SAMPLE CONTRACT

MEDICARE ADVANTAGE HMO

AND

MEDICARE PART D (PRESCRIPTION DRUGS)

(company name)

GROUP APPLICATION

Entire Agreement: This Group Application, including the Evidence of Coverage for Medicare Advantage HMO and Medicare Part D, Summary of Benefits, any Supplemental Benefits, and any Exhibits, Amendments, endorsements, inserts or attachments, herein defined as ("Agreement") constitutes the entire Agreement between the CITY OF HOUSTON, TEXAS ("Group"), a home rule city of the State of Texas, and ________________, a ______________ (state of incorporation) __________________ (legal entity) licensed as a health maintenance organization ("HMO"), and on the Effective Date of Coverage, supersedes all other prior and contemporaneous arrangements, understandings, agreements, negotiations, and discussions between the parties, whether written or oral, previously issued by HMO for Covered Services provided under this Agreement.

- Exhibit I Additional Terms and Conditions,
- Exhibit II Premium Rates,
- Exhibit IIA Rate Renewal Calculation Formula,
- Exhibit III Evidence of Coverage and Summary of Benefits for Medicare Advantage HMO and Medicare Part D, and
- Exhibit IV HMO Medicare Part D Formulary and Excluded Drug Listing

are attached hereto and are incorporated in their entirety herein.

Governmental Approval: The provisions of this entire Agreement may be filed with the Centers for Medicare and Medicaid Services ("CMS") after its approval by the Group and prior to the distribution of any of the terms hereof, including the provisions contained in the Evidence of Coverage and Summary of Benefits and all documents incorporated therein, to persons eligible for Coverage under the Plan. HMO may be required to revise such terms and provisions to obtain CMS’s approval or to comply with Federal law and regulation, and Group agrees to such changes subject to the prior written approval of Group’s Human Resources Director.
Group: City of Houston


Group Agreement Effective Date: JANUARY 1, 2021

Term of Group Agreement: The initial term shall be: From January 1, 2021 to December 31, 2023. Thereafter, this Agreement can be renewed for two (2) successive optional one-year terms, in accordance with the terms and conditions as set forth in Exhibit II.

HMO Premium Rates: For Premium Rates see Exhibit II attached hereto and incorporated in its entirety herein.

Premium Due Dates: The Group Agreement Effective Date and the 1st day of each succeeding calendar month. Premium due date shall be subject to a thirty (30) day grace period.
Notices:

All notices to either Party to the Agreement must be in writing and must be delivered by hand, facsimile, United States registered or certified mail, return receipt requested, United States Express Mail, Federal Express, UPS, or any other national overnight express delivery service. The notice must be addressed to the Party to whom the notice is given at its address set out below or other address the receiving Party has designated previously by proper notice to the sending Party. Postage or delivery charges must be paid by the Party giving the notice.

COMPANY NAME: XYZ COMPANY

And to Group at:

CITY OF HOUSTON, TEXAS

Human Resources Director
611 Walker, 4th Floor
Houston, Texas 77002
Signatures.

The Parties have executed this Agreement in multiple copies, each of which is an original. Each person signing this Agreement represents and warrants that he or she is duly authorized and has legal capacity to execute and deliver this Agreement. Each Party represents and warrants to the other that the execution and delivery of this Agreement and the performance of such Party’s obligations hereunder have been duly authorized and that the Agreement is a valid and legal agreement binding on such Party and enforceable in accordance with its terms. The Parties hereby agree that each Party may sign and deliver this Agreement electronically or by electronic means and that an electronic transmittal of a signature, including but not limited to, a scanned signature page, will be as good, binding, and effective as an original signature.

**ATTEST/SEAL:**

<table>
<thead>
<tr>
<th>XYZ COMPANY:</th>
<th>ATTEST/SEAL:</th>
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<tr>
<td>By: ____________</td>
<td>By: ____________</td>
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<td>Name: ______________</td>
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**ATTEST/SEAL:**

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<th>CITY OF HOUSTON, TEXAS</th>
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<td>By: ____________</td>
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<tr>
<td>City Secretary</td>
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**APPROVED:**

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<tr>
<th>COUNTERSIGNED</th>
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<tr>
<td>By: ____________</td>
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<tr>
<td>Group’s Human Resources Director</td>
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<tr>
<th>Sr. Assistant City Attorney</th>
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<td>L.D. File No. ______________</td>
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Chief Procurement Officer

**APPROVED AS TO FORM:**

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<tr>
<th>DATE COUNTERSIGNED</th>
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<tr>
<td>By: ____________</td>
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</table>
EXHIBIT I TO GROUP APPLICATION

Additional Terms and Conditions

A. **Compliance With Equal Employment Opportunity Ordinance.** HMO shall comply with all provisions of the City’s Equal Employment Opportunity Ordinance as set out in Section 15-17 of the Code of Ordinances.

B. **Minority and Women Business Enterprises.** HMO agrees to use its good faith efforts to carry out the policy of the Group with regard to minority and women business enterprises as set out in Exhibit I-A.

C. **Allocation and Appropriation of Funds by the Group.** HMO agrees to the terms and conditions set out in Exhibit I-B regarding the Group’s allocation and appropriation of funds to pay HMO under this Agreement.

D. **Service Performance Standards.** HMO agrees to meet the service performance criteria set out in Exhibit I-C.

E. **Management Reports.** HMO will provide the management reports that are listed in Exhibit I-D to the Group at such times as are mutually agreed upon between the Group and HMO.

F. **Supplemental Terms & Conditions.** HMO and Group agree to be bound by all applicable supplemental terms and conditions set forth in Exhibit I-E.

G. **Insurance.** HMO agrees to the requirements for insurance coverage as set forth in Exhibit I-F.

H. **Drug Forms.** HMO agrees to comply with all the requirements and procedures set forth in the Mayor's Drug Abuse Detection and Deterrence Procedures for Contractors, Executive Order No. 1-31 (“Executive Order”) as set forth in Exhibit I-G.
**EXHIBIT “I-A”**

Minority and Women Business Enterprises

It is the Group’s policy to ensure that Minority and Women Business Enterprises ("MWBEs") have the full opportunity to compete for and participate in City contracts. The objectives of Chapter 15, Article V of the City of Houston Code of Ordinances, relating to City-wide Percentage Goals for contracting with MWBEs, are incorporated into this Agreement. HMO shall comply with the City’s Minority and Women Business Enterprise ("MWBE") programs as set out in Chapter 15, Article V of the City of Houston Code of Ordinances.

HMO shall make good faith efforts to award subcontracts or supply agreements in at least an amount equal to three percent (3%) of the costs incurred under this Agreement to meet the established annual MWBE goals. Those costs can include IPAs, pharmacies, DME providers, home health facilities, clinics, printers, caterers, couriers, and other related firms, excluding taxes, hospital charges and outpatient surgery facility charges. The City of Houston's policy does not require HMO to in fact meet or exceed this goal, but it does require HMO to objectively demonstrate that it has made good faith efforts to do so. To this end, HMO shall maintain records showing:

1. subcontracts and supply agreements with Minority Business Enterprises,
2. subcontracts and supply agreements with Women’s Business Enterprises, and
3. specific efforts to identify and award subcontracts and supply agreements to MWBEs.

HMO shall submit periodic reports of its efforts under this Section to the Office of Business Opportunity (“OBO”) Director in the form and at the times he or she prescribes.

HMO acknowledges that it has reviewed the requirements for good faith efforts on file with the City’s Office of Business Opportunities (“OBO”) and will comply with them.

In addition to the above MWBE goal, the Group has a strong commitment to offering its employees a diverse Provider network. The Group will monitor the Provider network to ensure that it represents a cross section of the community and that at least thirty percent (30%) of the physicians are minority and/or female.
EXHIBIT "B"

HMO Limit of Appropriation

(1) The City's duty to pay money to HMO under this Agreement is limited in its entirety by the provisions of this Section.

(2) In order to comply with Article II, Sections 19 and 19a of the City's Charter and Article XI, Section 5 of the Texas Constitution, the City has appropriated and allocated the sum of $______________ to pay money due under this Agreement (the "Original Allocation") during the City’s current fiscal year. The executive and legislative officers of the City, in their discretion, may allocate supplemental funds (each a “Supplemental Allocation” and collectively, the “Supplemental Allocations”) for this Agreement, but they are not obligated to do so. Therefore, the parties have agreed to the following procedures and remedies.

(3) The City has not allocated supplemental funds or made a Supplemental Allocation for this Agreement unless the City has issued to HMO a Service Release Order, or similar form approved by the City Controller, containing the language set out below. When necessary, the Supplemental Allocation shall be approved by motion or ordinance of City Council.

NOTICE OF SUPPLEMENTAL ALLOCATION OF FUNDS

By the signature below, the City Controller certifies that, upon the request of the Director, the supplemental sum set out below has been allocated for the purposes of the Agreement out of funds appropriated for this purpose by the City Council of the City of Houston. This Supplemental Allocation has been charged to such appropriation.

$ ______________

(4) The Original Allocation plus all Supplemental Allocations are the “Allocated Funds”. The City shall never be obligated to pay any money under this Agreement in excess of the Allocated Funds. HMO must assure itself that sufficient allocations have been made to pay for services it provides. If Allocated Funds are exhausted, HMO’s only remedy is suspension or termination of its performance under this Agreement, and it has no other remedy in law or in equity against the City and no right to damages of any kind.
EXHIBIT “I-C”

SERVICE PERFORMANCE STANDARDS

The Service Performance Standards described herein shall apply to the Agreement between HMO and Group to which this Exhibit I-C is attached; provided, however, HMO will not be obligated to satisfy any provision of this Exhibit I-C if enrollment in the HMO Coverage offered by HMO is less than nine hundred (900) Members. In the event that enrollment drops to five hundred (500) Members or fewer, Group will withdraw the Performance Standards for HMO for such year and shall reinstate the Performance Standards for subsequent optional Contract Years during which enrollment equals or exceeds nine hundred (900) Members. The Service Performance Standards set out in this Exhibit I-C are limited solely to the medical benefit Coverage under HMO and do not include the following: prescription drug, hearing, vision, alternative health services, silver sneakers, or similar or dissimilar program(s), or other supplemental services, (collectively “Supplemental Benefits”), if applicable, under the medical management programs provided by HMO when elected by the Group.

