1 Physician Charges. Physician agrees to accept payment as outlined within each Payer Agreement.

5.2 Payment in Full. Physician shall accept as payment in full, for Covered Services provided, the compensation offered by Payer and agreed to by Provider. Physician hereby agrees that in no event, including but not limited to nonpayment by the Payer and/or IPA, or Payer and/or IPA insolvency, or breach of this Agreement, shall Physician bill, charge, collect a deposit from, seek compensation, person other than Payer and/or IPA pursuant to this Agreement, except insofar as what is permitted by Section 5.3 below. Physician further agrees that (1) this provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Covered Person and (2) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Physician and Covered Persons or other person acting on their behalf.

5.3 Copayments and Deductibles. Physician understands and agrees that the Payer (or, if applicable, IPA) has no responsibility to pay any amount except as described in Paragraph 5.1 above and Physician shall bill and attempt to collect copayments, deductibles, and any other fees which are the Covered Person's responsibility under such Covered Person's health benefit plan or policy. For medical services not covered by this Agreement and for so long as not prohibited by IPA and/or Payer, Physician may bill a Covered Person or other responsible party at a mutually-agreeable charge. Physician agrees to notify the Covered Person, in advance of providing any uncovered services or any services for which the patient is not eligible, that the medical service is not covered and that the Covered Persons will be responsible for all charges.

5.4 Billing Forms. Physician will use the standard CMS 1500 or such other claim form furnished by Payer or IPA to bill for services rendered. IPA reserves the right to review all bills submitted by Physician to the Payer.

5.5 Reimbursement and Billing Procedures. Physician agrees to comply with the reimbursement and billing procedures required by IPA or Payer. Physician will submit a Clean Claim for Covered Services rendered to Covered Persons to the applicable Payor or its designated representative as required in the Payer Agreement. Payers will be expected to comply with the Clean Claims requirements of Articles 3.70-3C 3A and 20A.18B, Texas Insurance Code, and the rules promulgated, thereunder and with current Texas State Law pertaining to prompt payment of claims, currently SB 418, or any successor legislation. Physician agrees to comply with the Texas Civil Practice and Remedies Code, Chapter 146, regarding timely billing.

5.6 Payer's Liability. Unless otherwise specified in writing by IPA, Physician specifically acknowledges and agrees that the Payer shall have the full and final responsibility and liability for payment of claims and that IPA is not responsible for, does not guarantee, and does not assume liability for payment of any Physician claim. Unless otherwise provided for in this Agreement or specified in writing by IPA, all final claims decisions will be the responsibility of the Payer. Physician acknowledges and agrees that if IPA specifies in writing to Physician that IPA and not Payer has full and final responsibility for payment of claims or Physician's reimbursement, then under no circumstances will Physician seek claim payment from such Payer.

5.7 Coordination of Benefits. Physician agrees to adhere to individual payer requirements related to coordination of benefits.

6. MEDICAL RECORDS AND CONFIDENTIALITY

6.1 Maintenance of Medical Records. Physician shall maintain medical records for at least a period of time specified by state law or the Payer Plan, and make readily available to IPA, Payer, and governmental agencies with regulatory authority, all medical and related administrative records of Covered Persons that receive Covered Services, as required by IPA in accordance with this Agreement or pursuant to applicable law.

6.2 Transferability. Physician agrees, upon request of the Covered Person or other Participating Provider, and subject to applicable disclosure and confidentiality laws, to transfer a copy of the medical records of the Covered Person to such other Participating Provider on a timely basis not to exceed fifteen (15) days from the date of request.. This obligation shall survive any subsequent termination or expiration of this Agreement.

6.3 Access to Medical Records. Subject to applicable disclosure and confidentiality laws, Physician shall upon request provide IPA, Payer, or any duly designated third party with reasonable access to medical records, books, and other records of Physician relating to Covered Services provided to Covered Persons, and to the cost thereof, during the term of this Agreement and thereafter for a period in conformance with Section 10.4 and State and Federal law. IPA and the Payer shall be entitled to obtain copies of Covered Person's medical records. In addition, Physician will provide IPA with all records necessary to carry out IPA's and/or Payer's utilization management and quality improvement programs. The provisions of this paragraph shall not operate to waive or limit any restriction on release or disclosure of patient records established in any other provisions of this Agreement or as otherwise required by law.

