

THE TEXAS DEPARTMENT OF	§	IN THE DISTRICT COURT OF
INSURANCE,	§	
<i>Plaintiff,</i>	§	
	§	
v.	§	TRAVIS COUNTY, TEXAS
	§	
BRIGHT HEALTHCARE INSURANCE	§	
COMPANY OF TEXAS	§	
<i>Defendant.</i>	§	455th JUDICIAL DISTRICT

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

TO THE HONORABLE JUDGE OF SAID COURT:

Cantilo & Bennett, L.L.P., Special Deputy Receiver of Bright Healthcare Insurance Company of Texas (the “SDR” and “BHICOT,” respectively) files this *Application to Approve Settlement Agreement [US Renal Care, Inc.]* (the “Application”), and shows the following:

I. INTRODUCTION

1.1 The SDR seeks approval of a settlement in connection with its claims involving overpayments made by BHICOT to US Renal Care, Inc. and its affiliates (collectively, “USRC”). The SDR seeks this Court’s approval of the settlement under TEX. INS. CODE § 443.154(y) because it involves a claim exceeding \$1 million. A true and correct copy of the Settlement Agreement (the “USRC Settlement Agreement”) is attached as **Exhibit 1**. In summary, the USRC Settlement Agreement provides for USRC to pay the SDR \$2.3 in full and final settlement of all claims by the SDR against USRC, full releases by both the SDR and USRC, and (3) the SDR to seek Receivership Court approval of the settlement.

1.3 The settlement is in the best interests of the receivership estates and their policyholders and creditors and has been approved by the Receiver.

II. BACKGROUND

2.1. On November 29, 2023, the Court entered an *Agreed Order Appointing Liquidator, Permanent Injunction, and Notice of Automatic Stay* appointing the Texas Commissioner of Insurance as Liquidator of Bright. Effective November 29, 2023, the Texas Commissioner of Insurance, as Liquidator, appointed CANTILO & BENNETT, L.L.P. as Special Deputy Receiver of Bright.

III. JURISDICTION

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

3.2. The SDR is authorized to file this Application pursuant to TEX. INS. CODE § 443.154 (y). The subject matter of this Application has been referred to the Special Master appointed in this proceeding in accordance with THE *Order of Reference to Master* entered on November 29, 2023.

IV. DISPUTE WITH USRC

4.1 Before receivership, BHICOT and USRC entered into a Network Participation Agreement (the “Network Agreement”). The Network Agreement is attached as **Exhibit 2**. Pursuant to the Network Agreement, BHICOT agreed to pay USRC for certain medical services provided by USRC to BHICOT insureds pursuant to the terms of the Network Agreement. The Network Agreement provided that BHICOT would be entitled to recover from USRC in the event that claims submitted by USRC were overpaid. BHICOT eventually determined that it had overpaid USRC in the amount of \$2,906,200.16 and sought refund of the overpayments. USRC disputed the amount of the alleged overpayment as well as the SDR’s right to recover those overpayments pursuant to the Network Agreement. After negotiation, and further review of the complex accounting for the overpayments, the parties agreed to the terms of the USRC Settlement.

V. THE USRC SETTLEMENT

5.1 The SDR moves the Court to approve the settlement with USRC. The USRC Settlement Agreement (Exhibit 1) requires Receivership Court approval of its terms, which includes payment by USRC of the sum of \$2.3 million to the SDR. This represents approximately 80% of the sum initially demanded by the SDR. This settlement would avoid the cost of arbitrating in Minneapolis Minnesota (as required under the Network Agreement). The settlement avoids the potential that certain defenses asserted by USRC would be successful in the arbitration.

VI. NOTICE

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

VII. OFFER OF PROOF AND VERIFICATION

7.1 This Application is verified by the affidavit and certification pursuant to TEX. INS. CODE § 443.017(b) by Michael Marcin, Partner in Cantilo & Bennett, L.L.P., Special Deputy Receiver of Bright Healthcare Insurance Company of Texas.

VIII. NOTICE

8.1 SDR has served this Application to all known parties in interest, including all affected guaranty associations, and all individuals and entities identified by the SDR in the Certificate of Service by e-mail and, as noted, by mail or overnight delivery to certain government agencies.

PRAYER

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

1. Granting the Application;
2. Approving the USRC Settlement Agreement in the same or substantially similar format as Exhibit 1;
3. Authorizing the SDR to proceed with the performance of its duties under the USRC Settlement Agreement and to accept USRC's payment of \$2.3 million as resolution of its claims against USRC;
4. Authorizing the SDR to take any action necessary to carry out the Order;
5. Finding that the Order constitutes a final judgment fully resolving all issues relating to the Application, provided that this Court shall retain jurisdiction to issue further orders pursuant to TEX. INS. CODE Chapter 443;
6. Finding that the Order shall not affect in any way, the Receiver's and the SDR's immunities

from suit and shall not give rise to any right to sue or create any causes of action against the Receiver or the SDR;

7. Finding that the Permanent Injunction and the automatic stay under TEX. INS. CODE § 443.008 remain in effect;
8. Ordering that the SDR and USRC shall pay their own respective attorneys' fees and costs that have arisen, and may continue to arise, in connection with this Order and the USRC Settlement Agreement; and
9. Granting the SDR such other and further relief to which it may justly entitled.

Respectfully submitted,

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

**Attorney for CANTILO & BENNETT, L.L.P.,
Special Deputy Receiver of
Bright Healthcare Insurance Company of Texas**

APPLICANT'S NOTICE OF SUBMISSION

Under the terms of the Agreed Order of Reference to Master entered by the District Court in this cause, the *Special Deputy Receiver's Application to Approve Settlement Agreement [US Renal Care, Inc.]* is hereby set for written submission before the Special Master, Tom Collins, on **May 11, 2026.**

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

1. Any objection must be filed with the Travis County District Clerk at least three (3) calendar days before the submission date.
2. A copy of any objection shall be served by e-mail by such date on:
 - (a) The Special Master's Docket Clerk, at specialmasterclerk@tdi.texas.gov;
 - (b) The undersigned counsel, Greg Pierce at gpierce@gpiercelaw.com; and
 - (c) All interested parties, including those listed on the SDR's Certificate of Service.
3. The objecting party shall coordinate with the SDR's counsel and the Docket Clerk [(512) 676-6915] to obtain an oral hearing setting for argument on the Application and Objection, and complete and attach an "Objecting Party's Notice of Oral Hearing" to the objection.
4. The written objection must specifically list all reasons for objection with supporting references to and discussion of statutory and case authorities. Reasons not stated in writing will not be considered orally.
5. **Please note that if an objection is not filed as described in the Notice of Submission, the Master may consider the Application without a hearing.**
6. **Failure to file timely a written objection before the Special Master constitutes a waiver of the right to object to the Special Master's recommendation to the District Court.**
7. Any Acknowledgment of Notice and Waiver to be filed by the Texas Life and Health Insurance Guaranty Association or other interested party should be filed at least three (3) calendar days before the submission or hearing date.

/s/ Greg Pierce
Gregory A. Pierce

CERTIFICATE OF SERVICE

I certify that on April 24, 2026, a true and correct copy of the foregoing *Special Deputy Receiver's Application to Approve Settlement Agreement [US Renal Care, Inc.]* was served pursuant to the Order of Reference to Master, the Texas Rules of Civil Procedure and TEX. INS. CODE 443.007(d) on the following by email, except as specifically otherwise noted.

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

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

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

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

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

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

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

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

Via First Class Mail
INTERNAL REVENUE SERVICE
Special Procedures Branch
300 East 8th Street, Suite 352
Mail Stop 5026AUS
Austin, Texas 78701

Via e-Service: sstrickland@mwlaw.com
Stanton Strickland
MITCHELL, WILLIAMS, SELIG, GATES &
WOODYARD, P.L.L.C.
500 W. 5th Street, Ste. 1150
Austin, Texas 78701
Counsel for Bright Health Management, Inc

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

Via Email: ASimon@fmdlegal.com
Via Email: Bgould@fmdlegal.com
Adrienne J. Simon
Blake Gould
Fultz Maddox Dickens PLC
101 South Fifth Street, 27th Floor
Louisville, KY 40202
*Counsel for THC Houston, LLC d/b/a Kindred
Hospital Houston Northwest*

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

Via Email: Milan.Shah@cms.hhs.gov
Via Email: Kelly.Drury@cms.hhs.gov
Via Email: Beth.Karpiak@cms.hhs.gov
Via Email: Nia.Blasingame1@cms.hhs.gov
Milan Shah, Kelly Drury, Beth Karpiak, and
Nia Blasingame
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance
Oversight
7501 Wisconsin Ave
Bethesda, MD 21814

Via e-Service: csoltero@maynardnexsen.com
Via e-Service: lalcantar@maynardnexsen.com
Carlos R. Soltero
Lisa Poole Alcantar
Maynard Nexsen
2500 Bee Caves Road
Building 1, Ste 150
Austin, Texas 78746
Counsel for Bright Health Management, Inc.

