

SERFF Tracking Number: UHLC-126551708 State: Arkansas
 Filing Company: UnitedHealthcare of Arkansas, Inc. State Tracking Number: 45217
 Company Tracking Number:
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
 Product Name: Sheridan Provider Agreement
 Project Name/Number: /

Filing at a Glance

Company: UnitedHealthcare of Arkansas, Inc.
 Product Name: Sheridan Provider Agreement
 TOI: H21 Health - Other

SERFF Tr Num: UHLC-126551708 State: Arkansas
 SERFF Status: Closed-Approved-
 Closed State Tr Num: 45217

Sub-TOI: H21.000 Health - Other
 Filing Type: Form

Co Tr Num: State Status: Approved-Closed
 Reviewer(s): Rosalind Minor
 Author: Ebony Terry Disposition Date: 04/02/2010
 Date Submitted: 03/21/2010 Disposition Status: Approved-
 Closed

Implementation Date Requested: On Approval
 State Filing Description:

Implementation Date:

General Information

Project Name:
 Project Number:
 Requested Filing Mode:
 Explanation for Combination/Other:
 Submission Type: New Submission
 Overall Rate Impact:
 Filing Status Changed: 04/02/2010

Status of Filing in Domicile: Authorized
 Date Approved in Domicile:
 Domicile Status Comments:
 Market Type:
 Group Market Size:
 Group Market Type:
 Explanation for Other Group Market Type:
 State Status Changed: 04/02/2010
 Created By: Ebony Terry
 Corresponding Filing Tracking Number:

Deemer Date:
 Submitted By: Ebony Terry
 Filing Description:
 Sheridan Provider Contract

Company and Contact

Filing Contact Information

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 Rockville, MD 20850

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Filing Company Information

<i>SERFF Tracking Number:</i>	<i>UHLC-126551708</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>UnitedHealthcare of Arkansas, Inc.</i>	<i>State Tracking Number:</i>	<i>45217</i>
<i>Company Tracking Number:</i>			
<i>TOI:</i>	<i>H21 Health - Other</i>	<i>Sub-TOI:</i>	<i>H21.000 Health - Other</i>
<i>Product Name:</i>	<i>Sheridan Provider Agreement</i>		
<i>Project Name/Number:</i>	<i>/</i>		
UnitedHealthcare of Arkansas, Inc.	CoCode: 95446	State of Domicile: Arkansas	
Plaza West Building	Group Code:	Company Type: HMO	
415 North McKinley Street, Suite 300	Group Name:	State ID Number:	
Little Rock, AK 72205	FEIN Number: 63-1036819		
(952) 992-7428 ext. [Phone]			

Filing Fees

Fee Required?	Yes
Fee Amount:	\$50.00
Retaliatory?	No
Fee Explanation:	2 forms x fee
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
UnitedHealthcare of Arkansas, Inc.	\$100.00	03/21/2010	35043219

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	04/02/2010	04/02/2010

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Disposition

Disposition Date: 04/02/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Form	Provider Agreement	Approved-Closed	Yes
Form	Provider Agreement	Approved-Closed	Yes

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Form Schedule

Lead Form Number:

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	UHC/MGA.01.2010	Policy/Contract	Provider Agreement	Initial			Sheridan MGA version -5.pdf
04/02/2010	eridan	al	Certificate				
Approved-Closed	UHC/FAC.MGA.ANCL	Policy/Contract	Provider Agreement	Initial			Arkansas_Reg_Require_FPA_MGA2006 (4).pdf
04/02/2010	-	al	REGAPX.0 Certificate				
	8.06.AR						

Medical Group Participation Agreement

This Agreement is entered into by and between UnitedHealthcare Insurance Company, contracting on behalf of itself and the other entities that are United's Affiliates (as defined in this Agreement) (collectively referred to as "United") and Sheridan Healthcorp and the entities that are Medical Group's Affiliates (as defined in this Agreement) (collectively, "Medical Group") and any additional entities for either United or Medical Group created or added hereafter shall be accomplished in the manner provided in Sections 3.1, 3.2 and 3.3 below.

This Agreement is effective on May 1, 2009, except with respect to Neighborhood Health Partnership, Inc. (the "United Effective Date.") This Agreement is effective with respect to Neighborhood Health Partnership, Inc. on January 1, 2009 (the "Neighborhood Health Effective Date"). The United Effective Date and the Neighborhood Health Effective Date may be referred to collectively as the "Effective Date." For purposes of renewal terms, the Effective Date shall be May 1, 2009.

The parties recognize that this Agreement has been executed such that a retro-loading of the contract is needed. The parties further recognize that the retro-loading of the Agreement will require reprocessing of claims submitted and paid prior to the time this Agreement is loaded. As a result, the time period by which any interest or penalty might be due on any claim submitted and paid with dates of service from the noted Effective Date through forty-five days from the date the Agreement is fully executed ("Retro-Load Period") will not commence until after such Retro-Load Period has expired plus 180 days. The parties also recognize that due to the retro-loading of this Agreement, there may be claims submitted during the Retro-Load Period with dates of service during the Retro-Load Period, but not yet paid during the Retro-Load Period. In such cases, the time period by which any interest or penalty might be due on any such claim as otherwise required by applicable law will not commence until the Retro-Load Period has expired or the complete claim is filed in accordance with the terms and conditions of this Agreement, whichever is later.

