



**COMMISSIONERS COURT  
COMMUNICATION**

COURT ORDER NUMBER 145155  
PAGE 1 OF 23  
DATE: 5/6/2025

**SUBJECT: CONSIDERATION OF AN ANCILLARY SERVICES AGREEMENT WITH CIGNA HEALTHCARE OF TEXAS, INC. FOR CLINICAL HEALTH CARE SERVICES AT THE TARRANT COUNTY PUBLIC HEALTH DEPARTMENT**

**\*\*\* CONSENT AGENDA \*\*\***

**COMMISSIONERS COURT ACTION REQUESTED**

It is requested that the Commissioners Court consider an Ancillary Services Agreement with Cigna HealthCare of Texas, Inc. for the clinical health care services at Tarrant County Public Health (TCPH).

**BACKGROUND**

TCPH provides clinical health care services to the residents of Tarrant County throughout various clinics and programs. TCPH continues to pursue enrollment and participation in additional commercial and state health plans to best provide services to our patients and community.

On October 21, 2014, the Commissioners Court, through Court Order #118802, approved a Managed Care Provider Agreement with Cigna HealthCare of Texas.

In an effort to maintain compliance with the requirements of the Medicare Advantage program, this agreement contains provisions required to be included in provider agreements by the Centers for Medicare and Medicaid Services (CMS).

In addition, if approved, TCPH will expand its billing and reimbursement capabilities with Cigna HealthCare of Texas Inc. to encompass all healthcare products available with Cigna HealthCare of Texas Inc.

The term of the agreement is from May 1, 2025, or as signed by the Commissioners Court, and shall remain in effect unless a new agreement is entered into or terminated by either party upon ninety (90) days' advance written notification of termination. All other terms and conditions not hereby amended remain in full force and effect.

The Criminal District Attorney's Office has reviewed this document as to form.

**FISCAL IMPACT**

All associated reimbursements will be deposited in the Public Health fund T0400-2025 and various related Public Health grants.

SUBMITTED BY	Public Health	PREPARED BY:	Gary Collins
		APPROVED BY:	Amanda Campbell

## Ancillary Services Agreement

This Ancillary Services Agreement (“Agreement”) is between Cigna HealthCare of Texas, Inc. (“Cigna”) and County of Tarrant (“Provider”) and is effective upon Cigna’s execution and implementation of the Agreement into its administrative systems. Provider will be notified of the Effective Date via Cigna’s return of the signed contract to Provider, and will be indicated in the space below.

Effective Date: May 1, 2025

### SECTION 1. DEFINITIONS

- 1.1 Administrative Guidelines  
means the rules, policies and procedures adopted by Cigna or a Payor to be followed by Provider in providing services and doing business with Cigna and Payors under this Agreement.
- 1.2 Benefit Plan  
means a certificate of coverage, summary plan description or other document or agreement which specifies the health care services to be provided or reimbursed for the benefit of a Participant.
- 1.3 Cigna Affiliate  
means any subsidiary or affiliate of The Cigna Group.
- 1.4 Coinsurance  
means a payment that is the financial responsibility of the Participant under a Benefit Plan for Covered Services that is calculated as a percentage of the contracted reimbursement rate for such services or, if reimbursement is on a basis other than a fee-for-service amount, as a percentage of a Cigna determined fee schedule or as a Cigna determined percentage of actual charges.
- 1.5 Copayment  
means a payment that is the financial responsibility of the Participant under a Benefit Plan for Covered Services that is calculated as a fixed dollar amount.
- 1.6 Covered Services  
means those health care services for which a Participant is entitled to receive coverage under the terms and conditions of the Participant’s Benefit Plan.
- 1.7 Deductible  
means a payment for Covered Services calculated as a fixed dollar amount that is the financial responsibility of the Participant under a Benefit Plan prior to qualifying for reimbursement for subsequent health care costs under the terms of a Benefit Plan.
- 1.8 Medically Necessary/Medical Necessity

means services and supplies that satisfy the Medical Necessity requirements under the applicable Benefit Plan. No service is a Covered Service unless it is Medically Necessary.

1.9 Participant

means any individual, or eligible dependent of such individual, whether referred to as "Insured", "Subscriber", "Member", "Participant", "Enrollee", "Dependent", or similar designation, who is eligible and enrolled to receive Covered Services, or who is a continuing care patient as defined by applicable federal law.

1.10 Participating Provider

means a hospital, physician or group of physicians, or any other health care practitioner or entity that has a direct or indirect contractual arrangement with Cigna to provide Covered Services with regard to the Benefit Plan covering the Participant.

1.11 Payor

means the person or entity obligated to a Participant to provide reimbursement for Covered Services under the Participant's Benefit Plan and which Cigna has agreed may access services under this Agreement. Cigna is the Payor only for Covered Services under an insurance policy or HMO contract issued by a Cigna company.

1.12 Quality Management

means the program described in the Administrative Guidelines relating to the quality of Covered Services provided to Participants.

1.13 Utilization Management

means a process to review and determine whether certain health care services provided or to be provided are Medically Necessary and in accordance with the Administrative Guidelines.

