Facility 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 _____ ("Facility").

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

i) _____, ___ or

ii) the first day of the first calendar month that begins at least 30 days after the date when this Agreement has been executed by all parties.

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

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

The parties therefore enter into this Agreement.

Article I
Definitions

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

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

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

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

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

1.5 **Facility Records** are Facility's medical, financial and administrative records related to Covered Services rendered by Facility under this Agreement, including claims records.

1.6 **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 reimbursement rates and terms set forth in this Agreement. The Payment Policies may change from time to time as described in section 5.1 of this Agreement.

1.7 **Payer** is an entity obligated to a Customer to provide reimbursement for Covered Services under the Customer's Benefit Plan, and authorized by United to access Facility's services under this Agreement.

1.8 **Protocols** are the programs and administrative procedures adopted by United or a Payer to be followed by Facility in providing services and doing business with United and Payers under this Agreement. Protocols may include, among other things, credentialing and recredentialing processes, utilization management and care management processes, quality improvement, peer review, Customer grievance, or concurrent review. Protocols may change from time to time as described in section 4.4 of this Agreement.

1.9 **Subcontractor** is an individual or entity contracted or otherwise engaged by a party to this Agreement.

1.10 **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 Facility**. Facility, by virtue of its execution and delivery of this Agreement, represents and warrants as follows:

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

ii) Facility has all requisite corporate power and authority to conduct its business as presently conducted, and to execute, deliver and perform its obligations under this Agreement. The execution, delivery and performance of this Agreement by Facility have been duly and validly authorized by all action necessary under its organizational documents and applicable corporate law. This Agreement has been duly and validly executed and delivered by Facility and (assuming the due authorization, execution and delivery of this Agreement by United) constitutes a valid and binding obligation of Facility, enforceable against Facility in accordance with its terms, except as 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 Facility do not and will not violate or conflict with (a) the organizational documents of Facility, (b) any material agreement or instrument to which Facility is a party or by which Facility or any material part of its property is bound, or (c) applicable law.

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

v) Facility has 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 Facility pursuant to this Agreement will be deemed to constitute the representation and warranty by Facility to United that (a) the representations and warranties of Facility 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) Facility has complied with the requirements of this Agreement with respect to the Covered Services involved and the submission of the 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 Facility) 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 Facility's services.

i) This Agreement applies to Covered Services provided at Facility's service locations set forth in Appendix 1. If a service location is not listed in Appendix 1, this section 3.1 and this Agreement should nevertheless be understood as applying to Facility's actual service locations that existed when this Agreement was executed, rather than to a billing address, post office box, or any other address set forth in Appendix 1.

In the event Facility intends to begin providing services at other service locations or under other Taxpayer Identification Number(s), Facility will provide 60[45] days' advance notice to United. Those additional service locations or Taxpayer Identification Numbers

will become subject to this Agreement only upon the written agreement of the parties. This subsection 3.1(i) applies to cases when Facility adds the location itself (such as through new construction or through conversion of a free-standing location to provider-based), and when Facility acquires, merges with or otherwise becomes affiliated with an existing provider that was not already under contract with United or a United Affiliate to participate in a network of health care providers.

ii) Facility will provide 60[45] days' advance notice to United in the event Facility intends to acquire or be acquired by, merge with, or otherwise become affiliated with another provider of health care services that is already under contract with United or a United Affiliate to participate in a network of health care providers. If one of these events occurs, this Agreement and the other agreement will each remain in effect and will continue to apply as they did prior to the acquisition, merger or affiliation, unless otherwise agreed to in writing by all parties to such agreements.

Similarly, Facility will provide 60[45] days' advance notice to United if Facility intends to buy assets of, or lease space from, a facility under contract directly with United or a United Affiliate to participate in a network of health care providers. If that occurs, and Facility provides services at that location, but does not assume the United contract held by the prior operator, Covered Services rendered at that location will be subject to the same rates and other key terms (including term and termination) as applied under the prior operator's contract.

iii) Facility will provide 60[45] days' advance notice to United in the event Facility intends to transfer all or some of its assets to another entity, with the result that all or some of the Covered Services subject to this Agreement will be rendered by the other entity rather than by Facility. In addition, Facility will request that United approve the assignment of this Agreement as it relates to those Covered Services, and if approved by United, Facility will ensure the other entity agrees to assume this Agreement. This subsection 3.1(iii) does not limit United's right under section 9.4 of this Agreement to elect whether to approve the assignment of this Agreement. This subsection 3.1(iii) applies to arrangements under which another provider intends to lease space from Facility, or intends to enter into a subcontract with Facility to perform services, after the Effective Date of this Agreement, so that Covered Services that were subject to this Agreement as of the Effective Date of this Agreement are rendered and billed instead by the other provider rather than by Facility after the lease or subcontract takes place.