/s/ Greg Pierce

Gregory A. Pierce

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


AFFIDAVIT OF MICHAEL P. MARCIN

State of Texas

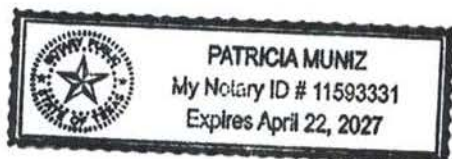
County of Travis

BEFORE ME, the undersigned authority appeared Michael P. Marcin, who after being by me duly sworn, stated the following under oath:

1. "My name is Michael P. Marcin. I am of sound mind, capable of making this affidavit, and am competent to testify to the matters contained in this affidavit.
2. I am a partner in CANTILO & BENNETT, L.L.P., the Special Deputy Receiver of Bright Health Insurance Company of Texas, Inc. (the "SDR" and "BHICOT" respectively), I am duly authorized to make this Affidavit on behalf of the SDR.
3. I have reviewed the *Special Deputy Receiver's Application to Approve Settlement Agreement [US Renal Care, Inc.]* and the facts stated therein are true and correct based on my personal knowledge, my review of estate records and my consultation with the staff and subcontractors.
4. I certify that the exhibits, books, company accords, papers, correspondence, and/or other records and documents attached hereto were produced pursuant to TEX. INS. CODE § 443.017, are either true and correct copies of records of BHICOT and were received from the custody of BHICOT or found among its effects, or were created by and filed with the Receiver's office in connection with the receivership of this delinquent company, and are held by the Special Deputy Receiver in its official capacity."

By: 
Michael P. Marcin

SUBSCRIBED AND SWORN TO BEFORE ME on April 24, 2026, by Michael P. Marcin, Special Deputy Receiver of Bright Health Insurance Company of Texas, Inc.




Notary Public

EXHIBIT 1

SETTLEMENT AGREEMENT

This Settlement Agreement (“Agreement”) is made effective as of _____, 2026, by and between CANTILO & BENNETT, L.L.P., Special Deputy Receiver for Bright Health Insurance Company of Texas (“SDR” and “BHICOT,” respectively), US Renal Care, Inc. and its affiliated entities listed on the attached **Exhibit A** (collectively, “USRC”). The SDR and USRC shall be collectively referred to as the “Parties.”

WHEREAS, BHICOT was placed into receivership on November 29, 2023 in the action styled Cause No. D-1-GN-23-008361, *Texas Department of Insurance v. Bright Healthcare Insurance Company of Texas*, In the 455th Judicial District Court, Travis County, Texas (the “**BHICOT Liquidation Proceeding**”);

WHEREAS, the SDR and USRC have disputes regarding the Network Participation Agreement Between Ancillary Group and Bright Health Management, Inc. and obligations owed under that agreement;

WHEREAS, on January 9, 2026, the SDR filed its Demand for Arbitration against USRC in the arbitration styled AAA Case No. 01-26-000-01346 (the “**Arbitration**”);

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

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

- 1.1 **Recitals.** The Parties hereby acknowledge and agree that each and all of the recitals set forth herein are true and correct and are incorporated by this reference and made a part hereof for all purposes.
- 1.2 **Consideration.** USRC agrees to pay to the SDR, in full satisfaction of all obligations owed to the SDR and/or BHICOT, the sum of \$2,300,000 (the “Consideration”).
- 1.3 **Releases by SDR.** Upon payment of the Consideration, the SDR releases USRC, all current and former shareholders, officers, directors, employees, agents, and attorneys of USRC from any and all claims, rights, demands, losses, expenses, costs, liabilities, actions, causes of action, suits or compensation of any nature, whether based in tort, contract, equity or any other theory of recovery that BHICOT and/or the SDR ever had, now has, or might have in the future based upon anything from the beginning of the world to the date and time of this agreement.
- 1.4 **Releases by USRC.** Upon payment of the Consideration, USRC releases BHICOT and the SDR, including all employees, attorneys, agents, affiliates and representatives (including their respective predecessors, successors, assigns, heirs,

executors, and administrators) from any and all claims, rights, demands, losses, expenses, costs, liabilities, actions, causes of action, suits or compensation of any nature, whether based in tort, contract, equity or any other theory of recovery that USRC ever had, now has, or might have in the future based upon anything from the beginning of the world to the date and time of this agreement.

- 1.5 **Dismissal.** Upon payment of the Consideration (as defined in ¶1.2), the Parties agree to seek dismissal of the Arbitration.
- 1.6 **Effectiveness.** The Parties to this Agreement recognize that it will become effective only after approval by the court in the BHICOT Liquidation Proceeding. The SDR agrees to seek approval in the BHICOT Liquidation Proceeding. This Agreement is binding upon the Parties, subject only to approval of the Court in the BHICOT Liquidation Proceeding. In the event that the Court in the BHICOT Liquidation Proceeding denies approval of this Agreement, this Agreement shall be null and void, and no statements made by the Parties in this Agreement, any motion for approval of the Agreement, at any hearing regarding an application to approve the Agreement, or in negotiations for settlement of the disputes that are the subject of this Agreement, may be used for any purpose whatsoever by the Parties.
- 1.7 **Binding.** Upon approval by the Court in the BHICOT Liquidation Proceeding, this Agreement is binding upon and inures to the benefit of the respective Parties hereto and their respective successors and assigns.
- 1.8 **Authorization.** Each Party represents and warrants that it is authorized to execute this Agreement, and that the person signing this Agreement on their behalf is authorized to execute this Agreement on their behalf.
- 1.9 **All Terms.** The provisions of this Agreement comprise all of the terms, conditions, agreements, and representations of the Parties respecting their agreement, as set forth herein. This Agreement may not be altered or amended or waived except by written agreement executed by all Parties. All Parties agree that the terms of this Agreement have in no way been changed, modified or expanded by any oral agreements or representations entered into or made by any party prior to or at the execution of this Agreement.
- 1.10 The Parties acknowledge that each of them has had the opportunity to engage counsel of his or its own choice and has been offered an opportunity to review this Agreement with chosen counsel. The Parties further acknowledge that they have, through their respective counsel or otherwise, participated or had the opportunity to participate in the preparation of this Agreement, and it is understood that no provision will be construed more strictly against any Party.
- 1.11 **Governing Law.** The Parties agree that this Agreement shall be governed by the laws of the State of Texas.
- 1.12 **No Admission.** The Parties agree that this Agreement represents a compromise of disputed claims, the liability for which each party hereto has expressly denied. The execution of this Agreement by any party hereto shall not be deemed an admission of liability or fault on the part of any person or entity executing this Agreement.
- 1.13 **Counterparts.** This Agreement may be executed in one or more original or facsimile counterparts each of which shall be deemed an original, but also which

together will constitute on and the same instrument. Further, facsimile copies or electronic signatures shall be treated as originals for all purposes.

1.14 **Notices.** All notices to the SDR relating to this Agreement shall be made by email to Greg Pierce at gpierce@gpiercelaw.com. All notices to USRC shall be made by email to Alison Andersen at alison.andersen@afslaw.com or at such different address as the Parties shall hereafter specify by written notice.

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

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

1.15.2 **Attorneys' Fees.** If any legal action, arbitration or other proceeding is commenced to enforce or interpret any provision of this Agreement, the prevailing party shall be entitled to an award of its actual fees and expenses, including, without limitation, attorneys' fees and disbursements (including fees on appeal) expert witness fees and disbursements. The term "prevailing party" shall include a party who receives substantially the relief desired whether by settlement, dismissal, summary judgment, judgment or otherwise.

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

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

1.15.5 **Closing Costs.** All costs and expenses of the Parties' performance of their respective obligations hereunder shall be borne by the party incurring such cost or expense. Without limiting the generality of the foregoing, each party shall be responsible for the costs and expenses of their respective attorneys.

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

Date: _____

CANTILO & BENNETT, L.L.P.,
SPECIAL DEPUTY RECEIVER FOR
BRIGHT HEALTH CARE INSURANCE COMPANY
OF TEXAS

By: _____

Its: _____

Date: _____

US RENAL CARE, INC.

By: _____

Title: _____

Date: _____	Corva Clinics, LLC - Webster a/k/a U.S. Renal Care Webster Dialysis By: _____ Its: _____
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Date: _____	DSI Chinatown Hemodialysis, LLC a/k/a US Renal Care Chinatown Dialysis By: _____ Its: _____
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Date: _____	Liberty Dialysis - Duncanville LLC a/k/a U.S. Renal Care Premier Dialysis Duncanville By: _____ Its: _____
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Date: _____	Liberty Dialysis - Mesquite LLC a/k/a U.S. Renal Care Premier Dialysis Mesquite By: _____ Its: _____
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Date: _____	Liberty Dialysis - Rockwall LLC a/k/a U.S, Renal Care Premier Dialysis Rockwall By: _____ Its: _____
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Date: _____	RDC 12 Partners, LLC a/k/a U.S. Renal Care Premier Dialysis Richardson By: _____ Its: _____
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Date: _____	Space City Dialysis Pasadena - DSI LLC a/k/a US Renal Care Space City Dialysis LLC By: _____ Its: _____
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Date: _____	USRC Cedar Hill LLC a/k/a U.S. Renal Care Premier Dialysis Cedar Hill By: _____ Its: _____
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Date: _____	USRC East Ft Worth, L.P. By: _____ Its: _____
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Date: _____	USRC Garland LLC By: _____ Its: _____
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Date: _____	USRC Gulfgate LLC a/k/a US Renal Care Gulfgate Kidney Center By: _____ Its: _____
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Date: _____	USRC Keller, L.P. By: _____ Its: _____
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Date: _____	USRC Kingwood, L.P. a/k/a U.S. Renal Care Kingwood Dialysis By: _____ Its: _____
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Date: _____	USRC Plano Dexter LLC By: _____ Its: _____
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Date: _____	USRC Plano, LLC a/k/a U.S. Renal Care Plano Dialysis By: _____ Its: _____
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Date: _____	USRC Richardson, LLC a/k/a U.S. Renal Care Richardson Dialysis By: _____ Its: _____
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Date: _____	USRC Rowlett, LLC a/k/a U.S. Renal Care Rowlett Dialysis By: _____ Its: _____
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Date: _____	USRC Royal Central, LLC a/k/a US Renal Care Royal Central Dialysis By: _____ Its: _____
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Date: _____	USRC South Arlington, LLC By: _____ Its: _____
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Date: _____	USRC Sunnyvale, LLC a/k/a US Renal Care Sunnyvale Dialysis By: _____ Its: _____
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Date: _____	USRC Tarrant, L.P. By: _____ Its: _____
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Date: _____	USRC West Fork, LLC By: _____ Its: _____
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Date: _____	USRC West University, LLC a/k/a U.S. Renal Care West University Dialysis By: _____ Its: _____
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Date: _____	WMDC Partners, LLC By: _____ Its: _____
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EXHIBIT 2