## SECTION 2. DUTIES OF PROVIDER

2.1 Provider Services

Provider shall provide Covered Services to Participants upon the terms and conditions set forth in this Agreement and the Administrative Guidelines. All services provided by Provider within the scope of Provider's practice or license must be provided on a participating basis. Regardless of Provider's physical location, all aspects of Provider's practice are participating under the terms of this Agreement unless Covered Services are provided under the terms of another applicable Cigna participation agreement.

2.2 Standards

Provider shall provide Covered Services with the same standard of care, skill and diligence customarily used by similar providers in the community, the requirements of applicable law, and the standards of applicable accreditation organizations. Provider shall provide Covered Services to all Participants in the same manner, under the same standards, and with the same time availability as offered to other patients. Provider shall not differentiate or discriminate in the treatment of any Participant because of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, age,

health status, veteran's status, handicap or source of payment. Provider shall assure that all health care providers who perform any of the services for which Provider is responsible under this Agreement maintain all necessary licenses or certifications required by state and federal law. Provider shall immediately restrict, suspend, or terminate any such health care provider from providing services to Participants under this Agreement if such provider ceases to meet the licensing/certification requirements or other professional standards described in this Agreement.

2.3 Insurance/Application for Participation Information

Provider shall maintain general and professional liability coverage in a form and amount acceptable to Cigna, give Cigna evidence of such coverage upon request and provide Cigna with immediate written notice of a material modification or termination of such insurance. Provider shall also notify Cigna in writing within 30 days of any material change in the information contained in Provider's application for participation with Cigna.

2.4 Administrative Guidelines

Provider shall comply with the Administrative Guidelines. Some or all Administrative Guidelines may be communicated in the form of a provider reference manual, in other written materials distributed by Cigna to Provider and/or at a website identified by Cigna. Administrative Guidelines may change from time to time. Cigna will give Provider advance notice of material changes to Administrative Guidelines.

2.5 Quality Management

Provider shall comply with the requirements of and participate in Quality Management as specified in the Administrative Guidelines.

2.6 Utilization Management

Provider shall comply with the requirements of and participate in Utilization Management as specified in this Agreement and the Administrative Guidelines. Payment may be denied for failure to comply with such Utilization Management requirements, and Provider shall not bill the Participant for any such denied payment. Cigna's Utilization Management requirements include, but are not limited to, the following: a) precertification must be secured from Cigna or its designee for those services and procedures for which it is required as specified in the Administrative Guidelines; b) Provider must provide Cigna or Cigna's designee with all of the information requested by Cigna or its designee to make its Utilization Management determinations within the timelines specified by Cigna or its designee in such request; and c) Provider will refer Participants to and/or use Participating Providers for the provision of Covered Services except in the case of an emergency or as otherwise required by law. If Provider inappropriately refers a Participant to a non-Participating Provider in a non-emergency situation without the Participant's express written consent, and thereby cause the Participant to become responsible, for the charges of the non-Participating Provider, or to incur more charges than if such care had been received from a Participating Provider, Cigna or a Cigna Affiliate may, in its sole discretion, satisfy the obligation to the non-Participating Provider for such services. If this occurs,

Cigna or a Cigna Affiliate may offset the amount paid to such non-Participating Provider for such services against future compensation payable to Provider.

2.7 Records

Provider shall maintain medical records and documents relating to Participants as may be required by applicable law and for the period of time required by law. Medical records of Participants and any other records containing individually identifiable information relating to Participants will be regarded as confidential, and Provider and Cigna shall comply with applicable federal and state law regarding such records. Provider will obtain Participants' consent to or authorization for the disclosure of private and medical record information for any disclosures required under this Agreement if required by law. Upon request, Provider will provide Cigna with a copy of Participants' medical records and other records maintained by Provider relating to Participants. These records shall be provided to Cigna at no charge and within the timeframes requested by Cigna and will also be made available during normal business hours for inspection by Cigna, Cigna's designee, accreditation organizations, or to any governmental agency that requires access to these records. This provision survives the termination of this Agreement.

2.8 Cooperation with Cigna and Cigna Affiliates

Provider shall cooperate with Cigna in the implementation of Cigna's Participant appeal procedure. Provider shall also cooperate with Cigna and Cigna Affiliates in implementing those policies and programs as may be reasonably requested by Cigna or a Cigna Affiliate for purposes of Cigna's or the Cigna Affiliate's business operations or required by Cigna or a Cigna Affiliate to comply with applicable law or accreditation requirements.

### SECTION 3. DUTIES OF CIGNA

3.1 Payors, Benefit Plan Types, Notice of Changes to Benefit Plan Types

Cigna may allow Payors to access Provider's services under this Agreement for the following Benefit Plan types: a) Benefit Plans where Participants are offered a network of Participating Providers and are required or given the option to select a Primary Care Physician; b) Benefit Plans where Participants are offered a network of Participating Providers and are not required or given the option to select a Primary Care Physician; and c) Benefit Plans where Participants are not offered a network of Participating Providers from which they may receive Covered Services. Benefit Plans may include workers' compensation plans. Cigna will give Provider advance notice if Cigna changes this list of Benefit Plan types for which Payors may access Provider's services under this Agreement.

3.2 Benefit Information

Cigna will give Provider access to benefit information concerning the type, scope and duration of benefits to which a Participant is entitled as specified in the Administrative Guidelines.

