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PHYSICIAN GROUP SERVICES AGREEMENT

THIS PHYSICIAN GROUP SERVICES AGREEMENT (“Agreement”), effective as of July 1, 2025 (the “**Effective Date**”), is made and entered into by and between MCC Health, PBC (“**MCC**”), contracting on behalf of the health benefit plan sponsor(s) identified on Attachment C (each a “**Plan Sponsor**”) and the affiliated physician groups of Baylor Scott & White Health identified on Attachment A (each a “**Provider**” and collectively “**Providers**”).

WHEREAS, each Plan Sponsor identified on Attachment C is contracting individually with Providers through its agent MCC, and this Agreement shall be interpreted as a separate agreement for each Plan Sponsor;

WHEREAS, Plan Sponsor sponsors a self-funded health benefit plan regulated by ERISA, as defined below (“**Plan**”), for its employees and their dependents who are eligible for and enrolled in the Plan (“**Participants**”); and

WHEREAS, each party wishes to enter into this Agreement to facilitate the delivery of Covered Services (as defined below) by Providers to Participants.

NOW THEREFORE, in consideration of the terms and conditions set forth herein, the parties agree as follows:

SECTION 1. DEFINITIONS

- 1.1 Covered Services means those health care items and services for which the Plan is financially responsible. An item or service is only a Covered Service if it is medically necessary, as defined by the Plan.
- 1.2 ERISA means the Employee Retirement Income Security Act of 1974, as amended.

SECTION 2. DUTIES OF PROVIDERS

- 2.1 Health Care Services. Providers shall furnish Covered Services to Participants pursuant to the terms and conditions set forth in this Agreement. Providers shall verify the eligibility of Participant(s) prior to furnishing Covered Services, in accordance with Section 3.1. Each Provider shall ensure that its employees, health care providers, directors, officers, representatives, contractors, and agents (“**Personnel**”) comply with the applicable requirements of this Agreement. Providers retain full authority to control their business operations, locations, equipment, Personnel, and scope of services, provided that they also satisfy their respective obligations under this Agreement.
- 2.2 Standards. Providers shall furnish Covered Services in accordance with applicable law, ethical guidelines, and standards of care. Providers shall not differentiate or discriminate in the treatment of any Participant because of (i) the person’s status as a Participant; or (ii) any protected classification, including but not limited to race, national origin, sex, gender, sexual orientation, and disability. For the benefit of Participants, Providers shall make commercially reasonable efforts to refer Participants to other in-network providers of Plan.

Providers shall ensure coverage for Participants on a 24/7 basis in a manner that is appropriate to the applicable Provider's specialty. Providers shall reasonably participate in quality improvement, case management, or similar programs offered by Plan Sponsor for the benefit of Participants.

- 2.3 Credentialing. Providers and their respective Personnel shall maintain all necessary licenses, accreditations, certifications and/or training required by law and the Plan in order to furnish Covered Services. Pursuant to the Delegation of Credentialing Agreement effective July 1, 2025 between Baylor Scott and White Health and MCC, MCC and Plan Sponsors delegate to Baylor Scott and White Health the responsibility to credential and recredential Providers.
- 2.4 Roster. The roster of Providers listed on Attachment A may be modified upon written notice to Plan Sponsor, without the necessity of amending this Agreement. Plan Sponsor shall add each new Provider or Provider location within thirty (30) days of receipt of notice. Provider shall promptly notify MCC of any changes to the name, address or tax identification number of any Provider location and MCC shall make such changes in its systems and notify Plan Sponsor of such changes within ten (10) business days of receipt of Provider's notice.
- 2.5 Records. Providers shall maintain medical records and documents relating to Participants as required by applicable law and for the period of time required by law. Medical records of Providers and any other records containing individually identifiable information relating to Participants shall be regarded as confidential, and Providers and Plan Sponsor shall comply with applicable federal and state law regarding such records. Subject to Section 6.2, Providers shall provide Plan Sponsor and government agencies with access to and/or copies of any records related to Participants or this Agreement as reasonably necessary or as required by law.
- 2.6 Data. Providers and Plan Sponsor shall cooperate in exchanging such data as may be necessary to fulfill the purposes of this Agreement, subject to Section 6.2.

