

SERFF Tracking Number: UHLC-125708259 State: Arkansas
 Filing Company: UnitedHealthcare of Arkansas, Inc. State Tracking Number: 39393
 Company Tracking Number:
 TOI: HOrg02G Group Health Organizations - Health Sub-TOI: HOrg02G.002B Any Size Group - POS
 Maintenance (HMO)
 Product Name: HMO
 Project Name/Number: Provider Agreement Appendix 2/

Filing at a Glance

Company: UnitedHealthcare of Arkansas, Inc.

Product Name: HMO

TOI: HOrg02G Group Health Organizations - Health Maintenance (HMO)

Sub-TOI: HOrg02G.002B Any Size Group - POS

Filing Type: Form

SERFF Tr Num: UHLC-125708259 State: ArkansasLH

SERFF Status: Closed

State Tr Num: 39393

Co Tr Num:

State Status: Approved-Closed

Co Status:

Reviewer(s): Rosalind Minor

Authors: Lori Anderson, Cathy Dykhouse

Disposition Date: 06/26/2008

Date Submitted: 06/24/2008

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Provider Agreement Appendix 2

Project Number:

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 06/26/2008

State Status Changed: 06/26/2008

Corresponding Filing Tracking Number:

Filing Description:

Please see attached the revised Appendix 2, Benefit Plan Description, for your review and approval:

Status of Filing in Domicile: Authorized

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Group Market Type:

Deemer Date:

- CCC.Nat'l.App2_06.08

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This revised Appendix 2, Benefit Plan Description, replaces the current appendix that is filed with the approved Convenient Care Clinic Participation Agreement (form number: CCC.Nat'l.10.06, approved 11/20/2006). The Convenient Care Clinic Agreement is a national agreement, used for all United affiliates across the country. With that in mind, we have found it necessary to revise, Appendix 2, Benefit Plan Description, to better describe all of our benefit plan types which are included and excluded from the Convenient Care Clinic Participation Agreement.

To assist the Department's review, I've attached the following informational copies:

- Redlined version of Appendix 2.
- Convenient Care Clinic Participation Agreement (form number: CCC.Nat'l.10.06, approved 11/20/2006).
- Arkansas Regulatory Requirements Appendix; this Appendix is made part of the Agreement (form number: UHC/FAC.MGA.ANCL-REGAPX.08.06.AR, approved 11/20/2006).

Company and Contact

Filing Contact Information

Cathy Dykhouse, Regulatory Affairs Specialist Cathy_Dykhouse@uhc.com
 106 Farmer's Alley (269) 216-2105 [Phone]
 Kalamazoo, MI 49005-1100 (269) 216-2168[FAX]

Filing Company Information

UnitedHealthcare of Arkansas, Inc.	CoCode: 95446	State of Domicile: Arkansas
Plaza West Building	Group Code:	Company Type: HMO
415 North McKinley Street, Suite 300		
Little Rock, AK 72205	Group Name:	State ID Number:
(952) 992-7428 ext. [Phone]	FEIN Number: 63-1036819	

Filing Fees

Fee Required?	Yes
Fee Amount:	\$50.00
Retaliatory?	Yes
Fee Explanation:	\$50.00 per provider agreement filing
Per Company:	No

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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
UnitedHealthcare of Arkansas, Inc.	\$50.00	06/24/2008	21064014

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/26/2008	06/26/2008

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Disposition

Disposition Date: 06/26/2008

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Redline Version of Appendix 2	Approved-Closed	No
Supporting Document	Convenient Care Clinic Participation Agreement - Informational Copy	Approved-Closed	Yes
Supporting Document	Arkansas Regulatory Requirements Appendix - Informational Copy	Approved-Closed	Yes
Form	Convenient Care Clinic Agreement Appendix 2	Approved-Closed	Yes

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Form Schedule

Lead Form Number: CCC.Nat'l.App2_06.08

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	CCC.Nat'l.App2_06.08	Other	Convenient Care Clinic Agreement Appendix 2	Initial			CCC Appendix 2_06 08 Filing Version.pdf

Appendix 2

Benefit Plan Descriptions

1. Clinic will participate in the network of physicians and other health care professionals and providers established by United (“Participating Providers”) for the Benefit Plan types described below:

- Benefit Plans where Customers are offered a network of Participating Providers and must select a primary physician, [other than Benefit Plans sponsored or issued by the entities currently known as MD-Individual Practice Association, Inc. (“MDIPA”) or Optimum Choice, Inc. (“OCI”)]. Such Benefit Plans may or may not include an out-of-network benefit.
- Benefit Plans where Customers are offered a network of Participating Providers but are not required to select a primary physician. Such Benefit Plans may or may not include an out-of-network benefit.
- Benefit Plans where Customers are not offered a network of Participating Providers from which they may receive Covered Services.
- [Benefit Plans administered or serviced by OneNet PPO, LLC (f/k/a Alliance PPO, LLC).]
- [Benefit Plans for OneNet PPO, LLC (f/k/a Alliance PPO, LLC) workers’ compensation benefit programs.]
- [Medicaid Benefit Plans.]
- [Benefit Plans sponsored, issued or administered by any Payer where the Benefit Plan is intended to replace, either partially or in its entirety, the original Medicare coverage (Medicare Part A and Medicare Part B) issued to beneficiaries by the Centers for Medicare and Medicaid Services (“CMS”) (“Medicare Benefit Plans”), other than Medicare Advantage Private Fee-For-Service Plans[, and Benefit Plans sponsored or administered by a subsidiary of either PacifiCare Health Plan Administrators, Inc. or PacifiCare Health Systems, LLC.]]
- [Benefit Plans for workers’ compensation benefit programs.]

2. Clinic will **not** participate in the network of physicians and other health care professionals and providers established by United for the Benefit Plan types described below:

- [Benefit Plans sponsored or issued by the entities currently known as MD-Individual Practice Association, Inc. (“MDIPA”) or Optimum Choice, Inc. (“OCI”) where Customers are offered a network of Participating Providers and must select a primary physician.]
- [Medicaid Benefit Plans.]
- Medicare Advantage Private Fee-For-Service Plans.
- [Benefit Plans sponsored, issued or administered by any Payer where the Benefit Plan is intended to replace, either partially or in its entirety, the original Medicare coverage (Medicare Part A and Medicare Part B) issued to beneficiaries by the Centers for Medicare and Medicaid Services.]
- [Benefit Plans for workers’ compensation benefit programs.]

- [Benefit Plans for workers' compensation benefit programs, other than OneNet PPO, LLC workers' compensation benefit programs.]
- Benefit Plans for-Medicare Select.
- [Benefit Plans that access the PacifiCare HMO network (as distinguished from the UnitedHealthcare network or the PacifiCare PPO network) for physician and other professional services, except that this Agreement may be applied to such Benefit Plans in cases where such Benefit Plans also provide a higher level of benefits for Customers to access to the PacifiCare PPO network than to access nonparticipating providers.]
- [Benefit Plans sponsored or administered by a subsidiary of either PacifiCare Health Plan Administrators, Inc. or PacifiCare Health Systems, LLC, where the Benefit Plan is intended to replace, either partially or in its entirety, the original Medicare coverage (Medicare Part A and Medicare Part B) issued to beneficiaries by the Centers for Medicare and Medicaid Services ("CMS").]
- [Benefit Plans sponsored or administered by a subsidiary of either PacifiCare Health Plan Administrators, Inc. or PacifiCare Health Systems, LLC, for Customers in the state of Washington.]

(Note: Although certain Benefit Plans may be excluded from this Agreement, there can be a separate agreement between United or United's affiliates and Clinic or Clinic's affiliates providing for Clinic's participation in a network for certain of those Benefit Plans.)

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Rate Information

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Supporting Document Schedules

Review Status:
Bypassed -Name: Certification/Notice Approved-Closed 06/26/2008
Bypass Reason: This does not apply to our provider agreement filing; please see form schedule.
Comments:

Review Status:
Bypassed -Name: Application Approved-Closed 06/26/2008
Bypass Reason: This does not apply to our provider agreement filing; please see form schedule.
Comments:

Review Status:
Satisfied -Name: Convenient Care Clinic Approved-Closed 06/26/2008
Participation Agreement -
Informational Copy
Comments:
Per my filing description, please see attached informational approved Convenient Care Clinic Participation Agreement
Attachment:
UHC_CCC natl 10 06_approvedCopy.pdf

Review Status:
Satisfied -Name: Arkansas Regulatory Requirements Approved-Closed 06/26/2008
Appendix - Informational Copy
Comments:
Per my filing description, please see attached informational approved Arkansas Regulatory Requirements Appendix.
This appendix is made part of the Convenient Care Clinic Participation Agreement.
Attachment:
UHC_FAC MGA ANCL_REGAPX 08 06approvedCopy.pdf

Convenient Care Clinic Participation Agreement

This Agreement is entered into by and between United HealthCare Insurance Company, contracting on behalf of itself, and the other entities that are United's Affiliates including without limitation those affiliates listed in Exhibit 1 (collectively referred to as "United") and _____ ("Facility") and _____ ("Clinic")

This Agreement is effective on the later of the following dates (the "Effective Date"):

- i) _____, 200_ or
- ii) _____ the first day of the first calendar month that begins at least 30 days after the date when this Agreement has been executed by all parties.

