

SERFF Tracking Number:	UHLC-126586695	State:	Arkansas
Filing Company:	UnitedHealthcare of Arkansas, Inc.	State Tracking Number:	45441
Company Tracking Number:			
TOI:	H21 Health - Other	Sub-TOI:	H21.000 Health - Other
Product Name:	AR Provider Contract Filing		
Project Name/Number:	/		

Filing at a Glance

Company: UnitedHealthcare of Arkansas, Inc.

Product Name: AR Provider Contract Filing

TOI: H21 Health - Other

Sub-TOI: H21.000 Health - Other

Filing Type: Form

SERFF Tr Num: UHLC-126586695 State: Arkansas

SERFF Status: Closed-Approved- State Tr Num: 45441

Closed

Co Tr Num:

State Status: Approved-Closed

Reviewer(s): Rosalind Minor

Author: Ebony Terry

Disposition Date: 04/20/2010

Date Submitted: 04/15/2010

Disposition Status: Approved-

Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

General Information

Project Name:

Project Number:

Requested Filing Mode:

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 04/20/2010

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: 04/20/2010

Created By: Ebony Terry

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Ebony Terry

Filing Description:

The standard suite of Arkansas provider contracts have been updated adding language allowing Arkansas providers to provide services to customers with the River Valley product.

Company and Contact

Filing Contact Information

Ebony Terry, Compliance Analyst

4 Taft Court

Rockville, MD 20850

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301-838-5611 [Phone]

301-838-5676 [FAX]

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Filing Company Information

UnitedHealthcare of Arkansas, Inc.	CoCode: 95446	State of Domicile: Arkansas
Plaza West Building	Group Code:	Company Type: HMO
415 North McKinley Street, Suite 300	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: \$300.00
 Retaliatory? No
 Fee Explanation: 6 Forms
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
UnitedHealthcare of Arkansas, Inc.	\$300.00	04/15/2010	35701262

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	04/20/2010	04/20/2010

SERFF Tracking Number: UHLC-126586695

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Disposition

Disposition Date: 04/20/2010

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 and Redlines	Approved-Closed	Yes
Form	Provider Contract	Approved-Closed	Yes
Form	Provider Contract	Approved-Closed	Yes
Form	Provider Contract	Approved-Closed	Yes
Form	Provider Contract	Approved-Closed	Yes
Form	Regulatory Appendix	Approved-Closed	Yes
Form	Regulatory Appendix	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 04/20/2010	UHC/FPA. ANC.AR.03.10	Policy/Cont ract/Fratern al	Provider Contract Certificate	Initial			AR ANC_FPA_filing_RVP 03 10 2010.CLEAN.pdf
Approved-Closed 04/20/2010	UHC/MGA. 03.10 AR	Policy/Cont ract/Fratern al	Provider Contract Certificate	Initial			AR MGA_filing_RVP 03 10 2010-CLEAN.pdf
Approved-Closed 04/20/2010	UHC/SMG A. 03.10 AR	Policy/Cont ract/Fratern al	Provider Contract Certificate	Initial			AR SMGA_filing_RVP 03 10 2010-CLEAN.pdf
Approved-Closed 04/20/2010	UHC/SPA. PAT 03.10 AR	Policy/Cont ract/Fratern al	Provider Contract Certificate	Initial			AR-SPA PAT_filing_RVP 03 10 2010-CLEAN.pdf
Approved-Closed 04/20/2010	UHC/SPA. SMGA.RE GAPX.08.06.AR	Policy/Cont ract/Fratern al	Regulatory Appendix Certificate	Initial			Arkansas Reg App - 2006 SPA.pdf
Approved-Closed 04/20/2010	UHC/FAC. MGA.ANCL - REGAPX.08.06.AR	Policy/Cont ract/Fratern al	Regulatory Appendix Certificate	Initial			Arkansas_Reg_Require_FPA_MGA2006 (4).pdf

Facility Participation Agreement

This Agreement is entered into by and between UnitedHealthcare Insurance Company, contracting on behalf of itself, UnitedHealthcare of Arkansas, Inc., [UnitedHealthcare Plan of the River Valley, Inc.,] and the other entities that are United's Affiliates (collectively referred to as "United") and _____ ("Facility").

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

- i) _____, 201_ or
- ii) the first day of the first calendar month that begins at least 30 days after the date when this Agreement has been executed by all parties.

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

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

The parties therefore enter into this Agreement.

Article I. **Definitions**

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

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

1.2 "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 fee for health care services charged by Facility that does not exceed the fee Facility would ordinarily charge another person regardless of whether the person is a Customer.

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

1.5 "Payment Policies" are the guidelines adopted by United outside of this Agreement for calculating payment of claims to facilities (including claims of Facility under this Agreement).

The Payment Policies may change from time to time as discussed in section 5.1 of this Agreement.

1.6 “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 Facility’s services under this Agreement.

1.7 “Protocols” are the programs, protocols and administrative procedures adopted by United or a Payer to be followed by Facility 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 4.4 of this Agreement.

1.8 “United’s Affiliates” are those entities controlling, controlled by, or under common control with UnitedHealthcare Insurance Company.

Article II. **Representations and Warranties**

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

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

b) Facility has all requisite corporate power and authority to conduct its business as presently conducted, and to execute, deliver and perform its obligations under this Agreement. The execution, delivery and performance of this Agreement by Facility have been duly and validly authorized by all action necessary under its organizational documents and applicable corporate law. This Agreement has been duly and validly executed and delivered by Facility and (assuming the due authorization, execution and delivery of this Agreement by United) constitutes a valid and binding obligation of Facility, enforceable against Facility in accordance with its terms, except as such enforceability may be limited by the availability of equitable remedies or defenses and by applicable bankruptcy, insolvency, reorganization, moratorium or similar laws affecting the enforcement of creditors' rights generally.

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

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

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

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

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

b) United has all requisite corporate power and authority to conduct its business as presently conducted, and to execute, deliver and perform its obligations under this Agreement. The execution, delivery and performance of this Agreement by United have been duly and validly authorized by all action necessary under its organizational documents and applicable corporate law. This Agreement has been duly and validly executed and delivered by United and (assuming the due authorization, execution and delivery of this Agreement by Facility) constitutes a valid and binding obligation of United, enforceable against United in accordance with its terms, except as such enforceability may be limited by the availability of equitable remedies or defenses and by applicable bankruptcy, insolvency, reorganization, moratorium or similar laws affecting the enforcement of creditors' rights generally.

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

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

Article III. **Applicability of this Agreement**

3.1 Facility's Services. This Agreement applies to Covered Services provided at Facility's service locations set forth in Appendix 1. In the event Facility begins providing services at other locations, or under other tax identification number(s), (either by operating such locations itself, or by acquiring, merging or affiliating with an existing provider 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 tax identification numbers, or locations will become subject to this Agreement only upon the written agreement of the parties.

Ancillary Only (but not Lab): Replace paragraph above with the following:

3.1 Facility's Services. This Agreement applies to Covered Services provided at Facility's service locations set forth in Appendix 1. In the event Facility begins providing services at other locations, new types of facilities, or under other tax identification number(s), (either by operating such locations itself, or by acquiring, merging or affiliating with an existing provider 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 tax identification numbers, new types of facilities, or locations, will become subject to this Agreement only upon the written agreement of the parties. For purposes of this Section 3.1, types of facilities shall include

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

Ancillary Only: Replace paragraph above with the following: In the event Facility acquires or is acquired by, merges with, or otherwise becomes affiliated with another provider of health care services that is already under contract with United or one of United's Affiliates to participate in a network of health care providers, the payment rates set forth in the applicable Payment Appendix to this Agreement shall remain in effect for each of Facility's locations specified in this Agreement and the payment rates for the acquired provider shall be the lesser of (1) the rates set forth in the other agreement, or (2) the rates set forth in the applicable Payment Appendix to this Agreement.

Facility may transfer all or some of its assets to another entity, with the result that all or some of the Covered Services subject to this Agreement will be rendered by the other entity rather than by Facility, but only if Facility 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 9.4 of this Agreement to elect whether to approve the assignment of this Agreement.

Ancillary Only: Replace paragraph above with the following:

Facility will not transfer all or some of its assets to any other entity during the term of this Agreement, with the result that all or some of the Covered Services subject to this Agreement will be rendered by the other entity rather than by Facility, without the express written agreement of United.

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

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

This section does not authorize Facility to bill or collect from Customers for Covered Services for which claims are denied or otherwise not paid. That issue is addressed in sections 6.5 and 6.8 of this Agreement.

3.4 Patients who are not Customers. This Agreement does not apply to services rendered to patients who are not Customers at the time the services were rendered. Section 6.6 of this Agreement addresses circumstances in which claims for services rendered to such persons are inadvertently paid.

Ancillary Provider Only

3.5 Health Care. Facility acknowledges that this Agreement and Customer Benefit Plans do not dictate the health care provided by Facility, or govern a physician's or hospital'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 a hospital and with Customers and their physicians, and not with United or any Payer.

3.5 Health Care. Facility acknowledges that this Agreement and Customer Benefit Plans do not dictate the health care provided by Facility, or govern Facility'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 Facility and with Customers and their physicians, and not with United or any Payer.

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

ANCILLARY ONLY Add the following:

Remove this clause for ancillary providers that do not provide this service

[3.7 Services Rendered by a Facility that is a provider of emergency transport and other related health care services. The following provisions of this Agreement do not apply to services rendered by a Facility that is a provider of emergency transport and other related health care services when taking Customer to the nearest emergency facility in an emergent situation in order for Customer to be stabilized and to receive screening examinations:

i) the requirement in section 3.3 that Facility first obtain the Customer's written consent in order to seek and collect payment from a Customer for non-covered services (however, Facility shall obtain the Customer's consent as soon as it is reasonable to do so consistent with Facility's legal obligations regarding the provision of emergency transport and other related health care services when taking Customer to the nearest emergency facility in an emergent situation in order for Customer to be stabilized and to receive screening examinations and then, only if the consent is not obtained by the admissions personnel of the emergency facility to which the Customer is brought);

ii) the statement in section 3.5 that the decision regarding what care is to be provided remains with Facility and with Customers and their physicians. Instead the decision regarding what care is to be provided remains with Facility and with Customers to the extent they are able to discuss the care to be provided by Facility;

iii) the requirements in Section 4.3; however, Facility will provide services 24 hours a day, seven days a week;

iv) Sections 4.4.1 and 4.4.3;

v) the requirement in section 4.9 that Facility obtain the Customer's consent to authorize Facility to provide access to requested information or records as contemplated in section 4.10 (however, Facility shall obtain the Customer's consent as soon as it is reasonable to do so consistent with Facility's legal obligations regarding the provision of emergency transport and other related health care services when taking Customer to the nearest emergency facility in an emergent situation in order for Customer to be stabilized and to receive screening examinations and then, only if the Facility keeps medical records);

vi) the requirements in section 4.10 regarding medical records (but only if Facility does not keep medical records because such records are instead kept by the emergency facility to which the Customer is brought);

vii) the requirements in Section 4.11 regarding certain quality data (but only if Facility does not collect and review such quality data because the collection and review of such quality data is instead done by the emergency facility to which the Customer is brought);

viii) the requirement in section 6.6 that, prior to rendering services, Facility ask the patient to present his or her Customer identification card (however, Facility shall ask patient to present his or her Customer identification card as soon as it is reasonable to do so consistent with Facility's legal obligations regarding the provision of emergency transport and other related health care services when taking Customer to the nearest emergency facility in an emergent situation in order for Customer to be stabilized and to receive screening examinations and then, only if the role is not instead played by the admissions personnel of the emergency facility to which the Customer is brought).]

Article IV. **Duties of Facility**

4.1 Provide Covered Services. Facility will provide Covered Services to Customers. Facility must be in compliance with section 2.1(d) of this Agreement and credentialed by United or its delegate prior to furnishing any Covered Services to Customers under this Agreement.

4.2 Nondiscrimination. Facility 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.

4.3 Accessibility. Facility will be open 24 hours a day, seven days a week.

Ancillary Language: Replace the above 4.3 with the following:

[4.3 Accessibility. At a minimum, Facility will be open during normal business hours, Monday through Friday.]

4.4 Cooperation with Protocols. Facility 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) Facility will use reasonable commercial efforts to direct Customers only to other providers that participate in United's network, except as permitted under the Customer's Benefit Plan or otherwise authorized by United or Payer.

2) Facility will make its best efforts to assure that all Facility-based physician groups participate in United's network as long as this Agreement is in effect.

In the event that a Facility-based physician group is not a participating provider with United, Facility's Chief Financial Officer or equivalent senior level officer ("Facility Representative") will assist United in its efforts to negotiate an agreement with such group. Upon request by United, Facility Representative will:

a) meet with Facility-based physician group to encourage participation. Facility Representative shall provide United with meeting minutes of any such meeting within 15 days. Meeting minutes will include a summary of the key discussion points and an outline of any actionable resolution options deemed by Facility Representative.

b) write letter(s) to Facility-based physician group encouraging the group to negotiate in good faith with United. The letter will also outline any contractual requirements in the agreement between Facility and Facility-based physician group that requires Facility-based physician group to (1) negotiate in good faith with third party payers, (2) participate in third party payer networks, and (3) other provisions related to Facility-based physician group's participation with third party payers.

c) invoke any applicable penalties or other contractual terms in its agreement with Facility-based physician group related to its non-participating status with a third party payer.

d) allow independent legal counsel (mutually agreeable to all relevant parties) to review Facility/Facility-based physician agreement to ensure Facility is fully invoking all the relevant terms and conditions of such agreement to require or promote Facility-based physician group's participation status with United.

United warrants that it will negotiate with Facility-based physician groups in good faith. Facility acknowledges that United will have no responsibility for the credentialing of any employed or sub-contracted Facility-based provider.

3) Facility 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 Facility 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.

United may change the Protocols from time to time. United will use reasonable commercial efforts to inform Facility at least 30 days in advance of any material changes to the Protocols. United may implement changes in the Protocols without Facility's consent if such change is applicable to all or substantially all of the facilities in United's network located in the same state as Facility. Otherwise, changes to the Protocols proposed by United to be applicable to Facility are subject to the terms of section 9.2 of this Agreement applicable to amendments.

4.5 Employees and subcontractors. Facility will assure that its employees, affiliates and any individuals or entities subcontracted by Facility 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 Facility’s obligations and accountability under this Agreement with regard to such services. Facility affiliates are those entities that control, are controlled by or are under common control with Facility.

4.6 Licensure. Facility will maintain, without material restriction, such licensure, registration, and permits as are necessary to enable Facility to lawfully perform this Agreement. In addition, Facility shall either: (1) obtain and maintain The Joint Commission accreditation; or (2) in lieu of The Joint Commission accreditation, adopt CMS National Hospital Voluntary Reporting Initiative (NQF Core Measures).

4.7 Liability Insurance. Facility shall procure and maintain liability insurance. Except to the extent coverage is a state mandated placement, Facility’s 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. Facility's liability insurance shall be, at a minimum, of the types and in the amounts set forth below. Facility's 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, Facility shall submit to United in writing evidence of insurance coverage.

<u>TYPE OF INSURANCE</u>	<u>MINIMUM LIMITS</u>
Medical malpractice and/or professional liability insurance	Five Million Dollars (\$5,000,000.00) per occurrence and aggregate
Commercial general and/or umbrella liability insurance	Five Million Dollars (\$5,000,000.00) per occurrence and aggregate

In lieu of purchasing the insurance coverage required in this section, Facility may, with the prior written approval of United, self-insure its medical malpractice and/or professional liability, as well as its commercial general liability. Facility shall maintain a separate reserve for its self-insurance. Prior to the Effective Date, Facility shall provide 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. Facility will provide a similar statement during the term of this Agreement upon United’s request, which will be made no more frequently than annually. Facility will assure that its self-insurance fund will comply with applicable laws and regulations.

4.8 Notice. Facility will give notice to United within 10 days after any event that causes Facility to be out of compliance with section 4.6 or 4.7 of this Agreement, or of any change in Facility’s name, ownership, control, or Taxpayer Identification Number. [In addition, Facility will give written notice to United 45 days prior to the effective date of changes in existing remit address(es) and other demographic information. *[Lab Only Additional language: United shall*

have the right to terminate this Agreement upon ten (10) days written notice to Facility in the event there is any change in the controlling interest of Facility modifying the percentage ownership interest outlined in Exhibit 2 to this Agreement.] This section does not apply to changes of ownership or control that result in Facility being owned or controlled by an entity with which it was already affiliated prior to the change.

[4.9 Customer consent to release of medical record information. Facility will obtain any Customer consent required in order to authorize Facility to provide access to requested information or records as contemplated in section 4.10 of this Agreement, including copies of the Facility's medical records relating to the care provided to Customer.]

4.10 Maintenance of and Access to Records. Facility will maintain adequate medical, financial and administrative records related to Covered Services rendered by Facility 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.

Facility will provide access to these records as follows:

i) to United or its designees, in connection with United's utilization management/ Care CoordinationSM, quality assurance and improvement and for claims payment and other administrative obligations, including reviewing Facility's compliance with the terms and provisions of this Agreement and appropriate billing practice. Facility 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 Facility, United, or Payers.

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

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

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

United recognizes that Facility has the sole discretion to select the metrics which it will track from time to time and that Facility's primary goal in so tracking is to advance the quality of patient care. If the information that Facility chooses to report on is available in the public domain in a format that includes all data elements required by United, United will obtain quality information directly from the source to whom Facility reported. If the Facility does not report

metrics in the public domain, on a quarterly basis, Facility will share these metrics with United as tracked against a database of all discharged, commercial patients (including patients who are not United customers). United may publish this data to entities to which United renders services or seeks to render services, and to Customers. Notwithstanding the foregoing, Facility agrees that it will participate in The Leapfrog Group's annual patient safety survey.

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

4.13 Electronic connectivity. When made available by United, Facility will do business with United electronically. Facility will use www.unitedhealthcareonline.com to check eligibility status, claims status, and submit requests for claims adjustment for products supported by UnitedHealthcare Online® or other online resources as supported for additional products. Facility agrees to use www.unitedhealthcareonline.com for additional functionalities (for instance, notification of admission) after United informs Facility that such functionalities have become available for the applicable Customer.

4.14. Implementation of Patient Safety Programs. Facility will implement quality programs recommended by nationally recognized third parties (such as The Leapfrog Group and CMS) as designated by United from time-to-time such as The Leapfrog Group's programs related to Computer Physician Order Entry (CPOE), Evidence-based Hospital Referral (EHR), ICU Physician Staffing (IPS), and the 27 other patient safety practices arrived at by national consensus (National Quality Forum Safe Practices).

Ancillary Only: Replace the paragraph(s) above with the following:

[4.14 Implementation of Patient Safety Programs. Facility will implement quality programs recommended by nationally recognized independent third parties on a reasonably prompt basis].

4.15. "Never Events". In the event a "never event" occurs in connection with Facility rendering services to a Customer, Facility will take the steps recommended by the Leapfrog Group. At present, these steps are set forth in the Leapfrog Group's "Position Statement on Never Events" (<http://www.leapfroggroup.org>) and are as follows:

- Apologize to the patient and/or family affected by the never event;
- Report the event to United and to at least one of the following agencies: The Joint Commission, as part of its Sentinel Events policy; state reporting program for medical errors; or a Patient Safety Organization (e.g. Maryland Patient Safety Center);
- Perform a root cause analysis, consistent with instructions from the chosen reporting agency; and
- Waive all costs directly related to the event. In order to waive such costs, Facility will not submit a claim for such costs to United or Payer and will not seek or accept payment for such costs from the Customer or anyone acting on behalf of the Customer.

For purposes of this section 4.15, a "never event" is an event included in the list of 28 "serious reportable events" published by the National Quality Forum (NQF) in October 2006, as the list may be updated from time to time by the NQF and adopted by Leapfrog.

Ancillary Only: Delete section 4.15 and replace with the following:

4.15. This section intentionally left blank.

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

5.1 Payment of Claims. As described in further detail in Article VI of this Agreement, Payers will pay Facility for rendering Covered Services to Customers. United will make its Payment Policies available to Facility online or upon request. United may change its Payment Policies from time to time.

5.2 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.

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

5.4 Notice. United will give written notice to Facility within 10 days after any event that causes United to be out of compliance with section 5.2 or 5.3 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.

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

5.6 Electronic connectivity United will do business with Facility 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 4.13, and will make information available as to which products are supported by www.unitedhealthcareonline.com.

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

Article VI. **Submission, Processing, and Payment of Claims**

6.1 Form and content of claims. Facility must submit claims for Covered Services in a manner and format prescribed by United, as further described in the Protocols. Unless otherwise

directed by United, Facility shall submit claims using current [CMS 1500 or] UB04 or successor forms for paper claims and HIPAA standard professional or institutional claim formats for electronic claims, as applicable, with applicable coding including, but not limited to, ICD-9-CM, CPT, Revenue and HCPCS coding.

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

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

6.4 Payment of claims. Payer will pay claims for Covered Services as further described in the applicable Payment Appendix to this Agreement and in accordance with Payment Policies.

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

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

6.5 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 Facility does not comply with a Protocol or does not file a timely claim under section 6.3 of this Agreement. Payment may also be denied for services provided that are determined by United to be medically unnecessary, and Facility may not bill the Customer for such services unless the Customer has, with knowledge of United's determination of a lack of medical necessity, agreed in writing to be responsible for payment of those charges.

In the event that payment of a claim is denied for lack of notification or for untimely filing, the denial will be reversed if Facility 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, Facility did not know and was unable to reasonably determine that the patient was a Customer,
- ii) that Facility took reasonable steps to learn that the patient was a Customer, and
- iii) that Facility promptly provided notification, or filed the claim, after learning that the patient was a Customer.

6.6 Retroactive correction of information regarding whether patient is a Customer. Prior to rendering services, Facility shall ask the patient to present his or her Customer identification card. In addition, Facility may contact United to obtain the most current information on the patient as a Customer.

However, Facility 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 Facility 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 6.10 of this Agreement. Facility may then directly bill the individual, or other responsible party, for such services.

6.7 Payment under this Agreement is payment in full. Payment as provided under section 6.4, 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. Facility 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 6.7, regardless of whether such amount is less than Facility's billed charge or Customary Charge.

6.8 Customer "Hold Harmless." Facility 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 Facility's billed charge or Customary Charge, or for any amounts denied or not paid under this Agreement due to:

- i) Facility's failure to comply with the Protocols,
- ii) Facility's failure to file a timely claim,
- iii) Payer's Payment Policies,
- iv) inaccurate or incorrect claim processing,
- v) insolvency or other failure by Payer to maintain its obligation to fund claims payments, if Payer is United, or is an entity required by applicable law to assure that its Customers not be billed in such circumstances, ,or
- vi) a denial based on medical necessity or prior authorization, except as provided in section 6.5.

This obligation to refrain from billing Customers applies even in those cases in which Facility believes that United or Payer has made an incorrect determination. In such cases, Facility 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 clause v) of this Section 6.8, Facility may seek payment directly from the Payer or from Customers covered by that Payer. However, Facility 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), Facility then gives United 15 days prior written notice of Facility'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 6.8 and section 6.7 will survive the termination of this Agreement, with regard to Covered Services rendered prior to when the termination takes effect.

6.9 Consequences for failure to adhere to Customer protection requirements. If Facility 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 6.7 or 6.8 of this Agreement, Facility shall be in breach of this Agreement. This section 6.9 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 Facility to collect such payment from Customer.

In the event of such a breach, Payer may deduct, from any amounts otherwise due Facility, the amount wrongfully collected from Customers, and may also deduct an amount equal to any costs or expenses incurred by the Customer, United or Payer in defending the Customer from such action and otherwise enforcing sections 6.7 through 6.9 of this Agreement. Any amounts deducted by Payer in accordance with this provision shall be used to reimburse the Customer and to satisfy any costs incurred. The remedy contained in this paragraph does not preclude United from invoking any other remedy for breach that may be available under this Agreement.

6.10 Correction of overpayments or underpayments of claims. In the event that either Party believes that a claim has not been paid correctly, or that funds were paid beyond or outside of what is provided for under this Agreement, either party may seek correction of the payment, except that Facility may not seek correction of a payment more than 12 months after it was made.

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

Article VII. **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 before a panel of three arbitrators in accordance with the Commercial Dispute Procedures of the American Arbitration Association, as they may be amended from time to time (see <http://www.adr.org>). Unless otherwise agreed to in writing by the parties, the party wishing to pursue the Dispute must initiate the arbitration within one year after the date on which notice of the Dispute was given or shall be deemed to have waived its right to pursue the dispute in any forum.

Any arbitration proceeding under this Agreement shall be conducted in (name of county) County, (state). The arbitrator(s) may construe or interpret but shall not vary or ignore the terms of this

Agreement and shall be bound by controlling law. The arbitrator(s) shall have no authority to award punitive, exemplary, indirect or special damages, except in connection with a statutory claim that explicitly provides for such relief.

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

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

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

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

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

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

Article VIII. **Term and Termination**

8.1 Term. This Agreement shall take effect on the Effective Date. This Agreement shall have an initial term of three years and renew automatically for renewal terms of one year, until terminated pursuant to section 8.2.

For local market Ancillary Provider:

[8.1 Term. This Agreement shall take effect on the Effective Date. This Agreement shall have an initial term of one year and renew automatically for renewal terms of one year, until terminated pursuant to section 8.2.]

8.2 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 180 days prior written notice, effective at the end of the initial term or effective at the end of any renewal term;

Local Ancillary Only
 [(ii) by either party, upon 90 days written notice, effective at the end of the initial term or 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 VII 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 4.7 or section 5.2 of this Agreement; or
- v) by United upon 10 days written notice in the event Facility loses accreditation.
- vi) By United, upon 90 days notice, in the event:
 - a) Facility loses approval for participation under United’s credentialing plan, or
 - b) Facility does not successfully complete the United’s re-credentialing process as required by the credentialing plan.