SECTION 3. DUTIES OF PLAN SPONSOR

- 3.1 Participant Identification; Benefits. Plan Sponsor or its designee shall provide a readily-accessible means for verification of Participants' eligibility and benefits. If Provider follows the procedure for verification of eligibility or pre-certification or authorization of coverage or benefits and provides Covered Services in reliance on such verification or authorization, Plan Sponsor shall not retroactively deny, withhold, reduce, or request a refund for, payment for any Covered Services if it is later determined that the determination of eligibility or authorization of coverage or benefits was in error.
- 3.2 Cost Share. For Covered Services rendered by Provider under this Agreement, Plan Sponsor shall either (i) ensure that the Plan does not require any cost share amounts from Participants; or (ii) collect any such cost share amounts directly from Participant.
- 3.3 Relationship to Plan. MCC shall bind through a written agreement each Plan Sponsor and its Plans to comply with all applicable provisions of this Agreement. MCC's agreements

with Plan Sponsors shall not vary, alter or contradict the terms of this Agreement. Provider acknowledges and agrees that each Plan Sponsor is singularly responsible for its own compliance under this Agreement, and there is no joint and several liability among Plan Sponsors by virtue of this Agreement. Upon request, MCC shall reasonably assist Provider in its collection efforts from a Plan Sponsor upon Provider's request including, but not limited to: (i) providing a copy of MCC's agreement with the Plan Sponsor and any other agreements signed by the Plan Sponsor relating to the claim; (ii) providing written communication exchanged between MCC and the Plan Sponsor relating to a claim; (iii) providing notice to the Plan Sponsor that additional amounts are due on a claim, including loss of discount; and/or (iv) providing Plan Sponsor contact information to Provider.

- 3.4 Addition of Plan Sponsors. MCC shall provide at least thirty (30) days' written notice to Provider of the proposed addition of a Plan Sponsor to Attachment C. Provider must affirmatively agree in writing to the addition of the Plan Sponsor in Attachment C. MCC may remove Plan Sponsor(s) from the Agreement upon advance written notice to Provider. Any written notice or agreement in writing under this section 3.4 may be effected by e-mail by an authorized representative of MCC or Provider, as applicable.
- 3.5 Policies and Procedures. Plan Sponsor reserves the right to adopt and amend policies and procedures for administration of the Plan and this Agreement. Plan Sponsor shall make any such policies and procedures available to Providers, and, to the extent not in conflict with the terms of this Agreement, Providers agree to comply with the same. Notwithstanding the foregoing, any policies, procedures or rules which are reasonably likely to: (i) result in denials of claims for payment submitted by Provider; (ii) result in delays of payment for claims submitted by Provider; (iii) change the processes, protocols or procedures Provider must follow in order for services to be covered or claims to be paid; or (iv) increase the administrative procedures which Provider must follow or otherwise impose an additional administrative burden on Provider; shall require the prior written agreement of Providers. In the event of a conflict between this Agreement and the Plan Sponsor's policies and procedures, this Agreement shall prevail.
- 3.6 Plan Document. Plan Sponsor retains sole responsibility for ensuring that (i) its Plan(s) and its operations comply with ERISA and any other applicable law; and (ii) its Plan document(s) are consistent with the requirements of this Agreement, such that the terms and conditions of this Agreement may be given full force and effect without violating the Plan document(s). Plan Sponsor is also solely responsible for ensuring that its designee(s), including but not limited to any third party administrator, comply with the terms of this Agreement.