Through contracts with physicians and other providers of health care services, United maintains one or more networks of providers that are available to Customers. Medical Group is a provider of health care services. United wishes to arrange to make Medical Group's services available to Customers. Medical Group 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, under which a Payer is obligated to provide coverage of Covered Services for a Customer.

1.2 "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.

1.3 "Customary Charge" is the retail fee for health care services charged by Medical Group that Medical Group would ordinarily charge another person before being afforded a discount from those retail fees.

1.4 "Customer" is a person eligible and enrolled to receive coverage from a Payer for Covered Services.

1.5 "Medical Group 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 shareholder, partner, or employee of Medical Group, or who practices as a subcontractor of Medical Group. However, a subcontractor of Medical Group is a Medical Group Physician only with regard to services rendered to patients of Medical Group and billed under Medical Group's tax identification number. Additionally, a subcontractor is not a Medical Group Physician with regard to any services rendered in a physician's office other than those locations listed in Appendix 1.

1.6 "Medical Group Non-Physician Provider" is a advanced registered nurse practitioner, anesthesia assistant, certified registered nurse anesthetist, surgical assistant, physician assistant, nurse practitioner, physical therapist, occupational therapist, speech therapist, mental health provider, or licensed social worker, who is duly authorized

under the laws of the jurisdiction in which Covered Services are provided, and who renders Covered Services as an employee or subcontractor of Medical Group. However, a subcontractor of Medical Group is a Medical Group Non-Physician Provider only with regard to services rendered to patients of Medical Group and billed under Medical Group's tax identification number. Additionally, a subcontractor is not a Medical Group Non-Physician Provider with regard to any services rendered in a physician's office other than those locations listed in Appendix 1.

1.7 "Medical Group Professional" is a Medical Group Physician or a Medical Group Non-Physician Provider.

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 Medical Group's services under this Agreement. The following entities may be a Payer:

- United;
- United's Affiliates; and
- Any entity receiving administrative services from United or one of United's Affiliates; when the entity is a managed care entity that is not United's Affiliates, those administrative services must include claims processing services.

1.10 "Protocols" are the programs, protocols and administrative procedures adopted by United or a Payer to be followed by Medical Group 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.

1.11 "United's Affiliates" are those entities controlling, controlled by, or under common control with United HealthCare Insurance Company. The list of United's Affiliates as of December 31, 2008 is attached as Exhibit A. United will provide an updated list to Medical Group upon request.

1.12 "Medical Group Affiliates" are those entities controlling, controlled by, or under common control with Sheridan Healthcare, Inc. or its subsidiaries or affiliates (as defined by the securities laws of the United States). The list of Medical Group's Affiliates as of (date) is attached as Attachment A to Appendix 1 of this Agreement. Medical Group will provide an updated list to Medical Group upon request.

Article II. Representations and Warranties

2.1 Representations and Warranties of Medical Group. Each entity which is part of the Medical Group, by virtue of its execution and delivery of this Agreement, represents and warrants as follows:

(a) Each of the entities comprising the Medical Group is a duly organized and validly existing legal entity in good standing under the laws of its their respective jurisdictions of organization.

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

(c) The execution, delivery and performance of this Agreement by each of the entities comprising the Medical Group do not and will not violate or conflict with (i) the organizational documents of any of the entities comprising the Medical Group, (ii) any material agreement or instrument to which any of the entities comprising the Medical Group is a party or by which any of the entities comprising the Medical Group or any material part of their property is bound, or (iii) applicable laws or regulations. Each of the entities comprising the Medical Group has the unqualified authority to bind, and does bind, their selves and their respective Medical Group Professionals to all of the terms and conditions of this Agreement, including any Appendices, Attachments and Exhibits, as applicable.

(d) Each of the entities comprising the Medical Group 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) Except as otherwise provided in this Agreement, each of the entities comprising the Medical Group has been given an opportunity to review the Effective Date Protocols and Effective Date 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. In no event or circumstance shall any of the Protocols, Payment Policies or any other policies, procedures or directives of United or any Payer require Medical Group, any Medical Group Physician or Medical Group Non-Physician Provider to provide medical services in any manner which does not conform to the generally recognized standards of medical care.

(f) Each submission of a claim by Medical Group pursuant to this Agreement shall be deemed to constitute the representation and warranty by it to United that (i) it has complied with the requirements of this Agreement with respect to the Covered Services involved and the submission of such claim, (ii) the charge amount set forth on the claim is the Customary Charge and (iii) the claim is a valid claim.

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

(a) each of the entities comprising United is a duly organized and validly existing legal entity in good standing under the laws of their respective jurisdictions of organization.

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

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

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

Article III. Applicability of this Agreement

3.1 Medical Group's Services and Medical Group Affiliation Events. This Agreement applies to Medical Group's practice locations set forth in Appendix 1. In the event Medical Group begins providing services at other locations (either by creating a new entity which becomes a part of the Medical Group, 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 be added to Appendix 1 and become subject to this Agreement 30 days after United receives the notice required under section 5.7(v) of this Agreement.

In the event Medical Group acquires or is acquired by, merges with, or otherwise becomes affiliated with another entity (each, a "Medical Group Affiliation Event" and collectively, the "Medical Group Affiliation Events") that provides 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 Medical Group Affiliation Event, until the earlier of the expiration or termination of the other agreement or one year after the date of the Medical Group Affiliation Event unless otherwise agreed to in writing by all parties to such agreements. Thereafter this Agreement shall apply.