8.3 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, Facility 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 Facility after Facility leaves the provider network accessed by Payer.	As applicable

Article IX.
Miscellaneous Provisions

9.1 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.

[**9.1 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, except that this Agreement does not supersede a national agreement between the parties or their affiliates.]

9.2 Amendment. This Agreement may only be amended in a writing signed by both parties, except that this Agreement may be unilaterally amended by United upon written notice to Facility in order to comply with applicable regulatory requirements. 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.

9.3 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.

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

9.5 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.

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

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

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

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

- a) any proprietary business information, not available to the general public, obtained by the party from the other party; or
- b) 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.

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

National Ancillary Agreements Only- Replace the above paragraph with the following:
[9.10 Governing Law. This Agreement will be governed by and construed in accordance with the laws of the State of Minnesota, and any other applicable law.]

9.11 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 regulatory appendix will control, to the extent it is applicable.

9.12 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.

9.13 Survival. Sections 4.10, 6.7, 6.8, Article VII and sections 8.3 and 9.9 (except for the last paragraph) of this Agreement will survive the termination of this Agreement.

Lab only

9.14 or 9.15 Data Services. The parties incorporate by reference the Data Services Appendix attached to this Agreement.

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

[Facility]

Address to be used for giving notice to Facility under the Agreement:

Signature _____ Street _____

Print Name _____ City _____

Title _____ State _____ Zip Code _____

Date _____ E-mail _____

UnitedHealthcare Insurance Company, on behalf of itself, UnitedHealthcare of Arkansas, Inc., [UnitedHealthcare Plan of the River Valley, Inc.,] and its other affiliates, as signed by its authorized representative:

Signature _____ Signature _____

Print Name _____ Print Name _____

Title _____ Title: _____

Date _____ Date _____

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

Street _____

City _____

State _____ *Zip Code* _____

IN THE EVENT THIS AGREEMENT INCLUDES TWO SIGNATURE BLOCKS FOR UNITED, THIS AGREEMENT IS NOT BINDING UPON UNITED UNLESS EACH OF THE TWO UNITED SIGNATURE BLOCKS ARE EXECUTED.

Attachments

- ___ Appendix 1: Facility Location and Service Listings
- ___ Appendix 2: Benefit Plan Descriptions
- ___ [Appendix (ies) 3: Fee Schedule Samples (1500 billers only)]
- ___ [Appendix 3 [4]: Additional Protocols]
- ___ State Regulatory Requirements Appendix (list all states as applicable)

- ___ All Payer Appendix (Appendices)
- ___ Medicare Advantage Regulatory Requirements Appendix
- ___ Medicare Advantage Payment Appendix
- ___ Medicare Select Payment Appendix
- ___ [Medicaid Regulatory Requirements Appendix]
- ___ [Medicaid Payment Appendix]
- ___ Other _____
- ___ Exhibit 1 United Affiliates Licensed as an Insurance Company or HMO
- ___ Exhibit 2 Ownership Attestation

IMPORTANT NOTE: Facility acknowledges its obligation under Section 4.8 to promptly report any change in Facility's name or Taxpayer Identification Number. Failure to do so may result in denial of claims or incorrect payment.

**Appendix 1
Facility Location and Service Listings**

[Facility System Name]

BILLING ADDRESS

[Facility Name]
[Street Address]
[City, State Zip]
[TIN]
[NPI]

[FACILITY LOCATIONS]

[Facility Name]
[Street Address]
[City, State Zip]
[Phone #]
[TIN]

[Facility Name]
[Street Address]
[City, State Zip]
[Phone #]
[TIN]

[Facility Name]
[Street Address]
[City, State Zip]
[Phone #]
[TIN]

[OTHER SERVICE LOCATIONS]

[Facility Name]
[Street Address]
[City, State Zip]
[Phone #]
[TIN]

[Facility Name]
[Street Address]
[City, State Zip]
[Phone #]
[TIN]

[Facility Name]
[Street Address]
[City, State Zip]
[Phone #]
[TIN]

Appendix 2 Benefit Plan Descriptions

United may allow Payers to access Facility's services under this Agreement for the Benefit Plan types listed 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.]
- [Benefit Plans for Workers' compensation benefit programs]
- [Benefit Plans for Medicare Select.]

Facility 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.
- [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"). Note: Although Medicare Benefit Contracts, as described above, are excluded from this Agreement, there can be a separate agreement between United and Facility or between United's affiliates and Facility's affiliates providing for Facility's participation in a network for certain of those Medicare Benefit Plans.]
- [Benefit Plans for Workers' compensation benefit programs]
- [Benefit Plans for Medicare Select.]

[Appendix 3

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

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

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

[Appendix 3]

Fee Schedule Sample: Options PPO

Representative Options PPO Fee Schedule Sample: *[Fee Schedule ID]*

The provisions of this fee schedule apply to Covered Services rendered by Facility to Customers covered by Benefit Plans marketed under the name “Options PPO” and Benefit Plans where Customers are not offered a network of participating physicians and other health care professionals from which they may receive Covered Services.

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

Fee Schedule Sample: Products other than Options PPO

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

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

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

[Appendix 3

Representative Medicare Fee Schedule Sample [*Fee Schedule ID*]

The provisions of this fee schedule apply to services rendered by Facility to Medicare Customers covered by 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. The provisions of this fee schedule do not apply to services Facility renders to Medicare beneficiaries pursuant to a commercial Benefit Plan.

United will use best efforts to update the amounts for services listed in the attached fee schedule that are based on the CMS physician Medicare fee schedule on or before the later of (a) ninety (90) days after the effective date of any modification made by CMS to the CMS physician Medicare fee schedule; provided, however, in the event CMS makes a change to such modification after the effective date of such modification, United will use best efforts to update the methodology and factors in accordance with such subsequent change within ninety (90) days after the date on which CMS places information regarding such subsequent change in the public domain, or (b) ninety (90) days after the date on which CMS initially place information regarding such modification in the public domain (e.g., CMS distributes program memoranda to providers).

Amounts listed in the attached sample fee schedule are gross amounts. Any co-payments, deductibles or coinsurance that the Medicare Customer is responsible to pay under his or her Benefit Plan will be subtracted from the amount listed in the attached sample fee schedule in determining the amount to be paid by the Payer. The actual payment amount is also subject to matters described in our Agreement, including Payment Policies. This information is subject to the confidentiality provisions of this Agreement.]

[Appendix [3] [4]]
Additional Protocols

Protocols for the Customers of the River Valley Entities:

UnitedHealthcare Services Company of the River Valley, Inc., UnitedHealthcare Plan of the River Valley, Inc., and UnitedHealthcare Insurance Company of the River Valley (collectively referred to as “River Valley Entities”) were acquired and became United Affiliates.

For Customers enrolled in Benefit Plans (other than Medicare Benefit Plans) issued by the River Valley Entities or under which a River Valley Entity provides administrative services under an agreement with a Payer and included in this Agreement as set forth in Appendix 2, Facility will be subject to the programs, protocols and administrative procedures described in or made available to Facility through the River Valley Provider Manual (the “River Valley Manual”) and the Payment Policies of the River Valley Entities. When the Agreement refers to the administrative manual or guide, it is also referring to the River Valley Manual. The River Valley Manual is available to Facility upon request or online at <https://www.uhcrivervalley.com>. In the event of any conflict between the River Valley Manual or River Valley Payment Policies on the one hand and any of the following: the Agreement, any United programs, protocols, administrative procedures (including payment policies and guidelines for calculating payments), or the UnitedHealthcare Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide (the “Administrative Manual”) in connection with any matter pertaining to a Customer enrolled in a Benefit Plan (other than a Medicare Benefit Plan) issued by the River Valley Entities, the River Valley Manual or River Valley Payment Policies, as applicable, shall govern, unless applicable statutes or regulations dictate otherwise. United may make changes to the Administrative Manual, River Valley Manual or other administrative protocols and River Valley Payment Policies upon 30 days’ electronic or written notice to Facility.]

For use with Lab agreements only

Exhibit 2

ATTESTATION OF {NAME OF LAB}

State of _____

County of { }

Before me the undersigned Notary appeared _____, who being either known personally to me and/or presenting proper identification, was duly sworn by me and testified as follows:

(1) “My name is _____. I am over the age of 18, fully competent to give this Attestation and have personal knowledge of the facts stated in it.”

(2) “I hereby certify that {ENTITY NAME or NAME OF LAB} has XX% ownership of the {NAME OF THE LAB}.”

(3) “I hereby certify that the following entities have the following percentage ownership of the {NAME OF THE LAB}: {List all entities and percentage ownership}.”

(4) “I hereby certify that at no time will there be any change in the controlling interest modifying the current percentage ownership as set forth herein of the {NAME OF THE LAB}.”

(5) “I hereby certify that at no time will the {NAME OF THE LAB} assets, liabilities, revenues and expenses be consolidated from {NAME OF THE LAB} to any other laboratory or its affiliates such that all or some of the Covered Services subject to the Agreement will be rendered by such other laboratory or its affiliates.”

Further this Affiant sayeth not.

Signed this _____ day of _____, 200_.

[Affiant signature]

Notary Stamp/Certification

Notary Signature

Date of Notary’s Signature

Expiration date of Notary authority

Medical Group Participation Agreement

This Agreement is entered into by and between UnitedHealthcare Insurance Company, contracting on behalf of itself, UnitedHealthcare of Arkansas, Inc., [UnitedHealthcare Plan of the River Valley, Inc.] and the other entities that are United's Affiliates (collectively referred to as "United"), and _____ ("Medical Group").

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

- i) _____, 201_ or
- ii) the first day of the first calendar month that begins at least 30 days after the date when this Agreement has been executed by all parties.

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, whether delivered in paper, electronic, or other format, under which a Payer is obligated to provide coverage of Covered Services for a Customer.

1.2 "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 fee for health care services charged by Medical Group that does not exceed the fee Medical Group would ordinarily charge another person regardless of whether the person is a Customer.

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 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.

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 UnitedHealthcare Insurance Company.

Article II. **Representations and Warranties**

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

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

(b) Medical Group has all requisite corporate power and authority to conduct its business as presently conducted, and to execute, deliver and perform its obligations under this

Agreement. The execution, delivery and performance of this Agreement by Medical Group have been duly and validly authorized by all action necessary under its organizational documents and applicable corporate law.

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

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

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

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

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

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

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

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

Article III.
Applicability of this Agreement

3.1 Medical Group's Services. 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 opening such locations itself, or by acquiring, merging or coming under common ownership and control with an existing provider of services that was not already under contract with United or one of United's Affiliates to participate in a network of health care providers), such additional locations will become subject to this Agreement 30 days after United receives the notice required under section 5.7(v) of this Agreement.

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

Medical Group may transfer all or some of its assets to another entity, if the result of such transfer would be that all or some of the Covered Services subject to this Agreement will be rendered by the other entity rather than by 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 Payers and Benefit Plan types. United may allow Payers to access Medical Group's services under this Agreement for the Benefit Plan types described in Appendix 2. Appendix 2 may be modified by United upon 30 days written or electronic notice.

3.3 Services not covered under a Benefit Plan. This Agreement does not apply to services not covered under the applicable Benefit Plan. Medical Group may seek and collect payment from a Customer for such services, provided that the Medical Group first obtain 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.

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

3.5 Health Care. Medical Group acknowledges that this Agreement and Customer Benefit Plans 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 Customers, and not with United or any Payer.

3.6 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.

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. 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 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 Protocols applicable to Customers enrolled in certain Benefit Plans.

United may change the Protocols from time to time. United will use reasonable commercial efforts to inform 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.

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	Three Million Dollars (\$3,000,000.00) per occurrence and 5 Million Dollars aggregate (\$5,000,000.00), if Medical Group insures all Medical Group Professionals in a single policy [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 One Million Dollars (\$1,000,000.00) per occurrence and 3 Million Dollars (\$3,000,000.00) aggregate]
Commercial general and/or umbrella liability insurance	One Million Dollars (\$1,000,000.00) per occurrence and aggregate

In lieu of purchasing the insurance coverage required in this section, 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.

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

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

United recognizes that Medical Group has the sole discretion to select the metrics which it will track from time to time and that Medical Group's primary goal in so tracking is to advance the

quality of patient care. If the information that Medical Group chooses to report on is available in the public domain in a format that includes all data elements required by United, United will obtain quality information directly from the source to whom Medical Group reported. If the Medical Group does not report metrics in the public domain, on a quarterly basis, Medical Group will share these metrics with United as tracked against a database of all commercial patients (including patients who are not United customers). United may publish this data to entities to which United renders services or seeks to render services, and to Customers.

5.11 Compliance with law. 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 do business with United electronically. Medical Group will use www.unitedhealthcareonline.com to check eligibility status, claims status, and submit requests for claims adjustments for Customers enrolled in products supported by www.unitedhealthcareonline.com. Medical Group agrees to use 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 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.

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 manner and format prescribed by United, as further described in the Protocols. Unless otherwise directed by United, Medical Group shall submit claims using current CMS 1500 form or its successor for paper claims and HIPAA standard professional or institutional claim formats for electronic claims, as applicable, with applicable coding including, but not limited to, ICD, CPT, Revenue and HCPCS coding.

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 six 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 90 days from the date that Covered Services are rendered. In the event United requests additional information in order to process the claim, Medical Group will provide such additional information within 90 days of United's request. If Payer is not the primary payer, and Medical Group is pursuing payment from the primary payer, the 90 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 lesser of Medical Group's Customary Charge or the applicable fee schedule (as further described in Appendix 3 to this Agreement), and in accordance with Payment Policies.

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

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

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

United routinely updates its fee schedule in response to additions, deletions, and changes to CPT codes by the American Medical Association, price changes for immunizations and injectable medications, and in response to similar changes (additions and revisions) to other service coding and reporting conventions that are widely used in the health care industry, such as those maintained by the Centers for Medicaid and Medicare Services (for example HCPCS, etc.).

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

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

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

7.5 Denial of Claims for Not Following Protocols, Not Filing Timely, or Lack of Medical Necessity. Payment may be denied in whole or in part if 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 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.

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, regardless of whether such amount is less than Medical Group's billed charge or 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 Customary 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) inaccurate or incorrect claim processing,
- v) insolvency or other failure by Payer to maintain its obligation to fund claims payments, if Payer is United, or is an entity required by applicable law to assure that its Customers not be billed in such circumstances, or
- vi) a denial based on medical necessity or prior authorization, except as permitted under section 7.5.

This obligation to refrain from billing Customers applies even in those cases in which 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 v), 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), 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, Payer may deduct, from any amounts otherwise due Medical Group, the amount wrongfully collected from Customers, and may also deduct an amount equal to any costs or expenses incurred by the Customer, United or Payer in defending the Customer from such action and otherwise enforcing sections 7.7 through 7.9 of this Agreement. Any amounts deducted by Payer in accordance with this provision shall be used to reimburse the Customer and to satisfy any costs incurred. The remedy contained in this paragraph does not preclude United from invoking any other remedy for breach that may be available under this Agreement.

7.10 Correction of overpayments or underpayments of claims. In the event that either Party believes that a claim has not been paid correctly, or that funds were paid beyond or outside of what is provided for under this Agreement, either party may seek correction of the payment, except that Medical Group may not seek correction of a payment more than 12 months after it was made.

Medical Group will repay overpayments within 30 days of notice of the 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 30 days after posting it as a credit balance.

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

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 Medical Group fails to do so, United may hold Medical Group liable for any attorneys fees, costs, or administrative expenses incurred by United as a result.

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

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

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

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

In the event that any portion of this Article or any part of this Agreement is deemed to be unlawful, invalid or unenforceable, such unlawfulness, invalidity or unenforceability shall not serve to invalidate any other part of this Article or Agreement. In the event any court determines

that this arbitration procedure is not binding or otherwise allows litigation involving a Dispute to proceed, the parties hereby waive any and all right to trial by jury in, or with respect to, such litigation. Such litigation would instead proceed with the judge as the finder of fact.

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

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

Article IX.
Term and Termination

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

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

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

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

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

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

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

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

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

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

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

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

- i) any proprietary business information, not available to the general public, obtained by the party from the other party;
- 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, and any other applicable law.

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

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

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

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

[Medical Group]

Signature _____ Street _____

Print Name _____ City _____

Title _____ State _____ Zip Code _____

D/B/A _____ Phone _____

Date _____ E-mail _____

UnitedHealthcare Insurance Company, on behalf of itself, UnitedHealthcare of Arkansas, Inc., [UnitedHealthcare Plan of the River Valley, Inc.] and its other affiliates, as signed by its authorized representative:

Signature _____ Signature _____

Print Name _____ Print Name _____

Title _____ Title: _____

Date _____ Date _____

Attachments

___ Appendix 1: Medical Group Practice Locations

___ Appendix 2: Benefit Plan Descriptions

___ Appendix 3: Fee Schedule Sample

[___ Appendix 4: Additional Protocols]

___ State Regulatory Requirements Appendix (list all states as applicable)

___ Medicare Advantage Regulatory Requirements Appendix

___ Other

**Appendix 1
Medical Group Practice Locations**

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

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

BILLING ADDRESS

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

Practice Name _____
 Street Address _____
 City _____ State _____ Zip _____
 Tax ID Number (TIN) _____
 National Provider ID [NPI] _____

PRACTICE LOCATIONS (complete one for each service location)

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



Clinic Name	Clinic Name	Clinic Name
Street Address	Street Address	Street Address
City	City	City
State and Zip Code	State and Zip Code	State and Zip Code

Phone Number	Phone Number	Phone Number
TIN (If different from above)	TIN (If different from above)	TIN (If different from above)

Appendix 2 Benefit Plan Descriptions

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.]
- [Benefit Plans for Workers’ compensation benefit programs]

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
- [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"). Note: Although Medicare Benefit Contracts, as described above, are excluded from this Agreement, there can be a separate agreement between United and Medical Group or between United’s affiliates and Medical Group’s affiliates providing for Medical Group’s participation in a network for certain of those Medicare Benefit Plans.]
- [Benefit Plans for Workers’ compensation benefit programs]

Appendix 3
Fee Schedule Sample: Options PPO
Representative Options PPO Fee Schedule Sample for : [insert name of Fee Schedule]

The provisions of this fee schedule apply to Covered Services rendered by Medical Group to Customers covered by Benefit Plans marketed under the name “Options PPO” and Benefit Plans where Customers are not offered a network of participating physicians and other health care professionals from which they may receive Covered Services [, except Anesthesia Management covered services rendered by Anesthesia Practitioners. Fee Schedule Sample(s) for Anesthesia Management covered services rendered by Anesthesia Practitioners are described in a separate Exhibit 1 to this Appendix 3.]

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

Appendix 3
Fee Schedule Sample: Products other than Options PPO
Representative All-Payer Fee Schedule Sample(s) for :[insert name of Fee Schedule]

Unless another fee schedule to this Agreement applies specifically to a particular Benefit Plan as it covers a particular Customer, the provisions of this fee schedule apply to Covered Services rendered by Medical Group to Customers covered by Benefit Plans sponsored, issued or administered by all Payers. [except Anesthesia Management Covered Services rendered by Anesthesia Practitioners. Fee Schedule Sample(s) for Anesthesia Management Covered Services rendered by Anesthesia Practitioners are described in a separate Exhibit 1 to this Appendix 3.]

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

[Appendix 3A]

For Dates of Service Effective: [mm/dd/yyyy]

Fee Schedule Specifications : : [Fee Schedule ID]

**[Appendix 3, Exhibit 1
Anesthesia Fee Schedule Exhibit: Options PPO**

Representative Options PPO Fee Schedule Sample *[insert name of Fee Schedule]*

The provisions of this exhibit apply to Anesthesia Management Covered Services rendered by Anesthesia Practitioners to Customers covered by Benefit Plans marketed under the name “Options PPO” and Benefit Plans where Customers are not offered a network of participating physicians and other health care professionals from which they may receive Covered Services.

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

**[Appendix 3, Exhibit 1
Anesthesia Fee Schedule Exhibit: Products other than Options PPO**

Representative Fee Schedule Sample *[insert name of Fee Schedule]*

Unless another exhibit to Appendix 3 applies specifically to a particular Benefit Plan as it covers a particular Customer, the provisions of this exhibit apply to Anesthesia Management Covered Services rendered by Anesthesia Practitioners to Customers covered by Benefit Plans sponsored, issued or administered by all Payers.

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

[Appendix 3

Representative Medicare Fee Schedule Sample [Insert Name Of Fee Schedule]

The provisions of this fee schedule apply to services rendered by Medical Group to Medicare Customers covered by 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. The provisions of this fee schedule do not apply to services Medical Group renders to Medicare beneficiaries pursuant to a commercial Benefit Plan.

United will use best efforts to update the amounts for services listed in the attached fee schedule that are based on the CMS physician Medicare fee schedule on or before the later of (a) ninety (90) days after the effective date of any modification made by CMS to the CMS physician Medicare fee schedule; provided, however, in the event CMS makes a change to such modification after the effective date of such modification, United will use best efforts to update the methodology and factors in accordance with such subsequent change within ninety (90) days after the date on which CMS places information regarding such subsequent change in the public domain, or (b) ninety (90) days after the date on which CMS initially place information regarding such modification in the public domain (e.g., CMS distributes program memoranda to providers).

Amounts listed in the attached sample fee schedule are gross amounts. Any co-payments, deductibles or coinsurance that the Medicare Customer is responsible to pay under his or her Benefit Plan will be subtracted from the amount listed in the attached sample fee schedule in determining the amount to be paid by the Payer. The actual payment amount is also subject to matters described in our Agreement, including Payment Policies. This information is subject to the confidentiality provisions of this Agreement.]

**[Appendix 4
Additional Protocols**

Protocols for the Customers of the River Valley Entities:

UnitedHealthcare Services Company of the River Valley, Inc., UnitedHealthcare Plan of the River Valley, Inc., and UnitedHealthcare Insurance Company of the River Valley (collectively referred to as “River Valley Entities”) were acquired and became United Affiliates.

For Customers enrolled in Benefit Plans (other than Medicare Benefit Plans) issued by the River Valley Entities or under which a River Valley Entity provides administrative services under an agreement with a Payer and included in this Agreement as set forth in Appendix 2, Facility will be subject to the programs, protocols and administrative procedures described in or made available to Facility through the River Valley Provider Manual (the “River Valley Manual”) and the Payment Policies of the River Valley Entities. When the Agreement refers to the administrative manual or guide, it is also referring to the River Valley Manual. The River Valley Manual is available to Facility upon request or online at <https://www.uhcrivervalley.com>. In the event of any conflict between the River Valley Manual or River Valley Payment Policies on the one hand and any of the following: the Agreement, any United programs, protocols, administrative procedures (including payment policies and guidelines for calculating payments), or the UnitedHealthcare Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide (the “Administrative Manual”) in connection with any matter pertaining to a Customer enrolled in a Benefit Plan (other than a Medicare Benefit Plan) issued by the River Valley Entities, the River Valley Manual or River Valley Payment Policies, as applicable, shall govern, unless applicable statutes or regulations dictate otherwise. United may make changes to the Administrative Manual, River Valley Manual or other administrative protocols and River Valley Payment Policies upon 30 days’ electronic or written notice to Facility.]

INTRODUCTION

Our agreement consists of this contract, the appendices, and the additional materials we reference in the attached Appendix 1.

Guiding principles

We strive to operate in accordance with the following principles:

- *We want to work together with America's best physicians to improve the health care experience of our customers.*
- *We respect and support the physician/patient relationship while adhering fairly to the contract for benefits we provide our customers.*
- *Whether a particular treatment is covered under a benefit contract should not determine if the treatment is provided. Physicians and health care professionals should provide the care they believe is necessary regardless of coverage.*
- *You should discuss treatment options with patients regardless of coverage. We encourage that communication.*
- *Physicians should describe any factors that could affect their ability to render appropriate care. Matters such as professional training, financial incentives, availability constraints, religious or philosophical beliefs, and similar matters are all things that a physician should consider discussing with a patient. We encourage these communications. We urge full disclosure.*
- *Fairness and efficiency will govern the ways in which we administer our products. We will make our determinations promptly. Our commitments to our customers will be clear. We will honor our agreements. When it comes to coverage determinations, the language of the benefit contract will take precedence.*

Next steps

Please read this agreement. If you have questions, write to or call:

**UnitedHealthcare
Network Management**

{ address }

(xxx)xxx-xxxx]

You can visit our website at www.unitedhealthcareonline.com (UnitedHealthcare Online[®]) for additional details on items described in the agreement. If the agreement is acceptable to you, please sign both of the enclosed copies of the contract, and send both copies to the address above.

MEDICAL GROUP CONTRACT

UnitedHealthcare Insurance Company is entering into this agreement with you. It is doing so on behalf of itself, UnitedHealthcare of Arkansas, Inc. [UnitedHealthcare Plan of the River Valley, Inc.,] and its other affiliates for certain products and services we offer our customers, all of which we describe in the attached Appendix 2.

This agreement applies to you and to your professional staff (the physicians and other professionals who are your employees, or your independent contractors providing services to your patients, and who are subject to credentialing by us) and the services you provide at the locations in the attached Appendix 5. When this agreement refers to “you”, it also refers to your professional staff. Your professional staff is bound to the same requirements of this agreement as you are. You represent to us that you have the authority to bind your professional staff to this agreement.

What you will do

You need to be credentialed in accordance with our Credentialing Plan, as referenced in Appendix 1, for the duration of this agreement.

