PROVIDER SERVICES AGREEMENT

THIS PROVIDER SERVICES AGREEMENT (“**Agreement**”), effective as of January 1, 2025 (the “**Effective Date**”), is made and entered into by and between MCC Health, PBC, contracting on behalf of the health benefit plan sponsor(s) identified on Attachment C (each a “**Plan Sponsor**”) and Texas Allergy Center and its affiliated providers and facilities as listed on Attachment A (individually and collectively referred to herein as “**Provider**”).

WHEREAS, each Plan Sponsor identified on Attachment C is contracting individually with Provider through its agent MCC Health, PBC, 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**”);

WHEREAS, Provider consists of one or more licensed health care providers; and

WHEREAS, each party wishes to enter into this Agreement to facilitate the delivery of Covered Services (as defined below) by Provider 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, as further described in Attachment A. 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 PROVIDER

2.1 Provider Services. Provider shall furnish Covered Services to Participants pursuant to the terms and conditions set forth in this Agreement, including Attachment A. Provider shall verify the eligibility of Participant(s) prior to furnishing Covered Services, in accordance with Section 3.1. Provider shall bind its employees, health care providers, directors, officers, representatives, contractors, and agents (“**Personnel**”) to the applicable requirements of this Agreement. Provider retains full authority to control its business operations, locations, equipment, Personnel, and scope of services, provided that it also satisfies its obligations under this Agreement.

2.2 Standards. Provider shall furnish Covered Services in accordance with applicable law, ethical guidelines, and standards of care. Provider 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, Provider shall make commercially reasonable efforts to refer Participants to other in-network providers of Plan. Provider shall ensure coverage for Participants on a 24/7 basis in a manner that is appropriate to Provider's specialty. Provider shall participate in any quality improvement, case management, or similar programs offered by Plan Sponsor for the benefit of Participants.

2.3 Credentialing. Provider and its Personnel shall maintain all necessary licenses, accreditations, certifications and/or training required by law and the Plan in order to furnish Covered Services. Provider shall (i) provide Plan Sponsor or its designee with evidence of such qualifications prior to the Effective Date and upon request; and (ii) immediately notify Plan Sponsor of any change to such information or the occurrence of any event identified in Section 5.2(b). Provider Personnel who are subject to credentialing must have their credentials verified by Provider prior to furnishing Covered Services under this Agreement.

2.4 Participating Locations and Providers. Provider shall render Covered Services to Participants at the service locations and through the individual health care providers, if applicable, listed on Attachment A. Provider shall notify Plan Sponsor or its designee promptly of any changes in its providers, services, and/or service locations.

2.5 Records. Provider 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 Provider and any other records containing individually identifiable information relating to Participants shall be regarded as confidential, and Provider and Plan Sponsor shall comply with applicable federal and state law regarding such records. Subject to Section 6.1, Provider shall provide Plan Sponsor and government agencies with access to and/or copies of any records related to Participants or this Agreement at no additional charge as reasonably necessary or as required by law.

2.6 Data. The parties shall cooperate in exchanging such data as may be necessary to fulfill the purposes of this Agreement, subject to Section 6.1.

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.

3.2 Relationship to Plan. MCC Health, PBC shall bind each Plan Sponsor and its Plans to comply with all applicable provisions 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.

3.3 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 Provider, and Provider agrees to comply with the same. In the event of a conflict between this Agreement and the Plan documents, the Plan documents shall prevail.

SECTION 4. PAYMENTS

4.1 Payments. Provider agrees to accept the applicable rate set forth in Attachment B as payment in full for Covered Services furnished to Participant. Provider shall submit complete claims to Plan Sponsor's third party administrator, as directed by Plan Sponsor, or as otherwise set forth in Attachment B. Provider shall use the claim and coding guidelines published by the Centers for Medicare & Medicaid Services ("**CMS**"). Provider shall submit claims within ninety (90) days of the date of service, the date of discharge, or the date of adjudication by the primary payor, as applicable. Provider shall make best efforts to submit claims electronically. Provider shall not seek reimbursement from Participant(s) for Covered Services, except as may be described in Attachment B.

4.2 Non-Covered Services. Provider may bill Participant 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 is not 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. Provider shall follow coordination of benefits rules as directed by Plan Sponsor. Where Plan is the secondary payor, Provider 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 does not intend to engage in routine prepayment utilization management activities. 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 Provider, in Plan Sponsor's sole discretion, (i) Plan Sponsor may recoup such payment upon notice to Provider; and/or (ii) Provider shall refund 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.

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 additional one (1) year terms, 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 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.

b. MCC Health, PBC may terminate this Agreement 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 found liable for malpractice; (vi) is insolvent; (vii) engages in fraud, waste or abuse; (viii) acts, or fails to act, in a manner that places Plan, Plan Sponsor or a Participant at material risk.

c. 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.

d. Each Plan Sponsor may exercise these termination rights individually as to its participation in the Agreement. MCC Health, PBC may also exercise these termination rights as party to the Agreement.