6.4 Confidentiality of Medical Records. Physician agrees that information concerning Covered Persons shall be kept confidential and shall not be disclosed to any person except as authorized by State and Federal law. Physician will maintain complete records for each Covered Person receiving Physician Services from the date of service as required by federal, state, or local law. Physician agrees to maintain the confidentiality of information in these records and to release these records only with the written consent of the Covered Person or as otherwise authorized by law. Physician and IPA agree to conduct their relationship in accordance with all applicable laws and regulations, including the Texas Health and Safety Code, Ch. 181, Subchapters A & B and regulations promulgated pursuant, thereto, regulating Medical Record Privacy in Texas and the

federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the regulations promulgated thereunder upon the effective date of April 14, 2003 and any revision to date by HIPAA. Physician and IPA will execute the Business Associate Agreement attached as Exhibit D, and further agree to comply with all HIPAA privacy policies and procedures as may be required to assure compliance. This confidentiality provision shall remain in effect notwithstanding any subsequent termination or expiration of this Agreement.

6.5 Proprietary IPA Information. Physician may, from time to time, receive proprietary information from IPA. Physician agrees that such information shall be kept confidential and, unless otherwise required by law, shall not be disclosed to any person except as authorized in writing by IPA.

7. INDEPENDENT RELATIONSHIP

None of the provisions of this Agreement are intended to create nor shall be deemed or construed to create any relationship between IPA and Physician other than that of independent parties contracting with each other. Neither of the parties hereto, nor any of their respective officers, directors, or employees, shall be construed to be the agent, employee or representative of the other. Neither party is authorized to represent the other for any purpose whatsoever without the prior consent of the other. Subject to the following sentence of this section, Physician shall maintain control over the diagnosis and treatment of all Covered Persons under his or her care, and nothing in this Agreement shall alter or is intended to alter the physician-patient relationship.

8. INSURANCE

Physician shall maintain for the entire scope of practice such policies of comprehensive general and professional liability insurance as shall be necessary to insure Physician against any claim or claims for damages arising by reason of personal injuries or death occasioned, directly or indirectly, in connection with the performance of any service provided by Physician pursuant to this Agreement.

The amounts and extent of such insurance coverage and the insurer providing the coverage shall be subject to the approval of IPA. All policies described above shall be effective no later than the effective date of this Agreement, and shall remain in effect thereafter until the termination of this Agreement. Physician shall, upon execution of this Agreement and at such times thereafter as IPA may request, furnish evidence of such insurance either in the form of certificates from the insurer of such insurance or photocopies of the policy itself. Physician shall notify, or cause Physician's insurer to notify, in writing thirty (30) days prior to any modification, cancellation, or termination of any such insurance coverage for any reason whatsoever.

9. NON-EXCLUSIVITY

Nothing contained in this Agreement shall preclude Physician from participating in or contracting with any other healthcare provider organization, managed care plan, health maintenance organization, insurer, employer, or any other third party Payer, or directly with any Payer.

10. TERM AND TERMINATION

10.1 Term. This Agreement shall become effective on the Effective Date and shall remain in effect for one year. Unless earlier terminated, the Agreement shall automatically renew for successive terms of one (1) year each.

10.2 Termination. This Agreement may be terminated as follows:

a. Either party may terminate this Agreement, with or without cause effective at the end of the initial period by giving the other party ninety (90) days notice prior to the end of the initial term. Thereafter, either party may terminate this Agreement, with or without cause, by giving at least ninety (90) days prior notice to the other party. Physician may request the Board of Directors of IPA to reconsider IPA's decision to terminate Physician without cause. The Board, in its sole

discretion, will reconsider the without cause termination and either affirm or modify IPA's decision.

b. IPA shall have the right to terminate this Agreement immediately if the Physician: (i) suffers revocation, termination or suspension of his license; (ii) is found guilty of a criminal offense; (iii) is found liable for gross misconduct in providing care; (iv) fails to meet the requirements of Section 3.2 or 3.3 of this Agreement; (v) experiences a loss or material reduction in the amount of professional liability insurance coverage; (vi) fails to report any of the events set forth in 3.11 (vii) makes a misrepresentation or material omission on any application for provider membership or with regard to any other information submitted to Network; (viii) makes an assignment of (or attempts to assign) this Agreement or (ix) or fails to pay dues within ninety (90) days of date of invoice.

c. Either party may terminate this Agreement upon thirty (30) days prior notice if the other party breaches this Agreement and fails to cure within that notice period.