**NETWORK PARTICIPATION AGREEMENT
BETWEEN ANCILLARY GROUP AND
BRIGHT HEALTH MANAGEMENT, INC.**

This Network Participation Agreement (“Agreement”) is by and between Bright Health Management Inc., on behalf of itself, Bright Health Insurance Company, and its other and its Affiliates (collectively “Bright Health”) and, US Renal Care, Inc. and its Affiliates (collectively “Ancillary Group”). This Agreement is effective on 8/1/2019 (“the Effective Date”).

RECITALS

Bright Health offers affordable, consumer directed health benefit plans with a simple, integrated technology experience;

Ancillary Group is a medical practice with physicians and other health professionals that furnish efficient, high-quality health care to patients; and

Bright Health wishes to arrange for Ancillary Group to furnish health care services to its Members. Ancillary Group wishes to provide such services under the terms and conditions set forth in this Agreement.

AGREEMENT

Now therefore, the parties agree as follows:

1. Definitions. Terms used in this Agreement that are not defined elsewhere are defined in **Exhibit 1**.

2. Scope of Agreement. This Agreement applies to Covered Services provided by Ancillary Group to Members enrolled in Benefit Plans described in **Exhibit 2**. Ancillary Group agrees to accept Members enrolled in all Benefit Plan types offered by Bright Health covered by this Agreement.

3. Ancillary Group Obligations.

a. **Care Delivery.** Ancillary Group will provide Covered Services in accordance with (i) this Agreement; (ii) the Program Requirements; (iii) applicable standards of care; and (iv) applicable law.

b. **Individual Network Providers.** Ancillary Group represents and warrants that all Network Providers, including without limitation all employees, subcontractors, and Affiliates, agree to participate in all Benefit Plan types offered by Bright Health under this Agreement and agree to be bound by the terms of this Agreement, including without limitation Bright Health’s Program Requirements and all applicable requirements in the regulatory appendices.

c. **Provider Directories and Billing Information.** Ancillary Group will supply to Bright Health the following information:

i. A complete list of Ancillary Group’s participating professionals and other appropriate Network Providers that, as of the execution date, have been identified by Ancillary Group as participating in the Bright Health network through this Agreement, including without limitation participating professional’s status with respect to accepting new patients, clinic affiliation, or specialty.

ii. Any additional data as necessary to satisfy Bright Health’s regulatory filings regarding network adequacy.

iii. The data and any updates will be supplied in the form of a minimum data set, in a Bright Health approved format.

iv. Ancillary Group will provide a thirty (30) day prior written notice of updates to the Provider Demographic and Billing Information previously sent to Bright Health for additions, service location changes, and other changes to the roster of Participating Providers.

v. Ancillary Group will provide ninety (90) days advance written notice to Bright Health of a termination of an individual practice location or Network Provider.

vi. On an annual basis, Ancillary Group will conduct an audit of its own Provider Demographic and Billing Information. Ancillary Group will correct inaccuracies in the data found in the audit and will provide such corrections in writing to Bright Health within thirty (30) days of the conclusion of the audit. From time to time, Bright Health may conduct audits of Ancillary Group’s Provider Demographic and Billing Information and Ancillary Group agrees to cooperate with such audits.

d. **Credentialing.** Ancillary Group will cooperate with Bright Health’s credentialing and re-credentialing process and assist in promptly providing all credentialing information requested by Bright Health. Ancillary Group will assure that Network Providers maintain appropriate credentials and admitting privileges. Ancillary Group will notify Bright Health within thirty (30) days of any material changes affecting a Network Provider’s qualifications to provide Covered Services under this Agreement.

- e. Program Requirements. Ancillary Group agrees to comply with and reasonably assures that providers will comply with Program Requirements. Program Requirements may be updated by Bright Health from time to time. Program Requirements and updates will be made available to Ancillary Group and Network Providers by posting them online or upon request. If Ancillary Group disputes a change to the Program Requirements or a provider manual, the parties agree to meet and discuss a resolution.
- f. Notification of Material Change. Ancillary Group will promptly notify Bright Health of any of the following within 30 days: any adverse action against its license, certification, Medicare or Medicaid participation status, accreditation status, or any other material adverse event related to Ancillary Group that would materially interfere with Ancillary Group's performance of its duties and obligations under this Agreement.
- g. New Ancillary Group Affiliates and Change of Control. If Ancillary Group participates in a Change of Control, Ancillary Group will provide advance written sixty (60) day notice of such Change of Control and the Agreement will remain in full force and effect unless otherwise objected to by Bright Health.
- h. Addition of New Service Locations. If a new service location is added to Ancillary Group's network subject to this Agreement, Ancillary Group will notify Bright Health of such new service location in writing within the timeframe set forth in **Section 3(c) Provider Directories and Billing Information** above and that service location will become a Network Provider upon successfully completing the credentialing process, unless Bright Health notifies Ancillary Group within a commercially reasonable time after receiving notice, declining the addition of the new service location. Bright Health shall use best efforts to update the credentials of the Ancillary Group with new information within ninety (90) days from receipt of the notice of changes.
- i. Services Provided to Bright Health Traveling Members. Ancillary Group agrees that Members who are enrolled in Benefit Plans offered elsewhere and not included in **Exhibit 2**, but who travel to the Ancillary Group's delivery areas covered by this Agreement ("Traveling Members"), may access Ancillary Group on an in-network basis. Ancillary Group will be reimbursed for Covered Services to Traveling Members in accordance with the rates in this Agreement and other applicable provisions of this Agreement will apply to such provision of Covered Services, including without limitation **Section 5(c) Member Protection Provision** and applicable regulatory provisions. The cost sharing amounts for Traveling Members will apply as provided for in the Bright Health benefit documents issued to Traveling Members.

4. Bright Health Obligations.

- a. Payment. Bright Health will pay Ancillary Group for Covered Services rendered to Members at the rates set forth in this Agreement.
- b. Notification of Material Change. Bright Health will promptly notify Ancillary Group of any of the following: any adverse action against its license, certification, Medicare or Medicaid participation status, accreditation status, or any other material adverse action that would materially interfere with Bright Health's ability to offer Benefit Plans under this Agreement or with Bright Health's performance of its duties and obligations under this Agreement.
- c. Ancillary Group Identified as Participants in Bright Health Network. Bright Health will determine when to identify Ancillary Group as participating in the Bright Health network in provider directories and other informational materials provided to Members during the term of this Agreement.
- d. Practice of Medicine and Ancillary Group Communications with Members. Notwithstanding anything herein to the contrary, it is understood and agreed that Bright Health does not practice medicine and that Ancillary Group will retain exclusive responsibility for medical care provided pursuant to this Agreement to Members. Bright Health acknowledges and agrees that Ancillary Group may discuss any and all treatment options with Members, and any other matters related to Members' health condition, regardless of Bright Health's coverage for such options, and that Bright Health will not interfere with such communication with Members.

