Provider Organization
Participation Agreement

This Agreement is entered into by and between UnitedHealthcare Insurance Company, contracting on behalf of itself, UnitedHealthcare of Ohio, Inc., UnitedHealthcare Community Plan of Ohio, Inc. and the other entities that are United Affiliates (collectively referred to as "United") and _____ ("Organization").

This Agreement is effective on the later of _____,__ or the first day of the first calendar month that begins at least 30 days after the date this Agreement has been executed by all parties (the "Effective Date").

Through contracts with physicians and other providers of health care services, United maintains one or more networks of providers that are available to Customers. Organization facilitates agreements between its member providers and payers, and represents that it is lawfully authorized to do so.

United wishes to make health care services available to Customers through Organization. Organization 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:

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.

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.

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

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

***Additional Language**: PHO agreements only.*
Organization Facility is a hospital, duly licensed and qualified under the laws of the jurisdiction in which Covered Services are provided, that has an agreement in effect with Organization that authorizes Organization to act on behalf of the Organization Facility's negotiations with Payers, along the lines described in this Agreement.

Organization Physician is a physician, as defined by the laws of the jurisdiction in which Covered Services are provided, and is duly licensed and qualified under those laws, who has an agreement, directly or through another entity such as a medical group, in effect with Organization that authorizes Organization to act on behalf the Organization Physicians in their negotiations with Payers, along the lines described in this Agreement.

Organization Non-Physician Provider is a health care professional other than an Organization Physician, who is duly authorized under the laws of the jurisdiction in which Covered Services are provided, and who has an agreement, directly or through another entity such as a medical group, in effect with Organization that authorizes Organization to act on behalf of the Organization Non-Physician Providers in their negotiations with Payers, along the lines described in this Agreement.

Organization Professional or Organization Provider is an Organization Physician or an Organization Non-Physician Provider, including a medical group practice.

***Substitute Language**: For PHO agreements, replace the term "Organization Professional or Organization Provider" with the following two separate terms, "Organization Professional" and "Organization Provider."*
Organization Professional is an Organization Physician or an Organization Non-Physician Provider, including a medical group practice.

Organization Provider is an Organization Professional or an Organization Facility.

***Additional Language**: PHO agreements only.*
Participating Facility is an Organization Facility that participates in United's network through this Agreement.

Participating Professional is an Organization Professional who participates in United's network through this Agreement.

Participating Provider is a Participating Professional that participates in United's network through this Agreement.

***Substitute Language**: For PHO agreements, replace the term "Participating Provider" with the following "Participating Provider" definition.*
Participating Provider is a Participating Professional or a Participating Facility that participates in United's network through this Agreement.

Payment Policies are the guidelines adopted by United for calculating payment of claims to providers of health care services. The Payment Policies operate in conjunction with the specific contract rates and terms set forth in the Payment Appendix or Payment Appendices to this Agreement. The Payment Policies may change from time to time as described in section 7.1 of this Agreement.

Payer is a person or entity obligated to a Customer to provide reimbursement for Covered Services under the Customer's Benefit Plan, and authorized by United to access Participating Providers' services under this Agreement.

Protocols are the programs, protocols and administrative procedures adopted by United or a Payer to be followed by Participating Providers in providing services and doing business with United and Payers under this Agreement. 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. Protocols may change from time to time as described in section 6.4 of this Agreement.

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

i) Organization is duly organized and a validly existing legal entity in good standing under the laws of its jurisdiction of organization. Organization has full authority to enter into this Agreement on behalf of itself and all Participating Providers, and its involvement in this Agreement does not violate any laws applicable to contracting between health care providers and payers. This Agreement has been duly and validly executed and delivered by Organization and (assuming the due authorization, execution and delivery of this Agreement by United) constitutes a valid and binding obligation of Organization and Participating Providers, enforceable against Organization and Participating Providers in accordance with its terms, except as 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.

ii) Organization 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 Organization have been duly and validly authorized by all action necessary under its organizational documents and applicable corporate law.

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

iv) Organization and Participating Providers have obtained and hold all registrations, permits, licenses, and other approvals and consents, and have made all filings, that are required to obtain from or make with all governmental entities under applicable law in order to conduct their respective businesses as presently conducted and to enter into and perform their obligations under this Agreement.

v) Organization and Participating Providers have been given an opportunity to review the Protocols and Payment Policies. See the Additional Manuals Appendix for additional information regarding the Protocols and Payment Policies applicable to Customers enrolled in certain Benefit Plans.

vi) Each submission of a claim by a Participating Provider pursuant to this Agreement will be deemed to constitute the representation and warranty by Participating Provider to United that (a) the representations and warranties of Participating Provider set forth in this section 2.1 and elsewhere in this Agreement are true and correct as of the date the claim is submitted, (b) it has complied with the requirements of this Agreement with respect to the Covered Services involved and the submission of such claim, (c) the charge amount set forth on the claim is the Customary Charge and (d) 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:

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

ii) 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 Organization) constitutes a valid and binding obligation of United, enforceable against United in accordance with its terms, except as 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.

iii) The execution, delivery and performance of this Agreement by United do not and will not violate or conflict with (a) the organizational documents of United, (b) 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 (c) applicable law.

iv) 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 Organization Services. This Agreement applies to Covered Services provided by Participating Providers. Organization Providers can become Participating Providers as further described in Article IV of this Agreement. The Agreement applies to Covered Services provided at Participating Provider's service locations set forth in Appendix 1-A for each Participating Provider. If a service location is not listed in Appendix 1-A for a particular Participating Provider, this section 3.1 and the Agreement should nevertheless be understood as applying to Participating Provider's actual service locations that existed when this Agreement became applicable to the Participating Provider, rather than to a billing address, post office box, or any other address set forth in Appendix 1-A.

In the event a Participating Professional begins providing services at other service locations, or under other Taxpayer Identification Number(s), those additional service locations or Taxpayer Identification Numbers will become subject to the Agreement 30 days after United receives the notice required under section 6.14(v) of this Agreement. ***Additional Language:*** *PHO agreements only.* In the event a Participating Facility begins providing services at other service locations, or under other Taxpayer Identification Number(s), those additional Taxpayer Identification Numbers, or locations will become subject to this Agreement only upon the written agreement of the parties.

This subsection 3.1 applies to cases when such Participating Provider adds the location itself (such as through new construction) and when such Participating Provider acquires, merges with, or otherwise becomes affiliated with an existing provider that was not already under contract with United or one of the United Affiliates to participate in a network of health care providers.

3.2 **Payers and Benefit Plans.** United may allow Payers to access Participating Provider's services under this Agreement for certain Benefit Plans, as described in Appendix 2. United may modify Appendix 2 without amendment to include or exclude Benefit Plans in Appendix 2 by providing 30 days prior written or electronic notice to Organization.

In addition to changes allowed above, United may make additional changes to Appendix 2 as described in section 3 of that appendix.

Section 10.4 of this Agreement will apply to Covered Services provided to Customers covered by Benefit Plans that are added to the list in Appendix 2 of Benefit Plans excluded from this Agreement as described above.

3.3 **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 8.6 of this Agreement addresses circumstances in which claims for services rendered to those patients are inadvertently paid by a Payer.

3.4 **Health care.** This Agreement and Benefit Plans do not dictate the health care provided by Participating Provider, or govern Participating Provider's determination of what care to provide patients, even if those patients are Customers. The decision regarding what care is to be provided remains with Participating Provider and with Customers, and not with United or any Payer.

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

Additional Language:

3.6 **Services rendered by Facility-Based Professionals.**

i) **Definition and applicability.** For purposes of this section 3.6, "Facility-Based Professional" means an Organization Professional who provides substantially all of his or her professional services in a facility setting (such as, hospital inpatient, hospital outpatient, or ambulatory surgical center). Facility-Based Professionals include, but are not limited to, emergency room physicians, pathologists, radiologists, anesthesiologists (other than for pain management services), certified registered nurse anesthetists ("CRNAs"), hospitalists, and intensivists. All of the provisions of this Agreement, including those listed in this section 3.6, apply to services rendered by Organization Professionals who are not acting as Facility-Based Professionals at the time the services are rendered.

ii) **Services provided by a facility.** The following provisions of this Agreement do not apply to services rendered by Organization Professionals, when acting as Facility-Based Professionals, so long as the facility performs the requirement instead:

a) Section 6.6 with regard to the requirement to purchase and maintain commercial general and/or umbrella liability insurance.

b) Section 6.7 with regard to the requirement to obtain the Customer's consent to provide access to medical record data.

c) Section 6.8 with regard to the requirement to maintain medical records.

d) Section 6.9 with regard to the requirement to collect and review certain quality data.

e) Section 8.5(ii) with regard to the requirement to obtain the Customer's written consent prior to providing services that are not Covered Services.

f) Section 8.6 with regard to the requirement to request the patient to present his or her Customer identification card.

iii) **Other provisions not applicable.** The following provisions of this Agreement do not apply to services rendered by Organization Professionals, when acting as Facility-Based Professionals:

a) Section 6.4(i)(a) with regard to the requirement to direct Customers only to other participating providers.

b) Sections 6.4(i)(b)(1) and (2) with regard to the requirement to notify Customers' primary care physicians of referrals to other providers and the requirement to provide Covered Services pursuant to the terms and limitations of the referral notification issued by or on behalf of the Customer's primary care physician,

c) Section 6.4(i)(b)(3) with regard to the requirement to notify Customers' primary care physicians of admissions.

d) Section 6.14(ii) with regard to the requirement to provide notice to United of any suspension, revocation, condition, limitation, qualification or other material restriction of an Organization Physician's staff privileges at any licensed hospital, nursing home or other facility at which an Organization Physician has staff privileges during the term of this Agreement, but only if Facility-Based Professionals do not have hospital admitting privileges.