10.3 No Limitation of Rights. Nothing contained herein shall be construed to limit either party's lawful remedies in the event of a material breach of this Agreement.

10.4 Access to Records. Notwithstanding termination of this Agreement, IPA, and Payer shall continue to have access to the records maintained by Physician in accordance with Section 6.1 for a period of three (3) years from the date of the provision of the Covered Services to Covered Persons to which the records refer for purposes consistent with the rights, duties, and obligations under this Agreement and Payer Agreements.

10.5 Post Termination. Following termination of this Agreement, Physician shall continue to provide Covered Services to any Covered Person who is under active treatment either until such treatment is completed or responsibility is assumed by another Participating Provider. IPA and Physician shall use best efforts to cooperate to accomplish an appropriate referral to another Participating Provider within thirty (30) days of termination of this Agreement.

11. GENERAL PROVISIONS

11.1 Amendments. This Agreement may be amended in writing as mutually agreed upon by the parties. In addition, annually, or to comply with legal requirements, IPA may amend any provision of this Agreement upon thirty (30) days prior written notice to Physician. Any other amendments shall require approval by the IPA Board with concurrence of the majority of the IPA membership before being effective. Physician shall be deemed to have accepted IPA's amendment if Physician accepts such amendment in writing within the thirty (30) days notice period. In the event that Physician objects to such amendment, Physician shall have the right to terminate this Agreement upon thirty (30) days prior notice to IPA, such notice to be received by IPA no more than thirty (30) days after IPA has provided notice of such amendment to Physician.

11.2 Assignment. This Agreement, being intended to secure the services of and be personal to the Physician, shall not be assigned, sublet, delegated or transferred by Physician without the prior written consent of IPA. IPA may assign the Agreement (including the rights, duties, and obligations of IPA and Physician) to any entity affiliated with or related to IPA. This Agreement shall inure to the benefit of and shall bind the successors and permitted assignees of the parties hereto.

11.3 Notice. Any notice required to be given pursuant to the terms and provisions hereof shall be in writing and sent by hand delivery or by certified mail, return receipt requested, postage prepaid, to IPA or to the Physician at the respective addresses indicated herein. Notice shall be deemed to be effective when mailed or hand delivered, but notice of change of address shall be effective upon receipt.

11.4 Governing Law and Venue. This Agreement shall be governed in all respects by the laws of the State of Texas. The venue of any legal action arising from the Agreement shall be in Harris County, Texas, and IPA and Physician specifically waive any right of venue that either might otherwise have.

11.5 Severance of Invalid Provisions. If any provision of this Agreement is held to be illegal, invalid, or unenforceable under present or future laws effective during the term hereof, such provision shall be fully severable. This Agreement shall be construed and enforced as if such illegal, invalid, or unenforceable provision had never comprised a part hereof, and the remaining provisions shall remain in full force and effect unaffected by such severance, provided that the invalid provision is not material to the overall purpose and operation of this Agreement.

11.6 Waiver. The waiver by either party of any breach of any provision of this Agreement or warranty representation herein set forth shall not be construed as a waiver of any subsequent breach of the same or any other provision. The failure to exercise any right hereunder shall not operate as a waiver of such right. All rights and remedies provided herein are cumulative.

11.7 Entire Agreement. This Agreement contains all the terms and conditions agreed upon by the parties hereto regarding the subject matter of this Agreement. Any prior agreements, promises, negotiations, or representations, either oral or written, relating to the subject matter of this Agreement not expressly set forth in this Agreement are of no force or effect.

IN WITNESS WHEREOF, the foregoing Agreement between IPA and Physician is entered into by and between the undersigned parties, to be effective on the Effective Date stated below.

IPA

By: ___________________________________
President
Texas Professional Healthcare Alliance, Inc.

Address for Notices:
Texas Professional Healthcare Alliance, Inc.
Administrative Service Center
PO Box 503
Stilwell, Kansas 66085

Date Signed: ______________________

EFFECTIVE DATE OF AGREEMENT:

____
(assigned by IPA)

PHYSICIAN

Print Full Legal Name:

____

____

Address for Notices:

____

____

____

Date Signed: _____________________

TIN: ____________________________

INDEPENDENT PHYSICIANS' ASSOCIATION
BUSINESS ASSOCIATE AGREEMENT

This Business Associate Addendum is entered into as of the effective date of the Agreement between Texas Professional Healthcare Alliance, Inc., a Texas non-profit corporation (hereinafter referred to as "IPA") and provider of services listed on the signature page of referenced agreement, (hereinafter referred to as "Physician") and attached to and incorporated by reference and Addendum to Agreement.