SECTION 4. PAYMENTS

- 4.1 Payments. Providers agree to accept the applicable rate set forth in Attachment B as payment in full for Covered Services furnished to Participants. Providers shall submit complete claims to Plan Sponsor's third party administrator, as directed by Plan Sponsor, or as otherwise set forth in Attachment B. Plan Sponsor must obligate its third party administrator to comply with the applicable terms of this Agreement. Provider must be paid for all claims for Covered Services furnished to Participants within thirty (30) days of

submission of a complete claim. A claim shall be considered complete if it is submitted on a UB-04 or CMS 1500 form (or its successor) or comparable electronic format and accurately contains all the following information: patient name, patient's date of birth, Participant identification number, Provider's name, address and tax ID number, date(s) of service or purchase, diagnosis narrative or ICD-10 code (or its successor), procedure narrative or CPT-4 code, services and supplies provided, attending physician, the Provider's charges and any other data elements, attachments or information which may be mutually agreed upon in writing by the Parties. Providers shall use the billing and coding guidelines published by the Centers for Medicare & Medicaid Services ("CMS"), including the then-current coding guidelines published by CMS's National Correct Coding Initiative. Providers shall submit claims within ninety-five (95) days of the date of service, the date of discharge, or the date of adjudication by the primary payor, as applicable. Providers shall make best efforts to submit claims electronically. Providers shall not seek reimbursement from Participants for Covered Services, except as may be described in Attachment B. If Plan Sponsor or Plan Sponsor's third party administrator determines that a bill is not a complete claim, it must notify Provider in writing by facsimile or electronic mail within fifteen (15) calendar days of receipt of the claim of the specific additional information needed to constitute a complete claim and pay the complete claim within thirty (30) calendar days of receipt of the resubmitted claim from Provider. Plan Sponsor or Plan Sponsor's third party administrator fails to notify Provider of any additional information needed to have a complete claim within fifteen (15) calendar days of initial receipt of the claim, the claim shall be deemed to be complete and paid accordingly. If complete and accurate payment of a complete claim is not received by Provider within thirty (30) days of receipt of the complete claim, Plan Sponsor shall no longer be eligible for the rates set forth on Attachment B and shall be obligated to pay the claim at Provider's normal billed charges and Provider may elect to terminate this Agreement. MCC is not responsible for any payment to Provider for Covered Services.

- 4.2 Non-Covered Services. Providers may bill Participants for any item or service that is not considered a Covered Service by the Plan, provided that (i) Provider has informed Participant in advance that the specified item or service may not be a Covered Service; and (ii) Participant has agreed in writing to receive, and be financially responsible for, that particular item or service prior to it being provided.
- 4.3 Coordination of Benefits. Providers shall follow coordination of benefits rules as directed by Plan Sponsor. Where Plan is the secondary payor, Providers shall bill and collect from the primary payor before submitting a claim under Section 4.1.
- 4.4 Overpayments. The parties acknowledge and agree that Plan Sponsor will not conduct prepayment utilization management activities for Covered Services rendered by Providers under this Agreement. Nevertheless, in the event Plan Sponsor reasonably determines that it has made payment for item(s) and/or service(s) that are not Covered Services, or that were provided to a patient who was not a Participant on the date of service, or where there is a finding of fraud, waste or abuse by a Provider, in Plan Sponsor's sole discretion, Plan Sponsor may request a refund of such payment upon written notice to the applicable Provider with documentation supporting the refund and Provider shall refund or appeal such overpayment within thirty (30) days of demand from Plan Sponsor. Disagreements

about such overpayments shall be subject to the dispute resolution procedures set forth in Section 6.6. Plan Sponsor may not seek refund of an overpayment from Provider more than one hundred eighty (180) days after the date payment was made.

SECTION 5. TERM AND TERMINATION

5.1 Term. This Agreement shall commence as of the Effective Date and shall remain in full force and effect until the end of the then-current calendar year, unless earlier terminated as provided in Section 5.2. Thereafter, the Agreement shall automatically renew for an additional one (1) year, unless either party provides notice of non-renewal at least ninety (90) days prior to the end of the then-current contract year.