Article IV
Participation of Organization Providers in United's Network

4.1 Organization Providers as Participating Providers. Within [___] days after the execution of this Agreement, United and Organization will mutually develop and approve a list of Organization Providers who will be Participating Providers. That list is attached as Appendix 1. On a quarterly basis, Organization will provide United with a current list of all Organization Providers.

Nothing in this Agreement precludes United from negotiating its own arrangements with any Organization Provider, including Participating Providers that choose to participate in United's network on a direct basis.

In the event a Participating Provider participates in one or more other independent physician associations or physician/hospital organizations under contract with United, Participating Provider must select one independent physician association or physician/hospital organization arrangement

through which the Participating Provider will participate with United. In the event the Participating Provider does not make a selection within [X] days of the effective date of that Participating Provider's participation with United under this Agreement, United may make the selection. In any case, the independent physician association or physician/hospital organization arrangement selected will be the only such arrangement governing the relationship between United and the Participating Provider.

United will use reasonable commercial efforts to notify Organization in the event a Participating Provider chooses to participate in United's network through a direct contract with United or through another independent physician association or physician/hospital organization.

Organization will provide to United a roster of all Participating Providers on a monthly basis with all of the data elements as United may reasonably request to ensure accuracy of provider directories.

4.2 Organization Providers that are not Participating Providers. Despite an Organization Provider being listed on Appendix 1, an Organization Provider is not a Participating Provider if:

i) the Organization Provider has been denied participation based on United's credentialing program, has not submitted a credentialing application (to the extent United's credentialing program applies to that Organization Provider), or has submitted a credentialing application to United that remains pending; or

ii) the Organization Provider has been terminated from participation in United's network under this Agreement or any other agreement with United through which the Organization Provider participated in United's network; or

iii) the Organization Provider is subject, or becomes subject, to a direct agreement with United to participate in United's network as described in section 4.1 of this Agreement; or

iv) the Organization Provider participates in United's network through an arrangement between United and another independent physician association or physician/hospital organization as described in section 4.1 of this Agreement.

4.3 Credentialing. This section 4.3 applies to Participating Providers that are subject to United's credentialing program. Participating Providers will participate in and cooperate with United's credentialing program, and must be credentialed by United or its delegate prior to furnishing any Covered Services under this Agreement.

4.4 New Organization Professionals through a medical group. When a health care professional becomes an Organization Professional by joining a medical group that is a Participating Professional, the parties will work together to arrange for the new Organization Professional to be credentialed by United, so that the health care professional can become a Participating Professional. Organization will notify United at least 30 days before the health care professional becomes an Organization Professional. In the event that the medical group's agreement with the new health care professional provides for a starting date that would make it impossible for Organization to provide 30 days advance notice to United, then Organization will give notice to United as soon as reasonably possible but no later than five business days after receiving notice from medical group of the new health care professional. In either case, the new health care professional will submit and complete a credentialing application to United or its delegate within 30 days of signing the agreement to join the medical group and thus the Organization, unless the new health care professional already has been credentialed by United and is already a participant in United's

network or unless United's credentialing program does not apply to the new Organization Professional. In addition, on a monthly [quarterly] basis, Organization will provide to United the information described in the Medical Group Professional Roster to this Agreement with respect to the new Organization Professional.

4.5 Covered Services by Organization Professionals who are not participating providers. Organization Professional will staff its service locations so that Covered Services can appropriately be rendered to Customers by Organization Professionals who participate in United's network. An Organization Professional who does not participate in United's network, pursuant to section 4.2(i) or (ii) of this Agreement, will not render Covered Services to a Customer.

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

4.6 List of Participating Providers. As needed, United and Organization will consult from time to time in order to confirm their shared understanding as to which Organization Providers are currently Participating Providers.

Article V
Duties of Organization

5.1 Organization Services. Organization will arrange for Participating Providers to render Covered Services to all Customers. Organization will cause Participating Providers to comply with all applicable obligations set forth in this Agreement, including those set forth in Articles VI and VIII. Any communications from Organization that set forth these obligations to the Participating Providers be reviewed and approved by United before such communications may take effect with respect to United.

5.2 Organization/United coordinator. Organization will appoint a coordinator who will assume the day-to-day responsibilities with regard to Organization's performance under this Agreement and serve as the primary liaison with United. The coordinator will also assist United or Payer in responding promptly to Customer complaints and grievances, and assist United or Payer in resolving other Customer issues including, but not limited to, balance billing of Customers by Participating Providers.

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

5.4 Liability insurance. Organization will procure and maintain 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 will be, at a minimum, of the types and in the amounts set forth below. Upon request, Organization will submit to United in writing evidence of insurance coverage.

TYPE OF INSURANCE	MINIMUM LIMITS
Professional liability insurance, including coverage for errors and omissions	One Million Dollars ($1,000,000.00) per occurrence and Three 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

5.5 **Notices by Organization.** Organization will give written notice to United within 10 days after any event that causes Organization to be out of compliance with section 5.3 or 5.4 of this Agreement. Organization will give notice to United at least 30 days prior to any change in Organization's name, ownership, control, or Taxpayer Identification Number. This section does not apply to changes of ownership or control that result in Organization being owned or controlled by an entity with which it was already affiliated prior to the change. In addition, Organization will give written notice to United within 10 days after it learns of the departure of any Participating Provider from Organization.

5.6 **Maintenance of and access to records**.

i) **Maintenance.** Organization will maintain financial and administrative records related to services rendered by Organization under this Agreement for at least 6 years following the termination of the Agreement, unless a longer retention period is required by applicable law.

ii) **Access.** Organization will provide access to these records as follows:

a) to United or its designees, in connection with United's utilization management, quality assurance and improvement and for claims payment, health care operations and other administrative obligations, including reviewing Organization's compliance with the terms and provisions of this Agreement. Organization will provide access during ordinary business hours within 14 days after a request is made, except in cases of a United billing audit involving an allegation of fraud, abuse or the health and safety of a Customer (in which case, access must 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

b) to agencies of the government, in accordance with applicable law, to the extent that access is necessary to comply with regulatory requirements applicable to Organization, United, or Payers.

Organization will cooperate with United on a timely basis in connection with any such record request including, among other things, in the scheduling of and participation in an interview to review findings, within 30 days after United's request.

Organization will provide copies of records requested by United free of charge**.**

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

5.8 **Electronic connectivity.** When made available by United, Organization, on behalf of itself or Participating Providers, will do business with United electronically using www.UHCprovider.com, or other electronic resources as made available by United.

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

5.10 Organization documents. Upon request, Organization will provide to United documents related to Organization's organization and its operations as an Organization, including any agreements Organization has in place with providers of health care services. If Organization intends to make any substantial changes to such documents which would materially affect this Agreement, Organization will submit to United any proposed changes for United's prior review and/or approval. Organization agrees that any such changes implemented without United's prior review and/or approval will not take effect with respect to this Agreement at United's sole discretion. Organization also agrees that if any terms in any Organization documents conflict or appear to conflict with this Agreement, including any Appendices, Attachments and Exhibits, as applicable, the terms in this Agreement will prevail.

Article VI
Duties of Participating Providers

6.1 Provide Covered Services. Participating Providers will provide Covered Services to Customers.

Additional Language: Add this sentence to the end of 6.1 for PHO agreements only.
Additionally, Participating Facilities will comply with the provisions of the Participating Facility Requirements Appendix attached to this Agreement.

6.2 Nondiscrimination. Participating Providers will not discriminate against any patient, with regard to quality or accessibility of services, on the basis that the patient is a Customer. Participating Providers will not require a Customer to pay a "membership fee" or other fee in order to access Participating Providers for Covered Services (except for copayments, 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.

6.3 Accessibility. Participating Professionals will be open during normal business hours and will provide or arrange for the provision of advice and assistance to Customers in emergency situations 24 hours a day, seven days a week.

6.4 Protocols.

i) **Cooperation with Protocols**. Participating Providers will cooperate with and be bound by United's and Payers' Protocols. The Protocols include but are not limited to all of the following:

a) For non-emergency covered Services, Participating Providers will assist Customers to maximize their benefits by referring or directing Customers only to other providers that participate in United's network, except as otherwise authorized by United through United's process for approving out-of-network services at in-network benefit levels.

b) If the Customer's Benefit Plan requires the Customer to receive certain Covered Services from or upon referral by a primary care physician, Organization Professionals must adhere to the following additional protocols:

1) Notify Customer's primary care physician of referrals to other participating or non-participating providers.

2) Render Covered Services pursuant to the terms and limitations of the referral notification issued by or on behalf of the Customer's primary care physician.

