[[Facility Participation Agreement] [Medical Group Participation Agreement] [Ancillary Provider Participation Agreement] [FQHC Participation Agreement] [RHC Participation Agreement] [IHCP Participation Agreement]]

This Agreement is entered into by and between [applicable United Legal entity inserted here] (collectively referred to as "United") and [Provider Name inserted here] ("[[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]]") for the purposes of making [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]]'s services available to Members through one or more networks of providers maintained by United.

This Agreement is effective on [Month ##, ####] (the "Effective Date").

Article I
Definitions

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

1.1 Benefit Plans:

- **Benefit Plan:** 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 Member.

- **Individual Exchange Benefit Plans:** 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).

- **Medicare Advantage Benefit Plans:** 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.

- **Non-Governmental Benefit Plans:** Benefit Plans other than Medicare Advantage Benefit Plans, State Government Program Benefit Plans, or Individual Exchange Benefit Plans.

- **Participating Benefit Plans:** Those Individual Exchange Benefit Plans, Medicare Advantage Benefit Plans, Non-Governmental Benefit Plans, VA CCN Benefit Plans, and State Government Program Benefit Plans in which [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] participates as described in the Network Participation Appendix.

- **State Government Program Benefit Plans:** Medicaid Benefit Plans, CHIP Benefit Plans, Medicaid Long Term Care Benefit Plans, Benefit Plans for the Uninsured, and Other Governmental Benefit Plan, as each may be described in the Network Participation Appendix.

- **VA CCN Benefit Plans:** Benefit Plans sponsored, issued, or administered by the Veterans Affairs (VA) for veterans enrolled in the patient enrollment system established and operated by the VA under 38 U.S.C. Section 1705.

1.2 Provider:

- **Customary Charge:** The fee for health care services charged by [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] that does not exceed the fee [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] would ordinarily charge another person regardless of whether the person is a Member.

- **[[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]]Records:** [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]]'s medical, financial and administrative records related to Covered Services rendered by [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] under this Agreement, including claims records.

Note to regulator: This definition will be used only when the provider is a Medical Group, an FQHC, an RHC, or an IHCP

- **[[Medical Group] [FQHC] [RHC] [IHCP]]Non-Physician Provider:** A healthcare professional, other than a [[Medical Group] [FQHC] [RHC] [IHCP]][[Medical Group] [FQHC] [RHC] [IHCP]] Physician.

Note to regulator: This definition will be used only when the provider is a Medical Group, an FQHC, an RHC, or an IHCP

- **[[[Medical Group] [FQHC] [RHC] [IHCP]]Physician:** A physician, as defined by the laws of the jurisdiction in which Covered Services are provided and listed on the [[Medical Group] [FQHC] [RHC] [IHCP]] Professional Roster.]

Note to regulator: This definition will be used only when the provider is a Medical Group, an FQHC, an RHC, or an IHCP

- **[[[Medical Group] [FQHC] [RHC] [IHCP]] Professional:** A [[Medical Group] [FQHC] [RHC] [IHCP]] Physician or a [[Medical Group] [FQHC] [RHC] [IHCP]]Non-Physician Provider.]

1.3 Payer and Member:

- **Alternate Payer:** An entity, other than a Payer, that has an agreement, directly or indirectly, with a Payer (as defined in this Agreement) that authorizes that entity to access [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]]'s services under this Agreement. Alternate Payers may include, but are not limited to, insurance carriers, workers compensation insurance carriers, risk management entities, claims management entities, and third-party administrators. Any references to "Payer" in this Agreement include Alternate Payers, unless otherwise expressly provided for herein or in the applicable Supplement or other Protocol.

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

- **Member**: A person eligible and enrolled to receive coverage from a Payer for Covered Services.

- **[Payer:** An entity obligated to a Member to provide reimbursement for Covered Services under the Member's Benefit Plan, and authorized by United to access [[Facility] [Medical Group]

[Ancillary Provider] [FQHC] [RHC] [IHCP]][[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]]'s services under this Agreement.]

1.4 General

Note to regulator: This definition of Expansion will be used when the provider is a SNF, Lab, Medical Group, Facility, FQHC, RHC, or IHCP

- **[Expansion:** Any of the following situations: (a) providing health care services or products at a service location that is not an Included Service Location, (b) providing health care services or products under a Taxpayer Identification Number that is not an Included TIN, or (c) any acquisition of or affiliation with another facility or group of healthcare providers, regardless of the form or structure of such transaction.]

