

SERFF Tracking Number: UHLC-127854930 State: Arkansas
 Filing Company: UnitedHealthcare of Arkansas, Inc. State Tracking Number: 50368
 Company Tracking Number: OHCS-PHYSHEALTHPROVIDERAGMT(V2011)
 TOI: HOrg02G Group Health Organizations - Health Sub-TOI: HOrg02G.002C Any Size Group - HMO
 Maintenance (HMO)
 Product Name: OHCS-PhysHealthProviderAgmt(v2011)
 Project Name/Number: OHCS-PhysHealthProviderAgmt(v2011)/OHCS-PhysHealthProviderAgmt(v2011)

Filing at a Glance

Company: UnitedHealthcare of Arkansas, Inc.

Product Name: OHCS- SERFF Tr Num: UHLC-127854930 State: Arkansas
 PhysHealthProviderAgmt(v2011)

TOI: HOrg02G Group Health Organizations - SERFF Status: Closed-Approved- State Tr Num: 50368
 Health Maintenance (HMO) Closed

Sub-TOI: HOrg02G.002C Any Size Group - Co Tr Num: OHCS- State Status: Approved-Closed
 HMO PHYSHEALTHPROVIDERAGMT(V
 2011)

Filing Type: Form

Reviewer(s): Rosalind Minor
 Author: Kelly Smith Disposition Date: 12/02/2011
 Date Submitted: 11/30/2011 Disposition Status: Approved-
 Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: OHCS-PhysHealthProviderAgmt(v2011)
 Project Number: OHCS-PhysHealthProviderAgmt(v2011)
 Requested Filing Mode: Review & Approval
 Explanation for Combination/Other:
 Submission Type: New Submission
 Group Market Type: Employer
 Filing Status Changed: 12/02/2011
 State Status Changed: 12/02/2011
 Created By: Kelly Smith
 Corresponding Filing Tracking Number: OHCS-
 PhysHealthProviderAgmt(v2011)
 PPACA: Not PPACA-Related
 PPACA Notes: null
 Filing Description:
 OHCS Provider Agreement Template and related Amendment

Status of Filing in Domicile: Not Filed
 Date Approved in Domicile:
 Domicile Status Comments:
 Market Type: Group
 Group Market Size: Small and Large
 Overall Rate Impact:
 Deemer Date:
 Submitted By: Kelly Smith

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Company and Contact

Filing Contact Information

Kelly Smith, Manager RGA Kelly_Smith@uhc.com
 800 King Farm Blvd. 240-632-8061 [Phone]
 Suite 500
 Rockville, MD 20850

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: \$100.00
 Retaliatory? No
 Fee Explanation: \$50 x2
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
UnitedHealthcare of Arkansas, Inc.	\$100.00	11/30/2011	54145214

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	12/02/2011	12/02/2011

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Disposition

Disposition Date: 12/02/2011

Implementation Date:

Status: Approved-Closed

HHS Status: HHS Approved

State Review: Reviewed-No Actuary

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	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	Regulatory Requirements Addendum - form# ACN PROVIDER AGMT - AR REG ADDEND 08.06, approved	Approved-Closed	Yes
Supporting Document	OHCS-PhysHealthProviderAgmt(v2011) - Cover Letter	Approved-Closed	Yes
Form	OHCS-PhysHealthProviderAgmt(v2011)	Approved-Closed	Yes
Form	OptumHealth/AMEND (add'l plans)-2011	Approved-Closed	Yes

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Form Schedule

Lead Form Number: OHCS-PhysHealthProviderAgmt(v2011)

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 12/02/2011	OHCS-PhysHealthProviderAgmt(v2011)	Other	OHCS-PhysHealthProviderAgmt(v2011)	Initial		55.600	OHCS-PhysHealthProviderAgmt_v2011__Final100411_.pdf
Approved-Closed 12/02/2011	OptumHealth/AMEND (add'l plans)-2011	Other	OptumHealth/AMEND (add'l plans)-2011	Initial		61.800	OH - AMEND_Add'l Plans_- FINAL_092611_.pdf

**OPTUMHEALTH CARE SOLUTIONS, INC.
PROVIDER AGREEMENT**

THIS AGREEMENT (“Agreement”) is entered into by and between OptumHealth Care Solutions, Inc. (“OptumHealth”) and the undersigned person (“Individual”) or entity (“Group”), (Individual and Group are also individually and collectively referred to as “Provider”), and sets forth the terms and conditions under which Provider shall participate in one or more networks developed by OptumHealth to render Covered Services to Members. This Agreement supersedes and replaces any existing provider agreements between the parties related to the provision of Covered Services.

Through contracts with Providers of health care services, OptumHealth maintains one or more networks of providers that are available to Members. Provider is a provider of health care services.

OptumHealth wishes to arrange to make Provider’s services available to Members. Provider wishes to provide such services, under the terms and conditions set forth in this Agreement.

The parties therefore enter into this Agreement.