SECTION I - DEFINITIONS

**Average Speed to Answer or Wait Time in Queue** means the time the Member spends on hold after being placed in queue.

**Claim Processing Accuracy** means the accuracy rate achieved by HMO in processing claims in accordance with the provisions of a group’s medical benefit Coverage administered by HMO.

**Coverage Area** means the following counties in the State of Texas:

1. Austin County
2. Brazoria County
3. Chambers County
4. Dallas County
5. Fort Bend County
6. Galveston County (following zip codes): 77510, 77511, 77517, 77518, 77539, 77546, 77549, 77563, 77565, 77568, 77573, 77574, 77590, 77591, 77592
7. Harris County
8. Hardin County
9. Jefferson County
10. Liberty County
11. Montgomery County
12. Orange County
13. Rockwall County
14. Tarrant County
15. Waller County

**Health Management** means wellness/disease management programs that are designed to improve the health status of Members. The two standard health management programs include diabetes and...
congestive heart failure.

**Measurable Claims** means notification on a form acceptable to HMO that a service has been rendered or furnished to a Member in accordance with the provisions of the Group’s medical benefit Coverage in effect on the date a service is rendered or furnished. This notification must set forth the full details of such service including, but not limited to, the Member’s name; age; sex; Subscriber identification number and group number. Notification must also provide the name and address of the provider of service, a specific itemized statement of the service rendered or furnished, the date of service, applicable diagnosis, and the fee for such service. Such claim is measurable if, when received by HMO, it contains all of the information required to process the claim. If any additional information is required to process the claim, including medical records or supporting documentation, the claim is not considered a Measurable Claim.

**Reporting Date** means sixty (60) days after the end of each calendar quarter (i.e., quarter ending March 31, June 30, September 30 and December 31), or the next business day if the Reporting Date falls on a weekend or holiday.

**Settlement Period** means the 90-day period following the end of each calendar year (i.e., the period ending March 31) during which the percentage of premiums at risk must be paid by HMO to Group for failure to meet HMO’s service performance standards.

**Top Two-Box Score** means a net of the highest two categories of a rating scale. For example, if the scale is: Strongly Disagree, Somewhat Disagree, Neither Agree nor Disagree, Somewhat Agree and Strongly Agree, then the combined category of Somewhat Agree and Strongly Agree is the Top Two-Box Score.

**SECTION II - SERVICE PERFORMANCE STANDARDS**

1. The Service Performance Standards set out in this Exhibit I-C and Addendum I-C-1 are limited solely to Fee-for-Service claims paid directly by HMO. Service Performance Standards do not apply to capitation payments paid by HMO or delegated entity.

2. The Service Performance Standards set out in this Exhibit I-C and Addendum I-C-1 are limited solely to the HMO medical benefit Coverage under HMO and do not include prescription drug, vision, hearing Coverage or other Supplemental Benefits.

3. All obligations, terms, conditions, promises, agreements, and language in the Agreement apply equally to the obligations, terms, conditions, promises, agreements, and language in this Exhibit I-C and Addendum I-C-1.

**SECTION III - CALCULATION**

1. In measuring HMO’s service performance, percentage levels of performance will be rounded to the nearest tenth of one percent (0.1%).

2. All measurement and calculation methods used in determining performance results are in accordance with the performance reporting guidelines as follows:

   **Average Speed to Answer**
   The Average Speed to Answer is the telephone response time that is measured from the time calls are put in queue until they reach their final destination and are answered by a customer service representative. The Average Speed to Answer is provided by telephone reports, which compute the average number of seconds that Members spend on hold waiting for their call to be answered.
**Claim Processing Accuracy**

Claim Processing Accuracy is determined from an audit of randomly selected claims. The Claim Processing Accuracy percentage is calculated dividing the number of accurately processed claims by the number of claims selected in the sample. All claim data fields are reviewed; however, only errors resulting in a payment error (overpayment or underpayment) are counted as processing errors. Also included are misapplied deductibles and co-share amounts.

Claims excluded as errors are claims with administrative inaccuracies that do not impact claims disposition, future claims disposition, or customer reporting.

**Member Communications**

Member Communications include all informational materials related to the Plan and provided to covered City of Houston Retirees and their eligible dependents. These materials also include documents required by the Centers for Medicare and Medicaid Services (CMS) such as the Evidence of Coverage (EOC) and the Annual Notice of Change (ANOC).

**Client Satisfaction**

Based upon “top two-box” satisfaction/approval results using a standard five-point survey tool, Group shall experience a satisfaction rating of 90% or better, regarding client services and medical management teams, reporting and analytics.

**Member Satisfaction**

The percent of Member satisfaction will be measured based on all respondents to the HMO Member Satisfaction Survey who rate the overall performance of HMO. The standard will be measured based on the percentage of satisfaction of all respondents in the Coverage Area within the State of Texas. The Member satisfaction survey measures all aspects of a Member’s experience including medical services, provider network, claims, customer service, communication, and Plan documents.

**SECTION IV - TIMING**

1. The Service Performance Standards in this Agreement shall be measured and reported as provided in Addendum I-C-1.

2. Unless stated otherwise in this SECTION IV, the only period in which HMO’s service performance will be settled and for which the Group may receive a refund is on an annual basis.

3. Any claims incurred before January 1, 2021 and any inquiries related to such claims will be excluded from the measurement of HMO’s service performance and the Group’s refund based thereon for settlement periods set forth in Addendum I-C-1.

4. For measurement of the Service Performance Standards to continue, Premiums must be received by HMO in accordance with the terms detailed in the Agreement.

5. If for any reason the Agreement is terminated prior to the end of any Settlement Period, or enrollment in the HMO Coverage offered by HMO falls below nine hundred (900) Members HMO’s service performance will not be measured and the Group will not receive any refund based on that part of the Settlement Period in which the Agreement was in effect.

**SECTION V - DETERMINATION**

1. HMO will report the service performances measurements to the Group in accordance with this Exhibit I-C and Addendum I-C-1 to Group no later than the Reporting Date. All measurement and calculation methods used in determining performance results shall be made based on activities from the
HMO’s Group Medicare Advantage membership in the aggregate. HMO shall refund to the Group any amounts due in accordance with this Exhibit I-C and Addendum I-C-1 in the form of an offset against Premium, in one lump sum within ninety (90) days following the applicable Settlement Period. However, if the Agreement has been terminated or is at the end of its term, HMO will repay the amount in a lump sum within five (5) months following the end of the applicable Settlement Period.

2. HMO will be obligated to measure its service performance but will not be obligated to refund the Group based thereon until the Agreement has been executed and is on file with HMO.

3. HMO will not be obligated to measure its service performance and will not be obligated to refund the Group or provide reporting as set forth in Exhibit I-D based thereon for any portion of Settlement Period in which the Group:
   a. Fails to provide HMO with timely changes in enrollment or Membership information or any other reports or information as may be necessary for HMO to perform its administrative duties, including but not limited to identification or certification of claimants eligible for benefits, dates of eligibility, number of Retirees and Dependents covered under HMO, or
   b. Fails to pay Premiums in accordance with the terms in the Agreement,
   c. Membership falls below a threshold of 900 enrolled City of Houston Members.

4. If for any reason there is a significant change in the benefit structure or the administrative procedures of the HMO Coverage offered by HMO during any Settlement Period, HMO reserves the right to modify the level of performance and/or the medical Premiums at risk in this Exhibit I-C and Addendum I-C-1, provided Group agrees to modifications of medical Premium at risk.

5. HMO will not be obligated to measure any Service Performance Standard impacted by changes requested in writing by the Group during the time period required to modify the HMO system and to complete all other tasks necessary to achieve the same qualitative standard of execution that existed before the change was requested. All changes or Amendments must be submitted to HMO in accordance with the notice provisions of the Agreement.
   a. If either party desires to utilize an outside auditing firm to perform an audit, both parties must mutually agree as to the selection of such audit firm. The audit will be performed at the expense of whichever party has requested the outside auditing firm. If HMO does not approve the outside auditing firm requested by the Group, HMO may elect to require the Group to use HMO’s designated Public Accounting firm to perform the audit at the Group’s expense. All such audits by outside auditing firms shall be subject to HMO’s external review procedures and guidelines in existence at the time such audit is performed, a copy of which shall be furnished to the Group, upon request, prior to the commencement of any audit.
## ADDENDUM I-C-1
### PERFORMANCE GUARANTEES

<table>
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<tr>
<th>Service Level</th>
<th>Measurement</th>
<th>Service Level Target</th>
<th>Monthly Fees at Risk</th>
<th>Frequency of Measurement &amp; Assessment*</th>
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<tr>
<td>Implementation and Go Live Dates</td>
<td>Measured and reported no later than one month after the initial go-live date.</td>
<td>100% of MA services will take effect and be fully operational on the go live date(s) as specified in the Contract.</td>
<td>$_______ for the first day and $_______ for each subsequent calendar day the deadline that medical claims administrative services are not fully operational.</td>
<td>One-time</td>
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<td>All MA services shall take effect/ go live and be fully operational on the initial go-live date as specified in the Contract. (excluding ID cards). The go-live date is January 1.</td>
<td>Measured and reported no later than one month after the initial go-live date.</td>
<td>100% of MA services will take effect and be fully operational on the go live date(s) as specified in the Contract.</td>
<td>$_______ for the first day and $_______ for each subsequent calendar day the deadline that medical claims administrative services are not fully operational.</td>
<td>Annually</td>
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### Claims Processing

| Financial accuracy of claims processed | To determine the financial accuracy rate, the total payment amount reviewed minus the absolute value of overpayments and underpayments is divided by the total amount reviewed. | 99.5% or greater | $_______ for each tenth of a percentage below the standard. $_______ annual maximum. HMO will reimburse the City’s retirees 100% of the value of the error(s) if the HMO’s error results in a loss to Medicare-eligible retirees and their Medicare-eligible dependents. If the HMO’s error results in a loss to HMO, the City will not be responsible for making HMO whole for the resulting loss. Additionally, $_______ per day will be assessed, measured from the date HMO was notified, or self-identified the error until the date is accurately corrected in HMO’s system. | Measured Quarterly and Assessed Annually |