3) Notify the Customer's primary care physician of all admissions.

c) As further described in the Protocols, Participating Providers will provide notification and participate in utilization management programs regarding 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.

ii) **Availability of Protocols.** The Protocols will be made available to Participating Providers on-line or upon request. Some or all Protocols also may be disseminated in the form of an administrative manual or guide or in other communications. Currently, the Protocols may be found at www.UHCprovider.com or as indicated in the Additional Manual Appendix, if applicable. United will notify Participating Providers of any changes in the location of the Protocols.

iii) **Changes to Protocols.** United may change the Protocols from time to time. United will use reasonable commercial efforts to inform Participating Providers at least 30 days in advance of any material changes to the Protocols. United may implement changes in the Protocols without the consent of Participating Providers if the change is applicable to all or substantially all similarly situated providers of health care services in United's network located in the same state as Participating Providers. Otherwise, changes to the Protocols proposed by United to be applicable to Participating Providers are subject to requirements regarding amendments in section 11.2 of this Agreement.

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

6.6 Liability insurance. Participating Professionals will procure and maintain 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 will be, at a minimum, of the types and in the amounts set forth below. Medical malpractice insurance will be either occurrence or claims made with an extended period reporting option. Upon request, Organization will submit to United in writing evidence of insurance coverage.

	Minimum Limits
Type of Insurance	**Participating Professionals**
Medical malpractice and/or professional liability insurance	$1,000,000.00 per occurrence and $3,000,000.00 aggregate

Commercial general and/or umbrella liability insurance	$1,000,000.00 per occurrence and aggregate

In lieu of purchasing the insurance coverage required in this section, Participating Professional may self-insure its medical malpractice and/or professional liability, as well as its commercial general liability. Participating Professional will maintain a separate reserve for its self-insurance. If Participating Professional uses the self-insurance option described in this paragraph, Participating Professional 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. Participating Professionals will provide a similar statement during the term of this Agreement upon United's request, which will be made no more frequently than annually. Participating Professionals will assure that its self-insurance fund will comply with applicable laws and regulations.

6.7 Customer consent to release of medical record information. Participating Provider will obtain any Customer consent required in order to authorize Participating Provider to provide access to requested information or records as contemplated in section 6.8 of this Agreement, including copies of the Participating Providers' medical records relating to the care provided to Customer.

6.8 Maintenance of and access to records.

i) **Maintenance.** Participating Provider will maintain medical, financial and administrative records related to Covered Services rendered by 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.

ii) **Access.** Participating Provider will provide access to these records as follows:

a) to United or its designees, in connection with United's utilization management, quality assurance and improvement and for claims payment, health care operations and other administrative obligations, including reviewing Participating Providers' compliance with the terms and provisions of this Agreement and appropriate billing practice. Participating Provider will provide access during ordinary business hours within 14 days after a request is made, except in cases of a United billing audit involving an allegation of fraud or abuse or the health and safety of a Customer (in which case, access must 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). If records are requested to adjudicate a claim or to make a decision regarding a request for correction under section 8.10, to review an appeal, Participating Provider will provide copies of the requested records within 14 days after the request is made; and

b) to agencies of the government, in accordance with applicable law, to the extent that access is necessary to comply with regulatory requirements applicable to Participating Provider, United, or Payers.

Participating Providers will cooperate with United on a timely basis in connection with any such record request including, among other things, in the scheduling of and participation in an interview to review findings within 30 days after United's request.

Participating Providers will provide copies of records requested by United free of charge**.**

6.9 Access to data. Participating Provider represents that in conducting its operations, it collects and reviews certain quality data relating to care rendered by Participating Provider 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 Participating Provider has the sole discretion to select the metrics which it will track from time to time and that Participating Providers' primary goal in tracking quality data is to advance the quality of patient care. If the information that Participating Providers choose 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 that source. If Participating Providers do not report metrics in the public domain, on a quarterly basis, Participating Providers will share these metrics with United as tracked against a database of all commercial patients (including patients who are not Customers). United may publish this data to entities to which United renders services or seeks to render services, and to Customers.

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

6.11 Electronic connectivity. When made available by United, Participating Providers will do business with United electronically using www.UHCprovider.com, or other electronic resources as made available by United.

6.12 Employees and subcontractors. Participating Providers will ensure that their employees, affiliates and any individuals or entities subcontracted by Participating Providers 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 Participating Providers' obligations and accountability under this Agreement with regard to those services.

6.13 Laboratory services. Participating Providers will be reimbursed for Covered Services that are laboratory services only if (i) Participating Providers are certified through the Clinical Laboratory Improvement Amendments (CLIA) to perform those services, or (ii) those services have "waived" status under CLIA and Participating Providers are performing those services pursuant to a CLIA Certificate of Waiver. Participating Providers must not bill Customers for any other laboratory services.

6.14 Notices by Participating Providers. Participating Providers will give written notice to United within 10 days after any event that causes Participating Provider to be out of compliance with section 6.5 or 6.6 of this Agreement. Participating Provider will give notice to United at least 30 days prior to any change in Participating Provider's name, ownership, control, or Taxpayer Identification Number. This section does not apply to changes of ownership or control that result in Participating Provider being owned or controlled by an entity with which it was already affiliated prior to the change. In addition, Participating Provider 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 Participating Professional's licenses, certifications and permits by any government agency under which a Participating Professional is authorized to provide health care services;

ii) any suspension, revocation, condition, limitation, qualification or other material restriction of a Participating Professional's staff privileges at any hospital, nursing home or other facility at which a Participating Professional has staff privileges during the term of this Agreement;

iii) an indictment, arrest or conviction of a Participating Professional for a felony, or for any criminal charge related to the practice of the Participating Professional's profession;

iv) the departure of any Participating Provider from Organization; or

v) any changes to the information contained in Appendix 1-A**.**

Article VII
Duties of United and Payers

7.1 **Payment of claims.** As described in further detail in Article VIII of this Agreement, Payers will pay Participating Providers for rendering Covered Services to Customers. United will make its Payment Policies available to Participating Providers online and upon request. United may change its Payment Policies from time to time, and will make information available describing the change.

7.2 **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.

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

7.4 **Notice by United.** United will give written notice to Organization within 10 days after any event that causes United to be out of compliance with section 7.2 or 7.3 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.

7.5 **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.

7.6 **Electronic connectivity.** United will do business with Organization and Participating Providers electronically using www.UHCprovider.com, or other electronic resources as made available by United.

7.7 **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 those services.

Article VIII
Submission, Processing, and Payment of Claims

8.1 Form and content of claims. Participating Provider must submit claims for Covered Services as described in the Protocols, using current, correct, and applicable coding. Participating Providers will submit claims only for services performed by Participating Providers or their staff. Pass through billing is not payable under this Agreement.

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

8.3 Time to file claims. Unless a longer timeframe is required under applicable law, all information necessary to process a claim must be received by United no more than [90] days from the date Covered Services are rendered. If Payer is not the primary payer on a claim, and Participating Professional is pursuing payment from the primary payer, the period in which Participating Professional must submit the claim will begin on the date Participating Professional receives the claim response from the primary payer.

In the event United requests additional information in order to process a claim, Participating Professional will provide that additional information within 90 days of United's request, unless a longer timeframe is required under applicable law.

8.4 Payment of claims for Covered Services. Payer will pay claims for Covered Services rendered by Participating Professionals according to the least of i) the contract rates in the applicable Payment Appendix, ii) the Participating Professional's Customary Charge, or iii) as otherwise described in the Payment Appendix. Payment will be subject to 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 the Payment Appendix(ices) for Participating Professionals 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 payment appendices for Participating Professionals: (a) to remain current with applicable coding practices; (b) in response to price changes for immunizations and injectable medications; and (c) to remain in compliance with HIPAA requirements. United will not attempt to communicate routine updates of this nature. Ordinarily, United's fee schedule is updated using similar methodologies for similar services.

United will give Participating Professionals at least 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 a Participating

Professional's overall reimbursement under this Agreement, the Participating Professional may terminate his or her participation in United's network by giving 60 days written notice to United, provided that the notice is given within 30 days after United's notice of the fee schedule change.

8.5 Denial of claims for not following Protocols, for not filing timely, for services not Covered under the Customer's Benefit Plan, or for lack of medical necessity.

The provisions in this section 8.5 apply to Participating Professionals.

i) **Non-compliance with Protocol.** Payment may be denied in whole or in part if Participating Professional does not comply with a Protocol or does not file a timely claim as required under section 8.3 of this Agreement. Participating Professional may request reconsideration of the denial and the denial will be reversed if Participating Professional can show one or more of the following:

a) the denial was incorrect because Participating Professional complied with the Protocol.

b) at the time the Protocols required notification or prior authorization, Participating Professional (1) did not know and was unable to reasonably determine that the patient was a Customer, (2) Participating Professional took reasonable steps to learn that the patient was a Customer and (3) Participating Professional promptly submitted a claim after learning the patient was a Customer.