BACKGROUND

The undersigned Parties have or are entering into the Business Arrangement pursuant to which Physician may furnish services for, on behalf of or through IPA that require both parties to access health information that is protected by state and/or federal law;

Physician and IPA desire that each obtain access to such information in accordance with the terms specified herein;

NOW THEREFORE, in consideration of the mutual promises set forth in this Addendum and other good and valuable consideration, the sufficiency and receipt of which are hereby severally acknowledged, the parties agree as follows:

1. Obligations. Either Party may receive from the other health information that is protected under applicable state and/or federal law, including without limitation, protected health information ("PHI") as defined in the regulations at 45 C.F.R. Parts 160 and 164 (the "Privacy Standards") promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). All capitalized terms not otherwise defined in this Addendum shall have the meanings set forth in the Privacy Standards. The Parties agree not to use or disclose (or permit the use or disclosure of) PHI in a manner that would violate the requirements of the Privacy Standards if the PHI were used or disclosed by CMEF in the same manner. The Parties shall use appropriate safeguards to prevent the use or disclosure of PHI other than as expressly permitted under this Addendum.

2. Use of PHI. The Parties may use PHI solely for the benefit of the other and only (i) for the purpose of performing services for or on behalf of the other as such services are defined in their Business Arrangement, and (ii) as necessary for the proper management and administration of their relationship or to carry out the legal responsibilities of Physician, provided that such uses are permitted under federal and state law. Both Parties shall retain all rights in the PHI not granted herein. Use and disclosure of de-identified health information, whether provided by one party to the other or derived from any PHI received from or on behalf of a party, is not permitted unless expressly authorized in this Addendum or in writing by the party giving the PHI.

3. Disclosure of PHI. Each Party may disclose PHI as necessary to perform its obligations under the Business Arrangement and as permitted by law, provided that each shall in such case: (a) obtain reasonable assurances from any person to whom the information is disclosed that it will be held confidential and further used and disclosed only as required by law or for the purpose for which it was disclosed to the person or entity; (b) agree to immediately notify the other of any instances of which it is aware that PHI is being used or disclosed for a purpose that is not otherwise provided for in this Addendum or for a purpose not expressly permitted by the Privacy Standards; and, (c) ensure that all disclosures of PHI are subject to the principle of "minimum necessary use and disclosure," i.e., only the minimum PHI that is necessary to accomplish the intended purpose may be disclosed. If a party discloses PHI received from the other , or created or received by one party on behalf of the other , to agents, including a subcontract (collectively, "Recipients"), they shall require Recipients to agree in writing to the same restrictions and conditions that apply to the each party under this Addendum. To the extent permitted by law, each party shall be fully liable to the other for any acts, failures or omissions of Recipients in furnishing the services as if they were the party's own acts, failures or omissions. Each party shall report to the other any use or disclosure of PHI not permitted by this Addendum, of which it becomes aware, such report to be made within five (5) days of a party's becoming aware of such use or disclosure. The Parties agree to mitigate, to the extent practical and unless otherwise requested by a

party in writing, any harmful effect that is known to a party and is the result of a use or disclosure of PHI in violation of this Addendum.

4. Individual Rights Regarding Designated Record Sets. If a party maintains a Designated Record Set on behalf of the other, that party shall (a) permit an individual to inspect or copy PHI contained in that set about the individual under conditions and limitations required under 45 CFR §164.524, as it may be amended from time to time, and (b) amend PHI maintained by a party as requested by the other. Each Party shall respond to any request from the other for access by an individual within five (5) days of such request and shall make any amendment requested by a party within ten (10) days of such request. The information shall be provided in the form or format requested, if it is readily producible in such form or format, or in summary, if the individual has agreed in advance to accept the information in summary form. A reasonable, cost-based fee for copying PHI may be charged. Each Party shall accommodate an individual's right to have access to PHI about the individual in a Designated Record Set in accordance with the Privacy Standards set forth at 45 CFR §164.526, as it may be amended from time to time, unless the regulation provides for a denial or an exception expressly applies. As applicable, either shall determine whether a denial is appropriate or an exception applies. A Party shall notify the other within five (5) days of receipt of any request for access or amendment by an individual. Both Parties shall have a process in place for requests for amendments and for appending such requests to the Designated Record Set.