<p>| Claims Processing: Accurately implement Benefits or Program Changes | HMO will accurately and correctly implement and administer any benefit or program changes. | 100% | HMO will reimburse the City's retirees 100% of the value of the error(s) if the HMO's error results in a loss to Medicare-eligible retirees and their Medicare-eligible dependents. If the HMO's error results in a loss to HMO, the City will not be responsible for making HMO whole for the resulting loss. Additionally, $_______ per day will be assessed and measured from the date HMO was notified, or self-identified the error until the date is accurately corrected in HMO's system. | Measured ongoing per occurrence and assessed Annually |</p>
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<tr>
<th>Service Level</th>
<th>Measurement</th>
<th>Service Level Target</th>
<th>Monthly Fees at Risk</th>
<th>Frequency of Measurement &amp; Assessment</th>
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<td>Customer Service</td>
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<td>$_________ for each percentage point below the threshold for a month, measured separately for IVR and live MSR inbound calls. $_________ annual maximum.</td>
<td>Measured Monthly and Assessed Annually</td>
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<tr>
<td>Average Speed of Answer (ASA)</td>
<td>The response level must be maintained each month. The average speed of answer will be measured by HMO's standard internal call reports produced by HMO's automated phone system. These reports shall be submitted to the City monthly and measured &amp; summarized in quarterly reports.</td>
<td>95% of all inbound City specific Member calls selecting the IVR will be answered within 10 seconds or less on average, and 30 seconds for member calls selecting a live Member Service Representative (MSR). This excludes calls abandoned before answering.</td>
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<tr>
<td>Telephone Abandonment Rate</td>
<td>The abandonment rate will be measured by HMO’s standard internal call reports for City-specific calls produced by HMO’s automated phone system for all member calls. These reports shall be submitted to the City monthly for monitoring purposes and summarized in quarterly reports.</td>
<td>Average call abandonment rate will be equal to or less than 3%.</td>
<td>$_________ for each percentage point above the threshold, measured on a monthly basis. $_________ annual maximum.</td>
<td>Measured Monthly and Assessed Annually</td>
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<td>Communications</td>
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<tr>
<td>Approval of Communications</td>
<td>Correspondence and information (whether written, electronic, telephonic, or in any other medium or form) developed by HMO and intended for Members, (e.g., open enrollment materials, network changes) must be reviewed and approved by the City prior to dissemination. This standard will be measured quarterly if any communications materials were developed during the previous quarter.</td>
<td>HMO will submit correspondence and information to the City for review and approval prior to dissemination.</td>
<td>$_________ per occurrence of communication materials being released without the City's review and approval. $_________ annual maximum.</td>
<td>Measured Quarterly and assessed Annually</td>
</tr>
<tr>
<td>Reporting</td>
<td>HMO must create and generate an electronic file of claims utilization and cost in a mutually agreed upon format. The report shall be submitted by the 15th Business day of the month following the end of quarter. Report shall be completed as described in the RFP.</td>
<td>HMO will provide an accurate report by the 15th Business day of the month following the end of a quarter. This report shall include at least the following data elements: • Members • Allowed Claims • Paid Claims • Member Cost Sharing • Pharmacy Rebates • Pharmacy Manufacturer Discount • Pharmacy Federal Reinsurance • CMS Revenue • CMS Risk Scores • disenrollment Report with Reason • Disease Management Enrollment by Program</td>
<td>$_________ per day for each business day that the standard is not met.</td>
<td>Measured Quarterly and assessed Annually</td>
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<td>HMO must provide January and July MMR Reports</td>
<td>The January MMR shall be submitted by the end of January. The July MMR shall be submitted by the end of July.</td>
<td>HMO will provide accurate MMR reports by the last day of the month of January and July, as appropriate.</td>
<td>$_________ per day for each business day that the standard is not met.</td>
<td>Measured Semiannually and assessed Annually</td>
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<tr>
<td>Service Level</td>
<td>Measurement</td>
<td>Service Level Target</td>
<td>Monthly Fees at Risk</td>
<td>Frequency of Measurement &amp; Assessment*</td>
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<td>Eligibility</td>
<td>Initial and Open Enrollment eligibility files will be loaded within 5 business days of receipt. Files must be received by 12:00 midnight EST; otherwise, written notification of the file delivery (off schedule) must be provided and receipt confirmed by HMO. If the file is received after 12:00 midnight EST the guarantee period commences upon file receipt.</td>
<td>Loaded accurately, in use, and notification transmitted to the City within 5 business days of receipt.</td>
<td>$_______ per day for each business day that the standard is not met. $_______ annual maximum.</td>
<td>Annually</td>
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<td>Eligibility updates (monthly)</td>
<td>Monthly update eligibility files will be loaded within 24 hours of receipt. Files must be received by 12:00 midnight EST; otherwise, written notification of the file delivery (off schedule) must be provided and receipt confirmed by HMO. If the file is received after 12:00 midnight EST the guarantee period commences upon file receipt.</td>
<td>Loaded accurately, in use, and notification transmitted to the City within 24 hours of receipt.</td>
<td>$_______ per business day the standard is not met. $_______ annual maximum</td>
<td>Measured Monthly and Assessed Annually</td>
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<tr>
<td>Eligibility updates (daily)</td>
<td>Daily update eligibility files will be loaded within 12 hours of receipt. Files must be received by 12:00 midnight EST; otherwise, written notification of the file delivery (off schedule) must be provided and receipt confirmed by HMO. If the file is received after 12:00 midnight EST the guarantee period commences upon file receipt.</td>
<td>Loaded accurately, in use, and notification transmitted to the City within 12 hours of receipt. Measured daily and assessed monthly.</td>
<td>$_______ per hour that the standard is not met. $_______ annual maximum</td>
<td>Measured Daily and Assessed Annually</td>
</tr>
<tr>
<td>ID Cards</td>
<td>100% of Members will have received accurate ID cards that are postmarked within 10 Business days of HMO’s receipt of the eligibility extract from each year’s open enrollment.</td>
<td>100% of Members will have received accurate ID cards that are postmarked within 10 Business days of HMO’s receipt of the eligibility extract from each year’s open enrollment.</td>
<td>$_______ per business day the standard is not met.</td>
<td>Measured and Assessed Annually</td>
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**Satisfaction**
### Client Satisfaction

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<thead>
<tr>
<th>Achievement</th>
<th>90% satisfaction or better with the implementation process.</th>
<th>$________ per year for each percentage point below the threshold for a month.</th>
<th>Measured Quarterly and Assessed Annually</th>
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<tr>
<td>Description</td>
<td>Achieve satisfaction (defined as “top two-box” satisfaction/ approval using an approved standard 5 pt. survey tool) on a survey completed by the Group assessing satisfaction with the client services team, the medical management team reporting and analytics. Submit survey to the Group’s management team within thirty business days after the end of each Quarter.</td>
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<td>Satisfaction rate will be a minimum of 90%</td>
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### Member Satisfaction

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<th>Achievement</th>
<th>$________ per day for each business day that the standard is not met.</th>
<th>Measured Monthly and Assessed Annually</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>Achieve minimum satisfaction rate of 90% by respondents to an approved member satisfaction survey program (defined as “top two-box” satisfaction/ approval using an approved standard 5 pt. survey tool); based on the City’s specific results and sent to all participants. Submit survey results to the Group within sixty business days after the end of each Calendar Year.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HMO will provide an accurate report by the 15th Business day of the month following the end of a quarter.</td>
<td></td>
</tr>
</tbody>
</table>

### Additional Reporting

<table>
<thead>
<tr>
<th>Achievement</th>
<th>$________ per year</th>
<th>Measured Quarterly and Assessed Annually</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>Timely Quarterly Reporting for MWBE Compliance and Evidence of Good Faith Effort</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Quarterly MWBE reports shall be submitted by the 15th Business day of the month following the end of a quarter, in a mutually agreed upon format.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HMO will provide an accurate report by the 15th Business day of the month following the end of a quarter.</td>
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</tr>
<tr>
<td></td>
<td>Timely Pay or Play Quarterly Compliance Reporting</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Quarterly Pay or Play reports shall be submitted by the 15th Business day of the month in which the quarter ends, in a mutually agreed upon format.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HMO will provide an accurate report by the 15th Business day of the month in which the quarter ends.</td>
<td></td>
</tr>
<tr>
<td>Total Performance Guarantee per year in the aggregate</td>
<td>$________ per year</td>
<td></td>
</tr>
</tbody>
</table>

*Each penalty will be assessed per measurement period.*

The foregoing is subject to all of the following terms and conditions:

1. **HMO’s performance under the service performance standards will be reported by HMO at the end of each quarter and Settlement Period, within sixty (60) days after the end of the applicable quarter or Settlement Period. Performance under each standard will be considered separately.**

2. **If HMO is found to be in material breach of a standard, HMO agrees to repay the amount at risk that is allocated to that standard, in the form of an offset against Premium, in one (1) lump sum payment at the end of the applicable settlement period. However, if the Agreement has been terminated or is at the end of its term, HMO will repay the amount in a lump sum within five (5) months following the end of the applicable Settlement Period.**

3. **Repayment of the amounts specified herein shall not be the City of Houston’s sole remedy in the event that HMO materially breaches one (1) or more of the service performance standards and shall not prejudice the City against termination for cause as provided for in the Agreement.**

4. **All performance results calculated as a percentage will be rounded to the nearest one-tenth (1/10) of one (1) percent (.1%). If the second decimal numeral is five (5) or greater, then the first decimal numeral will increase by one (1). If the second decimal numeral is four (4) or less, the first decimal numeral shall remain unchanged.**
EXHIBIT “I-D”

HMO MANAGEMENT REPORTS

HMO shall provide the following reports to Group. Such reports will provide data necessary for Group to analyze their medical costs (professional and institutional), prescription costs, catastrophic costs, disease management effectiveness as well as cost analysis by provider specialty. In addition, HMO can devise and develop various Management reports as requested by the Group.