3.2 Payers and Benefit Plans. United may allow Payers to access Facility'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 Facility.

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

Section 8.3 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 6.6 of this Agreement

addresses circumstances in which claims for services rendered to those patients are inadvertently paid.

3.4 Health care. This Agreement and Benefit Plans do not dictate the health care provided by Facility, or govern Facility'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 Facility and with Customers and their physicians, and not with United or any Payer.

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

Article IV
Duties of Facility

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

4.2 Nondiscrimination. Facility will not discriminate against any patient, with regard to quality or accessibility of services, on the basis that the patient is a Customer.

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

4.4 Protocols.

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

a) For non-emergency Covered Services, Facility 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) Facility will make reasonable commercial efforts to ensure that all Facility-based providers participate in United's network as long as this Agreement is in effect.

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

1) meet with Facility-based provider to encourage participation and require exchange of 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.

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

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

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

United will negotiate with Facility-based providers in good faith. United has no responsibility for the credentialing of any employed or sub-contracted Facility-based provider.

c) As further described in the Protocols, Facility 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 Facility online or upon request. Some or all Protocols also may be disseminated in the form of an administrative manual or guide or in other communications. Currently, the Protocols may be found at www.UHCprovider.com, or as indicated in the Additional Manuals Appendix, if applicable. United will notify Facility of any changes in the location of the Protocols.

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

4.5 Employees and Subcontractors. Facility will ensure that its employees, affiliates and any individuals or entities subcontracted by Facility to render services in connection with this Agreement adhere to the requirements of this Agreement. The use of employees, affiliates or Subcontractors to render services in connection with this Agreement will not limit Facility's obligations and accountability under this Agreement with regard to those services. Facility affiliates are those entities that control, are controlled by or are under common control with Facility.

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

4.7 Liability insurance. Facility will procure and maintain liability insurance. Except to the extent coverage is a state mandated placement, Facility's coverage must be placed with insurance carriers that have an A.M. Best Rating of A-VII or better, and that are authorized or approved to write coverage in the state in which the Covered Services are provided. Facility's liability insurance must be, at a minimum, of the types and in the amounts set forth below. Facility's medical malpractice insurance must be either occurrence or claims made with an extended period reporting option of at least three years. Prior to the Effective Date of this Agreement and within 10 days of each policy renewal thereafter, Facility will submit to United in writing evidence of insurance coverage.

TYPE OF INSURANCE	MINIMUM LIMITS
Medical malpractice and/or professional liability insurance	$5,000,000.00 per occurrence/claim and aggregate
Commercial general and/or umbrella liability insurance	$5,000,000.00 per occurrence/claim and aggregate
[Automobile Liability	$5,000,000.00 - combined single limit]

Substitute:

TYPE OF INSURANCE	MINIMUM LIMITS
Medical malpractice and/or professional liability insurance	$10,000,000.00 per occurrence/claim and aggregate
Commercial general and/or umbrella liability insurance	$5,000,000.00 per occurrence/claim and aggregate
[Automobile Liability	$5,000,000.00 - combined single limit]

In lieu of purchasing the insurance coverage required in this section, Facility may self-insure any of the required insurance. Facility will maintain a separate reserve for its self-insurance. Prior to the Effective Date, Facility will provide a statement, verified by an independent auditor or actuary, that its reserve funding levels and process of funding appears adequate to meet the requirements of this section and fairly represents the financial condition of the fund. Facility will provide a similar statement during the term of this Agreement upon United's request, which will be made no more frequently than annually. Facility will assure that its self-insurance fund will comply with applicable laws and regulations.

4.8 Notice by Facility. Facility will give notice to United within 10 days after any event that causes Facility to be out of compliance with section 4.6 or 4.7 of this Agreement. Facility will give notice to United at least 30 days prior to any change in Facility's name, ownership, control, NPI, or Taxpayer Identification Number.