5. Accounting of Disclosures. Each Party shall make available to the other in response to a request from an individual, information required for an accounting of disclosures of PHI with respect to the individual, in accordance with 45 CFR §164.528, as it may be amended from time to time, incorporating exceptions to such accounting designated under the regulation. Such accounting is limited to disclosures that were made in the six (6) years prior to the request and shall not include any disclosures that were made prior to the compliance date of the Privacy Standards. Each party shall provide such information necessary to provide an accounting within thirty (30) days of the other's request. Such accounting must be provided without cost to the individual or to a party if it is the first accounting requested by an individual within any twelve (12) month period; however, a reasonable, cost-based fee may be charged for subsequent accountings if a Party informs the other and the other party informs the individual in advance of the fee, and the individual is afforded an opportunity to withdraw or modify the request. Such accounting shall be provided as long as a party maintains PHI.

6. Withdrawal of Consent or Authorization. If the use or disclosure of PHI in this Addendum is based upon an individual's specific consent or authorization for the use of his or her PHI, and (i) the individual revokes such consent or authorization in writing, (ii) the effective date of such authorization has expired, or (iii) the consent or authorization is found to be defective in any manner that renders it invalid, Physician agrees, if it has notice of such revocation or invalidity, to cease the use and disclosure of any such individual's PHI except to the extent it has relied on such use or disclosure, or where an exception under the Privacy Standards expressly applies.

7. Records and Audit. A party shall make available to the other and to the United States Department of Health and Human Services or its agents, its internal practices, books, and records relating to the use and disclosure of PHI received from, created, or received by a party on behalf of the other for the purpose of determining that party's compliance with the Privacy Standards or any other health oversight agency, in a timely manner designated by a party or the Secretary. Except to the extent prohibited by law, each party agrees to notify the other immediately upon receipt by that party of any and all requests served upon that party for information or documents by or on behalf of any and all government authorities.

8. Notice of Privacy Practices. Any use or disclosure permitted by this Addendum may be amended by such Notice. Physician agrees that it will establish and post Notices as required by law and notify IPA of any amendment to the Notice. The amended Notice shall not affect permitted uses and disclosures on which IPA has relied prior to the receipt of such Notice.

9. Confidentiality. Each Party shall take any steps required to (i) protect PHI from unauthorized uses or disclosures and (ii) maintain the confidentiality and integrity of PHI. Prior to any permitted disclosure of PHI, Physician shall require the person or entity to which it intends to disclose PHI to assume all of the same duties with respect to PHI that Physician has under this Addendum. Physician

shall be fully liable to IPA and any affected individuals for any acts, failures or omissions of Recipients as though they were its own acts, failures or omissions.

10. Term and Termination.

10.1 Any termination pursuant to the documents that govern the Business Arrangement shall not affect the respective obligations or rights of the parties arising under this Addendum prior to the effective date of termination, all of which shall continue in accordance with their terms; and provided that the effective date of Sections 4 and 5 shall be in accordance with the provisions of those sections.

10.2 IPA, at its sole discretion, may immediately terminate this Addendum and shall have no further obligations to Physician hereunder if any of the following events shall have occurred and be continuing (a) Physician shall fail to observe or perform any material covenant or Addendum contained in this Addendum for ten (10) days after written notice thereof has been given to Physician by CMEF; or (b) a violation by Physician of any provision of the Privacy Standards or applicable federal or state privacy law.

10.3 Upon termination of this Addendum for any reason, Each Party agrees either to return to the other or to destroy all PHI received from the other party that is in the possession or control of a party or its agents. Each party shall provide timely notice to the other certifying the PHI it destroyed. In the case of information for which it is not feasible to "return or destroy," each party shall continue to comply with the covenants in this Addendum with respect to such PHI and shall comply with other applicable state or federal law, which may require a specific period of retention, redaction, or other treatment. Termination of this Addendum shall be cause for IPA to terminate the Business Arrangement.

11. No Warranty. PHI IS PROVIDED SOLELY ON AN "AS IS" BASIS. CMEF DISCLAIMS ALL OTHER WARRANTIES, EXPRESS OR IMPLIED, INCLUDING, BUT NOT LIMITED TO, IMPLIED WARRANTIES OF MERCHANTABILITY, AND FITNESS FOR A PARTICULAR PURPOSE.

