Name according to W-9 form with d/b/a: Collin County Government d/b/a Collin County Health Care Servs.
Federal Tax Identification Number: 756000873

AMERIGROUP TEXAS, INC. d/b/a AMERIGROUP Community Care
PARTICIPATING PROVIDER AGREEMENT
For Physicians and Allied Health Professionals

THIS PARTICIPATING PROVIDER AGREEMENT (this "Agreement") is made by and between AMERIGROUP Texas, Inc. d/b/a AMERIGROUP Community Care ("AMERIGROUP") and the undersigned Provider ("Provider"), effective as of the date of complete execution of this Agreement (the "Effective Date").

RECITALS:

A. AMERIGROUP is authorized to arrange for the provision of managed health care services to Covered Persons enrolled in any Program as more specifically defined below.

B. Provider is authorized in the State of Texas to provide Covered Services to Covered Persons.

C. AMERIGROUP desires that Provider provides the Covered Services contemplated herein to Covered Persons pursuant to the terms and conditions set forth in this Agreement, and Provider desires to provide such services.

AGREEMENT:

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

ARTICLE I
DEFINITIONS

The following terms shall have the meanings set forth below with respect to services furnished under the Medicaid Program, and as specifically set forth, the Medicare Program.

1.1 Agency. "Agency" means a federal, state or local agency, administration, board or other governing body responsible for the governance or administration of a Program. With respect to the operation of the Programs, Agency means, without limitation, THHSC and CMS.

1.2 Behavioral Health Care Services. "Behavioral Health Care Services" means services rendered for the treatment of mental health or drug and alcohol conditions.

1.3 CMS. "CMS" means the Center for Medicare & Medicaid Services, an administrative agency within the United States Department of Health & Human Services ("HHS").

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1.4 Clean Claim. "Clean Claim" means a claim received by AMERIGROUP for adjudication, in a nationally accepted format in compliance with standard coding guidelines, which requires no further information, adjustment, or alteration by the Provider of the services in order to be processed and paid by AMERIGROUP, and which meets requirements of the Provider Manual, consistent with 28 TAC 21.2803 *et seq*.

1.5 Covered Person. "Covered Person" means a person who is an eligible Program beneficiary and who is enrolled as an AMERIGROUP member in accordance with applicable Program enrollment requirements.

1.6 Covered Services. "Covered Services" means those health care services (including Behavioral Health Care Services) that a Covered Person is entitled to receive through AMERIGROUP pursuant to Regulatory Requirements, and for which an **Attachment A** is attached hereto setting forth the Providers' reimbursement under one or more Programs.

1.7 Emergency Behavioral Health Condition. "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: (a) requires immediate intervention and/or medical attention without which Covered Persons would present an immediate danger to themselves or others, or (b) which renders Covered Persons incapable of controlling, knowing or understanding the consequences of their actions.

1.8 Emergency Medical Condition. "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 health of an individual in serious jeopardy, (b) serious impairment to bodily functions, (c) serious dysfunction of any bodily organ or part, (d) serious disfigurement, or (e) in the case of pregnant woman, serious jeopardy to the health of the woman or her unborn child.

1.9 Emergency Services. "Emergency Services" means covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish such services under this contract and are needed to evaluate or stabilize an Emergency Medical Condition and/or an Emergency Behavioral Health condition, including Post-Stabilization Care.

1.10 HIPAA Regulations. "HIPAA Regulations" shall mean those regulations adopted pursuant to the Health Insurance Portability and Accountability Act of 1996 and codified at Title 45 of the Code of Federal Regulations (C.F.R.) relating to the privacy and security of protected health information, and including, without limitation, any amendments or successor laws, rules or regulations thereto.

1.11 Medically Necessary.

(a) Health care services that are:

(i) 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 a Covered Person, or endanger life;

(ii) provided at appropriate facilities and at the appropriate levels of care for the treatment of a Covered Person's health conditions;

(iii) consistent with health care practice guidelines and standards that are endorsed by professionally recognized health care organizations or governmental agencies;

(iv) consistent with the diagnoses of the conditions;

(v) no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;

(vi) not experimental or investigative;

and

(vii) not primarily for the convenience of the Covered Person or Provider; and,

(b) Behavioral Health Services that:

(i) 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;

(ii) are in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care;

(iii) are furnished in the most appropriate and least restrictive setting in which services can be safely provided;

(iv) are the most appropriate level or supply of service that can safely be provided;

(v) could not be omitted without adversely affecting the Covered Person's mental and/or physical health or the quality of care rendered;

(vi) are not experimental or investigative;

and

(vii) are not primarily for the convenience of the Covered Person or Provider.

1.12 Participating Provider. "Participating Provider" includes, as appropriate, any "Participating Hospital," "Participating Physician," "Participating Physician Group" or any other person or entity that (a) is licensed to provide the health care services such person or entity is

providing under the laws of Texas; (b) is party to a participation agreement with AMERIGROUP to provide Covered Services to Covered Persons, or is an employee or subcontractor of a Participating Provider and will be furnishing Covered Services hereunder; and (c) is, if applicable, duly credentialed by AMERIGROUP in accordance with AMERIGROUP credentialing requirements for the services the Participating Provider provides. The definition of "Participating Provider" includes, but is not limited to, Provider.

1.13 Primary Care Physician/Primary Care Provider. "Primary Care Physician" or "Primary Care Provider" means a Participating Physician or other Participating Provider who (a) is credentialed in accordance with AMERIGROUP credentialing requirements for Primary Care Physicians or Primary Care Providers; (b) provides Primary Care Services; and (c) practices in the medical specialty areas of general practice, internal medicine, pediatrics, family medicine, or such other medical specialty areas as are specified to provide Primary Care Services in an applicable Program Contract.

1.14 Primary Care Services. "Primary Care Services" means (a) those Covered Services provided to a Covered Person involving initial and basic primary medical care, including, but not limited to, the Covered Services specifically identified as primary care services in an applicable Program Contract, and (b) the supervision and coordination of the delivery of these Covered Services to a Covered Person.

1.15 Program. "Program" means a Texas STAR and/or STAR+Plus Medicaid managed care program ("Medicaid"), a state or local Child Health Insurance Program ("CHIP"), the CHIP Perinatal Program ("CHIP Perinatal"), a Medicare Advantage program ("Medicare"), or any successor programs thereto, and such other federal, state or local program related to, or administered in conjunction with, Medicare, Medicaid, or CHIP including, without limitation, any program providing coverage for eligible family members of CHIP beneficiaries or persons eligible for coverage under both the Medicare and Medicaid Programs, and for which an **Attachment A** is incorporated into this Agreement setting forth the Providers' reimbursement for a respective Program.

1.16 Program Contract. "Program Contract" means any contract between AMERIGROUP and a jurisdiction, or any applicable Agency of a jurisdiction, which governs the delivery of managed health care services to Program beneficiaries.

1.17 Regulatory Requirements. "Regulatory Requirements" means any requirements imposed by applicable federal, state or local laws, rules, regulations, a Program Contract, or otherwise imposed by an Agency in connection with the operation of a Program or the performance required by either party under this Agreement.

1.18 TDSHS. "TDSHS" shall mean the Texas Department of State Health Services.

1.19 TDI. "TDI" shall mean the Texas Department of Insurance.

1.20 THHSC. "THHSC" shall mean the Texas Health and Human Services Commission.

1.21 TDMHMR. "TDMHMR" shall mean the Texas Department of Mental Health and Mental Retardation.

ARTICLE II
AMERIGROUP OBLIGATIONS

2.1 Identification Cards. AMERIGROUP shall issue each Covered Person an identification card reflecting the Covered Person's name, the Covered Person's selected Primary Care Physician, the Covered Person's AMERIGROUP identification number, and such other information as required by an Agency. A sample identification card will be provided upon request of Provider.

2.2 Provider Manual. AMERIGROUP shall furnish Provider with the applicable Provider Manual(s) for each Program referencing the policies and procedures established by AMERIGROUP including, without limitation, eligibility verification, utilization review, drug utilization, quality assurance, provider grievances, appeals and such other policies and procedures applicable to AMERIGROUP and Provider as required by Regulatory Requirements, and to otherwise effect the delivery of managed health care services to Covered Persons hereunder. AMERIGROUP shall provide Provider with at least thirty (30) days prior notice of any material modifications to such Provider Manual thereafter. To the extent mandated by Regulatory Requirements, AMERIGROUP shall provide at least ninety (90) days prior notice if any such material modifications change AMERIGROUP payment policies.

2.3 Policies and Procedures. AMERIGROUP shall reference material policies and procedures applicable to Provider in the Provider Manual. Notwithstanding the above, AMERIGROUP's failure to include a specific policy or procedure in the Provider Manual shall not limit the applicability of such policy and procedure to Provider; provided that AMERIGROUP uses its commercially reasonable efforts to notify Provider of such policy. AMERIGROUP shall furnish Provider with written notice of any material modifications to such policies and procedures during the term of this Agreement, and shall respond to Provider inquiries related to such policies and procedures in a timely manner. Provider shall comply with all AMERIGROUP policies and procedures communicated to Provider by AMERIGROUP.