Medical Group may transfer all or some of its assets to another entity that is not a Medical Group Affiliate, 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 Medical Group, but only if Medical Group 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 United Affiliation Events. In the event United acquires or is acquired by, merges with, or otherwise becomes affiliated with another entity that offers, issues or administers benefit plans (each an "United Affiliation Event" and collectively, the "United Affiliation Events") that is already under contract with any of the entities which comprise Medical Group then this Agreement and the other agreement will each remain in effect and will continue to apply as they did prior to the United Affiliation Event, until the earlier of the expiration or termination of the other agreement or one year from the date of the United Affiliation Event unless otherwise agreed to in writing by all parties to such agreements. Thereafter this Agreement shall apply.

The intent of the parties in this Section 3.2 is to maintain the status quo as to the rights of a United Affiliate referenced in Appendix 4, or a new United Affiliate that becomes subject to this Agreement under this Section 3.2, to deny claims based on Medical Group's failure to comply with Protocols. United may only deny a claim based on Medical Group's failure to meet the applicable standard under section 5.4 with regard to the Protocols of such United Affiliates to the extent that Medical Group's previous contract with that United Affiliate afforded the United Affiliate such a right, and subject to Medical Group's appeal rights under this Agreement, section 7.10 related to underpayments, and the dispute resolution process set forth in Article VIII.

3.3 Payers and Benefit Plan types. United may allow Payers to access Medical Group's services (other than Facility-Based Medical Professional'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 notice.

Payers (including United's Affiliates) shall access, pursuant to the terms of this Agreement, Medical Group's services rendered by Facility-Based Medical Group Professionals, except as follows:

United will not be required to allow access to a Payer if such access would cause the Payer, who are not one of United's Affiliates, to be in breach of another agreement;

United will not be required to allow access to a Payer that is one of United's Affiliates if access would cause such United's Affiliate to be in breach with an existing agreement with another provider or customer;

United will not be required to allow access to a Payer, if Payer is also a provider and Payer's Benefit Plan for its employee's provides for a limited network which does not include the facilities at which Facility-Based Medical Professionals provide services; provided, however, such Payers may access the services of Facility-Based Medical Professionals providing emergency services;

United will not be required to allow access to a Payer that is not one of United's Affiliates, if such Payer does not access United's network of contracted facilities, physicians and other medical professionals or Payer opts to only access a limited portion of United's network of contracted facilities, physicians and other medical professionals and such limited access does not include facilities at which Medical Group provides services; provided, however, such Payers may access the services of Facility-Based Medical Professionals providing emergency services;

Subject to Section 3.2, United will not be required to allow access under this Agreement to a Payer that has entered into a direct contract with Medical Group for Medical Group's services;

United will not allow access to a Payer if the parties mutually agree to exclude Medical Group's services

When Benefit Plans offer United's network of providers, an identification card will be provided to Customers by Payers. A reference to United and/or one of United's Affiliates will appear on the identification card. A listing of all providers who participate in United's network of providers will be made available to Customers covered under these Benefit Plan types, and the Customers are incented to receive services from providers who participate in United's network of providers. Such incentives may include, but are not limited to, a higher level of coverage and/or the potential reduction or elimination of co-payment, deductible or coinsurance for which the Customer is responsible under the Benefit Plan.

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

This section does not authorize Medical Group 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.

3.5 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.

3.6 Health Care. Medical Group acknowledges that this Agreement, Customer Benefit Plans, Payment Policies, and Protocols do not dictate the health care provided by Medical Group or Medical Group Professionals, or govern Medical Group's or Medical Group 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 Medical Group Professionals and with our Customers, and not with United or any Payer. United will not direct Medical Group's provision of clinical services.

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

3.8 Services Rendered by Hospital-Based Medical Group Professionals. For purposes of this section 3.8, "Facility-Based Medical Group Professional" means a Medical Group Professional who, directly or through Medical Group, is under contract with a hospital, ambulatory surgery center or other facility to render Covered Services to the facility's patients at the facility. Facility-Based Medical Group Professionals include, but are not limited to, emergency room physicians, pathologists, radiologists, anesthesiologists, certified registered nurse anesthetists, anesthesia assistants, advanced nurse practitioners, physician assistants, hospitalists, and intensivists.

The following provisions of this Agreement do not apply to services rendered by Facility-Based Medical Group Professionals:

- i) the requirement in section 3.4 that Medical Group first obtain the Customer's written consent in order to seek and collect payment from a Customer for non-covered services;
- ii) Sections 4.2(i), 4.3, 4.4, 4.5(vi) and the credentialing and recredentialing processes as set forth in the Protocols;
- iii) Sections 5.4(1), 5.4(2) and 5.4 (3);
- iv) Section 5.8;
- v) the requirements in section 5.9 regarding medical records;
- vi) section 5.10 regarding the collection and review of certain quality data (but only if Medical Group does not collect and review quality data relating to care rendered by such Medical Group because such data is instead collected and reviewed by the hospital); and
- vii) the requirement in section 7.6 that, prior to rendering services, the Medical Group ask the patient to present his or her Customer identification card.

All of the provisions of this Agreement, including those listed in this section 3.8, apply to services rendered by Medical Group Professionals who are not acting as Facility-Based Medical Group Professionals.

Article IV.

Participation of Medical Group Professionals in United's Network

4.1 Medical Group Professionals as Participating Providers. Except as described under section 4.2, all Medical Group Professionals will participate in United's network. Medical Group has the authority to bind, and will bind, all new Medical Group Professionals to the obligations of this Agreement

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

- i) A Medical Group Physician (or a Medical Group Non-Physician Provider, 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 Medical Group Professional who has been terminated from participation in United's network pursuant to section 4.5 of this Agreement.