Quarterly Reports:

(a) Total claims report (professional, institutional, prescription drug)
(b) Top 25 primary diagnoses by health benefits paid; to include diagnosis description; claimant count, paid amount
(c) Top 25 primary diagnoses by volume of claims paid to include diagnosis description, claimant count, paid amount
(d) Top 10 hospitals based on inpatient benefits paid; to include # of admissions and benefits paid
(e) Total Prescription drug claims paid per quarter; to include generic, non-generic, mail order, retail, # of scripts and total dollars paid
(f) Top 25 prescriptions ranked by benefits paid. To include drug name, # scripts filled per each drug and benefits paid per each prescription
(g) Top 25 prescriptions ranked by volume; to include drug name, # scripts filled per each drug and benefits paid per each prescription
(h) Per member per month professional costs by provider specialty report.
(i) Per member per month institutional costs by institutional service category report
(j) Top claimants over $25,000 (de-identified Member listing)
(k) Enrollment / Disenrollment Reconciliation Report – by Month
(l) Disenrollment report (reason for disenrollment).
(m) Encounter Data
(n) Out-of-network utilization report
(o) Disease management enrollment by program / disease category
(p) Emergency room utilization report
(q) HCC Analysis
(r) Summary – HCC Analysis
(s) MWBE reports
(t) Pay or Play (POP) reports
(u) Semi-annual Monthly Membership Report (MMR) as provided to CMS
(v) Semi-annual Model Output Report (MOR) as provided to CMS
(w) Ad hoc reports as required

Annual Reports:

(a) Loss ratio reports and other actuarial reports as documentation for subsequent years’ rate setting (provide examples of renewal documentation)
(b) Annual satisfaction survey (provide examples of satisfaction surveys, including comments from dissatisfied enrollees)
EXHIBIT “I-E”
SUPPLEMENTAL TERMS & CONDITIONS

I. DEFINITIONS

Except as expressly otherwise provided in the Agreement or unless the context otherwise requires, the following words and phrases used in this Agreement shall have the following meanings:


“Calendar Year” means the period beginning 12:00:01 a.m. central time January 1 of any year and ending 11:59:59 p.m. Central Standard Time December 31 of the same year.

“Contract Year” means the initial Contract Year, which runs from January 1, 2021 through December 31, 2023 and the period of twelve (12) months commencing on the effective date of any subsequent renewal and each twelve (12) month period thereafter, unless otherwise terminated as hereinafter provided.

“Director” means the Director of the City of Houston Human Resources Department or such other person as he or she designates.

“Chief Procurement Officer” (“CPO”) means the Chief Procurement Officer of the City of Houston, as set forth in Chapter 15 of the Houston Code of Ordinances.

“Group” means the City of Houston.

“HMO” means COMPANY NAME, a Texas _______________ company organized as a health maintenance organization and licensed by the Texas Department of Insurance.

“Member” (or “Plan Member” or “Group Member”) means a person with Medicare who is eligible to get Coverage Services, who has enrolled in Plan and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (“CMS:”).

“Member Effective Date” means the first date on which an individual Member is entitled to receive benefits under the Plan.

“Party” or “Parties” means one or all of the entities set out in the Preamble who are bound by this Agreement.

“Termination Date” means (a) for a Member, the last date on which the Member is eligible for Coverage, or (b) for the Group, the last date on which this Agreement is in force.

II. TERMINATION

A. Termination of Members

1. No Coverage will be provided to any Member if the Group fails to pay the Premium for the first month of this Agreement by February 15, 2021. This Agreement may be terminated for non-payment of Premium if the Group fails to pay Premiums for the second or subsequent months by the end of the thirty (30) day grace period. If so terminated, a Member’s Termination Date shall be the day following the expiration of the grace period and the Member shall be liable for the cost of services received during the grace period.

2. For any Member who ceases to be eligible under the EOC or this Agreement the Termination Date shall be the date such eligibility ceases.
3. If the Member is an inpatient on the Termination Date of this Agreement, benefits will terminate for such Member at 12:01 a.m. on the day next following the Termination Date. However, in the event that Group replaces the Plan with another group health care plan or program of any kind, HMO shall cooperate with such other plan or program in the orderly transition of covered care for Members who are then inpatients.

4. Termination shall occur if Member is involved in fraudulent, abuse or misuse of Identification Card.

5. For a Dependent who qualifies as a Survivor, the Termination Date shall be the earliest of the following dates:
   a. As to any Dependent child of the deceased Subscriber, the last day of the Plan month in which such Dependent child ceases to be a Dependent as defined by the Plan;
   b. The last day of the Plan month in which the Dependent becomes eligible for coverage hereunder as an Eligible Employee, or becomes eligible for coverage under Medicare or any other employer-sponsored policy, plan or program of group health coverage; or
   c. The date of termination of the Plan.

B. Termination of Member Coverage

1. Member’s Coverage will terminate for any of the following reasons:
   a. this Agreement terminates;
   b. Member voluntarily disenrolls from the Plan.

2. The Member no longer lives in the Service Area, or if the Member resides temporarily outside the Service Area for more than six (6) consecutive months;

3. The Member becomes covered becomes covered under an alternative Medicare Advantage Plan;

4. HMO’s contract with CMS terminates;

5. Member’s death.

6. Non-payment of Premium;

7. if Member is involved in fraudulent, abuse or misuse of Identification Card;

9. The date Group terminates the Plan; or

10. Upon dissolution, insolvency or bankruptcy of HMO.

C. Termination of this Agreement

1. The Group may terminate this Agreement for cause:
   a. Ninety (90) days after delivery of written notice by Group to HMO, with a copy of the notice to the CPO, upon material failure of HMO to comply with this Agreement, unless such failure described in the notice is cured within said ninety (90) days; provided, however, such termination shall be effective at the end of the month following the
expiration of such ninety (90) day period.

b. Upon 90 days written notice to the HMO, with a copy of the notice to the CPO, if HMO makes a material change to any provision required by law to be disclosed to Group or Members; provided, however, such termination shall be effective at the end of the month following the expiration of such ninety (90) day period.

c. HMO becomes insolvent;

d. All or a substantial part of HMO’s assets are assigned for the benefit of its creditors; or

e. a receiver or trustee is appointed for HMO.

2. The Group may terminate this Agreement for convenience:

The Group may terminate this Agreement at any time by giving ninety (90) days written notice to HMO, with a copy of the notice to the CPO; provided, however, such termination shall be effective at the end of the month following the expiration of such ninety (90) day period (together the “notice period”). The Group’s right to terminate this Agreement for convenience is cumulative of all rights and remedies which exist now or in the future.

On receiving the notice, HMO shall, unless the notice directs otherwise, discontinue all services and cancel Coverage under this Agreement as of the day following the expiration of the notice period. As soon as practicable after receiving the termination notice, HMO shall submit an invoice showing in detail the Premiums due under this Agreement up to the termination date. The Group shall pay any Premiums due HMO through the end of the notice period, unless the Premiums exceed the allocated funds remaining under this Agreement.

TERMINATION OF THIS AGREEMENT AND RECEIPT OF PREMIUMS FOR COVERAGE IN EFFECT ARE HMO’S ONLY REMEDIES FOR THE GROUP’S TERMINATION FOR CONVENIENCE, WHICH DOES NOT CONSTITUTE A DEFAULT OR BREACH OF THIS AGREEMENT. HMO WAIVES ANY CLAIM (OTHER THAN ITS CLAIM FOR PAYMENT AS SPECIFIED IN THIS SECTION), IT MAY HAVE NOW OR IN THE FUTURE FOR FINANCIAL LOSSES OR OTHER DAMAGES RESULTING FROM THE GROUP’S TERMINATION FOR CONVENIENCE.

3. HMO may terminate the Group upon ninety (90) days written notice, unless such failure described in the notice is cured within said ninety (90) days, in the case of:

a. The Group has committed fraud or intentional misrepresentation of a material fact to HMO; or

b. No Members live in the Service Area; or

3. Noncompliance by the Group with, or changes in, material provisions of the Plan relating to the Group’s contribution toward Premium and eligibility requirements for membership in the Group, which requirements are, in accordance with federal laws, applicable to the offering of a group health plan in the large group market.

4. HMO may terminate the Group upon thirty (30) days’ written notice in the case of non-payment of Premium through the end of the thirty (30) day grace period, and if so terminated, all Coverage will be canceled as of the day following the expiration of the grace period; however Members shall be financially responsible for reimbursement of the claims of Providers for Covered Services provided to Members during and subsequent to the grace period.
5. HMO may terminate the Group upon one hundred and eighty (180) days’ written notice if HMO ceases to offer Coverage in the Service Area in accordance with state or federal law.

6. Except as specified above, HMO shall not have the right to terminate this Agreement.

7. The fact that Members are not notified by Group or HMO of the termination of their Coverage due to the termination of the Agreement shall not be deemed to be the continuation of a Member’s Coverage beyond the date Coverage terminates.

D. Notification of Members’ Ineligibility

Group shall notify HMO within thirty (30) days after a Member ceases to be eligible for benefits under this Agreement. Failure to do so will make the Group liable for any expenses incurred by the Plan, whether or not paid, due to the Group’s failure to notify.

E. Refunds/Credits

If the Coverage of a Member is terminated, Premium payments received on account of the terminated Member applicable to periods after the Effective Date of termination shall be refunded or credited to Group, at HMO’s sole option, within thirty (30) days, and neither HMO nor the Group shall have any further liability under this Agreement with respect to such Member. The maximum refund or credit allowable is equal to two (2) months of Premium applicable to such terminated Member, which shall include the month during which HMO is notified in writing of such termination and the next previous month, if applicable. Any claim for refund or credit by Group must be made within sixty (60) days from the Effective Date of termination of the Member’s Coverage or otherwise such claims shall be deemed waived.