You must notify us in a timely manner about certain services you provide in accordance with our Administrative Guide so that we can provide our customers with the services we have committed to provide. If you do not so notify us about these services, you will not be reimbursed for the services, and you may not charge our customer.

Within one year of the effective date of this agreement, you must conduct business with us entirely on an electronic basis to the extent that we are able to conduct business electronically (described in the Administrative Guide), including but not limited to determining whether your patient is currently a customer, verifying the customer’s benefit, and submitting your claim. We will communicate enhancements in UnitedHealthcare Online® functionality as they become available and will make information available to you as to which products are supported by UnitedHealthcare Online.

You must submit your claims within 90 days of the date of service. After we receive your claim, if we request additional information in order to process your claim, you must submit this additional information within 90 days of our request. If your claim or the additional information is not submitted within these timeframes, you will not be reimbursed for the services, and you may not charge our customer.

You will submit claims only for services performed by you or your staff. Pass through billing is not payable under this agreement and may not be billed to our customer. For laboratory services, you will only be reimbursed for the services that you are certified through the Clinical Laboratory Improvement Amendments (CLIA) to perform, and you must not bill our customers for laboratory services for which you are not certified.

You will submit claims that supply all applicable information. These claims are complete claims. Further information about complete claims is provided in our Administrative Guide.

If you disagree with our payment determination on a claim, you may submit an appeal as described in our Administrative Guide.

You will not charge our customers anything for the services you provide, if those services are covered services under their benefit contract, but the applicable co-pay, coinsurance or deductible amount. If the services you provide are denied or otherwise not paid due to your failure to notify us, to file a timely claim, to submit a complete claim, to respond to our request for information, or based on our reimbursement policies and methodologies, you may not charge our customer. If the services you provide are denied for

reason of not being medically necessary, you may not charge our customer unless our customer has, with knowledge of our determination of a lack of medical necessity, agreed in writing to be responsible for payment of those charges. If the services you provide are not covered under our customer's benefit contract, you may, of course, bill our customer directly. You will not require a customer to pay a "membership fee" or other fee in order to access you for covered services (except for co-payments, coinsurance and/or deductibles provided for under the customer's benefit contract) and will not discriminate against any customer based on the failure to pay such a fee.

You will cooperate with our reasonable requests to provide information that we need. We may need this information to perform our obligations under this agreement, under our programs and agreements with our customers, or as required by regulatory or accreditation agencies.

You will refer customers only to other network physicians and providers, except as permitted under our customer's benefit contract, or as otherwise authorized by us or the participating entity.

What we will do

We or the other applicable participating entity will promptly adjudicate and pay your complete claim for services covered by our customer's benefit contract. If you submit claims that are not complete,

- You may be asked for additional information so that your claim may be adjudicated; or
- Your claim may be denied and you will be notified of the denial and the reason for it; or
- We may in our discretion attempt to complete the claim and have it paid by us or the other applicable participating entity based on the information that you gave in addition to the information we have.

If governing law requires us to pay interest or another penalty for a failure to pay your complete claim for covered services within a certain time frame, we will follow those requirements. The interest or other penalty required by law will be the only additional obligation for not satisfying in a timely manner a payment obligation to you. In addition, if we completed a claim of yours that was not complete, there shall be no interest or other late payment obligation to you even if we subsequently adjust the payment amount based on additional information that you provide.

The applicable participating entity will reimburse you for the services you deliver that our customer's benefit contract covers. The amount you receive will be based on the lesser of your billed charges or our fee schedule, which is described at Appendix 1 and is subject to the reimbursement (coding) policies and methodologies of us and the participating entities. Our reimbursement policies and methodologies are updated periodically and will be made available to you online or upon request. To request a copy of our reimbursement policies and methodologies, write to UnitedHealthcare, Network Management, {address}. Your reimbursement is also subject to our rules concerning retroactive eligibility, subrogation and coordination of benefits (as described in the Administrative Guide). We recognize CPT reporting guidelines as developed by the American Medical Association, as well as ICD diagnostic codes and hospital-based revenue codes. Following these guidelines does not imply a right to reimbursement for all services as coded or reported.

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

We routinely update our fee schedule in response to additions, deletions and changes to CPT codes by the American Medical Association, price changes for immunizations and injectable medications, and in response to similar changes (additions and revisions) to other service coding and reporting conventions that are widely used in the health care industry, such as those maintained by the Centers for Medicaid and Medicare Services (for example HCPCS, etc.). Ordinarily, our fee schedule is updated using similar methodologies for similar

services. We will not generally attempt to communicate routine maintenance of this nature and will generally implement updates within 90 days from the date of publication.

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

If either of us believes that a claim has not been paid correctly, either of us may seek correction of the payment within a 12-month period following the date the claim was paid, except that overpayments as a result of abusive or fraudulent billing practices may be pursued by us beyond the 12-month time frame mentioned above. In the event of an overpayment, we will correct these errors by adjusting future claim payment and/or by billing you for the amount of the overpayment.

Your professional staff and Practice Locations

You represent to us that all of the members of your professional staff, as of the date you executed this agreement, are listed in Appendix 4. All of the members of your professional staff will participate in our network through this agreement, except in cases in which one of your professional staff is not accepted for participation or is removed from participation under our credentialing program, or removed from participation by us immediately due to that professional being sanctioned by any governmental agency or authority (including Medicare or Medicaid), or having lost a license to provide all or some of the professional services under this agreement, or no longer having hospital admitting privileges in any participating hospital. Your professional staff will cooperate with our credentialing program.

If a new professional joins your professional staff, you will give us 60 days notice and provide the information included in Appendix 4. You will assure that the new professional will promptly submit a credentialing application to us (unless the new professional is already credentialed with us) and cooperate with our credentialing program.

You will assure that a member of your professional staff who has not been approved or is not in good standing under our credentialing program will not provide covered services to our customers. In the event that professional does provide covered services, you will not bill us, our customer, or anyone acting on our customer's behalf for the service, and you will assure that the professional also does not bill for the service.

If a professional leaves your professional staff, you will notify us within ten business days after you become aware that the professional will leave. The notice will include the date that the professional will depart from your professional staff. If you know the future contact information for the professional and whether the professional will continue to practice after leaving your professional staff, you will make reasonable commercial efforts to include that information in the notice and will provide that information to us if we request it.

This agreement applies to your practice locations identified in Appendix 5. If you begin providing services at other locations (either by opening such locations yourself, or by acquiring, merging or coming under common ownership and control with an existing provider of services that was not already under contract with us or one of our affiliates to participate in a network of health care providers), those additional locations will become subject to this agreement 30 days after we receive notice from you.

If you acquire or are acquired by, merged with, or otherwise become affiliated with another provider of health care services that is already under contract with us or one of our affiliates to participate in a network of health care providers, this agreement and the other agreement will each remain in effect and will continue to apply as they did prior to the acquisition, merger or affiliation, unless otherwise agreed to in writing by all parties to those agreements.

If you decide to transfer some or all of your assets to another entity, and the result of the transfer would be that all or some of the services subject to this agreement would be rendered by the other entity rather than by you, you must first request that we approve an assignment of this agreement as it relates to those services and the other entity must agree to assume this agreement.

How long our agreement lasts; how it gets amended; and how it can end

Assuming you are credentialed by us, and we execute this agreement, you will receive a copy from us with the effective date noted below the signature block. It continues until one of us terminates it.

We can amend this agreement or any of the appendices on 90 days written or electronic notice by sending you a copy of the amendment. Your signature is not required to make the amendment effective. However, if you do not wish to continue your participation with our network as changed by an amendment that is not required by law or regulation but that includes a material adverse change to this agreement, then you may terminate this agreement on 60 days written notice to us so long as you send this termination notice within 30 days of your receipt of the amendment.

In addition, either you or we can terminate this agreement, effective on an anniversary of the date this agreement begins, by providing at least 90 days prior written notice. Either you or we can terminate this agreement at any time if the other party has materially breached this agreement, by providing 60 days written notice, except that if the breach is cured before our agreement ends, the agreement will continue.

Either of us can immediately terminate this agreement if the other becomes insolvent or has bankruptcy proceedings initiated.

Finally, we can immediately terminate this agreement if any governmental agency or authority (including Medicare or Medicaid) sanctions you.

We both agree that termination notices under this agreement must be sent by certified mail, return receipt requested, to [UnitedHealthcare, Network Management, {address}], or to the post office address you provided us. We both will treat termination notices as “received” on the third business day after they are sent.

About data and confidentiality

We agree that your medical records do not belong to us. You agree the information contained in the claims you submit is ours. We both will protect the confidentiality of our customers’ information in accordance with applicable state and federal laws, rules, and regulations.

We are both prohibited from disclosing to third parties any fee schedule or rate information. There are three exceptions:

- You can disclose to our customer information relating to our payment methodology for a service the customer is considering (e.g., global fee, fee for service), but not specific rates (unless for purposes of benefit administration).
- We and the participating entities may use this information to administer our customers’ benefit contracts and to pay your claims. We also may permit access to information by auditors and other consultants who need the information to perform their duties, subject to a confidentiality agreement.
- We both may produce this information in response to a court order, subpoena or regulatory requirement to do so, provided that we use reasonable efforts to seek to maintain confidential treatment for the information, or to a third party for an appropriate business purpose, provided that the disclosure is pursuant to a confidentiality agreement and the recipient of the disclosure is not a competitor of either of us.

What if we do not agree

We will resolve all disputes between us by following the dispute procedures set out in our Administrative Guide. If either of us wishes to pursue the dispute beyond those procedures, they will submit the dispute to binding arbitration in accordance with the Commercial Dispute Procedures of the American Arbitration Association (see <http://www.adr.org>) within one year.

We both expressly intend that any dispute between us be resolved on an individual basis so that no other dispute with any third party(ies) may be consolidated or joined with our dispute. We both agree that any arbitration ruling by an arbitrator allowing class action arbitration or requiring consolidated arbitration involving any third party(ies) would be contrary to our intent and would require immediate judicial review of such ruling. The arbitrator will not vary the terms of this agreement and will be bound by governing law. We both acknowledge that this agreement involves interstate commerce, and is governed by the Federal Arbitration Act, 9 U.S.C. § 1 *et seq.* The arbitrator will not have the authority to award punitive or exemplary damages against either of us, except in connection with a statutory claim that explicitly provides for such relief. Arbitration will be conducted in {county}, {state}.

If a court allows any litigation of a dispute to go forward, we both waive rights to a trial by jury with respect to that litigation, and the judge will be the finder of fact. Any provision of this agreement that is invalid or unenforceable shall not affect the validity or enforceability of the remaining provisions of this agreement or the validity or enforceability of the offending provision in any other situation or in any other jurisdiction. This section of the agreement shall survive and govern any termination of this agreement.

What is our relationship to one another

You are an independent contractor. This means we do not have an employer-employee, principal-agent, partnership, joint venture, or similar arrangement. It also means that you make independent health care treatment decisions. We do not. We do not reserve any right to control those treatment decisions. It further means that each of us is responsible for the costs, damages, claims, and liabilities that result from our own acts.

You will look to the applicable participating entity for reimbursement for the products and services under our agreement. This means that we are not financially responsible for claims payment for groups that are self-funded or that are not affiliated with us.

We may assign this agreement to any entity that is an affiliate of UnitedHealthcare Insurance Company at the time of the assignment.

This is it

This contract, the appendices and the items referenced in the attached Appendix 1, constitute our entire understanding. It replaces any other agreements or understandings with regard to the same subject matter - - oral or written - - that you have with us or any of our affiliates.

Federal law and the applicable law of the jurisdiction where you provide health care services govern our agreement. Such laws and the rules and regulations promulgated under them, when they are applicable, control and supersede our agreement. The Regulatory Appendix referenced in Appendix 1, and any

attachment to it, is expressly incorporated to govern our agreement and is binding on both of us. In the event of any inconsistent or contrary language between the Regulatory Appendix (when it applies) and any other part of our agreement, including but not limited to appendices, amendments and exhibits, the Regulatory Appendix will control.

Conclusion

If you agree with these terms, please execute both copies of the agreement below and return them to us. With your signature, you confirm you understand the contract, including the dispute resolution procedures described in the section of this agreement entitled "What if we do not agree", the appendices and the items referenced in the attached Appendix 1.

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

AGREED BY:

Medical Group (print):

Address to be used for giving notice under the agreement:

Signature _____

Street _____

Print Name and Title _____

City _____

DBA (if applicable) _____

State _____ Zip Code _____

Date _____ TIN _____

E-mail _____

UnitedHealthcare Insurance Company, on behalf of itself, UnitedHealthcare of Arkansas, Inc. [, UnitedHealthcare Plan of the River Valley, Inc.,] and its other affiliates, as signed by its authorized representative:

For Internal Use Only:

Signature _____

Print Name _____

Date _____

For office use only:

Month, day and year in which agreement is first effective: ____ / ____ / ____

Appendix 1

We include as part of our agreement the following additional materials that bind you and us:

- Appendix 2** **Definitions, Products and Services**
This appendix sets forth definitions for our “customer” and “participating entities” as well as lists the type of benefit contracts offered to our customers.
- Appendix 3** **Fee Schedule Sample(s).** This document includes a portion of our fee schedule for the most frequent procedures you perform, or for those procedures you have requested. Additional portions of the fee schedule can be requested by writing to [UnitedHealthcare, Network Management, {address}]
- Appendix 4** This document provides information about the members of your professional staff.
- Appendix 5** This document provides information about your practice locations.
- State
Regulatory
Requirements
Appendix** In some instances, states add requirements to our agreement that are set forth in this appendix.
- Medicare
Regulatory
Requirements
Appendix** (This appendix applies only if you are in our Medicare network)
Your participation in our network for customers with Medicare benefit contracts is subject to additional Medicare requirements set forth in this appendix
- [Medicaid
Regulatory
Requirements
Appendix]** [(This appendix applies only if you are in our Medicaid network)
Your participation in our network for customers with Medicaid benefit contracts is subject to additional Medicaid requirements set forth in this appendix]
- Administrative
Guide** We have enclosed a copy of our Administrative Guide. This guide governs the mechanics of our relationship. Our Administrative Guide may be viewed by going to www.unitedhealthcareonline.com. We may make changes to the guide upon 30 days’ electronic or written notice to you.

[Additionally, for customers enrolled in benefit contracts (other than Medicare benefit contracts) issued by the River Valley Entities or under which a River Valley Entity provides administrative services under an agreement with us or a participating entity and included in this agreement as set forth in Appendix 2, you will be subject to the programs, protocols and administrative procedures described in or made available to you through the River Valley Provider Manual (the “River Valley Manual”) and the payment policies of the River Valley Entities. When the agreement refers to the administrative manual or guide, it is also referring to the River Valley Manual. The River Valley Manual is available to you upon request and online at <https://www.uhcrivervalley.com>. In the event of any conflict between the River Valley Manual or River Valley payment policies on the one hand and any of the following: the agreement, any

United programs, protocols, administrative procedures (including payment policies and guidelines for calculating payments), or the UnitedHealthcare Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide (the “Administrative Manual”) in connection with any matter pertaining to a customer enrolled in a benefit contract (other than a Medicare benefit contract) issued by the River Valley Entities, the River Valley Manual or River Valley Payment Policies, as applicable, shall govern, unless applicable statutes or regulations dictate otherwise.] We may make changes to the Administrative Manual[, River Valley Manual] or other administrative protocols [and River Valley Payment Policies] upon 30 days’ electronic or written notice to you.]

**Credentialing
Plan**

To review our credentialing plan, visit www.unitedhealthcareonline.com. This plan requires your professional staff to be covered by malpractice insurance in amounts with carriers and on terms and conditions that are customary for professionals like them in your community. To request access to, or a copy of, our credentialing plan, write to [UnitedHealthcare, Network Management, {address}].

Appendix 2

Definitions, Products and Services

- 1. Customer.** Individuals who are enrolled in benefit contracts insured or administered by us or any participating entity are included in our use of the phrase “customer” in this agreement.
- 2. Participating entities.** The following entities have access to our agreement:
 - UnitedHealthcare Insurance Company and its affiliates
 - Groups receiving administrative services from UnitedHealthcare Insurance Company or its affiliates or that have arranged for network access through an entity that has contracted with UnitedHealthcare Insurance Company or one of its affiliates.
- 3. Products and services.** We may include you in networks where your patients are enrolled in benefit contracts of the types generally described below:
 - Benefit contracts where individuals are offered a network of participating physicians and other health care professionals and must select a primary care physician, who in some cases must approve any care provided by other health care providers. An option for this benefit contract allows individuals to receive health services from non-participating physicians.
 - Benefit contracts where individuals are offered a network of participating physicians and other health care providers but are not required to select a primary care physician. An option for this benefit contract allows individuals to receive health services from non-participating physicians.
 - Benefit contracts where individuals are not offered a network of participating physicians and other health care providers.
 - [Medicare benefit contracts that (A) are sponsored, issued or administered by us or another applicable participating entity 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.]
 - [Benefit contracts for Workers' compensation benefit programs]

However, this agreement does not apply to the following:

- Benefit contracts 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 benefit contracts that (A) are sponsored, issued or administered by us or another applicable participating entity 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"). Note: Although Medicare benefit contracts, as described above, are excluded from this agreement, there can be a separate agreement between us or between our and your affiliates or other entity authorized to contract on behalf of you providing for your participation in a network for certain Medicare benefit contracts.]
- Medicare Advantage Private Fee-For-Service Plans.
- Benefit contracts for Medicare Select

- [Benefit contracts for Workers' compensation benefit programs]

Appendix 3- Options PPO

Representative Options PPO Fee Schedule Sample for: [insert name of *Fee Schedule*]

The provisions of this fee schedule apply to covered services rendered by you to customers covered by benefit contracts marketed under the name “Options PPO” and benefit contracts where customers are not offered a network of participating physicians and other health care professionals from which they may receive covered services [, except Anesthesia Management covered services rendered by Anesthesia Practitioners. Fee Schedule Sample(s) for Anesthesia Management covered services rendered by Anesthesia Practitioners are described in a separate Exhibit 1 to this Appendix 3].

Unless specifically indicated otherwise, amounts listed in the fee schedule represent global fees and may be subject to reductions based on appropriate modifier (for example, professional and technical modifiers). Any co-payment, deductible or coinsurance that the customer is responsible to pay under the customer’s benefit contract will be subtracted from the listed amount in determining the amount to be paid by us or the participating entity. The actual payment amount is also subject to matters described in this agreement, such as the reimbursement policies. Please remember that this information is subject to the confidentiality provisions of this agreement.

Appendix 3 - Products other than Options PPO

Representative All-Payer Fee Schedule Sample(s) for:[insert name of *Fee Schedule*]

Unless another fee schedule to this agreement applies specifically to a particular benefit contract as it covers a particular customer, the provisions of this fee schedule apply to covered services rendered by you to customers covered by benefit contracts sponsored, issued or administered by all participating entities [, except Anesthesia Management covered services rendered by Anesthesia Practitioners. Fee Schedule Sample(s) for Anesthesia Management covered services rendered by Anesthesia Practitioners are described in a separate Exhibit 1 to this Appendix 3].

Unless specifically indicated otherwise, amounts listed in the fee schedule represent global fees and may be subject to reductions based on appropriate modifier (for example, professional and technical modifiers). Any co-payment, deductible or coinsurance that the customer is responsible to pay under the customer's benefit contract will be subtracted from the listed amount in determining the amount to be paid by us or the participating entity. The actual payment amount is also subject to matters described in this agreement, such as the reimbursement policies. Please remember that this information is subject to the confidentiality provisions of this agreement.

[Appendix 3A

For Dates of Service Effective: mm/dd/yyyy

Fee Schedule Specifications : [Fee Schedule ID]

**[Appendix 3, Exhibit 1
Anesthesia Fee Schedule Exhibit: Options PPO**

Representative Options PPO Fee Schedule Sample: *[insert name of Fee Schedule]*

The provisions of this exhibit apply to Anesthesia Management covered services rendered by Anesthesia Practitioners to customers covered by benefit contracts marketed under the name “Options PPO” and benefit contracts where customers are not offered a network of participating physicians and other health care professionals from which they may receive covered services.

Unless specifically indicated otherwise, amounts listed in the fee schedule represent global fees and may be subject to reductions based on appropriate modifier (for example, professional and technical modifiers). Any co-payment, deductible or coinsurance that the customer is responsible to pay under the customer’s benefit contract will be subtracted from the listed amount in determining the amount to be paid by us or the participating entity. The actual payment amount is also subject to matters described in this agreement, such as the reimbursement policies. This information is subject to the confidentiality provisions of the agreement.]

**[Appendix 3, Exhibit 1
Anesthesia Fee Schedule Exhibit: Products other than Options PPO**

Representative Fee Schedule Sample:[insert name of *Fee Schedule*]

Unless another exhibit to Appendix 3 applies specifically to a particular benefit contract as it covers a particular customer, the provisions of this exhibit apply to Anesthesia Management covered services rendered by Anesthesia Practitioners to customers covered by benefit contracts sponsored, issued or administered by all participating entities.

Unless specifically indicated otherwise, amounts listed in the fee schedule represent global fees and may be subject to reductions based on appropriate modifier (for example, professional and technical modifiers). Any co-payment, deductible or coinsurance that the customer is responsible to pay under the customer's benefit contract will be subtracted from the listed amount in determining the amount to be paid by us or the participating entity. The actual payment amount is also subject to matters described in this agreement, such as the reimbursement policies. This information is subject to the confidentiality provisions of the agreement.]

[Appendix 3

Representative Medicare Fee Schedule Sample [Insert Name of Fee Schedule]

The provisions of this fee schedule apply to services rendered by you to our Medicare customers covered by Medicare benefit contracts that (A) are sponsored, issued or administered by us or another applicable participating entity 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. The provisions of this fee schedule do not apply to services you render to Medicare beneficiaries pursuant to a commercial benefit contract.

We will use our best efforts to update the amounts for services listed in the attached fee schedule that are based on the CMS physician Medicare fee schedule on or before the later of (a) ninety (90) days after the effective date of any modification made by CMS to the CMS physician Medicare fee schedule; provided, however, in the event CMS makes a change to such modification after the effective date of such modification, we will use our best efforts to update the methodology and factors in accordance with such subsequent change within ninety (90) days after the date on which CMS places information regarding such subsequent change in the public domain, or (b) ninety (90) days after the date on which CMS initially place information regarding such modification in the public domain (e.g., CMS distributes program memoranda to providers).

Amounts listed in the attached sample fee schedule are gross amounts. Any co-payments, deductibles or coinsurance that our Medicare customer is responsible to pay under his or her benefit contract will be subtracted from the amount listed in the attached sample fee schedule in determining the amount to be paid by us or by a participating entity. The actual payment amount is also subject to matters described in our agreement, including our reimbursement policies.]

**Appendix 4
Your Professional Staff**

Appendix 4 PHYSICIAN ROSTER

NOTE: Please attach additional copies of this page if you need to list additional Providers.

Name of Provider Representative(s) (First Name, MI, Last Name)	Degree (MD, DO, etc.)	Male or Female (M/F)	Provider Specialty(ies)		State License #	UPIN #	Foreign Language(s) Spoken	Admitting Hospital(s)
			1) Primary	2) Secondary				
			1)					1) 2)
			1)					1) 2)
			1)					1) 2)
			1)					1) 2)
			1)					1) 2)
			1)					1) 2)

**Appendix 5
Your Practice Locations**

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

BILLING ADDRESS

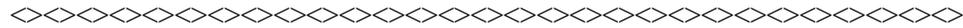
All sites of service billing under all TINs listed in Appendix 5 must be included as par providers.
Identify only if a common name and address appears on all medical group practice location bills that utilize the medical group's Tax ID under the Agreement.

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

National Provider Identification (NPI) Number _____

PRACTICE LOCATIONS (complete one for each service location)

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



Clinic Name	Clinic Name	Clinic Name
Street Address	Street Address	Street Address
City	City	City
State and Zip Code	State and Zip Code	State and Zip Code
Phone Number	Phone Number	Phone Number

TIN (If different from above)	TIN (If different from above)	TIN (If different from above)

INTRODUCTION

Our agreement consists of this contract, the appendices, and the additional materials we reference in the attached Appendix 1.

Guiding principles

We strive to operate in accordance with the following principles:

- *We want to work together with America's best physicians [practitioners] to improve the health care experience of our customers.*
- *We respect and support the physician[practitioner]/patient relationship while adhering fairly to the contract for benefits we provide our customers.*
- *Whether a particular treatment is covered under a benefit contract should not determine if the treatment is provided. Physicians[Practitioners] and health care professionals should provide the care they believe is necessary regardless of coverage.*
- *You should discuss treatment options with patients regardless of coverage. We encourage that communication.*
- *Physicians[Practitioners] should describe any factors that could affect their ability to render appropriate care. Matters such as professional training, financial incentives, availability constraints, religious or philosophical beliefs, and similar matters are all things that a physician [practitioner] should consider discussing with a patient. We encourage these communications. We urge full disclosure.*
- *Fairness and efficiency will govern the ways in which we administer our products. We will make our determinations promptly. Our commitments to our customers will be clear. We will honor our agreements. When it comes to coverage determinations, the language of the benefit contract will take precedence.*

Next steps

Please read this agreement. If you have questions, write to or call:

UnitedHealthcare
Network Management
{ address }

{(xxx)xxx-xxxx}

You can visit our website at www.unitedhealthcareonline.com (UnitedHealthcare Online®) for additional details on items described in the agreement. If the agreement is acceptable to you, please sign both of the enclosed copies of the contract, and send both copies to the address above.

PHYSICIAN [PRACTITIONER] CONTRACT

UnitedHealthcare Insurance Company is entering into this agreement with you. It is doing so on behalf of itself, UnitedHealthcare of Arkansas, Inc. [UnitedHealthcare Plan of the River Valley, Inc.,] and its other affiliates for certain products and services we offer our customers, all of which we describe in the attached Appendix 2.