4.3 Credentialing. Medical Group and Medical Group Physicians will participate in and cooperate with United's credentialing program (subject to the delegated credentialing agreement between the parties, so long as that agreement remains in effect). Medical Group Non-Physician Providers will participate in and cooperate with United's credentialing program to the extent such Medical Group Non-Physician Providers are subject to credentialing by United.

4.4 New Medical Group Professionals. Medical Group will notify United at least 30 days before a physician becomes a Medical Group Physician. In the event that the Medical Group's agreement with the new Medical Group Physician provides for a starting date that would make it impossible for Medical Group to provide 30 days advance notice to United, then Medical Group will give notice to United within five business days after reaching agreement with the new Medical Group Physician. In either case, the new Medical Group Physician will submit and complete a credentialing application to United within 30 days of the new Medical Group Physician's agreement to join Medical Group, unless the new Medical Group 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 Medical Group Non-Physician Providers who are subject to credentialing by United.

4.5 Termination of a Medical Group Professional from United's Network. United may terminate a Medical Group Professional'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 Medical Group Professional within 30 days after United provided notice to Medical Group of the breach;
- ii) the suspension, revocation, condition, limitation, qualification or other material restriction on a Medical Group Professional's licenses, certifications and permits by any government agency under which the Medical Group Professional is authorized to provide health care services;
- iii) the suspension, revocation, condition, limitation, qualification or other material restriction of a Medical Group Physician's staff privileges at any licensed hospital, nursing home or other facility at which the Medical Group Physician 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 Medical Group Professional'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 Medical Group of the Medical Group Professional's termination according to the notice provision set forth in section 10.8 of this Agreement.

4.6 Covered Services by Medical Group Professionals who are not Participating Providers. Medical Group will staff its service locations so that Covered Services can appropriately be rendered to Customers by Medical Group Professionals who participate in United's network. A Medical Group Professional who does not participate in United's network, pursuant to section 4.2 of this Agreement, will not render Covered Services to a Customer.

In the event Covered Services are rendered by a Medical Group Professional who does not participate in United's network, Medical Group and the Medical Group 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.

Article V.
Duties of Medical Group

5.1 Provide Covered Services. Medical Group will provide Covered Services to Customers.

5.2 Nondiscrimination. Medical Group 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. Medical Group will not require a Customer to pay a “membership fee” or other fee in order to access Medical Group 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 membership fee or other fee.

5.3 Accessibility. Medical Group will provide or arrange for the provision of advice and assistance to Customers in emergency situations 24 hours a day, seven days a week.

5.4 Cooperation with Protocols. Medical Group 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. Medical Group will use reasonable commercial efforts to direct Customers only to other providers that participate in United’s network, except as otherwise authorized by United or Payer.

2. If the Customer’s Benefit Plan requires the Customer to receive certain Covered Services from or upon referral by a primary care physician, all referral physicians must adhere to the following additional protocols when those Covered Services are provided:

a. Notify Customer’s primary care physician of referrals to other participating or non-participating providers.

b. Covered Services must be provided pursuant to the terms and limitations of the referral notification issued by or on behalf of the Customer’s primary care physician.

c. If the Medical Group Physician providing the Covered Services is a referral physician, the Medical Group Physician must also notify the Customer’s primary care physician of all admissions in accordance with the required time frames.

3. Medical Group 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 Medical Group 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 administrative manual or guide applicable to Customers enrolled in certain Benefit Plans.

United may change the Protocols from time to time. United shall inform Medical Group at least 30 days in advance of any material changes to the Protocols. United may implement changes in the Protocols without Medical Group’s consent if such change is applicable to all or substantially all of the medical groups in United’s network located in the same state as Medical Group and that practice the same specialty as Medical Group. Otherwise, changes to the Protocols proposed by United to be applicable to Medical Group are subject to the terms of section 10.2 of this Agreement that are applicable to amendments.

In the event that Medical Group believes that a change in the Protocols would result in increased costs for Medical Group, Medical Group may provide written notice to United of that belief; any such notice must explain and quantify the projected financial impact to Medical Group of the change in the Protocols. In the event Medical Group sends such a notice, Medical Group and United will consult together about the issue and United, through an amendment, will adjust the fee schedule attached in Appendix 3 to eliminate the projected financial impact or otherwise negotiate a mutually agreeable resolution. If the issue is not resolved to either party’s satisfaction, the dissatisfied party may initiate dispute resolution pursuant to Article VIII of this Agreement. In the event the issue is arbitrated, the arbitration’s scope will be limited to quantifying the financial impact to Medical Group of the change in the Protocols, and the arbitrator may award no more than the amount necessary to cover Medical Group’s increased costs in light of that change. The arbitrator may also consider the impact of other changes made by United in its Protocols that have reduced Medical Group’s costs, and may balance any such reduction against the impact of the increased costs at issue. The change may be implemented while the dispute resolution process is proceeding, and the arbitrator cannot order that the change not take place or be reversed.

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

5.6 Liability Insurance. Medical Group will assure that Medical Group and all Medical Group 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, Medical Group shall submit to United in writing evidence of insurance coverage.