2.4 Reports. AMERIGROUP shall provide to Provider such utilization profiles or other reports, if any, which AMERIGROUP is required to provide to Provider under Regulatory Requirements.

2.5 Provider Listing; Marketing/Advertising. For the purposes of enrolling and referring Covered Persons, marketing, complying with Program Contract requirements, reporting to Agencies, and otherwise carrying out the terms and conditions of this Agreement, AMERIGROUP shall be entitled to use the name(s), business address(es), and phone number(s) of Provider including any individual Participating Provider employed by or under contract with Provider to provide services hereunder. AMERIGROUP shall, and shall be entitled to, use information related to any such individual Participating Provider's education, specialty, subspecialty, licensure, certification and hospital affiliation for the purposes described above.

2.6 Credentialing. Except as mutually agreed by the parties and as evidenced in writing by a Delegated Credentialing Addendum to this Agreement, AMERIGROUP shall credential Provider and all Participating Providers providing services hereunder on behalf of Provider pursuant to AMERIGROUP credentialing criteria applicable to Provider and any such Participating Providers.

2.7 Schedule of Benefits and Determination of Covered Services. AMERIGROUP shall provide Provider with schedules of Covered Services for applicable Programs and will notify Provider in a timely manner of any material amendments or modifications to such schedules.

2.8 Affiliate Services.

(a) Covered Services furnished to members of certain out-of-state entities affiliated with AMERIGROUP, including, without limitation, other AMERIGROUP health plans ("Affiliates"), shall be paid in accordance with the rates set forth in this Agreement or such other rates established by the Affiliate's state Program governing care to out-of-state members. Such services will be furnished in accordance with the terms and conditions of the Provider Manual. Notwithstanding the above, for purposes of this Section, "Affiliate Services" shall mean those services required to be furnished to an Affiliate's members pursuant to the applicable Program in the state in which the Affiliate is responsible for furnishing services.

(b) AMERIGROUP shall be responsible for coordinating between Provider and the applicable Affiliate for any member of an Affiliate that receives services at Provider. AMERIGROUP shall ensure that the Affiliate adjudicates and pays for services furnished hereunder in accordance with this Agreement.

(c) Nothing in this Agreement shall be construed to make Provider a participating provider of any Affiliate, and Provider shall not be identified as such in any Affiliate directory of participating providers.

(d) Affiliates shall be deemed third party beneficiaries of this Section.

(e) Amerigroup Insurance Company ("AIC") shall be deemed an Affiliate of AMERIGROUP and Covered Services furnished to Covered Persons enrolled with AIC shall be paid in accordance with the rates set forth in this Agreement and shall be furnished in accordance with the terms and conditions of this Agreement.

ARTICLE III
PROVIDER OBLIGATIONS

3.1 Provider Services. Provider shall provide to Covered Persons those Covered Services within the scope of Provider's licensure, expertise, and usual and customary range of services pursuant to the terms and conditions of this Agreement, and shall be responsible to AMERIGROUP for its performance hereunder. Provider shall provide to Covered Persons access to 24 hour-per-day, 7 day-per-week urgent and emergency services as required by Regulatory Requirements.

3.2 Licensure and Accreditation. At all times during the term of this Agreement, Provider shall (a) maintain in good standing all applicable licenses, certifications and registrations required for Provider to furnish services hereunder; (b) be a certified Medicare and certified Medicaid Provider, to the extent required under the Programs; (c) obtain and maintain accreditation by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) or from another applicable nationally recognized accrediting body, and (d) not be subject to any determination or action that would adversely impact Provider's license or status as a certified Medicare and Medicaid provider. Provider shall ensure that each of Provider's employees is duly licensed, certified or registered as required under a Program and applicable standards of professional ethics and practice. Provider shall notify AMERIGROUP within three (3) business days following Provider's receipt of any notice of any restrictions upon, or any suspension or loss of, any licensure, certification or registration, or receipt of any notice of any restrictions, suspension or revocation of such accreditation required hereunder. Provider shall submit to AMERIGROUP evidence of Provider's satisfaction of the requirements set forth in this section upon AMERIGROUP's reasonable request. Subject to Regulatory Requirements, AMERIGROUP has the right to immediately terminate this Agreement upon the expiration, surrender, revocation, restriction, or suspension of any accreditation, certification or license required hereunder. Provider shall obtain and maintain a National Provider Identification Number ("NPI") as required by applicable law. Provider can obtain NPIs through the National Plan and Provider Enumerator System located at: https://nppes.cms.hhs.gov/NPPES/Welcome.do.

3.3 Covered Person Verification. Provider shall establish a Covered Person's eligibility for services prior to rendering services, except in the case of an Emergency Medical Condition where such verification may be impractical. In the case of an Emergency Medical Condition, Provider shall establish a Covered Person's eligibility as soon as reasonably practical. AMERIGROUP shall provide a system for Providers to contact AMERIGROUP to verify Covered Person eligibility 24 hours a day, 7 days per week. Nothing contained in this Agreement shall, or shall be construed to, require advance notice, coverage verification, or pre-authorization for emergency room services provided in accordance with the federal Emergency Medical Treatment and Active Labor Act ("EMTALA") prior to Provider's rendering such services.

3.4 Provider Responsibility. AMERIGROUP shall not be liable for, nor will it exercise control or direction over, the manner or method by which Provider provides services to Covered Persons. Provider shall be solely responsible for all medical advice and services provided by Provider to Covered Persons. Provider acknowledges and agrees that AMERIGROUP may deny payment for provider services rendered to a Covered Person which it determines are not Medically Necessary, are not Covered Services pursuant to an applicable Program Contract, or are not otherwise provided in accordance with this Agreement. Neither such a denial nor any action taken by AMERIGROUP pursuant to a utilization review, referral, or discharge planning program shall operate to modify Provider's obligation to provide appropriate services to a Covered Person under applicable law and any code of professional responsibility. Nothing in this Agreement shall be construed as prohibiting any Participating Provider from discussing treatment or non-treatment options with Covered Persons irrespective of whether such treatment options are Covered Services.

3.5 Coordinated and Managed Care. Provider shall participate in AMERIGROUP systems designed to facilitate the coordination of health care services. Subject to medical judgment, patient care interests, and a patient's express instructions, and recognizing that the level of Covered Services provided by Provider may be affected by the Provider's scope of services, Provider shall report clinical encounter data as required by such systems, and shall obtain all required Covered Person consents or authorizations necessary for Provider to report such clinical encounter data to AMERIGROUP.

3.6 Concurrent Review. Provider agrees to provide access to AMERIGROUP employees to review Covered Persons' medical records and perform on-site concurrent review during normal business hours. AMERIGROUP employees will cooperate with the requirements of the Provider while on Provider's premises. During any such on-site concurrent review, Provider shall provide AMERIGROUP with access to a telephone and appropriate work space to conduct the review.

3.7 Compliance with Credentialing, Utilization Management, Quality Assurance, Grievance, Coordination of Benefits, Third Party Liability and other Rules, Regulations, Policies and Procedures. Provider shall comply and cooperate with all AMERIGROUP, Program Contract and Agency requirements related to credentialing, utilization management, quality assurance, grievances, coordination of benefits and third party liability. Provider shall comply with the terms of the Provider Manual.

3.8 Insurance Coverage.

(a) Professional Liability. At all times during the term of this Agreement, Provider shall maintain professional liability insurance, including maintaining such tail or prior acts coverage necessary to avoid any gap in coverage for claims arising from incidents occurring during the term of this Agreement. Such insurance shall (i) be obtained from a carrier authorized to conduct business in the jurisdiction in which Provider operates; and (ii) maintain minimum policy limits equal to $100,000.00 per occurrence and $300,000.00 in the aggregate.

(b) General Liability. At all times during the term of this Agreement, Provider shall maintain general comprehensive liability insurance from a carrier authorized to conduct business in the jurisdiction in which Provider operates, in amounts required under Regulatory Requirements. Said insurance shall cover Provider's premises, insuring Provider against any claim of loss, liability, or damage caused by or arising out of the condition or alleged condition of said premises, or the furniture, fixtures, appliances, or equipment located therein, together with the standard liability protection against any loss, liability or damage resulting from the operation of a motor vehicle by Provider, Provider's employees or agents.

(c) Workers Compensation. Provider shall maintain workers' compensation insurance for Provider's employees. Said insurance shall be obtained from a carrier authorized to conduct business in the jurisdiction in which Provider operates and shall provide such limits of coverage as required by Regulatory Requirements.

(d) Evidence of Insurance. Provider shall provide AMERIGROUP with evidence of Provider's compliance with the foregoing insurance requirements as reasonably

requested by AMERIGROUP from time to time during the term of this Agreement, but in no event less than annually. Provider shall provide AMERIGROUP with at least thirty (30) days prior written notice of any cancellation or non-renewal of any required coverage or any reduction in the amount of Provider's coverage, and shall secure replacement coverage meeting the requirements hereunder so as to ensure no lapse in coverage. Provider shall furnish AMERIGROUP with a certificate of insurance evidencing such replacement coverage. Provider shall also furnish a certificate of insurance to a requesting Agency upon request. Provider may maintain coverage hereunder through a self-funded insurance plan, provided that Provider maintains actuarially sound reserves related to such self-funded plan and provides to AMERIGROUP on a semi-annual basis an opinion letter from an independent actuarial firm or other proof reasonably acceptable to AMERIGROUP attesting to the financial adequacy of such reserves.