5. Bright Health and Ancillary Group Obligations Related to Claims.

- a. Claims Submission. Ancillary Group agrees to submit claims for Covered Services electronically to the extent possible, in a manner and format as required by Bright Health within ninety (90) days, but in any event no later than two hundred forty (240) days from the date of service; from the date the Ancillary Group receives an explanation of payment or other information indicating that a payer other than Bright Health is primary; or from the date the Ancillary Group receives information identifying the patient as a Member if Ancillary Group furnished services without knowing that the patient was a Member.
- b. Prompt Pay. Bright Health will pay Ancillary Group for uncontested portions of claims submitted for Covered Services rendered to Members in accordance with applicable state or federal prompt payment regulations. If a claim for Covered Services rendered to a Member in Commercial Benefit Plans is subject to an interest payment, Bright Health will follow applicable state law for the payment of such interest payment. If a claim for Covered Services rendered to a Medicare Advantage Member is subject to an interest payment, Bright Health will apply the interest rate set forth by the Department of Treasury pursuant to the federal Prompt Payment Act.

c. Member Protection Provision. Ancillary Group acknowledges and agrees that payment under this Agreement, together with any amounts for which the Member is responsible under the applicable Benefit Plan, is payment in full. Ancillary Group agree not to bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member for Covered Services provided pursuant to this Agreement, other than Member Expenses. This Section applies to the provision of all Covered Services, including in the case of Bright Health's non-payment or insolvency, or breach by Bright Health of this Agreement. The provisions of this Section will be construed in favor of the Member, will survive the termination of this Agreement regardless of the reason for termination, and will supersede any oral or written contrary agreement between Ancillary Group and a Member, or the representative of a Member.

d. Member Expenses. Bright Health agrees that Ancillary Group may pursue collection of Member Expenses subject to the terms of this Agreement and applicable law.

e. Coding. Ancillary Group will follow, and will assure that Network Providers follow, Bright Health's coding accuracy and billing requirements and will cooperate with any and all Bright Health claims reconciliation procedures as outlined in the Program Requirements and other materials made available to Ancillary Group by Bright Health. Ancillary Group will cooperate with, and assure that Network Providers cooperate with, Bright Health's quality improvement programs and coding accuracy programs, including without limitation coding accuracy related to risk adjustment.

f. Claims Adjustments. In processing claims, Bright Health may edit, bundle, or re-bundle to the primary procedure those services that are part of, incidental to, or inclusive of the primary procedure; and make other reasonable and appropriate adjustments to billing or coding, including without limitation inappropriate billing or coding (e.g., duplicative claim submissions, mutually exclusive procedures, gender/procedure mismatches, age/procedure mismatches). To the extent possible, such claims processing adjustments will be performed according to the then-current CMS billing and coding requirements and other applicable industry standard guidelines. Notwithstanding the foregoing, in the event of a conflict between Bright Health's claims processing adjustments and any provisions of this Agreement, this Agreement will govern.

g. Administrative Denial. Bright Health may deny a claim in whole or in part for failure to adhere to its Program Requirements, provided that Bright Health's Program Requirements set forth the grounds for such a denial. If Bright Health denies a Network Provider claim partially or totally (on an administrative basis or for any other valid reason), such denial will be communicated in a remittance advice or other appropriate written notice indicating the reason for the denial. If Bright Health requires additional information to support a claim, Network Provider will supply such information within sixty (60) days after receiving the claims denial indicating more information is required. Ancillary Group may submit a request for reconsideration to Bright Health within one hundred eighty (180) days after the receipt of a partial or total denial of a claim. The request for reconsideration must include any documentation or information reasonably necessary to support the request for reconsideration. If the claim did not require a medical necessity determination, Bright Health will respond to the request with a reconsideration decision within sixty (60) days after receipt of sufficient information from Network Provider for Bright Health to make a determination regarding the reconsideration request. If the claim was denied for the failure of Network Provider to seek a prior authorization for medical necessity, Network Provider may ask for a retrospective medical necessity determination in the reconsideration. Bright Health will respond to the request with a reconsideration decision (including the result of the retrospective medical necessity determination) within ninety (90) days after receipt of sufficient information from Network Provider for Bright Health to make a medical necessity determination and to decide on the reconsideration request. If, in its review of the claim, Bright Health determines that the services in question were (i) Covered Services, (ii) medically necessary, and (iii) would have been paid by Bright Health had Network Provider not failed to follow Bright Health's Program Requirements, then Bright Health will reverse its denial and pay the claim in accordance with this Agreement within thirty (30) days following the determination.

h. Overpayment/Underpayment Process. If either party believes that a claim has not been paid correctly, either party may seek correction of the payment by giving the other party written notice as described below and agrees to follow the process outlined below and in Program Requirements.

i. Network Provider will submit all requests for corrections in writing, including electronically, and will include information reasonably necessary to identify the claim and the basis of the request. If the correction is undisputed, Bright Health will respond within thirty (30) days following its receipt of such request and remit undisputed amounts to Network Provider. If the request is disputed by Bright Health, the parties will follow the procedures for resolving such disputed request as set forth in more detail in Program Requirements and through the dispute resolution process in Section 6 below.

ii. If Bright Health seeks the refund of an overpayment, Bright Health will notify the Network Provider in writing, including electronically, of such request and will include information reasonably necessary to identify the claim and the basis of the request. The Network Provider must repay the overpaid amount, submit a corrected claim, or dispute the overpayment request in writing within sixty (60) days of receiving the request. If Bright Health does not receive payment, a corrected claim, or written contestation within sixty (60) days, Bright Health may recoup the overpayment through electronic adjustments in future payment cycles, using industry standard procedures identifying the claim overpayment for which the adjustment is made. If Network Provider

disputes the overpayment request during the sixty-day period, the parties will follow the dispute resolution process in Section 6 below. If, after the parties reach resolution under this Section, Network Provider owes Bright Health for overpayments, Bright Health may recoup such overpayments through electronic adjustments as described in this Section.

iii. Regardless of any provision to the contrary, with the exception of fraud or abusive claims practices by a Network Provider, a request for a correction must be initiated by a party no later than three hundred sixty-five (365) days from the date of the original explanation of payment or the right to seek a correction is waived. In the case of suspected fraud or abusive billing practices by a Network Provider, Bright Health may seek recovery of overpayments at any time.

i. Non-Covered Services. If Network Provider furnishes services to Members that are not Covered Services under a Benefit Plan, either because the service was provided after the individual ceased to be a Member or on some other basis, Bright Health is under no obligation to reimburse the services. Subject to applicable law, Network Provider may bill the Member for such services, provided that Network Provider followed Bright Health's Program Requirements related to the services. Ancillary Group acknowledges and agrees that Ancillary Group will not arrange for a Member to self-pay for a non-Covered Service unless the Network Provider has first obtained a denial under the Benefit Plan from Bright Health for such service or unless the service is listed as explicitly excluded in the Member's benefit document. Ancillary Group agree, to the extent possible, to inform the Member that the service is not covered in advance of the providing the service.

j. New Technology or Medical Service. Ancillary Group will notify Bright Health of a New Technology or Medical Service ninety (90) days prior to making such technology or service available to Members. A New Technology or Medical Service is subject to a Bright Health determination whether the New Technology or Medical Service is a non-Covered Service, either because it is not included in the Benefit Plans; is unproven, investigational, or experimental; or on some other basis. The reimbursement rate will be the rate of the closest equivalent Covered Services unless a different rate is agreed upon by the parties. Covered Services that have New Codes and Non-Medicare Valued Codes, as that term is defined herein, but are not considered a New Technology or Medicare Service, will be reimbursed as described in the payment appendices attached to this Agreement.

6. Dispute Resolution.

a. Informal Dispute Resolution. The parties will work together in good faith to resolve disputes between them. If a disagreement arises between the parties that cannot be resolved through informal discussions, the aggrieved party shall bring the issue to the other party for resolution by sending a written demand and a description of the issue ("Dispute"). Bright Health and Ancillary Group will assign the appropriate level management (medical directors, network management directors, claims subject matter experts, etc.), who will meet to discuss and seek to resolve the Dispute. Resolution of the matter must be consistent with the terms of this Agreement.

b. Arbitration. If the Dispute is not resolved through the informal processes in paragraph 6(a), either party may initiate arbitration proceedings by submitting the Dispute for binding arbitration to the American Arbitration Association no later than one year from the date of the written demand. Disputes between the parties will be resolved through arbitration in accordance with this Section, whether in connection with matters within the scope or outside the scope of this Agreement. The arbitration will proceed according to the commercial dispute procedures of the American Arbitration Association. If either party does not file for arbitration within one year after the date of the demand, the Dispute will be waived. Arbitrations shall be conducted in Hennepin County, Minnesota. The parties waive any right to class arbitration and any and all claim to punitive, exemplary, or special damages pursuant to the arbitration of Disputes under this Section.

c. Arbitration Award. The decision of the arbitrator(s) shall be binding; judgment on the arbitration award may be entered in any court having jurisdiction over such award.

d. Disputes after Termination. This Section survives the termination of this Agreement. Any Disputes arising after termination shall be resolved by binding arbitration pursuant to this Section.

7. Term and Termination.

a. Term. The initial term of this Agreement will commence at midnight at the start of the day on the Effective Date and continue in full force and effect for one (1) year ("Initial Term"). This agreement will renew automatically for renewal terms of one (1) year until terminated pursuant to this Section.

b. Termination of Agreement. This Agreement may be terminated as follows:

- i. By mutual written agreement of Bright Health and Ancillary Group;
- ii. By either party, without cause, upon prior written notice of ninety (90) days. Parties agree to use best efforts to make this effective at the end of the initial term or effective at the end of any renewal term

iii. By either party, in the event of a material breach of this Agreement by the other party, upon thirty (30) days prior written notice to the other party specifying in detail the nature of the breach. Unless cure is not reasonably possible, the breaching party will have sixty (60) days (or such longer period as mutually agreed by the parties) from the date of receipt of notice of termination to cure such breach, and if such breach is cured, then the notice of termination will be void of and of no effect;

iv. By either party, immediately upon written notice, due to the other party's loss or suspension of licensure, loss of government authorization, or loss of other qualifications that would render the party unable to perform its obligations under this Agreement.

c. **Termination of a Particular Network Provider from this Agreement.** A Network Provider may be removed from Bright Health's network, without terminating this Agreement, by Bright Health:

i. In the event of a material breach of this Agreement by the Network Provider, upon thirty (30) days prior written notice to the Network Provider specifying in detail the nature of the breach. Unless cure is not reasonably possible, the Network Provider will have sixty (60) days (or such longer period as mutually agreed by the parties) from the date of receipt of notice of termination to cure such breach, and if such breach is cured, then the notice of termination will be void of and of no effect.