Drafting note: for use only when mutually agreed upon fixed effective date requires retroactive loading to our systems, upon mutual agreement by both parties and where state statutes do not prohibit use.

[The parties recognize that in the event this Agreement has not been executed timely in relationship to the effective date, no interest or penalty otherwise required under applicable law will be due on any claim which requires reprocessing as a result of the untimely execution.]

Through contracts with physicians and other providers of health care services, United maintains one or more networks of providers that are available to Customers. Clinic is a provider of health care services.

United wishes to arrange to make Clinic's services available to Customers. Clinic wishes to provide such services, under the terms and conditions set forth in this Agreement.

The parties therefore enter into this Agreement.

Article I. Definitions

The following terms when used in this Agreement have the meanings set forth below:

1.1 "Benefit Plan" means a certificate of coverage, summary plan description, or other document or agreement, whether delivered in paper, electronic, or other format, under which a Payer is obligated to provide coverage of Covered Services for a Customer.

1.2 "Clinic Physician" is a Doctor of Medicine ("M.D."), or a Doctor of Osteopathy ("D.O."), duly licensed and qualified under the laws of the jurisdiction in which Covered Services are provided, who practices as a either a shareholder, partner, or employee of Clinic, or who has an arrangement with Clinic to supervise Clinic Practitioners in the rendering of health care services. However, a subcontractor of Clinic is a Clinic Physician only with regard to services rendered to patients of Clinic and billed under Clinic's tax identification number. Additionally, a physician is not a Clinic Physician with regard to any services rendered other than the Covered Services rendered by a Clinic Practitioner under this Agreement.

1.3 "Clinic Practitioner" is a physician assistant or nurse practitioner, duly authorized under the laws of the jurisdiction in which Covered Services are provided, and who practices at Clinic, under the supervision of a Clinic Physician, and is either a shareholder, partner, or employee of Clinic, or practices as a subcontractor of Clinic. However, a subcontractor of Clinic is a Clinic Practitioner only with regard to services rendered to patients of Clinic and billed under Clinic's tax identification number.

Additionally, a subcontractor is not a Clinic Practitioner with regard to any services rendered in a clinic other than those locations listed in Appendix 1.

1.4 “Clinic Professional” is a Clinic Physician or a Clinic Practitioner.

1.5 “Covered Service” is a health care service or product for which a Customer is entitled to receive coverage from a Payer, pursuant to the terms of the Customer’s Benefit Plan with that Payer.

1.6 “Customary Charge” is the fee for health care services charged by Clinic that does not exceed the fee Clinic would ordinarily charge another person regardless of whether the person is a Customer.

1.7 “Customer” is a person eligible and enrolled to receive coverage from a Payer for Covered Services.

1.8 “Payment Policies” are the guidelines adopted by United for calculating payment of claims under this Agreement. The Payment Policies may change from time to time as discussed in section 7.4 of this Agreement.

1.9 “Payer” is an entity obligated to a Customer to provide reimbursement for Covered Services under the Customer’s Benefit Plan, and authorized by United to access Clinic’s services under this Agreement.

1.9 “Protocols” are the programs, protocols and administrative procedures adopted by United or a Payer to be followed by Clinic in providing services and doing business with United and Payers under this Agreement. These Protocols may include, among other things, credentialing and recredentialing processes, utilization management and care management processes, quality improvement, peer review, Customer grievance, concurrent review, or other similar United or Payer programs. The Protocols may change from time to time as discussed in section 5.4 of this Agreement.

1.10 “United’s Affiliates” are those entities controlling, controlled by, or under common control with United HealthCare Insurance Company including, without limitation, the licensed health maintenance organizations or insurance companies set forth on Exhibit 1. United will provide an updated list of such United Affiliates periodically upon request.

Article II.

Representations and Warranties

2.1 Representations and Warranties of Clinic. Clinic, by virtue of its execution and delivery of this Agreement, represents and warrants as follows:

(a) Clinic is a duly organized and validly existing legal entity in good standing under the laws of its jurisdiction of organization.

(b) Clinic has all requisite corporate power and authority to conduct its business as presently conducted, and to execute, deliver and perform its obligations under this Agreement. The execution, delivery and performance of this Agreement by Clinic have been duly and validly authorized by all action necessary under its organizational documents and applicable corporate law.

(c) The execution, delivery and performance of this Agreement by Clinic do not and will not violate or conflict with (i) the organizational documents of Clinic, (ii) any material agreement or instrument to which Clinic is a party or by which Clinic or any material part of its property is bound, or (iii) applicable law. Clinic has the unqualified authority to bind, and does bind, itself and Clinic

Professionals to all of the terms and conditions of this Agreement, including any Appendices, Attachments and Exhibits, as applicable.

(d) Clinic has obtained and holds all registrations, permits, licenses, and other approvals and consents, and has made all filings, that it is required to obtain from or make with all governmental entities under applicable law in order to conduct its business as presently conducted and to enter into and perform its obligations under this Agreement.

(e) Clinic has been given an opportunity to review the Protocols and Payment Policies and acknowledges that it is bound by the Protocols and that claims under this Agreement will be paid in accordance with the Payment Policies.

(f) Each submission of a claim by Clinic pursuant to this Agreement shall be deemed to constitute the representation and warranty by it to United that (i) the representations and warranties of it set forth in this section 2.1 and elsewhere in this Agreement are true and correct as of the date the claim is submitted, (ii) it has complied with the requirements of this Agreement with respect to the Covered Services involved and the submission of such claim, (iii) the charge amount set forth on the claim is the Customary Charge and (iv) the claim is a valid claim.

2.2 Representations and Warranties of United. United, by virtue of its execution and delivery of this Agreement, represents and warrants as follows:

(a) United is a duly organized and validly existing legal entity in good standing under the laws of its jurisdiction of organization.

(b) United has all requisite corporate power and authority to conduct its business as presently conducted, and to execute, deliver and perform its obligations under this Agreement. The execution, delivery and performance of this Agreement by United have been duly and validly authorized by all action necessary under its organizational documents and applicable corporate law.

(c) The execution, delivery and performance of this Agreement by United do not and will not violate or conflict with (i) the organizational documents of United, (ii) any material agreement or instrument to which United is a party or by which United or any material part of its property is bound, or (iii) applicable law.

(d) United has obtained and holds all registrations, permits, licenses, and other approvals and consents, and has made all filings, that it is required to obtain from or make with all governmental entities under applicable law in order to conduct its business as presently conducted and to enter into and perform its obligations under this Agreement.

Article III. **Applicability of this Agreement**

3.1 Clinic's Services. This Agreement applies to the states and Clinic's practice locations set forth in Appendix 1. In the event Clinic begins providing services at other locations in a state that is included in Appendix 1 (either by opening such locations itself, or by acquiring, merging or coming under common ownership and control with an existing provider of services that was not already under contract with United or one of United's Affiliates to participate in a network of health care providers), such additional locations will become subject to this Agreement 30 days after United receives the notice required under section 5.7(v) of this Agreement.

In the event Clinic acquires or is acquired by, merges with, or otherwise becomes affiliated with another provider of health care services that is already under contract with United or one of United's Affiliates to participate in a network of health care providers, this Agreement and the other agreement will each remain in effect and will continue to apply as they did prior to the acquisition, merger or affiliation, unless otherwise agreed to in writing by all parties to such agreements.

Clinic may transfer all or some of its assets to another entity, if the result of such transfer would be that all or some of the Covered Services subject to this Agreement will be rendered by the other entity rather than by Clinic, but only if Clinic requests that United approve the assignment of this Agreement as it relates to those Covered Services and only if the other entity agrees to assume this Agreement. This paragraph does not limit United's right under section 10.4 of this Agreement to elect whether to approve the assignment of this Agreement.

3.2 Payers and Benefit Plan types. United may allow Payers to access Clinic's services under this Agreement for the Benefit Plan types described in Appendix 2. Appendix 2 may be modified by United upon 30 days written or electronic notice.

3.3 Services not covered under a Benefit Plan. This Agreement does not apply to services not covered under the applicable Benefit Plan. Clinic may seek and collect payment from a Customer for such services, provided that the Clinic first obtains the Customer's written consent.

This section does not authorize Clinic to bill or collect from Customers for Covered Services for which claims are denied or otherwise not paid. That issue is addressed in sections 7.5 and 7.8 of this Agreement.