3.9 Contracted Provider Requirements. Unless otherwise approved by AMERIGROUP, Provider and its employees shall perform all the services required hereunder directly and not pursuant to any subcontract between Provider and any other person or entity (a "Contracted Provider"). In the event that any portion of the services that Provider is responsible for hereunder are performed for or on behalf of Provider by a Contracted Provider, Provider shall be responsible for ensuring that such Contracted Provider furnishes such services in compliance with all of Provider's obligations under this Agreement including, without limitation, maintaining required insurance, and holding Covered Persons harmless for the cost of any services or supplies provided by Contracted Providers to such Covered Persons. This section shall not preclude Provider from using contract nursing services or obtaining *locums tenens* coverage for Participating Physicians that are on temporary leave.

3.10 Proprietary Information; Confidentiality.

(a) The parties acknowledge and agree that all the following information is proprietary: AMERIGROUP's quality assurance, utilization management, risk management and peer review programs; AMERIGROUP's credentialing procedures; this Agreement, including the rates of reimbursement payable under this Agreement; AMERIGROUP's Provider Manual; information related to AMERIGROUP programs, policies, protocols and procedures, and all information otherwise furnished to Provider by AMERIGROUP as a result of this Agreement. The parties agree not to use such proprietary information except for the purpose of carrying out their obligations under this Agreement. Neither party shall disclose any proprietary information to any person or entity without the other party's express written consent except pursuant to Regulatory Requirements or to the extent such information is available in the public domain or was acquired by such party from a third party not bound to preserve the confidentiality of such information.

(b) Provider and AMERIGROUP shall each treat all information which is obtained through its respective performance under the Agreement as confidential information to the extent that confidential treatment is required under applicable law and regulations, including without limitation 42 C.F.R. §422.118 and 45 C.F.R. Parts 160 and 164, as may be amended from time to time, and shall not use any information so obtained in any manner except as necessary to the proper discharge of its obligations and securing of its rights hereunder. Provider and AMERIGROUP shall each have a system in effect to protect all records and all other

documents deemed confidential by law which are maintained in connection with the respective activities of Provider or AMERIGROUP and performed in connection with this Agreement. Any disclosure or transfer of confidential information by Provider or AMERIGROUP will be in accordance with applicable law.

3.11 Provision of Non-Covered Services. Prior to the provision of any services to a Covered Person that are not Covered Services, Provider (a) shall advise the Covered Person, in writing, (i) of the nature of the service; (ii) that the service is not a Covered Service for which compensation is payable hereunder; and (iii) that the Covered Person will be responsible for paying for the service; (b) shall obtain a signed Private Pay form from such Covered Person; and (c) shall otherwise comply with all applicable law, Program Contract and Agency requirements related to the provision of non-covered services to Covered Persons.

3.12 Representations and Warranties.

(a) Provider Status. Provider hereby represents and warrants that Provider: (i) has the power and authority to enter into this Agreement; (ii) is legally organized and operated to provide the services contemplated hereunder; (iii) is not in violation of any licensure or accreditation requirement applicable to Provider under law, Program Contract or Agency rules; (iv) is in good standing with THHSC; (v) has not been convicted of bribery or attempted bribery of any official or employee of the jurisdiction in which Provider operates, nor made an admission of guilt of such conduct which is a matter of record; (vi) is capable of providing all data related to the services provided hereunder in a timely manner as reasonably required by AMERIGROUP to satisfy Regulatory Requirements, including, without limitation, data required under the Health Employer Data and Information Set and National Committee for Quality Assurance requirements; and (vii) qualifies as a participating provider in all Programs for which an **Attachment A** is attached hereto in accordance with the applicable Regulatory Requirements.

(b) Provider Information and Documentation. Provider represents and warrants that all information provided by Provider to AMERIGROUP, including without limitation, information relating to insurance coverage, quality assurance, credentialing, change of ownership of Provider and availability of medical care by Provider to Covered Persons, is true and correct as of the date such information is furnished, and Provider is unaware of any undisclosed facts or circumstances that would make such information inaccurate or misleading. Provider shall provide AMERIGROUP with written notice of any changes to such information within five (5) business days of such change.

3.13 Reporting Fraud and Abuse. Provider shall cooperate with AMERIGROUP's anti-fraud compliance program. If Provider identifies any actual or suspected fraud, abuse or misconduct in connection with the services rendered hereunder, in violation of state or federal law, Provider immediately shall report such activity directly to the Compliance Officer of AMERIGROUP in accordance with the Provider Manual.

3.14 Conformance with Law. Without limiting the applicability of any other sanctions and penalties that may be applicable for Provider's failure to conform with such federal, state and local laws, rules and regulations, Provider acknowledges and agrees that, in connection with the Medicare Program, Provider's failure to report potential fraud or abuse to CMS may result in

sanctions, cancellation of contract, or exclusion from participation in the Medicare Program. Provider agrees to comply with all state and federal laws, rules and regulations that apply to all persons receiving state and federal funds, including without limitation, all applicable Medicare laws, rules and regulations and all CMS instructions.

ARTICLE IV
REIMBURSEMENT

4.1 Claims Submission. Except to the extent Provider is compensated on a capitation basis under this Agreement, Provider shall submit claims on either a current CMS-1500 claim form for professional claims or a CMS-1450 claim form for institutional claims (or successor forms), or the electronic equivalent in the manner and to the location described in the Provider Manual. Provider is encouraged to submit claims information through electronic data interchange (EDI) that allows for automated processing and adjudication of claims. As AMERIGROUP continues to develop electronic interface systems for registration, eligibility and benefit verification and claims processing, Provider will use such electronic interface systems. Provider must use HIPAA compliant billing codes when billing or submitting encounter data. This applies to both electronic and paper claims. When billing codes are updated, Provider is required to use appropriate replacement codes for submitted claims for Covered Services. In its discretion, AMERIGROUP may amend the Agreement as it deems necessary to clarify changes to standard billing codes. Regardless of whether AMERIGROUP so amends the Agreement, AMERIGROUP shall not pay any claims submitted using non-compliant billing codes.

Claims must be submitted within ninety-five (95) days following the date service is rendered. Claims not received by AMERIGROUP from Provider within such period may be denied payment. AMERIGROUP will not deny Clean Claims for payment solely due to these claims being received after ninety-five (95) days from the date services were rendered in the event that Provider was unable to determine that the patient was an AMERIGROUP Covered Person, and where Provider timely filed such claim with another payor. In such event, Provider shall have ninety-five (95) days to resubmit such claim to AMERIGROUP from the date Provider receives a denial from the payor to which Provider originally submitted the claim. Such submission shall include proof of timely filing, and denial by, such other payor.

4.2 Reimbursement. As payment in full for Covered Services provided to Covered Persons hereunder, AMERIGROUP shall pay to Provider the reimbursement specifically set forth in Attachment A.

(a) AMERIGROUP shall adjudicate a Clean Claim in accordance with applicable law, within thirty (30) days following AMERIGROUP's receipt of such Clean Claim from Provider. AMERIGROUP shall pay Provider interest on all Clean Claims that are not adjudicated within such thirty (30) day period at a rate of 1.5% per month (18% per annum). Such interest shall not apply if Provider files duplicate claims prior to the expiration of the thirty (30) day adjudication timeframe.

(b) To the extent required by applicable Program Contract requirements, or to the extent required under applicable law, AMERIGROUP shall adjudicate claims for services submitted under this Agreement in accordance with Texas Insurance Code, Section 843.336,

Subchapter J (Prompt Payment of Physicians and Providers) and Texas Administrative Code, Title 28, Section 21.2801 *et. seq.*

(c) If Provider is compensated for services rendered to Covered Persons under this Agreement on a capitation basis, the parties shall comply with Texas Insurance Code Section 843.315 (a) through (i), to the extent such Section is applicable to the parties, regarding compensation and the selection of a primary physician or provider.

(d) Upon written request, Provider shall be entitled to receive such information as may be reasonably necessary for Provider to determine that Provider is being compensated in accordance with the terms of this Agreement. In accordance with 28 TAC Section 11.901(a)(11)(G), Provider may not use or disclose such information for any purpose other than Provider's practice management and billing activities. AMERIGROUP shall furnish Provider with at least ninety (90) days notice in the event of a material change to AMERIGROUP's claims payment methodology, unless the change is required by statute or regulation in a shorter timeframe. Provider acknowledges and agrees that such information is proprietary information and Provider shall not disclose such information to any person or entity without AMERIGROUP's express written consent.

(e) Provider shall provide encounter data, for capitated services rendered to Covered Persons in a timely manner and in accordance with the encounter data submission requirements established by AMERIGROUP and THHSC. Such data shall be provided in the manner that AMERIGROUP prescribes. This information includes, but is not limited to, statistical and descriptive medical, diagnostic and patient data for Covered Services rendered to Covered Persons.