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

4.10 Maintenance of and access to records.

i) **Maintenance.** Facility will maintain Facility Records for at least 10[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 to Agencies**. Facility will provide access to Facility Records to agencies of the government, in accordance with applicable law, to the extent access is necessary to comply with the requirements of such agencies as applicable to Facility, United or Payers.

iii) **Access to United.** Facility will provide United or its designees access to Facility Records for purposes of United's health care operations and other administrative obligations, including without limitation, utilization management, quality assurance and improvement, claims payment, and review or audit of Facility's compliance with the provisions of this Agreement and appropriate billing practices.

Facility will provide access to Facility Records by providing United electronic medical records ("EMR") access and electronic file transfer. When the requested Facility Records are not available through EMR access and electronic file transfer, Facility will submit those Facility Records through other means reasonably acceptable to United, such as facsimile, compact disc, or mail, that is suitable to the purpose for which United requested the Facility Records.

Facility Records provided by EMR access will be available to United on a 24 hour/7 day a week basis. Facility Records provided by electronic file transfer will be available to United within 24[48][72] hours of United's request for those Facility Records or a shorter time as may be required for urgent requests for Facility Records. Facility Records provided by other means will be available in the time frame specified in the request for the Facility Records; provided, however, Facility will have up to 14 days to provide the Facility Records for requests not related to urgent requests. Urgent requests are those requests for Facility Records to address allegations of fraud or abuse, matters related to the health and safety of a Customer, or related to an expedited appeal or grievance.

Facility may meet the requirements of this section 4.10 directly or through a subcontractor.

iv) **Audits.** Pursuant to paragraph (iii) above, United may request Facility Records from Facility for purposes of performing an audit of Facility's compliance with this Agreement, Facility's billing practices, or United's health care operations, including without limitation claims payments. In addition, United may perform audits at Facility's locations upon 14 days' prior notice. Facility will cooperate with United on a timely basis in connection with any such audit including, among other things, in the scheduling of and participation in an interview to review audit findings, within 30 days after United's request.

v) When Facility has provided records through EMR access or file transfer, United will not request duplicative paper records from Facility.

vi) Facility will provide Facility Records free of charge**.**

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

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

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

4.13 Electronic connectivity. When made available by United, Facility will do business with United electronically, including EMR access and connectivity, and HL7 admission discharge and transfer (ADT). Facility will use the UnitedHealthcare LINK (LINK) service tool, found at www.UHCprovider.com, and/or other electronic connectivity as available, to check eligibility status, claims status, and submit requests for claims adjustment for products supported by United's online resources and other electronic connectivity. Facility will use LINK or other tools for additional functionalities (for example, notification of admission, prior authorization and any other available transaction or viewing) after United informs Facility that these functionalities have become available for the applicable Customer.

4.14 Implementation of quality improvement and patient safety programs. Facility will implement quality programs applicable to 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.

4.15 Never events. In the event a "never event" occurs in connection with Facility rendering services to a Customer, 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.

iv) Waive all costs directly related to the event. In order to waive such costs, Facility will not submit a claim for such costs to United or Payer (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.

v) Interview patients and/or families who are willing and able, to gather evidence for the root cause analysis.

vi) Inform the patient and/or his/her family of the action(s) that Facility will take to prevent future recurrences of similar events based on the findings from the root cause analysis.

vii) Have a protocol in place to provide support for caregivers involved in never events, and make that protocol known to all caregivers and affiliated clinicians.

viii) Perform an annual review to ensure compliance with each element of Leapfrog's Never Events Policy for each never event that occurred.

ix) Make a copy of this policy available to patients upon request.

For purposes of this section 4.15, a "never event" is an event included in the list of "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.

Additional Language:
[4.15] [4.16] [Service Standards. Facility will comply with the additional requirements in the attached Service Standards Exhibit.]

Article V
Duties of United and Payers

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

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

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

5.4 Notice by United. United will give written notice to Facility within 10 days after any event that causes United to be out of compliance with section 5.2 or 5.3 of this Agreement, or of any change in United's name, ownership, control, or Taxpayer Identification Number. This section does not apply to changes of ownership or control that result in United being owned or controlled by an entity with which it was already affiliated prior to the change.

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

5.6 **Electronic connectivity.** As described in section 4.13 of this Agreement, United will do business with Facility electronically. United will communicate enhancements in its electronic connectivity functionality as they become available.

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

Article VI
Submission, Processing, and Payment of Claims

6.1 **Form and content of claims.** Facility must submit claims for Covered Services as described in the Protocols, using current, correct and applicable coding.