TYPE OF INSURANCE	MINIMUM LIMITS
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). This insurance requirement will also be satisfied if the Medical Group insures each Medical Group Professional separately, and the coverage for each Medical Group Professional is at least Two Hundred Fifty Thousand Dollars (\$250,000.00) per occurrence and Seven Hundred Fifty Thousand Dollars (\$750,000.00) 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, Medical Group may, with the prior written approval of United, self-insure its medical malpractice and/or professional liability, as well as its commercial general liability. Medical Group shall maintain a separate reserve for its self-insurance. If Medical Group will use the self-insurance option described in this paragraph, Medical Group 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. Medical Group will provide a similar statement during the term of this Agreement upon United's request, which will be made no more frequently than annually. Medical Group will assure that its self-insurance fund will comply with applicable laws and regulations.

5.7 Notice. Medical Group will give notice to United within 10 days after any event that causes Medical Group to be out of compliance with section 5.5 or 5.6 of this Agreement, or of any change in Medical Group's name, ownership, control, or Taxpayer Identification Number. This section does not apply to changes of ownership or control that result in Medical Group being owned or controlled by an entity with which it was already affiliated prior to the change. In addition, Medical Group 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 Medical Group Professional's licenses, certifications and permits by any government agency under which a Medical Group Professional is authorized to provide health care services;
- ii) any suspension, revocation, condition, limitation, qualification or other material restriction of a Medical Group Physician's staff privileges at any licensed hospital, nursing home or other facility at which a Medical Group Physician has staff privileges during the term of this Agreement;
- iii) indictment, arrest or conviction of a Medical Group Professional for a felony, or for any criminal charge related to the practice of the Medical Group Professional's profession;
- iv) the departure of any Medical Group Professional from Medical Group; or
- v) any changes to the information contained in Appendix 1.

5.8 Customer consent to release of Medical Record Information. Medical Group will obtain any Customer consent required in order to authorize Medical Group to provide access to requested information or records as

contemplated in section 5.9 of this Agreement, including copies of the Medical Group's medical records relating to the care provided to Customer.

5.9 Maintenance of and Access to Records. Medical Group will maintain adequate medical, financial and administrative records related to Covered Services rendered by Medical Group 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. Medical Group 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 Medical Group's compliance with the terms and provisions of this Agreement and appropriate billing practice. Medical Group will provide access during ordinary business hours within fourteen 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 Medical Group, United, or Payers.

Medical Group 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.

Upon invoice from Medical Group, United will pay for copies of records requested by United. Payment will be made at a rate of \$0.25 per page, not to exceed a total of \$25.00 per record, unless a different rate is specified under state law

5.10 Access to Data. Medical Group will collect and provide to United the aggregate data relating to quality of care rendered by Medical Group to its commercial patient population that Medical Group provides to other third party insurers.

5.11 Compliance with law. Medical Group 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, Medical Group will make reasonable commercial efforts to do business with United electronically, including using 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 and also including using www.unitedhealthcareonline.com for additional functionalities (for instance, notification of admission) after United informs Medical Group that such functionalities have become available for the applicable Customer.

5.13 Employees and subcontractors. Medical Group will assure that its employees, affiliates and any individuals or entities subcontracted by Medical Group 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 Medical Group's obligations and accountability under this Agreement with regard to such services.

For laboratory services, Medical Group will only be reimbursed for services that Medical Group is certified through the Clinical Laboratory Improvement Amendments (CLIA) to perform, and Medical Group must not bill Customers for any laboratory services for which Medical Group 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 Medical Group 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 Medical Group 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 laws and 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 do business with Medical Group 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.

6.8 Joint Operating Committee. United and Medical Group will each designate key management staff to serve on a Joint Operating Committee. The Joint Operating Committee will meet quarterly and will discuss matters pertinent to the business relationship between the parties and use their reasonable best efforts to amicably resolve any matters of concern to either party. Among other matters, the Joint Operating Committee may review data on Medical Group's clinical performance under the Agreement and discussions of claims payment issues, and avoidance of the need for voluminous claims submissions or resubmissions.

6.9 Payer Agreement. United will make reasonable commercial efforts to evaluate a Payer's financial ability to meet its claims payment obligations and to terminate or bring into compliance a Payer that has defaulted.

Article VII.

Submission, Processing, and Payment of Claims

7.1 Form and content of claims. Medical Group must submit claims for Covered Services in a mutually acceptable electronic manner using industry standard formats. Unless otherwise directed by United, Medical Group shall submit claims using current CMS 1500 form for paper claims and HIPAA standard professional or institutional claim formats for electronic claims as applicable, whichever is appropriate, with applicable coding including, but not limited to, ICD, CPT, Revenue and HCPCS coding.

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

7.2 Electronic filing of claims. Within 6 months after the Effective Date of this Agreement, Medical Group 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 180 days from the date that Covered Services are rendered or the date Medical Group becomes aware United is the payer or processing for a Payer. In the event United requests additional information in order to process the claim, Medical Group will provide such additional information within 180 days of United's request. If Payer is not the primary payer, and Medical Group is pursuing payment from the primary payer, the 180 day filing limit will begin on the date Medical Group receives the claim response from the primary payer.