**SECTION 1
Definitions**

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

1.1 “Benefit Contract” is a benefit plan that includes health care coverage, is sponsored, issued or administered by Plan and contains the terms and conditions of a Member’s coverage, including applicable copayments, deductibles, and limits on coverage for services rendered outside specified networks.

1.2 “Covered Service” is a health care service or product for which a Member is entitled to receive coverage from a Payer, including the terms of the Member’s Benefit Contract with that Payer.

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

1.4 “Emergency Services” are services provided for a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- (1) Placing the patient’s health in serious jeopardy;
- (2) Serious impairment to bodily functions;
- (3) Serious dysfunction of any bodily organ or part.

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

1.6 “Member Expenses” are any amounts that are the Member’s responsibility to pay Provider in accordance with Member’s Benefit Contract.

1.7 “Participating Provider” is an OptumHealth contracted and credentialed health care professional, 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 Provider, or who practices as a subcontractor of Provider. However, a subcontractor of Provider is a Participating Provider only with regard to services rendered to patients of Provider and billed under Provider’s Federal Tax I.D. number.

1.8 “Payer” is an entity or person obligated to a Member to provide reimbursement for Covered Services. Payer may be OptumHealth, Plan, workers compensation insurer, automobile liability insurer, or other third party entity as designated by OptumHealth or Plan, and authorized by OptumHealth, to access Provider’s services under this Agreement.

1.9 “Plan” is the entity or person, including but not limited to third parties participating in the rental of this Agreement, as described further in Section 8.5, authorized by OptumHealth to access one or more networks of Participating Providers developed by OptumHealth.

1.10 “Plan Summary” is a written summary that identifies the Plan, the applicable fee schedule and specific unique requirements for the particular Plan. The Plan Summary is further described in Section 2.3 and referenced throughout this Agreement.

1.11 “Protocols” are the programs and administrative procedures adopted by OptumHealth or a Plan to be followed by Provider and Participating Providers in providing services and doing business with OptumHealth and Plans under this Agreement. The Protocols are further discussed in Section 4.6 of this Agreement.

SECTION 2 Applicability of this Agreement

2.1 Provider’s Services. This Agreement applies to Provider’s practice locations established as of the Effective Date of this Agreement, which shall be updated from time to time upon agreement of the parties. In the event Provider 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 OptumHealth to participate in a network of health care providers), such additional locations will become subject to this Agreement 30 days after OptumHealth receives notice.

In the event Provider acquires or is acquired by, merges with, or otherwise becomes affiliated with another Provider of health care services that is already under contract with OptumHealth 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.

2.2 Provider Participation. Provider shall participate in those Plans designated by OptumHealth in Plan Summaries. OptumHealth and Plan reserve the right to determine Provider’s participation in one or more networks, even though Provider has a contract with OptumHealth.

2.3 Plan Summaries. Upon execution of this Agreement, and within 30 calendar days of receiving a written request from Provider, OptumHealth shall supply applicable Plan Summaries for Plans with which Provider is currently participating. During the term of the Agreement, OptumHealth shall provide relevant Plan Summaries to Provider via written or electronic methods. Plan Summaries are incorporated into this Agreement by this reference. Provider shall notify OptumHealth in writing within 15 days of receiving a Plan Summary if Provider wishes not to participate in the program described in the Plan Summary. In some instances, a Provider's signature may be required to participate in the Plan; such requirements will be communicated to Provider upon distribution of the Plan Summary.

In the event there are any significant changes to the content of a Plan Summary, Provider will be notified in advance. Plan Summaries shall remain in effect for as long as OptumHealth has a valid contract with Plan, or until OptumHealth notifies Provider, 30 days in advance, of any changes in Provider's status under each Plan Summary.

2.4 Services not Covered under a Benefit Contract. This Agreement does not apply to services not covered under the applicable Benefit Contract. Provider may seek and collect payment from a Member for such services, provided that the Provider first obtains the Member's written consent. This Section does not authorize Provider to bill or collect from Members for Covered Services for which claims are denied or otherwise not paid.

2.5 Health Care. Provider acknowledges that this Agreement and Member Benefit Contracts do not dictate the health care provided by Provider, or govern Provider's determination of what care to provide its patients, even if those patients are Members. The decision regarding what care is to be provided remains with Provider and with Members, and not with OptumHealth or any Payer.

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

SECTION 3

Participation in OptumHealth's Network

3.1 Participating Providers. Except as described under Section 3.2 and subject to Section 3.4, all health care professionals employed by or under contract with Provider will participate in OptumHealth's network; provided however, if Provider is contracted as an Individual, then this Section 3.1 shall apply only to the Individual Provider as a Participating Provider. Provider has the authority to bind, and will bind, all new Participating Providers to the obligations of this Agreement.

3.2 Requirements for Participating Providers. A Participating Provider:

- (1) Must not have been denied participation in OptumHealth's credentialing process;
- (2) Must have been notified of approval for participation after completion of the credentialing process; and

- (3) Must not have been terminated from participation in OptumHealth's network pursuant to Section 3.5 of this Agreement.