A claim is also subject to denial for other reasons permitted under the Agreement. Reversal of a claim denial under this subsection (i) does not preclude United from upholding a denial for one of these other reasons.

ii) **Non-Covered Services.** Services not covered under the applicable Benefit Plan are not subject to the rates or discounts of this Agreement. Participating Professional may seek and collect payment from a Customer for such services (provided that Participating Professional obtained the Customer's prior written consent).

iii) **Denials for lack of medical necessity through the prior authorization process.** If a service would otherwise be a Covered Service, but is not a Covered Service under the applicable Benefit Plan because it is determined through the prior authorization process to not meet the requirement of medical necessity, as defined in the Benefit Plan or applicable law (or not meet a similar concept in the Benefit Plan, such as not being consistent with nationally recognized scientific evidence as available, or not being consistent with prevailing medical standards and clinical guidelines), Participating Professional may seek or collect payment from the Customer, if, prior to receiving the service, the Customer had knowledge of the determination of non-coverage and specifically agreed in writing to be responsible for payment of those charges.

8.6 Retroactive correction of information regarding whether patient is a Customer. Prior to rendering services, Participating Provider will ask the patient to present his or her Customer identification card. In addition, Participating Provider may contact United to obtain the most current information available to United on the patient's status as a Customer.

However, such information provided by United is subject to change retroactively, under any of the following circumstances:

i) if United has not yet received information that an individual is no longer a Customer;

ii) if the individual's Benefit Plan is terminated retroactively for any reason including, but not limited to, non-payment of premium;

iii) as a result of the Customer's final decision regarding continuation of coverage pursuant to state and federal laws; or

iv) if eligibility information United receives is later proven to be false.

If Participating Provider 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 are not payable under this Agreement, and any payments made with regard to those services may be recovered as overpayments under the process described in section 8.10 of this Agreement. Participating Provider may then directly bill the individual, or other responsible party, for those services.

8.7 Payment under this Agreement is payment in full. Payment as provided under section 8.4 of this Agreement, together with any copayment, deductible or coinsurance for which the Customer is responsible under the Benefit Plan, is payment in full for a Covered Service. Participating Provider will not seek to recover, and will not accept any payment from Customer, United, Payer or anyone acting on any of their behalves, in excess of payment in full as provided in this section 8.7, regardless of whether that amount is less than Participating Provider's billed charge or Customary Charge.

8.8 Customer hold harmless. Participating Provider 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 Participating Provider's billed charge or Customary Charge, or for any amounts denied or not paid under this Agreement due to:

i) Participating Provider's failure to comply with the Protocols,

ii) Participating Provider'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 these circumstances, or

vi) a denial based on lack of medical necessity or consistency with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines, except as permitted under section 8.5 of this Agreement.

This obligation to refrain from billing Customers applies even in those cases in which Participating Provider believes that United or Payer has made an incorrect determination. In such cases, Participating Provider 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 8.8, Participating Provider may seek payment directly from the Payer or from Customers covered by that Payer if Participating Provider first inquires in writing to United as to whether the Payer has defaulted and, if so confirmed, gives United 15 days prior written notice of Participating Provider'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.

Section 8.7 and this section 8.8 will survive the termination of this Agreement, with regard to Covered Services rendered prior to when the termination takes effect.

8.9 Consequences for failure to adhere to Customer protection requirements. If Participating Provider collects payment from, brings a collection action against, or asserts a lien against a Customer for Covered Services rendered (other than for the applicable copayment, deductible or coinsurance), contrary to section 8.7 or 8.8 of this Agreement, Participating Provider will be in breach of this Agreement. This section 8.9 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 Participating Provider to collect such payment from Customer.

In the event of such a breach, Payer may deduct, from any amounts otherwise due Participating Provider, 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 and otherwise enforcing sections 8.7 through 8.9 of this Agreement. Any amounts deducted by Payer in accordance with this provision will 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.

8.10 Correction of claims payments. If Participating Provider does not seek correction of a given claim payment or denial by giving notice to United within 12 months after the claim was initially processed, Participating Provider will have waived any right to subsequently seek such correction under this section 8.10, or through dispute resolution under Article IX of this Agreement or in any other forum.

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

Recovery of overpayments may be accomplished by offsets against future payments.

8.11 Claims payment issues arising from departure of Participating Professional. In the event a Participating Professional departs from a medical group that is a Participating Provider, and uncertainty arises as to whether that medical group or some other entity is entitled to receive payment for certain services rendered by such former Participating Professional, the parties will cooperate with each other in good faith in an attempt to resolve the situation appropriately.

In the event that Participating Professional's failure to give timely notice under section 6.14 (iv) of this Agreement resulted in claims payments being made incorrectly to the medical group that is a Participating Provider, that medical group will promptly notify United and return such payments

to United. In the event that medical group fails to do so, United may hold the medical group liable for any attorneys' fees, costs, or administrative expenses incurred by United as a result.

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

Article IX
Dispute Resolution

The parties will work together in good faith to resolve any and all disputes between them ("Disputes") including, but not limited to the existence, validity, scope or termination of this Agreement or any term thereof, and all questions of arbitrability, with the exception of any question regarding the availability of class arbitration or consolidated arbitration, which is expressly waived below. Disputes also include any dispute in which Participating Provider is acting as the assignee of one or more Customer. In such cases, Participating Provider agrees that the provisions of this Article IX will apply, including without limitation the requirement for arbitration.

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 Organization or Participating Provider before Organization or Participating Provider may invoke any right to arbitration under this Article IX.

For Disputes regarding payment of claims, a party must have timely initiated and completed the claim reconsideration and appeal process as set forth in the Administrative Guide in order to initiate the Dispute process.

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 may do so only by submitting the Dispute to binding arbitration conducted by the American Arbitration Association ("AAA") in accordance with the AAA Healthcare Payor Provider Arbitration Rules, as they may be amended from time to time (see http://www.adr.org), except that, in any case involving a Dispute in which a party seeks an award of $1,000,000 or greater or seeks termination of this Agreement, a panel of three arbitrators will be used; a single arbitrator cannot award $1,000,000 or more or order that this Agreement is terminated. The arbitrator(s) will be selected from the AAA National Healthcare Roster (as described in the AAA Healthcare Payor Provider Arbitration Rules) or the AAA's National Roster of Arbitrators (as described the AAA Commercial Arbitration Rules and Mediation Procedures). Unless otherwise agreed to in writing by the parties, if the party wishing to pursue the Dispute does not initiate the arbitration within one year after the date on which written notice of the Dispute was given, or, for Disputes subject to the procedures or processes described in the previous paragraph, within one year after the completion of the applicable procedure or process, it will have waived its right to pursue the Dispute in any forum.

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

Except as may be required by law, neither a party, including without limitation, the parties' representatives, consultants and counsel of record in the arbitration, nor an arbitrator may disclose the existence, content, or results of any arbitration hereunder, or any Confidential Arbitration Information, without the prior written consent of all parties. "Confidential Arbitration Information" means any written submissions in an arbitration by either party, discovery exchanged, evidence submitted, transcriptions or other records of hearings in the matter and any orders and awards issued, and any reference to whether either party won, lost, prevailed, or did not prevail against the other party in any arbitration proceeding, as well as any settlement agreement related to an arbitration. However, judgment on the award may be entered under seal in any court having jurisdiction thereof, by either party.

The parties expressly intend that any arbitration be conducted on an individual basis, so that no third parties may be consolidated or joined or allowed to proceed with class arbitration. The parties agree that any arbitration ruling allowing class arbitration, or requiring consolidated arbitration involving any third party(ies), would be contrary to the terms of this Agreement and require immediate judicial review. Notwithstanding anything in this Agreement to the contrary, this paragraph may not be severed from Article IX of the Agreement under any circumstances, including but not limited to unlawfulness, invalidity or unenforceability.

The decision of the arbitrator(s) on the points in dispute will be binding. The parties acknowledge that because this Agreement affects interstate commerce, the Federal Arbitration Act applies.

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, the litigation. The 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 the termination exist, the matter will be resolved through arbitration under this Article IX. While the arbitration remains pending, the termination for breach will not take effect.

This Article IX will survive any termination of this Agreement.

Article X
Term and Termination

10.1 **Term.** This Agreement will take effect on the Effective Date. This Agreement has an initial term of [three] years and renews automatically for renewal terms of one year, until terminated pursuant to section 10.2 of this Agreement.

10.2 **Termination of this Agreement.** This Agreement may be terminated by United or Organization as follows:

i) upon 180 days' prior written notice, effective at the end of the initial term or any renewal term.

ii) upon 60 days' prior written notice in the event of a material breach of this Agreement by the other party, which notice will include a specific description of the alleged breach; however, the termination will not take effect if the breach is cured within 60 days after notice of the termination or if the termination is deferred under Article IX of this Agreement.

iii) upon 10 days' prior 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 this Agreement.

10.3 Termination of a Participating Provider. United may terminate a Participating Provider's participation in United's network as follows:

i) immediately, upon becoming aware of any of the following:

a) The suspension, revocation, condition, limitation, qualification or other material restriction on a Participating Provider's license, certification and/or permit by any government agency under which the Participating Provider is authorized to provide health care services.

b) The suspension, revocation, condition, limitation, qualification or other material restriction of a Participating Professional's staff privileges at any licensed hospital, nursing home or other facility at which the Participating Professional has staff privileges during the term of this Agreement.

c) Any criminal charge related to the practice of Participating Provider's profession or for an indictment, arrest, or conviction for a felony.

d) A sanction imposed by any governmental agency or authority, including Medicare or Medicaid.

e) The failure to meet the requirements of United's credentialing program to the extent that those requirements apply to the Participating Provider.

f) Participating Provider's agreement with Organization terminates for any reason.

ii) United may also terminate a Participating Provider's participation in United's network as follows:

a) Upon 90 days' prior written notice to Participating Provider and Organization.

b) Upon 60 days' prior written notice in the event of a material breach of this Agreement by the Participating Provider, which notice will include a specific description of the alleged breach; however, the termination will not take effect if the breach is cured within 60 days after notice of the termination or if the termination is deferred under Article IX of this Agreement.