(f) With respect to Medicare Covered Services, AMERIGROUP shall pay Provider interest on the unpaid portion of Medicare Clean Claims not adjudicated within such period as required under applicable prompt pay requirements, at a rate equal to the CMS interest rate in effect at the time of such charge. AMERIGROUP will update the CMS interest rate applicable to this Agreement on a prospective basis within thirty (30) days following its publication in the Federal Register.

(g) AMERIGROUP reserves the right to use a code editing software as reasonably required by AMERIGROUP to ensure claims adjudication in accordance with industry standards, including, but not limited to, determining which services are considered part of, incidental to, or inclusive of the primary procedure and ensuring medically appropriate age, gender, diagnosis, frequency, and units billed.

4.3 Financial Incentives. No provision in this Agreement shall, or shall be construed to, create any financial incentive for Provider to withhold Medically Necessary services.

4.4 Recoveries from Third Parties. Provider acknowledges and agrees that claims payments made by AMERIGROUP pursuant to Program requirements are subject to Program requirements regarding third party liability. Provider shall cooperate with AMERIGROUP's policies and procedures related to third party liability recovery in the event claims for services rendered by Provider to a Covered Person are related to an illness or injury for which a third

party may be liable, including, without limitation, claims that may be covered by automobile insurance, workers' compensation coverage, other health insurance, or otherwise give rise to a claim for third party liability, coordination of benefits or subrogation (to the extent permitted by Regulatory Requirements). Provider shall take all reasonable actions required by AMERIGROUP to assist AMERIGROUP in obtaining such recoveries, including executing any appropriate documents reasonably requested by AMERIGROUP to enforce such claims or to assign any payments to AMERIGROUP.

4.5 Right of Offset. AMERIGROUP shall be entitled to offset an amount equal to any overpayments made by AMERIGROUP to Provider against any payments due and payable by AMERIGROUP to Provider under this Agreement.

4.6 Capitation of Contracted Providers; Encounter Data Requirements. If Provider is compensated for services provided pursuant to this Agreement on a capitated basis, AMERIGROUP shall pay the monthly capitation payment payable hereunder in accordance with its then current policies and procedures and in compliance with any requirements more specifically set forth in Article VI. If Provider is compensated for services provided hereunder on a capitated basis, Provider shall:

(a) provide to AMERIGROUP such encounter data related to the services provided by Provider to Covered Persons hereunder, in a form and on a schedule, as required by AMERIGROUP from time to time;

(b) arrange and coordinate all capitated Covered Services for Covered Persons assigned to Provider or one of Provider's Participating Physicians for such capitated Covered Services;

(c) accept the capitation payment payable hereunder as payment in full for all such capitated Covered Services provided to such Covered Persons; and

(d) comply with any additional requirements under law, Program Contract or Agency requirements applicable to capitation compensation arrangements, including, without limitation, any requirements more specifically set forth in Article VI.

ARTICLE V
PROVISIONS APPLICABLE TO PHYSICIANS AND ALLIED HEALTH PROVIDERS

5.1 Primary Care Provider Services. If Provider is furnishing Primary Care Services under this Agreement, Provider shall, and shall cause the Primary Care Providers employed by or under contract with Provider to, accept as patients all Covered Persons who are eligible to receive their Primary Care Services from Provider or a Primary Care Provider employed by or under contract with Provider. Provider further agrees to provide, or to arrange for the provision of, appropriate Primary Care Services to such Covered Persons. Provider and any Primary Care Providers employed by or under contract with Provider, shall refer Covered Persons to Specialist Physicians only in accordance with procedures established by AMERIGROUP.

5.2 Specialist Physician Services. If Provider is furnishing Specialist Physician services under this Agreement, Provider, and the Specialist Physicians employed by or under

contract with Provider, shall accept as patients all Covered Persons who are referred by Primary Care Providers to Provider. Provider shall provide, or arrange for the provision of, appropriate Specialist Physician Covered Services (as may be more specifically described in **Attachment A** to this Agreement). Provider and any Specialist Physicians employed by or under contract with Provider, shall refer Covered Persons to other Specialist Physicians only in accordance with procedures established by AMERIGROUP.

5.3 Hospital Affiliation and Privileges. Provider, in the case of a solo provider, or any providers employed by or under contract with Provider, in the case of a group provider, shall maintain in effect privileges to practice at one or more Participating Hospitals. Provider shall immediately notify AMERIGROUP in the event any such hospital privileges are revoked, limited, surrendered, or suspended at any hospital or health care facility.

5.4 Participating Provider Requirements. If Provider is a group provider, Provider shall cause all Participating Providers employed by or under contract with Provider to comply with all terms and conditions of this Agreement. Notwithstanding the foregoing, Provider acknowledges and agrees that AMERIGROUP is not obligated to accept as Participating Providers all providers employed by or under contract with Provider.

5.5 Federally Qualified Health Centers. If Provider is a federally qualified health center ("FQHC") or a rural health center ("RHC"), as defined under applicable federal law, Provider shall comply with all requirements related to FQHCs and RHCs under Regulatory Requirements including, without limitation, compliance with the service quality standards required in connection with current and future clinical quality reporting methods that are applicable to FQHCs and administered by federal oversight agencies.

5.6 Post-Stabilization. Provider shall comply with all applicable law related to the post-stabilization care of a Covered Person after an Emergency Medical Condition has been stabilized.

5.7 Automatic Termination; Automatic Exclusion.

(a) Automatic Termination. If Provider is an individual Provider, in addition to the other termination provisions set forth in this Agreement, this Agreement shall automatically and immediately terminate upon the expiration, surrender, revocation or restriction of Provider's medical staff privileges at any one or more Participating Hospitals or if Provider fails to maintain active staff privileges with respect to at least one (1) Participating Hospital.

If Provider is a group medical practice, in addition to the other termination provisions set forth in this Agreement, this Agreement shall automatically and immediately terminate only with regard to the individual Participating Provider who is subject to the expiration, surrender, revocation, restriction or suspension of the Provider's medical staff privileges at any one or more Participating Hospitals, or if Provider fails to maintain active staff privileges with respect to at least one Participating Hospital.

(b) Automatic Exclusion. If Provider is a group provider, then upon the occurrence of any of the actions described in subparagraph (a) above related to the medical staff

privileges of an individual Participating Provider employed by or contracted with Provider, AMERIGROUP shall be entitled to exclude such Participating Provider from participation under this Agreement.

5.8 Exclusion of Individual Participating Providers. Notwithstanding any other provision contained in this Agreement, AMERIGROUP shall be entitled to exclude from participation under this Agreement an individual Participating Provider employed by or contracted with Provider, for any of the reasons included in, and in accordance with the terms and conditions of, the termination provisions otherwise included in the Agreement. In the event of such exclusion, this Agreement shall continue in full force and effect as to all other Participating Providers employed by or contracted with Provider who are not so excluded.

5.9 Effect of Termination or Exclusion of Specialist Physicians. In the event any Specialist Physicians employed by or under contract with Provider are excluded from participation under this Agreement, or in the event that Provider is a Specialist Physician, if this Agreement is terminated for any reason, AMERIGROUP shall notify all affected Covered Persons under treatment by such Specialist Physician of such termination prior to the effective date of such termination.

ARTICLE VI
COMPLIANCE WITH REGULATORY REQUIREMENTS

6.1 Compliance with Regulatory Requirements. AMERIGROUP and Provider shall each comply with all applicable Regulatory Requirements related to this Agreement. The failure of this Agreement to expressly reference a Regulatory Requirement applicable to either party in connection with their duties and responsibilities hereunder shall in no way limit such party's obligation to comply with such Regulatory Requirement.

6.2 Medicare Co-payments and Deductibles; Limitations of Billing.

(a) In connection with the Medicare Program, except for costs associated with non-Covered Services provided to a Covered Person, applicable co-payments and deductibles as permitted under the Medicare Program and set forth in the AMERIGROUP Provider Manual or in the schedule of benefits for the Medicare Program are the only amounts that Provider may collect from a Medicare-eligible Covered Person in connection with Covered Services. Provider acknowledges that Medicaid cost-sharing requirements may preclude Provider's collection of co-payments or deductibles from dual eligible Medicare and Medicaid Covered Persons.

(b) Provider shall be responsible for collecting any applicable co-payments or permitted deductibles at the time of service in accordance with the policies and procedures set forth in the AMERIGROUP Provider Manual.

(c) Provider understands that if Provider initiates any actions to collect payment from any Medicare-eligible Covered Person over and above allowable co-payments, excluding payment for services not covered under the Medicare Program, AMERIGROUP will initiate and maintain such necessary action to stop Provider or Provider's employee, agent, assign, trustee, or successor in interest from maintaining such action against such Medicare-eligible Covered Person.

(d) Covered Persons eligible for both Medicare and Medicaid will not be held liable for Medicare Part A and B cost sharing when the State of Texas is responsible for paying such amounts. AMERIGROUP will not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the member under title XIX if the member were not enrolled in such a plan. The provider will accept AMERIGROUP's payment as payment in full or bill the appropriate State source, as appropriate.