This agreement applies to you and the services you provide in all of your practice arrangements and for all of your tax identification numbers, except that if your services are covered under an agreement between us and a medical group that you are part of, services that you provide through that medical group will be subject to that other agreement and not this agreement.

What you will do

You need to be credentialed in accordance with our Credentialing Plan, as referenced in Appendix 1, for the duration of this agreement.

You must notify us in a timely manner about certain services you provide in accordance with our Administrative Guide so that we can provide our customers with the services we have committed to provide. If you do not so notify us about these services, you will not be reimbursed for the services, and you may not charge our customer.

Within one year of the effective date of this agreement, you must conduct business with us entirely on an electronic basis to the extent that we are able to conduct business electronically (described in the Administrative Guide), including but not limited to determining whether your patient is currently a customer, verifying the customer's benefit, and submitting your claim. We will communicate enhancements in UnitedHealthcare Online® functionality as they become available and will make information available to you as to which products are supported by UnitedHealthcare Online.

You must submit your claims within 90 days of the date of service. After we receive your claim, if we request additional information in order to process your claim, you must submit this additional information within 90 days of our request. If your claim or the additional information is not submitted within these timeframes, you will not be reimbursed for the services, and you may not charge our customer.

You will submit claims only for services performed by you or your staff. Pass through billing is not payable under this agreement and may not be billed to our customer. For laboratory services, you will only be reimbursed for the services that you are certified through the Clinical Laboratory Improvement Amendments (CLIA) to perform, and you must not bill our customers for laboratory services for which you are not certified.

You will submit claims that supply all applicable information. These claims are complete claims. Further information about complete claims is provided in our Administrative Guide.

If you disagree with our payment determination on a claim, you may submit an appeal as described in our Administrative Guide.

You will not charge our customers anything for the services you provide, if those services are covered services under their benefit contract, but the applicable co-pay, coinsurance or deductible amount. If the services you provide are denied or otherwise not paid due to your failure to notify us, to file a timely claim, to submit a complete claim, to respond to our request for information, or based on our reimbursement policies and methodologies, you may not charge our customer. If the services you provide are denied for reason of not being medically necessary, you may not charge our customer unless our customer has, with knowledge of our determination of a lack of medical necessity, agreed in writing to be responsible for payment of those charges. If the services you provide are not covered under our customer's benefit contract, you may, of course, bill our customer directly. You will not require a customer to pay a "membership fee" or other fee in order to access you for covered services (except for co-payments, coinsurance and/or deductibles provided for under the customer's benefit contract) and will not discriminate against any customer based on the failure to pay such a fee.

You will cooperate with our reasonable requests to provide information that we need. We may need this information to perform our obligations under this agreement, under our programs and agreements with our customers, or as required by regulatory or accreditation agencies.

You will refer customers only to other network physicians and providers, except as permitted under our customer's benefit contract, or as otherwise authorized by us or the participating entity.

What we will do

We or the other applicable participating entity will promptly adjudicate and pay your complete claim for services covered by our customer's benefit contract. If you submit claims that are not complete,

- You may be asked for additional information so that your claim may be adjudicated; or
- Your claim may be denied and you will be notified of the denial and the reason for it; or
- We may in our discretion attempt to complete the claim and have it paid by us or the other applicable participating entity based on the information that you gave in addition to the information we have.

If governing law requires us to pay interest or another penalty for a failure to pay your complete claim for covered services within a certain time frame, we will follow those requirements. The interest or other penalty required by law will be the only additional obligation for not satisfying in a timely manner a payment obligation to you. In addition, if we completed a claim of yours that was not complete, there shall be no interest or other late payment obligation to you even if we subsequently adjust the payment amount based on additional information that you provide.

The applicable participating entity will reimburse you for the services you deliver that our customer's benefit contract covers. The amount you receive will be based on the lesser of your billed charges or our fee schedule, which is described at Appendix 1 and is subject to the reimbursement (coding) policies and methodologies of us and the participating entities. Our reimbursement policies and methodologies are updated periodically and will be made available to you online or upon request. To request a copy of our reimbursement policies and methodologies, write to UnitedHealthcare, Network Management, {address}. Your reimbursement is also subject to our rules concerning retroactive eligibility, subrogation and coordination of benefits (as described in the Administrative Guide). We recognize CPT reporting guidelines as developed by the American Medical Association, as well as ICD diagnostic codes and hospital-based revenue codes. Following these guidelines does not imply a right to reimbursement for all services as coded or reported.

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

We routinely update our fee schedule in response to additions, deletions and changes to CPT codes by the American Medical Association, price changes for immunizations and injectable medications, and in response to similar changes (additions and revisions) to other service coding and reporting conventions that are widely used in the health care industry, such as those maintained by the Centers for Medicaid and Medicare Services (for example HCPCS, etc.). Ordinarily, our fee schedule is updated using similar methodologies for similar services. We will not generally attempt to communicate routine maintenance of this nature and will generally implement updates within 90 days from the date of publication.

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

If either of us believes that a claim has not been paid correctly, either of us may seek correction of the payment within a 12-month period following the date the claim was paid, except that overpayments as a result of abusive or fraudulent billing practices may be pursued by us beyond the 12-month time frame mentioned above. In the event of an overpayment, we will correct these errors by adjusting future claim payment and/or by billing you for the amount of the overpayment.

How long our agreement lasts; how it gets amended; and how it can end

Assuming you are credentialed by us, and we execute this agreement, you will receive a copy from us with the effective date noted below the signature block. It continues until one of us terminates it.

We can amend this agreement or any of the appendices on 90 days written or electronic notice by sending you a copy of the amendment. Your signature is not required to make the amendment effective. However, if you do not wish to continue your participation with our network as changed by an amendment that is not required by law or regulation but that includes a material adverse change to this agreement, then you may terminate this agreement on 60 days written notice to us so long as you send this termination notice within 30 days of your receipt of the amendment.

In addition, either you or we can terminate this agreement, effective on an anniversary of the date this agreement begins, by providing at least 90 days prior written notice. Either you or we can terminate this agreement at any time if the other party has materially breached this agreement, by providing 60 days written notice, except that if the breach is cured before our agreement ends, the agreement will continue.

Either of us can immediately terminate this agreement if the other becomes insolvent or has bankruptcy proceedings initiated.

Finally, we can immediately terminate this agreement if any governmental agency or authority (including Medicare or Medicaid) sanctions you, if you no longer have your license to practice medicine, if you no longer have hospital admitting privileges in any participating hospital, or in accordance with the terms of our Credentialing Plan.

We both agree that termination notices under this agreement must be sent by certified mail, return receipt requested, to UnitedHealthcare, Network Management, {address}, or to the post office address you provided us. We both will treat termination notices as “received” on the third business day after they are sent.

About data and confidentiality

We agree that your medical records do not belong to us. You agree the information contained in the claims you submit is ours. We both will protect the confidentiality of our customers’ information in accordance with applicable state and federal laws, rules, and regulations.

We are both prohibited from disclosing to third parties any fee schedule or rate information. There are three exceptions:

- You can disclose to our customer information relating to our payment methodology for a service the customer is considering (e.g., global fee, fee for service), but not specific rates (unless for purposes of benefit administration).
- We and the participating entities may use this information to administer our customers’ benefit contracts and to pay your claims. We also may permit access to information by auditors and other consultants who need the information to perform their duties, subject to a confidentiality agreement.
- We both may produce this information in response to a court order, subpoena or regulatory requirement to do so, provided that we use reasonable efforts to seek to maintain confidential treatment for the information, or to a third party for an appropriate business purpose, provided that the disclosure is pursuant to a confidentiality agreement and the recipient of the disclosure is not a competitor of either of us.

What if we do not agree

We will resolve all disputes between us by following the dispute procedures set out in our Administrative Guide. If either of us wishes to pursue the dispute beyond those procedures, they will submit the dispute to binding arbitration in accordance with the Commercial Dispute Procedures of the American Arbitration Association (see <http://www.adr.org>) within one year.

We both expressly intend that any dispute between us be resolved on an individual basis so that no other dispute with any third party(ies) may be consolidated or joined with our dispute. We both agree that any arbitration ruling by an arbitrator allowing class action arbitration or requiring consolidated arbitration involving any third party(ies) would be contrary to our intent and would require immediate judicial review of such ruling. The arbitrator will not vary the terms of this agreement and will be bound by governing law. We both acknowledge that this agreement involves interstate commerce, and is governed by the Federal Arbitration Act, 9 U.S.C. § 1 *et seq.* The arbitrator will not have the authority to award punitive or exemplary damages against either of us, except in connection with a statutory claim that explicitly provides for such relief. Arbitration will be conducted in {county}, {state}.

If a court allows any litigation of a dispute to go forward, we both waive rights to a trial by jury with respect to that litigation, and the judge will be the finder of fact. Any provision of this agreement that is invalid or unenforceable shall not affect the validity or enforceability of the remaining provisions of this

agreement or the validity or enforceability of the offending provision in any other situation or in any other jurisdiction. This section of the agreement governs any dispute between us arising before or after execution of this agreement and this section shall survive and govern any termination of this agreement.

What is our relationship to one another

You are an independent contractor. This means we do not have an employer-employee, principal-agent, partnership, joint venture, or similar arrangement. It also means that you make independent health care treatment decisions. We do not. We do not reserve any right to control those treatment decisions. It further means that each of us is responsible for the costs, damages, claims, and liabilities that result from our own acts.

You will look to the applicable participating entity for reimbursement for the products and services under our agreement. This means that we are not financially responsible for claims payment for groups that are self-funded or that are not affiliated with us.

We may assign this agreement to any entity that is an affiliate of UnitedHealthcare Insurance Company at the time of the assignment.

This is it

This contract, the appendices and the items referenced in the attached Appendix 1, constitute our entire understanding. It replaces any other agreements or understandings with regard to the same subject matter - - oral or written - - that you have with us or any of our affiliates.

Federal law and the applicable law of the jurisdiction where you provide health care services govern our agreement. Such laws and the rules and regulations promulgated under them, when they are applicable, control and supersede our agreement. The Regulatory Appendix referenced in Appendix 1, and any attachment to it, is expressly incorporated to govern our agreement and is binding on both of us. In the event of any inconsistent or contrary language between the Regulatory Appendix (when it applies) and any other part of our agreement, including but not limited to appendices, amendments and exhibits, the Regulatory Appendix will control.

Conclusion

If you agree with these terms, please execute both copies of the agreement below and return them to us. With your signature, you confirm you understand the contract, including the dispute resolution procedures described in the section of this agreement entitled “What if we do not agree”, the appendices and the items referenced in the attached Appendix 1.

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

AGREED BY:

Physician [Practitioner]

Address to be used for giving notice under the agreement:

Signature _____ Street _____

Print Name _____ City _____

DBA (if applicable) _____ State _____ Zip Code _____

Date _____ TIN _____ E-mail _____

National Provider Identification (NPI) Number _____

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

For Internal Use Only:

Signature _____

Print Name _____

Date _____

For office use only:

Month, day and year in which agreement is first effective: ____ / ____ / ____

Appendix 1

We include as part of our agreement the following additional materials that bind you and us:

Appendix 2

Definitions, Products and Services

This appendix sets forth definitions for our “customer” and “participating entities” as well as lists the type of benefit contracts offered to our customers.

Appendix 3

Fee Schedule Sample. This document includes a portion of our fee schedule for the most frequent procedures you perform, or for those procedures you have requested. Additional portions of the fee schedule can be requested by writing to [UnitedHealthcare, Network Contract Support, 1311 W. President George Bush Highway, Suite 100, Mail Route: TX023-1000, Richardson, TX 75080-9870].

Appendix 4

Locations. This document provides information about your office, billing, and mailing locations. Please remember that, as described on page 2, this agreement applies to all of your locations even if you do not list all of your current locations or if you add a location in the future.

State Regulatory Requirements Appendix

In some instances, states add requirements to our agreement that are set forth in this appendix.

Medicare Regulatory Requirements Appendix

(This appendix applies only if you are in our Medicare network)
Your participation in our network for customers with Medicare benefit contracts is subject to additional Medicare requirements set forth in this appendix

[Medicaid Regulatory Requirements Appendix]

[(This appendix applies only if you are in our Medicaid network)
Your participation in our network for customers with Medicaid benefit contracts is subject to additional Medicaid requirements set forth in this appendix]

Administrative Guide

We have enclosed a copy of our Administrative Guide. This guide governs the mechanics of our relationship. Our Administrative Guide may be viewed by going to www.unitedhealthcareonline.com.

Additionally, for customers enrolled in benefit contracts (other than Medicare benefit contracts) issued by the River Valley Entities or under which a River

Valley Entity provides administrative services under an agreement with us or a participating entity and included in this agreement as set forth in Appendix 2, you will be subject to the programs, protocols and administrative procedures described in or made available to you through the River Valley Provider Manual (the “River Valley Manual”) and the payment policies of the River Valley Entities. When the agreement refers to the administrative manual or guide, it is also referring to the River Valley Manual. The River Valley Manual is available to you upon request or online at <https://www.uhcrivervalley.com>. In the event of any conflict between the River Valley Manual or River Valley payment policies on the one hand and any of the following: the agreement, any United programs, protocols, administrative procedures (including payment policies and guidelines for calculating payments), or the UnitedHealthcare Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide (the “Administrative Manual”) in connection with any matter pertaining to a customer enrolled in a benefit contract (other than a Medicare benefit contract) issued by the River Valley Entities, the River Valley Manual or River Valley Payment Policies, as applicable, shall govern, unless applicable statutes or regulations dictate otherwise.] We may make changes to the Administrative Manual[, River Valley Manual] or other administrative protocols [and River Valley Payment Policies] upon 30 days’ electronic or written notice to you.]

**Credentialing
Plan**

To review our credentialing plan, visit www.unitedhealthcareonline.com. This plan requires you to carry malpractice insurance in amounts with carriers and on terms and conditions that are customary for physicians like you in your community. To request access to, or a copy of, our credentialing plan, write to UnitedHealthcare, Network Management, {address}.

Appendix 2 Definitions, Products and Services

1. **Customer.** Individuals who are enrolled in benefit contracts insured or administered by us or any participating entity are included in our use of the phrase “customer” in this agreement.
2. **Participating entities.** The following entities have access to our agreement:
 - UnitedHealthcare Insurance Company and its affiliates;
 - Groups receiving administrative services from UnitedHealthcare Insurance Company or its affiliates or that have arranged for network access through an entity that has contracted with UnitedHealthcare Insurance Company or one of its affiliates.
3. **Products and services.** You will participate in networks where your patients are enrolled in benefit contracts of the types generally described below:
 - Benefit contracts where individuals are offered a network of participating physicians and other health care professionals and must select a primary care physician, who in some cases must approve any care provided by other health care providers. An option for this benefit contract allows individuals to receive health services from non-participating physicians.
 - Benefit contracts where individuals are offered a network of participating physicians and other health care providers but are not required to select a primary care physician. An option for this benefit contract allows individuals to receive health services from non-participating physicians.
 - Benefit contracts where individuals are not offered a network of participating physicians and other health care providers.
 - [Medicare benefit contracts that (A) are sponsored, issued or administered by us or another applicable participating entity 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.]
 - [Benefit contracts for Workers' compensation benefit programs.]

You will **not** participate in networks where your patients are enrolled in benefit contracts of the types generally described below:

- Benefit contracts 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.
- [Medicare Benefit contracts that (A) are sponsored, issued or administered by us or another applicable participating entity 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"). Note: Although Medicare benefit contracts, as described above, are excluded from this agreement, there can be a separate agreement between us

or between our and your affiliates or other entity authorized to contract on behalf of you providing for your participation in a network for certain Medicare benefit contracts.]

- [Benefit contracts for Workers' compensation benefit programs.]
- Benefit contracts for Medicare Select.

Appendix 3- Options PPO

Representative Options PPO Fee Schedule Sample: [insert name of Fee Schedule]

The provisions of this fee schedule apply to covered services rendered by you to customers covered by benefit contracts marketed under the name “Options PPO” and benefit contracts where customers are not offered a network of participating physicians and other health care professionals from which they may receive covered services [, except Anesthesia Management covered services rendered by Anesthesia Practitioners. Fee Schedule Sample(s) for Anesthesia Management covered services rendered by Anesthesia Practitioners are described in a separate Exhibit 1 to this Appendix 3].

Unless specifically indicated otherwise, amounts listed in the fee schedule represent global fees and may be subject to reductions based on appropriate modifier (for example, professional and technical modifiers). Any co-payment, deductible or coinsurance that the customer is responsible to pay under the customer’s benefit contract will be subtracted from the listed amount in determining the amount to be paid by us or the participating entity. The actual payment amount is also subject to matters described in this agreement, such as the reimbursement policies. Please remember that this information is subject to the confidentiality provisions of this agreement.

Appendix 3- Products other than Options PPO

Representative All-Payer Fee Schedule Sample: *[insert name of Fee Schedule]*

Unless another fee schedule to this agreement applies specifically to a particular benefit contract as it covers a particular customer, the provisions of this fee schedule apply to covered services rendered by you to customers covered by benefit contracts sponsored, issued or administered by all participating entities [, except Anesthesia Management covered services rendered by Anesthesia Practitioners. Fee Schedule Sample(s) for Anesthesia Management covered services rendered by Anesthesia Practitioners are described in a separate Exhibit 1 to this Appendix 3].

Unless specifically indicated otherwise, amounts listed in the fee schedule represent global fees and may be subject to reductions based on appropriate modifier (for example, professional and technical modifiers). Any co-payment, deductible or coinsurance that the customer is responsible to pay under the customer's benefit contract will be subtracted from the listed amount in determining the amount to be paid by us or the participating entity. The actual payment amount is also subject to matters described in this agreement, such as the reimbursement policies. Please remember that this information is subject to the confidentiality provisions of this agreement.

[Appendix 3A

For Dates of Service Effective: mm/dd/yyyy

Fee Schedule Specifications: [Fee Schedule ID]]

**[Appendix 3, Exhibit 1
Anesthesia Fee Schedule Exhibit: Options PPO**

Representative Options PPO Fee Schedule Sample: [insert name of Fee Schedule]

The provisions of this exhibit apply to Anesthesia Management covered services rendered by Anesthesia Practitioners to customers covered by benefit contracts marketed under the name “Options PPO” and benefit contracts where customers are not offered a network of participating physicians and other health care professionals from which they may receive covered services.

Unless specifically indicated otherwise, amounts listed in the fee schedule represent global fees and may be subject to reductions based on appropriate modifier (for example, professional and technical modifiers). Any co-payment, deductible or coinsurance that the customer is responsible to pay under the customer’s benefit contract will be subtracted from the listed amount in determining the amount to be paid by us or the participating entity. The actual payment amount is also subject to matters described in this agreement, such as the reimbursement policies. This information is subject to the confidentiality provisions of the agreement.]

**[Appendix 3, Exhibit 1
Anesthesia Fee Schedule Exhibit: Products other than Options PPO**

Representative Fee Schedule Sample:[insert name of *Fee Schedule*]

Unless another exhibit to Appendix 3 applies specifically to a particular benefit contract as it covers a particular customer, the provisions of this exhibit apply to Anesthesia Management covered services rendered by Anesthesia Practitioners to customers covered by benefit contracts sponsored, issued or administered by all participating entities.

Unless specifically indicated otherwise, amounts listed in the fee schedule represent global fees and may be subject to reductions based on appropriate modifier (for example, professional and technical modifiers). Any co-payment, deductible or coinsurance that the customer is responsible to pay under the customer's benefit contract will be subtracted from the listed amount in determining the amount to be paid by us or the participating entity. The actual payment amount is also subject to matters described in this agreement, such as the reimbursement policies. This information is subject to the confidentiality provisions of the agreement.]

[Appendix 3

Representative Medicare Fee Schedule Sample [insert name of *Fee Schedule*]

The provisions of this fee schedule apply to services rendered by you to our Medicare customers covered by Medicare benefit contracts that (A) are sponsored, issued or administered by us or another applicable participating entity and (B) replace, either partially or in its entirety, the original Medicare coverage (Medicare Part A and Medicare Part B) issued to beneficiaries by CMS, other than Medicare Advantage Private Fee-For-Service Plans. The provisions of this fee schedule do not apply to services you render to Medicare beneficiaries pursuant to a commercial benefit contract.

We will use our best efforts to update the amounts for services listed in the attached fee schedule that are based on the CMS physician Medicare fee schedule on or before the later of (a) ninety (90) days after the effective date of any modification made by CMS to the CMS physician Medicare fee schedule; provided, however, in the event CMS makes a change to such modification after the effective date of such modification, we will use our best efforts to update the methodology and factors in accordance with such subsequent change within ninety (90) days after the date on which CMS places information regarding such subsequent change in the public domain, or (b) ninety (90) days after the date on which CMS initially place information regarding such modification in the public domain (e.g., CMS distributes program memoranda to providers).

Amounts listed in the attached sample fee schedule are gross amounts. Any co-payments, deductibles or coinsurance that our Medicare customer is responsible to pay under his or her benefit contract will be subtracted from the amount listed in the attached sample fee schedule in determining the amount to be paid by us or by a participating entity. The actual payment amount is also subject to matters described in our agreement, including our reimbursement policies.]

Appendix 4 - LOCATIONS

NOTE: Please attach additional copies of this page if you need to list additional locations.
 Please remember that, as described on page 2, this agreement applies to all of your locations even if you do not list all of your current locations or if you add a location in the future.

Provider:

Primary Service Location Address:	Address:		
	City:	State:	Zip:
	Tel #:	Fax #:	
Billing Address:	Address:		
	City:	State:	Zip:
	Tel #:	Fax #:	

Additional Service Location Address:	Address:		
	City:	State:	Zip:
	Tel #:	Fax #:	
Billing Address:	Address:		
	<input type="checkbox"/> Same as above	City:	State:
		Tel #:	Fax #:
		Zip:	

Mailing Address:	Address:		
	City:	State:	Zip:
	Tel #:	Fax #:	

Arkansas Regulatory Requirements Appendix

In addition to our understandings in the agreement between you and us, there are certain additional items which Arkansas laws and regulations require us to include in our contract. This appendix sets forth those items and is made part of the agreement between you and us.

These requirements apply to products or benefit plans sponsored, issued or administered by or accessed through us, 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.

We 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 between you and us, this appendix shall control except with regard to benefit contracts outside the scope of this appendix.

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

For the purpose of this appendix, "enrollee" or "member" shall mean our customers who are enrolled in benefit contracts insured or administered by us or any participating entity.

Provisions applicable to benefit contracts regulated under Arkansas HMO laws:

1. Continued Provision of Health Care Services.

(a) Following Termination due to Insolvency. You agree that in the event the agreement between you and us is terminated because of our insolvency, you shall continue the provision of health care services to an enrollee who is receiving care from you for the duration of the period for which premiums have been paid to us on behalf of an enrollee or until the enrollee's discharge from an inpatient facility if enrollee was confined to an inpatient facility on the date of our insolvency.

(b) Continuity of Care After Termination. If the agreement between you and us is terminated for any reason, you shall continue the provision of health care services to an enrollee who is receiving care from you 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 enrollee ceases to be covered by us. You shall be reimbursed in accordance with the agreement between you and us for all such health care services rendered subsequent to the termination of that agreement.

2. Hold Harmless. In the event that we or the participating entity fails to pay for covered health care services as set forth in the agreement between you and us, an enrollee shall not be liable to you for any sums owed by us or the participating entity. You shall not collect or attempt to collect from an enrollee any sums owed by us or the participating entity. You (and your agents, trustees, or assignees) may not maintain an action at law against an enrollee to collect sums owed by us; nor make any statement, either written or oral, to any enrollee that makes a demand for, or would lead a reasonable person to believe that a demand is being made for payment for any amounts owed by us or the participating entity.

3. Examinations. During the term of the agreement between you and us and for three (3) years after termination, you agree to allow examination of medical records of enrollees and records of yours in conjunction with an examination of us 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 an enrollee obtained from the enrollee 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 enrollee, 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 enrollee and us wherein the data or information is pertinent. We shall be entitled to claim any statutory privileges against the disclosure that you (or the provider who furnished the information to us) are entitled to claim.

5. Enrollee Medical Records. You shall maintain an active record for each enrollee who receives health care services from you. Such record shall be kept current, complete, legible and available to us 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 an enrollee's medical record shall be indelibly added to the record, dated and signed or initialed by the person making the entry. You 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 enrollee, 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 enrollee's medical record shall include: the reason for the encounter, evidence of the assessment of the enrollee's health problems; current diagnosis of the enrollee, 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. You shall document that you have reviewed all outcomes of ancillary reports and taken follow-up actions regarding report results that are deemed significant by you.

6. Communication with Enrollees. Nothing in the agreement between you and us shall be construed as prohibiting, restricting or penalizing you in any way for disclosing to an enrollee any health care information that you deem 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 us or a participating entity in the agreement between you and us.

7. Provider Input. As requested by us, you shall provide input to us regarding our medical policy, utilization review criteria and procedures, quality and credentialing criteria and medical management procedures.

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

9. Recoupment. You, we and the participating entity shall comply with the applicable requirements as set forth in Arkansas Code Annotated §23-63-18 *et seq* and Arkansas Rule 85 regarding recoupment of paid claims.