ii. Immediately, upon written notice from Bright Health to Network Provider, in the event of:

1. any misrepresentation or fraud in the credentialing process or an action which constitutes gross misconduct or may jeopardize the health and safety of a Member;

2. Network Provider's loss, suspension, restriction or action regarding his or her license to practice medicine or dentistry, narcotic registration certificate issued by the Drug Enforcement Administration ("DEA"), certification to participate in Medicare or Medicaid, or other qualification to practice has been revoked, suspended, or otherwise materially restricted; or the Network Provider has been excluded from federal health care programs or otherwise sanctioned by a government agency;

3. for those participating professionals who require admitting privileges to perform under this Agreement, the loss of medical staff privileges such that participating professional is no longer in a position to admit Members to any participating facility.

d. **Obligations of Parties After Termination.** In the event of the termination or expiration of this Agreement for any reason, Ancillary Group will continue to provide transitional health services to Members as required by law and be compensated under the payment terms of this Agreement in effect at the time of the termination, including without limitation providing inpatient services to a hospitalized Member until the date such Member is discharged, if applicable based on Ancillary Group service scope and providing transitional services to any Member with a "serious medical condition" for the greater of (1) thirty (30) days or (2) as required by applicable law. "Serious medical condition" means "a health condition or illness that requires medical attention, and where failure to provide the current course of treatment through the current provider would place the person's health in serious jeopardy, and includes cancer, acute myocardial infarction, and pregnancy," or such other definition specified by applicable law. Following termination, Ancillary Group will reasonably assist Bright Health with satisfaction of its reporting obligations by furnishing data regarding Covered Services provided by Ancillary Group pursuant to this Agreement. In the event a particular Network Provider is terminated from this Agreement, this paragraph will apply with regard to that Network Provider.

8. Liability of Parties, Laws, Regulations and Licenses.

a. **Responsibility.** Each party will be responsible for damages, claims, liabilities or judgments, which may arise as a result of its own negligence or intentional wrongdoing.

b. **Insurance.** Each party will maintain self-insured coverage or insurance policies of professional liability, general liability, workers' compensation, and other insurance coverage as required by law and as reasonably necessary to insure itself and its employees against any claims, liabilities, damages, or judgements that arise out of the performance of this Agreement. In particular, Ancillary Group and Network Providers will carry medical malpractice insurance sufficient to satisfy applicable law and to insure itself and Network Providers against any claims, liabilities, damages, or judgements that arise out of the provision of Covered Services to Members. Upon a party's request, the other party will provide the requesting party with a current certificate of insurance as reasonable proof that the party has obtained adequate insurance coverage pursuant to the terms of this Section.

c. **Laws, Regulations and Licenses.**

i. **Ancillary Group Licensure and Authority to Conduct Business.** Ancillary Group will maintain all licenses, certificates of need, and any other governmental authorization necessary to perform its obligations under this Agreement. Ancillary Group represents and warrants that Ancillary Group and Network Providers are in good standing with all federal health programs as of the date this Agreement was executed and will give prompt notice to Bright Health of any change in such good standing.

ii. Bright Health Licensure and Authority to Conduct Business. Bright Health will maintain all licenses, certifications, permits, and financial solvency and reserve requirements necessary to perform its obligations under this Agreement. Bright Health represents and warrants that it is in good standing with all federal health care programs as of the date this Agreement was executed and will give prompt notice to Ancillary Group of any change in such good standing.

iii. Laws and Regulations. Bright Health and Ancillary Group agree to comply with all applicable state and federal laws and regulations as they relate to this Agreement, including without limitation Section 1557 of the Affordable Care Act and all other applicable state and federal nondiscrimination laws.

iv. Confidentiality of Member Information and Records. Bright Health and Ancillary Group will comply with all applicable privacy and security requirements in the Health Insurance Portability and Accountability Act, as amended by the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act") and any other amendments and implementing regulations (together, "HIPAA"), and in accordance with all other applicable state and federal privacy and security laws.

v. Regulatory Requirements Addendums. One or more regulatory appendices may be attached to this Agreement, setting forth additional provisions included in this Agreement in order to satisfy regulatory requirements related to specific types of Benefit Plans. For Network Providers operating in multiple states, in addition to the attached State Regulatory Appendix, additional regulatory appendices are made available in Program Requirements posted on Bright Health's provider portal. Such additional provisions are incorporated by reference into this Agreement and the parties agree to comply with all such regulatory requirements for those types of Benefit Plans to which the regulatory requirements apply and to assure that their employees, subcontractors, Affiliates, and Network Providers understand and adhere to the regulatory provisions as well. To the extent that the regulatory requirements are inconsistent with other provisions of this Agreement, including those provisions found in other exhibits, appendices, and attachments, the regulatory requirements will prevail for those Benefit Plans to which the regulatory requirements apply.

vi. National Partnership. Bright Health and Ancillary Group will form a national partnership through this Agreement as further outlined in **Exhibit 6**. With the exception of the regulatory requirements, to the extent there is an inconsistency between **Exhibit 6** and any other provision of the Agreement, **Exhibit 6** will prevail.

9. Miscellaneous.

a. Maintenance of Records. The parties will maintain their respective medical, eligibility, enrollment/disenrollment, financial and other administrative records related to Covered Services rendered by Ancillary Group to Members under this Agreement, in such form and such time periods as required by applicable state and federal laws, regulations, licensing, and accreditation requirements to which each individual party is respectively subject.

b. Bright Health Corporate and Entity Changes. If Bright Health participates in a Change of Control, Bright Health will notify Ancillary Group of such occurrence in writing within a commercially reasonable time. This Agreement will remain in full force and effect between the parties; or, if necessary to continue the Agreement, will be assigned to the new successor entity, provided that the applicable regulatory approvals permit assignment of this Agreement. If such a regulatory prohibition exists, the parties will negotiate in good faith to determine the continuation of the Agreement.

c. Assignment. Bright Health may in its sole discretion assign this Agreement to an Affiliate or to a third party in the instance of a Change of Control, as an additional party to this Agreement. Ancillary Provider may in its sole discretion assign this Agreement to an Affiliate or to a third party in the instance of a Change of Control, as an additional party to this Agreement. Neither party to unreasonably withhold consent.

d. Government Agency Access. Ancillary Group will permit duly authorized and legally entitled state and federal agencies, or accreditation organizations access to review records related to Covered Services provided to Members within the scope of the agencies' or accreditation organizations' authority.

e. Audits. During the term of this Agreement, Bright Health will have the right to conduct audits of Ancillary Group which are for reasonable purposes related to the performance of this Agreement. With the exception of audits in connection with government inquiries, audits related to health and safety concerns, or a fraud investigation, Bright Health audit requests will be submitted in writing to Ancillary Group, which requests will include the proposed commencement date and the purpose, type and scope of the audit. Following receipt of any such audit requests, Ancillary Group will communicate with Bright Health to discuss alternative start dates if reasonably necessary, the scope of any such audit request, as well as any issues or concerns regarding the requested audit. If the Bright Health audit is in preparation for, or in connection with, a government inquiry into Bright Health activities under this Agreement, the notice, timing, subject matter, and other aspects of the audit will be subject to the audit requirements established by the government inquiry. If the audit is a Bright Health audit related to the health and safety of Members or to a fraud investigation, Ancillary Group agrees to give Bright Health access to records related to the purposes of the audit within forty-eight (48) hours after Bright Health's request. If Bright Health seeks to engage a third party in an audit on its behalf, such auditor will agree to comply with the applicable terms and conditions of this Agreement, including those provisions related to confidentiality.

f. Access to Data. Ancillary Group acknowledges and agrees that Bright Health may collect, analyze, and integrate data relating to the provision of Covered Services to Members and related to other Ancillary Group or Network Provider obligations under this Agreement in order to meet regulatory obligations and for reasonable business purposes. Ancillary Group agrees that data, including medical records, will be supplied to Bright Health by Ancillary Group in the normal course of business at no cost, including data supplied to support claims submissions, HEDIS and risk adjustment reporting, other data supplied in the performance of this Agreement, and data supplied in the event the Department of Health and Human Services (“HHS”), a state department of insurance, or other applicable regulatory authority requests records related to Covered Services or to this Agreement generally. Ancillary Group agree to supply such data to Bright Health or to the applicable regulatory authority in a timely manner and at no cost. Alternatively, if requested by the government authority, or if inspection is an acceptable alternative to supplying the records, Ancillary Group may make the requested records available for inspection by the government authority during normal business hours. This provision survives termination of this Agreement.

g. Independent Contractors. Bright Health and Ancillary Group, in performing their respective duties and obligations under this Agreement, are at all times acting and performing as independent contractors with respect to each other, and nothing in this Agreement is intended to create, nor will be construed to create, an employer/employee relationship, a partnership, a joint venture, or any other form of relationship between the parties to this Agreement.

h. Controlling Law. This Agreement will be governed by and construed under, and any dispute between the parties based on or arising out of this Agreement will be determined under the laws of the state of Minnesota and, where applicable, under the laws of the United States of America.

i. Entire Agreement; Amendments or Modifications of Agreement. With regard to the subject matter of this Agreement: (i) this Agreement supersedes all previous agreements or understandings between the parties; (ii) this Agreement, together with all exhibits and attachments hereto, constitutes the entire agreement of the parties; and (iii) neither of the parties has made any agreements, representations, or warranties to the other except those set forth in this Agreement and the exhibits and attachments hereto. This Agreement may only be amended by a written amendment signed by both parties; with the exception that Bright Health may update or add regulatory appendices to reflect material changes in law and regulations without amending this Agreement.