5.2 Termination.

- a. Either party may terminate this Agreement at any time without cause upon ninety (90) days written notice to the other party.
- b. Either party may terminate this Agreement for cause due to a material breach by the other party by giving thirty (30) days' prior written notice. The notice of termination for cause shall not be effective if the breaching party cures the breach to the reasonable satisfaction of the non-breaching party within such notice period.
- c. MCC may terminate this Agreement or a Provider immediately by written notice in the event Provider: (i) fails to maintain licensure or accreditation; (ii) fails to maintain insurance as required by this Agreement; (iii) is convicted of a crime; (iv) is excluded from a federal health care program; (v) is insolvent; (vi) engages in fraud, waste or abuse; or (vii) is found guilty of medical malpractice for Health Care Services involving a Participant.
- d. Any obligation arising prior to the date of termination, and any provision that by its nature is intended to survive, shall survive termination. Further, this Agreement shall continue to apply to Covered Services (i) for up to ninety (90) days following termination to the extent necessary to allow Participants to transition to other health care providers; or (ii) until the date of discharge, for any Participant with inpatient status as of the date of termination; or (iii) the period of time specified by continuity of care requirements under applicable law.
- e. Each Plan Sponsor or Provider may exercise these termination rights individually as to its participation in the Agreement. MCC may also exercise these termination rights as party to the Agreement.

SECTION 6. GENERAL PROVISIONS

6.1 Disclaimer. MCC is not responsible to any individual or entity for any damages arising from Plan Sponsor or Provider's acts or omissions hereunder.

6.2 HIPAA, Confidentiality, Non-Disclosure.

- a. The parties, Plan Sponsor and Providers shall comply with all applicable laws and regulations regarding maintenance and disclosure of Participants' medical records and other individually identifiable health information. In particular, the parties, Plan Sponsor and Providers shall comply with the applicable provisions of the Health Insurance Portability and Accountability Act of 1996, the Health Information Technology for Economic and Clinical Health Act, and the applicable rules and regulations promulgated thereunder, all as amended from time to time (collectively, "**HIPAA**").
 - b. The parties, Plan Sponsor and Providers shall keep strictly confidential any and all proprietary information of any of the other entities that may be given or disclosed, or that may be learned directly or indirectly, pursuant to this Agreement. In addition, no party, Plan Sponsor or Provider shall use such confidential information for its own benefit (other than to implement this Agreement) or disclose such confidential information to any other person or entity (except those professional advisors who are bound to confidentiality) without the express prior written consent of the entity that owns or controls the confidential information, or as required by law. Notwithstanding the foregoing, this Agreement and its attachments shall not be considered confidential information hereunder.
 - c. This Section 6.2 shall survive the termination of this Agreement.
- 6.3 Patient Choice/Discussion of Treatment Options. The parties acknowledge and agree that nothing in this Agreement shall be construed to (i) interfere with a Participant's freedom of choice to receive medical services from Providers or any other health care provider; or (ii) prohibit, impede, or interfere in discussions between Participants and health care providers regarding medical treatment options. A Provider shall be under no obligation to furnish a Covered Service to which the Provider has a moral or ethical objection.
- 6.4 Professional Judgment. Plan Sponsor shall not exercise control or direction over the manner or method by which Providers render Covered Services under this Agreement and shall not interfere with the professional medical judgment of any health care provider. Each party shall be responsible for its own act or omissions.
- 6.5 Independent Contractors. Each party acts as an independent contractor to the other party. Neither party has express or implied authority to assume or create any obligation on behalf of the other. Neither party's employees, agents, or representatives have any right to the employee benefits offered by the other party solely by virtue of this Agreement.
- 6.6 Insurance. Each Provider represents and warrants that it has and shall maintain professional, general liability, and other applicable industry standard insurance coverage against claims arising out of its or its Personnel's acts or omissions hereunder, at minimum amounts of no less than \$1,000,000 per occurrence and \$3,000,000 in the annual aggregate or a comparable program of self-insurance. Provider represents and warrants that it has and shall maintain cyber security insurance coverage at a minimum amount of \$5,000,000 in the annual aggregate or a comparable program of self-insurance.