3.3 Participant and Participating Provider Identification

Cigna will establish a system of Participant identification and will identify Participating Providers to those Payors and Participants who are offered a network of Participating Providers. However, Cigna makes no representations or guarantees concerning the number of Participants that will be referred to Provider as a result of this Agreement and reserves the right to direct Participants to selected Participating Providers and/or influence a Participant's choice of Participating Provider.

#### SECTION 4. COMPENSATION

##### 4.1 Payments

Payments for Covered Services will be the lesser of the billed charge or the applicable fee under Exhibit A, subject to the Administrative Guidelines and minus any applicable Copayments, Coinsurance and Deductibles. The rates in this Agreement will be payment in full for all services furnished to Participants under this Agreement. Provider shall look solely to Payor for payment for Covered Services except for Copayments, Coinsurance and Deductibles. Provider shall submit claims for Covered Services at the location identified by Cigna and in the manner and format specified in this Agreement and the Administrative Guidelines. Claims for Covered Services must be submitted within 90 days of the date of service or, if Payor is the secondary payor, within 90 days of the date of the explanation of payment from the primary payor. Claims received after this 90 day period may be denied except as provided in the Administrative Guidelines, and Provider shall not bill Cigna, the Payor or the Participant for those denied services. Amounts due and owing under this Agreement with respect to complete claims for Covered Services will be payable within the timeframes required by applicable law.

##### 4.2 Underpayments

If Provider believes a Covered Service has been underpaid, Provider must submit a written request for an appeal or adjustment with Cigna or its designee within 180 days from the date of Payor's payment or explanation of payment. The request must be submitted in accordance with the dispute resolution process set out in the Administrative Guidelines. Requests for appeals or adjustments submitted after this date may be denied for payment, and Provider will not be permitted to bill Cigna, the Payor or the Participant for those services.

##### 4.3 Copayments, Coinsurance and Deductibles

Provider may charge Participants applicable Copayments, Coinsurance and Deductibles in accordance with the process set out in the Administrative Guidelines.

##### 4.4 Limitations on Billing Participants

Provider agrees that in no event, including but not limited to nonpayment by Payor, Payor's insolvency or breach of this Agreement shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Participants or persons other than the applicable Payor for Covered Services or for any amounts denied or not paid under this Agreement due to Provider's failure to comply with the requirements of Cigna's or its designee's Utilization Management Program or other Administrative Guidelines, or failure to file a timely claim or appeal. This provision does not prohibit collection of any applicable

Copayments, Coinsurance and Deductibles. This provision survives termination of this Agreement, is intended to be for the benefit of Participants, and supersedes any oral or written agreement to the contrary now existing or hereafter entered into between Provider and a Participant or persons acting on the Participant's behalf. Modifications to this section will become effective no earlier than the date permitted by applicable law.

4.5 Billing Patients Who Cease to Be Participants

Provider may bill a patient directly for any services provided following the date that patient ceases to be a Participant, and Payor has no obligation to pay for services for such patients.

4.6 Participant Incentives Prohibited

Provider shall not directly or indirectly establish, arrange, encourage, participate in or offer any Participant incentive.

(A) Participant Incentive means any arrangement by Provider:

- (1) to reduce or satisfy a Participant's cost-sharing obligations (including, but not limited to Copayments, Deductible and/or Coinsurance);
- (2) to pay on behalf of or reimburse a Participant for any portion of the Participant's costs for coverage under a policy or plan insured or administered by Cigna or a Cigna Affiliate;
- (3) that provides a Participant with any form of material, financial incentive (other than the reimbursement terms under this Agreement), to receive Covered Services from Provider or its affiliates.

(B) In the event of non-compliance with this provision:

- (1) Cigna may terminate this Agreement, such non-compliance being a "material breach" of this Agreement;
- (2) Provider shall not be entitled to reimbursement under this Agreement with respect to Covered Services provided to a Participant in connection with a Participant Incentive, and;
- (3) Cigna may take such other action appropriate to enforce this provision.

4.7 Non-Medically Necessary Services

Provider shall not charge a Participant for a service that is not Medically Necessary unless, in advance of providing the service, Provider has notified the Participant that the particular service will not be covered and the Participant acknowledges in writing that he or she will be responsible for payment for such service.

4.8 Reimbursement of Amounts Collected In Error

If Provider collects payment from a Participant when not permitted to collect under either this Agreement or the Administrative Guidelines, Provider must repay the amount within 2 weeks of a request from Cigna or the Participant or of the date Provider has knowledge of the error. If Provider fails to make the repayments, then Cigna may (but is not obligated to) reimburse the Participant the amount inappropriately paid and then withhold this amount from future payments.

4.9 Overpayments

Provider shall refund to Cigna any excess payment made by a Payor to Provider if Provider is for any reason overpaid for health care services or supplies. Cigna may, at its option, deduct the excess payment from other amounts payable, and Provider will be notified of any such deduction as specified in the Administrative Guidelines.

4.10 Audits

Upon reasonable notice and during regular business hours, Cigna or its designee will have the right to review and make copies of all records maintained by Provider with respect to all payments received by Provider from all sources for Covered Services provided to Participants. Cigna or its designee will have the right to conduct audits of such records and may audit its own records to determine if amounts have been properly paid under this Agreement. Any amounts determined to be due and owing as a result of such audits must be promptly paid or, at the option of the party to whom such amounts are owed, offset against amounts due and owing by such party hereunder. This provision survives the termination of this Agreement.