j. Notices. Any formal written notice submitted by one party to the other under the terms of this Agreement will be deemed effectively given: (a) on receipt if delivered personally, by facsimile, or by commercial courier service; (b) published to Bright Health’s provider portal; (c) on the third day after deposit in the United States mail (unless a different date is shown on the return receipt if sent postage prepaid registered or certified United States mail, return receipt requested), to the address set forth in conjunction with each party’s signature on this Agreement or to any other address designated by a party through written notice to the other party. Additionally, Bright Health may give notice by posting such notice on Bright Health’s provider portal.

k. Waivers of Default. The waiver by either party of one or more defaults on the part of the other party in the performance of obligations under this Agreement will not be construed to operate as a waiver of any prior or subsequent defaults. All such waivers must be set forth specifically in writing and signed by the waiving party.

l. Confidentiality of Information. Neither party, nor their agents, officers, directors, principals, employees, or contractors, will disclose to third parties, any of the terms of this Agreement, confidential or proprietary business information which it receives from the other party, including, but not limited to, financial statements, trade secrets, protocols and Program Requirements that are not publicly known, and reimbursement rates set forth in the payment appendix or payment appendices to this Agreement; except that: (1) Ancillary Group may disclose information to a Member relating to the Member’s treatment and related reimbursement information; and (2) Bright Health may file the form of this Agreement, excluding reimbursement rates set forth in this Agreement, with any federal or state regulatory entity as may be required by applicable law. Nothing in this provision will be deemed to prohibit the parties from releasing confidential or proprietary information received from the other party if it is required in response to a valid subpoena or court order, in response to other valid governmental demands for the information, or to employees, officers or agents who have a need to know such information in order to carry out the performance of this Agreement (and the parties agree to assure that such individuals have been informed of, and agree to comply with, the obligations in this provision); or if necessary to enforce this Agreement.

m. No Third Party Beneficiary. Nothing in this Agreement, express or implied, is intended or should be construed to confer upon any person or entity other than the parties of this Agreement, any right, remedy or claim by reason of this Agreement as third-party beneficiary. The terms of this Agreement are for the sole benefit of the parties and their successors and assigns

n. Severability. In the event any provision of this Agreement is determined to be invalid, illegal, or unenforceable for any reason and in any respect, such invalidity, illegality, or unenforceability will not affect the remainder of this Agreement, which will be and remain in full force and effect, enforceable in accordance with its terms. In addition, the parties will engage in good faith negotiations to reach agreement upon an amendment to this Agreement that will replace such invalid, illegal, or unenforceable provision with a lawful provision that is as similar as possible to such provision. To the extent that there is any conflict between this Agreement and any other document regarding

benefits, insurance, payment, or reimbursement for the services rendered by Ancillary Group, including but not limited to any provider manual or plan document, the provisions of this Agreement shall control.

[Remainder of this page intentionally left blank; signature page to follow.]

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

IN WITNESS WHEREOF, the undersigned have executed this Agreement by their duly authorized officers, intending to be legally bound hereby.

Bright Health Management Inc.

Signature: *Brian Beutner*
Name: Brian Beutner
Title: Corporate Secretary
Date: Sep 4, 2019

Bright Health Insurance Company

Signature: *Brian Beutner*
Name: Brian Beutner
Title: Corporate Secretary
Date: Sep 4, 2019

Bright Health Management, Inc. and Affiliates

219 North 2nd Street
Minneapolis, MN 55401
Attn: Legal Department

Ancillary Group

Signature: **Nancy Gill** Digitally signed by Nancy Gill
Date: 2019.08.29 10:14:42
-05'00'
Name: Nancy Gill
Title: VP, Managed Care
Date: 8/29/2019

Ancillary Group

Address: 5851 Legacy Circle, Ste 900
City, State: Plano, TX, 75024
Attn: VP Managed Care

EXHIBIT 1
DEFINITIONS

1. **Affiliate:** An entity controlled by, controlling, or under common control with another entity. For purposes of this Agreement, Affiliate includes the regulated entities under which Bright Health may issue Benefit Plans in the service areas covered by this Agreement.
2. **Association Health Plans:** coverage offered to members of an association with which Bright Health contracts to provide health care coverage pursuant to applicable Federal Department of Labor and State regulations.
3. **Benefit Plan:** A plan of health care benefits issued or administered by Bright Health under which Members receive coverage for Covered Services.
4. **Commercial Benefit Plans:** Benefit Plans issued or administered by Bright Health that are designed for purchase by individuals or groups and are not intended for government health programs such as Medicare, Medicaid, or the Children's Health Insurance Program. Commercial Benefit Plans include without limitation Exchange Benefit Plans, Off-Exchange Benefit Plans, Limited Benefit Plans, and Association Health Plans.
5. **Covered Services:** Health care services and supplies for which a Member is entitled to coverage under a Benefit Plan.
6. **Change of Control:** A merger, acquisition, joint venture, divestiture, or other transaction in which an entity that is not an Affiliate of a party acquires a controlling ownership share of that party or one of its Affiliates.
7. **Exchange Benefit Plans:** subsidized and unsubsidized benefit plans sold on the state and federal health insurance marketplaces established under the Affordable Care Act ("ACA") or sold through other channels created by subsequent legislation at the state or federal level intended to replace the ACA marketplaces;
8. **Individual and Family Plans (IFP):** Individual and Family Plans include Exchange Benefit Plans and Off-Exchange Benefit Plans.
9. **Limited Benefit Plans:** Bright Secure and other indemnity coverage, short term limited duration, or other types of limited benefit plans;
10. **Member:** An individual who is eligible to receive benefits for Covered Services under a Benefit Plan.
11. **Member Expenses:** Any amounts that are the Member's responsibility to pay for Covered Services pursuant to the Member's Benefit Plan, including without limitation co-payments, coinsurance, deductibles, and other cost-share amounts.
12. **New Technology or Medical Service:** Ancillary Group addition of a new technology, expansion of an existing technology, or addition of a new type of service that is treated by CMS in the original Medicare program as a substantial clinical improvement over existing technology or medical services, and that CMS concludes is inadequately reimbursed by existing DRGs and other original Medicare reimbursement schedules and is therefore eligible for new reimbursement amounts.
13. **Network Provider:** a Ancillary Group, individual physician, or other professional and other type of provider that is an employee, subcontractor, Affiliate, or contracted downstream provider of Ancillary Group and that participates in the Bright Health Network through this Agreement.
14. **Off-Exchange Benefit Plans:** Commercial Benefit Plans that are eligible for sale in commercial individual and group markets.
15. **Program Requirements:** Bright Health's policies and procedures, protocols, payment and coding rules, and administrative requirements, that establish the rules for Ancillary Group to participate in Bright Health's network and carry out the terms of this Agreement, including without limitation rules related to claims submission, coding and billing, prior authorization, utilization review programs, referral to specialists, credentialing procedures, Bright Health's quality improvement and accreditation programs, and risk adjustment and claims reconciliation programs.
16. **Provider Demographic and Billing Information:** means industry standard demographic information, all service locations, and all other information necessary to populate Bright Health's provider directories in a complete, accurate, and up-to-date manner, and with sufficient detail to satisfy state and federal regulatory requirements for accuracy of provider directories; and complete, accurate, and up-to-date billing information sufficient to permit Bright Health to pay claims promptly and accurately, including without limitation the TIN, NPI, and claim remittance address.

EXHIBIT 2

BENEFIT PLANS

Ancillary Group will participate in Bright Health's network for the following types of Benefit Plans:

Commercial Benefit Plans: Benefit Plans issued or administered by Bright Health that are designed for purchase by individuals or groups and are not intended for government health programs such as Medicare, Medicaid, or the Children's Health Insurance Program. Commercial Benefit Plans include without limitation:

- a. Individual and Family Plans (IFP). IFP Benefit Plans include:
 - i. Off-Exchange Benefit Plans: benefit plans that are eligible for sale in commercial individual and group markets; and
 - ii. Exchange Benefit Plans: subsidized and unsubsidized benefit plans sold on the state and federal health insurance marketplaces established under the Affordable Care Act ("ACA") or sold through other channels created by subsequent legislation at the state or federal level intended to replace the ACA marketplaces.
- b. Limited Benefit Plans: Bright Secure and other indemnity coverage, short term limited duration, or other types of limited benefit plan.
- c. Association Health Plans: coverage offered to members of an association with which Bright Health contracts to provide health care coverage pursuant to applicable Federal Department of Labor and State regulations.

Medicare Advantage Benefit Plans: Benefit Plans issued or administered by Bright Health pursuant to the Medicare Advantage program.

Bright Health may update the list of detailed Benefit Plans under this Agreement by providing Ancillary Group with ninety (90) days advance written notice prior to the to the effective date of the change in Benefit Plans.

EXHIBIT 3

ANCILLARY PROVIDER SERVICE LOCATIONS

See attached list of facilities and Ancillary Groups, including TIN and NPI numbers.