3.4 Patients who are not Customers. This Agreement does not apply to services rendered to patients who are not Customers at the time the services were rendered. Section 7.6 of this Agreement addresses circumstances in which claims for services rendered to such persons are inadvertently paid by a Payer.

3.5 Health Care. Clinic acknowledges that this Agreement and Customer Benefit Plans do not dictate the health care provided by Clinic or Clinic Professionals, or govern Clinic's or Clinic Professional's determination of what care to provide its patients, even if those patients are Customers. The decision regarding what care is to be provided remains with Clinic Professionals and with Customers, and not with United or any Payer.

3.6 Communication with Customers. Nothing in this Agreement is intended to limit Clinic's or Clinic Professional's right or ability to communicate fully with a Customer regarding the Customer's health condition and treatment options. Clinic and Clinic Professionals are free to discuss all treatment options without regard to whether or not a given option is a Covered Service. Clinic and Clinic Professionals are free to discuss with a Customer any financial incentives Clinic may have under this Agreement, including describing at a general level the payment methodologies contained in this Agreement.

Article IV.

Participation of Clinic Professionals in United's Network

4.1 Clinic Professionals as Participating Providers. Except as described under section 4.2, all Clinic Physicians will participate in United's network pursuant to a separate participation agreement, either directly or through another entity. Clinic Practitioners participate in United's network through this

Agreement. Clinic has the authority to bind, and will bind, all new Clinic Professionals to the obligations of this Agreement.

4.2 Clinic Professionals who are not Participating Providers. The following Clinic Professionals are not participating providers in United's network:

- i) A Clinic Physician (or a Clinic Practitioner, in the event such provider is of a provider type that United credentials) who has been denied participation in United's credentialing program, whose credentialing application has not been submitted, or whose credentialing application remains pending; or
- ii) A Clinic Professional who has been terminated from participation in United's network pursuant to section 4.5 of this Agreement.

4.3 Credentialing. Clinic and Clinic Physicians will participate in and cooperate with United's credentialing program. Clinic Practitioners will participate in and cooperate with United's credentialing program to the extent such Clinic Practitioners are subject to credentialing by United.

4.4 New Clinic Professionals. Clinic will notify United at least 30 days before a physician becomes a Clinic Physician. In the event that the Clinic's agreement with the new Clinic Physician provides for a starting date that would make it impossible for Clinic to provide 30 days advance notice to United, then Clinic will give notice to United within five business days after reaching agreement with the new Clinic Physician. In either case, the new Clinic Physician will submit and complete a credentialing application to United within 30 days of the new Clinic Physician's agreement to join Clinic, unless the new Clinic Physician already has been credentialed by United and is already a participant in United's network.

The requirements of this section 4.4 also apply to new Clinic Practitioners who are subject to credentialing by United.

4.5 Termination of a Clinic Practitioner from United's Network. United may terminate a Clinic Practitioner's participation in United's network, without terminating this Agreement, immediately upon becoming aware of any of the following:

- i) material breach of this Agreement that is not cured by Clinic Practitioner within 30 days after United provided notice to Clinic of the breach;
- ii) the suspension, revocation, condition, limitation, qualification or other material restriction on a Clinic Practitioner's licenses, certifications and permits by any government agency under which the Clinic Practitioner is authorized to provide health care services;
- iii) the suspension, revocation, condition, limitation, qualification or other material restriction of a Clinic Practitioner's staff privileges at any licensed hospital, nursing home or other facility at which the Clinic Practitioner has staff privileges during the term of this Agreement;
- iv) an indictment, arrest or conviction for a felony, or for any criminal charge related to the practice of Clinic Practitioner's profession;
- v) a sanction imposed by any governmental agency or authority, including Medicare or Medicaid; or
- vi) pursuant to United's Credentialing Plan.

United will notify Clinic of the Clinic Practitioner's termination according to the notice provision set forth in section 10.8 of this Agreement.

4.6 Covered Services by Clinic Professionals who are not Participating Providers. Clinic will staff its service locations so that Covered Services can appropriately be rendered to Customers by Clinic Professionals who participate in United's network, as required by United. A Clinic Professional who

does not participate in United's network as required by United, pursuant to sections 4.1 and 4.2 of this Agreement, will not render Covered Services to a Customer.

In the event Covered Services are rendered by a Clinic Professional who does not participate in United's network as required by United, Clinic and the Clinic Professional will not submit a claim or other request for payment to United or Payer, and will not seek or accept payment from the Customer.

4.7 Supervision of Clinic Practitioners. Clinic will ensure that Clinic Practitioners provide Covered Services to Customers under the supervision of a Clinic Physician who participates in United's network. A Clinic Physician who is a participating provider will be available at all times for consultation with Clinic Practitioners either on site or by electronic access including, but not limited to telephone, facsimile and e-mail. Clinic will ensure that Clinic Practitioners and Clinic Physicians maintain compliance with all applicable statutes and regulations, and adhere to Clinic's policies and procedures including any national guidelines, regarding the provision of health care services. Clinic will further ensure that Clinic Physicians do not bill United or Customers for the supervision of Covered Services if they provide such Covered Services directly to Customers. Such Covered Services will be pursuant to the terms of the participation agreement through which such Clinic Physicians participate in United's networks rather than through this Agreement.

Article V. **Duties of Clinic**

5.1 Provide Covered Services. Clinic will provide Covered Services to Customers.

5.2 Nondiscrimination. Clinic will not discriminate against any patient, with regard to quality of service or accessibility of services, on the basis that the patient is a Customer. Clinic will not require a Customer to pay a "membership fee" or other fee in order to access Clinic for Covered Services (except for co-payments, coinsurance and/or deductibles provided for under Customer's Benefit Plan) and will not discriminate against any Customer based on the failure to pay such a fee.

5.3 Accessibility. Clinic will provide or arrange for the provision of advice and assistance to Customers during normal business hours.

5.4 Cooperation with Protocols. Clinic will cooperate with and be bound by United's and Payers' Protocols. The Protocols include but are not limited to all of the following:

1. Clinic will direct Customers only to other providers that participate in United's network, except as otherwise authorized by United or Payer.
2. Clinic will provide notification for certain Covered Services, accept and return telephone calls from United staff, and respond to United requests for clinical information, as required by United or Payer as described in the Protocols.

The Protocols will be made available to Clinic online or upon request. Some or all Protocols also may be disseminated in the form of an administrative manual or guide or in other communications. See Appendix 4 for additional information on the Protocols applicable to Customers enrolled in certain Benefit Plans.

United may change the Protocols from time to time. United will use reasonable commercial efforts to inform Clinic at least 30 days in advance of any material changes to the Protocols.

5.5 Licensure. Clinic and Clinic Professionals will maintain, without material restriction, such licensure, certification, registration, and permits as are necessary to enable Clinic and Clinic Professionals to lawfully perform this Agreement.

5.6 Liability Insurance. Clinic will assure that Clinic and all Clinic Professionals are covered by liability insurance. Except to the extent coverage is a state mandated placement, the liability coverage must be placed with responsible, financially sound insurance carriers authorized or approved to write coverage in the state in which the Covered Services are provided. The liability insurance shall be, at a minimum, of the types and in the amounts set forth below. Medical malpractice insurance shall be either occurrence or claims made with an extended period reporting option. Prior to the Effective Date of this Agreement and within 10 days of each policy renewal thereafter, Clinic shall submit to United in writing evidence of insurance coverage.

<u>TYPE OF INSURANCE</u>	<u>MINIMUM LIMITS</u>
Medical malpractice and/or professional liability insurance	One Million Dollars (\$1,000,000.00) per occurrence and three Million Dollars aggregate (\$3,000,000.00), if Clinic insures all Clinic Professionals in a single policy [This insurance requirement will also be satisfied if the Clinic insures each Clinic Professional separately, and the coverage for each Clinic Professional is at least One Million Dollars (\$1,000,000.00) per occurrence and 3 Million Dollars (\$3,000,000.00) aggregate]
Commercial general and/or umbrella liability insurance	One Million Dollars (\$1,000,000.00) per occurrence and aggregate

In lieu of purchasing the insurance coverage required in this section, Clinic may, with the prior written approval of United, self-insure its medical malpractice and/or professional liability, as well as its commercial general liability. Clinic shall maintain a separate reserve for its self-insurance. If Clinic will use the self-insurance option described in this paragraph, Clinic will provide to United, prior to the Effective Date, a statement verified by an independent auditor or actuary that its reserve funding levels and process of funding appears adequate to meet the requirements of this section and fairly represents the financial condition of the fund. Clinic will provide a similar statement during the term of this Agreement upon United's request, which will be made no more frequently than annually. Clinic will assure that its self-insurance fund will comply with applicable laws and regulations.