4.11 Coordination of Benefits

Certain claims for Covered Services are claims for which another payor may be primarily responsible under Coordination of Benefit (COB) rules. Provider may pursue those claims in accordance with the process set out in the Administrative Guidelines.

Cigna's Payment as Secondary Payor (Non-Medicare)

Cigna's payment when added to the amount payable from other sources under the applicable COB rules, will be no greater than the payment for Covered Services under the Cigna provider agreement, and is subject to the terms and conditions of the Participant's health benefit plan and applicable state and federal law. Use of applicable COB provisions may result in a payment from Cigna that, when added to the amount payable from other sources, is less than 100 percent of the payment for Covered Services under the Cigna provider agreement. Payment may, however, be in a lesser amount as determined by the terms of the participant's benefit plan.

Medicare is the Primary Payor

When the Cigna plan is the secondary payor to Medicare, Provider and Cigna are required to follow Medicare billing rules. Payment will be made in accordance with all applicable Medicare requirements, including but not limited to Medicare COB rules. The Medicare COB rules require Cigna's financial responsibility as the secondary payor to be limited to the Participant's financial liability (i.e., the applicable Medicare copayment, coinsurance, and/or deductible) after application of the Medicare-approved amount. The Medicare payment plus the Participant liability (applicable Medicare copayment, coinsurance, and/or deductible) amounts constitute payment in full, and Provider is prohibited from collecting any monies in excess of this amount.

4.12 Applicability of the Rates

The rates in this Agreement apply to all services provided to Participants in the Benefit Plan types covered by this Agreement, including services covered under a Participant's in or out-of-network benefits, and whether the Payor or Participant is financially responsible for payment.

4.13 Excluded Services

This Agreement excludes services that Cigna has elected to obtain under an arrangement between Cigna or a Cigna Affiliate and a national or regional vendor or provider or a capitated provider, except as otherwise agreed by Cigna. Provider will not be reimbursed and will not bill Participants for any such excluded services. If Cigna notifies Provider that it no longer chooses to exclude a particular service from this Agreement, that service will no longer be excluded and those services will be reimbursed as specified in Exhibit A.

4.14 Provider Facilities

This Agreement shall specifically exclude those services rendered at Provider facilities other than those facilities agreed upon and utilized as of the Effective Date unless otherwise agreed in writing by Cigna.

## SECTION 5. TERM AND TERMINATION

5.1 Term of This Agreement

This Agreement begins on the Effective Date and continues from year to year unless terminated as set forth below.

5.2 How This Agreement Can Be Terminated

Either Provider or Cigna can terminate this Agreement at any time by providing at least 90 days advance written notice. Either Provider or Cigna can terminate this Agreement immediately if the other becomes insolvent. Cigna can terminate this Agreement immediately (or upon such longer notice required by applicable law, if any) if Provider no longer maintains the licenses required to perform its duties under this Agreement, Provider is disciplined by any licensing, regulatory, accreditation organization, or any other professional organization with jurisdiction over Provider, or if Provider no longer satisfies Cigna's credentialing requirements. Upon termination of this Agreement for any reason, the rights of each party terminate, except as provided in this Agreement. Termination will not release Provider or Cigna from obligations under this Agreement prior to the effective date of termination.

5.3 Services upon Termination

Upon termination of this Agreement, Provider shall continue to provide Covered Services for specific conditions for which a Participant was under Provider's care at the time of such termination so long as the Participant retains eligibility under a Benefit Plan until the later of the completion of such services or the date required by applicable law. Provider shall be compensated for Covered Services provided to any such Participant in accordance with the terms of the applicable Benefit Plan and applicable law. Provider has no obligation under this Agreement to provide services to individuals who cease to be Participants.

## SECTION 6. GENERAL PROVISIONS

6.1 Confidentiality

As a result of this Agreement, Provider may have access to certain of Cigna's confidential and proprietary information. Provider shall hold such information, including the terms of this Agreement, in confidence and will not use or disclose such information to any person without the prior written consent of Cigna except as may be required by law. This provision shall not be construed to prohibit Cigna from disclosing information to Cigna Affiliates or the agents or subcontractors of Cigna or Cigna Affiliates or from disclosing the terms and conditions of this Agreement, including reimbursement rates, to existing or potential Payors, Participants or other customers of Cigna or Cigna Affiliates or their representatives. This provision does not prohibit communications necessary or appropriate for the delivery of health care services, communications about coverage and coverage appeal rights or any other communications specifically protected under applicable law. This provision survives the termination of this Agreement.

6.2 Independent Parties

Provider is an independent contractor. Cigna and Provider do not have an employer-employee, principal-agent, partnership, or similar relationship. Nothing in this Agreement, including Provider's participation in care collaboration, population management, pay for performance, Quality Management, Utilization Management, and other similar programs, nor any coverage determination made by Cigna or a Payor, is intended to interfere with or affect Provider's independent judgment in providing health care services to its patients. Nothing in the Agreement is intended to create any right for Cigna or any other party to intervene in or influence your medical decision-making regarding any Participant.