Provisions applicable to benefit contracts regulated by the State of Arkansas but not subject to Arkansas HMO laws:

- 1. Continuity of Care After Termination.** If the agreement between you and us is terminated for any reason, you shall continue the provision of health care services to an enrollee who is receiving care from you 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 enrollee ceases to be covered by us. You shall be reimbursed in accordance with the agreement between you and us for all such health care services rendered subsequent to the termination of that agreement.
- 2. Communication with Enrollees.** Nothing in the agreement between you and us shall be construed as prohibiting, restricting or penalizing you in any way for disclosing to an enrollee any health care information that you deem 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 us in the agreement between you and us.
- 3. Provider Input.** As requested by us, you shall provide input to us regarding our medical policy, utilization review criteria and procedures, quality and credentialing criteria and medical management procedures.
- 4. Prompt Pay.** We and the participating entity shall pay claims in accordance with the claims processing and payment provisions contained in Arkansas Insurance Department Rule and Regulation 43, Unfair Claims Settlement Practices, Sections 11-15.
- 5. Recoupment.** You, we and the participating entity shall comply with the applicable requirements as set forth in Arkansas Code Annotated §23-63-18 *et seq* and Arkansas Rule 85 regarding recoupment of paid claims.

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-126586695

State: Arkansas

Filing Company: UnitedHealthcare of Arkansas, Inc.

State Tracking Number: 45441

Company Tracking Number:

TOI: H21 Health - Other

Sub-TOI: H21.000 Health - Other

Product Name: AR Provider Contract Filing

Project Name/Number: /

Supporting Document Schedules

		Item Status:	Status
			Date:
Bypassed - Item:	Flesch Certification	Approved-Closed	04/20/2010
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status
			Date:
Bypassed - Item:	Application	Approved-Closed	04/20/2010
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status
			Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	04/20/2010
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status
			Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	04/20/2010
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status
			Date:
Satisfied - Item:	Cover Letter and Redlines	Approved-Closed	04/20/2010
Comments:			
Attachments:			
	Cover Letter Provider Contracts 4.15.10.pdf		
	AR ANC_FPA_filing_RVP 03 10 2010.REDLINED.pdf		
	AR MGA_filing_RVP 03 10 2010-REDLINED.pdf		

SERFF Tracking Number: UHLC-126586695

State: Arkansas

Filing Company: UnitedHealthcare of Arkansas, Inc.

State Tracking Number: 45441

Company Tracking Number:

TOI: H21 Health - Other

Sub-TOI: H21.000 Health - Other

Product Name: AR Provider Contract Filing

Project Name/Number: /

AR SMGA _filing_ RVP 03 10 2010-REDLINED.pdf

AR-SPA PAT _filing_ RVP 03 10 2010-REDLINED.pdf

April 15, 2010,

Via U.S. Mail

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

NAIC: 95446 UnitedHealthcare of Arkansas, Inc.®

Form # UHC/SMGA. 03.10 AR
UHC/SPA.PAT 03.10 AR
UHC/FPA.ANC.AR.03.10
UHC/MGA. 03.10 AR

Dear Ms. Minor,

On behalf of UnitedHealthcare of Arkansas, Inc., please accept this correspondence as a submission of the above referenced Provider Agreement Forms ("Agreements") and their corresponding appendices for the Arkansas Insurance Department's ("the Department") review.

This submission has been submitted electronically via SERFF and UnitedHealthcare of Arkansas, Inc. recognizes that we may not implement these forms 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

Facility Participation Agreement

This Agreement is entered into by and between UnitedHealthcare Insurance Company, contracting on behalf of itself, UnitedHealthcare of Arkansas, Inc., [\[UnitedHealthcare Plan of the River Valley, Inc.\]](#) and the other entities that are United's Affiliates (collectively referred to as "United") [including without limitation those affiliates listed in Exhibit 1] and _____ ("Facility").

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

- i) _____, ~~200~~[201](#) or
- ii) the first day of the first calendar month that begins at least 30 days after the date when this Agreement has been executed by all parties.

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

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

The parties therefore enter into this Agreement.

Article I. **Definitions**

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

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

1.2 "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 fee for health care services charged by Facility that does not exceed the fee Facility would ordinarily charge another person regardless of whether the person is a Customer.

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

1.5 "Payment Policies" are the guidelines adopted by United outside of this Agreement for calculating payment of claims to facilities (including claims of Facility under this Agreement).

The Payment Policies may change from time to time as discussed in section 5.1 of this Agreement.

1.6 “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 Facility’s services under this Agreement.

1.7 “Protocols” are the programs, protocols and administrative procedures adopted by United or a Payer to be followed by Facility 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 4.4 of this Agreement.

1.8 “United’s Affiliates” are those entities controlling, controlled by, or under common control with UnitedHealthcare Insurance Company.

Article II. **Representations and Warranties**

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

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

b) Facility has all requisite corporate power and authority to conduct its business as presently conducted, and to execute, deliver and perform its obligations under this Agreement. The execution, delivery and performance of this Agreement by Facility have been duly and validly authorized by all action necessary under its organizational documents and applicable corporate law. This Agreement has been duly and validly executed and delivered by Facility and (assuming the due authorization, execution and delivery of this Agreement by United) constitutes a valid and binding obligation of Facility, enforceable against Facility in accordance with its terms, except as such enforceability may be limited by the availability of equitable remedies or defenses and by applicable bankruptcy, insolvency, reorganization, moratorium or similar laws affecting the enforcement of creditors' rights generally.

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

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

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

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

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

b) United has all requisite corporate power and authority to conduct its business as presently conducted, and to execute, deliver and perform its obligations under this Agreement. The execution, delivery and performance of this Agreement by United have been duly and validly authorized by all action necessary under its organizational documents and applicable corporate law. This Agreement has been duly and validly executed and delivered by United and (assuming the due authorization, execution and delivery of this Agreement by Facility) constitutes a valid and binding obligation of United, enforceable against United in accordance with its terms, except as such enforceability may be limited by the availability of equitable remedies or defenses and by applicable bankruptcy, insolvency, reorganization, moratorium or similar laws affecting the enforcement of creditors' rights generally.

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

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

Article III. **Applicability of this Agreement**

3.1 Facility's Services. This Agreement applies to Covered Services provided at Facility's service locations set forth in Appendix 1. In the event Facility begins providing services at other locations, or under other tax identification number(s), (either by operating such locations itself, or by acquiring, merging or affiliating with an existing provider 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 tax identification numbers, or locations will become subject to this Agreement only upon the written agreement of the parties.

Ancillary Only (but not Lab): Replace paragraph above with the following:

3.1 Facility's Services. This Agreement applies to Covered Services provided at Facility's service locations set forth in Appendix 1. In the event Facility begins providing services at other locations, new types of facilities, or under other tax identification number(s), (either by operating such locations itself, or by acquiring, merging or affiliating with an existing provider 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 tax identification numbers, new types of facilities, or locations, will become subject to this Agreement only upon the written agreement of the parties. For purposes of this Section 3.1, types of facilities shall include

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

Ancillary Only: Replace paragraph above with the following: In the event Facility acquires or is acquired by, merges with, or otherwise becomes affiliated with another provider of health care services that is already under contract with United or one of United's Affiliates to participate in a network of health care providers, the payment rates set forth in the applicable Payment Appendix to this Agreement shall remain in effect for each of Facility's locations specified in this Agreement and the payment rates for the acquired provider shall be the lesser of (1) the rates set forth in the other agreement, or (2) the rates set forth in the applicable Payment Appendix to this Agreement.

Facility may transfer all or some of its assets to another entity, with the result that all or some of the Covered Services subject to this Agreement will be rendered by the other entity rather than by Facility, but only if Facility 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 9.4 of this Agreement to elect whether to approve the assignment of this Agreement.

Ancillary Only: Replace paragraph above with the following:

Facility will not transfer all or some of its assets to any other entity during the term of this Agreement, with the result that all or some of the Covered Services subject to this Agreement will be rendered by the other entity rather than by Facility, without the express written agreement of United.

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

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

This section does not authorize Facility to bill or collect from Customers for Covered Services for which claims are denied or otherwise not paid. That issue is addressed in sections 6.5 and 6.8 of this Agreement.

3.4 Patients who are not Customers. This Agreement does not apply to services rendered to patients who are not Customers at the time the services were rendered. Section 6.6 of this Agreement addresses circumstances in which claims for services rendered to such persons are inadvertently paid.

(Ancillary Provider Only)

3.5 Health Care. Facility acknowledges that this Agreement and Customer Benefit Plans do not dictate the health care provided by Facility, or govern a physician's or hospital'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 a hospital and with Customers and their physicians, and not with United or any Payer.

3.5 Health Care. Facility acknowledges that this Agreement and Customer Benefit Plans do not dictate the health care provided by Facility, or govern Facility'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 Facility and with Customers and their physicians, and not with United or any Payer.

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

ANCILLARY ONLY Add the following:

Remove this clause for ancillary providers that do not provide this service

[3.7 Services Rendered by a Facility that is a provider of emergency transport and other related health care services. The following provisions of this Agreement do not apply to services rendered by a Facility that is a provider of emergency transport and other related health care services when taking Customer to the nearest emergency facility in an emergent situation in order for Customer to be stabilized and to receive screening examinations:

i) the requirement in section 3.3 that Facility first obtain the Customer's written consent in order to seek and collect payment from a Customer for non-covered services (however, Facility shall obtain the Customer's consent as soon as it is reasonable to do so consistent with Facility's legal obligations regarding the provision of emergency transport and other related health care services when taking Customer to the nearest emergency facility in an emergent situation in order for Customer to be stabilized and to receive screening examinations and then, only if the consent is

not obtained by the admissions personnel of the emergency facility to which the Customer is brought);

ii) the statement in section 3.5 that the decision regarding what care is to be provided remains with Facility and with Customers and their physicians. Instead the decision regarding what care is to be provided remains with Facility and with Customers to the extent they are able to discuss the care to be provided by Facility;

iii) the requirements in Section 4.3; however, Facility will provide services 24 hours a day, seven days a week;

iv) Sections 4.4.1 and ~~4.4.4.4.3~~;

v) the requirement in section 4.9 that Facility obtain the Customer's consent to authorize Facility to provide access to requested information or records as contemplated in section 4.10 (however, Facility shall obtain the Customer's consent as soon as it is reasonable to do so consistent with Facility's legal obligations regarding the provision of emergency transport and other related health care services when taking Customer to the nearest emergency facility in an emergent situation in order for Customer to be stabilized and to receive screening examinations and then, only if the Facility keeps medical records);

vi) the requirements in section 4.10 regarding medical records (but only if Facility does not keep medical records because such records are instead kept by the emergency facility to which the Customer is brought);

vii) the requirements in Section 4.11 regarding certain quality data (but only if Facility does not collect and review such quality data because the collection and review of such quality data is instead done by the emergency facility to which the Customer is brought);

viii) the requirement in section 6.6 that, prior to rendering services, Facility ask the patient to present his or her Customer identification card (however, Facility shall ask patient to present his or her Customer identification card as soon as it is reasonable to do so consistent with Facility's legal obligations regarding the provision of emergency transport and other related health care services when taking Customer to the nearest emergency facility in an emergent situation in order for Customer to be stabilized and to receive screening examinations and then, only if the role is not instead played by the admissions personnel of the emergency facility to which the Customer is brought).]

Article IV. **Duties of Facility**

4.1 Provide Covered Services. Facility will provide Covered Services to Customers. Facility must be in compliance with section 2.1(d) of this Agreement and credentialed by United or its delegate prior to furnishing any Covered Services to Customers under this Agreement.

4.2 Nondiscrimination. Facility 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.

4.3 Accessibility. Facility will be open 24 hours a day, seven days a week.

Ancillary_Replace the above 4.3 with the following:

[4.3 Accessibility. At a minimum, Facility will be open during normal business hours, Monday through Friday.]

4.4 Cooperation with Protocols. Facility 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) Facility will use reasonable commercial efforts to direct Customers only to other providers that participate in United's network, except as permitted under the Customer's Benefit Plan or otherwise authorized by United or Payer.
- 2) Facility will make its best efforts to assure that all Facility-based physician groups participate in United's network as long as this Agreement is in effect.

In the event that a Facility-based physician group is not a participating provider with United, Facility's Chief Financial Officer or equivalent senior level officer ("Facility Representative") will assist United in its efforts to negotiate an agreement with such group. Upon request by United, Facility Representative will:

- a) meet with Facility-based physician group to encourage participation. Facility Representative shall provide United with meeting minutes of any such meeting within 15 days. Meeting minutes will include a summary of the key discussion points and an outline of any actionable resolution options deemed by Facility Representative.
- b) write letter(s) to Facility-based physician group encouraging the group to negotiate in good faith with United. The letter will also outline any contractual requirements in the agreement between Facility and Facility-based physician group that requires Facility-based physician group to (1) negotiate in good faith with third party payers, (2) participate in third party payer networks, and (3) other provisions related to Facility-based physician group's participation with third party payers.
- c) invoke any applicable penalties or other contractual terms in its agreement with Facility-based physician group related to its non-participating status with a third party payer.
- d) allow independent legal counsel (mutually agreeable to all relevant parties) to review Facility/Facility-based physician agreement to ensure Facility is fully invoking all the relevant terms and conditions of such agreement to require or promote Facility-based physician group's participation status with United.

United warrants that it will negotiate with Facility-based physician groups in good faith. Facility acknowledges that United will have no responsibility for the credentialing of any employed or sub-contracted Facility-based provider.

- 3) Facility 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 Facility 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.

United may change the Protocols from time to time. United will use reasonable commercial efforts to inform Facility at least 30 days in advance of any material changes to the Protocols. United may implement changes in the Protocols without Facility's consent if such change is applicable to all or substantially all of the facilities in United's network located in the same state as Facility. Otherwise, changes to the Protocols proposed by United to be applicable to Facility are subject to the terms of section 9.2 of this Agreement applicable to amendments.

4.5 Employees and subcontractors. Facility will assure that its employees, affiliates and any individuals or entities subcontracted by Facility 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 Facility's obligations and accountability under this Agreement with regard to such services. Facility affiliates are those entities that control, are controlled by or are under common control with Facility.

4.6 Licensure. Facility will maintain, without material restriction, such licensure, registration, and permits as are necessary to enable Facility to lawfully perform this Agreement. In addition, Facility shall either: (1) obtain and maintain ~~JCAHO~~[The Joint Commission](#) accreditation; or (2) in lieu of ~~JCAHO~~[The Joint Commission](#) accreditation, adopt CMS National Hospital Voluntary Reporting Initiative (NQF Core Measures).

4.7 Liability Insurance. Facility shall procure and maintain liability insurance. Except to the extent coverage is a state mandated placement, Facility's 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. Facility's liability insurance shall be, at a minimum, of the types and in the amounts set forth below. Facility's 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, Facility shall submit to United in writing evidence of insurance coverage.

<u>TYPE OF INSURANCE</u>	<u>MINIMUM LIMITS</u>
Medical malpractice and/or professional liability insurance	Five Million Dollars (\$5,000,000.00) per occurrence and aggregate
Commercial general and/or umbrella liability insurance	Five Million Dollars (\$5,000,000.00) per occurrence and aggregate

In lieu of purchasing the insurance coverage required in this section, Facility may, with the prior written approval of United, self-insure its medical malpractice and/or professional liability, as

well as its commercial general liability. Facility shall maintain a separate reserve for its self-insurance. Prior to the Effective Date, Facility shall provide 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. Facility will provide a similar statement during the term of this Agreement upon United's request, which will be made no more frequently than annually. Facility will assure that its self-insurance fund will comply with applicable laws and regulations.

4.8 Notice. Facility will give notice to United within 10 days after any event that causes Facility to be out of compliance with section 4.6 or 4.7 of this Agreement, or of any change in Facility's name, ownership, control, or Taxpayer Identification Number. [In addition, Facility will give written notice to United 45 days prior to the effective date of changes in existing remit address(es) and other demographic information. *[Lab Only Additional language:* United shall have the right to terminate this Agreement upon ten (10) days written notice to Facility in the event there is any change in the controlling interest of Facility modifying the percentage ownership interest outlined in Exhibit 2 to this Agreement.] This section does not apply to changes of ownership or control that result in Facility being owned or controlled by an entity with which it was already affiliated prior to the change.

[4.9 Customer consent to release of medical record information. Facility will obtain any Customer consent required in order to authorize Facility to provide access to requested information or records as contemplated in section 4.10 of this Agreement, including copies of the Facility's medical records relating to the care provided to Customer.]

4.10 Maintenance of and Access to Records. Facility will maintain adequate medical, financial and administrative records related to Covered Services rendered by Facility 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.

Facility will provide access to these records as follows:

i) to United or its designees, in connection with United's utilization management/ Care CoordinationSM, quality assurance and improvement and for claims payment and other administrative obligations, including reviewing Facility's compliance with the terms and provisions of this Agreement and appropriate billing practice. Facility 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 Facility, United, or Payers.

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

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

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

United recognizes that Facility has the sole discretion to select the metrics which it will track from time to time and that Facility's primary goal in so tracking is to advance the quality of patient care. If the information that Facility chooses to report on is available in the public domain in a format that includes all data elements required by United, United will obtain quality information directly from the source to whom Facility reported. If the Facility does not report metrics in the public domain, on a quarterly basis, Facility will share these metrics with United as tracked against a database of all discharged, commercial patients (including patients who are not United customers). United may publish this data to entities to which United renders services or seeks to render services, and to Customers. Notwithstanding the foregoing, Facility agrees that it will participate in The Leapfrog Group's annual patient safety survey. **4.12 Compliance with law.** Facility will comply with applicable regulatory requirements, including but not limited to those relating to confidentiality of Customer medical information.

4.13 Electronic connectivity. When made available by United, Facility will do business with United electronically. Facility will use www.unitedhealthcareonline.com to check eligibility status, claims status, and submit requests for claims adjustment for products supported by UnitedHealthcare Online® or other online resources as supported for additional products. Facility agrees to use www.unitedhealthcareonline.com for additional functionalities (for instance, notification of admission) after United informs Facility that such functionalities have become available for the applicable Customer.

4.14. Implementation of Patient Safety Programs. Facility will implement quality programs recommended by nationally recognized third parties (such as The Leapfrog Group and CMS) as designated by United from time-to-time such as The Leapfrog Group's programs related to Computer Physician Order Entry (CPOE), Evidence-based Hospital Referral (EHR), ICU Physician Staffing (IPS), and the 27 other patient safety practices arrived at by national consensus (National Quality Forum Safe Practices).

Ancillary Only: Replace the paragraph(s) above with the following:

[4.14 Implementation of Patient Safety Programs. Facility will implement quality programs recommended by nationally recognized independent third parties on a reasonably prompt basis].

4.15. "Never Events". In the event a "never event" occurs in connection with Facility rendering services to a Customer, Facility will take the steps recommended by the Leapfrog Group. At present, these steps are set forth in the Leapfrog Group's "Position Statement on Never Events" (<http://www.leapfroggroup.org>) and are as follows:

- Apologize to the patient and/or family affected by the never event;

- Report the event to United and to at least one of the following agencies: The Joint Commission, as part of its Sentinel Events policy; state reporting program for medical errors; or a Patient Safety Organization (e.g. Maryland Patient Safety Center);
- Perform a root cause analysis, consistent with instructions from the chosen reporting agency; and
- Waive all costs directly related to the event. In order to waive such costs, Facility will not submit a claim for such costs to United or Payer and will not seek or accept payment for such costs from the Customer or anyone acting on behalf of the Customer.

For purposes of this section 4.15, a "never event" is an event included in the list of 28 "serious reportable events" published by the National Quality Forum (NQF) in October 2006, as the list may be updated from time to time by the NQF and adopted by Leapfrog.

Ancillary Only: Delete section 4.15 and replace with the following:
4.15. This section intentionally left blank.

Article V.

Duties of United and Payers

5.1 Payment of Claims. As described in further detail in Article VI of this Agreement, Payers will pay Facility for rendering Covered Services to Customers. United will make its Payment Policies available to Facility online or upon request. United may change its Payment Policies from time to time.

5.2 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.

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

5.4 Notice. United will give written notice to Facility within 10 days after any event that causes United to be out of compliance with section 5.2 or 5.3 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.

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

5.6 Electronic connectivity United will do business with Facility 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 4.13, and will make information available as to which products are supported by www.unitedhealthcareonline.com.

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

Article VI.

Submission, Processing, and Payment of Claims

6.1 Form and content of claims. Facility must submit claims for Covered Services in a manner and format prescribed by United, as further described in the Protocols. Unless otherwise directed by United, Facility shall submit claims using current [CMS 1500 or] UB04 or successor forms for paper claims and HIPAA standard professional or institutional claim formats for electronic claims, as applicable, with applicable coding including, but not limited to, ICD-9-CM, CPT, Revenue and HCPCS coding.

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

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

6.4 Payment of claims. Payer will pay claims for Covered Services as further described in the applicable Payment Appendix to this Agreement and in accordance with Payment Policies.

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

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

6.5 Denial of Claims for Not Following Protocols ~~or~~, Not Filing Timely, or Lack of Medical Necessity. Payment may be denied in whole or in part if Facility does not comply with a Protocol or does not file a timely claim under section 6.3 of this Agreement. Payment may also be denied for services provided that are determined by United to be medically unnecessary, and Facility may not bill the Customer for such services unless the Customer has, with knowledge of United's determination of a lack of medical necessity, agreed in writing to be responsible for payment of those charges.

In the event that payment of a claim is denied for lack of notification or for untimely filing, the denial will be reversed if Facility 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, Facility did not know and was unable to reasonably determine that the patient was a Customer,
- ii) that Facility took reasonable steps to learn that the patient was a Customer, and
- iii) that Facility promptly provided notification, or filed the claim, after learning that the patient was a Customer.

6.6 Retroactive correction of information regarding whether patient is a Customer. Prior to rendering services, Facility shall ask the patient to present his or her Customer identification card. In addition, Facility may contact United to obtain the most current information on the patient as a Customer.

However, Facility 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 Facility 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 6.10 of this Agreement. Facility may then directly bill the individual, or other responsible party, for such services.

6.7 Payment under this Agreement is payment in full. Payment as provided under section 6.4, 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. Facility 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 6.7, regardless of whether such amount is less than Facility's billed charge or Customary Charge.

6.8 Customer "Hold Harmless." Facility 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 Facility's billed charge or Customary Charge, or for any amounts denied or not paid under this Agreement due to:

- i) Facility's failure to comply with the Protocols,
- ii) Facility's failure to file a timely claim,
- iii) Payer's Payment Policies,
- iv) inaccurate or incorrect claim processing,

- v) insolvency or other failure by Payer to maintain its obligation to fund claims payments, if Payer is United, or is an entity required by applicable law to assure that its Customers not be billed in such circumstances. .or
- vi) a denial based on medical necessity or prior authorization, except as provided in section 6.5.

This obligation to refrain from billing Customers applies even in those cases in which Facility believes that United or Payer has made an incorrect determination. In such cases, Facility 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 clause v) of this Section 6.8, Facility may seek payment directly from the Payer or from Customers covered by that Payer. However, Facility 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), Facility then gives United 15 days prior written notice of Facility'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 6.8 and section 6.7 will survive the termination of this Agreement, with regard to Covered Services rendered prior to when the termination takes effect.

6.9 Consequences for failure to adhere to Customer protection requirements. If Facility 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 6.7 or 6.8 of this Agreement, Facility shall be in breach of this Agreement. This section 6.9 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 Facility to collect such payment from Customer.

In the event of such a breach, Payer may deduct, from any amounts otherwise due Facility, the amount wrongfully collected from Customers, and may also deduct an amount equal to any costs or expenses incurred by the Customer, United or Payer in defending the Customer from such action and otherwise enforcing sections 6.7 through 6.9 of this Agreement. Any amounts deducted by Payer in accordance with this provision shall be used to reimburse the Customer and to satisfy any costs incurred. The remedy contained in this paragraph does not preclude United from invoking any other remedy for breach that may be available under this Agreement.

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

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

Article VII.
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 before a panel of three arbitrators in accordance with the Commercial Dispute Procedures of the American Arbitration Association, as they may be amended from time to time (see <http://www.adr.org>). Unless otherwise agreed to in writing by the parties, the party wishing to pursue the Dispute must initiate the arbitration within one year after the date on which notice of the Dispute was given or shall be deemed to have waived its right to pursue the dispute in any forum.

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

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

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

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

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

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

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

Article VIII.
Term and Termination

8.1 Term. This Agreement shall take effect on the Effective Date. This Agreement shall have an initial term of three years and renew automatically for renewal terms of one year, until terminated pursuant to section 8.2.

For local market Ancillary Provider:

[8.1 Term. This Agreement shall take effect on the Effective Date. This Agreement shall have an initial term of one year and renew automatically for renewal terms of one year, until terminated pursuant to section 8.2.]

8.2 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 180 days prior written notice, effective at the end of the initial term or effective at the end of any renewal term;

Local Ancillary Only

[ii) by either party, upon 90 days written notice, effective at the end of the initial term or 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 VII 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 4.7 or section 5.2 of this Agreement; or
- v) by United upon 10 days written notice in the event Facility loses accreditation.
- vi) By United, upon 90 days notice, in the event:
 - a) Facility loses approval for participation under United’s credentialing plan, or
 - b) Facility does not successfully complete the United’s re-credentialing process as required by the credentialing plan.

8.3 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, Facility 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 –	Through postpartum follow up

Moderate Risk and High Risk	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 Facility after Facility leaves the provider network accessed by Payer.	As applicable

Article IX.
Miscellaneous Provisions

9.1 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.

Ancillary only: [9.1 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, except that this Agreement does not supersede a national agreement between the parties or their affiliates.]

9.2 Amendment. This Agreement may only be amended in a writing signed by both parties, except that this Agreement may be unilaterally amended by United upon written notice to Facility in order to comply with applicable regulatory requirements. 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.

9.3 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.

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

9.5 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.

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

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

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

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

- a) any proprietary business information, not available to the general public, obtained by the party from the other party; or
- b) 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.