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

6.3 **Time to file claims.** 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 on a claim, and Facility is pursuing payment from the primary payer, the period in which Facility must submit the claim will begin on the date Facility receives the claim response from the primary payer.

6.4 **Payment of claims for Covered Services.** Payer will pay claims for Covered Services according to the amount specified in the applicable Payment Appendix(ices) to this Agreement and in accordance with Payment Policies.

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

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

6.5 **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.**

A) This section 6.5(A) does not initially apply to the following Benefit Plans ("Excluded Benefit Plans"):

[(1) Benefit Plans administered by United Affiliate UMR, Inc.]

[(1)][(2)] Benefit Plans listed in the Additional Manuals Appendix to this Agreement, if such Appendix is included in this Agreement.

Excluded Benefit Plans are subject to section 6.5(B) below. If in the future United modifies the utilization management program applicable to the Excluded Benefit Plans, 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 6.5(A) to apply to those Excluded Benefit Plans by giving 90 days written notice to Facility.

i) **Non-compliance with Protocol.** Compliance with Protocols and timely claim filing are conditions precedent to payment under this Agreement. United will, at its discretion, deny payment in whole or in part if Facility does not comply with a Protocol or does not file a timely claim as required under the Agreement.

In the event payment is denied under this subsection 6.5(A)(i) for Facility's failure to comply with a Protocol regarding notification or regarding lack of coverage approval on file, Facility may request reconsideration of the denial, and the denial under this subsection 6.5(A)(i) will be reversed if Facility can show:

a) the denial was incorrect because Facility complied with the Protocol; or
b) Facility's services were medically necessary (as "medically necessary" is defined in subsection 6.5(A)(vii)); or
c) at the time the Protocols required notification or prior authorization, Facility did not know and was unable to reasonably determine that the patient was a Customer, Facility took reasonable steps to learn that the patient was a Customer, and 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 6.5(A).

The grounds stated in clause (c) above are also a basis for reconsideration of a denial for lack of timely claim filing under section 6.3 of this Agreement.

A claim denied under this subsection 6.5(A)(i) is also subject to denial for other reasons permitted under the Agreement; reversal of a denial under this subsection 6.5(A)(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. Facility may seek and collect payment from a Customer for such services (provided that Facility obtained the Customer's written consent), except as provided below in subsections 6.5(A)(iv), (v) and (vi).

If an inpatient 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, 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) 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), 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 services are not medically necessary (including cases in which some days are determined to be medically necessary and additional days in the same admission are determined to not 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 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 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 6.5(A)(iv) in cases in which services cannot be determined to be medically necessary due to omission of information or failure to respond timely to United's request for information; Facility may request reconsideration of such a denial on grounds of medical necessity.

United will not reduce payment under this subsection 6.5(A)(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 appropriately have been rendered at a lower level of care (for instance, observation or ambulatory surgery rather than inpatient). If Facility submits a claim for the level of care deemed not medically necessary, United may deny the claim, and Facility will not seek or collect payment from the Customer. A claim may also be denied in whole or in part under this subsection 6.5(A)(v) in cases in which services cannot be determined to be medically necessary due to omission of information or failure to respond timely to United's request for information; Facility may request reconsideration of such a denial on grounds of medical necessity.

vi) **Delay in service.** If United determines that Facility did not execute a physician's written order (for instance, an admission 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); 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 6.5(A)(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 6.5(A)(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 6.5(A)(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.

B) This section 6.5(B) only applies to Excluded Benefit Plans.

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

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

i) that, at the time the Protocols required notification or at the time the claim was due, Facility did not know and was unable to reasonably determine that the patient was a

Customer,
ii) that Facility took reasonable steps to learn that the patient was a Customer, and
iii) that Facility promptly provided notification, or filed the claim, after learning that the patient was a Customer.

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

6.6 Retroactive correction of information regarding whether patient is a Customer. Prior to rendering services, Facility will ask the patient to present his or her Customer identification card. In addition, Facility 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 Facility provides health care services to an individual, and it is determined that the individual was not a Customer at the time the health care services were provided, those services 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 6.10 of this Agreement. Facility may then directly bill the individual, or other responsible party, for those services.

6.7 Payment under this Agreement is payment in full. Payment as provided under section 6.4 of this Agreement, together with any co-payment, deductible or coinsurance for which the Customer is responsible under the Benefit Plan, is payment in full for a Covered Service. Facility will not seek to recover, and will not accept, any payment from Customer, United, Payer or anyone acting on their behalf, in excess of payment in full as provided in this section 6.7, regardless of whether that amount is less than Facility's billed charge or Customary Charge.