6.3 Indemnification

Each party agrees to indemnify, defend and hold harmless the other, its agents and employees from and against any and all liability or expense, including defense costs and legal fees, incurred in connection with third party claims for damages of any nature, including but not limited to bodily injury, death, personal injury, property damage, or other damages arising from the performance of or failure to perform, its obligations under this Agreement, unless it is determined that the liability was the direct consequence of negligence or willful misconduct on the part of the other party, its agents or employees. This provision shall survive the termination of this Agreement.

6.4 Internal Dispute Resolution

Disputes that might arise between the parties regarding the performance or interpretation of the Agreement must first be resolved through the applicable internal dispute resolution process outlined in the Administrative Guidelines. In the event the dispute is not resolved through that process, either party can request in writing that the parties attempt in good faith to resolve the dispute promptly by negotiation between designated representatives of the parties who have authority to settle the dispute. If the matter is not resolved within 60 days of such a request, either party may initiate arbitration by providing written notice to the other. With respect to a payment or termination dispute (excluding termination with notice), Provider must submit a request for arbitration within 12 months of the date of the letter communicating the final decision under Cigna's internal dispute resolution process unless applicable law

specifically requires a longer time period to request arbitration. If arbitration is not requested within that 12 month period, Cigna's final decision under its internal dispute resolution process will be binding on Provider, and Provider shall not bill Cigna, Payor or the Participant for any payment denied because of the failure to timely submit a request for arbitration.

6.5 Arbitration

If the dispute is not resolved through Cigna's internal dispute resolution process, the controversy shall be resolved through binding arbitration. The arbitration shall be conducted in accordance with the Rules of the American Arbitration Association then in effect, and which to the extent of the subject matter of the arbitration, shall be binding not only on all parties to the agreement, but on any other entity controlled by, in control of or under common control with the party to the extent that such affiliate joins in the arbitration, and judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction thereof. Each party shall assume its own costs, but the compensation and expenses of the arbitrator and any administrative fees or costs shall be borne equally by the parties. The decision of the arbitrator shall be final, conclusive and binding, and no action at law or in equity may be instituted by either party other than to enforce the award of the arbitrator. The parties intend this alternative dispute resolution procedure to be a private undertaking and agree that an arbitration conducted under this provision shall not be consolidated with an arbitration involving other parties, and that the arbitrator shall be without power to conduct an arbitration on a class basis.

6.6 Material Adverse Change Amendments

For amendments that are a material adverse change in the terms of this Agreement, Cigna can amend this Agreement by providing 90 days advance written notice except if a shorter notice period is required to comply with changes in applicable law. The change will become effective at the end of the 90 day notice period or, if applicable, the shorter notice period required to comply with changes in applicable law. If Provider objects to the material adverse change and notifies Cigna of its intent to terminate within 30 days of the date of the notice of amendment, the termination will be effective at the end of the 90 day notice of the material adverse change or, if applicable, at the end of the shorter notice period required to comply with changes in applicable law, unless Cigna agrees to retract the amendment, in which case the Agreement will remain in force without the proposed amendment.

6.7 All Other Amendments

For amendments that are not material adverse changes in the terms of this Agreement, Cigna can amend this Agreement by providing 30 days advance written notice to Provider. Alternatively, both parties can agree in writing to amend this Agreement.

6.8 Assignment and Delegation

Neither Cigna nor Provider may assign any rights or delegate any obligations under this Agreement without the written consent of the other party; provided, however, that any reference to Cigna includes any successor in interest and Cigna may assign its duties,

rights and interests under this Agreement in whole or in part to a Cigna Affiliate or may delegate any and all of its duties to a third party in the ordinary course of business.

6.9 Sale of Business/Change in Management

If, during the term of this Agreement, Provider desires (i) to sell, transfer or convey its business or any substantial portion of its business assets to another entity, or Provider is the subject of a sale, transfer or conveyance of its business by another entity, or (ii) Provider enters into a management contract with another entity, Provider shall so advise Cigna in writing at least 120 days prior to the transaction effective date in order to obtain Cigna's written consent as to which Cigna participating provider agreement applies, if any, to services rendered by you or the surviving entity, on a post-transaction basis. Failure to provide advance notification and obtain Cigna's written consent will result in Cigna determining which, if any, Cigna participating provider agreement applies to services rendered on a post-transaction basis. Dependent upon when Cigna learns of the transaction, this may result in a retroactive adjustment to reimbursement and an overpayment recovery process. Provider warrants and covenants that this Agreement will be part of the transfer, and will be assumed by the new entity and that the new entity will honor and be fully bound by the terms and conditions of this Agreement unless the new entity already has an agreement with Cigna or a Cigna Affiliate, in which case Cigna, in its sole discretion, will determine which Agreement will prevail. Notwithstanding the above, if Cigna, in its sole discretion, is of the opinion that the Agreement cannot be satisfactorily performed by the assuming entity or does not want to do business with that entity for whatever reason, Cigna may terminate this Agreement by giving Provider 60 days written notice, notwithstanding any other provision in the Agreement.

6.10 Acquisitions and Other Arrangements

This Agreement shall not, without Cigna's written consent, be applicable to any hospital, physician or physician group or ancillary provider that is acquired (directly or indirectly) by or enters into a management, co-management, professional services, leasing, joint venture or similar agreement or arrangement with Provider or a Provider affiliate. Provider shall notify Cigna 120 days in advance of any such acquisition or arrangement.