12. Equitable Relief. Each party understands and acknowledges that any disclosure or misappropriation of any PHI in violation of this Addendum will cause the other irreparable harm, the amount of which may be difficult to ascertain, and therefore agrees that the affected party shall have the right to apply to a court of competent jurisdiction for specific performance and/or an order restraining and enjoining any such further disclosure or breach and for such other relief as the affected party shall deem appropriate. Such right of the affected party is to be in addition to the remedies otherwise available to the affected party at law or in equity. Both parties expressly waive the defense that a remedy in damages will be adequate and further waive any requirement in an action for specific performance or injunction for the posting of a bond by the affected party.

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ATTACHMENT A

MEDICARE ADVANTAGE PROGRAM REQUIREMENTS

The terms and conditions herein are included to meet federal statutory and regulatory requirements of the federal Medicare Advantage Program under Part C of Title XVIII of the Social Security Act ("Medicare Advantage Program"). Provider understands that the specific terms as set forth herein are subject to amendment in accordance with federal statutory and regulatory changes to the Medicare Advantage Program. Such amendment shall not require the consent of Provider or Medicare Advantage Plan and will be effective immediately on the effective date thereof.

1. **Books and Records; Governmental Audits and Inspections.** Provider shall permit the Department of Health and Human Services ("HHS"), the Comptroller General, or their designees to inspect, evaluate and audit all books, records, contracts, documents, papers and accounts relating to Provider's performance of the Agreement and transactions related to the CMS Contract (collectively, "Records"). The right of HHS, the Comptroller General or their designees to inspect, evaluate and audit Provider's Records for any particular contract period under the CMS Contract shall exist for a period of ten (10) years from the later to occur of (i) the final date of the contract period for the CMS Contract or (ii) the date of completion of the immediately preceding audit (if any) (the "Audit Period"). Provider shall keep and maintain accurate and complete Records throughout the term of the Agreement and the Audit Period.

2. **Privacy and Confidentiality Safeguards.** Provider shall safeguard the privacy and confidentiality of Members and shall ensure the accuracy of the health records of Members. Provider shall comply with all state and federal laws and regulations and administrative guidelines issued by CMS pertaining to the confidentiality, privacy, data security, data accuracy and/or transmission of personal, health, enrollment, financial and consumer information and/or medical records (including prescription records) of Members, including, but not limited, to the Standards for Privacy of Individually Identifiable Information promulgated pursuant to the Health Insurance Portability and Accountability Act.

3. **Member Hold Harmless.** Provider shall not, in any event (including, without limitation, non-payment by Medicare Advantage Plan or breach of the Agreement), bill, charge, collect a deposit from, seek compensation or remuneration or reimbursement from or hold responsible, in any respect, any Member for any amount(s) that Medicare Advantage Plan may owe to Provider for services performed by Provider under the Agreement. This provision shall not prohibit Provider from collecting supplemental charges, co-payments or deductibles specified in the Benefit Plans. Provider agrees that this provision shall be construed for the benefit of the Member and shall survive expiration, non-renewal or termination of the Agreement regardless of the cause for termination.

4. **Delegation of Activities or Responsibilities.** To the extent activities or responsibilities under a CMS Contract are delegated to Provider pursuant to the Agreement ("Delegated Activities"), Provider agrees that (i) the performance of the Delegated Activities and responsibilities thereof shall be subject to monitoring on an ongoing basis by Medicare Advantage Plan; and (ii) in the event that the Medicare Advantage Plan or CMS determine that Provider has not satisfactorily performed any Delegated Activity or responsibility thereof in accordance with the CMS Contract, applicable laws and regulations and CMS instructions, then Medicare Advantage Plan shall have the right, at any time, to revoke the Delegated Activities by terminating the Agreement in whole or in part, and shall have the right to institute corrective action plans or seek other remedies or curative measures as contemplated by the Agreement. Provider shall not further delegate any activities or requirements without the prior written consent of Medicare Advantage Plan. To the extent that the Delegated Activities include professional credentialing services, Provider agrees that the credentials of medical professionals affiliated or contracted with Provider will either be (i) directly reviewed by Medicare Advantage Plan, or (ii) Provider's credentialing process will be reviewed and approved by Medicare Advantage Plan and Medicare Advantage Plan shall audit Provider's credentialing process on an ongoing basis. Provider acknowledges that Medicare Advantage Plan retains the right to approve, suspend or terminate any medical professionals, as well as any arrangement regarding the credentialing of medical professionals.