F. Health Status Termination.

Coverage will not be terminated on the basis of a Member’s health status or health care needs, nor because a Member has exercised the Member’s rights under the Appeals and Grievance process as set forth in the Evidence of Coverage.

III. PAYMENT REQUIREMENTS

1. The required payments for the services and benefits made available hereunder are set forth in this Agreement and shall be due and payable in advance on or before the first day of the month for which each such payment is made or is to be made. No proration of the payments will be made under this Agreement and change in Members’ status shall be effective only on the first day of each month.

2. Interest on late Premiums from the date such Premiums were due will be charged at a rate not to exceed the maximum allowable by law. Unpaid interest will be due and payable upon notice thereof to Group from HMO. However, no interest shall accrue until thirty (30) days after the Group is invoiced for the late Premium.

IV. IDENTIFICATION CARDS

1. HMO shall issue identification cards for the Members.

2. Possession of an HMO identification card in and of itself confers no rights to services or other benefits. The holder of the card and the name on the card must be the same and the holder of the card must be, in fact, a Member on whose behalf all applicable charges under this Agreement have actually been paid. Any person receiving services or other benefits to which he or she is not entitled pursuant to this Agreement, through use of an HMO identification card or otherwise, shall be chargeable therefore at the actual cost of services rendered. If any Member permits the use of his or her HMO identification card by any other person, such card may be recalled and invalidated by HMO, and all rights of such Member pursuant to this
V. AMENDMENT OF AGREEMENT

1. This Agreement may be amended at any time, without the consent of the Members, or any other person having beneficial interest in it, upon written request made by the Group and agreed to by HMO. Any such Amendment shall be without prejudice to any claim arising prior to the date of such Amendment.

2. HMO may alter or revise the terms of this Agreement and/or any Evidence of Coverage including the Summary of Benefits and Premiums, if necessary in order to comply with state, federal or local law. Specifically, upon mutual agreement, HMO and Group, by and through Group’s Human Resources Director or such other person with similar authority, may alter or revise the terms of this Agreement and/or any Evidence of Coverage including the Summary of Benefits and Premiums as a result of changes implemented by Group or HMO. In the event of such alteration or revision, including any increase in Premium due to additional benefit enhancements, mandated benefits or expanded eligibility criteria, or other changes in laws specifically applicable to health maintenance organizations or Medicare Advantage plans that raise HMO’s cost of providing benefits under the Plan, HMO shall give the Group at least sixty (60) days prior written notice, which notice shall be considered to have been given when mailed to the Group at the address shown on the records of HMO. The alteration or revision shall become effective on the date contained in the notice, unless the Group provides written notice within fifteen (15) days after giving of notice by HMO of its intention to terminate this Agreement. Any increase in Premium must be limited to actual demonstrated cost increases and shall be approved by the Group’s Human Resources Director or such other person with similar authority.

3. Furthermore, the parties acknowledge and agree that HMO may alter, amend, or otherwise modify the Member’s Evidence of Coverage to increase benefits, decrease Copayments, Coinsurance, or otherwise provide Members with additional services or benefits (collectively “Enhanced Benefits”) by providing Group’s Human Resources Director with not less than sixty (60) days prior written notice; provided, however, that Group shall not be obligated to pay HMO additional Premiums related directly to such Enhanced Benefits.

VI. LIMITATIONS

The rights of Members and obligations of HMO, participating physicians, participating Hospitals and providers under this Agreement are subject to the following limitations:

A. Major Disaster or Epidemic.
In the event of any major disaster or epidemic that would severely limit the ability of participating physicians, providers and/or Hospitals to provide health care services on a timely basis, participating physicians, participating Hospitals and providers shall, in good faith, use their best efforts to render the benefits and services covered insofar as practical according to their, best judgment and within the limitation of such facilities and personnel as are then available. If HMO participating physicians, participating Hospitals and providers shall have, in good faith, used their best efforts to render benefits and services in the aforesaid manner, they shall have no further liability or obligation for delay or failure to provide such benefits and services due to a shortage of available facilities or personnel resulting from such disaster or epidemic.

B. Circumstances Beyond HMO or Participating Physician or Provider Control.
In the event that, due to circumstances not reasonably within the control of HMO, participating physicians or providers such as the complete or partial destruction of facilities because of Act of God war (whether declared or not),, riot, civil insurrection, civil disturbance, act of terrorism or acts of foreign or domestic
enemies, invasion, work stoppage, embargo and/or strike, and/or industrial dispute, court order, governmental intervention, change in law, non performance by the other party or any third party, or failure of telecommunications equipment, or the rendering of benefits and services covered hereunder is delayed or rendered impractical, neither HMO nor any participating physician or provider shall have any liability or obligation on account of such delay or such failure to provide such benefits and services if they shall have, in good faith, used their best efforts to render the benefits and services covered insofar as practical according to their best judgment and within the limitation of such facilities and personnel as are then available.

C. Limitations as Set Out in the Evidence of Coverage and Summary of Benefits.
The benefits provided in the Plan are also limited by the limitations and exclusions as set out in the Evidence of Coverage.

D. Non-Covered Services.
HMO shall not be responsible for the reimbursement for services or treatment of complications that result from any non-covered service, procedure or treatment. HMO shall not be responsible for prescription drugs and/or medications related to any non-covered service, procedure or treatment.

VII. RELEASE

HMO AGREES TO AND SHALL RELEASE THE GROUP, ITS AGENTS, EMPLOYEES, OFFICERS, AND LEGAL REPRESENTATIVES (COLLECTIVELY THE “GROUP”) FROM ALL LIABILITY FOR INJURY, DEATH, DAMAGE, OR LOSS TO PERSONS OR PROPERTY SUSTAINED IN CONNECTION WITH OR INCIDENTAL TO PERFORMANCE UNDER THIS AGREEMENT, EVEN IF THE INJURY, DEATH, DAMAGE, OR LOSS IS CAUSED BY THE GROUP'S SOLE OR CONCURRENT NEGLIGENCE AND/OR THE GROUP'S STRICT PRODUCTS LIABILITY OR STRICT STATUTORY LIABILITY. HMO HEREBY COVENANTS AND AGREES NOT TO SUE THE GROUP FOR ANY CLAIMS, DEMANDS, OR CAUSES OF ACTION DIRECTLY OR INDIRECTLY RELATED TO ITS RELEASE UNDER THIS SECTION. FOR THE AVOIDANCE OF DOUBT, THIS COVENANT NOT TO SUE DOES NOT APPLY TO CLAIMS FOR BREACH OF THIS AGREEMENT.

VIII. INDEMNIFICATION

HMO AGREES TO AND SHALL DEFEND, INDEMNIFY, AND HOLD THE GROUP, ITS AGENTS, EMPLOYEES, OFFICERS, AND LEGAL REPRESENTATIVES (COLLECTIVELY THE “GROUP”) HARMLESS FOR ALL CLAIMS, CAUSES OF ACTION, LIABILITIES, FINES, AND EXPENSES (INCLUDING, WITHOUT LIMITATION, REASONABLE ATTORNEYS’ FEES, COURT COSTS, AND ALL OTHER DEFENSE COSTS AND INTEREST) FOR INJURY, DEATH, DAMAGE, OR LOSS TO PERSONS OR PROPERTY SUSTAINED IN CONNECTION WITH OR INCIDENTAL TO PERFORMANCE UNDER THIS AGREEMENT INCLUDING, WITHOUT LIMITATION, THOSE CAUSED BY:

1. HMO’S AND/OR ITS AGENTS’, EMPLOYEES’, OFFICERS’, DIRECTORS’, CONTRACTORS’, OR SUBCONTRACTORS’ (COLLECTIVELY IN NUMBERED PARAGRAPHS 1-3, “HMO”) ACTUAL OR ALLEGED NEGLIGENCE OR INTENTIONAL ACTS OR OMISSIONS;

2. THE GROUP’S AND HMO’S ACTUAL OR ALLEGED CONCURRENT NEGLIGENCE, WHETHER HMO IS IMMUNE FROM LIABILITY OR NOT; AND

3. THE GROUP’S AND HMO’S ACTUAL OR ALLEGED STRICT PRODUCTS LIABILITY OR STRICT STATUTORY LIABILITY, WHETHER HMO IS IMMUNE FROM LIABILITY OR NOT.
HMO SHALL DEFEND, INDEMNIFY, AND HOLD THE GROUP HARMLESS DURING THE TERM OF THIS AGREEMENT AND FOR FOUR YEARS AFTER THE AGREEMENT TERMINATES. HMO’S INDEMNIFICATION IS LIMITED TO $1,000,000 PER OCCURRENCE. HMO SHALL NOT INDEMNIFY THE CITY FOR THE CITY’S SOLE NEGLIGENCE.

IX. SUBCONTRACTOR’S INDEMNITY

HMO SHALL REQUIRE ALL OF ITS SUBCONTRACTORS (AND THEIR SUBCONTRACTORS) TO RELEASE AND INDEMNIFY THE GROUP TO THE SAME EXTENT AND IN SUBSTANTIALLY THE SAME FORM AS ITS RELEASE AND INDEMNITY TO THE GROUP.

X. INDEMNIFICATION PROCEDURES

1) Notice of Claims. If the Group or HMO receives notice of any claim or circumstances which could give rise to an indemnified loss, the receiving party shall give written notice to the other party within 30 days. The notice must include the following:
   (a) a description of the indemnification event in reasonable detail,
   (b) the basis on which indemnification may be due, and
   (c) the anticipated amount of the indemnified loss.

This notice does not estop or prevent the Group from later asserting a different basis for indemnification or a different amount of indemnified loss than that indicated in the initial notice. If the Group does not provide this notice within the 30-day period, it does not waive any right to indemnification except to the extent that HMO is prejudiced, suffers loss, or incurs expense because of the delay.