6.3 Medicare Reporting Requirements.

(a) In accordance with 42 C.F.R. §422.504(i); AMERIGROUP and Provider expressly agree:

(i) HHS, the Comptroller General of HHS (the "Comptroller General") or their designees, may audit, evaluate, or inspect any books, contracts, medical records, patient care documentation, and all other records of AMERIGROUP and Provider, as well as their related entities, contractors, subcontractors or transferees, that pertain to any aspect of the services performed under this Agreement, reconciliation of benefit liabilities, and determination of amounts payable under this Agreement, or as the Secretary of HHS (the "Secretary") may deem necessary to enforce this Agreement.

(ii) AMERIGROUP and Provider each agree to make available, for the purposes specified in 42 C.F.R. §422.504(e), their respective premises, physical facilities and equipment, records relating to Covered Persons and any additional relevant information that CMS may require.

(iii) HHS, the Comptroller General, or their designees' right to inspect, evaluate and audit shall extend through ten (10) years from the final date of the Medicare Program contract or the completion of a final audit by CMS related to same, whichever is later, unless CMS determines there is a special need to retain a particular record or group of records for a longer period than ten (10) years and so notifies AMERIGROUP at least 30 days prior to the normal disposition date, or CMS determines there is a reasonable possibility of fraud.

(b) In accordance with 42 C.F.R. §422.504(a)(8), Provider shall comply with reporting requirements in 42 C.F.R. §422.516 and the requirements in 42 C.F.R. §422.310 for submitting data to CMS.

6.4 Non-Discrimination. Provider shall abide by the federal Civil Rights Act of 1964, the Federal Rehabilitation Act of 1973, and all other applicable statutes, regulations and orders (including, without limitation, Executive Orders 11246 and 11375, "Equal Employment Opportunities") as amended, and any and all successor statutes, regulations and related orders. Provider shall not exclude any Covered Person from participation in any aid, care, service or other benefit, or deny any Covered Person such services on the grounds of race, color, national origin, sex, age, disability, political beliefs or religion. Provider shall not subject any Covered Person to discrimination due to such Covered Person's status as a Program Contract beneficiary.

6.5 Hold Harmless Clause Pursuant to Texas Administrative Code. Provider agrees that in no event, including, but not limited to non-payment by AMERIGROUP, AMERIGROUP insolvency, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek

compensation, remuneration, or reimbursement from or have any recourse against a Covered Person or any person acting on behalf of a Covered Person for services provided pursuant to this Agreement. This provision shall not prohibit collection of supplemental charges or co-payments on AMERIGROUP's behalf made in accordance with the terms of applicable Program Contracts. Provider further agrees that this section shall survive the termination of this Agreement regardless of the cause giving rise to such termination and shall be construed to be for the benefit of Covered Person, and that this provision supercedes any oral or written contrary agreement now existing or hereafter entered into between Provider and a Covered Person or persons acting on such Covered Person's behalf. Any modification, addition or deletion to the provisions of this subsection shall be effective on a date no earlier than fifteen (15) days after the Texas Commissioner of Insurance has received written notice of such proposed modification, addition or deletion.

6.6 Required Texas Insurance Code Provisions. In accordance with Texas Insurance Code, Section 843.361, Provider shall comply with the following provisions:

(a) Provider shall hold a Covered Person harmless for payment of the cost of Covered Services in the event AMERIGROUP fails to pay Provider for such Covered Services.

(b) Provider shall post, in the office of Provider, a notice to Covered Persons on the process for resolving complaints with AMERIGROUP, such notice to include the Texas Department of Insurance's toll-free telephone number for filing complaint.

(c) If Provider is a podiatrist licensed by the Texas State Board of Podiatric Medical Examiners,

(i) Provider may request, and AMERIGROUP shall provide not later than the 30th day after the date of the request, a copy of the coding guidelines and payment schedules applicable to the compensation that Provider will receive under this Agreement;

(ii) AMERIGROUP may not unilaterally make material retroactive revisions to the coding guidelines and payment schedules; and

(iii) Provider may, practicing within the scope of the law regulating podiatry, furnish x-rays and nonprefabricated orthotics covered by this Agreement.

(d) AMERIGROUP shall not engage in any retaliatory action, including termination of, or refusal to renew this Agreement, against Provider because Provider has on behalf of a Covered Person, reasonably filed a complaint against AMERIGROUP or has appealed a decision of AMERIGROUP.

(e) Nothing contained in this Agreement shall, or shall be construed to, purport to indemnify AMERIGROUP for any tort liability resulting from acts or omissions of AMERIGROUP.

6.7 Medicaid and CHIP Program Contract Requirements. Pursuant to the Medicaid and CHIP Program Contracts, the following provisions shall apply:

(a) Provider understands that services provided under this Agreement are funded by state and federal funds under the Medicaid program. Provider is subject to all state and federal laws, rules, regulations, waivers, policies and guidelines, court-ordered consent decrees, settlement agreements, or other court orders that apply to all persons or entities receiving state and federal funds. Provider understands that any violation by Provider of state or federal law relating to the delivery of services by Provider under this Agreement, or any violation of the THHSC/AMERIGROUP contract could result in liability for money damages, and/or civil or criminal penalties and sanctions under state and/or federal law. Provider agrees to comply with applicable state laws, rules, and regulations and THHSC's requests regarding personal and professional conduct generally applicable to the service locations and otherwise conduct themselves in a businesslike and professional manner. If Provider provides acute care services hereunder, Provider must be enrolled as a Medicaid provider with THHSC or its agent and must have a Texas Provider Identification Number ("TPIN"). Provider understands and agrees that THHSC reserves the right and retains the authority to make reasonable inquiry and conduct investigations into Provider and Covered Person complaints.

(b) Provider understands and agrees that AMERIGROUP has the sole responsibility for payment of Covered Services rendered by Provider under this Agreement. In the event of AMERIGROUP insolvency or cessation of operations, Provider's sole recourse is against AMERIGROUP through the bankruptcy, conservatorship, or receivership estate of AMERIGROUP.

(c) Except as expressly permitted hereunder, Provider is prohibited from billing or collecting any amount from a Medicaid Covered Person for Covered Services rendered pursuant to this Agreement. Provider understands and agrees THHSC is not liable or responsible for payment for any Medicaid Covered Services provided to mandatory Medicaid Covered Persons under this Agreement. Provider acknowledges and understands that federal and state laws provide severe penalties for any provider who attempts to collect any payment or bill a Medicaid recipient for a Covered Service.

(d) Provider is responsible for collecting at the time of the service any applicable CHIP program co-payments or deductibles given the limitations on those co-payments and deductibles set forth in applicable law and the CHIP Program Contract. Provider shall not charge co-payments or deductibles to: CHIP Covered Persons of Native American Tribes; a CHIP Covered Person with an ID card that indicates the Covered Person has met his or her cost-sharing obligation for the balance of their term of coverage; or co-payments to CHIP Covered Persons for well-child or well-baby visits or immunizations.

(e) In accordance with 42 C.F.R. §438.206(b)(3) and the CHIP Member's Rights and Responsibilities and at no additional cost to the Covered Person, Provider must allow Covered Persons to access a second opinion from a Participating Provider or a non-participating provider if a Participating Provider is not available at no additional cost to the Covered Person. Under the CHIP program, co-payments are the only amounts Provider may collect from Covered Person, except for the costs associated with unauthorized non-emergency services provided to a Covered Person by out of network providers for non-covered services.

(f) AMERIGROUP shall initiate and maintain any action necessary to stop Provider or Provider's employee, agent, assign, trustee, or successor-in-interest from maintaining an action against THHSC or any Covered Person, to collect payment from THHSC or any such Covered Person over and above allowable co-payments or deductibles, excluding payment for services not covered under the CHIP Program.

(g) Provider understands and agrees that there is no right of subrogation, contribution or indemnification against THHSC for any duty owed to Provider by AMERIGROUP pursuant to this Agreement or any judgment rendered against AMERIGROUP. THHSC's liability to AMERIGROUP's employees, agents and subcontractors, if any, will be governed by the Texas Tort Claims Act, as amended or modified. THHSC does not assume liability for the action of, or judgments rendered against AMERIGROUP, its employees, agents, or subcontractors. Provider agrees that it has no right to indemnification or contribution from THHSC for any judgment rendered against AMERIGROUP or its providers.

(h) Provider understands and agrees that Covered Persons are not to be held liable for AMERIGROUP's debts in the event of AMERIGROUP's insolvency.

(i) Providers shall not interfere with or place any lien upon the right of the State of Texas or AMERIGROUP, acting as the State's agent, to recovery from third party resources. Providers shall not seek recovery in excess of the Medicaid payable amount or otherwise violate state and federal laws.

(j) Provider acknowledges and agrees that this Agreement is subject to all state and federal laws and regulations relating to fraud, abuse or waste in health care, the Medicaid program and the CHIP program. Provider shall cooperate and assist THHSC and any state or federal agency that is charged with the duty of identifying, investigating, sanctioning or prosecuting suspected fraud, abuse, or waste. Provider shall provide originals and/or copies of any and all information, allow access to premises and provide records to the Office of Inspector General, THHSC or its authorized agent(s), CMS, the U.S. Department of Health and Human Services, FBI, TDI, the Texas Attorney General's Medicaid Fraud Control Unit, U.S. Comptroller General, Office of the State Auditor of Texas, or other unit of state government upon request, and free-of-charge. If Provider places the 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. Provider shall report any suspected fraud or abuse including any suspected fraud and abuse committed by AMERIGROUP or a Medicaid/ CHIP recipient to the THHSC Office of Inspector General. Provider agreements that are requested by any agency with authority to investigate and prosecute fraud and abuse must be produced at the time and place required by THHSC or the requesting agency. Provider agreements requested in response to a Public Information request must be produced within forty-eight (48) hours of the request.