7.4 Payment of claims.

Payer will pay claims for Covered Services according to the applicable fee schedule (as further described in Appendix 3 to this Agreement), and in accordance with Payment Policies. United and Payers will process at least 90% of complete claims (as defined below) within 30 days of the date of receipt and 100% of complete claims within 60 days of the date of receipt. In the event that any claims remain unprocessed (paid in full or denied appropriately), then Medical Group may send a notice to United of such unprocessed claims. United shall process (pay in full or deny appropriately) such remaining claims within sixty (60) days of such notice. Failure to so process the remaining claims shall be a breach under this Agreement and the Medical Group's prior notice shall constitute notice per section 9.3(iii); provided, however, failure to process claims within the timeframes in the previous sentence will not give rise to a material breach unless it is a systemic or repeated failure that is not immaterial and that is not resolved through the Joint Operating Committee. Disputes, other than routine claims appeals, as to whether certain claims should be paid or the amounts that should be paid for certain claims will be handled through the Joint Operating Committee and, if not otherwise resolved, the Dispute Resolution process described in Article XIII.

For purposes of this paragraph, a "complete claim" is a claim that includes all the information required for processing (as described in the Administrative Guide or some other Protocol made known by United) and does not include claims pended for coordination of benefits or for which United has requested medical records in order to process the claim; however, if a claim is subject to state claims payment regulation and the applicable state regulation uses a conflicting definition of "complete claim" or "clean claim", the definition in state law will be used to determine whether that state-regulated claim is a "complete claim" for purposes of this paragraph. For purposes of this paragraph, a claim shall be deemed paid on the day the payment is mailed or sent electronically to Medical Group. Nothing in the paragraph changes or limits the obligation of Payers to pay appropriate interest or penalties for untimely claims payment as required by applicable law.

ii) Claims for Covered Services subject to coordination of benefits will be paid in accordance with applicable law.

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

iv) United will make its Payment Policies available to Medical Group online or upon request. United may change its Payment Policies from time to time. In the event United changes a Payment Policy and Medical Group believes that the change would result in reduced reimbursement for Medical Group, then Medical Group may provide written notice to United of that belief; any such notice must explain the basis for Medical Group's belief and quantify the projected financial impact to Medical Group of the change in the Payment Policy.

In the event Medical Group sends such a notice, Medical Group and United will consult together about the issue and United, through an amendment, will adjust fee schedule attached in Appendix 3 to eliminate the projected financial impact or otherwise negotiate a mutually agreeable resolution. If the issue is not resolved to either party's satisfaction, the dissatisfied party may initiate dispute resolution pursuant to Article VIII of this Agreement. In the event the issue is arbitrated, the arbitration's scope will be limited to quantifying the financial impact to Medical Group of the change in the Payment Policy, and the arbitrator may award no more than the amount necessary to cover Medical Group's increased costs in light of that change. The arbitrator may also consider the impact of other changes made by United in its Payment Policies that have increased Medical Group's reimbursement, and may balance any such increase against the impact of the reduced reimbursement at issue. The change may be implemented while the dispute resolution process is proceeding, and the arbitrator cannot order that the change not take place or be reversed.

For purposes of this section 7.4, a Benefit Plan is not a Payment Policy.

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 Medical Group 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 reasonably and appropriately determined by United to be medically unnecessary, and Medical Group 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.

If a denial of payment results from a change in the Protocols without Medical Group having been informed of the change at least 30 days in advance of the date of service, United or Payer will reverse the denial on appeal.

In the event United or Payer provides authorization to Medical Group (or to another physician or to a facility) that the services in question are approved and are Covered Services, and Medical Group provides such services in reliance on that authorization, United or Payer may not deny payment for such services on the basis of Medical Necessity unless Medical Group (or another physician or a facility) provided fraudulent, incomplete or inaccurate information in obtaining such authorization. For purposes of this paragraph, mere confirmation that United or Payer has received notification does not constitute an authorization.

In the event that payment of a claim is denied for lack of notification or for untimely filing, the denial will be reversed if Medical Group 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, Medical Group did not know and was unable to reasonably determine that the patient was a Customer,
- ii) that Medical Group took reasonable steps to learn that the patient was a Customer, and
- iii) that Medical Group 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, Medical Group will ask the patient to present his or her Customer identification card. In addition, Medical Group may contact United to obtain the most current information on the patient as a Customer.

However, Medical Group 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 Medical Group 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. Medical Group 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. Medical Group 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 for any Covered Service regardless of whether such amount is less than Medical Group's Customary Charge.

7.8 Customer "Hold Harmless." Medical Group 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 Medical Group's billed charge, or for any amounts denied or not paid under this Agreement due to:

- i) Medical Group's failure to comply with the Protocols,
- ii) Medical Group's failure to file a timely claim,
- iii) Payer's Payment Policies,
- iv) a denial based on medical necessity or prior authorization (except as provided in Section 7.5),
- v) inaccurate or incorrect claim processing,
- vi) 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

This obligation to refrain from billing Customers applies even in those cases in which Medical Group believes that United or Payer has made an incorrect determination. In such cases, Medical Group 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 vi), Medical Group may seek payment directly from the Payer or from Customers covered by that Payer. However, Medical Group 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 and shall be timely given), Medical Group then gives United 15 days prior written notice of Medical Group'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 Medical Group 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, Medical Group 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 Medical Group to collect such payment from Customer.

In the event of such a breach, Medical Group shall promptly reimburse the Customer .

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 by giving the other party notice, within 12 months after the payment was initially made, that it believes the payment was made incorrectly.

The 12 month limit will not apply to recovery of overpayments in either of the following circumstances:

- i) the overpayment resulted from fraud by or on behalf of Medical Group, or
- ii) United's ability to discover the overpayment during the 12 month period was hindered by Medical Group's failure to provide full and timely cooperation with an audit by United.

Undisputed underpayments or overpayments will be repaid within 45 days of notice of the underpayment or overpayment. Medical Group 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 45 days after posting it as a credit balance.