2) Defense of Claims
   (a) Assumption of Defense. HMO may assume the defense of the claim at its own expense with counsel chosen by it that is reasonably satisfactory to the City Attorney. HMO shall then control the defense and any negotiations to settle the claim, subject to the City Attorney’s consent or agreement to the settlement, which consent or agreement shall not unreasonably be withheld. Within 10 days after receiving written notice of the indemnification request, HMO must advise the Group as to whether or not it will defend the claim. If HMO does not assume the defense, the Group shall assume and control the defense, and all defense expenses constitute an indemnification loss.

   (b) Continued Participation. If HMO elects to defend the claim, the Group may, at its own cost, retain separate counsel to participate in (but not control) the defense and to participate in (but not control) any settlement negotiations.

XI. PAYMENT OF SUBCONTRACTORS

1) In accordance with the Texas Prompt Payment Act, HMO shall make timely payments to all persons and entities supplying labor, materials, or equipment by, through, or under HMO in the performance of this Agreement.

2) IN ACCORDANCE WITH THE TEXAS PROMPT PAYMENT ACT, HMO SHALL MAKE TIMELY PAYMENTS TO ALL PERSONS AND ENTITIES THAT HMO HAS HIRED TO SUPPLY LABOR, MATERIALS, OR EQUIPMENT FOR THE PERFORMANCE OF THIS AGREEMENT. HMO SHALL DEFEND AND INDEMNIFY THE GROUP FROM ANY CLAIMS OR LIABILITY ARISING OUT OF HMO’S FAILURE TO MAKE THESE PAYMENTS REGARDLESS OF WHETHER THE FAILURE TO PAY IS CAUSED BY, OR CONTRIBUTED TO, IN
WHOLE OR IN PART, THE NEGLIGENCE (WHETHER SOLE, JOINT OR CONCURRENT), OR GROSS NEGLIGENCE (WHETHER SOLE, JOINT OR CONCURRENT), STRICT LIABILITY, INTENTIONAL ACTS, OR OTHER CONDUCT OR LIABILITY OF THE GROUP, ITS AGENTS, EMPLOYEES, OFFICERS, AND LEGAL REPRESENTATIVES.

3) Failure of HMO to pay its employees as required by law shall constitute a default under this Agreement, for which HMO and its surety shall be liable on HMO’s performance bond if HMO fails to cure the default as provided under this Agreement.

XII. LICENSES AND PERMITS

HMO shall obtain, maintain, and pay for all licenses, permits, and certificates including all professional licenses required by any statute, ordinance, rule, or regulation for the performance under this Agreement. HMO shall immediately notify the Director of any suspension, revocation, or other detrimental action against its license.

XIII. MEDICARE SECONDARY PAYER REQUIREMENTS.

Generally. HMO and the Group agree to comply with all Medicare Secondary Payer (“MSP”) Mandates that apply to Group, the Plan and HMO (“MSP Requirements”).

XIV. MISCELLANEOUS

A. Records and Information

1. HMO shall have the right, at any reasonable time, to examine the Group’s records, including payroll records of employers having employees covered through the Group, with respect to eligibility and monthly payments under this Agreement.

2. Information from medical records of Members and information received from physicians or providers or facilities incident to the physician-patient provider-patient or facility-patient relationship shall be kept confidential in accordance with all applicable state and federal requirements including but not limited to HIPAA. Such information, except as reasonably necessary in connection with the administration of this Agreement, or as required by law, may not be disclosed without the written consent of the Member.

3. For the purposes of administering the Plan, HMO may, to the extent legally allowable and without further consent of or notice to any Member, release to or obtain from any insurance company or other organization or person any information, with respect to any person, that HMO deems to be necessary for such purposes. Any person claiming benefits under the Plan shall furnish to HMO such information as may be necessary to implement the Plan.

4. The Application completed by Member authorizes any physician, health professional or facility to make such records, photographs or information available to HMO as HMO may reasonably request on behalf of Member.

B. Telephone.
The telephone number of HMO, which may be subject to change from time to time, is ______________. The facsimile number of HMO is ______________.

C. Assignment.
Neither party to this Agreement shall assign or transfer its rights, duties or obligations under this Agreement without the prior written consent of the other party. Other than as expressly provided
by this Agreement, any attempted assignment, by operation of law or otherwise, shall be void and unenforceable. This Agreement shall inure to the benefit of and shall bind the successors and permitted assignees of the parties hereto. The benefits to a Member under this Agreement are personal to the Member and are not assignable or otherwise transferable.

D. Severability.
If any part of this Agreement is for any reason found to be unenforceable, all other parts remain enforceable unless the result materially prejudices either Party.

E. Incorporation by Reference.
The Evidence of Coverage, the Application and any Amendments to any of the foregoing attached hereto, form a part of this Agreement as if fully set forth herein. Any direct conflict or ambiguity between this Agreement and the EOC will be resolved under terms most favorable to the Member.

F. Authority.
Any alteration or revision to this Agreement must be in writing, signed by an officer of HMO and an official of Group and attached to the affected form to be valid. No other person has the authority to change this Agreement or to waive any of its provisions.

G. List of Providers of Services.
From time to time, HMO will provide to the Group for dissemination to Members a list of providers who provide the services and benefits covered under this Agreement.

H. Furnishing Information.
Any person claiming or who may claim benefits under the Plan shall facilitate the access of or furnish to HMO such information as may be necessary to implement this Agreement, and HMO may release or obtain such information as needed to implement the provisions of this Agreement.

I. Independent Agents.

1. The relationships between HMO and participating providers and facilities is that of independent contractors. Participating providers and facilities are not agents or employees of HMO nor is HMO an employee or agent of any participating providers and facility. Participating providers and facilities shall maintain the provider/facility-patient relationship with Members and shall be the only parties responsible to Members for the services that they provide.

2. The relationship between HMO and physicians and other health professionals is that of independent contractors. Physicians and health professionals are not agents or employees of HMO, nor is HMO or any employee of HMO an employee or agent of any physician or health professional. Physicians and health professionals shall maintain the physician-patient or health professional-patient relationship with Members.

3. Neither the Group nor any Member thereof is the agent or representative of HMO, and neither shall be liable for any acts or omissions of HMO, its agents or employees, any physician, any provider, or any other person or organization with which HMO has made or hereafter shall make arrangements for the performance of services under this Agreement.

J. Provider Communication.
HMO will not prohibit, attempt to prohibit or discourage any physician or health professional from discussing or communicating to a Member or a Member’s designee any information or opinions regarding the Member’s health care, any provisions of the Plan as it relates to the medical needs of the Member or the fact that the physician or health professional’s contract with the HMO has terminated or that the physician or health professional will no longer be providing services under the HMO.
K. State Law.
If this Agreement contains any provision not in conformity with Texas state law or other applicable laws, it shall not be rendered invalid but shall be construed and applied as if it were in full compliance according to applicable Texas state law and other applicable laws.

L. Incontestability.
All statements made by a Member are considered representations and not warranties. A statement may not be used to void, cancel, or non-renew a Member’s Coverage or reduce benefits unless it is in a written enrollment Application signed by the Member and a signed copy of the enrollment Application has been furnished to the Member. Coverage may only be contested because of fraud or intentional misrepresentation of fact on the enrollment Application.

M. Confidentiality.
Information contained in the medical records of Members and information received from physicians, surgeons, Hospitals or other health professionals incident to the physician-patient relationship or Hospital-patient relationship shall be kept confidential in accordance with applicable law. Information may not be disclosed without the consent of the Member except as may be permitted by applicable law, including HIPAA and any amendments to it, or reasonably necessary by HMO in connection with the administration of this Plan, or in the compiling of aggregate statistical data. Such information that is identifiable with an individual Member may not be disclosed to Group, in connection with the conduct of Appeals or otherwise, without the written consent of the affected Member.

N. Governing Law and Venue.
This Agreement shall be construed and interpreted in accordance with the applicable laws of the State of Texas, to the extent not otherwise superseded by Federal law, and City of Houston. Venue for any disputes relating in any way to this Agreement shall lie exclusively in Harris County, Texas.

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

P. Pay or Play.
The requirements and terms of the City of Houston Pay or Play program, as set out in Executive Order 1-7, as revised from time to time, are incorporated into this Agreement for all purposes. HMO has reviewed Executive Order No. 1-7, as revised, and shall comply with its terms and conditions.

Q. Anti-Boycott of Israel
HMO certifies that HMO is not currently engaged in, and agrees for the duration of this Agreement not to engage in, the boycott of Israel as defined by Section 808.001 of the Texas Government Code.

R. Zero Tolerance Policy for Human Trafficking and Related Activities
The requirements and terms of the City of Houston’s Zero Tolerance Policy for Human Trafficking and Related Activities, as set forth in Executive Order 1-56, as revised from time to time, are incorporated into this Agreement for all purposes. HMO has reviewed Executive Order 1-56, as revised, and shall comply with its terms and conditions as they are set out at the time of the Countersignature Date. HMO shall notify the CPO, City Attorney, and the Director of any information regarding possible violation by HMO or its subcontractors providing services or goods
under this Agreement within 7 days of HMO becoming aware of or having a reasonable belief that such violations may have occurred, have occurred, or are reasonably likely to occur.

S. Inspections and Audits
Group representatives may perform or have performed: (i) audits of HMO’s books and records; and (ii) inspections of all places where work is undertaken in connection with this Agreement. HMO shall keep its books and records available for this purpose for at least three years after this Agreement terminates. If the books and records are located outside of Harris County, Texas, HMO agrees to make them available in Harris County, Texas. This provision does not affect the applicable statute of limitations.

T. Enforcement
The City Attorney or his or her designee may enforce all legal rights and obligations under this Agreement without further authorization. HMO shall provide to the City Attorney all documents and records that the City Attorney requests to assist in determining HMO’s compliance with this Agreement, with the exception of those documents made confidential by federal or State law or regulation.

U. Survival
HMO shall remain obligated to the Group under all clauses of this Agreement that expressly or by their nature extend beyond the expiration or termination of this Agreement, including, but not limited to, the indemnity provisions.