3.3 Credentialing. Provider and Participating Providers will participate in and cooperate with OptumHealth's credentialing process.

3.4 New Participating Providers. The new health care professional must complete the OptumHealth credentialing process and receive notice from OptumHealth of credentialing approval prior to becoming a Participating Provider in OptumHealth's network.

3.5 Termination of a Participating Provider from OptumHealth's Network. OptumHealth may terminate a Participating Provider's participation in OptumHealth's network, without terminating this Agreement, immediately upon becoming aware of any of the following:

- (1) Material breach of this Agreement that is not cured by Provider within 30 days after OptumHealth provided notice to Provider of the breach;
- (2) The suspension, revocation, condition, limitation, qualification or other material restriction on a Participating Provider's license(s), certification(s) and permit(s) by any government agency under which the Participating Provider is authorized to provide health care services;
- (3) An indictment, arrest or conviction for a felony, or for any criminal charge related to the practice of Participating Provider's profession;
- (4) A sanction imposed by any governmental agency or authority, including Medicare or Medicaid; or
- (5) Pursuant to OptumHealth's credentialing risk management program.

3.6 Covered Services by Non-Participating Providers. A health care professional who does not meet the requirements for participation set forth in Section 3.2 of this Agreement will not render Covered Services to a Member. In the event Covered Services are rendered by a health care professional who has not completed the OptumHealth credentialing process and has not been approved for participation in OptumHealth's network, Provider will not submit a claim or other request for payment to OptumHealth or Payer and will not seek or accept payment from the Member.

SECTION 4 Duties of Provider

4.1 Member Eligibility. Provider is responsible to verify Member's eligibility in accordance with instructions in the applicable Plan Summary. If Provider provides health care services to an individual, and it is later determined the individual was not a Member at the time the health care services were provided, those services shall not be eligible for payment under this Agreement. Provider may then directly bill the responsible party for such services. OptumHealth and Payer retain the right of final verification of eligibility and this verification supersedes any previous approval of care, verification of eligibility, and/or claims payment review.

4.2 Provide Covered Services. Provider will provide Covered Services to Members.

4.3 Nondiscrimination. Provider shall accept Members as new patients on the same basis as Provider is accepting non-Members as new patients and will not discriminate against any patient, with regard to race, religion, gender, color, national origin, age or physical or mental health status, quality of service or accessibility of services, whether Member is enrolled through a private purchaser or a publicly funded program such as Medicare or Medicaid, or on any other basis deemed unlawful under federal, state or local law, on the basis that the patient is a Member.

4.4 Accessibility. Provider shall ensure that Members have timely and reasonable access to Covered Services and shall at all times be reasonably available to Members as is appropriate. Provider will provide or arrange for the provision of advice and assistance (e.g. answering machine or service) to Members in emergency situations 24 hours a day, seven days a week.

4.5 Continuity of Care; Referral to Other Health Professionals. Provider shall furnish Covered Services in a manner providing continuity of care and ready referral of Members to other Providers at times as may be appropriate and consistent with standards of care in the community. If a Member requires additional services or evaluation, including, but not limited to radiology or laboratory tests and Emergency Services, Provider agrees to refer Member to his/her primary care physician or other participating health professionals in accordance with the terms and conditions of Member's Benefit Contract. A Member requiring Emergency Services shall also be referred to the "911" emergency response system.

4.6 Cooperation with Protocols. Provider and Participating Provider will cooperate with and be bound by OptumHealth's, Plan's and Payer's Protocols. The Protocols will be made available to Provider upon request. Some or all Protocols also may be disseminated in the form of an operations manual or guide or in other communications. This includes the OptumHealth Operations Manual, which is incorporated into this Agreement by reference. The Operations Manual describes, among other things, OptumHealth's administrative and operational procedures, such as credentialing, claims submission, audit and recovery review, and clinical submission requirements. OptumHealth, Plan and Payer may make changes to the Protocols from time to time. OptumHealth will use reasonable commercial efforts to inform Provider at least 30 days in advance of any material changes to the Protocols.

4.7 Licensure. Provider and Participating Providers will maintain, without material restriction, such licensure, registration, and permits as are necessary to enable Provider and Participating Providers to lawfully perform this Agreement.

4.8 Liability Insurance. Provider will assure that Provider, and all health care professionals employed by or under contract with Provider, to include Participating Provider, 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 or such limits as may be required in the Plan Summary. 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, Provider shall submit to OptumHealth in writing evidence of insurance coverage.

TYPE OF INSURANCE

MINIMUM LIMITS

Medical malpractice and/or professional liability insurance

If Provider is an Individual: Five Hundred Thousand Dollars (\$500,000) per occurrence and One Million Dollars (\$1,000,000) aggregate.

If Provider is a Group: One Million Dollars (\$1,000,000) per occurrence and Three Million Dollars aggregate (\$3,000,000), if Provider insures all Participating Providers in a single policy.