6.11 Use of Name

Provider agrees that Cigna may include descriptive information about Provider in literature distributed to existing or potential Participants, Participating Providers and Payors. That information will include, but not be limited to, Provider's name, telephone number, address, and specialties. Provider may identify itself as a Participating Provider with respect to those Benefit Plan types in which Provider participates with Cigna. Provider's use of Cigna's name or a Cigna Affiliate's name, or any other use of Provider's name by Cigna will be upon prior written approval or as the parties may agree.

6.12 Notices

Notices required under this Agreement shall be in writing and shall be deemed to have been duly given (i) on the third day after deposit in the United States mail, postage

prepaid, and properly addressed as specified below; or, (ii) on the date of delivery if sent via overnight delivery to the party to whom notice is to be given and properly addressed as specified below; or (iii) on the date of service if served personally on the party to whom notice is to be given. Cigna may also notify Provider by sending an electronic notice with automatic receipt verification to Provider's e-mail address if listed below. Either party can change the address for notices by giving written notice of the change to the other party in the manner just described.

The proper address for notices under this Agreement is as follows:

If to Cigna:  
1640 Dallas Pkwy  
Plano, TX 75093  
Attention: VP of Provider Contracting

If to Provider:  
County of Tarrant  
1101 S MAIN ST  
Fort Worth, TX 76104

Attention: Administrator/CEO

Email address: candie@catalyst-consultants.com

6.13 Governing Law/Regulatory Addenda

Applicable federal law and the law of the jurisdiction where Provider is domiciled governs this Agreement. One or more regulatory addenda may be attached to the Agreement setting out provisions that are required by law with respect to Covered Services rendered to certain Participants (i.e. Participants under an insured plan). These provisions are incorporated into this Agreement to the extent required by law and as specified in such Addenda.

6.14 Force Majeure

In the event that performance by either Cigna or Provider of any covenant, duty or obligation imposed under this Agreement becomes impossible or impracticable because of the occurrence of an event of force majeure, including, without limitation, acts of war, insurrection, civil strife and commotion, labor unrest, sentinel event, or acts of God, then performance of such covenant, duty or obligation by such party shall be excused during the continuance of such event of force majeure; provided, however, that such performance by such party shall be accomplished as soon as reasonably practicable after such event of force majeure has ceased.

6.15 Waiver of Breach/Severability/Entire Agreement/Copy of Original Agreement

If any party waives a breach of any provision of this Agreement, it will not operate as a waiver of any subsequent breach. If any portion of this Agreement is unenforceable for any reason, it will not affect the enforceability of any remaining portions. This

Agreement, including any exhibits to this Agreement, contains all of the terms and conditions agreed upon and supersedes all other agreements between the parties, either oral or in writing, regarding the subject matter. A copy of this fully executed Agreement is an acceptable substitute for the original fully executed Agreement.

IN WITNESS WHEREOF the parties have caused this Agreement to be executed by their duly authorized representatives below.

AGREED AND ACCEPTED BY:

**Provider**

County of Tarrant

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**Cigna**

Cigna HealthCare of Texas, Inc.

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Signature

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Signature

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Printed Name

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Printed Name

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Title

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Title

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Date Signed

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Date Signed

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756001170

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Federal Tax ID

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119483183

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National Provider Identifier

**ADDENDUM TO ANCILLARY AGREEMENT  
FOR THE STATE OF TEXAS**

The provisions set forth in this Addendum are being added to the Agreement to comply with legislative and regulatory requirements of the State of Texas regarding provider contracts with providers rendering health care services in the State of Texas. To the extent that such Texas laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans.

- (1) The definition for Emergency Services shall comply with Texas laws and regulations to the extent applicable.
- (2) To the extent applicable, Cigna will comply with all applicable Texas statutes and rules pertaining to prompt payment of Clean Claims with respect to payment to Provider for Covered Services under the Agreement.
- (3) Cigna's claims submission processes are set forth in Cigna's Provider reference manual, as amended from time to time. To the extent required by § 843.337 or § 1301.102 of the Insurance Code, Provider must submit a claim to Cigna not later than the 95th day after the date Provider provides the medical care or health care services for which the claim is made.
- (4) To the extent applicable, Cigna will not refuse to process or pay an electronically submitted Clean Claim because the claim is submitted with or in a batch submission with a Clean Claim that is deficient. A "batch submission" is a group of electronic claims submitted for processing at the same time within HIPAA standard ASC X12N 837 Transaction Set and identified by a batch control number.
- (5) Upon request and to the extent required by Texas law, Cigna will provide Provider with the information necessary to determine that Provider is being compensated in accordance with the Agreement.
- (6) If Provider is compensated on a discounted fee basis, the Participant's financial obligation for Deductibles or Coinsurance shall be determined based upon the discounted fee and not upon the full billed charge.
- (7) Provider acknowledges and agrees that the Agreement does not contain any financial incentive or make any payment that acts directly or indirectly as an inducement to limit Medically Necessary services. This provision shall not prohibit the savings from cost effective utilization of health services by contracting physicians or health care Providers from being shared with physicians or health care Providers in the aggregate.
- (8) Provider shall post a notice to Participants at the Provider's location on the process for resolving complaints with Cigna. The notice must include the Texas Department of

Insurance's toll-free telephone number for filing complaints.