- 6.7 Dispute Resolution. In the event that a dispute arises between the parties regarding the performance or interpretation of this Agreement, the parties agree that they shall first meet and attempt in good faith to resolve the dispute prior to the initiation of any other legal action. Such informal dispute resolution process may include mediation, upon the mutual agreement of the parties. If such efforts fail to produce a mutually acceptable resolution of the dispute, either party may initiate binding arbitration in Dallas County, Texas, in accordance with the rules of the American Health Law Association before a panel of three (3) arbitrators. Further, each Plan Sponsor may participate in dispute resolution individually if no other Plan Sponsor is affected by the dispute. The arbitration award shall not include any punitive, exemplary, or other non-economic damage component. The prevailing party shall recover the fees and expenses of each arbitrator and all other costs and expenses incurred in the arbitration, including reasonable attorneys' fees.
- 6.8 Modification for Change in Law. To the extent that any law, rule, regulation or standard of any authority having jurisdiction over a party to this Agreement or the subject matter of this Agreement (including an applicable accrediting agency) shall raise question as to the legality, enforceability, or appropriateness of this Agreement or any provision hereof, the parties agree to negotiate promptly regarding any modification needed to bring this Agreement into compliance with such applicable law, rule, regulation or standard. Should the parties be unable to agree upon such modification within a period of thirty (30) days from the date either party gave notice of the issue to the other party, or within such shorter period of time necessary to avoid illegality, this Agreement may be terminated by either party upon notice to the other party.
- 6.9 Entirety and Modification. This Agreement, together with the exhibits which are hereby incorporated by reference, constitutes the entire agreement between the parties with respect to the subject matter hereof, and as of the Effective Date, shall supersede any previous agreements or understandings, written or oral, between the parties. If Plan Sponsor has access to a Provider's services under a wrap network participation agreement, Plan Sponsor and Provider agree that Plan Sponsor shall be obligated to designate this Agreement as the agreement that controls Plan Sponsor's access to that Provider. Except as otherwise set forth herein, all modifications of the Agreement shall be in writing and signed by both parties.
- 6.10 Governing Law. This Agreement shall be interpreted and governed by the laws of the State of Texas, without regard to any conflicts of law principles, and without regard to any construction in favor of either party by reason of the drafting of this Agreement.
- 6.11 Assignment; Subcontracting. Except as otherwise permitted herein, neither party shall have the right to assign, delegate, or otherwise transfer any or all of its rights and/or obligations under this Agreement to any third party without the prior written consent of the other party, which consent shall not be unreasonably withheld; provided that MCC may assign to an affiliate or successor-in-interest. Further, each Plan Sponsor may assign its participation under this Agreement to any affiliate or successor-in-interest.
- 6.12 Compliance with Laws. Each party, Plan Sponsor and Provider will conduct itself in full compliance with applicable federal, state and local law. This Agreement has been

negotiated in an arms-length transaction and (i) does not require or guarantee any minimum level of Covered Services to be provided hereunder; and (ii) does not take into account any referrals or other business that may exist between the parties.

6.13 Use of Name and Other Information. MCO/Network may use the name, address, telephone number and a factual description of the Provider and services of Facility in handbooks and directories provided to Members or other Participating Providers without the prior written consent of Facility. Provider may use the name of MCO/Network in notification letters to physicians and patients without the prior written consent of MCO/Network.

Except as provided in this Section 6.13, Provider, Payor and MCO/Network reserve the right to use and control the use of its respective name, symbols, and trademarks and service marks presently existing and subsequently acquired. In addition, except as provided in this Section 6.13, neither MCO/Network, Payor nor Facility will use the name, symbol, trademark or service marks, presently existing or subsequently acquired, of MCO/Network, Payor or Provider without the prior written consent of such party and will cease any such use immediately upon receipt of written notice from the party or termination of this Agreement, whichever occurs first.

6.14 Notices. Any notice required under this Agreement must be in writing and either hand delivered or sent by United States mail postage prepaid or overnight courier to the applicable party at the address listed on the signature page. Either party may change its address for notices by giving written notice of the change to the other party in the same manner. Notwithstanding the foregoing, Plan Sponsor or its designee may send routine communications regarding this Agreement and/or the Plan to Providers via electronic means.