(k) AMERIGROUP shall not impose restrictions upon Provider's free communication with Covered Persons about a Covered Persons medical conditions, treatment options, AMERIGROUP referral policies, and other AMERIGROUP policies, including financial incentives or arrangements and all Medicaid Program managed care plans with who Provider contracts.

(l) Provider shall permit the THHSC Office of Inspector General and/ or the Texas Medicaid Fraud Control Unit to conduct private interviews of Provider and Providers' employees, contractors, and patients. Provider shall comply with all requests for information in the form and language requested. Provider and its employees and contractors shall cooperate fully in making themselves available in person for interviews, consultation, grand jury proceedings, pre-trial conference, hearings, trial and in any other process, including investigations. Provider's compliance with this section shall be at Provider's own expense.

(m) Providers shall not interfere with or place any lien upon the right of the State of Texas, acting as the State's agent, to recovery from third party resources. Providers shall not seek recovery in excess of the Medicaid payable amount or otherwise violate state and federal laws.

(i) Provider understands and agrees that the following shall apply to this Agreement: the 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;

(ii) the 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;

(iii) the Clean Air Act and the Federal Water Pollution Control Act, as amended, found at 42 C.F.R. 7401, *et seq.* and 33 U.S.C. 1251, *et seq.*, respectively.

(iv) the 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

(v) the 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.

(vi) Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990, and all requirements imposed by the regulations implementing these acts and all amendments to the laws and regulations. The regulations provide in part that no person in the United States shall on the grounds of race, color, national origin, sex, age, disability, political beliefs or religion be excluded from participation in, or denied, any aid, care, service or other benefits, or be subjected to any discrimination under any program or activity receiving federal funds.

(vii) the Immigration Reform Control Act of 1986 (8 U.S.C. §1101 *et seq.*) regarding employment verification and retention of verification forms.

(viii) the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191).

(n) In accordance with Regulatory Requirements, Provider shall protect the confidentiality of Member records, including patient records. Provider shall comply with the

HIPAA Privacy Rule governing the use and disclosure of protected health information for treatment, payment, and health care operations.

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

(ii) 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.

(iii) Provider acknowledges and agrees that this Agreement is subject to public disclosure under the Texas Public Information Act (Texas Government Code, Chapter 552).

(o) Provider shall protect the confidentiality of AIDS and HIV-related medical information and shall not discriminate against Covered Persons with communicable diseases.

(p) If Provider is a laboratory services provider, Provider shall report positive mycobacteriology culture results positive for M. Tuberculosis and M. Tuberculosis antibiotic susceptibility to TDSHS as required by 25 TAC Section 97.5(a). Provider shall report any Covered Person who is non-compliant, drug resistant, or who is or may be posing a public health threat to TDSHS or the local TB control program.

(q) If Provider provides contraceptive services or family planning services, Provider must provide to all Covered Persons requesting contraceptive services or family planning services counseling and education about family planning and family planning services available to Covered Persons. Provider shall have mechanisms in place to comply with federal and state laws governing Covered Person's (including minors') confidentiality for family planning services. Provider shall deliver family planning services according to the TDSHS Family Planning Service Delivery Standards. Provider shall not require parental consent for Covered Persons who are minors to receive family planning services.

(r) If Provider provides inpatient psychiatric services, Provider shall ensure that all Covered Persons receiving inpatient psychiatric services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge, which outpatient treatment must occur within seven (7) days from the date of discharge. Provider shall contact Covered persons who have missed appointments within twenty four (24) hours to reschedule appointments.

(s) Provider shall maintain written policies and procedures for informing and providing written information to all adult Covered Persons 18 years of age and older about their rights under state and federal law regarding advance directives, in advance of their receiving care, including, without limitation, their rights under applicable federal law and under the Advance Directives Act, Chapter 166, Texas Health and Safety Code.

(t) If Provider provides Consumer Directed Services, Provider must have a contract with the Department of Aging and Disability Services for the delivery of such services.

6.8 Provisions Applicable to Primary Care Providers. If Provider provides primary care services, Provider shall comply with the following provisions:

(a) Provider shall be accessible to Covered Persons 24 hours a day, 7 days a week. The following are acceptable phone arrangements for contracting Provider after normal business hours:

(i) Office phone is answered after-hours by an answering service which meets language requirements of the major population groups and which can contact Provider or another designated medical practitioner. All calls answered by an answering service must be returned within thirty (30) minutes.

(ii) Office phone is answered after normal business hours by a recording in the language of each of the major population groups served directing the patient to call another number to reach Provider or another provider designated by the Provider. Someone must be available to answer the designated provider's phone. Another recording is not acceptable.

(iii) Office phone is transferred after office hours to another location where someone will answer the phone and be able to contact Provider or another designated medical practitioner, who can return the call within 30 minutes.

The following procedures are not acceptable phone arrangements for contacting Provider after normal business hours:

(A) Office phone is only answered during office hours.

(B) Office phone is answered after-hours by a recording which tells patients to leave a message.

(C) Office phone is answered after-hours by a recording which directs patients to go to an Emergency Room for any services needed.

(D) Returning after-hours calls outside of 30 minutes.

(b) Provider shall provide primary care services and continuity of care to Covered Persons who are enrolled with or assigned to Provider. Primary care services are all services required by a Covered Person for the prevention, detection, treatment and cure of illness, trauma, disease or disorder, which are covered and/or required services under applicable Program Contracts. All services must be provided in compliance with generally accepted medical and behavioral health standards for the community in which services are rendered. Provider shall provide children under the age of 21 services in accordance with the American Academy of Pediatric recommendations and the Texas Health Steps periodicity schedule and provide adults services in accordance with the U.S. Preventive Services Task Force's publication "Put Prevention Into Practice."

(c) Provider shall assess the medical needs of Covered Persons for referral to specialty care providers and provide referrals as needed. Provider must coordinate care with specialty care providers after referral.

(d) For children under the age of 21, Provider shall provide or arrange to have provided all services required under Medicaid Program Contract relating to Texas Health Steps, Perinatal Services, Early Childhood Intervention, WIC, People With Disabilities or Chronic or Complex Conditions, and Health Education and Wellness and Prevention Plans. Provider shall cooperate and coordinate with AMERIGROUP to provide Covered Persons and the Covered Persons' family with knowledge of and access to available services.

(e) Provider shall have screening and evaluation procedures for detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders. Provider may provide any clinically appropriate behavioral health care services within the scope of Provider's practice.

6.9 Provisions Applicable to Other Provider Types. In accordance with the Medicaid Program Contract, if Provider provides any of the following provider type services, Provider shall comply with the applicable provisions set forth below:

(a) If Provider is a specialty care provider, Provider shall send a record of consultation and recommendations to a Covered Persons' PCP for inclusion in Covered Persons' medical record and report encounters to the Covered Persons' PCP and/or AMERIGROUP, as required.

(b) If Provider is a hospital or specialty care facility, Provider shall provide discharge plans to Covered Person or Covered Persons' family, to Covered Persons' PCP and to Covered Persons' specialty care physicians.

(c) If Provider is a federally qualified health center ("FQHC") or rural health center ("RHC"), Provider shall comply with the following provisions:

(i) Provider acknowledges and agrees that it will receive a cost settlement from THHSC and hereby agrees to accept initial payments from AMERIGROUP in an amount that is equal to or greater than AMERIGROUP's payment terms for other providers providing the same or similar services.

(ii) Provider shall validate the encounter and payment information contained in the FQHC or RHC report(s) provided by AMERIGROUP to Provider from time to time and execute and deliver to AMERIGROUP such reports after it agrees that it accurately reflects encounters and payments for the period reported.

6.10 Marketing Practices.

(a) Provider agrees to comply with THHSC's marketing policies and procedures as set forth in the Program Contract (which includes THHSC's Uniform Managed Care Manual). Provider is prohibited from engaging in the following marketing practices:

(b) Provider is prohibited from conducting any direct-contact marketing to prospective Covered Persons except through THHSC-sponsored enrollment events or engaging in direct marketing to Covered persons that is designed to increase enrollment in a particular health plan; provided that this section shall not be construed to restrict Provider from engaging in permissible marketing activities consistent with broad outreach objectives and application assistance.

6.11 State Auditors Office Investigation. Provider understands and agrees that the acceptance of funds under this Agreement 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.

6.12 Laboratory Compliance. If Provider performs laboratory services, Provider must meet all applicable state and federal requirements.

6.13 Other Medicare Requirements.

(a) Delegation. In accordance with 42 C.F.R. §422.504(i)(3)(iii), any services or other activity performed by a related entity, contractor, subcontractor, or first-tier or downstream entity of Provider in accordance with a contract or written agreement shall be consistent and comply with AMERIGROUP's contractual obligations with CMS. Provider shall comply with the requirements of 42 C.F.R. §422.504(i)(4) if any of AMERIGROUP's activities or responsibilities under its contract with CMS are delegated to other parties.