Exhibit 4A- Commercial Payment Appendix**Line of Business:** Commercial Benefit Plans**Contract Rates:** Bright Health agrees to pay Provider the lesser of Provider's billed charges and the rates set forth in this Payment Appendix

The provisions of this Payment Appendix apply to Covered Services provided to Members by Ancillary Group under **Commercial Benefit Plans** as defined in Exhibit 2. Bright Health Plan will apply the following reimbursement methodology specified below: For Outpatient Dialysis Providers

US Renal Care Commercial Plans Rate Schedule

Procedure	Rev Code	CPT Code	Rate
Hemodialysis	821	90999	\$778
Hemo/Training	821	90993	\$778
Home Hemodialysis*	821	90999	\$778
Home Hemo Training*	821	90999	\$778
Incenter AKI	821	G0491/90999	\$778
Ultrafiltration	881	90999	\$778
CAPD	841	90945	\$333
CAPD/Training	841	90993	\$778
CCPD	851	90945	\$333
CCPD/Training	851	90993	\$778
Parsabiv	636	J0606 (0.1 mg)	\$3.47
Sensipar	636	J0604 (1 mg)	\$0.95

US Renal Care Exchange Based Plans Rate Schedule

Procedure	Rev Code	CPT Code	Rate
Hemodialysis	821	90999	\$525
Hemo/Training	821	90993	\$525
Home Hemodialysis	821	90999	\$525
Home Hemo Training*	821	90999	\$525
Incenter AKI	821	G0491/90999	\$525
Ultrafiltration	881	90999	\$525
CAPD	841	90945	\$225
CAPD/Training	841	90993	\$525
CCPD	851	90945	\$225
CCPD/Training	851	90993	\$525
Parsabiv	636	J0606 (0.1 mg)	\$3.47
Sensipar	636	J0604 (1 mg)	\$0.95

. For those codes not valued by either Exhibit 4A reimbursement will be 50% of billed charges.

Exhibit 4B- Medicare Advantage Payment Appendix

Line of Business: Medicare Advantage Benefit Plans

Contract Rates: Bright Health agrees to pay Provider the lesser of Provider's billed charges and the rates set forth in this Payment Appendix

The provisions of this Payment Appendix apply to Covered Services provided to Members by Ancillary Group under Medicare Advantage Benefit Plans as defined in **Exhibit 2**.

US Renal Care Medicare Advantage Rate Schedule

Procedure	Rev Code	CPT Code	Rate
Hemodialysis	821	90999	\$350
Hemo/Training	821	90993	\$350
Home Hemodialysis*	821	90999	\$350
Home Hemo Training*	821	90999	\$350
Incenter AKI	821	G0491/90999	\$350
Ultrafiltration	881	90999	\$350
CAPD	841	90945	\$150
CAPD/Training	841	90993	\$350
CCPD	851	90945	\$150
CCPD/Training	851	90993	\$350
Parsabiv	636	J0606 (0.1 mg)	\$3.47
Sensipar	636	J0604 (1 mg)	\$0.95

Applicable Terms

Prevailing Medicare Fee Schedule: means the reimbursement that the provider would receive if the services were performed in the Medicare fee for service program in the same locality, including both reimbursement rules and reimbursement rates in effect for the services. For the purposes of the Prevailing Medicare Fee Schedule, among the other applicable Medicare reimbursement rules, Bright Health will apply the following:

- (a) the prevailing Medicare sequestration reduction imposed by the Budget Control Act of 2011, as amended, for services provided by Provider to Members under Medicare Advantage Benefit Plans. Such sequestration reduction will be applied at the same level and methodology as if the reimbursement were made in original Medicare. **NOTE: Agreed that Sequestration provision will not apply to US Renal Care Agreement**
- (b) for Providers who participate in the Merit-based Incentive Payment System, in Alternative Payment Models, or in other CMS performance-based payment programs; bonuses, penalties, or other adjustments applied to Provider reimbursement by CMS in original Medicare will not be included by Bright Health in the Prevailing Medicare Fee Schedule.

Prevailing Medicare Fee-Schedule Updates: Where applicable, prevailing Medicare Fee Schedule will be updated within 90 days of CMS publication of changes. Claims incurred with dates of service prior to such updates will not be reprocessed and will be reimbursed based on the rates in effect prior to such update.

New and Non-Medicare Valued Codes: Reimbursement for new codes shall be determined using the current RVUs at the time the new codes are added with the current locality and conversion factors until the next Medicare Fee Schedule Update. For codes that are not valued by applicable Medicare Fee Schedules, reimbursement shall be the lesser of Provider's billed charges or the Bright Health Fee Schedule. In the event a code is not valued by Medicare or the Bright Health Fee Schedule, reimbursement shall be 50% of Provider's billed charges.

EXHIBIT 5B

MEDICARE ADVANTAGE REGULATORY APPENDIX

Bright Health Management, Inc., and its affiliates (Bright Health Insurance Company and its other health plan affiliates) are engaged in the business of Medicare Advantage and Part D coverage through a contract with the Center for Medicare & Medicaid Services (CMS) ("MA Plan(s)"). Vendor or Provider provides services to MA Plan Members pursuant to an agreement with MA Plan (Agreement). Accordingly, Vendor or Provider agrees, on behalf of itself and its affiliates performing services to MA Members under the Agreement, to comply with the following provisions.

Any term not defined in this addendum shall have the same meaning as set forth in the Agreement. For purposes of this addendum, "**Member**" shall mean an individual who is enrolled in Bright Health Plans' MA coverage. In the event of a conflict with the Agreement, the terms of this addendum will control.

General Compliance Provisions

1. Delegated Activities and Reporting Requirements. The delegated activities and reporting responsibilities are specified in the Agreement. 42 CFR §§ 422.504(i)(4)(i).
2. Compliance with Medicare Laws, Regulations, and CMS Guidance. Vendor or Provider agrees to comply with all applicable Medicare laws, regulations, and CMS guidance. 42 CFR §§ 422.504(i)(4)(v) and 423.505(i)(4)(iv).
3. Compliance with MA Plan's Contract with CMS. Any services or other activity performed in accordance with this Agreement by Vendor or Provider are consistent and comply with the MA Plan's contractual obligations with CMS. 42 C.F.R. § 422.504(i)(3)(iii).
4. Medicare Compliance Program. Vendor or Provider agrees to develop and maintain an effective MA compliance program that meets CMS requirements and that includes without limitation: (a) an effective system for routine monitoring and auditing to identify compliance risks; (b) procedures and systems for prompt response to compliance issues; (c) written policies, procedures, and standards of conduct that articulate the Vendor or Provider's commitment to comply with all applicable Federal and state standards and describes compliance expectations; (d) designation of a compliance office and compliance committee responsible for oversight of the compliance plan; (e) effective lines of communication between the compliance officer and the MA Plan and the compliance officer and Vendor or Provider employees and contractors; (f) published and enforced disciplinary standards for noncompliance by employees and contractors, up to and including termination. Provide Medicare Standards of Conduct and policies and procedures to all employees and contractors who perform services pursuant to the Agreement. 42 CFR 422.503(b).
5. Report Compliance Concerns. Vendor or Provider agrees to report compliance or FWA concerns to the MA Plan within five (5) calendar days of discovery of an actual, suspected or potential compliance concern or FWA concern. If the matter is emergent, either because beneficiary access to care is affected or because of other critical impacts, Vendor or Provider must notify the MA Plan as soon as reasonably possible, and no later than twenty-four (24) hours from discovery. Vendor or Provider shall coordinate with MA Plan to (a) timely investigate compliance or FWA risk; (b) mitigate the FWA or compliance concern, and (c) implement the appropriate corrective action. 42 CFR § 422.503(b).
6. Exclusion. Vendor or Provider certifies that no member of its governing bodies and advisory boards, individual employed or contracted practitioners, all other employees and contractors, or affiliated provider organizations has been excluded from participation in federal contracts by: (a) U.S. Treasury Office of Foreign Assets Control; (b) Office of Inspector General of the Department of Health and Human Services; or (c) U.S. General Services Administration (GSA). Vendor or Provider agrees to monitor the exclusion lists published by the above federal agencies and perform background checks prior to hire and monthly thereafter for all employees, independent contractors, volunteers, and members of its governing bodies and advisory boards. Vendor or Provider shall also require any of its subcontracts to include such checks prior to hire and on a monthly basis thereafter. If any of its employees or other individuals are excluded by such federal agencies, Vendor or Provider agrees to notify the MA Plan and immediately remove the individual from any services performed under the Agreement on behalf of the MA Plan. 42 CFR § 422.503(b); 422.752(a); 423.504(d) and (i).
7. Investigations, Legal Actions, and Arbitrations. Vendor or Provider acknowledges to the best of its knowledge, information and belief, there are no past or pending investigations, legal actions, or matters subject to arbitration involving Vendor or Provider or any of its employees, contractors, Governing Body members, Downstream Entities, or any major shareholders (5% or more) on matters relating to payments from governmental entities, both federal and state, for health care and/or prescription drug services.

8. Convictions and Civil Judgements. Vendor or Provider acknowledges to the best of its knowledge, information, and belief that neither Vendor or Provider, nor any of its employees, contractors, Governing Body members, Downstream Entities, or any major shareholders (5% or more) have been criminally convicted nor has a civil judgment been entered against them for fraudulent activities nor are they sanctioned under any Federal program involving the provision of health care and/or prescription drug services.
9. Section 1557 of the Patient Protection and Affordable Care Act (ACA). Vendor or Provider shall comply with the nondiscrimination provisions, meaningful access requirements, language assistance services, and requirements of Section 1557 of the ACA requirements. 45 CFR §§ 92.1 – 92.303.
10. Certifications to Accuracy, Completeness, and Truthfulness of Data. If Vendor or Provider generates data to determine payment on behalf of MA Plan, then Vendor or Provider must certify (based on best knowledge, information and belief) the accuracy, completeness, and truthfulness of the data.
11. Marketing Guidelines. To the extent Vendor or Provider performs services or functions that are governed by the CMS Manual System, Pub. 100-16 Medicare Managed Care, Chapter 3, Medicare Marketing Guidelines for the Department of Health & Human Services Centers for Medicare & Medicaid Services, as amended, Vendor or Provider agrees to comply with such guidelines.