V. Remedies
All rights, powers, and remedies granted to either party by any particular term of the Agreement are in addition to, and not in limitation of, any rights, powers, or remedies that it has under any other term of the Agreement, at common law, in equity, by statute, or otherwise, and all such rights, powers, and remedies may be exercised separately or concurrently, in such order and as often as may be deemed expedient by either party. No delay or omission by either party to exercise any right, power, or remedy shall impair such right, power, or remedy to be construed to be a waiver of any breach or default or any acquiescence therein.

W. Preservation of Contracting Information
The requirements of Subchapter J, Chapter 552, Texas Government Code, may apply to this Agreement and HMO agrees that this Agreement can be terminated if HMO knowingly or intentionally fails to comply with a requirement of that subchapter. If the requirements of Subchapter J, Chapter 552, Texas Government Code, apply to this Agreement, then for the duration of this Agreement (including the initial term, any renewal terms, and any extensions), HMO shall preserve all Contracting Information, as defined by Section 552.003 of the Texas Government Code, related to this Agreement as provided by the records retention requirements applicable to the City pursuant to federal or state law or regulation, city ordinance or city policy, which record retention requirements include but are not limited to those set forth in Chapters 201 and 205 of the Texas Local Government Code and Texas Administrative Code Title 13, Chapter 7. Within five business days after receiving a request from the Director, HMO shall provide any Contracting Information related to this Agreement that is in the custody or possession of HMO. Upon the expiration or termination of this Agreement, HMO shall, at the Director’s election, either (a) provide, at no cost to the City, all Contracting Information related to this Agreement that is in the custody or possession of HMO, or (b) preserve the Contracting Information related to this Agreement as provided by the records retention requirements applicable to the City pursuant to federal or state law or regulation, city ordinance or City policy.

If HMO fails to comply with any one or more of the requirements of this Section, Preservation of
Contracting Information, or Subchapter J, Chapter 552, Texas Government Code, then, in accordance with and pursuant to the processes and procedures set forth in Sections 552.373 and 552.374 of the Texas Government Code, the Director shall provide notice to the HMO and may terminate this Agreement. To effect final termination, the Director must notify HMO in writing with a copy of the notice to the CPO. After receiving the notice, HMO shall, unless the notice directs otherwise, immediately discontinue all services under this Agreement, and promptly cancel all orders or subcontracts chargeable to this Agreement.

X. HMO’s Debt.

IF HMO, AT ANY TIME DURING THE TERM OF THIS AGREEMENT, INCURS A DEBT, AS THE WORD IS DEFINED IN SECTION 15-122 OF THE HOUSTON CITY CODE OF ORDINANCES, IT SHALL IMMEDIATELY NOTIFY THE CITY CONTROLLER IN WRITING. IF THE CITY CONTROLLER BECOMES AWARE THAT HMO HAS INCURRED A DEBT, HE OR SHE SHALL IMMEDIATELY NOTIFY HMO IN WRITING. IF HMO DOES NOT PAY THE DEBT WITHIN 30 DAYS OF EITHER SUCH NOTIFICATION, THE CITY CONTROLLER MAY DEDUCT FUNDS IN AN AMOUNT EQUAL TO THE DEBT FROM ANY PAYMENTS OWED TO HMO UNDER THIS AGREEMENT, AND HMO WAIVES ANY RE COURSE THEREFOR.

HMO SHALL FILE A NEW AFFIDAVIT OF OWNERSHIP, USING THE FORM DESIGNATED BY CITY, BETWEEN FEBRUARY 1 AND MARCH 1 OF EVERY YEAR DURING THE TERM OF THIS AGREEMENT.
EXHIBIT “F”

INSURANCE

1) Risks and Limits of Liability. HMO shall maintain the following insurance coverages in the following amounts:

<table>
<thead>
<tr>
<th>COVERAGE</th>
<th>LIMIT OF LIABILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workers’ Compensation</td>
<td>Statutory for Workers’ Compensation</td>
</tr>
<tr>
<td>Employer’s Liability</td>
<td>• Bodily Injury by Accident $500,000 (each accident)</td>
</tr>
<tr>
<td></td>
<td>• Bodily Injury by Disease $500,000 (policy limit)</td>
</tr>
<tr>
<td></td>
<td>• Bodily Injury by Disease $500,000 (each employee)</td>
</tr>
<tr>
<td>Commercial General Liability: Bodily and Personal Injury; Products and</td>
<td>Bodily Injury and Property Damage, Combined Limits of $1,000,000 each Occurrence,</td>
</tr>
<tr>
<td>Completed Operations Coverage</td>
<td>and $2,000,000 aggregate</td>
</tr>
<tr>
<td>Automobile Liability</td>
<td>$1,000,000 combined single limit for: (i) Any Auto; or (ii) All Owned, Hired, and</td>
</tr>
<tr>
<td></td>
<td>Non-Owned Autos</td>
</tr>
<tr>
<td>Professional Liability (if applicable)</td>
<td>$1,000,000 per occurrence; $2,000,000 aggregate</td>
</tr>
<tr>
<td>Excess Liability Coverage, or Umbrella Coverage, for Commercial General</td>
<td>$1,000,000</td>
</tr>
<tr>
<td>General Liability and Automobile Liability</td>
<td></td>
</tr>
</tbody>
</table>

Aggregate Limits are per 12-month policy period unless otherwise indicated.

2) Insurance Coverage. At all times during the term of this Agreement and any extensions or renewals, HMO shall provide and maintain insurance coverage that meets the Agreement requirements. Prior to beginning performance under the Agreement, at any time upon the Director’s request, or each time coverage is renewed or updated, HMO shall furnish to the Director current certificates of insurance, endorsements, all policies, or other policy documents evidencing adequate coverage, as necessary. HMO shall be responsible for and pay: (i) all premiums; and (ii) any claims or losses to the extent of any deductible amounts. HMO waives any claim it may have for premiums or deductibles against the City, its officers, agents, or employees. HMO shall also require all subcontractors or consultants whose subcontracts exceed $100,000 to provide proof of insurance coverage meeting all requirements stated above except amount. The amount must be commensurate with the amount of the subcontract, but no less than $500,000 per claim.

3.10.3 Form of insurance. The form of the insurance shall be approved by the Director and the City Attorney; such approval (or lack thereof) shall never: (i) excuse non-compliance with the terms of this Section; or (ii) waive or estop the Group from asserting its rights to terminate this Agreement. The policy issuer shall: (i) have a Certificate of Authority to
transact insurance business in Texas; or (ii) be an eligible non-admitted insurer in the State of Texas and have a Best’s rating of at least B+, and a Best’s Financial Size Category of Class VI or better, according to the most current Best’s Key Rating Guide.

3.10.4 Required Coverage. The City of Houston (the “Group”) shall be an Additional Insured under this Agreement, and all policies, except Professional Liability and Worker’s Compensation, shall explicitly name the City of Houston as an Additional Insured. The City of Houston shall enjoy the same coverage as the Named Insured without regard to other Agreement provisions. HMO waives any claim or right of subrogation to recover against the Group, its officers, agents, or employees, and each of HMO’s insurance policies except professional liability must contain coverage waiving such claim. Each policy, except Workers’ Compensation and Professional Liability, must also contain an endorsement that the policy is primary to any other insurance available to the Additional Insured with respect to claims arising under this Agreement. If professional liability coverage is written on a “claims made” basis, HMO shall also provide proof of renewal each year for two years after substantial completion of the Project, or in the alternative: evidence of extended reporting period coverage for a period of two years after substantial completion, or a project liability policy for the Project covered by this Agreement with a duration of two years after substantial completion. All certificates of insurance submitted by HMO shall be accompanied by endorsements for: (i) Additional Insured coverage in favor of the City for Commercial General Liability and Automobile Liability policies; and (ii) Waivers of Subrogation in favor of the City of Houston for Commercial General Liability, Automobile Liability and Workers’ Compensation/Employers’ Liability policies. The Director will consider all other forms on a case-by-case basis.

3.10.5 Notice. HMO SHALL GIVE 30 DAYS’ ADVANCE WRITTEN NOTICE TO THE DIRECTOR IF ANY OF ITS INSURANCE POLICIES ARE CANCELED OR NON-RENEWED. Within the 30-day period, HMO shall provide other suitable policies in order to maintain the required coverage. If HMO does not comply with this requirement, the Director, at his or her sole discretion, may immediately suspend HMO from any further performance under this Agreement and begin procedures to terminate for default.

3.10.6 Other Insurance. If requested by the Director, HMO shall furnish adequate evidence of Social Security and Unemployment Compensation Insurance, to the extent applicable to HMO’s operations under this Agreement.
EXHIBIT “I-G”

DRUG ABUSE DETECTION AND DETERRENCE

(1) It is the policy of the City to achieve a drug-free workforce and workplace. The manufacture, distribution, dispensation, possession, sale, or use of illegal drugs or alcohol by contractors while on City Premises is prohibited. HMO shall comply with all the requirements and procedures set forth in the Mayor's Drug Abuse Detection and Deterrence Procedures for Contractors, Executive Order No. 1-31 ("Executive Order"), which is incorporated into this Agreement and is on file in the City Secretary’s Office.

(2) Before the City signs this Agreement, HMO shall file with the Contract Compliance Officer for Drug Testing ("CCODT"):
   (a) a copy of its drug-free workplace policy,
   (b) the Drug Policy Compliance Agreement substantially in the form set forth in Exhibit "I-G-1," together with a written designation of all safety impact positions and,
   (c) if applicable (e.g. no safety impact positions), the Certification of No Safety Impact Positions, substantially in the form set forth in Exhibit "I-G-2."

   If HMO files a written designation of safety impact positions with its Drug Policy Compliance Agreement, it also shall file every 6 months during the performance of this Agreement or on completion of this Agreement if performance is less than 6 months, a Drug Policy Compliance Declaration in a form substantially similar to Exhibit "I-G-3." HMO shall submit the Drug Policy Compliance Declaration to the CCODT within 30 days of the expiration of each 6-month period of performance and within 30 days of completion of this Agreement. The first 6-month period begins to run on the date the City issues its Notice to Proceed or if no Notice to Proceed is issued, on the first day Administrator begins work under this Agreement.