Subject to this paragraph, Medical Group agrees that recovery of overpayments may be accomplished by offsets against future payments. United will provide written or electronic notice to Medical Group before using an offset as a means to recover an overpayment, and will not implement the offset if, within 30 days after the date of the notice, Medical Group refunds the overpayment or initiates an appeal. In the event that Medical Group is dissatisfied with the outcome of any such appeal, Medical Group may initiate the dispute resolution process described in Article VIII of this Agreement. During the pendency of the dispute resolution process, United will not implement the offset.

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

In the event that Medical Group's failure to give timely notice under section 5.7 (iv) of this Agreement resulted in claims payments being made incorrectly to Medical Group, Medical Group shall promptly call the situation to United's attention and return such payments to United.

In the event that both Medical Group and some other entity assert a right to payment for the same service rendered by the former Medical Group Professional, if United may refrain from paying either entity until the payment obligation is clarified. Provided that United acts in good faith, Medical Group 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 exclusively in Broward County, FL. 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 arbitrator(s) shall award applicable pre-judgment interest.

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 ruling by an arbitrator finding that this provision permits class 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. In the event this provision requiring the parties to submit their disputes to individual arbitration is found unconscionable, this arbitration agreement shall be stricken in its entirety.

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 Medical Group before Medical Group may invoke any right to arbitration under this Article VIII, provided however, that the exhaustion of these remedies do not involve any dispute over amounts due either party under this Agreement or the resolution of any change in any Payment Policies, Protocols and further that the exhaustion of remedies in no event shall be greater than ninety days and not require any additional time before becoming subject to arbitration described in the second paragraph of this Article.

To the extent not otherwise prohibited by the Federal Arbitration Act and case law interpreting it, the decision of the arbitrator(s) on the points in dispute will be binding unless the arbitrator's decision reflects a manifest disregard of law or fact or is otherwise subject to vacation, modification or correction under the Federal Arbitration Act, in which case it may be reviewed by any court of competent jurisdiction where the services in question were being provided, and judgment on the award may be entered in any court having jurisdiction thereof.

Except as set forth above, 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.

The prevailing party in any arbitration proceeding in connection with or arising out of this Agreement shall be entitled to have: (i) all of the costs of arbitration, including without limitation, the filing and administrative fees of the AAA and the cost of the arbitrator(s); and (ii) the prevailing party's own costs, fees and expenses including without limitation the prevailing party's reasonable attorney's fees, costs and expenses, at arbitration or on appeal promptly paid at the conclusion of such action by the non-prevailing party to the prevailing party.

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 (except for any matter covered in the Settlement Agreement between the Parties, dated as of April 14, 2009) 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 five 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.

9.3 Ongoing Services to Certain Customers After Termination Takes Effect. In the event a Customer is receiving any of the Covered Services listed below, as of the date the termination takes effect, Medical Group will continue to render those Covered Services to that Customer and this Agreement will continue to apply to those Covered Services, after the termination takes effect, for the length of time indicated below:

Inpatient Covered Services	30 days or until discharge, whichever comes first
Pregnancy, Third Trimester – Low Risk	Through postpartum follow up visit
Pregnancy, First, Second or Third Trimester – Moderate Risk and High Risk	Through postpartum follow up visit
Non-Surgical Cancer Treatment	30 days or a complete cycle of radiation or chemotherapy, whichever is greater
End Stage Kidney Disease and Dialysis	30 days
Symptomatic AIDS undergoing active treatment	30 days
Circumstances where Payer is required by applicable law to provide transition coverage of services rendered by Medical Group after Medical Group leaves the provider network accessed by Payer.	As applicable

**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. This Agreement may only be amended in writing signed by both parties. Additionally, this Agreement may be unilaterally amended by United upon written notice to Medical Group in order to comply with applicable regulatory requirements, provided that such unilateral amendment is imposed on a similar basis to all or substantially all of the medical groups in United’s network that would be similarly impacted by the regulation in question. United will provide at least 30 days notice of any such regulatory amendment, unless a shorter notice is necessary in order to accomplish regulatory compliance. Upon request by Medical Group, United will consult with Medical Group regarding the regulatory basis for any regulatory amendment to this Agreement. In the event Medical Group disputes whether a regulatory amendment to this Agreement by United is actually needed to achieve

regulatory compliance, Medical Group may initiate dispute resolution pursuant to Article VII of this Agreement to resolve that question. While the dispute resolution process is pending, the amendment will remain in effect.

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. Subject to sections 3.1 and 3.2, this Agreement may not be assigned by either party without the written consent of the other party, except either party may assign this Agreement to an entity affiliated with that party through common ownership, upon 30 days written notice to the other party.

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. The entities which comprise United and the entities which comprise Medical Group are the only entities with rights and remedies under the Agreement.

10.7 Notice. Any notice required to be given under this Agreement shall be in writing. All written notices shall be deemed to have been given when delivered in person, three days after being sent by first-class United States mail proper postage prepaid, or by a nationally recognized overnight courier service with signature required upon receipt on the date indicated it was signed for by the receiving party's employee or agent, 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 breach or 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, 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 (except legal advisors, accountants and other parties bound by written confidentiality agreements) any of the following information (except as required by law, regulation or 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 Medical Group renders Covered Services without regard to its conflicts of laws principles, and any other applicable Federal laws or regulations.

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. In addition, with respect to Covered Services rendered during the term of this Agreement or pursuant to Section 9.3 (or a similar continuity of care provision of a regulatory appendix), the terms of this Agreement will survive.