Commercial general and/or umbrella liability insurance

In the amount of the industry standard per occurrence and aggregate.

4.9 Notices. Provider will give notice to OptumHealth within 10 days after any event that causes Provider or Participating Provider to be out of compliance with Section 4 of this Agreement, or of any change in Provider's name, ownership, control or Federal Tax I.D. number. This Section does not apply to changes of ownership or control that result in Provider being owned or controlled by an entity with which it was already affiliated prior to the change. In addition, Provider will give written notice to OptumHealth within 10 days after it learns of any of the following:

- (1) Changes in liability insurance carriers, termination of, or any other material changes in Provider's liability insurance, including reduction of limits, erosion of aggregate, changes in retention or non-payment of premium;
- (2) Any suspension, revocation, condition, limitation, qualification or other material restriction on Provider or a Participating Provider's license(s), certification(s) and permit(s) by any government agency under which Provider or a Participating Provider is authorized to provide health care services;
- (3) Indictment, arrest or conviction of Provider or a Participating Provider for a felony, or for any criminal charge related to the practice of the Provider's or a Participating Provider's profession;
- (4) Claims or legal actions for professional negligence or bankruptcy;
- (5) Provider's or a Participating Provider's termination, for cause, from a provider network offered by any plan, including, without limitation, any health care service plan or health maintenance organization, any health insurer, any preferred provider organization, any employer, or any trust fund;
- (6) Any occurrence or condition that might materially impair the ability of Provider to discharge its duties or obligations under this Agreement;
- (7) Any condition or circumstance that may pose a direct threat to the safety of Provider, Providers' staff and/or Members;
- (8) The departure of any Participating Provider from Provider; or

- (9) A change in Provider's name, ownership or Federal Tax I.D. number.

4.10 Member consent to release of Medical Record Information. Provider will obtain any Member consent required in order to authorize Provider to provide access to requested information or records as contemplated in Section 4.11 of this Agreement, including copies of the Provider's medical records relating to the care provided to Member.

4.11 Maintenance of and Access to Records. Provider will maintain adequate medical, financial and administrative records related to Covered Services rendered by Provider or Participating Provider 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. Provider will provide access to these records as follows:

- (1) To OptumHealth or its designees, at no charge, in connection with OptumHealth's utilization management/care management, quality assurance and improvement and for claims payment and other administrative obligations, including reviewing Provider's compliance with the terms and provisions of this Agreement, audit and recovery functions, and appropriate billing practice. Provider will provide access during ordinary business hours within fourteen days after a request is made, except in cases of an OptumHealth audit involving a fraud investigation or the health and safety of a Member (in which case, access shall be given within 48 hours after the request) or of an expedited Member appeal or grievance (in which case, access will be given so as to enable OptumHealth to reasonably meet the timelines for determining the appeal or grievance); and
- (2) To agencies of the government, in accordance with applicable law, to the extent such access is necessary to comply with regulatory requirements applicable to Provider, OptumHealth or Payers.
- (3) Provider will cooperate with OptumHealth on a timely basis in connection with any records request within 30 days of OptumHealth's request. If such information and records are requested by OptumHealth, Provider shall provide copies of such records free of charge.

4.12 Compliance with law. Provider and Participating Provider will comply with applicable regulatory requirements, including but not limited to those relating to confidentiality of Member medical information.

4.13 Employees and subcontractors. Provider will assure that its employees, affiliates and any individuals or entities subcontracted by Provider, to include Participating Providers, to render services in connection with this Agreement adhere to the requirements of this Agreement. Such requirements include, but are not limited to, not billing Members for any amounts except Member Expenses and charges for services not covered under the Member's Benefit Contract in accordance with Section 2.4 of this Agreement. The use of employees, affiliates or subcontractors to render services in connection with this Agreement will not limit Provider's obligations and accountability under this Agreement with regard to such services.

SECTION 5

Submission, Processing and Payment of Claims

5.1 Form and content of claims. Provider must submit claims for Covered Services in a manner and format prescribed by OptumHealth, as further described in the Protocols and/or Plan Summary. Unless otherwise directed by OptumHealth or Plan, Provider shall submit claims using a 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. Such claims should be “clean claims.”

Provider will submit claims only for services performed by Provider or Participating Provider(s). Pass through billing is not payable under this Agreement.

5.2 Time to file claims. Provider shall submit claims as described in the applicable Plan Summary. All information necessary to process the claims must be received within the time frame stated in the Plan Summary. Provider agrees that claims received after the applicable time period may be rejected for payment.

5.3 Payment of claims. Payer will pay claims for Covered Services according to the applicable fee schedule per the Plan Summary, and in accordance with applicable Protocols, less any applicable Member Expenses. Claims for Covered Services subject to coordination of benefits will be paid in accordance with the Member’s Benefit Contract and applicable law. The obligation for payment under this Agreement is solely that of Payer, and not that of OptumHealth, unless OptumHealth is the Payer.