Additional language for PHO:

c) Upon 10 days prior written notice, in the event that a Participating Facility loses accreditation.

iii) As described in section 8.4 of this Agreement, a Participating Professional may terminate his or her participation under this Agreement in the event of a non-routine fee schedule change.

Notification of Participating Provider terminations will be in accordance with the notice provision set forth in section 11.8 of this Agreement.

10.4 Status of Participating Providers after termination of this Agreement takes effect. In the event this Agreement is terminated by Organization or United, for reasons other than material breach by United, this Agreement will remain in effect with respect to United and each Participating Provider, until terminated by United or by such Participating Provider as follows:

i) upon 180 days' prior written notice, effective at the end of the initial term or any renewal term.

ii) upon 60 days' prior written notice in the event of a material breach of this Agreement by the other party, which notice will include a specific description of the alleged breach; however, the termination will not take effect if the breach is cured within 60 days after notice of the termination or if the termination is deferred under Article IX of this Agreement.

iii) upon 10 days' prior written notice in the event the other party loses licensure or other governmental authorization necessary to perform this Agreement, fails to have insurance as required under this Agreement, or for the reasons stated in section 10.3.

10.5 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 effective date of the termination of a Participating Provider from United's network, or the effective date that a Benefit Plan is added to the list in Appendix 2 of Benefit Plans excluded from this Agreement, the Participating Provider will continue to render those Covered Services to that Customer and this Agreement will continue to apply to those Covered Services, after the termination or exclusion takes effect, for the length of time indicated below:

Covered Service	Continuity of Care Period
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
Any circumstance where Payer is required by applicable law to provide transition coverage of services rendered by Participating Provider after Participating Provider leaves the provider network accessed by Payer.	As required by applicable law

Article XI
Miscellaneous Provisions

11.1 Entire Agreement. In order for this Agreement to be binding, it must be executed by all parties through written or electronic signature. This Agreement is the entire agreement among the parties with regard to the subject matter, and supersedes any prior written or unwritten agreements between the parties or their affiliates with regard to the same subject matter.

11.2 Amendment. United may amend this Agreement on 90 days' written or electronic notice by sending Organization a copy of the amendment, except that United may provide less notice if an amendment is necessary in order to comply with applicable law or regulatory requirements. Neither Organization's nor Participating Provider's signature is 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 Organization or Participating Provider, then Organization may terminate this Agreement, or Participating Provider may terminate its participation, on 60 days' written or electronic notice to United by sending a termination notice within 30 days' after receipt of the amendment. Organization will provide a copy of the amendment to all Participating Providers within 10 days of Organization's receipt of the amendment from United.

11.3 Non-waiver. The waiver by either party of any breach of any provision of this Agreement will not operate as a waiver of any subsequent breach of the same or any other provision.

11.4 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 United Affiliates, upon 30 days' written notice to Organization and the Participating Providers.

Additionally, if United transfers to a third party all of its business described in a given line item in Appendix 2, section 1, or other line of business, United may assign this Agreement, only as it relates to that transferred business, to that third party. Such an assignment will not impact the relationship of the parties under this Agreement with regard to the remainder of United's business.

11.5 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.

11.6 No third-party beneficiaries. United and Organization and Participating Providers are the only entities with rights and remedies under this Agreement.

11.7 Calendar days. Unless this Agreement specifically provides otherwise, all references in this Agreement to a period of days refers to calendar days.

11.8 Notice procedures. Any notice required to be given under this Agreement must be in writing, except in cases in which this Agreement specifically permits electronic notice, or as otherwise permitted or required in the Protocols. Acceptable forms of written notice include facsimile, first class mail, certified mail, or overnight delivery by a national, recognized delivery service. All notices of termination of this Agreement by either party must be sent by certified mail, return receipt requested, addressed to the appropriate party at the address set forth on the signature portion of this Agreement. Each party will provide the other with proper addresses, facsimile numbers and electronic mail addresses. All notices will be deemed received upon receipt by the party to which notice is given or on the 5th business day following mailing, whichever occurs first.

11.9 Confidentiality. The parties will not disclose to a Customer, other health care provider, or other third party 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, including informing Customers, Benefit Plan

sponsors and/or referring providers about the cost of a particular Covered Service or set of Covered Services; or

iii) any customer list of the other party, regardless of how such customer list was generated.

This section 11.9 does not preclude the disclosure of information by United to a third party as part of the process by which the third party is considering whether to purchase services from United.

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.

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

11.11 Regulatory appendices. One or more regulatory appendices 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.

11.12 Severability. Except as otherwise set forth in this Agreement, any provision of this Agreement that is unlawful, invalid or unenforceable in any situation in any jurisdiction will 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.

11.13 Survival. Notwithstanding the termination of this Agreement, this Agreement will continue to apply to Covered Services rendered while this Agreement was in effect. Additionally, section 11.9 of this Agreement, (except for the last paragraph) will survive the termination of this Agreement.

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

[Organization]		*Address to be used to give notice to Organization under this Agreement.*	
Signature:	_____	Street:	_____
Print Name:	_____	City:	_____
Title:		State:	_____Zip Code _____
D/B/A:	_____	Phone:	_____
Date: _____		E-mail:	_____
		Fax:	_____

UnitedHealthcare Insurance Company, on behalf of itself, UnitedHealthcare of Ohio, Inc., UnitedHealthcare Community Plan of Ohio, Inc. and the other entities that are United Affiliates**, as signed by its authorized representative:**	
Signature:	_____
Print Name:	_____
Title:	_____
Date:	_____

Address to be used for giving notice to United under this Agreement
Street_____
City_____
State _____ Zip Code_____
Fax:_____
Email:_____

For office use only: [_____]
[_____]
Month, day and year in which Agreement is first effective: [_____]

Appendix 1
List of Participating Providers

Appendix 1-A
Participating Provider Service Locations and
Participating Professional Roster

Participating Provider attests that this Appendix identifies all services and locations covered under this Agreement.

If Participating Provider includes Organization Professionals, Participating Provider will provide to United the information described in the attached Participating Provider Professional Roster.

IMPORTANT NOTE: Participating Provider acknowledges its obligation under section 6.14 to promptly report any change in Participating Provider's name or Taxpayer Identification Number. Failure to do so may result in denial of claims or incorrect payment.

Practice Name_____
Street Address_____
City_____ State_____ Zip_____
Taxpayer Identification Number(s) (TIN) _____
National Provider ID (NPI) _____

PARTICIPATING PROVIDER LOCATION - List BOTH the Service Location and the Billing Address for the Service Location	
Service Location	**Billing Address for the Service Location (if different from above)**
Participating Provider Name	**Participating Provider Name**
Street Address	**Street Address**
City	**City**
State and Zip Code	**State and Zip Code**
Phone Number	**Phone Number**
TIN (*If different from above*)	
National Provider ID (NPI)	
ADDITIONAL PARTICIPATING PROVIDER LOCATIONS - List BOTH the Service Location and the Billing Address for the Service Location	
Service Location	**Billing Address for the Service Location**
Participating Provider Name	**Participating Provider Name**
Street Address	**Street Address**
City	**City**
State and Zip Code	**State and Zip Code**

Phone Number	**Phone Number**
TIN (*If different from above*)	
National Provider ID (NPI)	
Participating Provider Name	**Participating Provider Name**
Street Address	**Street Address**
City	**City**
State and Zip Code	**State and Zip Code**
Phone Number	**Phone Number**
TIN (*If different from above*)	
National Provider ID (NPI)	
Participating Provider Name	**Participating Provider Name**
Street Address	**Street Address**
City	**City**
State and Zip Code	**State and Zip Code**
Phone Number	**Phone Number**
TIN (*If different from above*)	
National Provider ID (NPI)	

Participating Professional Roster

IMPORTANT NOTE: Participating Professional acknowledges its obligation to notify United of any change in Participating Professionals in accordance with Article IV and section 6.14. Failure to do so may result in denial of claims or incorrect payment.

Participating Professional represents that it has provided United with a Participating Provider Professional Roster that includes all of the following data elements for each Participating Provider:

- Name of Professional (first name, middle initial, last name)
- Degree (MD, DO, NP, PA, other)
- Gender (M/F)
- Provider Specialty(ies) (primary, secondary, additional specialties)
- Operates as and willing to be listed/assigned as a Primary Care Professional "PCP" (Y/N)
- State License Number
- Medicaid ID Number
- NPI Number
- Foreign Language(s)
- Admitting Hospital(s)

If any data element is not applicable to a specific Participating Professional, Participating Professional will indicate "not applicable" in the appropriate field. Acceptable formats include in writing, electronically in Excel, ANSI, or text (comma delineated) formats.