Note to regulator: This definition of Expansion will be used when the provider is an ancillary provider other than a SNF or Lab

- **[Expansion:** Any of the following situations: (a) providing health care services or products at a service location that is not an Included Service Location, (b) providing health care services or products under a Taxpayer Identification Number that is not an included TIN, (c) any acquisition of or affiliation with another ancillary provider or group of healthcare providers, regardless of the form of structure of such transaction, or (d) offering services as a New Provider Type.]

- **Divestiture:** Any of the following situations: (a) any divestiture of an Included Service Location or entity with an Included TIN, or (b) [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]]'s cessation of the provision of health care services or products at an Included Service Location or under an Included TIN (whether via dissolution or otherwise).

- **Included Service Location:** Those locations included on the Service Locations Appendix or added in accordance with the [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]]Service Location provisions of this Agreement.

Note to regulator: This paragraph is included in the definition of Included Service Location when the provider is a Medical Group, FQHC, RHC or IHCP

[Included Service Locations include the following locations when a [[Medical Group] [FQHC] [RHC] [IHCP]]Professional provides Covered Services to a Member: (i) an inpatient setting (e.g., a general acute hospital, skilled nursing facility, long term acute care hospital, or specialty hospital) that is not located in an Out of Scope Location; (ii) a private residence where a Member receives care, so long as the residence is not located in an Out of Scope Location; and (iii) the location where a Member is physically located when Covered Services are provided via telemedicine, so long as the Member is not located in an Out of Scope Location.]

Note to regulator: This paragraph is included in the definition of Included Service Locations when the provider is a Home Health Agency or Home Infusion Provider

[Included Service Locations include the location, other than a hospital or other facility, where the Member receives care in a private residence, so long as the Member is not located in an Out of Scope Location.]

- **Included TIN**: Those Taxpayer Identification Numbers included on the Service Locations Appendix or added in accordance with the [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] Service Location provisions of this Agreement.

Note to regulator: The definition of New Provider Type is included when the provider is an ancillary provider other than SNF or Lab.

- **[New Provider Type:** Any type of health care provider other than [Ancillary provider type.]

- **Protocols:** The programs and administrative procedures established by United or a Payer to be followed by [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] in providing services and doing business with United and Payers under this Agreement. Protocols may include, without limitation, credentialing and recredentialing processes, utilization management and care management processes, quality improvement, peer review, Member grievance, concurrent review, or administrative manuals or guides. The Protocols are available online at www.UHCprovider.com or a successor location. The Administrative Guide Supplements Appendix contains additional information regarding the Protocols applicable to Members enrolled in certain Benefit Plans.

- **Proposed Change:** [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]]'s proposed change(s) to Included Service Locations and/or Included TINs in connection with an Expansion or Divestiture, including whether [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] desires the impacted service location(s) or Taxpayer Identification Number(s) to be added to, deleted from, or changed on the Service Locations Appendix.

- **Reimbursement Policies:** The guidelines adopted by United for calculating payment of claims to providers of health care services. The Reimbursement Policies operate in conjunction with the specific reimbursement rates and terms set forth in this Agreement.

- **Subcontractor:** An individual or entity contracted or otherwise engaged by a party to this Agreement.

- **United Affiliates:** Those entities controlling, controlled by, or under common control with UnitedHealthcare Insurance Company.

Article II
Scope of Agreement

2.1 [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] Service Locations

i) **Service Area**. This Agreement applies only to Covered Services provided at Included Service Locations under Included TINs. Included Service Locations and Included TINs as of the Effective Date are set forth in the Service Locations Appendix to this Agreement. This Agreement will not apply to Out of Scope Locations.

ii) **Changes to the Service Locations Appendix.** [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]]will provide United with written notice, in accordance with the notice provisions of this Agreement, at least 60 days prior to the proposed effective date of any Expansion or Divestiture. [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]]'s notice will include, at a minimum: (a) the proposed effective date of any Expansion or Divestiture; (b) the impacted service locations and Taxpayer Identifications Numbers; and (c) the Proposed Change. United will notify [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] within 60 days after receiving such notice if United agrees to the Proposed Change and, if applicable, the effective date of the Proposed Change.

iii) **Expansion**. Notwithstanding an Expansion, then, unless and until United agrees in writing otherwise:

a) This Agreement will remain in effect with respect to each Included Service Location and Included TIN prior to the Expansion.