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

i) Facility's failure to comply with the Protocols,
ii) Facility's failure to file a timely claim,
iii) Payer's Payment Policies,
iv) inaccurate or incorrect claim processing,
v) insolvency or other failure by Payer to maintain its obligation to fund claims payments, if Payer is United, or is an entity required by applicable law to assure that its Customers not be billed in these circumstances, or
v) a denial based on lack of medical necessity or based on consistency with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines, except as provided in section 6.5 of this Agreement.

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

Facility may seek payment directly from the Payer or from Customers upon 15 days prior notice to United, after Facility seeks and receives confirmation from United that the Payer is in default (other than a default covered by the above clause (v) of this section 6.8).For purposes of this paragraph, a default is a systematic failure by a Payer to fund claims payments related to Customers covered through that Payer. A default does not occur in the case of a dispute as to whether certain claims should be paid or the amounts that should be paid for certain claims.
This section 6.8 and section 6.7 will survive the termination of this Agreement, with regard to Covered Services rendered prior to when the termination takes effect.

6.9 Consequences for failure to adhere to Customer protection requirements. If Facility collects payment from, brings a collection action against, or asserts a lien against a Customer for Covered Services rendered (other than for the applicable co-payment, deductible or coinsurance), contrary to section 6.7 or 6.8 of this Agreement, Facility will be in breach of this Agreement. This section 6.9 will apply regardless of whether the Customer or anyone purporting to act on the Customer's behalf has executed a waiver or other document of any kind purporting to allow Facility to collect such payment from the Customer.

In the event of such a breach, Payer may deduct, from any amounts otherwise due Facility, the amount wrongfully collected from Customers, and may also deduct an amount equal to any costs or expenses incurred by the Customer, United or Payer in defending the Customer and otherwise enforcing sections 6.7 through 6.9 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.

6.10 Correction of claims payments. If Facility 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, it will have waived any right to subsequently seek such correction under this section 6.10, or through dispute resolution under Article VII of this Agreement or in any other forum.

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

Article VII
Dispute Resolution

The parties will work together in good faith to resolve any and all disputes between them ("Disputes") including but not limited to existence, validity, scope or termination of this Agreement or any term thereof, with the exception of any question regarding the arbitrability of the Dispute, and the availability of class

arbitration or consolidated arbitration, which is expressly waived below. Disputes also include any dispute in which Facility is acting as the assignee of one or more Customer. In such cases, Facility agrees that the provisions of this Article VII 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 Facility before Facility may invoke any right to arbitration under this Article VII. 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], [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 require immediate judicial review. Notwithstanding anything in this Agreement to the contrary, this paragraph may not be severed from Article VII 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 VII. While the arbitration remains pending, the termination for breach will not take effect.

This Article VII will survive any termination of this Agreement.

Article VIII
Term and Termination

8.1 **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 8.2 of this Agreement.

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

i) by mutual written agreement of the parties;
ii) by either party, upon at least 180 days' prior written notice, effective at the end of the initial term or effective at the end of any renewal term;
iii) by either party, 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 VII of this Agreement;
iv) by either party, 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 section 4.7 or section 5.2 of this Agreement;
v) by United, upon 10 days' prior written notice, in the event Facility loses accreditation; or
vi) by United, immediately upon written notice, in the event:
    a) Facility loses approval for participation under United's credentialing plan, or
    b) Facility does not successfully complete the United's re-credentialing process as required by the credentialing plan.

8.3 **Ongoing Services to certain Customers after termination takes effect.**

i) In the event a Customer is receiving any of the Covered Services listed below, as of the date the termination of this Agreement takes effect, Facility will continue to render those Covered Services to that Customer, and this Agreement will continue to apply to those Covered Services, after the termination takes effect, for the length of time indicated below:

Inpatient Covered Services	30 days or until discharge, whichever comes first
Pregnancy , Third Trimester – Low Risk	Through postpartum follow up visit