[Participating Facility Requirements Appendix

The provisions of this Appendix apply to Participating Facilities, and will supersede and replace any conflicting provision in the Agreement.

1.1 Accessibility. Participating Facilities will be open 24 hours a day, seven days a week.

1.2 Additional Participating Facility Protocols. Participating Facility will make reasonable commercial efforts to ensure that all facility-based physician groups participate in United's network as long as this Agreement is in effect.

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

i) meet with Organization facility-based physician group to encourage participation and require exchange or proposals. Facility Representative will provide United with meeting minutes within 15 days after the meeting. Meeting minutes will include a summary of the key discussion points and an outline of any actionable resolution options deemed by Facility Representative.

ii) write letter(s) to Organization 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 Participating Facility and Organization facility-based physician group that requires Organization facility-based physician group to negotiate in good faith with third party payers, or participate in third party payer networks, and any other provisions related to Organization facility-based physician group's participation with third party payers.

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

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

United will negotiate with Organization facility-based physician groups in good faith. United has no responsibility for the credentialing of any employed or sub-contracted Organization facility-based provider.

1.3 Liability insurance. Participating Facilities will procure and maintain 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 will be, at a minimum, of the types and in the amounts set forth below. Medical malpractice insurance will be either occurrence or claims made with an extended period reporting option. Upon request, Organization will submit to United in writing evidence of insurance coverage.

	Minimum Limits
Type of Insurance	**Participating Facilities**
Medical malpractice and/or professional liability insurance	$5,000,000.00 per occurrence and aggregate
Commercial general and/or umbrella liability insurance	$5,000,000.00 per occurrence and aggregate

In lieu of purchasing the insurance coverage required in this section, Participating Facility may self-insure its medical malpractice and/or professional liability, as well as its commercial general liability. Participating Facility will maintain a separate reserve for its self-insurance. If Participating Facility uses the self-insurance option described in this paragraph, Participating Facility 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. Participating Facilities will provide a similar statement during the term of this Agreement upon United's request, which will be made no more frequently than annually. Participating Facilities will assure that its self-insurance fund will comply with applicable laws and regulations.

1.4 Access to Data. Notwithstanding section 6.9 of the Agreement, Participating Facility agrees that it will participate in The Leapfrog Group's annual patient safety survey if Participating Facility is among the hospitals Leapfrog seeks to survey.

1.5 Implementation of quality improvement and patient safety programs. Participating Facility will implement quality programs applicable to Participating Facility that are 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), as may be updated from time to time in the Protocols.

1.6 Never events. In the event a "never event" occurs in connection with Participating Facility rendering services to a Customer, Participating Facility will take the then-current 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:

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

ii) 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);

iii) Perform a root cause analysis, consistent with instructions from the chosen reporting agency; and

iv) Waive all costs directly related to the event. In order to waive such costs, Participating Facility will not submit a claim for such costs to United or Payer (except as required by an applicable Payment Policy) 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 1.6, a "never event" is an event included in the list "serious reportable events" published by the National Quality Forum (NQF), as the list may be updated from time to time by the NQF and adopted by Leapfrog.

1.7 Time to file claims. Unless a longer timeframe is required under applicable law, all information necessary to process a claim must be received by United no more than 90 days from the date of discharge or from the date outpatient Covered Services are rendered. If Payer is not the primary payer, and Participating Facility is pursuing payment from the primary payer, the timely filing limit will begin on the date Participating Facility receives the claim response from the primary payer.

In the event United requests additional information in order to process a claim, Participating Facility will provide that additional information within 90 days of United's request, unless a longer timeframe is required under applicable law.

1.8 Payment of claims for Covered Services. Payer will pay claims for Covered Services rendered by Participating Facilities as further described in the applicable Payment Appendix to this

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.

1.9 Denial of claims for not following Protocols, for not filing timely, for services not Covered under the Customer's Benefit Plan, or for lack of medical necessity.

Note: If any provision of this section 1.9 conflicts with any Additional Manual, as described in the Additional Manuals Appendix, the Additional Manual controls, with respect to those Payers and Benefit Plans covered by the Additional Manual. However, the Additional Manual does not control where it conflicts with applicable statutes or regulations.

If in the future United modifies the utilization management program applicable to certain of the Benefit Plans described in the paragraph above, so as to make that program consistent with the utilization management program that applies to the other Benefit Plans subject to this Agreement, United may cause this entire section 1.9 to apply to those Benefit Plans by giving 90 days written notice to Participating Facility.

i) Non-compliance with Protocol. Payment may be denied in whole or in part if Participating Facility does not comply with a Protocol or does not file a timely claim as required under section 8.3 of this Agreement.

In the event payment is denied under this subsection 1.9(i) for Participating Facility's failure to comply with a Protocol regarding notification or regarding lack of coverage approval on file, Participating Facility may request reconsideration of the denial, and the denial under this subsection (i) will be reversed if Participating Facility can show:

a) the denial was incorrect because Participating Facility complied with the Protocol; or

b) Participating Facility's services were medically necessary (as "medically necessary" is defined in subsection (vii)); or

c) at the time the Protocols required notification or prior authorization, Participating Facility did not know and was unable to reasonably determine that the patient was a Customer, Participating Facility took reasonable steps to learn that the patient was a Customer, and Participating Facility promptly submitted a claim after learning the patient was a Customer.

The grounds stated in clause (b) above are also a basis for reconsideration of a denial under subsection (iii), (iv) or (v) of this section 1.9.

The grounds stated in clause (c) above are also a basis for reconsideration of a denial for lack of timely claim filing under section 8.3 of this Agreement.

A claim denied under this subsection (i) is also subject to denial for other reasons permitted under the Agreement; reversal of a denial under this subsection (i) does not preclude United from upholding a denial for one of these other reasons.

ii) Non-Covered Services. Services not covered under the applicable Benefit Plan are not subject to the rates or discounts of this Agreement. Participating Facility may seek and collect payment from a Customer for such services (provided that Participating Facility obtained the Customer's written consent), except as provided below in subsections 1.9(iv), (v) and (vi).

If a service is not a Covered Service because a discharge order has been written by a physician treating the Customer but the Customer has elected to remain an inpatient, Participating Facility may seek and collect payment from the Customer for those non-Covered Services, but only if, (a) prior to receiving the service, the Customer had knowledge of the discharge order and the lack of coverage for additional inpatient service and specifically agreed in writing to be responsible for payment of those charges; or (b) Participating Facility maintains a written record of the Customer's refusal to agree in writing to be responsible for those charges.

iii) Denials for lack of medical necessity through the prior authorization process. If a service would otherwise be a Covered Service, but is not a Covered Service under the applicable Benefit Plan because it is determined through the prior authorization process to not meet the Benefit Plan's requirement of medical necessity, as defined in the Benefit Plan or applicable law (or not meet a similar concept in the Benefit Plan, such as not being consistent with nationally recognized scientific evidence as available, or not being consistent with prevailing medical standards and clinical guidelines), Participating Facility may seek or collect payment from the Customer but only if, prior to receiving the service, the Customer had knowledge of the determination of non-coverage and specifically agreed in writing to be responsible for payment of those charges.

iv) Clinical review of inpatient bed days. If a determination is made after a Customer becomes an inpatient that certain services are not medically necessary (including cases in which a part of an admission is determined to be medically necessary and part of the same admission is determined not to be medically necessary), the claim with regard to services that are not medically necessary (including room, board, and other services for a given day) may be denied and Participating Facility must not seek or collect payment from the Customer. Payment will be made in accordance with the applicable payment appendix for the part of the admission that is determined to be medically necessary, and Participating Facility may collect from the Customer the applicable copayment, deductible or coinsurance for that part of the admission. A claim may also be denied in whole or in part under this subsection 1.9(iv) in cases in which services cannot be determined to be medically necessary due to omission of information or

failure to respond to United's request for information; Participating Facility may request reconsideration of such a denial on grounds of medical necessity.

United will not reduce payment under this subsection 1.9(iv) when the contract rate for the claim is not impacted by the length of stay, because the contract rate is determined by an MS-DRG or similar methodology and is not subject to an inpatient outlier provision.

v) Level of care determinations. United may determine that the level of care provided for a given service was not medically necessary, because the service could more appropriately have been rendered at a lower level of care (for instance, observation or ambulatory surgery rather than inpatient, or medical/surgical rather than ICU or CCU). If Participating Facility submits a claim for the level of care deemed not medically necessary, United may deny the claim, and Participating Facility will not seek or collect payment from the Customer. A claim may also be denied in whole or in part under this subsection (v) in cases in which services cannot be determined to be medically necessary due to omission of information or failure to respond to United's request for information; Participating Facility may request reconsideration of such a denial on grounds of medical necessity.

vi) Delay in service. If United determines that Participating Facility did not execute a physician's written order in a timely manner and that, as a result, the Customer's inpatient stay was lengthened, United may deny the claims with regard to the bed day(s) at the end of the stay that would not have been needed were it not for the delay in service (including room, board and other services for the given day), and process the claim based on the contract rate that would apply without that day(s); Participating Facility will not seek or collect payment from Customer in excess of the coinsurance, copayment or deductible associated with the claim as processed.