- (9) Cigna shall not engage in any retaliatory action, including termination of or refusal to renew the Agreement, because Provider, on behalf of a Participant, reasonably filed a complaint against Cigna or has appealed a decision of Cigna.
- (10) (A) Cigna will not as a condition of the Agreement or in any other manner prohibit, attempt to prohibit or discourage Provider from discussing with or communicating in good faith to a Participant who is a current, prospective or former patient or a party designated by such Participant, with respect to: a) information or opinions regarding the Participant's health care including the Participant's medical condition or treatment options; b) information or opinions regarding the provisions, terms, requirements or services of the Participant's health benefit plan as they relate to the medical needs of the Participant; c) the fact that Provider's contract with Cigna has terminated or that Provider will otherwise no longer be providing care for Cigna Participants; or d) the fact that, if medically Necessary Covered Services are not available through Participating Providers, Cigna must, upon the request of Provider, and within time appropriate to the circumstances relating to the delivery of the services and the condition of the Participant, but in no event to exceed 5 business days after receipt of reasonably requested documentation, allow referral to a non-participating Provider.
- (B) Cigna will not in any way penalize or terminate Provider or refuse to compensate Provider for Covered Services for communicating with a Participant who is a current, prospective or former patient, or a party designated by Participant, in any manner protected by this provision.
- (11) (A) If Cigna terminates the Agreement, Cigna shall give Provider not less than 90 days' prior written notice of the termination, except in the case of imminent harm to patient health, action against license to practice, or fraud, in which case termination may be immediate. Notwithstanding the foregoing, to the extent that the Agreement provides for a longer notification period with respect to termination of the Agreement by Cigna, such longer notification period will apply.
- (B) Notice and Hearing. If Cigna should choose to terminate the Agreement, Cigna will notify Provider of this decision in writing. The notice will include the reason(s) for the termination and a notice of Provider's right to request a hearing or review. On request and before the effective date of the termination, but within a period not to exceed 60 days, Provider shall be entitled to a review of the proposed termination by an advisory review panel.

When Cigna chooses to terminate Provider's participation with respect to its commercial HMO plans, the advisory review panel shall be composed of physicians and Providers appointed by Cigna, including at least one representative in Provider's specialty or a similar specialty, if available, who

serve on a standing Quality Management committee or Utilization Management committee.

The decision of the advisory review panel must be considered but is not binding on Cigna. On request, a copy of the recommendation of the advisory review panel and Cigna's determination shall be given to Provider. If Provider is unsatisfied with the determination, Provider may appeal the decision further pursuant to the Dispute Resolution procedures specified in the Agreement and Administrative Guidelines.

- (C) The requirements regarding notice and hearing set forth in subsection (B) above do not apply in the case of imminent harm to patient health, action against license to practice, or fraud.
- (D)
  - (1) In the event the Agreement is terminated by Provider, Cigna in Accordance with Insurance Code § 843.309, shall give reasonable advance notice of such termination to those Participants whom Provider is currently treating and who are affected by the termination.
  - (2) Cigna will provide assistance to Provider in the event the Agreement is voluntarily terminated by Provider, and Provider, in accordance with Insurance Code § 1301.160, must give reasonable advance notice of such termination to those Participants whom Provider is currently treating and who are affected by the termination.
  - (3) In the event the Agreement is terminated by Cigna, Cigna will notify those Participants whom Provider is currently treating and are affected by the Termination. Cigna may notify such Participants of the Provider's termination immediately if the Agreement is terminated for reasons related to imminent harm.
- (E)
  - (1) If Provider is terminated for reasons other than medical competence or professional conduct, Provider shall continue to provide Covered Services for those Participants who retain eligibility under a Benefit Plan and whom 1) Provider has identified to Cigna as having special circumstances (i.e. persons with a disability, acute condition, life-threatening illness, past the 24th week of pregnancy or a condition such that Provider reasonably believes that discontinuing care could cause harm to the Participant); and 2) Provider has requested to continue treatment. Provider shall be compensated for Covered Services provided pursuant to this provision in accordance with the compensation arrangements under the Agreement for a period of 9 months for those Participants diagnosed with a terminal illness at the time of termination of the Agreement, through delivery, immediate post-partum care and the follow-up checkup within the first 6 weeks of delivery for participants past the 24th week of pregnancy at the time of termination, and for a

period of 90 days following termination for all others.