SECTION 6. GENERAL PROVISIONS

6.1 HIPAA, Confidentiality, Non-Disclosure.

a. The parties 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 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. Each party shall keep strictly confidential any and all proprietary information of the other party that may be given or disclosed, or that may be learned directly or indirectly, pursuant to this Agreement. In addition, neither party 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 other party or as required by law. Notwithstanding the foregoing, this Agreement and its attachments shall not be considered confidential information hereunder.

c. This Section 6.1 shall survive the termination of this Agreement.

6.2 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 Provider or any other health care provider; or (ii) prohibit, impede, or interfere in discussions between Participants and health care providers regarding medical treatment options. Subject to Section 2.2, Provider shall be

under no obligation to furnish a Covered Service to which Provider has a moral or ethical objection.

6.3 Professional Judgment. Plan Sponsor shall not exercise control or direction over the manner or method by which Provider renders Covered Services under this Agreement and shall not interfere with the professional medical judgment of any health care provider. Accordingly, Provider shall indemnify and hold harmless Plan Sponsor and its agents for any and all damages arising from the acts or omissions of Provider or its Personnel under this Section 6.3. Provider shall notify Plan Sponsor or its designee immediately upon receipt of a grievance or complaint from a Participant.

6.4 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.

6.5 Insurance. 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 Provider's 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.

6.6 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. Further, each Plan Sponsor may participate in dispute resolution individually if no other Plan Sponsor is affected by the dispute.

6.7 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.

6.8 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 Provider's services under another agreement, e.g., a wrap network participation

agreement, this Agreement shall prevail. Except as otherwise set forth herein, all modifications of the Agreement shall be in writing and signed by both parties.

6.9 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.

6.10 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 Health, PBC 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. Provider may not subcontract with third parties to furnish Covered Services under this Agreement, unless otherwise authorized in writing by Plan Sponsor or its designee.

6.11 Compliance with Laws. Each party enters into this Agreement with the intent of conducting 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.

6.12 Use of Name and Other Information. Provider agrees that Plan Sponsor may include information about Provider on a publicly available website and in literature distributed to existing or potential Participants.

6.13 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 Provider via electronic means.

6.14 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.

6.15 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.

[SIGNATURE PAGE FOLLOWS]

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

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

PROVIDER: Texas Allergy Center

ATTACHMENT A

Covered Services and Participating Locations

The parties anticipate that Provider will furnish the following type(s) of Covered Services under this Agreement:

- Evaluation and Management
- Allergy Testing
- Allergy Injections

The parties anticipate that Provider will furnish Covered Services at the following locations:

- Texas Allergy Center, Toll Hill Plaza (West), 5310 Harvest Hill Rd, Suite 120, Dallas, TX 75230
- Texas Allergy Center, 411 N. Washington Ave., Suite 7200, Dallas, TX 75246

If applicable, Provider will furnish a roster of its individual health care providers prior to execution of this Agreement and at any time upon Plan Sponsor's request.

ATTACHMENT B

Reimbursement Rates

Plan Sponsor shall pay Provider for Covered Services at the lesser of billed charges or 110% of the then-current Medicare fee schedule applicable to the Covered Service. For Covered Services reimbursed under the Medicare Physician Fee Schedule, the Dallas Locality, Non-Facility Price shall apply. Notwithstanding the foregoing, Plan Sponsor shall not pay any supplemental or add-on payments that Medicare may otherwise pay to Provider under Medicare programs, including but not limited to any quality or value-based program payments, graduate medical education payments and/or bad debt reconciliations. Plan Sponsor or its designee shall have the right to determine the reimbursement rate for any item or service that does not have an established rate on a Medicare fee schedule.

The parties acknowledge and agree that Provider 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.

Same-day Payments

At its discretion, Plan Sponsor may offer Providers a method to request payment prior to the provision of a Covered Service. In such cases, Covered Service must be authorized by scheduling the provision of Covered Service using the "Mishe" electronic system. Adjudication of a claim for Covered Services within the Mishe electronic system will occur immediately after the provision of Covered Services. Upon adjudication, the Provider shall receive immediate transfer of the reimbursement rate for Covered Service.

Should the actual service differ from what was originally authorized at the time of scheduling, Providers may indicate the discrepancy using the Mishe electronic system during the adjudication process. Any reimbursement reconciliation will be made pursuant to the authorization of the new or modified service, but such reimbursement reconciliation will not delay payment for the originally authorized service.

Provider acknowledges that Covered Services rendered without proper authorization using the Mishe electronic system may not be eligible for same-day reimbursement and such reimbursements may be subject to standard claims processing procedures in accordance with Section 4.1.

ATTACHMENT C

Plans / Plan Sponsors

Radical Ventures, LLC (DBA Mark Cuban Companies)
Mark Cuban Cost Plus Drug Company, PBC (DBA Cost Plus Drugs)