United will not reduce payment under this subsection 1.9(vi) when the contract rate for a claim is not impacted by the length of stay, because the contract rate is determined by an MS-DRG or similar methodology and is not subject to an inpatient outlier provision.

vii) Definition. As used in subsection 1.9(iii), "medical necessity" or "medically necessary" will be defined in accordance with the applicable Benefit Plan and applicable law or regulatory requirements.

As used in subsections 1.9(i), (iv) and (v), "medical necessity" or "medically necessary" is defined as follows:

Medically Necessary - health care services provided for the purpose of preventing, evaluating, diagnosing or treating a sickness, injury, substance use disorder, condition, disease or its symptoms, that are all of the following as determined by United or its designee, within its sole discretion.

- In accordance with Generally Accepted Standards of Medical Practice.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the customer's sickness, injury, substance use disorder, disease or its symptoms.
- Not mainly for the Customer's convenience or that of the Customer's physician or other health care provider.

- Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Customer's sickness, injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on physician specialty society recommendations or professional standards of care may be considered. United reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within United's sole discretion.

Appendix 2
Benefit Plan Descriptions

Section 1. United may allow Payers to access Participating Provider's services under this Agreement for the Benefit Plan types described in each line item below, unless otherwise specified in section 2 of this Appendix 2:

- [Benefit Plans where Customers are offered a network of participating providers and must select a primary physician, who in some cases must approve any care provided by other health care providers. 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.]

- [Group PPO Medicare Advantage Benefit Plans.]

- [Medicare Advantage Benefit Plans.]

- [Benefit Plans for Medicare Select.]

- [Ohio Medicare and Medicaid Enrollees (MME) Benefit Plans.]

- [Ohio Medicaid Benefit Plans.]

- [Hoosier Care Connect Medicaid Benefit Plans.]

- [Kentucky Medicaid and CHIP Benefit Plans.]

- [Michigan Medicaid Benefit Plans and Michigan CHIP Benefit Plans, including but not limited to Michigan Children's Special Health Care Services Benefit Plans.]

- [Pennsylvania Medicaid Benefit Plans.]

- [Pennsylvania CHIP Benefit Plans.]

- [Individual Exchange Benefit Plans.]

- [Additional Network Benefit Plans. As used here Additional Network Benefit Plans means commercial narrow network Benefit Plan types in which Participating Provider does not participate, as described in section 2 of this Appendix 2, but that provide for an additional network of providers for outpatient emergency services, inpatient services following an emergency admission, urgent care services and services pre-approved by United. Additional Network Benefit Plan types will be identified by the notation "W500" on the Customer's ID card. United may modify this ID card notation in the future, and will provide Participating Provider with the updated information.]

Section 2. Notwithstanding the above section 1 of this Appendix 2, this Agreement will not apply to the Benefit Plan types described in the following line items:

- [This Agreement does not apply to commercial Benefit Plans other than those described in section 1, above.]

- [Benefit Plans where Customers are offered a network of participating providers and must select a primary physician, who in some cases must approve any care provided by other health care providers. 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 Advantage Benefit Plans other than Group PPO Medicare Advantage Benefit Plans.]

- [Medicare Advantage Benefit Plans.]

- [Ohio Medicare and Medicaid Enrollees (MME) Benefit Plans.]

- Medicare and Medicaid Enrollees (MME) Benefit Plans other than those separately addressed in this Appendix 2.

- Benefit Plans for workers' compensation benefit programs..

- Medicaid Benefit Plans other than those separately addressed in this Appendix 2.

- [Individual Exchange Benefit Plans.]

- [Benefit Plans for Medicare Select.]

- Medicare Advantage Private Fee-For-Service Benefit Plans and Medicare Advantage Medical Savings Account Benefit Plans.

- [Ohio Medicaid Benefit Plans.]

- [Hoosier Care Connect Medicaid Benefit Plans.]

- [Kentucky Medicaid and CHIP Benefit Plans.]

- [Michigan Medicaid Benefit Plans and Michigan CHIP Benefit Plans, including but not limited to Michigan Children's Special Health Care Services Benefit Plans.]

- [Pennsylvania Medicaid Benefit Plans.]

- [Pennsylvania CHIP Benefit Plans.]

- CHIP Benefit Plans.

- Other Governmental Benefit Plans.

- [UnitedHealthcare Navigate Benefit Plans. As used here, UnitedHealthcare Navigate Benefit Plans means commercial narrow network Benefit Plans for which the Customer selects or is assigned a primary care physician to manage the Customer's health care needs and referrals to network specialists, and that are marketed under a name that includes the word "Navigate". References to "UnitedHealthcare Navigate" also apply to any brand name adopted by United in the future to supplement and/or replace "UnitedHealthcare Navigate".]

- [UnitedHealthcare Core Benefit Plans. As used here, UnitedHealthcare Core Benefit Plans means commercial narrow network Benefit Plans marketed under a name that includes the word "Core". References to "UnitedHealthcare Core" also apply to any brand name adopted by United in the future to supplement and/or replace "UnitedHealthcare Core".]

- [UnitedHealthcare Charter Benefit Plans. As used here, UnitedHealthcare Charter Benefit Plans means commercial narrow network Benefit Plans for which the Customer selects or is assigned a primary care physician to manage the Customer's health care needs and referrals to network specialists, and that are marketed under a name that includes the word "Charter". References to "UnitedHealthcare Charter" also apply to any brand name adopted by United in the future to supplement and/or replace "UnitedHealthcare Charter".]

Note: Excluding certain Benefit Plans or programs from this Agreement does not preclude the parties or their affiliates from having or entering into a separate agreement providing for Participating Provider's participation in a network for such Benefit Plans or Programs.

Section 3. Definitions:

Note: United may adopt a different name for a particular Benefit Plan, and/or may modify information referenced in the definitions in this Appendix 2 regarding Customer identification cards. If that happens, section 1 or section 2 of this Appendix 2 will continue to apply to those Benefit Plans as it did previously, and United will provide Participating Provider with the updated information. Additionally, United may revise the definitions in this Appendix 2 to reflect changes in the names or roles of United's business units, provided that doing so does not change Participating Provider's participation status in Benefit Plans impacted by that change, and further provided that United provides Participating Provider with the updated information.

MEDICARE:

- **Medicare Advantage Benefit Plans** means Benefit Plans sponsored, issued or administered by a Medicare Advantage organization as part of:
  i) the Medicare Advantage program under Title XVIII, Part C of the Social Security Act, or
  ii) the Medicare Advantage program together with the Prescription Drug program under Title XVIII, Part C and Part D, respectively, of the Social Security Act,
  as those program names may change from time to time.

- [**PPO Medicare Advantage Benefit Plans** means Medicare Advantage Benefit Plans that (A) have a network of providers that have agreed to a contractually specified reimbursement for covered benefits with the organization offering the plan; (B) provide for reimbursement for all covered benefits regardless of whether the benefits are provided within the network of providers; and (C) are offered by an organization that is not licensed or organized under state law as an HMO.

- **Group PPO Medicare Advantage Benefit Plans** means PPO Medicare Advantage Benefit Plans that are employer/union-only group waiver Medicare Advantage Benefit Plans that offer customized benefits offered exclusively to eligible members of an employer/union group. These Benefit Plans will include a reference to "UnitedHealthcare Group Medicare Advantage (PPO)" on the face of the valid identification card of any Customer eligible for and enrolled in those Benefit Plans.]

- **Medicare and Medicaid Enrollees (MME) Benefit Plan** means the CMS sponsored Financial Alignment Demonstration Plan providing integrated care benefits for individuals eligible for both the state Medicaid program and the Medicare program (Parts A, B, C and D). At such time as this Benefit Plan is no longer a demonstration project and is fully implemented in the state, this definition will be interpreted to refer to the fully implemented plan.

MEDICAID, CHIP AND OTHER STATE PROGRAMS:

- **Medicaid Benefit Plans** means Benefit Plans that offer coverage to beneficiaries of a program that is authorized by Title XIX of the federal Social Security Act, and jointly financed by the federal and state governments and administered by the state.

- **Ohio Medicaid Benefit Plans** means Medicaid Benefit Plans issued in Ohio that include a reference to "UnitedHealthcare Community Plan" on the valid identification card of any Customer eligible for and enrolled in that Benefit Plan.

- [**Hoosier Care Connect Medicaid Benefit Plans** means Medicaid Benefit Plans issued in Indiana that include a reference to "UnitedHealthcare Community Plan" and "Hoosier Care Connect (HCC)" on the face of the valid identification card of any Customer eligible for and enrolled in that Benefit Plan.]

- **[Kentucky Medicaid and CHIP Benefit Plans** are Medicaid and CHIP Benefit Plans issued in Kentucky that include a reference to "UnitedHealthcare Community Plan" on the identification card of any Customer eligible for and enrolled in that Benefit Plan.]

- **[Michigan Medicaid Benefit Plans** means Medicaid Benefit Plans issued in Michigan under the program that is now known as the Comprehensive Health Care Program ("CHCP"), as that program name may change from time to time, that have a reference to "Michigan" on the identification card of any Customer eligible for and enrolled in that Benefit Plan.]