6.15 Waiver of Breach; Severability. If either party waives a breach of any provision of this Agreement, it shall not operate as a waiver of any subsequent breach. If any portion of this Agreement is deemed unenforceable for any reason, it shall not affect the enforceability of any remaining portions.

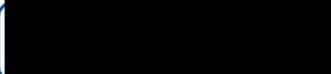
6.16 Multiple Counterparts. This Agreement may be executed in multiple counterparts, each of which shall be deemed an original for all purposes and all of which shall be deemed, collectively, one Agreement for each Plan Sponsor.

IN WITNESS WHEREOF, the parties hereto have duly executed this Agreement as set forth below.

MCC
contracting on behalf of the Plan Sponsor(s)
identified on Attachment C

PROVIDER
on behalf of Providers identified on
Attachment A

Signature:  _____

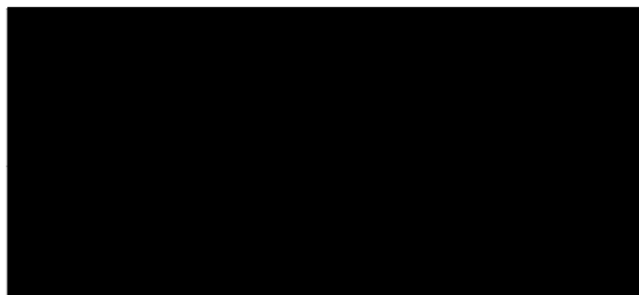
Signature:  _____

Name: [REDACTED]

Title: [REDACTED]

Date: 6/30/2025

Notice Address:



Name: [REDACTED]

Title: [REDACTED]

Date: 6/27/2025 | 5:58 AM PDT

Notice Address:

Attn: _____

ATTACHMENT A
Providers

[See attached rosters.]

ATTACHMENT B
Reimbursement Rates

Plan Sponsor shall pay Providers for Covered Services at the lesser of Provider's billed charges or the attached rate sheets. Notwithstanding the foregoing, Plan Sponsor shall not pay any supplemental or add-on payments that Medicare may otherwise pay to Providers under Medicare programs, including but not limited to any quality or value-based program payments, graduate medical education payments and/or bad debt reconciliations.

The parties acknowledge and agree that Providers shall not collect any coinsurance or other payment from any Participant for Covered Services furnished under this Agreement, except as otherwise directed by Plan Sponsor.

At its discretion, Plan Sponsor may offer Provider an option to request payment prior to the provision of a Covered Service. In such case, Provider must still submit a claim for the Covered Service in accordance with Section 4.1 of the Agreement. If Provider fails to submit a claim in accordance with Section 4.1, the payment shall be treated as an overpayment subject to Section 4.4 of the Agreement.

ATTACHMENT C

Plans / Plan Sponsors

Radical Ventures, LLC
Mark Cuban Cost Plus Drug Company, PBC

dba Name	Tax ID	Group NPI's
Century Integrated Partners	81-0872075	1447615711 1003811639; 1760488936; 1235135906; 1538164116; 1992429161; 1427054402; 1962153940; 1124809512; 1598658015; 1174416689;
HealthTexas Provider Network	75-2536818	1295628709
Hillcrest Family Health Center	74-2730350	1891796694
Hillcrest Physician Services	74-2967081	1649294323 1093779704, 1922061993, 1679691729, 1821475153,
Scott & White Clinic	74-2958277	1649820796
Scott & White Hospital Marble Falls RHC's	46-4007700	1295397859

Group NPI Entity

1003811639 HTPN service location outside of Dallas/Tarrant
1760488936 HTPN service location in Dallas county
1235135906 HTPN service location in Tarrant county
1538164116 specific to BSW Family Medical Center Rockwall
1992429161 One Medical w/ BSW Health(Tarrant)
1427054402 BSW Flower Mound
1962153940 One Medical w/ BSW Health(Dallas)
1124809512 One Medical w/ BSW Health (Other, outside of Dallas and Tarrant County)
1598658015 Other County-Symmetry Anesthesia
1174416689 Dallas County-Symmetry Anesthesia
1295628709 Tarrant County--Symmetry Anesthesia