OptumHealth and Plans routinely update fee schedules in response to additions, deletions and changes to CPT codes by the American Medical Association, and in response to similar changes 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. OptumHealth and Plans will not generally attempt to communicate routine maintenance of this nature and will generally implement updates within 90 days from the date of publication. OptumHealth and Plans reserve the right to use gap-fill fee sources where primary fee sources are not available.

OptumHealth will give Provider advanced written or electronic notice of non-routine fee schedule changes which will substantially alter the overall methodology or reimbursement level of the fee schedule.

5.4 Denial of Claims for Not Following Protocols, or Not Filing Timely. Payment may be denied in whole or in part if Provider does not comply with Protocols or does not file a timely claim as per Section 5.2 of this Agreement. Payment may also be denied for services provided that are determined by OptumHealth or Plan to be medically unnecessary, and if such denial occurs, Provider shall not bill the Member for such services unless the Member has, with knowledge of determination of a lack of medical necessity, agreed in writing in advance of services being rendered, to be responsible for payment of those charges.

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

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

If Provider provides health care services to an individual, and it is determined that the individual was not a Member 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 5.9 of this Agreement. Provider may then directly bill the individual, or other responsible party, for such services.

5.6 Payment under this Agreement is Payment in Full. Payment as provided under Section 5.3 of this Agreement, together with any applicable Member Expenses for which the Member is responsible under the Benefit Contract, is payment in full for a Covered Service. In accordance with Section 5.7 of this Agreement, Provider will not seek to recover, and will not accept any payment from Member (other than applicable Member Expenses), OptumHealth, Payer or anyone acting in their behalf, in excess of payment in full as provided in this Section 5.6, regardless of whether such amount is less than Provider's Customary Charge.

5.7 Member "Hold Harmless." Other than Member Expenses, Provider will not bill or collect payment, compensation, remuneration or reimbursement from or have any recourse against the Member or persons acting on behalf of the Member for Covered Services eligible for reimbursement, or seek to impose a lien, for the difference between the amount paid under this Agreement and Provider's Customary Charge, or for any amounts denied or not paid under this Agreement due to:

- (1) Provider's or Participating Provider's failure to comply with the Protocols;
- (2) Provider's failure to file a timely claim;
- (3) Payer's payment policies;
- (4) Inaccurate or incorrect claim processing;
- (5) Insolvency or other failure by Payer to maintain its obligation to fund claims payments;
- (6) A denial based on medical necessity or prior authorization, except as permitted under Section 5.4;
- (7) Claims for Covered Services subject to coordination of benefits in accordance with the Member's Benefit Contract and applicable law.

Provider shall not bill or collect payment from the Member for non-covered services, as defined by Members' Benefit Contract, unless Provider first obtains the Member's written consent, prior to the services being rendered.

The obligation to refrain from billing Members for Covered Services applies even in those cases in which Provider believes that OptumHealth or Payer has made an incorrect determination. In such cases, Provider may pursue remedies under this Agreement against OptumHealth or Payer, as applicable, but must still hold the Member harmless.

5.8 Consequences for Failure to Adhere to Member Protection Requirements. If Provider collects payment from, brings a collection action against, or asserts a lien against a Member for Covered Services rendered (other than for the applicable Member Expenses), Provider shall be in breach of this Agreement. This Section 5.8 will apply regardless of whether Member or anyone purporting to act on Member's behalf has executed a waiver or other document of any kind purporting to allow Provider to collect such payment from Member.

5.9 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 Provider may not seek correction of a payment more than 12 months after it was made.

Provider will repay overpayments within 30 days of notice of the overpayment. Provider will promptly report any credit balance that it maintains with regard to any claim overpayment under this Agreement, and will return such overpayment to Payer within 30 days after posting it as a credit balance. Provider agrees that recovery of overpayments may be accomplished by offsets against future payments.

SECTION 6 Dispute Resolution

OptumHealth and Provider will work together in good faith to resolve any disputes about their business relationship, including but not limited to the terms and conditions of this Agreement. If the parties are unable to resolve the dispute within 30 days following the date one party sent written notice of the dispute to the other party, and if OptumHealth or Provider wishes to pursue the dispute, it shall be submitted to binding arbitration in accordance with the rules of the American Arbitration Association ("AAA"). In no event may the arbitration be initiated more than one year following the sending of written notice of the dispute.

Any arbitration proceeding under this Agreement shall be conducted in a location agreed to by the parties or as selected by the AAA if the parties cannot agree on a location. The arbitrator(s) may construe or interpret but shall not vary or ignore the terms of this Agreement or the Member's Benefit Contract, shall have no authority to award any punitive or exemplary damages, and shall be bound by controlling law. If the dispute pertains to a matter which is generally administered by certain OptumHealth procedures, such as claims payment, credentialing or quality improvement plan, the procedures set forth in that plan must be fully exhausted by Provider before Provider may invoke his or her right to arbitration under this Section 6. The parties acknowledge that because this Agreement affects interstate commerce, the Federal Arbitration Act applies.