(b) Accountability. In accordance with 42 C.F.R. §422.504(i)(3)(ii), Provider may only delegate activities or functions to a provider, related entity, contractor, or subcontractor in a manner consistent with the requirements set forth in 42 C.F.R. §422.504(i)(4).

(c) Executive Order 13496. This provision is applicable to Providers who participate in AMERIGROUP's Medicare program under Medicare Parts C and D and receive at least $10,000 or more in payments from such AMERIGROUP Medicare program. Provider shall comply with the requirements of Executive Order 13496, 29 CFR 471, Appendix A to Subpart A.

6.14 Performance Within the U.S. Provider agrees that all services to be performed herein shall be performed in the United States of America. Breach, or anticipated breach, of the foregoing shall be a material breach of this Agreement and, without limitation of remedies, shall be cause for immediate termination of this Agreement.

6.15 No Payment Outside the U.S. Provider agrees that AMERIGROUP shall not provide any payments for items or services provided under the Agreement to any financial institution or entity located outside the United States of America.

ARTICLE VII
RECORDS

7.1 Records. Provider shall maintain medical, financial and administrative records concerning services provided to Covered Persons in accordance with industry standards and Regulatory Requirements, including without limitation applicable law regarding confidentiality of Covered Person information. Such records shall be retained by Provider for the period of time required under Regulatory Requirements, but in no event less than ten (10) years from the date the service is rendered. Provider shall provide state and federal agencies access to review records related to services provided hereunder in accordance with Regulatory Requirements. Provider shall permit AMERIGROUP or its designated agent to review records directly related to services provided to Covered Persons, either by providing such records to AMERIGROUP for off-site review, or on-site at Provider's facility, upon reasonable notice from AMERIGROUP and during regular business hours. Provider shall obtain all necessary releases, consents and authorizations from Covered Persons with respect to their medical records to permit AMERIGROUP access to such records. Provider shall supply the records described above at no charge upon request. The rights and obligations of the parties under this section shall survive the termination of this Agreement.

7.2 Record Transfer. Provider shall cooperate in the transfer of Covered Persons' medical records to other Participating Providers when required, subject to Regulatory Requirements, and shall assume the cost associated therewith. Following a Covered Person's request for record transfer, Provider shall transfer such Covered Person's medical records in Provider's custody within ten (10) days following the request, or such other time period required under applicable Regulatory Requirements.

ARTICLE VIII
COMPLAINT/DISPUTE RESOLUTION

8.1 Complaints of Covered Persons. AMERIGROUP shall notify the Provider concerning any complaint by a Covered Person involving that Provider or a Participating Provider of that Provider in accordance with procedures set forth in the Provider Manual. The provisions of this Article shall only apply to disputes that have complied fully with all grievance and appeal procedures set forth in the Provider Manual.

8.2 Negotiation of Disputes.

(a) In the event of a dispute arising out of this Agreement that is not resolved by, or is not within the scope of relationship management set forth in the Agreement, or that is not resolved by informal discussions among the Parties, the Parties shall negotiate the dispute. Any party may initiate negotiation by sending a written description of the dispute to the other Parties by certified or registered mail or personal delivery. The description shall explain the nature of the dispute in detail and set forth a proposed resolution, including a specific time frame within which the Parties must act. The Party receiving the letter must respond in writing within thirty (30) days with a detailed explanation of its position and a response to the proposed resolution. Within thirty (30) days of the initiating Party receiving this response, principals of

the Party who have authority to settle the dispute will meet to discuss the resolution of the dispute. The initiating Party shall initiate the scheduling of this negotiating session.

(b) In the event the Parties are unable to resolve the dispute following the negotiation, a Party shall have the right to pursue all available remedies at law or equity, including injunctive relief.

ARTICLE IX
TERM; TERMINATION

9.1 Initial Term and Renewal. Subject to the terms and conditions otherwise set forth in this Agreement, this Agreement shall have an initial term of two (2) years, commencing as of the Effective Date, and shall renew automatically thereafter for successive terms of one (1) year, unless either party notifies the other of its intent not to renew at least one hundred twenty (120) days prior to the end of the term.

9.2 Termination Without Cause. Notwithstanding any other provision included in this Agreement, Provider and AMERIGROUP shall each be entitled to terminate this Agreement at any time during its term by providing one hundred and twenty (120) days prior written notice to the other party.

9.3 Termination by Either Party for Cause. Either party may terminate this Agreement for Cause, defined as a material breach of this Agreement by the other party hereto, upon ninety (90) days prior written notice to the other party. The notice shall set forth the reasons for termination and provide the breaching party ninety (90) days to cure such material breach or the termination becomes effective.

9.4 Immediate Termination; Automatic Termination.

(a) Immediate Termination. AMERIGROUP shall be entitled to terminate this Agreement immediately upon AMERIGROUP's determination made in good faith and with reasonable belief that (A) a Covered Person's health is subject to imminent danger or a physician's ability to practice medicine is effectively impaired by an action of the Board of Medicine or other governmental agency or (B) Provider continues a practice or pattern of (1) substantial disregard for the rules and regulations of AMERIGROUP with respect to patient care, or (2) material deviation from the practice and quality assurance standards adopted by AMERIGROUP, or (C) Provider's continued participation could adversely affect the care of Covered Persons. In addition, AMERIGROUP may immediately terminate this Agreement upon the filing of a petition in bankruptcy for liquidation or reorganization by or against Provider, if Provider becomes insolvent, or if a receiver is appointed for Provider or its property. In the case of termination under this subsection, the effective date of such termination shall be the date set forth in AMERIGROUP's written notice to Provider notifying Provider of such termination.

(b) Automatic Termination. This Agreement shall automatically and immediately terminate upon the expiration, surrender, revocation, restriction or suspension of any professional license required for Provider to perform the services contemplated hereunder or Provider's participation in any applicable Program. In addition, if Provider is terminated, barred, suspended or otherwise excluded from participation in, or has voluntarily withdrawn as the result

of a settlement agreement related to, any program under Titles XVIII, XIX or XX of the Social Security Act, this Agreement shall automatically and immediately terminate.

(c) Continuation of Care to Covered Persons of Special Circumstance. In accordance with Section 843.309 of the Texas Insurance Code, the parties hereto acknowledge and agree that reasonable advance notice shall be given to Covered Persons whom Provider is currently treating of the impending termination of Provider from the AMERIGROUP provider network. In accordance with Section 843.362 of the Texas Insurance Code, except for termination of this Agreement with Provider for reasons of medical competence or professional behavior, nothing herein shall be construed to release AMERIGROUP from the obligation to reimburse Provider for providing ongoing Medically Necessary Covered Services in accordance with the dictates of medical prudence to a Covered Person of Special Circumstance, such as a person who has a disability, acute condition, life-threatening illness, or is past the twenty-fourth (24^{th}) week of pregnancy at no less than the compensation rate provided for under this Agreement in exchange for continuity of ongoing treatment of the Covered Person then receiving Medically Necessary treatment in accordance with the dictates of medical prudence. For the purposes of this Section, the term Special Circumstance means a condition such that the Provider reasonably believes that discontinuing care could cause harm to the patient. Special Circumstance shall be identified by the Provider who must request that the Covered Person be permitted to continue treatment with the Provider and agree not to seek payment from the Covered Person of any amounts for which the Covered Person would not be responsible if the Provider was still in the AMERIGROUP network. Any dispute between Provider and AMERIGROUP with respect to coverage for continued care to a Covered Person of Special Circumstance shall be resolved in accordance with the procedures set forth in the AMERIGROUP Provider Manual, as it may be amended from time to time. This Section does not extend the obligation of AMERIGROUP to reimburse Provider for ongoing treatment of a Covered Person 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 termination has been diagnosed with a terminal illness. However, the obligation of AMERIGROUP to reimburse the terminated Provider for services to a Covered Person who at the time of termination is past the twenty-fourth (24^{th}) week of pregnancy, extends through delivery of the child, immediate postpartum care, and the follow up checkup within the first six weeks of delivery.

(d) Termination for Gifts and Gratuities. AMERIGROUP may terminate this Agreement following the determination by a competent judicial or quasi-judicial authority and Provider's exhaustion of all legal remedies that Provider, its employees, agents or representatives have either offered or given any item of tangible or intangible property with a monetary value of more than fifty dollars ($50.00) to an officer or employee of THHSC or the State of Texas in violation of state law.

ARTICLE X
MISCELLANEOUS

10.1 Amendment.

(a) This Agreement may be amended by the mutual agreement of the parties as evidenced in a writing signed by the parties.

(b) In addition, AMERIGROUP shall be entitled to amend this Agreement as follows without the written agreement of Provider upon thirty (30) days prior written notice to Provider:

(i) If the amendment is being effected by AMERIGROUP to comply with a Regulatory Requirement, such amendment shall be effective as of the effective date set forth in the amendment. AMERIGROUP shall be entitled to amend the Agreement upon less than thirty (30) days prior written notice if a shorter notice period is required in order to comply with such Regulatory Requirement.