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

National Ancillary Agreements Only- Replace the above paragraph with the following:
[9.10 Governing Law. This Agreement will be governed by and construed in accordance with the laws of the State of Minnesota, and any other applicable law.]

9.11 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 regulatory appendix will control, to the extent it is applicable.

9.12 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.

9.13 Survival. Sections 4.10, 6.7, 6.8, Article VII and sections 8.3 and 9.9 (except for the last paragraph) of this Agreement will survive the termination of this Agreement.

Lab only

9.14 or 9.15 Data Services. The parties incorporate by reference the Data Services Appendix attached to this Agreement.

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

[Facility] *Address to be used for giving notice to Facility under the Agreement:*

Signature _____ Street _____
e _____

Print Name _____ City _____

Title _____ State _____ Zip Code _____

Date _____ E-mail _____
_____ mail _____

UnitedHealthcare Insurance Company, on behalf of itself, UnitedHealthcare of Arkansas, Inc., [UnitedHealthcare Plan of the River Valley, Inc.,] and its other affiliates [including without limitation those affiliates listed in Exhibit 1], as signed by its authorized representative:

Signature _____ Signature _____

Print Name _____ Print Name _____

Title _____ Title: _____

Date _____ Date _____

[Address to be used for giving notice to United under the Agreement]
Street _____
City _____
State _____ *Zip Code* _____

IN THE EVENT THIS AGREEMENT INCLUDES TWO SIGNATURE BLOCKS FOR UNITED, THIS AGREEMENT IS NOT BINDING UPON UNITED UNLESS EACH OF THE TWO UNITED SIGNATURE BLOCKS ARE EXECUTED.

Attachments

- ___ Appendix 1: Facility Location and Service Listings
- ___ Appendix 2: Benefit Plan Descriptions
- ___ [Appendix (ies) 3: Fee Schedule Samples (1500 billers only)]

___ [Appendix 3 [4]: Additional Protocols]

___ State Regulatory Requirements Appendix (list all states as applicable)

- ___ All Payer Appendix (Appendices)
- ___ Medicare Advantage Regulatory Requirements Appendix
- ___ Medicare Advantage Payment Appendix
- ___ Medicare Select Payment Appendix
- ___ [Medicaid Regulatory Requirements Appendix]
- ___ [Medicaid Payment Appendix]
- ___ Other _____

___ Exhibit 1 United Affiliates Licensed as an Insurance Company or HMO *National Ancillary only*

___ Exhibit 2 Ownership Attestation *Lab only*

IMPORTANT NOTE: Facility acknowledges its obligation under Section 4.8 to promptly report any change in Facility's name or Taxpayer Identification Number. Failure to do so may result in denial of claims or incorrect payment.

**Appendix 1
Facility Location and Service Listings**

[Facility System Name]

BILLING ADDRESS

[Facility Name]
[Street Address]
[City, State Zip]
[TIN]
[NPI]

[FACILITY LOCATIONS]

[Facility Name]
[Street Address]
[City, State Zip]
[Phone #]
[TIN]

[Facility Name]
[Street Address]
[City, State Zip]
[Phone #]
[TIN]

[Facility Name]
[Street Address]
[City, State Zip]
[Phone #]
[TIN]

[OTHER SERVICE LOCATIONS]

[Facility Name]
[Street Address]
[City, State Zip]
[Phone #]
[TIN]

[Facility Name]
[Street Address]
[City, State Zip]
[Phone #]
[TIN]

[Facility Name]
[Street Address]
[City, State Zip]
[Phone #]
[TIN]

Appendix 2 Benefit Plan Descriptions

United may allow Payers to access Facility's services under this Agreement for the Benefit Plan types listed 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.]
- [Benefit Plans for Workers' compensation benefit programs]
- [Benefit Plans for Medicare Select.]

Facility 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.
- [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"). Note: Although Medicare Benefit Contracts, as described above, are excluded from this Agreement, there can be a separate agreement between United and Facility or between United's affiliates and Facility's affiliates providing for Facility's participation in a network for certain of those Medicare Benefit Plans.]
- [Benefit Plans for Workers' compensation benefit programs]
- [Benefit Plans for Medicare Select.]

[Appendix 3

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

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

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

[Appendix 3

Fee Schedule Sample: Options PPO

Representative Options PPO Fee Schedule Sample : [*Fee Schedule ID*]

The provisions of this fee schedule apply to Covered Services rendered by Facility to Customers covered by Benefit Plans marketed under the name “Options PPO” and Benefit Plans where Customers are not offered a network of participating physicians and other health care professionals from which they may receive Covered Services.

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

Fee Schedule Sample: Products other than Options PPO

Representative ~~Options PPO~~ All Payer Fee Schedule Sample: [*Fee Schedule ID*]

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

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

[Appendix 3

Representative Medicare Fee Schedule Sample [*Fee Schedule ID*]

The provisions of this fee schedule apply to services rendered by Facility to Medicare Customers covered by 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. The provisions of this fee schedule do not apply to services Facility renders to Medicare beneficiaries pursuant to a commercial Benefit Plan.

United will use best efforts to update the amounts for services listed in the attached fee schedule that are based on the CMS physician Medicare fee schedule on or before the later of (a) ninety (90) days after the effective date of any modification made by CMS to the CMS physician Medicare fee schedule; provided, however, in the event CMS makes a change to such modification after the effective date of such modification, United will use best efforts to update the methodology and factors in accordance with such subsequent change within ninety (90) days after the date on which CMS places information regarding such subsequent change in the public domain, or (b) ninety (90) days after the date on which CMS initially place information regarding such modification in the public domain (e.g., CMS distributes program memoranda to providers).

Amounts listed in the attached sample fee schedule are gross amounts. Any co-payments, deductibles or coinsurance that the Medicare Customer is responsible to pay under his or her Benefit Plan will be subtracted from the amount listed in the attached sample fee schedule in determining the amount to be paid by the Payer. The actual payment amount is also subject to matters described in our Agreement, including Payment Policies. This information is subject to the confidentiality provisions of this Agreement.]

[Appendix [4]]
Additional Protocols

Protocols for the Customers of the River Valley Entities:

UnitedHealthcare Services Company of the River Valley, Inc., UnitedHealthcare Plan of the River Valley, Inc., and UnitedHealthcare Insurance Company of the River Valley (collectively referred to as “River Valley Entities”) were acquired and became United Affiliates.

For Customers enrolled in Benefit Plans (other than Medicare Benefit Plans) issued by the River Valley Entities or under which a River Valley Entity provides administrative services under an agreement with a Payer and included in this Agreement as set forth in Appendix 2, Facility will be subject to the programs, protocols and administrative procedures described in or made available to Facility through the River Valley Provider Manual (the “River Valley Manual”) and the Payment Policies of the River Valley Entities. When the Agreement refers to the administrative manual or guide, it is also referring to the River Valley Manual. The River Valley Manual is available to Facility upon request or online at <https://www.uhcrivervalley.com>. In the event of any conflict between the River Valley Manual or River Valley Payment Policies on the one hand and any of the following: the Agreement, any United programs, protocols, administrative procedures (including payment policies and guidelines for calculating payments), or the UnitedHealthcare Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide (the “Administrative Manual”) in connection with any matter pertaining to a Customer enrolled in a Benefit Plan (other than a Medicare Benefit Plan) issued by the River Valley Entities, the River Valley Manual or River Valley Payment Policies, as applicable, shall govern, unless applicable statutes or regulations dictate otherwise. United may make changes to the Administrative Manual, River Valley Manual or other administrative protocols and River Valley Payment Policies upon 30 days’ electronic or written notice to Facility.]

For use with Lab agreements only:

Exhibit 2

ATTESTATION OF {NAME OF LAB}

State of _____

County of { }

Before me the undersigned Notary appeared _____, who being either known personally to me and/or presenting proper identification, was duly sworn by me and testified as follows:

(1) “My name is _____. I am over the age of 18, fully competent to give this Attestation and have personal knowledge of the facts stated in it.”

(2) “I hereby certify that {ENTITY NAME or NAME OF LAB} has XX% ownership of the {NAME OF THE LAB}.”

(3) “I hereby certify that the following entities have the following percentage ownership of the {NAME OF THE LAB}: {List all entities and percentage ownership}.”

(4) “I hereby certify that at no time will there be any change in the controlling interest modifying the current percentage ownership as set forth herein of the {NAME OF THE LAB}.”

(5) “I hereby certify that at no time will the {NAME OF THE LAB} assets, liabilities, revenues and expenses be consolidated from {NAME OF THE LAB} to any other laboratory or its affiliates such that all or some of the Covered Services subject to the Agreement will be rendered by such other laboratory or its affiliates.”

Further this Affiant sayeth not.

Signed this _____ day of _____, 200_.

[Affiant signature]

Notary Stamp/Certification

Notary Signature

Date of Notary’s Signature

Expiration date of Notary authority

Medical Group Participation Agreement

This Agreement is entered into by and between ~~United HealthCare~~ UnitedHealthcare Insurance Company, contracting on behalf of itself, ~~United HealthCare~~ UnitedHealthcare of Arkansas, Inc., [UnitedHealthcare Plan of the River Valley, Inc.] and the other entities that are United's Affiliates (collectively referred to as "United"), and _____ ("Medical Group").

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

- i) _____, ~~200~~201 or
- ii) _____ the first day of the first calendar month that begins at least 30 days after the date when this Agreement has been executed by all parties.

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, whether delivered in paper, electronic, or other format, under which a Payer is obligated to provide coverage of Covered Services for a Customer.

1.2 "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 fee for health care services charged by Medical Group that does not exceed the fee Medical Group would ordinarily charge another person regardless of whether the person is a Customer.

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 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 ~~a person or~~ 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.

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~~ [UnitedHealthcare](#) Insurance Company.

Article II. **Representations and Warranties**

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

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

(b) Medical Group has all requisite corporate power and authority to conduct its business as presently conducted, and to execute, deliver and perform its obligations under this

Agreement. The execution, delivery and performance of this Agreement by Medical Group have been duly and validly authorized by all action necessary under its organizational documents and applicable corporate law.

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

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

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

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

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

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

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

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

Article III.
Applicability of this Agreement

3.1 Medical Group's Services. 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 opening such locations itself, or by acquiring, merging or coming under common ownership and control with an existing provider of services that was not already under contract with United or one of United's Affiliates to participate in a network of health care providers), such additional locations will become subject to this Agreement 30 days after United receives the notice required under section 5.7(v) of this Agreement.

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

Medical Group may transfer all or some of its assets to another entity, if the result of such transfer would be that all or some of the Covered Services subject to this Agreement will be rendered by the other entity rather than by 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 Payers and Benefit Plan types. United may allow Payers to access Medical Group's services under this Agreement for the Benefit Plan types described in Appendix 2. Appendix 2 may be modified by United upon 30 days written or electronic notice.

3.3 Services not covered under a Benefit Plan. This Agreement does not apply to services not covered under the applicable Benefit Plan. Medical Group may seek and collect payment from a Customer for such services, provided that the Medical Group first obtain 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.

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

3.5 Health Care. Medical Group acknowledges that this Agreement and Customer Benefit Plans 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 ~~OH~~ Customers, and not with United or any Payer.

3.6 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.

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. 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 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 Protocols applicable to Customers enrolled in certain Benefit Plans.](#)

United may change the Protocols from time to time. United will use reasonable commercial efforts to inform 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.

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	Three Million Dollars (\$3,000,000.00) per occurrence and 5 Million Dollars aggregate (\$5,000,000.00), if Medical Group insures all Medical Group Professionals in a single policy [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 One Million Dollars (\$1,000,000.00) per occurrence and 3 Million Dollars (\$3,000,000.00) aggregate]
Commercial general and/or umbrella liability insurance	One Million Dollars (\$1,000,000.00) per occurrence and aggregate

In lieu of purchasing the insurance coverage required in this section, 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.

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

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

United recognizes that Medical Group has the sole discretion to select the metrics which it will track from time to time and that Medical Group's primary goal in so tracking is to advance the

quality of patient care. ~~On~~If the information that Medical Group chooses to report on is available in the public domain in a format that includes all data elements required by United, United will obtain quality information directly from the source to whom Medical Group reported. If the Medical Group does not report metrics in the public domain, on a quarterly basis, Medical Group will share these metrics with United as tracked against a database of all commercial patients (including patients who are not United customers). United may publish this data to entities to which United renders services or seeks to render services, and to Customers.

5.11 Compliance with law. 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 ~~communicate~~do business with United electronically. Medical Group will use www.unitedhealthcareonline.com to check eligibility status, claims status, and submit requests for claims adjustments for Customers enrolled in products supported by www.unitedhealthcareonline.com. Medical Group agrees to use 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 regulatory requirements, including but not limited to those relating to confidentiality of Customer medical information and those relating to prompt payment of claims, to the extent those requirements are applicable.

6.6 Electronic connectivity. United will ~~communicate~~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.

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 manner and format prescribed by United, as further described in the Protocols. Unless otherwise directed by United, Medical Group shall submit claims using current CMS 1500 [form](#) or ~~UB92 forms~~its successor for paper claims and HIPAA standard professional or institutional claim formats for electronic claims, as applicable, with applicable coding including, but not limited to, ICD, CPT, Revenue and HCPCS coding.

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 six 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.

~~In the event the Centers for Medicare and Medicaid Services, in administering the fee for service Medicare program, adopts a paper claim user fee, this Agreement will incorporate the same approach, effective on the same date as it becomes effective for the fee for service Medicare program.~~

7.3 Time to file claims. All information necessary to process a claim must be received by United no more than 90 days from the date that Covered Services are rendered. In the event United requests additional information in order to process the claim, Medical Group will provide such additional information within 90 days of United's request. If Payer is not the primary payer, and Medical Group is pursuing payment from the primary payer, the 90 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 lesser of Medical Group's Customary Charge or the applicable fee schedule (as further described in Appendix 3 to this Agreement), and in accordance with Payment Policies.

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

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

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

United routinely updates its fee schedule in response to additions, deletions, and changes to CPT codes by the American Medical Association, price changes for immunizations and injectable medications, and in response to similar changes (additions and revisions) to other service coding and reporting conventions that are widely used in the health care industry, such as those maintained by the Centers for Medicaid and Medicare Services (for example HCPCS, etc.). Ordinarily, United's fee schedule is updated using similar methodologies for similar services. United will not generally attempt to communicate routine maintenance of this nature and will generally implement updates within 90 days from the date of publication.

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

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

7.5 Denial of Claims for Not Following Protocols ~~or~~, 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 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.

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, regardless of whether such amount is less than Medical Group's billed charge or 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 Customary 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) inaccurate or incorrect claim processing,
- v) insolvency or other failure by Payer to maintain its obligation to fund claims payments, if Payer is United, or is an entity required by applicable law to assure that its Customers not be billed in such circumstances, or
- vi) a denial based on medical necessity or prior authorization, except as permitted under section 7.5.

This obligation to refrain from billing Customers applies even in those cases in which 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 v), 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), 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, Payer may deduct, from any amounts otherwise due Medical Group, the amount wrongfully collected from Customers, and may also deduct an amount equal to any costs or expenses incurred by the Customer, United or Payer in defending the Customer from such action and otherwise enforcing sections 7.7 through 7.9 of this Agreement. Any amounts deducted by Payer in accordance with this provision shall be used to reimburse the Customer and to satisfy any costs incurred. The remedy contained in this paragraph does not preclude United from invoking any other remedy for breach that may be available under this Agreement.

7.10 Correction of overpayments or underpayments of claims. In the event that either Party believes that a claim has not been paid correctly, or that funds were paid beyond or outside of what is provided for under this Agreement, either party may seek correction of the payment, except that Medical Group may not seek correction of a payment more than 12 months after it was made.

Medical Group will repay overpayments within 30 days of notice of the 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 30 days after posting it as a credit balance.

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

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 Medical Group fails to do so, United may hold Medical Group liable for any attorneys fees, costs, or administrative expenses incurred by United as a result.

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

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

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

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

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

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

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

Article IX.
Term and Termination

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

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

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

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

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

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

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

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

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

10.8 Notice. Any notice required to be given under this Agreement shall be in writing, except in cases in which this Agreement specifically permits electronic notice, or as otherwise permitted or required in the Protocols. All written or electronic notices shall be deemed to have been given

when delivered in person, by electronic communication, by facsimile or, if delivered by first-class United States mail, on the date mailed, proper postage prepaid and properly addressed to the appropriate party at the address set forth on the signature portion of this Agreement or to another more recent address of which the sending party has received written notice. Notwithstanding the previous sentence, all notices of termination of this Agreement by either party must be sent by certified mail, return receipt requested.

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

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

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

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

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

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

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

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

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

[Medical Group]

Signature _____ Street _____

Print Name _____ City _____

Title _____ State _____ Zip Code _____

D/B/A _____ Phone _____

Date _____ E-mail _____

~~United HealthCare~~ UnitedHealthcare Insurance Company, on behalf of itself, UnitedHealthcare of Arkansas, Inc., [UnitedHealthcare Plan of the River Valley, Inc.] and its other affiliates, as signed by its authorized representative:

Signature _____ Signature _____

Print Name _____ Print Name _____

Title _____ Title: _____

Date _____ Date _____

[Attachments](#)

___ Appendix 1: Medical Group Practice Locations

___ Appendix 2: Benefit Plan Descriptions

___ Appendix 3: Fee Schedule Sample

[\[___ Appendix 4: Additional Protocols\]](#)

___ State Regulatory Requirements Appendix (list all states as applicable)

___ Medicare Advantage Regulatory Requirements Appendix

___ Other

Appendix 1
Medical Group Practice Locations

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

IMPORTANT NOTE: Medical Group acknowledges its obligation under Section 4.85.7 to promptly report any change in Medical Group’s name or Taxpayer Identification Number. Failure to do so may result in denial of claims or incorrect payment.

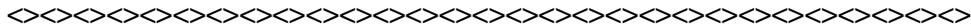
BILLING ADDRESS

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

Practice Name _____
 Street Address _____
 City _____ State _____ Zip _____
 Tax ID Number (TIN) _____
National Provider ID [NPI]

PRACTICE LOCATIONS (complete one for each service location)

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



Clinic Name	Clinic Name	Clinic Name
Street Address	Street Address	Street Address
City	City	City
State and Zip Code	State and Zip Code	State and Zip Code

Phone Number	Phone Number	Phone Number
TIN (If different from above)	TIN (If different from above)	TIN (If different from above)

Appendix 2 Benefit Plan Descriptions

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~~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 ~~where the Benefit Plan is intended to~~and (B) replace, either partially or in its entirety, the ~~traditional~~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.]
- [Benefit Plans for ~~workers~~Workers’ compensation benefit programs]

~~•~~ [Benefit Plans for Medicare Select]

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

- [Medicare Benefit Plans that (A) are sponsored, issued or administered by any Payer ~~where the Benefit Plan is intended to~~and (B) replace, either partially or in its entirety, the ~~traditional~~original Medicare coverage (Medicare Part A and Medicare Part B) issued to beneficiaries by the Centers for Medicare and Medicaid Services (“CMS”). Note: Although Medicare Benefit Contracts, as described above, are excluded from this Agreement, there can be a separate agreement between United and Medical Group or between United’s affiliates and Medical Group’s affiliates providing for Medical Group’s participation in a network for certain of those Medicare Benefit Plans.]
- [Benefit Plans for ~~workers~~Workers’ compensation benefit programs]

~~•~~ [Benefit Plans for Medicare Select.]

Appendix 3

Fee Schedule Sample: Options PPO

Representative ~~All Payer~~Options PPO Fee Schedule Sample for : [insert name of Fee Schedule-~~ID~~]

~~Unless another appendix to this Agreement applies specifically to a particular Benefit Plan as it covers a particular Customer, the~~The provisions of this ~~Appendix~~fee schedule apply to Covered Services *rendered by Medical Group to Customers covered by Benefit Plans* ~~sponsored, issued or administered by all Payers~~marketed under the name "Options PPO" and Benefit Plans where Customers are not offered a network of participating physicians and other health care professionals from which they may receive Covered Services /, except Anesthesia Management covered services rendered by Anesthesia Practitioners. Fee Schedule Sample(s) for Anesthesia Management covered services rendered by Anesthesia Practitioners are described in a separate Exhibit 1 to this Appendix 3.]

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

Appendix 3
Fee Schedule Sample: Products other than Options PPO
Representative All-Payer Fee Schedule Sample(s) for :[insert name of Fee Schedule]

Unless another fee schedule to this Agreement applies specifically to a particular Benefit Plan as it covers a particular Customer, the provisions of this fee schedule apply to Covered Services rendered by Medical Group to Customers covered by Benefit Plans sponsored, issued or administered by all Payers. [except Anesthesia Management Covered Services rendered by Anesthesia Practitioners. Fee Schedule Sample(s) for Anesthesia Management Covered Services rendered by Anesthesia Practitioners are described in a separate Exhibit 1 to this Appendix 3.]

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

[Appendix 3A

For Dates of Service Effective: [mm/dd/yyyy]

Fee Schedule Specifications : : [Fee Schedule ID]

**[Appendix 3, Exhibit 1
Anesthesia Fee Schedule Exhibit: Options PPO**

Representative Options PPO Fee Schedule Sample *[insert name of Fee Schedule]*

The provisions of this exhibit apply to Anesthesia Management Covered Services rendered by Anesthesia Practitioners to Customers covered by Benefit Plans marketed under the name “Options PPO” and Benefit Plans where Customers are not offered a network of participating physicians and other health care professionals from which they may receive Covered Services.

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

**[Appendix 3, Exhibit 1
Anesthesia Fee Schedule Exhibit: Products other than Options PPO**

Representative Fee Schedule Sample *[insert name of Fee Schedule]*

Unless another exhibit to Appendix 3 applies specifically to a particular Benefit Plan as it covers a particular Customer, the provisions of this exhibit apply to Anesthesia Management Covered Services rendered by Anesthesia Practitioners to Customers covered by Benefit Plans sponsored, issued or administered by all Payers.

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

[Appendix 3

Representative Medicare Fee Schedule Sample [Insert Name Of Fee Schedule]

The provisions of this fee schedule apply to services rendered by Medical Group to Medicare Customers covered by 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. The provisions of this fee schedule do not apply to services Medical Group renders to Medicare beneficiaries pursuant to a commercial Benefit Plan.

United will use best efforts to update the amounts for services listed in the attached fee schedule that are based on the CMS physician Medicare fee schedule on or before the later of (a) ninety (90) days after the effective date of any modification made by CMS to the CMS physician Medicare fee schedule; provided, however, in the event CMS makes a change to such modification after the effective date of such modification, United will use best efforts to update the methodology and factors in accordance with such subsequent change within ninety (90) days after the date on which CMS places information regarding such subsequent change in the public domain, or (b) ninety (90) days after the date on which CMS initially place information regarding such modification in the public domain (e.g., CMS distributes program memoranda to providers).

Amounts listed in the attached sample fee schedule are gross amounts. Any co-payments, deductibles or coinsurance that the Medicare Customer is responsible to pay under his or her Benefit Plan will be subtracted from the amount listed in the attached sample fee schedule in determining the amount to be paid by the Payer. The actual payment amount is also subject to matters described in our Agreement, including Payment Policies. This information is subject to the confidentiality provisions of this Agreement.]

[Appendix 4
Additional Protocols

Protocols for the Customers of the River Valley Entities:

UnitedHealthcare Services Company of the River Valley, Inc., UnitedHealthcare Plan of the River Valley, Inc., and UnitedHealthcare Insurance Company of the River Valley (collectively referred to as “River Valley Entities”) were acquired and became United Affiliates.

For Customers enrolled in Benefit Plans (other than Medicare Benefit Plans) issued by the River Valley Entities or under which a River Valley Entity provides administrative services under an agreement with a Payer and included in this Agreement as set forth in Appendix 2, Facility will be subject to the programs, protocols and administrative procedures described in or made available to Facility through the River Valley Provider Manual (the “River Valley Manual”) and the Payment Policies of the River Valley Entities. When the Agreement refers to the administrative manual or guide, it is also referring to the River Valley Manual. The River Valley Manual is available to Facility upon request or online at <https://www.uhcrivervalley.com>. In the event of any conflict between the River Valley Manual or River Valley Payment Policies on the one hand and any of the following: the Agreement, any United programs, protocols, administrative procedures (including payment policies and guidelines for calculating payments), or the UnitedHealthcare Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide (the “Administrative Manual”) in connection with any matter pertaining to a Customer enrolled in a Benefit Plan (other than a Medicare Benefit Plan) issued by the River Valley Entities, the River Valley Manual or River Valley Payment Policies, as applicable, shall govern, unless applicable statutes or regulations dictate otherwise. United may make changes to the Administrative Manual, River Valley Manual or other administrative protocols and River Valley Payment Policies upon 30 days’ electronic or written notice to Facility.]

INTRODUCTION

Our agreement consists of this contract, the appendices, and the additional materials we reference in the attached Appendix 1.

Guiding principles

We strive to operate in accordance with the following principles:

- *We want to work together with America's best physicians to improve the health care experience of our customers.*
- *We respect and support the physician/patient relationship while adhering fairly to the contract for benefits we provide our customers.*
- *Whether a particular treatment is covered under a benefit contract should not determine if the treatment is provided. Physicians and health care professionals should provide the care they believe is necessary regardless of coverage.*
- *You should discuss treatment options with patients regardless of coverage. We encourage that communication.*
- *Physicians should describe any factors that could affect their ability to render appropriate care. Matters such as professional training, financial incentives, availability constraints, religious or philosophical beliefs, and similar matters are all things that a physician should consider discussing with a patient. We encourage these communications. We urge full disclosure.*
- *Fairness and efficiency will govern the ways in which we administer our products. We will make our determinations promptly. Our commitments to our customers will be clear. We will honor our agreements. When it comes to coverage determinations, the language of the benefit contract will take precedence.*

Next steps

Please read this agreement. If you have questions, write to or call:

UnitedHealthcare
Network Management

{ address }

(xxx)xxx-xxxx]

You can visit our website at www.unitedhealthcareonline.com (UnitedHealthcare Online[®]) for additional details on items described in the agreement. If the agreement is acceptable to you, please sign both of the enclosed copies of the contract, and send both copies to the address above.