5.7 Notice. Clinic will give notice to United within 10 days after any event that causes Clinic to be out of compliance with section 5.5 or 5.6 of this Agreement, or of any change in Clinic's name, ownership, control, or Taxpayer Identification Number. This section does not apply to changes of ownership or control that result in Clinic being owned or controlled by an entity with which it was already affiliated prior to the change. In addition, Clinic will give written notice to United within 10 days after it learns of any of the following:

- i) any suspension, revocation, condition, limitation, qualification or other material restriction on a Clinic Professional's licenses, certifications and permits by any government agency under which a Clinic Professional is authorized to provide health care services;
- ii) any suspension, revocation, condition, limitation, qualification or other material restriction of a Clinic Physician's staff privileges at any licensed hospital, nursing home or other facility at which a Clinic Physician has staff privileges during the term of this Agreement;
- iii) indictment, arrest or conviction of a Clinic Professional for a felony, or for any criminal charge related to the practice of the Clinic Professional's profession;
- iv) the departure of any Clinic Professional that United credentials from Clinic; or
- v) any changes to the information contained in Appendix 1.

5.8 Customer consent to release of Medical Record Information. Clinic will obtain any Customer consent required in order to authorize Clinic to provide access to requested information or records as contemplated in section 5.9 of this Agreement, including copies of the Clinic's medical records relating to the care provided to Customer.

5.9 Maintenance of and Access to Records. Clinic will maintain adequate medical, financial and administrative records related to Covered Services rendered by Clinic under this Agreement, including claims records, for at least 6 years following the end of the calendar year during which the Covered Services are provided, unless a longer retention period is required by applicable law.

Clinic will provide access to these records as follows:

- i) to United or its designees, in connection with United's utilization management/care management, quality assurance and improvement and for claims payment and other administrative obligations, including reviewing Clinic's compliance with the terms and provisions of this Agreement and appropriate billing practice. Clinic will provide access during ordinary business hours within 14 days after a request is made, except in cases of a United audit involving a fraud investigation or the health and safety of a Customer (in which case, access shall be given within 48 hours after the request) or of an expedited Customer appeal or grievance (in which case, access will be given so as to enable United to reasonably meet the timelines for determining the appeal or grievance); and
- ii) to agencies of the government, in accordance with applicable law, to the extent such access is necessary to comply with regulatory requirements applicable to Clinic, United, or Payers.

Clinic will cooperate with United on a timely basis in connection with any such audit including, among other things, in the scheduling of and participation in an audit exit interview within 30 days of United's request.

If such information and records are requested by United, Clinic shall provide copies of such records free of charge.

5.10 Access to Data. Clinic represents that in conducting its operations, it collects and reviews certain quality data relating to care rendered by Clinic that is reported in a manner which has been validated by a third party as having a clear, evidence-based link to quality or safety (e.g., AHRQ standards) or which has been created by employer coalitions as proxies for quality (e.g., Leapfrog standards).

United recognizes that Clinic has the sole discretion to select the metrics which it will track from time to time and that Clinic's primary goal in so tracking is to advance the quality of patient care. On a quarterly basis, Clinic will share these metrics with United as tracked against a database of all commercial patients

(including patients who are not United customers). United may publish this data to entities to which United renders services or seeks to render services, and to Customers.

5.11 Compliance with law. Clinic will comply with applicable regulatory requirements, including but not limited to those relating to confidentiality of Customer medical information.

5.12 Electronic connectivity. When made available by United, Clinic will communicate with United electronically. Clinic will use www.unitedhealthcareonline.com to check eligibility status, claims status, and submit requests for claims adjustments for Customers enrolled in products supported by www.unitedhealthcareonline.com. Clinic agrees to use www.unitedhealthcareonline.com for additional functionalities (for instance, notification of admission) after United informs Clinic that such functionalities have become available for the applicable Customer.

5.13 Employees and subcontractors. Clinic will assure that its employees, affiliates and any individuals or entities subcontracted by Clinic to render services in connection with this Agreement adhere to the requirements of this Agreement. The use of employees, affiliates or subcontractors to render services in connection with this Agreement will not limit Clinic's obligations and accountability under this Agreement with regard to such services.

For laboratory services, Clinic will only be reimbursed for services that Clinic is certified through the Clinical Laboratory Improvement Amendments (CLIA) to perform, and Clinic must not bill Customers for any laboratory services for which Clinic lacks CLIA certification.

Article VI. **Duties of United and Payers**

6.1 Payment of Claims. As described in further detail in Article VII of this Agreement, Payers will pay Clinic for rendering Covered Services to Customers.

6.2 Liability Insurance. United will procure and maintain professional and general liability insurance and other insurance, as United reasonably determines may be necessary, to protect United and United's employees against claims, liabilities, damages or judgments that arise out of services provided by United or United's employees under this Agreement.

6.3 Licensure. United will maintain, without material restriction, such licensure, registration, and permits as are necessary to enable United to lawfully perform this Agreement.

6.4 Notice. United will give written notice to Clinic within 10 days after any event that causes United to be out of compliance with section 6.2 or 6.3 of this Agreement, or of any change in United's name, ownership, control, or Taxpayer Identification Number. This section does not apply to changes of ownership or control that result in United being owned or controlled by an entity with which it was already affiliated prior to the change.

6.5 Compliance with law. United will comply with applicable regulatory requirements, including but not limited to those relating to confidentiality of Customer medical information and those relating to prompt payment of claims, to the extent those requirements are applicable.

6.6 Electronic connectivity. United will communicate with Clinic electronically by providing eligibility status, claims status, and accepting requests for claim adjustments, for those products supported by www.unitedhealthcareonline.com. United will communicate enhancements in

www.unitedhealthcareonline.com functionality as they become available, as described in Section 5.12, and will make information available as to which products are supported by www.unitedhealthcareonline.com.

6.7 Employees and subcontractors. United will assure that its employees, affiliates and any individuals or entities subcontracted by United to render services in connection with this Agreement adhere to the requirements of this Agreement. The use of employees, affiliates or subcontractors to render services in connection with this Agreement will not limit United's obligations and accountability under this Agreement with regard to such services.

Article VII.

Submission, Processing, and Payment of Claims

7.1 Form and content of claims. Clinic must submit claims for Covered Services in a manner and format prescribed by United, as further described in the Protocols. Unless otherwise directed by United, Clinic shall submit claims using current CMS 1500 or UB92 forms for paper claims and HIPAA standard professional or institutional claim formats for electronic claims, as applicable, with applicable coding including, but not limited to, ICD, CPT, Revenue and HCPCS coding.

Clinic will submit claims only for services performed by Clinic or Clinic staff. Pass through billing is not payable under this Agreement.

7.2 Electronic filing of claims. Within six months after the Effective Date of this Agreement, Clinic will use electronic submission for all of its claims under this Agreement that United is able to accept electronically.

7.3 Time to file claims. All information necessary to process a claim must be received by United no more than 90 days from the date that Covered Services are rendered. In the event United requests additional information in order to process the claim, Clinic will provide such additional information within 90 days of United's request. If Payer is not the primary payer, and Clinic is pursuing payment from the primary payer, the 90 day filing limit will begin on the date Clinic receives the claim response from the primary payer.

7.4 Payment of claims. Payer will pay claims for Covered Services according to the lesser of Clinic's Customary Charge or the applicable fee schedule (as further described in Appendix 3 to this Agreement), and in accordance with Payment Policies.

Claims for Covered Services subject to coordination of benefits will be paid in accordance with the Customer's Benefit Plan and applicable law.

The obligation for payment under this Agreement is solely that of Payer, and not that of United unless United is the Payer.

Ordinarily, fee amounts listed in Appendix 3 are based upon primary fee sources. United reserves the right to use gap-fill fee sources where primary fee sources are not available.

United routinely updates its fee schedule in response to additions, deletions, and changes to CPT codes by the American Medical Association, price changes for immunizations and injectable medications, and in response to similar changes (additions and revisions) to other service coding and reporting conventions

that are widely used in the health care industry, such as those maintained by the Centers for Medicaid and Medicare Services (for example HCPCS, etc.).

Ordinarily, United's fee schedule is updated using similar methodologies for similar services. United will not generally attempt to communicate routine maintenance of this nature and will generally implement updates within 90 days from the date of publication.

United will give Clinic 90 days written or electronic notice of non-routine fee schedule changes which will substantially alter the overall methodology or reimbursement level of the fee schedule. In the event such changes will reduce Clinic's overall reimbursement under this Agreement, Clinic may terminate this Agreement by giving 60 days written notice to United, provided that the notice is given by Clinic within 30 days after the notice of the fee schedule change.

United will make its Payment Policies available to Clinic online or upon request. United may change its Payment Policies from time to time.

7.5 Denial of Claims for Not Following Protocols, Not Filing Timely, or Lack of Medical Necessity.

Payment may be denied in whole or in part if Clinic does not comply with a Protocol or does not file a timely claim under section 7.3 of this Agreement. Payment may also be denied for services provided that are determined by United to be medically unnecessary, and Clinic may not bill the Customer for such services unless the Customer has, with knowledge of United's determination of a lack of medical necessity, agreed in writing to be responsible for payment of those charges.