Pregnancy, First, Second or Third Trimester – Moderate Risk and High Risk	Through postpartum follow up visit
Non-Surgical Cancer Treatment	30 days or a complete cycle of radiation or chemotherapy, whichever is greater
End Stage Kidney Disease and Dialysis	30 days
Symptomatic AIDS undergoing active treatment	30 days
Ongoing services to Medicare Advantage Customers	As described below
Circumstances where Payer is required by applicable law to provide transition coverage of services rendered by Facility after Facility leaves the provider network accessed by Payer.	As applicable

ii) **Medicare Advantage Customers.** This section 8.3(ii) only applies if Facility participates in networks for Medicare Advantage Benefit Plans under this Agreement.

a) Ninety days prior to the effective date of the termination or expiration of this Agreement, United may remove Facility from any provider directory, online or in print, unless the parties agree otherwise.
b) To protect existing Medicare Advantage Customers who are patients of Facility from the disruption caused by the termination or expiration of this Agreement during the course of the Customer's Benefit Plan year, Facility will continue to provide Covered Services, and the terms of this Agreement will continue to apply, to Medicare Advantage Customers who have an existing relationship with Facility on the date the termination or expiration would be effective under the notice through the end of the calendar year. If the effective date of the termination or expiration would otherwise occur during the month of December, Facility will continue to provide Covered Services, and the terms of this Agreement will continue to apply, to such Medicare Advantage Customers through the end of the following calendar year. However, payment to Facility for such continued care, as described in this paragraph, will be the greater of the contract rate in place at the time the termination or expiration of the Agreement would have been effective, or 100% of CMS.

Section 8.3(b) does not apply if United has terminated this Agreement due to:
1) an uncured material breach,
2) Facility losing licensure or other governmental authorization necessary to perform this Agreement, or
3) Facility failing to have insurance as required under section 4.7 of this Agreement.

Article IX
Miscellaneous Provisions

9.1 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 between the parties with regard to its subject matter, and supersedes any prior written or unwritten agreements between the parties or their affiliates with regard to the same subject matter.

9.2 **Amendment.** In order for an amendment to this Agreement to be binding, it must be executed by all parties through written or electronic signature, except as otherwise provided in this section 9.2.

Additionally, United may amend this Agreement upon written notice to Facility in order to comply with applicable regulatory requirements but only if that amendment is imposed on a similar basis to all or substantially all of the facilities in United's network that would be similarly impacted by the regulation in question. United will provide at least 30 days' notice of any such regulatory amendment, unless a shorter notice period is necessary in order to comply with regulatory requirements.

9.3 **Nonwaiver.** 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.

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

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.

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

9.6 **No third-party beneficiaries.** United and Facility are the only entities with rights and remedies under this Agreement. Any claims, collection actions or disputes may not be assigned, transferred or sold by either party without the written consent of the other party.

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

9.8 **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.

9.9 **Confidentiality.** Neither party may 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 9.9 does not preclude the disclosure of information by United to a third party as part of the process by which the third party is evaluating administration of benefits or 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.

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

9.11 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.

9.12 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.

9.13 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 9.9 of this Agreement, (except for the last paragraph) will survive the termination of this Agreement.

9.14 Fines; Penalties. Facility will be responsible for any and all fines or penalties that may be assessed against United by any government agency that arise from Facility's failure to execute, deliver or perform its obligations under this Agreement.

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

[Name of Facility], as signed by its authorized representative:

Signature: _____

Print Name and Title: _____

Date: _____

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

Street: _____

City: _____

State: _____ Zip Code: _____

E-mail: _____

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:*_____

For office use only: [_____]
[*CLM deal number will be auto populated here*]
Month, day and year in which Agreement is first effective: [_____]

Appendix 1
Facility Location and Service Listings

[Facility System Name]

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

The location where Covered Services will be rendered ("Service Location") MUST be listed in this Appendix.

FACILITY LOCATION - List BOTH the Service Location and the Billing Address for the Service Location	
Service Location	**Billing Address for the Service Location**
Facility Name	**Facility Name**
Street Address	**Street Address**
City	**City**
State and Zip Code	**State and Zip Code**
Phone Number	**Phone Number**
TIN	
National Provider ID (NPI)	

ADDITIONAL FACILITY LOCATIONS - List BOTH the Service Location and the Billing Address for the Service Location	
Service Location	**Billing Address for the Service Location**
Facility Name	**Facility Name**
Street Address	**Street Address**
City	**City**
State and Zip Code	**State and Zip Code**
Phone Number	**Phone Number**
TIN	
National Provider ID (NPI)	

Facility Name	**Facility Name**
Street Address	**Street Address**
City	**City**
State and Zip Code	**State and Zip Code**
Phone Number	**Phone Number**
TIN	
National Provider ID (NPI)	
Facility Name	**Facility Name**
Street Address	**Street Address**
City	**City**
State and Zip Code	**State and Zip Code**
Phone Number	**Phone Number**
TIN	
National Provider ID (NPI)	

Appendix 2
Benefit Plan Descriptions

Section 1. United may allow Payers to access Facility'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 Facility 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 Facility 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 and CHIP 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.]