MEDICAL GROUP CONTRACT

~~United HealthCare~~UnitedHealthcare Insurance Company is entering into this agreement with you. It is doing so on behalf of itself, ~~United HealthCare~~UnitedHealthcare of Arkansas ~~Inc., Inc.~~ [UnitedHealthcare Plan of the River Valley, Inc.,] and its other affiliates for certain products and services we offer our customers, all of which we describe in the attached Appendix 2.

This agreement applies to you and to your professional staff (the physicians and other professionals who are your employees, or your independent contractors providing services to your patients, and who are subject to credentialing by us) and the services you provide at the locations in the attached Appendix 5. When this agreement refers to “you”, it also refers to your professional staff. Your professional staff is bound to the same requirements of this agreement as you are. You represent to us that you have the authority to bind your professional staff to this agreement.

What you will do

You need to be credentialed in accordance with our Credentialing Plan, as referenced in Appendix 1, for the duration of this agreement.

You must notify us in a timely manner about certain services you provide in accordance with our Administrative Guide so that we can provide our customers with the services we have committed to provide. If you do not so notify us about these services, you will not be reimbursed for the services, and you may not charge our customer.

Within one year of the effective date of this agreement, you must conduct business with us entirely on an electronic basis to the extent that we are able to conduct business electronically (described in the Administrative Guide), including but not limited to determining whether your patient is currently a customer, verifying the customer’s benefit, and submitting your claim. We will communicate enhancements in UnitedHealthcare Online® functionality as they become available and will make information available to you as to which products are supported by UnitedHealthcare Online.

You must submit your claims within 90 days of the date of service. After we receive your claim, if we request additional information in order to process your claim, you must submit this additional information within 90 days of our request. If your claim or the additional information is not submitted within these timeframes, you will not be reimbursed for the services, and you may not charge our customer.

You will submit claims only for services performed by you or your staff. Pass through billing is not payable under this agreement and may not be billed to our customer. For laboratory services, you will only be reimbursed for the services that you are certified through the Clinical Laboratory Improvement Amendments (CLIA) to perform, and you must not bill our customers for laboratory services for which you are not certified.

You will submit claims that supply all applicable information. These claims are complete claims. Further information about complete claims is provided in our Administrative Guide.

If you disagree with our payment determination on a claim, you may submit an appeal as described in our Administrative Guide.

You will not charge our customers anything for the services you provide, if those services are covered services under their benefit contract, but the applicable co-pay, coinsurance or deductible amount. If the

services you provide are denied or otherwise not paid due to your failure to notify us, to file a timely claim, to submit a complete claim, to respond to our request for information, or based on our reimbursement policies and methodologies, you may not charge our customer. If the services you provide are denied for reason of not being medically necessary, you may not charge our customer unless our customer has, with knowledge of our determination of a lack of medical necessity, agreed in writing to be responsible for payment of those charges. If the services you provide are not covered under our customer's benefit contract, you may, of course, bill our customer directly. You will not require a customer to pay a "membership fee" or other fee in order to access you for covered services (except for co-payments, coinsurance and/or deductibles provided for under the customer's benefit contract) and will not discriminate against any customer based on the failure to pay such a fee.

You will cooperate with our reasonable requests to provide information that we need. We may need this information to perform our obligations under this agreement, under our programs and agreements with our customers, or as required by regulatory or accreditation agencies.

You will refer customers only to other network physicians and providers, except as permitted under our customer's benefit contract, or as otherwise authorized by us or the participating entity.

What we will do

We or the other applicable participating entity will promptly adjudicate and pay your complete claim for services covered by our customer's benefit contract. If you submit claims that are not complete,

- You may be asked for additional information so that your claim may be adjudicated; or
- Your claim may be denied and you will be notified of the denial and the reason for it; or
- We may in our discretion attempt to complete the claim and have it paid by us or the other applicable participating entity based on the information that you gave in addition to the information we have.

If governing law requires us to pay interest or another penalty for a failure to pay your complete claim for covered services within a certain time frame, we will follow those requirements. The interest or other penalty required by law will be the only additional obligation for not satisfying in a timely manner a payment obligation to you. In addition, if we completed a claim of yours that was not complete, there shall be no interest or other late payment obligation to you even if we subsequently adjust the payment amount based on additional information that you provide.

The applicable participating entity will reimburse you for the services you deliver that our customer's benefit contract covers. The amount you receive will be based on the lesser of your billed charges or our fee schedule, which is described at Appendix 1 and is subject to the reimbursement (coding) policies and methodologies of us and the participating entities. Our reimbursement policies and methodologies are updated periodically and will be made available to you online or upon request. To request a copy of our reimbursement policies and methodologies, write to UnitedHealthcare, Network Management, {address}. Your reimbursement is also subject to our rules concerning retroactive eligibility, subrogation and coordination of benefits (as described in the Administrative Guide). We recognize CPT reporting guidelines as developed by the American Medical Association, as well as ICD diagnostic codes and hospital-based revenue codes. Following these guidelines does not imply a right to reimbursement for all services as coded or reported.

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

We routinely update our fee schedule in response to additions, deletions and changes to CPT codes by the American Medical Association, price changes for immunizations and injectable medications, and in response to similar changes (additions and revisions) to other service coding and reporting conventions that are widely used in the health care industry, such as those maintained by the Centers for Medicaid and Medicare Services (for example HCPCS, etc.). Ordinarily, our fee schedule is updated using similar methodologies for similar services. We will not generally attempt to communicate routine maintenance of this nature and will generally implement updates within 90 days from the date of publication.

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

If either of us believes that a claim has not been paid correctly, either of us may seek correction of the payment within a 12-month period following the date the claim was paid, except that overpayments as a result of abusive or fraudulent billing practices may be pursued by us beyond the 12-month time frame mentioned above. In the event of an overpayment, we will correct these errors by adjusting future claim payment and/or by billing you for the amount of the overpayment.

Your professional staff and Practice Locations

You represent to us that all of the members of your professional staff, as of the date you executed this agreement, are listed in Appendix 4. All of the members of your professional staff will participate in our network through this agreement, except in cases in which one of your professional staff is not accepted for participation or is removed from participation under our credentialing program, or removed from participation by us immediately due to that professional being sanctioned by any governmental agency or authority (including Medicare or Medicaid), or having lost a license to provide all or some of the professional services under this agreement, or no longer having hospital admitting privileges in any participating hospital. Your professional staff will cooperate with our credentialing program.

If a new professional joins your professional staff, you will give us 60 days notice and provide the information included in Appendix 4. You will assure that the new professional will promptly submit a credentialing application to us (unless the new professional is already credentialed with us) and cooperate with our credentialing program.

You will assure that a member of your professional staff who has not been approved or is not in good standing under our credentialing program will not provide covered services to our customers. In the event that professional does provide covered services, you will not bill us, our customer, or anyone acting on our customer's behalf for the service, and you will assure that the professional also does not bill for the service.

If a professional leaves your professional staff, you will notify us within ten business days after you become aware that the professional will leave. The notice will include the date that the professional will depart from your professional staff. If you know the future contact information for the professional and whether the professional will continue to practice after leaving your professional staff, you will make reasonable commercial efforts to include that information in the notice and will provide that information to us if we request it.

This agreement applies to your practice locations identified in Appendix 5. If you begin providing services at other locations (either by opening such locations yourself, or by acquiring, merging or coming under common ownership and control with an existing provider of services that was not already under contract with us or one of our affiliates to participate in a network of health care providers), those additional locations will become subject to this agreement 30 days after we receive notice from you.

If you acquire or are acquired by, merged with, or otherwise become affiliated with another provider of health care services that is already under contract with us or one of our affiliates to participate in a network of health care providers, this agreement and the other agreement will each remain in effect and will continue to apply as they did prior to the acquisition, merger or affiliation, unless otherwise agreed to in writing by all parties to those agreements.

If you decide to transfer some or all of your assets to another entity, and the result of the transfer would be that all or some of the services subject to this agreement would be rendered by the other entity rather than by you, you must first request that we approve an assignment of this agreement as it relates to those services and the other entity must agree to assume this agreement.

How long our agreement lasts; how it gets amended; and how it can end

Assuming you are credentialed by us, and we execute this agreement, you will receive a copy from us with the effective date noted below the signature block. It continues until one of us terminates it.

We can amend this agreement or any of the appendices on 90 days² written or electronic notice by sending you a copy of the amendment. Your signature is not required to make the amendment effective. However, if you do not wish to continue your participation with our network as changed by an amendment that is not required by law or regulation but that includes a material adverse change to this agreement, then you may terminate this agreement on 60 days² written notice to us so long as you send this termination notice within 30 days of your receipt of the amendment.

In addition, either you or we can terminate this agreement, effective on an anniversary of the date this agreement begins, by providing at least 90 days² prior written notice. Either you or we can terminate this agreement at any time if the other party has materially breached this agreement, by providing 60 days² written notice, except that if the breach is cured before our agreement ends, the agreement will continue.

Either of us can immediately terminate this agreement if the other becomes insolvent or has bankruptcy proceedings initiated.

Finally, we can immediately terminate this agreement if any governmental agency or authority (including Medicare or Medicaid) sanctions you.

We both agree that termination notices under this agreement must be sent by certified mail, return receipt requested, to [\[UnitedHealthcare, Network Management, {address}\]](#), or to the post office address you provided us. We both will treat termination notices as “received” on the third business day after they are sent.

About data and confidentiality

We agree that your medical records do not belong to us. You agree the information contained in the claims you submit is ours. We both will protect the confidentiality of our customers' information in accordance with applicable state and federal laws, rules, and regulations.

We are both prohibited from disclosing to third parties any fee schedule or rate information. There are three exceptions:

- You can disclose to our customer information relating to our payment methodology for a service the customer is considering (e.g., global fee, fee for service), but not specific rates (unless for purposes of benefit administration).
- We and the participating entities may use this information to administer our customers' benefit contracts and to pay your claims. We also may permit access to information by auditors and other consultants who need the information to perform their duties, subject to a confidentiality agreement.
- We both may produce this information in response to a court order, subpoena or regulatory requirement to do so, provided that we use reasonable efforts to seek to maintain confidential treatment for the information, or to a third party for an appropriate business purpose, provided that the disclosure is pursuant to a confidentiality agreement and the recipient of the disclosure is not a competitor of either of us.

What if we do not agree

We will resolve all disputes between us by following the dispute procedures set out in our Administrative Guide. If either of us wishes to pursue the dispute beyond those procedures, they will submit the dispute to binding arbitration in accordance with the Commercial Dispute Procedures of the American Arbitration Association (see <http://www.adr.org>) within one year.

We both expressly intend that any dispute between us be resolved on an individual basis so that no other dispute with any third party(ies) may be consolidated or joined with our dispute. We both agree that any arbitration ruling by an arbitrator allowing class action arbitration or requiring consolidated arbitration involving any third party(ies) would be contrary to our intent and would require immediate judicial review of such ruling. The arbitrator will not vary the terms of this agreement and will be bound by governing law. We both acknowledge that this agreement involves interstate commerce, and is governed by the Federal Arbitration Act, 9 U.S.C. § 1 *et seq.* The arbitrator will not have the authority to award punitive or exemplary damages against either of us, except in connection with a statutory claim that explicitly provides for such relief. Arbitration will be conducted in {county}, {state}.

If a court allows any litigation of a dispute to go forward, we both waive rights to a trial by jury with respect to that litigation, and the judge will be the finder of fact. Any provision of this agreement that is invalid or unenforceable shall not affect the validity or enforceability of the remaining provisions of this agreement or the validity or enforceability of the offending provision in any other situation or in any other jurisdiction. This section of the agreement shall survive and govern any termination of this agreement.

What is our relationship to one another

You are an independent contractor. This means we do not have an employer-employee, principal-agent, partnership, joint venture, or similar arrangement. It also means that you make independent health care treatment decisions. We do not. We do not reserve any right to control those treatment decisions. It further means that each of us is responsible for the costs, damages, claims, and liabilities that result from our own acts.

You will look to the applicable participating entity for reimbursement for the products and services under our agreement. This means that we are not financially responsible for claims payment for groups that are self-funded or that are not affiliated with us.

We may assign this agreement to any entity that is an affiliate of ~~United HealthCare~~[UnitedHealthcare](#) Insurance Company at the time of the assignment.

This is it

This contract, the appendices and the items referenced in the attached Appendix 1, constitute our entire understanding. It replaces any other agreements or understandings with regard to the same subject matter - - oral or written - - that you have with us or any of our affiliates.

Federal law and the applicable law of the jurisdiction where you provide health care services govern our agreement. Such laws and the rules and regulations promulgated under them, when they are applicable, control and supersede our agreement. The Regulatory Appendix referenced in Appendix 1, and any attachment to it, is expressly incorporated to govern our agreement and is binding on both of us. In the event of any inconsistent or contrary language between the Regulatory Appendix (when it applies) and any other part of our agreement, including but not limited to appendices, amendments and exhibits, the Regulatory Appendix will control.

Conclusion

If you agree with these terms, please execute both copies of the agreement below and return them to us. With your signature, you confirm you understand the contract, including the dispute resolution procedures described in the section of this agreement entitled "What if we do not agree", the appendices and the items referenced in the attached Appendix 1.

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

AGREED BY:

Medical Group (print):

Address to be used for giving notice under the agreement:

Signature _____

Street _____

Print Name and Title _____

City _____

DBA (if applicable) _____

State _____ Zip Code _____

Date _____ TIN _____

E-mail _____

~~United HealthCare~~UnitedHealthcare Insurance Company, on behalf of itself, ~~United HealthCare~~UnitedHealthcare of Arkansas ~~Inc., Inc.~~ [, UnitedHealthcare Plan of the River Valley, Inc.,] and its other affiliates, as signed by its authorized representative:

For Internal Use Only:

Signature _____

Print Name _____

Date _____

For office use only:

Month, day and year in which agreement is first effective: _____ / _____ / _____

Appendix 1

We include as part of our agreement the following additional materials that bind you and us:

- Appendix 2** **Definitions, Products and Services**
This appendix sets forth definitions for our “customer” and “participating entities” as well as lists the type of benefit contracts offered to our customers.
- Appendix 3** **Fee Schedule Sample(s).** This document includes a portion of our fee schedule for the most frequent procedures you perform, or for those procedures you have requested. Additional portions of the fee schedule can be requested by writing to [\[UnitedHealthcare, Network Management, {address}\]](#)
- Appendix 4** This document provides information about the members of your professional staff.
- Appendix 5** This document provides information about your practice locations.
- State Regulatory Requirements Appendix** In some instances, states add requirements to our agreement that are set forth in this appendix.
- Medicare Regulatory Requirements Appendix** (This appendix applies only if you are in our Medicare network)
Your participation in our network for customers with Medicare benefit contracts is subject to additional Medicare requirements set forth in this appendix
- [Medicaid Regulatory Requirements Appendix]** [(This appendix applies only if you are in our Medicaid network)
Your participation in our network for customers with Medicaid benefit contracts is subject to additional Medicaid requirements set forth in this appendix]
- Administrative Guide** We have enclosed a copy of our Administrative Guide. This guide governs the mechanics of our relationship. Our Administrative Guide may be viewed by going to www.unitedhealthcareonline.com. We may make changes to the guide upon 30 days’ electronic or written notice to you.
- [\[Additionally, for customers enrolled in benefit contracts \(other than Medicare benefit contracts\) issued by the River Valley Entities or under which a River Valley Entity provides administrative services under an agreement with us or a participating entity and included in this agreement as set forth in Appendix 2, you will be subject to the programs, protocols and administrative procedures described in or made available to you through the River Valley Provider Manual \(the “River Valley Manual”\) and the payment policies of the River Valley Entities. When the agreement refers to the administrative manual or guide, it is also referring to the River Valley Manual. The River Valley Manual](#)

is available to you upon request and online at <https://www.uhcrivervalley.com>. In the event of any conflict between the River Valley Manual or River Valley payment policies on the one hand and any of the following: the agreement, any United programs, protocols, administrative procedures (including payment policies and guidelines for calculating payments), or the UnitedHealthcare Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide (the “Administrative Manual”) in connection with any matter pertaining to a customer enrolled in a benefit contract (other than a Medicare benefit contract) issued by the River Valley Entities, the River Valley Manual or River Valley Payment Policies, as applicable, shall govern, unless applicable statutes or regulations dictate otherwise.] We may make changes to the Administrative Manual[, River Valley Manual] or other administrative protocols [and River Valley Payment Policies] upon 30 days’ electronic or written notice to you.]

**Credentialing
Plan**

To review our credentialing plan, visit www.unitedhealthcareonline.com. This plan requires your professional staff to be covered by malpractice insurance in amounts with carriers and on terms and conditions that are customary for professionals like them in your community. To request access to, or a copy of, our credentialing plan, write to [\[UnitedHealthcare, Network Management, {address}\]](#).

Appendix 2 Definitions, Products and Services

1. **Customer.** Individuals who are enrolled in benefit contracts insured or administered by us or any participating entity are included in our use of the phrase “customer” in this agreement.
2. **Participating entities.** The following entities have access to our agreement:
 - ~~United HealthCare~~[UnitedHealthcare](#) Insurance Company and its affiliates
 - Groups receiving administrative services from ~~United HealthCare~~[UnitedHealthcare](#) Insurance Company or its affiliates or that have arranged for network access through an entity that has contracted with ~~United HealthCare~~[UnitedHealthcare](#) Insurance Company or one of its affiliates.
3. **Products and services.** We may include you in networks where your patients are enrolled in benefit contracts of the types generally described below:
 - Benefit contracts where individuals are offered a network of participating physicians and other health care professionals and must select a primary care physician, who in some cases must approve any care provided by other health care providers. An option for this benefit contract allows individuals to receive health services from non-participating physicians.
 - Benefit contracts where individuals are offered a network of participating physicians and other health care providers but are not required to select a primary care physician. An option for this benefit contract allows individuals to receive health services from non-participating physicians.
 - Benefit contracts where individuals are not offered a network of participating physicians and other health care providers.
 - [~~Benefit~~[Medicare benefit](#) contracts that (A) are sponsored, issued or administered by us or another applicable participating entity ~~where the benefit contract is intended to~~[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.]
 - [Benefit contracts for ~~workers~~[Workers](#)' compensation benefit programs]

However, this agreement does not apply to the following:

- Benefit contracts 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.
- [~~Benefit~~[Medicare benefit](#) contracts that (A) are sponsored, issued or administered by us or another applicable participating entity ~~where the benefit contract is intended to~~[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"](#)). Note: Although Medicare benefit contracts, as described above, are excluded from this agreement, there can be a separate agreement between us or between our and your affiliates or other entity authorized to contract on behalf of you providing for your participation in a network for certain Medicare benefit contracts.]

- Medicare Advantage Private Fee-For-Service Plans.
- Benefit contracts for Medicare Select
- [Benefit contracts for ~~workers~~Workers' compensation benefit programs]

Appendix 3- Options PPO

Representative Options PPO Fee Schedule Sample for: [insert name of *Fee Schedule*]

The provisions of this fee schedule apply to covered services rendered by you to customers covered by benefit contracts marketed under the name “Options PPO” and benefit contracts where customers are not offered a network of participating physicians and other health care professionals from which they may receive covered services [, except Anesthesia Management covered services rendered by Anesthesia Practitioners. Fee Schedule Sample(s) for Anesthesia Management covered services rendered by Anesthesia Practitioners are described in a separate Exhibit 1 to this Appendix 3].

Unless specifically indicated otherwise, amounts listed in the fee schedule represent global fees and may be subject to reductions based on appropriate modifier (for example, professional and technical modifiers). Any co-payment, deductible or coinsurance that the customer is responsible to pay under the customer’s benefit contract will be subtracted from the listed amount in determining the amount to be paid by us or the participating entity. The actual payment amount is also subject to matters described in this agreement, such as the reimbursement policies. Please remember that this information is subject to the confidentiality provisions of this agreement.

Appendix 3 - Products other than Options PPO

Representative All-Payer Fee Schedule Sample(s) for: [insert name of *Fee Schedule*]

Unless another fee schedule to this agreement applies specifically to a particular benefit contract as it covers a particular customer, the provisions of this fee schedule apply to covered services rendered by you to customers covered by benefit contracts sponsored, issued or administered by all participating entities- [, except Anesthesia Management covered services rendered by Anesthesia Practitioners. Fee Schedule Sample(s) for Anesthesia Management covered services rendered by Anesthesia Practitioners are described in a separate Exhibit 1 to this Appendix 3].

Unless specifically indicated otherwise, amounts listed in the fee schedule represent global fees and may be subject to reductions based on appropriate modifier (for example, professional and technical modifiers). Any co-payment, deductible or coinsurance that the customer is responsible to pay under the customer's benefit contract will be subtracted from the listed amount in determining the amount to be paid by us or the participating entity. The actual payment amount is also subject to matters described in this agreement, such as the reimbursement policies. Please remember that this information is subject to the confidentiality provisions of this agreement.

[Appendix 3A

For Dates of Service Effective: mm/dd/yyyy *(insert only if escalators have been negotiated)*
Fee Schedule Specifications :-: [Fee Schedule ID]]

**[Appendix 3, Exhibit 1
Anesthesia Fee Schedule Exhibit: Options PPO**

Representative Options PPO Fee Schedule Sample: [insert name of Fee Schedule]

The provisions of this exhibit apply to Anesthesia Management covered services rendered by Anesthesia Practitioners to customers covered by benefit contracts marketed under the name “Options PPO” and benefit contracts where customers are not offered a network of participating physicians and other health care professionals from which they may receive covered services.

Unless specifically indicated otherwise, amounts listed in the fee schedule represent global fees and may be subject to reductions based on appropriate modifier (for example, professional and technical modifiers). Any co-payment, deductible or coinsurance that the customer is responsible to pay under the customer’s benefit contract will be subtracted from the listed amount in determining the amount to be paid by us or the participating entity. The actual payment amount is also subject to matters described in this agreement, such as the reimbursement policies. ~~Please remember that this~~ This information is subject to the confidentiality provisions of ~~this~~ the agreement.]

**[Appendix 3, Exhibit 1
Anesthesia Fee Schedule Exhibit: Products other than Options PPO**

Representative Fee Schedule Sample: [insert name of Fee Schedule]

Unless another exhibit to Appendix 3 applies specifically to a particular benefit contract as it covers a particular customer, the provisions of this exhibit apply to Anesthesia Management covered services rendered by Anesthesia Practitioners to customers covered by benefit contracts sponsored, issued or administered by all participating entities.

Unless specifically indicated otherwise, amounts listed in the fee schedule represent global fees and may be subject to reductions based on appropriate modifier (for example, professional and technical modifiers). Any co-payment, deductible or coinsurance that the customer is responsible to pay under the customer's benefit contract will be subtracted from the listed amount in determining the amount to be paid by us or the participating entity. The actual payment amount is also subject to matters described in this agreement, such as the reimbursement policies. ~~Please remember that this~~ This information is subject to the confidentiality provisions of ~~this~~the agreement.]

[Appendix 3

Representative Medicare Fee Schedule Sample [Insert Name of Fee Schedule]

The provisions of this fee schedule apply to services rendered by you to our Medicare customers covered by Medicare benefit contracts that ~~are~~ (A) are sponsored, issued or administered by us or another applicable participating entity and (B) replace, either partially or in its entirety, the original Medicare coverage (Medicare Part A and Medicare Part B) issued to beneficiaries by ~~CMS~~ [the Centers for Medicare and Medicaid Services \("CMS"\)](#), other than Medicare Advantage Private Fee-For-Service Plans. The provisions of this fee schedule do not apply to services you render to Medicare beneficiaries pursuant to a commercial benefit contract.

We will use our best efforts to update the amounts for services listed in the attached fee schedule that are based on the CMS physician Medicare fee schedule on or before the later of (a) ninety (90) days after the effective date of any modification made by CMS to the CMS physician Medicare fee schedule; provided, however, in the event CMS makes a change to such modification after the effective date of such modification, we will use our best efforts to update the methodology and factors in accordance with such subsequent change within ninety (90) days after the date on which CMS places information regarding such subsequent change in the public domain, or (b) ninety (90) days after the date on which CMS initially place information regarding such modification in the public domain (e.g., CMS distributes program memoranda to providers).

Amounts listed in the attached sample fee schedule are gross amounts. Any co-payments, deductibles or coinsurance that our Medicare customer is responsible to pay under his or her benefit contract will be subtracted from the amount listed in the attached sample fee schedule in determining the amount to be paid by us or by a participating entity. The actual payment amount is also subject to matters described in our agreement, including our reimbursement policies.]

Appendix 5 Your Practice Locations

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

BILLING ADDRESS

All sites of service billing under all TINs listed in Appendix 5 must be included as par providers.

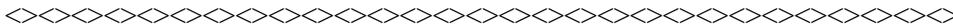
Identify only if a common name and address appears on all medical group practice location bills that utilize the medical group's Tax ID under the Agreement.

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

National Provider Identification (NPI) Number _____

PRACTICE LOCATIONS (complete one for each service location)

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



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

INTRODUCTION

Our agreement consists of this contract, the appendices, and the additional materials we reference in the attached Appendix 1.