(ii) To the extent the amendment is being effected by AMERIGROUP for a purpose other than compliance with a Regulatory Requirement, Provider shall be entitled to object to the amendment, by written notice provided to AMERIGROUP within thirty (30) days following Provider's receipt of such amendment. If a timely objection is received by AMERIGROUP, then the amendment shall take effect until the parties mutually agree on a resolution to the objection or this Agreement is terminated in accordance with the terms hereof.

10.2 Non-Exclusivity; Volume. This Agreement shall not, nor shall it be construed to, limit or restrict AMERIGROUP in any manner from entering into any other agreements of any nature whatsoever with other persons or entities for the provision of the same or similar services contemplated hereunder. Neither this Agreement, nor anything contained herein, shall guarantee or obligate AMERIGROUP or any other party to provide any minimum number of referrals to Provider hereunder.

10.3 Assignment.

(a) This Agreement may not be assigned by Provider without the prior written consent of AMERIGROUP.

(b) In the event of a partial assignment of this Agreement by AMERIGROUP, the obligations of the Provider shall be performed for AMERIGROUP with respect to the part retained and shall be performed for AMERIGROUP assignee with respect to the part assigned, and such assignee shall be solely responsible to perform all obligations of AMERIGROUP with respect to the part assigned.

(c) The rights and obligations of the parties hereunder shall inure to the benefit of, and shall be binding upon, any permitted successors and assigns of the parties hereto.

10.4 Indemnification.

To the extent Allowed by law,

(a) Provider agrees to indemnify, defend, and hold harmless AMERIGROUP and its officers, employees and agents from and against any and all liability, loss, claim, damage or expense, including defense costs and legal fees, incurred in connection with (i) Provider's breach of any representation and warranty made by Provider in this Agreement, and (ii) claims for damages of any nature whatsoever, including, but not limited to, bodily injury, death, personal injury or property damage arising from Provider's delivery of health care services or Provider's performance or failure to perform Provider's obligations hereunder.

(b) AMERIGROUP agrees to indemnify, defend, and hold harmless Provider and, if Provider is an entity, its officers, employees and agents from and against any and all liability, loss, claim, damage or expense, including defense costs and legal fees, incurred in connection with (i) AMERIGROUP's's breach of any representation and warranty made by AMERIGROUP in this Agreement, and (ii) claims for damages of any nature whatsoever, arising from AMERIGROUP's performance or failure to perform its obligations hereunder.

(c) Notwithstanding the foregoing subsections (a) and (b), this Section shall be null and void to the extent that it is interpreted to reduce insurance coverage to which either party is otherwise entitled, by way of any exclusion for contractually assumed liability or otherwise.

10.5 Waiver. Either party's waiver of any breach or violation of this Agreement by the other party shall not, nor shall it be construed to, constitute a waiver of any subsequent breach or violation of this Agreement by the other party.

10.6 Severability. The invalidity or unenforceability of any provision contained herein shall not affect the validity of any other provisions of this Agreement, and this Agreement shall be construed in all respects as if such invalid or unenforceable provision were omitted, or, to the extent permitted by applicable law, such invalid or unenforceable paragraph shall be replaced with another paragraph as similar in terms as may be possible and as may be legal, valid and enforceable.

10.7 Construction. This Agreement shall be construed without regard to any presumption or other rule requiring construction against the party causing this Agreement to be drafted.

10.8 Notice. Any notice required to be given under this Agreement shall be sent by U.S. First-Class Mail; certified mail, return receipt requested, postage prepaid; hand delivery; overnight prepaid delivery; or confirmed facsimile to the addresses set forth below, or to such other address designated by a party hereto by notice to the other party pursuant to the terms of this Agreement:

If to AMERIGROUP, at the address set forth in the Provider Manual.

If to Provider, to the address set forth in Provider's AMERIGROUP participation application.

10.9 Independent Contractor Status. Nothing contained herein shall, or shall be construed to, create a partnership, joint venture or any other relationship between the parties hereto other than that of independent contractors.

10.10 Entire Agreement. This Agreement, and any exhibits, attachments and amendments hereto, together with the AMERIGROUP Provider Manual, constitute the entire Agreement and understanding between the parties with respect to the subject matter hereof, and supersede any prior understandings and agreements between the parties, whether written or oral, with respect to the subject matter hereof.

10.11 Captions. The section headings in this Agreement are for convenience of reference only, shall not define or limit the provisions hereof, and shall have no legal effect whatsoever.

10.12 Coordination of Defense of Claims. The parties hereto shall make all reasonable efforts, consistent with advice of counsel and their requirements of their respective insurance policies and carriers, to coordinate the defense of claims in which either party is named a defendant, or has a substantial possibility of being named a defendant.

10.13 Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the State of Texas, excluding and without application of any conflicts of law principles.

10.14 Counterparts. This Agreement and any amendment hereto may be executed in two or more counterparts, each of which shall be deemed to be an original and all of which taken together shall constitute one and the same agreement.

10.15 Non-Performance. Neither party shall be liable, nor deemed to be in default hereunder, for any delay in performance or failure to perform under this Agreement which results directly or indirectly from acts of God, civil or military authority, acts of public enemy, war, accidents, fires, explosions, employee strikes or other work interruptions, earthquakes, floods, failure of transportation, or any cause beyond the reasonable control of such party. Provider acknowledges and agrees that this Agreement and the arrangement contemplated herein is subject to regulation by state and federal governmental authorities. In the event that any action of any such governmental authority impairs, limits, or delays either party's performance of any obligation hereunder, that party shall be excused from such performance, and party's failure to perform such obligation for such reason shall not constitute a breach of this Agreement.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed by their duly authorized officers or agents.

AMERIGROUP:

AMERIGROUP Texas, Inc.
d/b/a AMERIGROUP Community Care

By: _____

William A Jones [Name]

VP, HPS [Title]

JUN 2 4 2013 [Date]

Provider:

Collin County Government d/b/a Collin County Health Care Svcs
Name according to W-9 form with d/b/a

By: _____
(authorized signature)

Keith Self [Printed Name]

President [Title]

2300 Bloomdale Rd
Suite 4192 [Address]

McKinney, TX 75071

(972) 548-4631 [Telephone]

5/20/13 [Date]

Name according to W-9 form with d/b/a:	Collin County Government: Collin County Health Care d/b/a:
Federal Tax Identification Number:	756000873

ATTACHMENT A

AMERIGROUP Texas, Inc.
d/b/a AMERIGROUP Community Care

Specialist Services

CHIP Reimbursement

AMERIGROUP shall compensate Provider for Covered Services provided to Covered Persons, subject to all terms and conditions of this Agreement, benefit design, coordination of benefits (COB), applicable authorization requirements, applicable coinsurance, program eligibility and the Provider Manual, in an amount equal to the lesser of Eligible Charges or the amounts shown below.

Section I: Reimbursement

Service Description	Billing Code	Rate	Method
All Services	Applicable CPT/HCPCS code	100% of the Texas Medicaid Fee Schedule	Per Service

1. Payments specified as Texas Medicaid Fee Schedule refer to the applicable Texas Medicaid Fee Schedule in effect as of the date of service for the market(s) and program(s) covered by the Agreement at the time the Covered Service is initiated to the Covered Person. AMERIGROUP will update the Fee Schedule no more than sixty (60) days from the date of receipt of notice of final changes or on the effective date of such changes, whichever is later. Fee Schedule changes will be applied on a prospective basis.

2. All appropriate modifiers must be used in accordance with standard billing guidelines.

Section II: Notes

1. All services billed by Provider will be submitted on a CMS 1500 (or its successor) form or corresponding electronic format.

2. Eligible Charges are those charges billed by the Provider subject to conditions and requirements which make the service eligible for reimbursement. Eligibility for reimbursement of the service is dependent upon application of the following conditions and requirements: member program eligibility, provider program eligibility, benefit coverage, authorization requirements, Provider Manual guidelines, AMERIGROUP administrative, clinical, and reimbursement policies, and code editing logic. The allowed amount reimbursed for the eligible charge is based on the applicable fee schedule or contracted/negotiated rate after application of coinsurance, co-payments, deductibles, and coordination of benefits. AMERIGROUP will not reimburse Providers for items the Provider receives free of charge and items the Provider provides to the member free of charge.

Name according to W-9 form with d/b/a:	Collin County Government d/b/a: Collin County Health Care Svcs
Federal Tax Identification Number:	756000873

Section III: Exclusions

1. Any services not specified in this Attachment are not reimbursable.

Form **W-9**
(Rev. December 2011)
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
COLLIN COUNTY GOVERNMENT (Health Care Svs) office: 972.548.4731 fax: 972.548.4696

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) ▶

☑ Exempt payee

☑ Other (see instructions) ▶ county government

Address (number, street, and apt. or suite no.)
2300 Bloomdale Road #3100

City, state, and ZIP code
McKinney, TX 75071

List account number(s) here (optional)

Requester's name and address (optional)
Texas Medicaid + Healthcare
PO BOX 200795
Austin TX 78720-0795

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
7 5 - 6 0 0 0 8 7 3

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).

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 4.

Sign Here Signature of U.S. person ▶ [signature] Date ▶ 12-1-11

General Instructions

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

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, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions 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.

Note. If a requester gives 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 on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the 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 withholding on your share of partnership income.