In the event that payment of a claim is denied for lack of notification or for untimely filing, the denial will be reversed if Clinic appeals within 12 months after the date of denial and can show all of the following:

- i) that, at the time the Protocols required notification or at the time the claim was due, Clinic did not know and was unable to reasonably determine that the patient was a Customer,
- ii) that Clinic took reasonable steps to learn that the patient was a Customer, and
- iii) that Clinic promptly provided notification, or filed the claim, after learning that the patient was a Customer.

7.6 Retroactive Correction of Information Regarding Whether Patient Is a Customer. Prior to rendering services, Clinic will ask the patient to present his or her Customer identification card. In addition, Clinic may contact United to obtain the most current information on the patient as a Customer.

However, Clinic acknowledges that such information provided by United is subject to change retroactively, under the following circumstances: (1) if United has not yet received information that an individual is no longer a Customer; (2) if the individual's Benefit Plan is terminated retroactively for any reason including, but not limited to, non-payment of premium; (3) as a result of the Customer's final decision regarding continuation of coverage pursuant to state and federal laws; or (4) if eligibility information United receives is later proven to be false.

If Clinic provides health care services to an individual, and it is determined that the individual was not a Customer at the time the health care services were provided, those services shall not be eligible for payment under this Agreement and any claims payments made with regard to such services may be recovered as overpayments under the process described in section 7.10 of this Agreement. Clinic may then directly bill the individual, or other responsible party, for such services.

7.7 Payment under this Agreement is Payment in Full. Payment as provided under section 7.4 of this Agreement, together with any co-payment, deductible or coinsurance for which the Customer is responsible under the Benefit Plan, is payment in full for a Covered Service. Clinic will not seek to

recover, and will not accept any payment from Customer, United, Payer or anyone acting in their behalf, in excess of payment in full as provided in this section 7.7, regardless of whether such amount is less than Clinic's billed charge or Customary Charge.

7.8 Customer "Hold Harmless." Clinic will not bill or collect payment from the Customer, or seek to impose a lien, for the difference between the amount paid under this Agreement and Clinic's billed charge or Customary Charge, or for any amounts denied or not paid under this Agreement due to:

- i) Clinic's failure to comply with the Protocols,
- ii) Clinic's failure to file a timely claim,
- iii) Payer's Payment Policies,
- iv) inaccurate or incorrect claim processing,
- v) insolvency or other failure by Payer to maintain its obligation to fund claims payments, if Payer is United, or is an entity required by applicable law to assure that its Customers not be billed in such circumstances, or
- vi) a denial based on medical necessity or prior authorization, except as permitted under section 7.5.

This obligation to refrain from billing Customers applies even in those cases in which Clinic believes that United or Payer has made an incorrect determination. In such cases, Clinic may pursue remedies under this Agreement against United or Payer, as applicable, but must still hold the Customer harmless.

In the event of a default by a Payer other than those Payers covered by the above clause v), Clinic may seek payment directly from the Payer or from Customers covered by that Payer. However, Clinic may do so only if it first inquires in writing to United as to whether the Payer has defaulted and, in the event that United confirms that Payer has defaulted (which confirmation will not be unreasonably withheld), Clinic then gives United 15 days prior written notice of Clinic's intent to seek payment from Payer or Customers. For purposes of this paragraph, a default is a systematic failure by a Payer to fund claims payments related to Customers covered through that Payer; a default does not occur in the case of a dispute as to whether certain claims should be paid or the amounts that should be paid for certain claims.

This section 7.8 and section 7.7 will survive the termination of this Agreement, with regard to Covered Services rendered prior to when the termination takes effect.

7.9 Consequences for Failure to Adhere to Customer Protection Requirements. If Clinic collects payment from, brings a collection action against, or asserts a lien against a Customer for Covered Services rendered (other than for the applicable co-payment, deductible or coinsurance), contrary to section 7.7 or 7.8 of this Agreement, Clinic shall be in breach of this Agreement. This section 7.9 will apply regardless of whether Customer or anyone purporting to act on Customer's behalf has executed a waiver or other document of any kind purporting to allow Clinic to collect such payment from Customer.

In the event of such a breach, Payer may deduct, from any amounts otherwise due Clinic, the amount wrongfully collected from Customers, and may also deduct an amount equal to any costs or expenses incurred by the Customer, United or Payer in defending the Customer from such action and otherwise enforcing sections 7.7 through 7.9 of this Agreement. Any amounts deducted by Payer in accordance with this provision shall be used to reimburse the Customer and to satisfy any costs incurred. The remedy contained in this paragraph does not preclude United from invoking any other remedy for breach that may be available under this Agreement.

7.10 Correction of overpayments or underpayments of claims. In the event that either Party believes that a claim has not been paid correctly, or that funds were paid beyond or outside of what is

provided for under this Agreement, either party may seek correction of the payment, except that Clinic may not seek correction of a payment more than 12 months after it was made.

Clinic will repay overpayments within 30 days of notice of the overpayment. Clinic will promptly report any credit balance that it maintains with regard to any claim overpayment under this Agreement, and will return such overpayment to United within 30 days after posting it as a credit balance.

Clinic agrees that recovery of overpayments may be accomplished by offsets against future payments.

7.11 Claims Payment Issues Arising from Departure of Clinic Professionals from Clinic. In the event a Clinic Professional departs from Clinic and uncertainty arises as to whether Clinic or some other entity is entitled to receive payment for certain services rendered by such former Clinic Professional, the parties will cooperate with each other in good faith in an attempt to resolve the situation appropriately.

In the event that Clinic's failure to give timely notice under section 5.7 (iv) of this Agreement resulted in claims payments being made incorrectly to Clinic, Clinic shall promptly call the situation to United's attention and return such payments to United. In the event Clinic fails to do so, United may hold Clinic liable for any attorneys fees, costs, or administrative expenses incurred by United as a result.

In the event that both Clinic and some other entity assert a right to payment for the same service rendered by the former Clinic Professional, United may refrain from paying either entity until the payment obligation is clarified. Provided that United acts in good faith, Clinic will waive any right to receive interest or penalties under any applicable law relating to the prompt payment of claims.

Article VIII. **Dispute Resolution**

The parties will work together in good faith to resolve any and all disputes between them (hereinafter referred to as "Disputes") including but not limited to all questions of arbitrability, the existence, validity, scope or termination of the Agreement or any term thereof.

If the parties are unable to resolve any such Dispute within 60 days following the date one party sent written notice of the Dispute to the other party, and if either party wishes to pursue the Dispute, it shall thereafter be submitted to binding arbitration in accordance with the Commercial Dispute Procedures of the American Arbitration Association, as they may be amended from time to time (see <http://www.adr.org>). Unless otherwise agreed to in writing by the parties, the party wishing to pursue the Dispute must initiate the arbitration within one year after the date on which notice of the Dispute was given or shall be deemed to have waived its right to pursue the dispute in any forum.

Any arbitration proceeding under this Agreement shall be conducted in (name of county) County, (state). The arbitrator(s) may construe or interpret but shall not vary or ignore the terms of this Agreement and shall be bound by controlling law. The arbitrator(s) shall have no authority to award punitive, exemplary, indirect or special damages, except in connection with a statutory claim that explicitly provides for such relief.

The parties expressly intend that any dispute relating to the business relationship between them be resolved on an individual basis so that no other dispute with any third party(ies) may be consolidated or joined with our dispute. The parties agree that any arbitration ruling by an arbitrator allowing class action arbitration or requiring consolidated arbitration involving any third party(ies) would be contrary to their intent and would require immediate judicial review of such ruling.

If the Dispute pertains to a matter which is generally administered by certain United procedures, such as a credentialing or quality improvement plan, the policies and procedures set forth in that plan must be fully exhausted by Clinic before Clinic may invoke any right to arbitration under this Article VIII.

The decision of the arbitrator(s) on the points in dispute will be binding, and judgment on the award may be entered in any court having jurisdiction thereof. The parties acknowledge that because this Agreement affects interstate commerce the Federal Arbitration Act applies.

In the event that any portion of this Article or any part of this Agreement is deemed to be unlawful, invalid or unenforceable, such unlawfulness, invalidity or unenforceability shall not serve to invalidate any other part of this Article or Agreement. In the event any court determines that this arbitration procedure is not binding or otherwise allows litigation involving a Dispute to proceed, the parties hereby waive any and all right to trial by jury in, or with respect to, such litigation. Such litigation would instead proceed with the judge as the finder of fact.

In the event a party wishes to terminate this Agreement based on an assertion of uncured material breach, and the other party disputes whether grounds for such a termination exist, the matter will be resolved through arbitration under this Article VIII. While such arbitration remains pending, the termination for breach will not take effect.

This Article VIII governs any dispute between the parties arising before or after execution of this Agreement and shall survive any termination of the Agreement.