- (2) Provider shall not seek payment from the Participant with respect to services rendered pursuant to this provision of amounts for which the Participant would not be responsible if Provider were still a Participating Provider.
- (12) Nothing in the Agreement shall be construed to require Provider to indemnify Cigna for any tort liability resulting from acts or omissions of Cigna.
- (13) Provider shall hold Participants harmless for payment of the cost of Covered Services in the event Payor fails to pay Provider for such Covered Services.
- (14) Nothing in this Agreement shall be construed to require a referring Provider to bear the expenses of a referral for specialty care in or out of Cigna's Provider panel. Savings from cost-effective utilization of health services may, however, be shared with physicians and health care Providers in the aggregate.
- (15) To the extent that Cigna conducts, uses or relies upon economic profiling to terminate the Agreement, Cigna shall make available to Provider on request the economic profile of Provider, including the written criteria by which Provider's performance was measured. An economic profile will be adjusted to recognize the characteristics of Provider's practice that may account for variations from expected costs.
- (16) Quality assessment (as that term is defined under Texas law) shall be conducted through a panel of not less than 3 physicians selected by Cigna from among a list of participating physicians which list is to be provided by participating physicians in the applicable service area.
- (17) Provider may be required pursuant to procedures contained in the Administrative Guidelines, when referring a Participant to another provider, to disclose to Participant that the physician, provider or facility to whom Participant is referred might not be a participating provider; and, if applicable, that the Provider has an ownership interest in the facility to which Participant is referred. Such disclosure shall not be required when referring for emergency care, and as necessary to avoid interruption or delay of medically necessary care. Nothing in this section or in the Administrative Guidelines shall be construed to limit access to non-participating providers.
- (18) Provider shall, except for instances of emergency care as defined under state law, when referring a Participant to a facility for surgery: notify Participant that out-of-network providers may provide treatment and that Participant can contact Cigna for more information; notify Cigna that surgery has been recommended; and, notify Cigna of the facility that has been recommended for the surgery.
- (19) Provider shall comply with all applicable requirements of Insurance Code § 1661.005. Provider must refund the amount of an overpayment to a Participant no later than the

30th day after the date Provider determines that an overpayment has been made.

- (20) To the extent applicable, Provider may request, pursuant to procedures contained in the Administrative Guidelines, a waiver of any requirement for the use of information technology established or required by Chapter 1661 of the Texas Insurance Code as may be changed from time to time. A waiver granted under this section will expire September 1, 2013, or as otherwise permitted by applicable laws and regulations.
- (21) To the extent applicable, Provider may request, pursuant to procedures contained in the Administrative Guidelines, a waiver of any requirement for electronic submission established or required by Chapter 1213 of the Texas Insurance Code as may be changed from time to time.
- (22) To the extent applicable, nothing in this Agreement shall be construed to permit Cigna or Payor to directly or indirectly charge or hold Provider responsible for a fee for the adjudication of a claim.
- (23) The Agreement permits Cigna to contract with another party to provide access to Cigna's rights and responsibilities under this Agreement. Upon request, Cigna will provide information necessary to determine whether a particular party has been authorized to access Provider's health care services and contractual discounts under this Agreement. Any party authorized to access the health care services and contractual discounts under this Agreement must comply with all applicable terms, limitations, and conditions of the Agreement.
- (24) The fee schedule for each type of Benefit Plan is included in the exhibits to this Agreement. Notwithstanding the foregoing, Cigna may at its option provide the fee schedule for any Benefit Plan to Provider electronically.
- (25) Upon the request of Provider, Cigna will provide Provider with such information as is necessary to allow Provider to determine that a Payor is authorized to access the reimbursement rates under this Agreement.
- (26) Cigna shall cause each Payor that accesses Provider's discounts under this Agreement to comply with all applicable terms, limitations and conditions of this Agreement.

**Cigna**

**EXHIBIT C**

**Fee Schedule and Reimbursement Terms**

**This Rate Exhibit applies to the following Cigna Benefit Plans:**

**HMO Benefit Plans: Yes**

**Network Benefit Plans: Yes**

**Open Access Plus Benefit Plans: Yes**

**All Other: Yes**

**IFP - Individual Family Plan - Benefit Plan: Yes**

**LocalPlus Benefit Plan: Yes**

This is an Exhibit to an Agreement between:

Provider: County of Tarrant

Cigna Party: Cigna HealthCare of Texas, Inc.

Effective Date of Base Agreement: May 1, 2025

This Rate Exhibit:

Applies to: County of Tarrant

Federal Tax ID: 756001170

National Provider Identifier: 119483183

Effective Date: May 1, 2025

**I. DEFINITIONS**

Cigna Standard Fee Schedule

means the standard Cigna fee schedule applicable to the provider types (e.g. MD, DO, NP, PA etc.) as designated by Cigna in effect at the time of service and applicable to this Agreement for certain Covered Services provided to Participants. The Cigna Standard Fee Schedule is subject to change. For workers' compensation Benefit Plans, the Cigna Standard Fee Schedule shall not exceed the state fee schedule.

**II. FEE FOR SERVICE REIMBURSEMENT**

- A. Covered Services will be reimbursed at the lesser of billed charges or the applicable fee under the Cigna Standard Fee Schedule, less applicable Copayments, Deductibles and Coinsurance. Group agrees to identify the actual rendering provider's name providing services to Participants on the claim submission to Cigna.

B. The reimbursement terms set forth in this Exhibit are applicable to all services rendered as part of your practice or scope of license. Any services provided by an out of network provider or vendor as part of your practice or scope of license are not separately reimbursable.

**SIGNED AND EXECUTED** this \_\_\_\_\_ day of \_\_\_\_\_, 2025.

**COUNTY OF TARRANT  
STATE OF TEXAS**

By: Separate Electronic Signature Page  
Tim O'Hare  
County Judge

APPROVED AS TO FORM:

*Kimberly Colliet Wesley*  
\_\_\_\_\_  
Criminal District Attorney's Office\*

\*By law, the Criminal District Attorney's Office may only approve contracts for its clients. We reviewed this document as to form from our client's legal perspective. Other parties may not rely on this approval. Instead, those parties should seek contract review from independent counsel.