   (3) HMO also shall file updated designations of safety impact positions with the CCODT if additional safety impact positions are added to Administrator's employee work force.

   (4) HMO shall require that its subcontractors comply with the Executive Order, and HMO shall secure and maintain the required documents for City inspection.
EXHIBIT "I-G-1"

DRUG POLICY COMPLIANCE AGREEMENT

I, _______________________________ as an owner or officer of
(Name) (Print/Type) (Title)
_______________________________ (HMO)
(Name of Company)

have authority to bind HMO with respect to its bid, offer or performance of any and all contracts it may enter into with the City of Houston; and that by making this Agreement, I affirm that the HMO is aware of and by the time the contract is awarded will be bound by and agree to designate appropriate safety impact positions for company employee positions, and to comply with the following requirements before the City issues a notice to proceed:

1. Develop and implement a written Drug Free Workplace Policy and related drug testing procedures for the HMO that meet the criteria and requirements established by the Mayor's Amended Policy on Drug Detection and Deterrence (Mayor's Drug Policy) and the Mayor's Drug Detection and Deterrence Procedures for Contractors (Executive Order No. 1-31).
2. Obtain a facility to collect urine samples consistent with Health and Human Services (HHS) guidelines and a HHS certified drug testing laboratory to perform the drug tests.
3. Monitor and keep records of drug tests given and the results; and upon request from the City of Houston, provide confirmation of such testing and results.

I affirm on behalf of HMO that full compliance with the Mayor's Drug Policy and Executive Order No. 1-31 is a material condition of the contract with the City of Houston.

I further acknowledge that falsification, failure to comply with or failure to timely submit declarations and/or documentation in compliance with the Mayor's Drug Policy and/or Executive Order No. 1-31 will be considered a breach of the contract with the City and may result in non-award or termination of the contract by the City of Houston.

__________________________________
Date

__________________________________
HMO Name

__________________________________
Signature

__________________________________
Title
HMO’S CERTIFICATION
OF NO SAFETY IMPACT POSITIONS
IN PERFORMANCE OF A CITY CONTRACT

______________________________  ______________________________
(Name)                                  (Title)

as an owner or officer of ______________________________ (HMO)

(Name of Company)

have authority to bind HMO with respect to its bid, and hereby certify that HMO has no employee safety impact positions, as defined in §5.18 of Executive Order No. 1-31, that will be involved in performing

______________________________
(Project)

HMO agrees and covenants that it shall immediately notify the City of Houston Director of Human Resources if any safety impact positions are established to provide services in performing this City Contract.

______________________________  ______________________________
(Date)                                  (Typed or Printed Name)

______________________________
(Signature)

______________________________
(Title)
EXHIBIT "I-G-3"

DRUG POLICY COMPLIANCE DECLARATION

I, ______________________________________________________ as an owner

(Name)  (Print/Type)  (Title)

or officer of

__________________________________________________________ (HMO)

(Name of Company)

have personal knowledge and full authority to make the following declarations:

This reporting period covers the preceding 6 months from _________ to _________, 20___.

_____ A written Drug Free Workplace Policy has been implemented and employees notified.

Initials  The policy meets the criteria established by the Mayor’s Amended Policy on Drug Detection and Deterrence (Mayor’s Policy).

_____ Written drug testing procedures have been implemented in conformity with the

Initials  Mayor’s Drug Detection and Deterrence Procedures for Contractors, Executive Order No. 1-31. Employees have been notified of such procedures.

_____ Collection/testing has been conducted in compliance with federal Health and Human Services (HHS) guidelines.

Initials

_____ Appropriate safety impact positions have been designated for employee positions

Initials  performing on the City of Houston contract. The number of employees in safety impact positions during this reporting period is _________________.

_____ From _________ to _________, 20___ the following test has occurred

Initials  (Start date)  (End date)

<table>
<thead>
<tr>
<th>Random</th>
<th>Reasonable Suspicion</th>
<th>Post Accident</th>
<th>Total</th>
</tr>
</thead>
</table>

Number Employees Tested

Number Employees Positive

Percent Employees Positive

_____ Any employee who tested positive was immediately removed from the City worksite consistent with the Mayor’s Policy and Executive Order No. 1-31.
I affirm that falsification or failure to submit this declaration timely in accordance with established guidelines will be considered a breach of contract.

I declare under penalty of perjury that the affirmations made herein and all information contained in this declaration are within my personal knowledge and are true and correct.

__________________________
(Date)

__________________________
(Typed or Printed Name)

__________________________
(Signature)

__________________________
(Title)
EXHIBIT II TO GROUP APPLICATION

A. Initial Term.

1) First Agreement Year (January 1, 2021 through December 31, 2021)
Guaranteed monthly Premium Rate: $________ per each Medicare eligible Member enrolled as of the 1st of the month.

2) Second Agreement Year (January 1, 2022 through December 31, 2022)
For the Second Agreement Year: the Agreement shall expire on December 31, 2021 unless the Group’s Human Resources Director notifies HMO in writing, on or before September 30, 2021, of the Group’s intent to extend the Agreement for the Second Agreement Year at the monthly Premium rate, as set forth in HMO’s notification of renewal to the Group, which shall occur no later than July 30th, 2021. The Group’s renewal notice shall occur subsequent to notification to Group by HMO of its intention to remain a participant in the Medicare Advantage program. The notification from HMO shall also contain all applicable rate increases, as outlined in Exhibit II-A, and or applicable benefit changes, if any, proposed for the renewal period.

3) Third Agreement Year (January 1, 2023 through December 31, 2023)
For the Third Agreement Year: the Agreement shall expire on December 31, 2022 unless the Group’s Human Resources Director notifies HMO in writing, on or before September 30, 2022, of the Group’s intent to extend the Agreement for the Third Agreement Year, at the Premium rate, as set forth in HMO’s notification of renewal to the Group, which shall occur no later than July 30th, 2022. The Group’s renewal notice shall occur subsequent to notification to Group by HMO of its intention to remain a participant in the Medicare Advantage program. The notification from HMO shall also contain all applicable rate increases, as outlined in Exhibit II-A, and or applicable benefit changes, if any, proposed for the renewal period.

A. Renewal Option Terms

1) First Renewal Option Year (January 1, 2024 through December 31, 2024)
For the First Renewal Option Year of the Agreement: the Agreement shall expire on December 31, 2023 unless the Group’s Human Resources Director notifies HMO in writing, on or before September 30, 2023, of the Group’s intent to exercise its option to renew the Agreement for the First Renewal Option Year, at the monthly Premium rate, as set forth in HMO’s notification of renewal to the Group, which shall occur no later than July 30th, 2023. The Group’s renewal notice shall occur subsequent to notification to Group by HMO of its intention to remain a participant in the Medicare Advantage program. The notification from HMO shall also contain all applicable rate increases, as outlined in Exhibit II-A, and or applicable benefit changes, if any, proposed for the renewal period.

2) Second Renewal Option Year (January 1, 2025 through December 31, 2025)
For the Second Renewal Option Year of the Agreement, the Agreement shall expire on December 31, 2024 unless the Group’s Human Resources Director notifies HMO in writing, on or before September 30, 2024, of the Group’s intent to exercise its option to renew the Agreement for the Second Renewal Option Year, at the monthly Premium rate, as set forth in HMO’s notification of renewal to the Group, which shall occur no later than July 30th, 2024. The Group’s renewal notice shall occur subsequent to notification to Group by HMO of its intention to remain a participant in the Medicare Advantage program. The notification from HMO shall also contain all applicable rate increases, as outlined in Exhibit II-A, and or applicable benefit changes, if any, proposed for the renewal period.
**Miscellaneous**

The aforementioned Premium rates are contingent upon Group providing HMO face to face access to Medicare eligibles within Group to ensure: appropriate education, orientation of Members and the ability to maximize enrollment.

HMO shall have the option, in its sole discretion, to offer to include additional counties in the Service Area for Group’s Plan. Notwithstanding the foregoing, in the event HMO offers to expand the Service Area, such counties will only be added to this Plan upon the Group’s Human Resources Director’s prior written approval.
## EXHIBIT II-A TO GROUP APPLICATION

### RATE RENEWAL CALCULATION FORMULA

<table>
<thead>
<tr>
<th>Year to Date</th>
<th>PMPM</th>
</tr>
</thead>
</table>
| 1. Dates of Service | * January through December  
**January through February of the following year |
<p>| 2. Dates of Payment |
| 3. Member Months |
| <strong>Revenues</strong> |
| 4. Premium Revenue –CMS | $________ |
| 5. Adjusted Premium –City of Houston |
| Other Income |
| 6. Total Revenues |
| <strong>Medical Expenses</strong> |
| 7. Capitation –Professional |
| 8. Capitation –Other |
| 9. Disease Management |
| 10. FFS –Inpatient |
| 11. FFS –Outpatient |
| FFS –Pharmacy |</p>
<table>
<thead>
<tr>
<th>12. Total Medical Expenses</th>
</tr>
</thead>
<tbody>
<tr>
<td>13. Medical Loss Ratio</td>
</tr>
<tr>
<td>14. Trend Factor for Medical Inflation</td>
</tr>
<tr>
<td>15. Estimated CMS Revenue Change</td>
</tr>
<tr>
<td>16. Estimated Medical Loss Ratio</td>
</tr>
<tr>
<td>17. Allowable Medical Loss Ratio</td>
</tr>
<tr>
<td>18. Rate Increase Needed for Allowable MLR</td>
</tr>
<tr>
<td>19. Maximum Rate Increase Allowed Per Contract Year</td>
</tr>
<tr>
<td><strong>20. Total Adjusted Premium Including Trend Factor</strong></td>
</tr>
<tr>
<td>21. Impact of Mutually Agreed Upon Benefit Changes:</td>
</tr>
<tr>
<td>22. Final Adjusted Premium for New Contract Year</td>
</tr>
</tbody>
</table>

* A renewal shall be based upon dates of service covering a 12 month period.  
** A renewal shall be based upon claims paid over at least a 14 month period.
EVIDENCE OF COVERAGE

INSERT EOC