   In addition, Provider understands and agrees that Medicare Advantage Plan maintains ultimate accountability under its Medicare Advantage contract with CMS. Nothing in this Agreement shall be construed to in any way limit Medicare Advantage Plan's authority or responsibility to comply with applicable regulatory requirements.

5. **Prompt Payment.** Medicare Advantage Plan agrees to pay Provider in compliance with applicable state or federal law following its receipt of a "clean claim" for services provided to Medicare Advantage Plan Members. For purposes of this provision, a clean claim shall mean a claim for Provider services that has no defect or impropriety requiring special treatment that prevents timely payment by Medicare Advantage Plan.

6. **Compliance with Medicare Advantage Plan's Obligations, Provider Manual, Policies and Procedures**. Provider shall perform all services under the Agreement in a manner that is consistent and compliant with Medicare Advantage Plan's contract(s) with CMS (the "CMS Contract"). Additionally, Provider agrees to comply with the Medicare Advantage Plan Provider Manual and all policies and procedures relating to the Benefit Plans.

7. **Subcontracting**. Medicare Advantage Plan maintains ultimate accountability for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS. Provider shall not subcontract for the performance of Covered Services under this Agreement without the prior written consent of Medicare Advantage Plan. Every subcontract between Provider and a subcontractor shall (i) be in writing and comply with all applicable local, State and federal laws and regulations; (ii) be consistent with the terms and conditions of this Agreement; (iii) contain Medicare Advantage Plan and Member hold harmless language as set forth in Section 3 hereof; (iv) contain a provision allowing Medicare Advantage Plan and/or its designee access to such subcontractor's books and records as necessary to verify the nature and extent of the Covered Services furnished and the payment provided by Provider to subcontractor under such subcontract; and (v) be terminable with respect to Members or Benefit Plans upon request of Medicare Advantage Plan.

8. **Compliance with Laws.** Provider shall comply with all laws, regulations and instructions from CMS applicable to Provider's performance of services under the Agreement. Provider shall maintain all licenses, permits and qualifications required under applicable laws and regulations for Provider to perform the services under the Agreement. Without limiting the above, Provider shall comply with Federal laws designed to prevent or ameliorate fraud, waste and abuse, including but not limited to applicable provisions of Federal criminal law, the False Claims Act (31 U.S.C. 3729 et. seq.) and the anti-kickback statute (section 1128B(b) of the Social Security Act).

9. **Program Integrity.** Provider represents and warrants that Provider (or any of its staff) is not and has not been (i) sanctioned under or listed as debarred, excluded or otherwise ineligible for participation in the Medicare program or any Federal program involving the provision of health care or prescription drug services, or (ii) criminally convicted or has a civil judgment entered against it for fraudulent activities. Provider shall notify Medicare Advantage Plan immediately if, at any time during the term of the Agreement, Provider (or any of its staff) is (i) sanctioned under or listed as debarred, excluded or otherwise ineligible for participation in the Medicare program or any Federal program involving the provision of health care or prescription drug services, or (ii) criminally convicted or has a civil judgment entered against it for fraudulent activities. Provider acknowledges that Provider's participation in Medicare Advantage Plan shall be terminated if Provider (or any of its staff) is debarred, excluded or otherwise ineligible for participation in the Medicare program or any Federal program involving the provision of health care or prescription drug services.

10. **Continuation of Benefits**. Provider shall continue to provide services under the Agreement to Members in the event of (i) Medicare Advantage Plan's insolvency, (ii) Medicare Advantage Plan's discontinuation of operations or (iii) termination of the CMS Contract, throughout the period for which CMS payments have been made to Medicare Advantage Plan, and, to the extent applicable, for Members who are hospitalized, until such time as the Member is appropriately discharged.

11. **Incorporation of Other Legal Requirements.** Any provisions now or hereafter required to be included in the Agreement by applicable Federal or state laws and regulations or by CMS shall be binding upon and enforceable against the parties to the Agreement and be deemed incorporated herein, irrespective of whether or not such provisions are expressly set forth in the this Attachment or elsewhere in the Agreement.

12. **Conflicts.** In the event of a conflict between any specific provision of this Exhibit and any specific provision of the Agreement, the specific provisions of this Exhibit shall control.