- 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 Facility’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 Facility 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 Facility’s participation status in Benefit Plans impacted by that change, and further provided that United provides Facility 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 Facility may provide Covered Services under this Agreement, Facility 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 Facility 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 Facility.

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: _____ Physician/Practitioner _____ Facility/Ancillary

I. Compensation and Payment

Manner of Payment:

Physician	Facility/Ancillary
_____ 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 **_____ Indemnity**
_____ Commercial Plan other than Options PPO
_____ Worker's Compensation
_____ Medicare
_____ Medicaid

For additional detail see enclosed Benefit Plan Descriptions Appendix

III. Term/Duration of Contract

Duration:

_____ Facility Participation Agreement - _____ Years, with automatic renewal for One year terms thereafter
_____ Ancillary - _____ Years, with automatic renewal for One year terms thereafter
_____ Simplified Physician Agreement – One Year, with automatic annual renewal
_____ Practitioner Agreement – One Year, with automatic annual renewal
_____ Simplified Medical Group Agreement –_____ Years, with automatic annual renewal
_____ Medical Group Agreement - _____ Years, with automatic renewal for One year terms thereafter
_____Simplified Practitioner Group Agreement - _____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 its 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

Facility and Medical Group Participation Agreements - Please refer to the Dispute Resolution section of the agreement.

Simplified Physician Agreement (SPA), Practitioner Agreement (PAT), Medical Group Contract (SMGA) or Simplified Practitioner Agreement (SPGA) - Please refer to the "What if we do not agree" section of the agreement.

You can also find information in the Protocols section of the Administrative Guide.

VI. Subject and Order of Addenda

Simplified Physician Agreement/Practitioner Agreement _____ **Appendix 1 List of Appendices** _____ **Appendix 2 – Benefit Plan Descriptions Appendix** _____ **Payment Appendix(ices)** _____ **Appendix 3 _____** _____ **Appendix 4 _____** _____ **Medicare Regulatory Appendix** _____ **Medicaid Regulatory Appendix, including Medicaid Addendum** _____ **Ohio Regulatory Appendix**	Simplified Medical Group Agreement _____ **Appendix 1 (depending on template type)** _____ **Appendix 2 – Benefit Plan Descriptions Appendix** _____ **Payment Appendix(ices)** _____ **Appendix 3 _____** _____ **Appendix 4 _____** _____ **Medicare Regulatory Appendix** _____ **Medicaid Regulatory Appendix, including Medicaid Addendum** _____ **Ohio Regulatory Appendix**
Medical Group Agreement _____ **Appendix 1 (depending on template type)** _____ **Appendix 2 – Benefit Plan Descriptions Appendix** _____ **Additional Manuals** _____ **Payment Appendix(ices)** _____ **Medicare Regulatory Appendix** _____ **Medicaid Regulatory Appendix, including Medicaid Addendum** _____ **Ohio Regulatory Appendix**	Facility Participation Agreement _____ **Appendix 1 (depending on template type)** _____ **Appendix 2 – Benefit Plan Descriptions Appendix** _____ **Additional Manuals** _____ **Payment Appendix(ices)** _____ **Medicare Regulatory Appendix** _____ **Medicaid Regulatory Appendix, including Medicaid Addendum** _____ **Ohio Regulatory Appendix**
Ancillary Agreement _____ **Appendix 1 (depending on template type)** _____ **Appendix 2 – Benefit Plan Descriptions Appendix** _____ **Additional Manuals** _____ **Payment Appendix(ices)** _____ **Medicare Regulatory Appendix** _____ **Medicaid Regulatory Appendix, including Medicaid Addendum** _____ **Ohio Regulatory Appendix**	Simplified Practitioner Agreement _____ **Appendix 1 List of Appendices** _____ **Appendix 2 – Benefit Plan Descriptions Appendix** _____ **Payment Appendix(ices)** _____ **Appendix 3 _____** _____ **Appendix 4 _____** _____ **Medicare 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.