Records

12. Record Retention and Audit. Vendor or Provider agrees to retain any books, records, contracts, and other documents related to the MA Plan's MA contract with CMS for a period of ten (10) years from the final date of the MA contract or the completion of any audit, whichever is later. Vendor or Provider agrees to comply at no additional charge with any document requests by the MA Plan pursuant to an audit, for purposes of MA Plan oversight, or for any other reason related to the operation of the MA business. Vendor or Provider agrees to allow HHS, the Comptroller General, or their designees to audit and inspect any books, records, contracts, and other documents related to the MA Plan's MA contract with CMS for a period of ten (10) years from the final date of the MA contract or the completion of any audit, whichever is later. 42 CFR §§ 422.504(i)(2)(i) - 422.504(i)(2)(iv).
13. Data Privacy and Confidentiality of Records. Vendor or Provider shall comply with the confidentiality and Member record accuracy requirements including without limitation (1) abiding by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information, (2) ensuring that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas, (3) maintaining the records and information in an accurate and timely manner, and (4) ensuring timely access by Members to the records and information that pertain to them. 42 C.F.R. §§ 422.504(a)(13) and 422.118.

General Contract Provisions

14. Vendor Offshore Services. Vendor agrees that it will not perform offshore administrative services, or any other services on behalf of the MA Plan, or delegate to offshore entities without obtaining written prior approval from the MA Plan. If such approval is granted, Vendor agrees to demonstrate compliance with all laws, rules, and CMS guidance related to offshore services and related to the transmission of electronic data and protected health information offshore. MA Plan has the right to conduct an annual audit of the Vendor to evaluate the practices and procedures, including but not limited to PHI privacy and security controls, of the Vendor and the audit results will be used to evaluate the continuation of the offshore relationship.
15. Amendments Required by Law. If Medicare laws, regulations, or CMS guidance require a change to the terms of this addendum, this addendum may be modified by the MA Plan to reflect the changed requirements and such modification will become immediately upon written notice by the MA Plan providing the modified addendum to the Vendor or Provider without the need to amend the Agreement.
16. Monitoring and Termination. The MA Plan will monitor the Vendor or Provider's performance under the Agreement and this addendum on an ongoing basis. The MA plan and CMS have the right to revoke the delegation activities and may terminate the Agreement with Vendor or Provider if the MA Plan or CMS determines that Vendor or Provider has committed a violation of CMS rules, committed FWA, or has not performed satisfactorily under this addendum. 42 CFR § 422.504(i)(4) ((ii)-(iii)).
17. Flow-Down Requirements. Vendor or Provider (where services are delegated) will incorporate these requirements into its agreements with downstream providers, subcontractors, and delegated entities. The MA Plan retains the right to approve, suspend, or terminate Vendor or Provider's agreements with downstream providers, subcontractors, and delegated entities. 42 CFR § 422.504(i)(5), 423.505.

Vendor or Provider shall monitor and audit its downstream providers, subcontractors, and delegated entities (“Downstream Entity(ies)”) to ensure that they are in compliance with all applicable laws, regulations, and contractual requirements, including compliance with these Medicare Advantage provisions. If Vendor or Provider determines a Downstream Entity requires corrective action(s), Vendor or Provider shall ensure that such corrective action(s) are taken by its Downstream Entity. Vendor or Provider shall provide information about its Downstream Entity oversight, including any corrective action plans, to MA Plan upon request.

Notwithstanding any relationships that MA Plan may have with first tier, downstream, and related entities, MA Plan maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS. Vendor or Provider shall participate in and comply with MA Plan’s oversight program, including but not limited to, attending meetings; providing attestations; responding to document requests, FWA and General Compliance Training, policy, and procedure review requests; implementing corrective action plans imposed by MA Plan or CMS; participating in monitoring and reviews; and providing MA Plan with similar information about Vendor’s or Provider’s Downstream Entities.

Requirements Applicable Only to Providers

18. Hold Harmless. Provider agrees to accept the MA Plan’s MA contracted rate as payment in full and agrees not to hold Members liable for the payment of any fees that are the obligation of the MA Plan. 42 CFR §§ 422.504(i)(3)(i) and § 422.504(g).
19. Medicare-Medicaid Enrollees. For Members eligible for both Medicare and Medicaid, Provider agrees not to hold MA Enrollees liable for Medicare Part A and Part B cost sharing amounts where the Members are eligible for Medicare and Medicaid coverage and the state is responsible for paying such amounts. The Provider shall not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under Title XIX if the individual were not enrolled in such a plan. Providers will: (1) accept the MA plan payment as payment in full, or (2) bill the appropriate State source. 42 CFR §§ 422.504(i)(3)(i) and § 422.504(g)(1)(iii).
20. Credentialing. Where MA Plan has delegated credentialing to Provider for provider organizations and/or individual practitioners, Provider agrees to submit its credentialing process and upon reasonable request, the credentials of individual medical professionals and organizations affiliated with Provider, to the MA Plan for review and approval and Provider agrees that the MA Plan may monitor and audit the credentialing process on an ongoing basis. 42 CFR § 422.504(i)(4)(iv).
21. Termination Rights. MA Plan retains the right to approve, suspend, or terminate the selection of provider organizations and individual practitioners and MA Plan also retains the right to revoke the delegation of credentialing to Provider without triggering a termination of the Agreement. 42 CFR § 422(i)(5).
22. Prompt Payment. MA Plan agrees to pay clean claims within the time period required by MA regulations. If MA Plan reimburses clean claims outside of the time period required by MA regulations, MA Plan agrees to pay interest as set forth by the Department of Treasury pursuant to the federal Prompt Payment Act. Where Provider is responsible for paying claims on behalf of the MA Plan, Provider agrees to include in its contracts and adhere to all applicable federal and state requirements for the prompt payment of claims with respect to downstream providers. 42 CFR § 520(b)(1) & 504(c).
23. Stop-loss Protection. Where Provider accepts financial risk in its Agreement with the MA Plan, Provider agrees to comply with all CMS rules for physician incentive plans applicable to the arrangement, including without limitation obtaining stop-loss protection where required. 42 CFR § 422.208.
24. Non-Covered Services. With the exception of an explicitly excluded service in the Member’s MA Evidence of Coverage, Providers may not permit a Member to self-pay for a non-covered service unless the Member, or the Provider on the Member’s behalf, has first obtained an organization determination from the MA Plan denying coverage for the service. For an explicitly excluded service, Providers may permit the Member to self-pay for the service without an organization determination.
25. Provider Offshore Services. Provider agrees that it will notify the MA Plan before performing offshore administrative services, or any other services on behalf of the MA Plan. Provider agrees to demonstrate compliance with all laws, rules, and CMS guidance related to offshore services and related to the transmission of electronic data and protected health information offshore. MA Plan has the right to conduct an annual audit of the Provider to evaluate the practices and procedures related to offshore services.

EXHIBIT 6

NATIONAL PARTNERSHIPS

If any of the capitalized terms in this **Exhibit** are used or defined (or the equivalent terms are used or defined) in the Agreement, then the terms used in this **Exhibit** will have the same meaning as the terms (or equivalent terms) used or defined in the Agreement. For example, "Provider" as used in this Appendix, will have the same meaning as "Network Provider" "Facility," "Ancillary Group," "Ancillary Provider," "Physician," or "Professional," or other type of provider entity.

Bright Health may modify this **Exhibit** without amending the Agreement upon prior written notice of one hundred twenty (120) days to Provider. Solely for purposes of this **Exhibit**, notice will include written e-mail to Bright Health's primary point of contact at Provider. Provider will use best efforts to reflect new or modified Provider or service locations based on service area additions and will include the additional Provider or service locations in its periodic roster updates to Bright Health and will use best efforts to make such additions to its roster within 30 days of Bright Health's notice.

Service Areas

Provider will perform Covered Services for Members in the service areas set forth in this Exhibit ("Service Areas"):

Alabama
Arizona
Colorado
Florida
Georgia
Illinois
Nebraska
New York
Oklahoma
Ohio
North Carolina
South Carolina
Tennessee

Affiliates of Bright Health Management, Inc.

Alabama:	Bright Health Insurance Company of Alabama Inc.
Arizona:	Bright Health Company of Arizona
Colorado:	Bright Health Insurance Company
Florida:	Bright Health Insurance Company of Florida
Georgia:	Bright Health Company of Georgia
Illinois:	Bright Health Company of Illinois
Nebraska:	Bright Health Insurance Company
New York:	Bright Health Insurance Company of New York
Ohio:	Bright Health Insurance Company of Ohio, Inc.
Oklahoma:	Bright Health Insurance Company
North Carolina:	Bright Health Company of North Carolina
South Carolina:	Bright Health Company of South Carolina, Inc.
Tennessee:	Bright Health Insurance Company of Tennessee