Article IX. **Term and Termination**

9.1 Term. This Agreement shall take effect on the Effective Date. This Agreement shall have an initial term of two years and renew automatically for renewal terms of one year, until terminated pursuant to section 9.2.

9.2 Termination. This Agreement may be terminated under any of the following circumstances:

- i) by mutual written agreement of the parties;
- ii) by either party, upon at least 90 days prior written notice, effective at the end of the initial term or effective at the end of any renewal term;
- iii) by either party upon 60 days written notice in the event of a material breach of this Agreement by the other party, except that such a termination will not take effect if the breach is cured within 60 days after notice of the termination; moreover, such termination may be deferred as further described in Article VIII of this Agreement;
- iv) by either party upon 10 days written notice in the event the other party loses licensure or other governmental authorization necessary to perform this Agreement, or fails to have insurance as required under section 5.6 or section 6.2 of this Agreement; or
- v) by Clinic, as described in section 7.4 of this Agreement in the event of a non-routine fee schedule change.

Article X. **Miscellaneous Provisions**

10.1 Entire Agreement. This Agreement is the entire agreement between the parties with regard to the subject matter herein, and supersedes any prior written or unwritten agreements between the parties or their affiliates with regard to the same subject matter.

10.2 Amendment. United can amend this Agreement or any of the appendices on 90 days written or electronic notice by sending Clinic a copy of the amendment. Clinic's signature is not required to make the amendment effective. However, if the amendment is not required by law or regulation and would impose a material adverse impact on Clinic, then Clinic may terminate this Agreement on 60 days written or electronic notice to United by sending a termination notice within 30 days after receipt of the amendment.

10.3 Nonwaiver. The waiver by either party of any breach of any provision of this Agreement shall not operate as a waiver of any subsequent breach of the same or any other provision.

10.4 Assignment. This Agreement may not be assigned by either party without the written consent of the other party, except that this Agreement may be assigned by United to any of United's Affiliates.

10.5 Relationship of the Parties. The sole relationship between the parties to this Agreement is that of independent contractors. This Agreement does not create a joint venture, partnership, agency, employment or other relationship between the parties.

10.6 No Third-Party Beneficiaries. United and Clinic are the only entities with rights and remedies under the Agreement.

10.7 Delegation. United may delegate (but not assign) certain of its administrative duties under this Agreement to one or more other entities. No such delegation will relieve United of its obligations under this Agreement.

10.8 Notice. Any notice required to be given under this Agreement shall be in writing, except in cases in which this Agreement specifically permits electronic notice, or as otherwise permitted or required in the Protocols. All written or electronic notices shall be deemed to have been given when delivered in person, by electronic communication, by facsimile or, if delivered by first-class United States mail, on the date mailed, proper postage prepaid and properly addressed to the appropriate party at the address set forth on the signature portion of this Agreement or to another more recent address of which the sending party has received written notice. Notwithstanding the previous sentence, all notices of termination of this Agreement by either party must be sent by certified mail, return receipt requested.

Each party shall provide the other with proper addresses, facsimile numbers and electronic mail addresses of all designees that should receive certain notices or communication instead of that party.

10.9 Confidentiality. Neither party will disclose to a Customer, other health care providers, or other third parties any of the following information (except as required by an agency of the government):

- i) any proprietary business information, not available to the general public, obtained by the party from the other party; or
- ii) the specific reimbursement amounts provided for under this Agreement, except for purposes of administration of benefits.

At least 48 hours before either party issues a press release, advertisement, or other media statement about the business relationship between the parties, that party will give the other party a copy of the material the party intends to issue.

10.10 Governing Law. This Agreement will be governed by and construed in accordance with the laws of the state in which Clinic renders Covered Services, and any other applicable law.

10.11 Regulatory Appendices. One or more regulatory appendix may be attached to this Agreement, setting forth additional provisions included in this Agreement in order to satisfy regulatory requirements under applicable law. These regulatory appendices, and any attachments to them, are expressly incorporated into this Agreement and are binding on the parties to this Agreement. In the event of any inconsistent or contrary language between a regulatory appendix and any other part of this Agreement, including but not limited to appendices, amendments and exhibits, the provisions of the regulatory appendix will control, to the extent it is applicable.

10.12 Severability. Any provision of this Agreement that is unlawful, invalid or unenforceable in any situation in any jurisdiction shall not affect the validity or enforceability of the remaining provisions of this Agreement or the lawfulness, validity or enforceability of the offending provision in any other situation or jurisdiction.

10.13 Survival. Sections 5.9, 7.7, 7.8, Article VIII and sections 9.3 and 10.9 (except for the last paragraph) of this Agreement will survive the termination of this Agreement.

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

[Clinic]

Signature _____ Street _____

Print Name _____ City _____

Title _____ State _____ Zip Code _____

D/B/A _____ Phone _____

Date _____ E-mail _____

United HealthCare Insurance Company, on behalf of itself, and its other affiliates, as signed by its authorized representative:

Signature _____ Signature _____

Print Name _____ Print Name _____

Title _____ Title: _____

Date _____ Date _____

- ___ Exhibit 1: United Affiliates
- ___ Appendix 1: Clinic Practice Locations
- ___ Appendix 2: Benefit Plan Descriptions
- ___ Appendix 3: Fee Schedule Sample (*drafting note: all Fee Schedule Samples must be labeled Appendix 3*).
- ___ Appendix 4: Additional Protocols
- ___ State Regulatory Requirements Appendix (list all states as applicable)

- ___ Medicare Advantage Regulatory Requirements Appendix
- ___ Other (*drafting note: specify attachments*)

Exhibit 1
United's Affiliates Licensed for Health Products
as of **{June 30, 2006}**

{Drafting Note: Copy and insert the entities on the list that applies to national ancillary contracts from: Frontier/Legal Orgchart/Insurance Companies Nat'l Ancillary Contracts. Check date above and insert the latest version.}

Clinic attests that this Appendix identifies all services and locations covered under this Agreement

IMPORTANT NOTE: Clinic acknowledges its obligation under Section 5.7 to promptly report any change in Clinic’s name or Taxpayer Identification Number. Failure to do so may result in denial of claims or incorrect payment.

Appendix 1
Clinic Practice Locations
{State}

BILLING ADDRESS

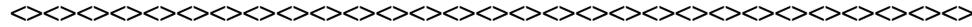
All sites of service billing under all TINs listed in appendix 1 must be included as par providers.

Identify only if a common name and address appears on all Clinic practice location bills that utilize the Clinic’s Tax ID under the Agreement.

Practice Name _____
 Street Address _____
 City _____ State _____ Zip _____
 Tax ID Number (TIN) _____

PRACTICE LOCATIONS (complete one for each service location)

Clinic Name	Clinic Name	Clinic Name
Street Address	Street Address	Street Address
City	City	City
State and Zip Code	State and Zip Code	State and Zip Code
Phone Number	Phone Number	Phone Number
TIN (If different from above)	TIN (If different from above)	TIN (If different from above)



Clinic Name	Clinic Name	Clinic Name
Street Address	Street Address	Street Address
City	City	City
State and Zip Code	State and Zip Code	State and Zip Code
Phone Number	Phone Number	Phone Number
TIN (If different from above)	TIN (If different from above)	TIN (If different from above)

Appendix 2

Benefit Plan Descriptions

Clinic will participate in the network of physicians and other health care professionals and providers established by United (“Participating Providers”) for the Benefit Plan types described below:

- Benefit Plans where Customers are offered a network of Participating Providers and must select a primary physician, [other than Benefit Plans sponsored or issued by the entities currently known as MD-Individual Practice Association, Inc. (“MDIPA”) or Optimum Choice, Inc. (“OCI”)]. Such Benefit Plans may or may not include an out-of-network benefit.
- Benefit Plans where Customers are offered a network of Participating Providers but are not required to select a primary physician. Such Benefit Plans may or may not include an out-of-network benefit.
- Benefit Plans where Customers are not offered a network of Participating Providers from which they may receive Covered Services.
- [Medicaid benefit contracts administered by our business unit Evercare, as indicated by a reference to Evercare on the face of the valid identification card of any customer eligible for and enrolled in such benefit contract.]
- [Benefit Plans sponsored, issued or administered by any Payer where the Benefit Plan is intended to replace, either partially or in its entirety, the traditional Medicare coverage (Medicare Part A and Medicare Part B) issued to beneficiaries by the Centers for Medicare and Medicaid Services.]
- [Benefit Plans for workers’ compensation benefit programs] *Drafting Note: Always include whenever possible to support potential expansion activity*
- [Benefit Plans for Medicare Select]

Clinic will **not** participate in the network of physicians and other health care professionals and providers established by United for the Benefit Plan types described below:

- [Benefit Plans sponsored or issued by the entities currently known as MD-Individual Practice Association, Inc. (“MDIPA”) or Optimum Choice, Inc. (“OCI”) where Customers are offered a network of Participating Providers and must select a primary physician.] *Drafting Note: Include highlighted text if MAMSI gated HMO product is not included.*
- [Benefit Plans for Medicaid Customers except Medicaid Benefit Plans administered by our business unit Evercare, as indicated by a reference to Evercare on the face of the valid identification card of any customer eligible for and enrolled in such benefit contract (Note: excluding Medicaid other than Medicaid Benefit Plans administered by United’s business unit Evercare from this Agreement does not preclude the parties or their affiliates from having a separate agreement pertaining to participation in a Medicaid network).] *Drafting Note: Should always be listed as not participating except that in RI and NY it may be participating or not participating*

- Medicare Advantage Private Fee-For-Service Plans *Drafting Note: Should NEVER be included.*
- [Benefit Plans sponsored, issued or administered by any Payer where the Benefit Plan is intended to replace, either partially or in its entirety, the traditional Medicare coverage (Medicare Part A and Medicare Part B) issued to beneficiaries by the Centers for Medicare and Medicaid Services.]
- [Benefit Plans for workers' compensation benefit programs]
- [Benefit Plans for ~~Medicare Select.~~]

For information and recommendations regarding disclosure of fees including examples, please refer to the [UHN Fee Schedule Disclosure Policy](http://uhn.uhc.com/tools/pnm/msps.html) located at:

<http://uhn.uhc.com/tools/pnm/msps.html>

Appendix 3

For Dates of Service Effective: mm/dd/yyyy *(insert only if escalators have been negotiated)*

Representative All Payer Fee Schedule Sample for : [Fee Schedule ID]

or

Representative All Payer Fee Schedule for : [Fee Schedule ID]

Unless another appendix to this Agreement applies specifically to a particular Benefit Plan as it covers a particular Customer, the provisions of this Appendix apply to Covered Services rendered by Clinic to Customers covered by Benefit Plans sponsored, issued or administered by all Payers.

Unless specifically indicated otherwise, amounts listed in the fee schedule represent global fees and may be subject to reductions based on appropriate modifier (for example, professional and technical modifiers). Any co-payment, deductible or coinsurance that the Customer is responsible to pay under the Customer's Benefit Plan will be subtracted from the listed amount in determining the amount to be paid by the Payer. The actual payment amount is also subject to matters described in this Agreement, such as the Payment Policies. This information is subject to the confidentiality provisions of this Agreement.

[Drafting Note: OneNet Protocols are included in the MAMSI protocol. If national stand-alone OneNet (or any other new) protocols are needed, language must be developed. Consider that all states to which the various protocols apply must be included in the header.]

Appendix 4 Additional Protocols

Protocol for PacifiCare Customers in the following states: CA, WA, OR, NV, OK, CO, AZ, and TX

For Customers enrolled in Benefit Plans issued or administered by a subsidiary of either PacifiCare Health Plan Administrators, Inc. or PacifiCare Health Systems, LLC (“PacifiCare Customers”), Clinic and Represented Providers will be subject to the Protocols described in or made available through the PacifiCare Provider Policy and Procedure Manual (“PacifiCare Manual”). When this Agreement refers to the Administrative Manual or Guide, it is also referring to the PacifiCare Manual. The PacifiCare Manual will be made available to Clinic and Represented Providers on line or upon request. In the event of any conflict between this Agreement or the UnitedHealthcare Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide (“Administrative Manual”) or other UnitedHealthcare administrative Protocols, and the PacifiCare Manual, in connection with any matter pertaining to a PacifiCare Customer, the PacifiCare Manual will govern, unless applicable Law dictates otherwise. United may make changes to the Administrative Manual or PacifiCare Manual or other administrative Protocols upon thirty (30) days’ electronic or written notice to Clinic.

Protocol for [MDIPA, OCI,] MLH, and OneNet Customers in the following states: MD, VA, DE, WV, DC, NC, SC, and PA

For services provided to customers enrolled in [MD-Individual Practice Association, Inc (“MDIPA”), Optimum Choice, Inc. (“OCI”), or] MAMSI Life & Health Insurance Company (“MLH”) Benefit Plans or any Benefit Plan serviced or administered by OneNet PPO, LLC (formerly “Alliance PPO LLC”) or any of the other foregoing companies (collectively “MAMSI Customers”), Clinic and Represented Providers will be subject to the Protocols set forth in Manual for Physicians and Health Care Practitioners (“MAMSI Manual”). The MAMSI Manual will be available to Clinic and Represented Providers on-line at www.MamsiUnitedHealthcare.com or upon request. In the event of any conflict between this Agreement or the UnitedHealthcare Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide (“Administrative Manual”) or other UnitedHealthcare administrative Protocols, and the MAMSI Manual in connection with any matter pertaining to a MAMSI Customer, the MAMSI Manual shall govern, unless applicable law dictates otherwise. United may make changes to the Administrative Manual or the administrative Protocols and MAMSI Manual upon thirty (30) days’ electronic or written notice to Clinic. *Drafting Note: Delete highlighted text if MAMSI gated HMO product is not included.*

Protocol for NHP Customers in Florida

For services provided to Customers enrolled in any Neighborhood Health Partnership, Inc. (“NHP”) Benefit Plans, Clinic and Represented Providers will be subject to the Protocols described in or made available to Clinic and Represented Providers in the NHP Provider Handbook (the “NHP Manual”). The Manual will be sent to you via courier or mail or made

available upon request. In the event of any conflict between this Agreement or the UnitedHealthcare Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide (“Administrative Manual”) or other UnitedHealthcare administrative Protocols, and the Manual in connection with any matter pertaining to a NHP Customer, the Manual shall govern, unless applicable Law dictates otherwise. United may make changes to the Manual or the administrative Protocols or Administrative Manual upon thirty (30) days’ electronic or written notice to Clinic.

Protocol the River Valley Entities Customers in the following states: IA, IL, TN, VA, MO and WI

United Healthcare Services Company of the River Valley, Inc. f/k/a John Deere Health Care, Inc., UnitedHealthcare Plan of the River Valley, Inc. f/k/a John Deere Health Plan, Inc. and UnitedHealthcare Insurance Company of the River Valley f/k/a John Deere Health Insurance, Inc. (collectively referred to as “River Valley Entities”) were acquired and became United Affiliates in February 2006.

For Customers enrolled in Benefit Plans issued by the River Valley Entities or under which a River Valley Entity provides administrative services under an agreement with a Payer and included in this Agreement as set forth in Appendix 2, Clinic and Represented Providers will be subject to the programs, protocols and administrative procedures described in or made available to Clinic and Represented Providers through the River Valley Provider Manual formerly the John Deere Health Provider Manual (the “River Valley Manual”) and the Payment Policies of the River Valley Entities. When the Agreement refers to the administrative manual or guide, it is also referring to the River Valley Manual. The River Valley Manual is available to Clinic and Represented Providers upon request. In the event of any conflict between the River Valley Manual or River Valley Payment Policies on the one hand and any of the following: the Agreement, any United programs, Protocols, administrative procedures (including Payment Policies and guidelines for calculating payments), or the UnitedHealthcare Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide (the “Administrative Manual”) in connection with any matter pertaining to a Customer of the River Valley Entities, the River Valley Manual or River Valley Payment Policies, as applicable, shall govern, unless applicable Law dictates otherwise. United may make changes to the Administrative Manual, River Valley Manual or other administrative Protocols and River Valley Payment Policies upon thirty (30) days’ electronic or written notice to Clinic.

Protocol for Oxford Health Plans Customers in the following states: NY, NJ, CT

i) United and/or United’s Affiliates underwrite or administer certain Benefit Plans currently marketed under the name “Oxford”; such Benefit Plans may be marketed under a different name in the future. For purposes of this Appendix, any one or more of these Benefit Plans are referred to as an “Oxford Benefit Plan” or “Oxford Benefit Plans.” In addition to the terms and conditions stated throughout this Agreement, the special terms and conditions described in this Appendix will apply to all Covered Services rendered under an Oxford Benefit Plan. In the event of any conflict or inconsistency between this Appendix and any other portion of this Agreement, the provisions of this Appendix shall control with regard to Oxford Benefit Plans.

ii) Oxford’s Protocols and Payment Policies are a subset of the Protocols and Payment Policies. Oxford’s utilization management Protocols apply to Oxford Benefit Plans. Those utilization management Protocols include, but are not limited to, referral requirements, precertification requirements, concurrent review, and determinations of medical necessity. The

Oxford Provider Reference Manual (the “Oxford Manual”) applies (and takes precedence over any conflicting provision in this Agreement or elsewhere in the Protocols or Payment Policies) to all Covered Services rendered to Customers under an Oxford Benefit Plan, but does not apply to Covered Services rendered to Customers under any other Benefit Plan. United may make changes to the Oxford Manual or the administrative Protocols and the Administrative Manual upon thirty (30) days’ electronic or written notice to Clinic.

iii) With respect to exclusive third-party vendor arrangements for Covered Services provided under Oxford Benefit Plans (for example, laboratory or radiology services), Clinic and Represented Providers must enter into a participation agreement with such third-party vendor in order for the Clinic and Represented Providers to be regarded as an Oxford participating provider of those Covered Services for Oxford Benefit Plans. In that event, the Oxford Protocols (as well as Oxford Payment Policies and applicable reimbursement methodologies) will be those of the third-party vendor as approved and adopted by Oxford, and will supersede those Oxford Protocols (as well as Oxford Payment Policies and reimbursement methodologies) otherwise applicable to such Covered Services under this Agreement.