The Remainder of this Page is intentionally left blank. Signatures appear on the next page.

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

The Entities Listed in Attachment A to Appendix 1 of this Agreement	
Signature	Street The Locations Listed on Attachment A of this Appendix 1
Print Name	City Sunrise
Title	State FL , Zip Code 33345-2376
D/B/A	Phone
Date	Email

UnitedHealthcare Insurance Company, on behalf of itself, UnitedHealthcare of Florida, Inc., and its other affiliates, as signed by its authorized representative:

Signature	Signature
Print Name John Lovelady	Print Name John Lovelady
Title SE Region Vice President	Title SE Region Vice President
Date	Date

Address to be used for giving notice to United under the Agreement

Street _____		
City _____	State _____	Zip _____

Month and year in which Agreement is first effective
--

Appendix 1: Medical Group Practice Locations

Appendix 2: Benefit Plan Descriptions

Appendix 3: Fee Schedule

Appendix 4 Additional Protocols

State Regulatory Requirements Appendix (list all states as applicable)

Arkansas, Colorado, Connecticut, Louisiana, Maryland, Massachusetts, Missouri, New Jersey, Vermont,
Washington, West Virginia, Nevada, Texas, Pennsylvania, New Mexico, North Carolina, Virginia

Medicare Advantage Regulatory Appendix

Other

**Appendix 1
Medical Group Practice Locations**

Medical Group attests that this Appendix identifies all services and locations covered under this Agreement.

1. BILLING ADDRESS

Practice Name: The Entities Listed in Attachment A to Appendix 1 of this Agreement

Street Address: The Locations Listed on Attachment A of this Appendix 1

City: State: Zip:

Tax ID Number (TIN): See Attachment A of this Appendix 1

National Provider ID (NPI): _____

PRACTICE LOCATIONS (complete one for each service location)

Clinic Name	Clinic Name	Clinic Name
See Attachment A to Appendix 1	_____	_____
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)
_____	_____	_____
National Provider ID (NPI)	National Provider ID (NPI)	National Provider ID (NPI)
_____	_____	_____

Appendix 2

Benefit Plan Descriptions

Medical Group 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. 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.

- Medicare Benefit Plans that (A) are sponsored, issued or administered by any Payer and (B) 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"), other than Medicare Advantage Private Fee-For-Service Plans.

Medical Group 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 for Medicaid Customers (Note: excluding Medicaid from this Agreement does not preclude the parties or their affiliates from having a separate agreement pertaining to participation in a Medicaid network.)

- Medicare Advantage Private Fee-For-Service Plans.

- Benefit Plans for Medicare Select

- Benefit Plans for Workers' compensation benefit programs

Notwithstanding anything in this Appendix or the Agreement that it is a part of, in the event that the Agreement does not apply to Medical Group for whatever reason regarding any Payer (including any United Affiliate) then Medical Group shall not be bound by the terms and conditions of this Agreement in seeking compensation from that Payer or its Customers and may seek reimbursement for services rendered to that Payer or its Customers in any manner not prohibited by applicable laws or regulations.

For reference purposes, the following fee schedules will be used to pay claims under this agreement:

PRODUCTS:	FEE SCHEDULES:	PROVIDER DESCRIPTION
Commercial - Florida	See attached appendix 3	
Commercial – Locations other than Florida	See attached appendix 3	
Medicare	See attached appendix 3	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	

**Attachment A to Appendix 1
List of Medical Group Entities**

See attached pages.

Exhibit A
United Entities

See attached pages.

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.

SERFF Tracking Number: UHLC-126551708

State: Arkansas

Filing Company: UnitedHealthcare of Arkansas, Inc.

State Tracking Number: 45217

Company Tracking Number:

TOI: H21 Health - Other

Sub-TOI: H21.000 Health - Other

Product Name: Sheridan Provider Agreement

Project Name/Number: /

Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification	Approved-Closed	04/02/2010
Bypass Reason:	N/A		
Comments:			
Bypassed - Item:	Application	Approved-Closed	04/02/2010
Bypass Reason:	N/A		
Comments:			
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	04/02/2010
Bypass Reason:	N/A		
Comments:			
Bypassed - Item:	Outline of Coverage	Approved-Closed	04/02/2010
Bypass Reason:	N/A		
Comments:			
Satisfied - Item:	Cover Letter	Approved-Closed	04/02/2010
Comments:			
Attachment:			
UHC AR Sheridan Cover.pdf			

March 21, 2010,
Via U.S. Mail

Rosalyn Minor
Arkansas Insurance Department
1200 West 3rd Street
Little Rock, Arkansas 72201

NAIC: 95446 United Healthcare of Arkansas, Inc.®
Form # UHC/MGA.01.2010.Sheridan
UHC/FAC.MGA.ANCL-REGAPX.08.06.AR

Dear Ms. Minor,

On behalf of United Healthcare of Arkansas, Inc., please accept this correspondence as a submission of the above referenced Provider Agreement Form and its corresponding appendix for the Arkansas Insurance Department's ("the Department") review.

This submission has been submitted electronically via SERFF and United Healthcare of Arkansas, Inc. recognizes that we may not implement this form until and unless approval has been granted. Should the Department have any immediate concerns or questions regarding this submission, please feel free to contact me at 240.632.8056, through the SERFF messaging system or at Ebony_N_Terry@uhc.com.

Respectfully,

Ebony N. Terry
Compliance Analyst
Enclosure
ENT