This Section 6 governs any dispute between the parties arising before or after execution of this Agreement and shall survive any termination of the Agreement.

SECTION 7

Term and Termination

7.1 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 7.2.

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

- (1) By mutual written agreement of the parties;
- (2) By either party, upon at least 90 days prior written notice;
- (3) 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;
- (4) 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 4.8 of this Agreement;
- (5) By Provider upon 60 days prior written notice to OptumHealth due to an amendment made to this Agreement pursuant to Section 8.2 of this Agreement;
or
- (6) By OptumHealth immediately if OptumHealth determines, in its sole discretion, that the health, safety or welfare of Members may be jeopardized by the continuation of this Agreement.

7.3 Ongoing Services to Certain Members After Termination Takes Effect. This Agreement will continue to apply to those Covered Services, after the termination takes effect, for circumstances where Payer is required by applicable law to provide transition coverage of services rendered by Provider after Provider leaves the provider network accessed by Payer. Provider shall continue to provide Covered Services authorized by OptumHealth to Members, who are receiving such services from Provider or a Participating Provider, as of the date of termination of this Agreement, until arrangements are completed for such Members to be transferred to another Participating Provider or pursuant to applicable State law. Payer shall pay Provider for such services at the Provider's contracted rate under this Agreement.

In the event that OptumHealth terminates a single Participating Provider within Provider Group, Provider must immediately transition Covered Services to other Participating Providers and ensure that the terminated Participating Provider no longer provides any services to Members.

SECTION 8

Miscellaneous Provisions

8.1 Entire Agreement. This Agreement is the entire agreement between the parties with regard to the subject matter herein.

8.2 Amendment. OptumHealth may amend this Agreement by sending a copy of the amendment to Provider at least 30 days prior to its effective date. The signature of Provider shall not be required. OptumHealth may also amend this Agreement to comply with the requirements of state and federal regulatory authorities, and shall give written notice to Provider of such amendment and its effective date. Unless such regulatory authorities direct otherwise, the signature of Provider will not be required.

8.3 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.

8.4 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 OptumHealth to any of OptumHealth's affiliates or by OptumHealth as described in Section 8.5.

8.5 Rental of Provider Agreement. OptumHealth may lease, assign, rent, or provide access to Provider's services and discounted rates pursuant to this Agreement, to a third party, allowing the third party to obtain the rights and responsibilities under this Agreement. Providers will be given the opportunity to opt-out of participation with such third parties who have entered into an agreement with OptumHealth for access to the OptumHealth network. If applicable, OptumHealth will provide information about the existence of third party access to this Agreement and will identify applicable third parties, and their clients, in accordance with Section 2.3 of this Agreement.

8.6 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.

8.7 Name, Symbol and Service Mark. During the term of this Agreement, Provider, OptumHealth and Plan shall have the right to use each other's name solely to make public reference to Provider as a Participating Provider. Provider, OptumHealth and Plan shall not otherwise use each other's name, symbol or service mark, or the name, symbol or service mark of Provider's, OptumHealth's and Plan's parent corporations or affiliates, without prior written approval.

8.8 No Third-Party Beneficiaries. Except as described in Section 8.5, OptumHealth and Provider are the only entities with rights and remedies under the Agreement.

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

8.10 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.

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

- (1) Any proprietary business information, not available to the general public, obtained by the party from the other party; or
- (2) 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.

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

8.13 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.

8.14 Medicaid Members. If a Medicaid Appendix is attached to this Agreement, Provider agrees to provide Covered Services to Members enrolled in a Benefit Contract for Medicaid recipients and to comply with any additional requirements set forth in the Medicaid Appendix. A Provider signature affirming participation may be required and/or requested prior to participation in a Medicaid program.

8.15 Medicare Members. If a Medicare Appendix is attached to this Agreement, Provider agrees to provide Covered Services to Members enrolled in a Benefit Contract for Medicare beneficiaries and to comply with any additional requirements set forth in the Medicare Appendix. Provider also understands that OptumHealth's agreements with Providers are subject to review and approval by the Centers for Medicare and Medicaid Services ("CMS").

8.16 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.

8.17 Survival. Any provisions of this Agreement (including but not limited to, Sections 4.10, 4.11, 4.12, 5.7, 6 and 8.11), or any applicable attachments, exhibits, and amendments that include provisions, which by their nature, extend beyond the termination of this Agreement, will survive the termination of this Agreement and will remain in effect until all such obligations are satisfied.

8.18 Effective Date. The Effective Date of this Agreement is _____.

THIS AGREEMENT CONTAINS A BINDING ARBITRATION PROVISION THAT MAY BE ENFORCED BY THE PARTIES, UNLESS CERTAIN STATE REGULATIONS OPOSE THIS PROVISION – SEE STATE SPECIFIC REGULATORY REQUIREMENTS ADDENDUM.