Note to Regulator: This paragraph b will be used when the provider is not an ancillary provider.

b) [This Agreement will not apply to health care services or products provided by an acquired facility or group of healthcare providers, or at any service location that is not an Included Service Location or through any Taxpayer Identification Number that is not an Included TIN.]

Note to Regulator: This paragraph b will be used when the provider is an ancillary provider.

b) [This Agreement will not apply to health care services or products provided by an acquired ancillary provider or group of healthcare providers, by or at a New Provider Type, at any service location that is not an Included Service Location, or through any Taxpayer Identification Number that is not an Included TIN.]

c) Any network participation agreement between United and any third party involved in the Expansion will remain in effect and will continue to apply as it did before the Expansion unless otherwise agreed to in writing by all parties to such agreements.

iv) **Divestiture**. Notwithstanding a Divestiture, unless and until United agrees in writing otherwise:

a) This Agreement will remain in effect with respect to each Included Service Location prior to the Divestiture. The Parties agree that the intent of this provision is to continue to apply [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]]'s existing rates and agreement terms to each Included Service Location, irrespective of any Divestiture.

b) This Agreement will not apply to health care services or products provided at any service location that is not an Included Service Location.

c) Any network participation agreement between United and any third party involved in the Divestiture will remain in effect and continue to apply as it did before the Divestiture unless otherwise agreed to in writing by all parties to such agreement.

Note to Regulator: The subsection regarding payment rates is included when the provider is an ancillary provider.

v). [**Payment Rates**. Notwithstanding anything in this section, if an Expansion or Divestiture involves another provider of health care services subject to another network participation agreement with United, the payment rates under this Agreement and the other agreement will be, as decided by United, either this Agreement's payment rates and the other agreement payment rates.]

2.2 Network Participation. United may allow Payers to access [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]]'s services under this Agreement for certain Benefit Plan types, as described in the Network Participation Appendix.

i) United reserves the right at any time to designate as participating in (a) one or more Benefit Plan types and/or (b) certain specific Benefit Plans within a given Benefit Plan type. United will provide [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] with 30

days' prior notice of the new Benefit Plan types and/or specific Benefit Plans within a given Benefit Plan type, along with the payment terms, regulatory requirements, and new Protocols (if any) applicable to the new Benefit Plans.

a) If the payment terms for such Benefit Plans are not different from the payment terms for Benefit Plans in which [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] already is participating within the associated Benefit Plan type, then [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] will accept such new Benefit Plans and payment terms and will comply with any related regulatory requirements.

b) If the payment terms for such Benefit Plans are different from the payment terms for Benefit Plans in which [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] already is participating within the associated Benefit Plan type and [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] does not object to the implementation of such new Benefit Plans and payment terms within the 30 days' notice period, [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] will be deemed to have accepted the new Benefit Plans and new payment terms. In the event [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] objects to the new Benefit Plans and new payment terms within the 30 days' notice period, the parties will confer in good faith to reach agreement. If such agreement cannot be reached, such new Benefit Plans, payment terms and any related regulatory requirements not previously applicable will not apply to this Agreement.

ii) United reserves the right at any time to exclude [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] from participation:(a) in one or more Benefit Plan types and/or (b) in certain specific Benefit Plans within a given Benefit Plan type. United will provide [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] with 30 days' prior notice of the excluded Benefit Plan types and/or specific Benefit Plans within a given Benefit Plan type. The section of this Agreement ongoing services will apply to Covered Services provided to Members covered by Benefit Plans from which [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] is excluded from participating as described in this paragraph.

iii) United may have Capitation arrangements in place with one or more Capitated Organizations. If [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] is the Capitated Organization, United will have a separate agreement with [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] for the Capitation arrangement. The applicable Benefit Plan types under the Capitation arrangement will be set forth in that agreement. When United has a Capitation arrangement in place with Capitated Organizations, whether that is with [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] or another entity, the provisions in the attached Capitation Arrangements and Financial Responsibility Appendix will apply. For purposes of this subsection, the terms "Capitation" and "Capitated Organization" are defined in the Capitation Arrangements and Financial Responsibility Appendix.

When Benefit Plans offer United's network of providers, an identification card will be provided to Members by Payers. A reference to United and/or one of the United Affiliates will appear on the identification card. A listing of providers who participate in United's network of providers for a given Benefit Plan will be made available to Members covered under that Benefit Plan. Unless otherwise required by applicable state or federal regulatory requirements, the Members will be encouraged to receive services from providers who participate in United's network of providers through the use of mechanisms in the Benefit Plan, such as a higher level of coverage and/or the

potential reduction or elimination of co-payment, deductible or for which the Member is responsible under the Benefit Plan.