Guiding principles

We strive to operate in accordance with the following principles:

- *We want to work together with America's best physicians [\[practitioners\]](#) to improve the health care experience of our customers.*
- *We respect and support the physician[\[practitioner\]](#)/patient relationship while adhering fairly to the contract for benefits we provide our customers.*
- *Whether a particular treatment is covered under a benefit contract should not determine if the treatment is provided. Physicians[\[Practitioners\]](#) and health care professionals should provide the care they believe is necessary regardless of coverage.*
- *You should discuss treatment options with patients regardless of coverage. We encourage that communication.*
- *Physicians[\[Practitioners\]](#) should describe any factors that could affect their ability to render appropriate care. Matters such as professional training, financial incentives, availability constraints, religious or philosophical beliefs, and similar matters are all things that a physician [\[practitioner\]](#) should consider discussing with a patient. We encourage these communications. We urge full disclosure.*
- *Fairness and efficiency will govern the ways in which we administer our products. We will make our determinations promptly. Our commitments to our customers will be clear. We will honor our agreements. When it comes to coverage determinations, the language of the benefit contract will take precedence.*

Next steps

Please read this agreement. If you have questions, ~~[e-mail your inquiry to {address}]~~ write to or call:

[UnitedHealthcare](#)
[Network Management](#)
[\[address\]](#)

[\(xxx\)xxx-xxxx](#)]

You can visit our website at www.unitedhealthcareonline.com (UnitedHealthcare Online[®]) for additional details on items described in the agreement. If the agreement is acceptable to you, please sign both of the enclosed copies of the contract, and send both copies to the address above.

PHYSICIAN [PRACTITIONER] CONTRACT

~~United HealthCare~~ UnitedHealthcare Insurance Company is entering into this agreement with you. It is doing so on behalf of itself ~~United HealthCare, UnitedHealthcare~~ of Arkansas, Inc., [, UnitedHealthcare Plan of the River Valley, Inc.,] and its other affiliates for certain products and services we offer our customers, all of which we describe in the attached Appendix 2.

This agreement applies to you and the services you provide in all of your practice arrangements and for all of your tax identification numbers, except that if your services are covered under an agreement between us and a medical group that you are part of, services that you provide through that medical group will be subject to that other agreement and not this agreement.

What you will do

You need to be credentialed in accordance with our Credentialing Plan, as referenced in Appendix 1, for the duration of this agreement.

You must notify us in a timely manner about certain services you provide in accordance with our Administrative Guide so that we can provide our customers with the services we have committed to provide. If you do not so notify us about these services, you will not be reimbursed for the services, and you may not charge our customer.

Within one year of the effective date of this agreement, you must conduct business with us entirely on an electronic basis to the extent that we are able to conduct business electronically (described in the Administrative Guide), including but not limited to determining whether your patient is currently a customer, verifying the customer's benefit, and submitting your claim. We will communicate enhancements in UnitedHealthcare Online® functionality as they become available and will make information available to you as to which products are supported by UnitedHealthcare Online.

You must submit your claims within 90 days of the date of service. After we receive your claim, if we request additional information in order to process your claim, you must submit this additional information within 90 days of our request. If your claim or the additional information is not submitted within these timeframes, you will not be reimbursed for the services, and you may not charge our customer.

You will submit claims only for services performed by you or your staff. Pass through billing is not payable under this agreement and may not be billed to our customer. For laboratory services, you will only be reimbursed for the services that you are certified through the Clinical Laboratory Improvement Amendments (CLIA) to perform, and you must not bill our customers for laboratory services for which you are not certified.

You will submit claims that supply all applicable information. These claims are complete claims. Further information about complete claims is provided in our Administrative Guide.

If you disagree with our payment determination on a claim, you may submit an appeal as described in our Administrative Guide.

You will not charge our customers anything for the services you provide, if those services are covered services under their benefit contract, but the applicable co-pay, coinsurance or deductible amount. If the services you provide are denied or otherwise not paid due to your failure to notify us, to file a timely claim,

to submit a complete claim, to respond to our request for information, or based on our reimbursement policies and methodologies, you may not charge our customer. If the services you provide are denied for reason of not being medically necessary, you may not charge our customer unless our customer has, with knowledge of our determination of a lack of medical necessity, agreed in writing to be responsible for payment of those charges. If the services you provide are not covered under our customer's benefit contract, you may, of course, bill our customer directly. You will not require a customer to pay a "membership fee" or other fee in order to access you for covered services (except for co-payments, coinsurance and/or deductibles provided for under the customer's benefit contract) and will not discriminate against any customer based on the failure to pay such a fee.

You will cooperate with our reasonable requests to provide information that we need. We may need this information to perform our obligations under this agreement, under our programs and agreements with our customers, or as required by regulatory or accreditation agencies.

You will refer customers only to other network physicians and providers, except as permitted under our customer's benefit contract, or as otherwise authorized by us or the participating entity.

What we will do

We or the other applicable participating entity will promptly adjudicate and pay your complete claim for services covered by our customer's benefit contract. If you submit claims that are not complete,

- You may be asked for additional information so that your claim may be adjudicated; or
- Your claim may be denied and you will be notified of the denial and the reason for it; or
- We may in our discretion attempt to complete the claim and have it paid by us or the other applicable participating entity based on the information that you gave in addition to the information we have.

If governing law requires us to pay interest or another penalty for a failure to pay your complete claim for covered services within a certain time frame, we will follow those requirements. The interest or other penalty required by law will be the only additional obligation for not satisfying in a timely manner a payment obligation to you. In addition, if we completed a claim of yours that was not complete, there shall be no interest or other late payment obligation to you even if we subsequently adjust the payment amount based on additional information that you provide.

The applicable participating entity will reimburse you for the services you deliver that our customer's benefit contract covers. The amount you receive will be based on the lesser of your billed charges or our fee schedule, which is described at Appendix 1 and is subject to the reimbursement (coding) policies and methodologies of us and the participating entities. Our reimbursement policies and methodologies are updated periodically and will be made available to you online or upon request. To request a copy of our reimbursement policies and methodologies, ~~[e-mail your request to {address}]~~ write to [UnitedHealthcare, Network Management, {address}](#). Your reimbursement is also subject to our rules concerning retroactive eligibility, subrogation and coordination of benefits (as described in the Administrative Guide). We recognize CPT reporting guidelines as developed by the American Medical Association, as well as ICD diagnostic codes and hospital-based revenue codes. Following these guidelines does not imply a right to reimbursement for all services as coded or reported.

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

We routinely update our fee schedule in response to additions, deletions and changes to CPT codes by the American Medical Association, price changes for immunizations and injectable medications, and in response to similar changes (additions and revisions) to other service coding and reporting conventions that are widely used in the health care industry, such as those maintained by the Centers for Medicaid and Medicare Services (for example HCPCS, etc.). Ordinarily, our fee schedule is updated using similar methodologies for similar services. We will not generally attempt to communicate routine maintenance of this nature and will generally implement updates within 90 days from the date of publication.

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

If either of us believes that a claim has not been paid correctly, either of us may seek correction of the payment within a 12-month period following the date the claim was paid, except that overpayments as a result of abusive or fraudulent billing practices may be pursued by us beyond the 12-month time frame mentioned above. In the event of an overpayment, we will correct these errors by adjusting future claim payment and/or by billing you for the amount of the overpayment.

How long our agreement lasts; how it gets amended; and how it can end

Assuming you are credentialed by us, and we execute this agreement, you will receive a copy from us with the effective date noted below the signature block. It continues until one of us terminates it.

We can amend this agreement or any of the appendices on 90 days² written or electronic notice by sending you a copy of the amendment. Your signature is not required to make the amendment effective. However, if you do not wish to continue your participation with our network as changed by an amendment that is not required by law or regulation but that includes a material adverse change to this agreement, then you may terminate this agreement on 60 days² written notice to us so long as you send this termination notice within 30 days of your receipt of the amendment.

In addition, either you or we can terminate this agreement, effective on an anniversary of the date this agreement begins, by providing at least 90 days² prior written ~~or electronic~~ notice. Either you or we can terminate this agreement at any time if the other party has materially breached this agreement, by providing 60 days² written notice, except that if the breach is cured before our agreement ends, the agreement will continue.

Either of us can immediately terminate this agreement if the other becomes insolvent or has bankruptcy proceedings initiated.

Finally, we can immediately terminate this agreement if any governmental agency or authority (including Medicare or Medicaid) sanctions you, if you no longer have your license to practice medicine, if you no longer have hospital admitting privileges in any participating hospital, or in accordance with the terms of our Credentialing Plan.

We both agree that termination notices under this agreement must be sent by certified mail, return receipt requested, to [UnitedHealthcare](#), Network Management, {address}, or to the post office address you provided us. We both will treat termination notices as “received” on the third business day after they are sent.

About data and confidentiality

We agree that your medical records do not belong to us. You agree the information contained in the claims you submit is ours. We both will protect the confidentiality of our customers' information in accordance with applicable state and federal laws, rules, and regulations.

We are both prohibited from disclosing to third parties any fee schedule or rate information. There are three exceptions:

- You can disclose to our customer information relating to our payment methodology for a service the customer is considering (e.g., global fee, fee for service), but not specific rates (unless for purposes of benefit administration).
- We and the participating entities may use this information to administer our customers' benefit contracts and to pay your claims. We also may permit access to information by auditors and other consultants who need the information to perform their duties, subject to a confidentiality agreement.
- We both may produce this information in response to a court order, subpoena or regulatory requirement to do so, provided that we use reasonable efforts to seek to maintain confidential treatment for the information, or to a third party for an appropriate business purpose, provided that the disclosure is pursuant to a confidentiality agreement and the recipient of the disclosure is not a competitor of either of us.

What if we do not agree

We will resolve all disputes between us by following the dispute procedures set out in our Administrative Guide. If either of us wishes to pursue the dispute beyond those procedures, they will submit the dispute to binding arbitration in accordance with the Commercial Dispute Procedures of the American Arbitration Association (see <http://www.adr.org>) within one year.

We both expressly intend that any dispute between us be resolved on an individual basis so that no other dispute with any third party(ies) may be consolidated or joined with our dispute. We both agree that any arbitration ruling by an arbitrator allowing class action arbitration or requiring consolidated arbitration involving any third party(ies) would be contrary to our intent and would require immediate judicial review of such ruling. The arbitrator will not vary the terms of this agreement and will be bound by governing law. We both acknowledge that this agreement involves interstate commerce, and is governed by the Federal Arbitration Act, 9 U.S.C. § 1 *et seq.* The arbitrator will not have the authority to award punitive or exemplary damages against either of us, except in connection with a statutory claim that explicitly provides for such relief. Arbitration will be conducted in {county}, {state}.

If a court allows any litigation of a dispute to go forward, we both waive rights to a trial by jury with respect to that litigation, and the judge will be the finder of fact. Any provision of this agreement that is invalid or unenforceable shall not affect the validity or enforceability of the remaining provisions of this agreement or the validity or enforceability of the offending provision in any other situation or in any other jurisdiction. This section of the agreement governs any dispute between us arising before or after execution of this agreement and this section shall survive and govern any termination of this agreement.

What is our relationship to one another

You are an independent contractor. This means we do not have an employer-employee, principal-agent, partnership, joint venture, or similar arrangement. It also means that you make independent health care treatment decisions. We do not. We do not reserve any right to control those treatment decisions. It further means that each of us is responsible for the costs, damages, claims, and liabilities that result from our own acts.

You will look to the applicable participating entity for reimbursement for the products and services under our agreement. This means that we are not financially responsible for claims payment for groups that are self-funded or that are not affiliated with us.

We may assign this agreement to any entity that is an affiliate of ~~United HealthCare~~UnitedHealthcare Insurance Company at the time of the assignment.

This is it

This contract, the appendices and the items referenced in the attached Appendix 1, constitute our entire understanding. It replaces any other agreements or understandings with regard to the same subject matter - - oral or written - - that you have with us or any of our affiliates.

Federal law and the applicable law of the jurisdiction where you provide health care services govern our agreement. Such laws and the rules and regulations promulgated under them, when they are applicable, control and supersede our agreement. The Regulatory Appendix referenced in Appendix 1, and any attachment to it, is expressly incorporated to govern our agreement and is binding on both of us. In the event of any inconsistent or contrary language between the Regulatory Appendix (when it applies) and any other part of our agreement, including but not limited to appendices, amendments and exhibits, the Regulatory Appendix will control.

Conclusion

If you agree with these terms, please execute both copies of the agreement below and return them to us. With your signature, you confirm you understand the contract, including the dispute resolution procedures described in the section of this agreement entitled "What if we do not agree", the appendices and the items referenced in the attached Appendix 1.

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

AGREED BY:

Physician [Practitioner]

Address to be used for giving notice under the agreement:

Signature _____

Street _____

Print Name _____

City _____

DBA (if applicable) _____

State _____ Zip Code _____

Date _____ TIN _____

E-mail _____

National Provider Identification (NPI) Number

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

For Internal Use Only:

Signature _____

Print Name _____

Date _____

For office use only:

Month, day and year in which agreement is first effective: _____ / _____ / _____

Appendix 1

We include as part of our agreement the following additional materials that bind you and us:

Appendix 2 **Definitions, Products and Services**

This appendix sets forth definitions for our “customer” and “participating entities” as well as lists the type of benefit contracts offered to our customers.

Appendix 3

Fee Schedule Sample. This document includes a portion of our fee schedule for the most frequent procedures you perform, or for those procedures you have requested. Additional portions of the fee schedule can be requested by ~~fe-mailing your request to {address}}~~ ~~writing to Network Management,~~ writing to [UnitedHealthcare, Network Contract Support, 1311 W. President George Bush Highway, Suite 100, Mail Route: TX023-1000, Richardson, TX 75080-9870].

Appendix 4

Locations. This document provides information about your office, billing, and mailing locations. Please remember that, as described on page 2, this agreement applies to all of your locations even if you do not list all of your current locations or if you add a location in the future.

State Regulatory Requirements Appendix

In some instances, states add requirements to our agreement that are set forth in this appendix.

Medicare Regulatory Requirements Appendix

(This appendix applies only if you are in our Medicare network)
Your participation in our network for customers with Medicare benefit contracts is subject to additional Medicare requirements set forth in this appendix

~~Medicare Payment~~ Medic aid Regulatory Requirements Appendix]

~~[(This appendix applies only if you are in our Medicare/Medicaid network-)~~
Your participation in our network for customers with Medicaid benefit contracts is subject to additional Medicaid requirements set forth in this appendix]

Administrative Guide

We have enclosed a copy of our Administrative Guide. This guide governs the mechanics of our relationship. Our Administrative Guide may be viewed by going to www.unitedhealthcareonline.com.

Additionally, for customers enrolled in benefit contracts (other than Medicare benefit contracts) issued by the River Valley Entities or under which a River Valley Entity provides administrative services under an agreement with us or a participating entity and included in this agreement as set forth in Appendix 2, you will be subject to the programs, protocols and administrative procedures

described in or made available to you through the River Valley Provider Manual (the “River Valley Manual”) and the payment policies of the River Valley Entities. When the agreement refers to the administrative manual or guide, it is also referring to the River Valley Manual. The River Valley Manual is available to you upon request or online at <https://www.uhcrivervalley.com>. In the event of any conflict between the River Valley Manual or River Valley payment policies on the one hand and any of the following: the agreement, any United programs, protocols, administrative procedures (including payment policies and guidelines for calculating payments), or the UnitedHealthcare Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide (the “Administrative Manual”) in connection with any matter pertaining to a customer enrolled in a benefit contract (other than a Medicare benefit contract) issued by the River Valley Entities, the River Valley Manual or River Valley Payment Policies, as applicable, shall govern, unless applicable statutes or regulations dictate otherwise.] We may make changes to the ~~guide~~Administrative Manual[, River Valley Manual] or other administrative protocols [and River Valley Payment Policies] upon 30 days’ electronic or written notice to you.]

Credentialing Plan

To review our credentialing plan, visit www.unitedhealthcareonline.com. This plan requires you to carry malpractice insurance in amounts with carriers and on terms and conditions that are customary for physicians like you in your community. To request access to, or a copy of, our credentialing plan, write to UnitedHealthcare, _____ Network _____ Management, _____ {address}.

Appendix 2

Definitions, Products and Services

1. **Customer.** Individuals who are enrolled in benefit contracts insured or administered by us or any participating entity are included in our use of the phrase “customer” in this agreement.
2. **Participating entities.** The following entities have access to our agreement:
 - ~~United HealthCare~~UnitedHealthcare Insurance Company and its affiliates;
 - Groups receiving administrative services from ~~United HealthCare~~UnitedHealthcare Insurance Company or its affiliates or that have arranged for network access through an entity that has contracted with ~~United HealthCare~~UnitedHealthcare Insurance Company or one of its affiliates.
3. **Products and services.** You will participate in networks where your patients are enrolled in benefit contracts of the types generally described below:
 - Benefit contracts where individuals are offered a network of participating physicians and other health care professionals and must select a primary care physician, who in some cases must approve any care provided by other health care providers. An option for this benefit contract allows individuals to receive health services from non-participating physicians.
 - Benefit contracts where individuals are offered a network of participating physicians and other health care providers but are not required to select a primary care physician. An option for this benefit contract allows individuals to receive health services from non-participating physicians.
 - Benefit contracts where individuals are not offered a network of participating physicians and other health care providers.
 - [~~Benefit Medicare benefit~~ contracts that (A) are sponsored, issued or administered by us or another applicable participating entity ~~where the benefit contract is intended to~~ and (B) replace, either partially or in its entirety, the ~~traditional~~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.]
 - [Benefit ~~Plans~~contracts for Workers' compensation benefit programs]
 - ~~[Benefit Plans for Medicare Select.]~~

You will **not** participate in networks where your patients are enrolled in benefit contracts of the types generally described below:

- Benefit contracts for Medicaid ~~customers.~~ Customers (Note: ~~Excluding~~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.]
- ~~[Benefit contracts sponsored, issued or administered by us or another applicable participating entity where the benefit contract is intended to replace, either partially or in its entirety, the traditional Medicare coverage (Medicare Part A and Medicare Part B) issued to beneficiaries by the Centers for Medicare and Medicaid Services.]~~
- Medicare Advantage Private Fee-For-Service Plans.

- [Medicare Benefit contracts that (A) are sponsored, issued or administered by us or another applicable participating entity 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"). Note: Although Medicare benefit contracts, as described above, are excluded from this agreement, there can be a separate agreement between us or between our and your affiliates or other entity authorized to contract on behalf of you providing for your participation in a network for certain Medicare benefit contracts.]
- [Benefit ~~Plans~~contracts for Workers' compensation benefit programs.]
- ~~[Benefit Plans~~contracts for Medicare Select].

Appendix 3A

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

~~Unless specifically indicated otherwise, amounts listed in the fee schedule represent global fees and may be subject to reductions based on appropriate modifier (for example, professional and technical modifiers). Any co-payment, deductible or coinsurance that the customer is responsible to pay under the customer's benefit contract will be subtracted from the listed amount in determining the amount to be paid by the payer. The actual payment amount is also subject to matters described in this agreement, such as the reimbursement policies. Please remember that this information is subject to the confidentiality provisions of this agreement.~~

Fee Schedule Specifications - : [Fee Schedule ID]

Appendix 3- Options PPO

Representative Options PPO Fee Schedule Sample: [insert name of Fee Schedule]

The provisions of this fee schedule apply to covered services rendered by you to customers covered by benefit contracts marketed under the name "Options PPO" and benefit contracts where customers are not offered a network of participating physicians and other health care professionals from which they may receive covered services [, except Anesthesia Management covered services rendered by Anesthesia Practitioners. Fee Schedule Sample(s) for Anesthesia Management covered services rendered by Anesthesia Practitioners are described in a separate Exhibit 1 to this Appendix 3].

Unless specifically indicated otherwise, amounts listed in the fee schedule represent global fees and may be subject to reductions based on appropriate modifier (for example, professional and technical modifiers). Any co-payment, deductible or coinsurance that the customer is responsible to pay under the customer's benefit contract will be subtracted from the listed amount in determining the amount to be paid by us or the participating entity. The actual payment amount is also subject to matters described in this agreement, such as the reimbursement policies. Please remember that this information is subject to the confidentiality provisions of this agreement.

Appendix 3- Products other than Options PPO

Representative All-Payer Fee Schedule Sample: [insert name of Fee Schedule]

Unless another fee schedule to this agreement applies specifically to a particular benefit contract as it covers a particular customer, the provisions of this fee schedule apply to covered services rendered by you to customers covered by benefit contracts sponsored, issued or administered by all participating entities [, except Anesthesia Management covered services rendered by Anesthesia Practitioners. Fee Schedule Sample(s) for Anesthesia Management covered services rendered by Anesthesia Practitioners are described in a separate Exhibit 1 to this Appendix 3].

Unless specifically indicated otherwise, amounts listed in the fee schedule represent global fees and may be subject to reductions based on appropriate modifier (for example, professional and technical modifiers). Any co-payment, deductible or coinsurance that the customer is responsible to pay under the customer's benefit contract will be subtracted from the listed amount in determining the amount to be paid by us or the participating entity. The actual payment amount is also subject to matters described in this agreement, such as the reimbursement policies. Please remember that this information is subject to the confidentiality provisions of this agreement.

**[Appendix 3, Exhibit 1
Anesthesia Fee Schedule Exhibit: Options PPO**

Representative Options PPO Fee Schedule Sample: [insert name of Fee Schedule]

The provisions of this exhibit apply to Anesthesia Management covered services rendered by Anesthesia Practitioners to customers covered by benefit contracts marketed under the name “Options PPO” and benefit contracts where customers are not offered a network of participating physicians and other health care professionals from which they may receive covered services.

Unless specifically indicated otherwise, amounts listed in the fee schedule represent global fees and may be subject to reductions based on appropriate modifier (for example, professional and technical modifiers). Any co-payment, deductible or coinsurance that the customer is responsible to pay under the customer’s benefit contract will be subtracted from the listed amount in determining the amount to be paid by us or the participating entity. The actual payment amount is also subject to matters described in this agreement, such as the reimbursement policies. This information is subject to the confidentiality provisions of the agreement.]

**[Appendix 3, Exhibit 1
Anesthesia Fee Schedule Exhibit: Products other than Options PPO**

Representative Fee Schedule Sample:[insert name of Fee Schedule]

Unless another exhibit to Appendix 3 applies specifically to a particular benefit contract as it covers a particular customer, the provisions of this exhibit apply to Anesthesia Management covered services rendered by Anesthesia Practitioners to customers covered by benefit contracts sponsored, issued or administered by all participating entities.

Unless specifically indicated otherwise, amounts listed in the fee schedule represent global fees and may be subject to reductions based on appropriate modifier (for example, professional and technical modifiers). Any co-payment, deductible or coinsurance that the customer is responsible to pay under the customer’s benefit contract will be subtracted from the listed amount in determining the amount to be paid by us or the participating entity. The actual payment amount is also subject to matters described in this agreement, such as the reimbursement policies. This information is subject to the confidentiality provisions of the agreement.]

[Appendix 3

Representative Medicare Fee Schedule Sample [insert name of Fee Schedule]

The provisions of this fee schedule apply to services rendered by you to our Medicare customers covered by Medicare benefit contracts that (A) are sponsored, issued or administered by us or another applicable participating entity and (B) replace, either partially or in its entirety, the original Medicare coverage (Medicare Part A and Medicare Part B) issued to beneficiaries by CMS, other than Medicare Advantage Private Fee-For-Service Plans. The provisions of this fee schedule do not apply to services you render to Medicare beneficiaries pursuant to a commercial benefit contract.

We will use our best efforts to update the amounts for services listed in the attached fee schedule that are based on the CMS physician Medicare fee schedule on or before the later of (a) ninety (90) days after the effective date of any modification made by CMS to the CMS physician Medicare fee schedule; provided, however, in the event CMS makes a change to such modification after the effective date of such modification, we will use our best efforts to update the methodology and factors in accordance with such subsequent change within ninety (90) days after the date on which CMS places information regarding such subsequent change in the public domain, or (b) ninety (90) days after the date on which CMS initially place information regarding such modification in the public domain (e.g., CMS distributes program memoranda to providers).

Amounts listed in the attached sample fee schedule are gross amounts. Any co-payments, deductibles or coinsurance that our Medicare customer is responsible to pay under his or her benefit contract will be subtracted from the amount listed in the attached sample fee schedule in determining the amount to be paid by us or by a participating entity. The actual payment amount is also subject to matters described in our agreement, including our reimbursement policies.]

Appendix 4 - LOCATIONS

NOTE: Please attach additional copies of this page if you need to list additional locations.
Please remember that, as described on page 2, this agreement applies to all of your locations even if you do not list all of your current locations or if you add a location in the future.

<u>Provider:</u>

<u>Primary Service Location Address:</u>	<u>Address:</u>		
	<u>City:</u>	<u>State:</u>	<u>Zip:</u>
	<u>Tel #:</u>	<u>Fax #:</u>	
<u>Billing Address:</u>	<u>Address:</u>		
	<u>City:</u>	<u>State:</u>	<u>Zip:</u>
	<u>Tel #:</u>	<u>Fax #:</u>	

<u>Additional Service Location Address:</u>	<u>Address:</u>		
	<u>City:</u>	<u>State:</u>	<u>Zip:</u>
	<u>Tel #:</u>	<u>Fax #:</u>	
<u>Billing Address:</u> <input type="checkbox"/> Same as above	<u>Address:</u>		
	<u>City:</u>	<u>State:</u>	<u>Zip:</u>
	<u>Tel #:</u>	<u>Fax #:</u>	

<u>Mailing Address:</u>	<u>Address:</u>		
	<u>City:</u>	<u>State:</u>	<u>Zip:</u>
	<u>Tel #:</u>	<u>Fax #:</u>	