Protocols for Medicaid Customers

For Customers enrolled in Medicaid Benefit Plans included in this Agreement as set forth in Appendix 2, Clinic will be subject to the programs, protocols and administrative procedures described in or made available to Facility through the applicable state Medicaid provider manual. When the Agreement refers to the administrative manual or guide, it is also referring to the applicable state Medicaid provider manual. The state provider manuals are available to Clinic upon request. In the event of any conflict between the applicable state Medicaid provider manual on the one hand and any of the following: the Agreement, any United programs, protocols, administrative procedures (including payment policies and guidelines for calculating payments), or the UnitedHealthcare Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide (the “Administrative Manual”) in connection with any matter pertaining to an eligible Medicaid Customer the state Medicaid provider manual, as applicable, shall govern, unless applicable statutes or regulations dictate otherwise. United may make changes to the Administrative Manual, state Medicaid provider manual or other administrative protocols upon 30 days’ electronic or written notice to Facility.

[Drafting Note: Insert all applicable state regulatory appendices.]

Arkansas Regulatory Requirements Appendix

This Arkansas Regulatory Requirements Appendix (the "Appendix") is made part of the Agreement entered into between **United HealthCare Insurance Company**, contracting on behalf of itself, **United HealthCare of Arkansas, Inc.**, and the other entities that are United's Affiliates (collectively referred to as "United") and the health care professional or entity named in the Agreement ("Provider").

This Appendix applies to products or benefit plans sponsored, issued or administered by or accessed through United to the extent such products are regulated under Arkansas laws provided, however, that the requirements in this Appendix will not apply to the extent they are preempted by the Medicare Modernization Act or other applicable law.

United and Provider each agree to be bound by the terms and conditions contained in this Appendix. In the event of a conflict or inconsistency between this Appendix and any term or condition contained in the Agreement, this Appendix shall control, except with regard to Benefit Plans outside the scope of this Appendix.

This Appendix will be deemed to be updated to incorporate any changes to the laws and regulations referenced herein, including any changes to definitions referenced herein, effective as of the date of such changes.

Unless otherwise defined in this Appendix, all capitalized terms contained in the Appendix shall be defined as set forth in the Agreement.

Provisions applicable to Benefit Plans regulated under Arkansas HMO laws:

1. Continued Provision of Covered Services.

(a) Following Termination due to United Insolvency. Provider agrees that in the event this Agreement is terminated because of United's insolvency, Provider shall continue the provision of Covered Services to a Customer who is receiving care from Provider for the duration of the period for which premiums have been paid to United on behalf of a Customer or until the Customer's discharge from an inpatient facility if Customer was confined to an inpatient facility on the date of United's insolvency.

(b) Continuity of Care After Termination. If this Agreement is terminated for any reason, Provider shall continue the provision of Covered Services to a Customer who is receiving care from Provider in relation to a current episode of treatment for an acute condition on and after the effective date of such termination until the first to occur of: (i) the current episode of treatment is completed; (ii) the end of ninety (90) days; or (iii) the Customer ceases to be covered by the Plan. Provider shall be reimbursed in accordance with this Agreement for all such Covered Services rendered subsequent to the termination of this Agreement.

2. Hold Harmless. In the event that Payer fails to pay for Covered Services as set forth in this Agreement, Customer shall not be liable to Provider for any sums owed by the Payer. Provider shall not collect or attempt to collect from Customer any sums owed by Payer. Provider (and Provider's agents, trustees, or assignees) may not maintain an action at law against a Customer to collect sums owed by Payer; nor make any statement, either written or oral, to any

Customer that makes demand for, or would lead a reasonable person to believe that a demand is being made for payment of any amounts owed by the health maintenance organization or Payer.

3. Examinations. During the term of this Agreement and for three (3) years after termination, Provider agrees to allow examination of medical records of Customers and records of Provider in conjunction with an examination of United conducted by the Arkansas Insurance Commissioner or Arkansas Director of the Department of Health, in accordance with Arkansas Statutes Section 23-76-122.

4. Confidentiality. Any data or information pertaining to the diagnosis, treatment, or health of a Customer obtained from the Customer or from any provider shall be held in confidence and shall not be disclosed to any person except to the extent that it may be necessary to carry out the purposes of applicable Arkansas law, upon the express consent of the Customer, pursuant to statute or court order for the production of evidence or the discovery thereof or in the event of a claim or litigation between the Customer and United wherein the data or information is pertinent. United shall be entitled to claim any statutory privileges against the disclosure that Provider (or provider who furnished the information to United) is entitled to claim.

5. Customer Medical Records. Provider shall maintain an active record for each Customer who receives Covered Services from Provider. Such record shall be kept current, complete, legible and available to United and Arkansas regulatory agencies. Each medical record shall contain sufficient information and data to support diagnosis, plan of treatment and other pertinent medical information such as medical history and progress notes. Each entry in a Customer's medical record shall be indelibly added to the record, dated and signed or initialed by the person making the entry. Provider shall have a means of identifying the name and professional title of each individual who makes an entry into the record. At a minimum, the medical record shall include: identification of the Customer, patient history, known past surgical procedures, known past and current diagnoses and problems, and known allergies and untoward reactions to drugs. With regard to each episode of care, the Customer's medical record shall include: the reason for the encounter, evidence of the Provider's assessment of the Customer's health problems; current diagnosis of the Customer, including the results of any diagnostic testing; plan of treatment, including any therapies and health education; and medical history relevant to the current episode of care. Provider shall document that Provider has reviewed all outcomes of ancillary reports and taken follow-up actions regarding report results that are deemed significant by the Provider.

6. Provider Communication with Customers. Nothing in this Agreement shall be construed as prohibiting, restricting or penalizing Provider in any way for disclosing to a Customer any health care information that Provider deems appropriate regarding the nature of treatment, risks or alternatives thereto, the availability of alternate therapies, consultations, or tests, the decision of utilization reviewers, or similar persons, to authorize or deny services, the process that is used to authorize or deny health care services or benefits, or information on financial incentives and structures used by United or Payer in this Agreement.

7. Provider Input. As requested by United, Provider shall provide input to United's medical policy, utilization management procedures, quality and credentialing criteria and medical management procedures.

8. Prompt Pay. United and Payer shall pay claims in accordance with claims processing and payment provisions contained in Arkansas Insurance Department Rule and Regulation 43, Unfair Claims Settlement Practices, Sections 11-15.

9. Recoupment. United, Payer and Provider shall comply with the applicable requirements as set forth in Arkansas Code Annotated § 23-63-1801 *et seq* and Arkansas Rule 85 regarding recoupment of paid claims.

Provisions applicable to Benefit Plans regulated by the State of Arkansas but not subject to Arkansas HMO laws:

1. Continuity of Care After Termination. If this Agreement is terminated for any reason, Provider shall continue the provision of Covered Services to a Customer who is receiving care from Provider in relation to a current episode of treatment for an acute condition on and after the effective date of such termination until the first to occur of: (a) the current episode of treatment is completed; (b) the end of ninety (90) days; or (c) the Customer ceases to be covered by the Plan. Provider shall be reimbursed in accordance with this Agreement for all such Covered Services rendered subsequent to the termination of this Agreement.

2. Provider Communication with Customers. Nothing in this Agreement shall be construed as prohibiting, restricting or penalizing Provider in any way for disclosing to a Customer any health care information that Provider deems appropriate regarding the nature of treatment, risks or alternatives thereto, the availability of alternate therapies, consultations, or tests, the decision of utilization reviewers, or similar persons, to authorize or deny services, the process that is used to authorize or deny health care services or benefits, or information on financial incentives and structures used by United or Payer in this Agreement.

3. Provider Input. As requested by United, Provider shall provide input to United's medical policy, utilization management procedures, quality and credentialing criteria and medical management procedures.

4. Prompt Pay. United and Payer shall pay claims in accordance with claims processing and payment provisions contained in Arkansas Insurance Department Rule and Regulation 43, Unfair Claims Settlement Practices, Sections 11-15.

5. Recoupment. United, Payer and Provider shall comply with the applicable requirements as set forth in Arkansas Code Annotated § 23-63-1801 *et seq* and Arkansas Rule 85 regarding recoupment of paid claims.