INDIVIDUAL PROVIDER

OR

GROUP PROVIDER

Clinic Name: _____

Address: _____

Address: _____

Signature of Individual Provider:

Signature of Owner/Program Director:

Print Name: _____

Print Name: _____

Title: _____

Title: _____

Date: _____

Date: _____

OptumHealth Care Solutions, Inc.

Mail Route: MN010-W120

6300 Olson Memorial Highway

Golden Valley, MN 55427

Telephone: (800) 873-4575

Signature: _____

Print Name: _____

Title: _____

Date: _____

AMENDMENT TO THE PROVIDER AGREEMENT

This Amendment (this "Amendment") is added to the Provider Agreement (the "Agreement") between OptumHealth Care Solutions, Inc. ("OptumHealth") and the undersigned individual or group entity ("Provider"). It is effective on the date it is countersigned on behalf of OptumHealth.

Provider agrees to participate in OptumHealth-authorized Plans or programs in order to provide Covered Services to individuals who receive their coverage under the Benefit Contracts of such Plans or programs.

In consideration of the terms and conditions set forth in this Amendment, the parties mutually agree as follows:

1. Capitalized terms used within this Amendment, which are not otherwise defined in this Amendment or its attachments, shall have the meaning assigned to them in the Agreement.
2. Provider agrees to provide Covered Services included in a Member's Benefit Contract on behalf of the following OptumHealth-authorized Plans or other such programs:

Please check the box of the below listed Plan(s) or program(s) you wish to participate in and sign below.

- | | |
|---------------------------------------------------------------------------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> Govt-sponsored program (state: ____)
(i.e. Medicaid, CHIP, Special Needs, etc.)]] | <input type="checkbox"/> Auto liability program(s)]] |
| <input type="checkbox"/> Workers' compensation program(s)]] | <input type="checkbox"/> Rental network program(s)]] |

3. OptumHealth shall supply applicable Plan Summary for the above selected Plan(s) or program(s) in accordance with the Plan Summary section of the Agreement.
4. Any regulatory requirements, if applicable to the above selected Plan(s) or program(s), shall be attached to this Amendment and shall be made a part of the Agreement.
5. Except as provided herein, all other terms and conditions of the Agreement shall remain in full force and effect.

OptumHealth Care Solutions, Inc.
Mail Route: MN010-W120
6300 Olson Memorial Highway
Golden Valley, MN 55427

Provider: _____
Address: _____

Signature: _____
Print Name: _____
Title: _____
Date: _____

Signature: _____
Print Name: _____
Title: _____
Date: _____
Tax ID #: _____
NPI #: _____
Medicaid #: _____

SERFF Tracking Number: UHLC-127854930 State: Arkansas
 Filing Company: UnitedHealthcare of Arkansas, Inc. State Tracking Number: 50368
 Company Tracking Number: OHCS-PHYSHEALTHPROVIDERAGMT(V2011)
 TOI: HOrg02G Group Health Organizations - Health Sub-TOI: HOrg02G.002C Any Size Group - HMO
 Maintenance (HMO)
 Product Name: OHCS-PhysHealthProviderAgmt(v2011)
 Project Name/Number: OHCS-PhysHealthProviderAgmt(v2011)/OHCS-PhysHealthProviderAgmt(v2011)

Supporting Document Schedules

	Item Status:	Status Date:
Bypassed - Item: Flesch Certification	Approved-Closed	12/02/2011
Bypass Reason: Flesch Scores - documented under Form Schedule Page Application - N/A Actuarial - N/A PPACA Compliance - N/A		

Comments:

	Item Status:	Status Date:
Bypassed - Item: Application	Approved-Closed	12/02/2011
Bypass Reason: Flesch Scores - documented under Form Schedule Page Application - N/A Actuarial - N/A PPACA Compliance - N/A		

Comments:

	Item Status:	Status Date:
Bypassed - Item: Health - Actuarial Justification	Approved-Closed	12/02/2011
Bypass Reason: Flesch Scores - documented under Form Schedule Page Application - N/A Actuarial - N/A PPACA Compliance - N/A		

Comments:

	Item Status:	Status Date:
Bypassed - Item: PPACA Uniform Compliance Summary	Approved-Closed	12/02/2011
Bypass Reason: Flesch Scores - documented under Form Schedule Page		

SERFF Tracking Number: UHLC-127854930 State: Arkansas
 Filing Company: UnitedHealthcare of Arkansas, Inc. State Tracking Number: 50368
 Company Tracking Number: OHCS-PHYSHEALTHPROVIDERAGMT(V2011)
 TOI: HOrg02G Group Health Organizations - Health Sub-TOI: HOrg02G.002C Any Size Group - HMO
 Maintenance (HMO)
 Product Name: OHCS-PhysHealthProviderAgmt(v2011)
 Project Name/Number: OHCS-PhysHealthProviderAgmt(v2011)/OHCS-PhysHealthProviderAgmt(v2011)
 Application - N/A
 Actuarial - N/A
 PPACA Compliance - N/A

Comments:

	Item Status:	Status Date:
Satisfied - Item: Regulatory Requirements Addendum - form# ACN PROVIDER AGMT - AR REG ADDEND 08.06, approved	Approved-Closed	12/02/2011

Comments:

Attachment:

ACN RegAddend_AR 08 06__OHCS Rev 110711_.pdf

	Item Status:	Status Date:
Satisfied - Item: OHCS- PhysHealthProviderAgmt(v2011) - Cover Letter	Approved-Closed	12/02/2011

Comments:

Attachment:

OHCS - PhysHealthProviderAgmt_v2011_ Cover Letter.pdf

Arkansas Regulatory Requirements Addendum

This Arkansas Regulatory Requirements Addendum (this “Addendum”) is made part of the Provider Agreement (the “Agreement”) entered into between **OptumHealth Care Solutions, Inc.** (“OptumHealth”) and the health care professional or entity named in the Agreement (“Provider”).

This Addendum applies to products or Benefit Contracts sponsored, issued or administered by or accessed through OptumHealth or OptumHealth’s contracted clients to the extent such products are regulated under Arkansas laws provided, however, that the requirements in this Addendum will not apply to the extent they are preempted by the Medicare Modernization Act or other applicable law.

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

OptumHealth and Provider acknowledge that Payor is obligated to comply with all state laws, statutes, and regulations that are applicable to entities such as Payor. The parties further acknowledge that certain Payors may not be a party to the Agreement and that any references to any obligations of Payor are an attempt by the parties to identify the Payor’s obligations under applicable state law.

This Addendum 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 Addendum, all capitalized terms contained in this Addendum shall be defined as set forth in the Agreement.

Provisions applicable to Benefit Contracts regulated under Arkansas HMO laws:

1. Continued Provision of Covered Services.

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

(b) Continuity of Care After Termination. If the Agreement is terminated for any reason, Provider shall continue the provision of Covered Services to a Member 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 Member ceases to be covered by the Plan. Provider shall be reimbursed in accordance with the Agreement for all such Covered Services rendered subsequent to the termination of the Agreement.

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

3. Examinations. During the term of the Agreement and for three (3) years after termination, Provider agrees to allow examination of medical records of Members and records of Provider in conjunction with an examination of OptumHealth 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 Member obtained from the Member 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 Member, 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 Member and OptumHealth wherein the data or information is pertinent. OptumHealth shall be entitled to claim any statutory privileges against the disclosure that Provider (or provider who furnished the information to OptumHealth) is entitled to claim.

5. Member Medical Records. Provider shall maintain an active record for each Member who receives Covered Services from Provider. Such record shall be kept current, complete, legible and available to OptumHealth 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 Member'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 Member, 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 Member's medical record shall include: the reason for the encounter, evidence of the Provider's assessment of the Member's health problems; current diagnosis of the Member, 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 Members. Nothing in the Agreement shall be construed as prohibiting, restricting or penalizing Provider in any way for disclosing to a Member 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 OptumHealth or Payor in the Agreement.

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

8. Prompt Pay. Payor 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. Payor 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 Contracts regulated by the State of Arkansas but not subject to Arkansas HMO laws:

1. Continuity of Care After Termination. If the Agreement is terminated for any reason, Provider shall continue the provision of Covered Services to a Member 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 Member ceases to be covered by the Plan. Provider shall be reimbursed in accordance with the Agreement for all such Covered Services rendered subsequent to the termination of the Agreement.

2. Provider Communication with Members. Nothing in the Agreement shall be construed as prohibiting, restricting or penalizing Provider in any way for disclosing to a Member 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 OptumHealth or Payor in the Agreement.

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

4. Prompt Pay. Payor 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. Payor 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.



November 30, 2011

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

Re: UnitedHealthcare of Arkansas, Inc.
NAIC No. 95446

OptumHealthcare Solutions, Inc. Provider Agreement Template Filings:

Form no.s: OHCS-PhysHealthProviderAgmt(v2011) and OptumHealth/AMEND (add'l plans)-2011

Dear Ms. Minor,

On behalf of UnitedHealthcare of Arkansas, Inc., I am submitting the enclosed OHCS Provider Agreement template and supporting documents for your department's review and approval. The proposed effective date is January 1, 2011. This Provider Agreement could be used for Commercial and Medicaid Members.

OHCS Provider Agreement Template - form # "OHCS -PhysHealthProviderAgmt(v2011)" – Intended use to contract with Physical Health type Providers (Chiro, PT/OT/ST, CAM Providers) who will provide services to Covered Members on behalf of United-affiliated products (**commercial and Medicaid**).

Amendment to the Provider Agreement - form # "OptumHealth/AMEND (add'l plans)-2011" - This Amendment document would **only be used** to add additional health plans or other programs (i.e. a Medicaid product) to a participating provider's current arrangement..This form would be used on an "as applicable" basis.

If you have any questions or concerns regarding this submission, please feel free to call me at the number shown below.

Sincerely,

Kelly Smith
Manager, Regulatory Affairs

Kelly_smith@uhc.com
Phone: 240-632-8061