- **[Michigan Children's Special Health Care Services Benefit Plans** ("CSHCS") means a Medicaid Benefit Plan, within the Michigan Department of Community Health ("MDCH") to find, diagnose, and treat children in Michigan who have chronic illnesses or disabling conditions, that include a reference to "Michigan" on the identification card of any Customer eligible for and enrolled in that Benefit Plan. CSHCS is mandated by the Michigan Public Health Code, Public Act 368 of 1978, in cooperation with the federal government under Title V of the Social Security Act and the annual MDCH Appropriations Act.]

- **[Pennsylvania Medicaid Benefit Plans** means Medicaid Benefit Plans issued in Pennsylvania that include a reference to "UnitedHealthcare Community Plan for Families" on the valid identification card of any Customer eligible for and enrolled in that Benefit Plan.]

- **Children's Health Insurance Program ("CHIP") Benefit Plans** means Benefit Plans under the program authorized by Title XXI of the federal Social Security Act that is jointly financed by the federal and state governments and administered by the state.

- **[Michigan CHIP Benefit Plans** means CHIP Benefit Plans issued in Michigan that include a reference to "Michigan" on the valid identification card of any Customer eligible for and enrolled in that Benefit Plan.]

- **[Pennsylvania CHIP Benefit Plans** means CHIP Benefit Plans issued in Pennsylvania that include a reference to "UnitedHealthcare Community Plan for Kids" on the valid identification card of any Customer eligible for and enrolled in that Benefit Plan.]

- **Other Governmental Benefit Plans** means Benefit Plans that are funded wholly or substantially by a state or district government or a subdivision of a state (such as a city or county), but do not include Benefit Plans for:
  i) employees of a state government or a subdivision of a state and their dependents;
  ii) students at a public university, college or school;
  iii) employer-based coverage of private sector employees, even if the employer receives a government subsidy to help fund the coverage;
  iv) Medicaid beneficiaries;
  v) Children's Health Insurance Program (CHIP) beneficiaries; and
  vi) Medicare and Medicaid Enrollees (MME).

OTHER:

- **Individual Exchange Benefit Plans** means benefit plans administered pursuant to the federal Patient Protection and Affordable Care Act including benefit plans marketed through Individual Exchanges administered by either the federal government and/or a state government, and any off-Exchange version of such benefit plans (but not including benefit plans which are offered by employers or other group sponsors through an exchange mechanism, whether operated by the employer or group or by the federal or state government or other third party.)

Additional Manuals Appendix

For some of the Benefit Plans for which Participating Provider may provide Covered Services under this Agreement, Participating Provider is subject to additional requirements of one or more additional provider manuals ("Additional Manuals"). When this Agreement refers to Protocols or Payment Policies, it is also referring to the Additional Manuals. An Additional Manual may be a separate document or it may be a supplement to the UnitedHealthcare Care Provider Administrative Guide ("UnitedHealthcare Administrative Guide").

For Benefit Plans subject to an Additional Manual, the Additional Manual controls if it conflicts with any of the following: (1) a provision of this Agreement or of the UnitedHealthcare Administrative Guide; or (2) a United Protocol or Payment Policy. However, the Additional Manual does not control where it conflicts with applicable statutes or regulations.

The Additional Manuals will be made available to Participating Provider on a designated website and upon request. The names of the Additional Manuals, the websites to view and download them, and the Benefit Plans to which they apply, are listed in Table 1 below. United may change the location of a website or the Customer identification card identifier used to identify Customers subject to a given Additional Manual; if United does so, United will inform Participating Provider.

United may make changes to the Additional Manuals subject to this Appendix in accordance with the provisions of this Agreement relating to Protocol and Payment Policy changes.

Table 1

Benefit Plan(s)	**Description of Applicable Additional Manual**	**Website**
[No Additional Manuals Apply]		
[Ohio Medicaid Benefit Plans	UnitedHealthcare Community Plan of Ohio Physician, Health Care Professional, Facility and Ancillary Provider Care Provider Manual: Medicaid	www.UHCprovider.com]
[Ohio Medicare and Medicaid Enrollees Benefit Plans	UnitedHealthcare Community Plan of Ohio Physician, Health Care Professional, Facility and Ancillary Provider Care Provider Manual: UnitedHealthcare Connected for MyCare Ohio	www.UHCprovider.com]
[Hoosier Care Connect Medicaid Benefit Plans,	Care Provider Manual for Physician, Health Care Professional, Facility and Ancillary - - Indiana - - Hoosier Care Connect	www.UHCprovider.com]
[Kentucky Medicaid and CHIP Benefit Plans	UnitedHealthcare Community Plan Physician, Health Care Professional, Facility and Ancillary Administrative Guide	www.UHCprovider.com]

[Michigan Medicaid Benefit Plans and Michigan CHIP Benefit Plans, including but not limited to Michigan Children's Special Health Care Services Benefit Plans	UnitedHealthcare Community Plan of Michigan Physician, Health Care Professional, Facility and Ancillary Care Provider Manual	www.UHCprovider.com]
[Pennsylvania Medicaid, CHIP, Healthy Pennsylvania Program	Pennsylvania UnitedHealthcare Community Plan Physician, Health Care Professional, Facility and Ancillary Administrative Guide.	www.UHCprovider.com]

HEALTH CARE PROVIDER SUMMARY DISCLOSURE FORM
UNITEDHEALTHCARE OF OHIO, INC.

HEALTH CARE PROVIDER: _____
Provider Type: _____ Provider Organization Participation Agreements (for IPAs and PHOs)

I. Compensation and Payment

Manner of Payment:

IPA	PHO
_____ Fee for Service	_____ Fee For Service (includes fixed rates, per unit and /or fee schedule)
_____ Capitation	_____ Per Visit
_____ Risk	_____ Other_____
_____ Other	

Reimbursement Methodology: See attached Appendix _____

Fee Schedule Information: Fee Schedule Samples are accessible via www.UHCprovider.com or by calling; Cleveland: 1-800-468-5001 Columbus: 1-800-328-8835 Cincinnati/Dayton (SW Ohio): 1-800-752-7106

Reimbursement Policies: Claim edits may be inquired through Claim Estimator at www.UHCprovider.com or by calling; Cleveland: 1-800-468-5001 Columbus: 1-800-328-8835 Cincinnati/Dayton (SW Ohio): 1-800-752-7106

II. List of Products or Networks Covered by this Agreement

- _____ **Options PPO**
- _____ **Commercial Plan other than Options PPO**
- _____ **Medicare**
- _____ **Medicaid**
- _____ **Indemnity**

For additional detail see enclosed Benefit Plan Descriptions Appendix

III. Term/Duration of Contract

Duration:

- _____ **Provider Organization Participation Agreement (Opt-In) - _____Years, with automatic renewal for one year terms thereafter**
- _____ **Provider Organization Participation Agreement (Single Signature) - _____Years, with automatic renewal for one year terms thereafter**

IV. Identity of person responsible for processing claims; Telephone Number

United HealthCare Insurance Company and/or United Affiliates.
Refer to Member ID Card for mailing and electronic submission of claims
For information regarding the contents of this form, please call:

- _____ **Cleveland – 1-800-468-5001**
- _____ **Columbus – 1-800-328-8835**
- _____ **Cincinnati/Dayton (SW Ohio) – 1-800-752-7106**

V. Dispute Resolution Process

Provider Organization Participation Agreements - Please refer to the Dispute Resolution section of the agreement.

You can also find information on the Dispute Resolution Process in the Administrative Guide.

VI. Subject and Order of Addenda	
Provider Organization Agreement (Opt-In) **_____ Appendix 1 (Opt-In Form)** **_____ Appendix 1-A (Participating Provider Service Locations and** **_____ Participating Professional Roster** **_____ Participating Facility Requirements Appendix (PHOs only)** **_____ Appendix 2 – Benefit Plan Descriptions Appendix** **_____ Additional Manuals Appendix** **_____ Payment Appendix(ices)** **_____ Medicare Advantage Regulatory Appendix** **_____ Medicaid Regulatory Appendix, including Medicaid Addendum** **_____ Ohio Regulatory Appendix**	**Provider Organization Agreement (Single Signature)** **Appendix 1 (List of Participating Providers)** **_____ Appendix 1-A (Participating Provider Service Locations and** **_____ Participating Professional Roster** **_____ Participating Facility Requirements Appendix (PHOs only)** **_____ Appendix 2 – Benefit Plan Descriptions Appendix** **_____ Additional Manuals Appendix** **_____ Payment Appendix(ices)** **_____ Medicare Advantage Regulatory Appendix** **_____ Medicaid Regulatory Appendix, including Medicaid Addendum** **_____ Ohio Regulatory Appendix**

IMPORTANT INFORMATION - PLEASE READ CAREFULLY

The information provided in this Summary Disclosure Form is a guide to the attached Health Care Contract as defined in section 3963.01(G) of the Ohio Revised Code. The terms and conditions of the attached Health Care Contract constitute the contract rights of the parties.

Reading this Summary Disclosure Form is not a substitute for reading the entire Health Care Contract. When you sign the Health Care Contract, you will be bound by its terms and conditions. These terms and conditions may be amended over time pursuant to section 3963.04 of the Ohio Revised Code. You are encouraged to read any proposed amendments that are sent to you after execution of the Health Care Contract.

Nothing in this Summary Disclosure Form creates any additional rights or causes of action in favor of either party.