Note to regulator: This section 2.3 is included when the provider is not a lab.

2.3 [**Health care.** This Agreement and Benefit Plans do not dictate the health care provided by [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] or govern [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]]'s determination of what care to provide patients, even if those patients are Members. The decision regarding what care is to be provided remains with Members and their physicians, and not with United or any Payer.]

Note to regulator: This section 2.3 is included when the provider is a lab.

2.3 **[Health care.** This Agreement and Benefit Plans do not dictate the health care provided by Ancillary provider. The decision regarding what care is to be provided remains with Members and their physicians, and not with United or any Payer.]

2.4 **Communication with Members.** Nothing in this Agreement is intended to limit [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]]'s right or ability to communicate fully with a Member and the Member's physician regarding the Member's health condition and treatment options. [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] is free to discuss all treatment options without regard to whether a given option is a Covered Service. [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] is free to discuss with a Member [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]]'s financial arrangements under this Agreement. [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] may also assist a Member in estimating the cost of a given Covered Service.

2.5 **Employees and Subcontractors.** Each party will ensure that its employees, affiliates, and any Subcontractors engaged to render services in connection with this Agreement adhere to the requirements of this Agreement. A party's use of such employees, affiliates and Subcontractors will not limit its obligations and accountability under this Agreement.

2.6 **Licensure.** Each party will maintain, without material restriction, such licensure, registration, and permits as are necessary to enable that party to lawfully perform this Agreement.

2.7 **Liability insurance.**

i) **United 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.

ii) **[[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] Liability insurance.** [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] will procure and maintain liability insurance. Except to the extent coverage is a state mandated placement, [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]]'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] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]]'s liability insurance must be, at a minimum, of the types and in the amounts set forth below. [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]]'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

upon written request by United, [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] will submit to United in writing evidence of insurance coverage.

Note to regulator: These liability levels are included when the provider is a hospital other than Level 1 Trauma Centers, Research/Teaching Hospitals, or offers invasive/neonatal/ specialized medical services or a rural or tertiary hospital

- [Medical malpractice and/or professional liability: $5,000,000 per occurrence/claim and aggregate
- Commercial General/Umbrella: $5,000,000 per occurrence/claim and aggregate
- Automobile: $5,000,000, combined single limit, if Facility provides transportation services]

Note to regulator: These liability levels are included when the provider is a hospital that is a Level 1 Trauma Center, a Research/Teaching Hospital, or offers invasive/neonatal/ specialized medical services

- [Medical malpractice and/or professional liability: $10,000,000 per occurrence/claim and aggregate
- Commercial General/Umbrella: $5,000,000 per occurrence/claim and aggregate
- Automobile: $5,000,000, combined single limit, if Facility provides transportation services]

Note to regulator: These liability levels are included when the provider is a hospital that is a rural or tertiary facility

- [Medical malpractice and/or professional liability: $1,000,000 per occurrence/claim and $3,000,000 aggregate
- Commercial General/Umbrella: 1,000,000 per occurrence/claim and $2,000,000 aggregate
- Automobile: $5,000,000, combined single limit, if Facility provides transportation services]

Note to regulator: These liability levels are included when the provider is a medical group, FQHC, RHC or IHCP which does not provide services in the following specialties: anesthesiologists, OB/GYN, Surgeons

- [Medical malpractice and/or professional liability: $1,000,000 per occurrence/claim and $3,000,000 aggregate
- Commercial General/Umbrella: $1,000,000 per occurrence and $2,000,000 aggregate]

Note to regulator: These liability levels are included when the provider is a medical group, FQHC, RHC or IHCP which provides services in the following specialties: anesthesiologists, OB/GYN, Surgeons

- [Medical malpractice and/or professional liability: $5,000,000 per occurrence/claim and aggregate
- Commercial General/Umbrella: $5,000,000 per occurrence/claim and aggregate]

Note to regulator: These liability levels are included when the provider is an optician or optical store.

- [Commercial General/Umbrella: $1,000,000 per occurrence/claim and $2,000,000 aggregate]

Note to regulator: These liability levels are included when the provider is a durable medical equipment provider

- [Medical Product Liability: $1,000,000 per occurrence/claim and $3,000,000 aggregate
- Commercial General/Umbrella: $1,000,000 per occurrence/claim and $2,000,000 aggregate]

Note to regulator: These liability levels are included when the provider is a SNF or birthing center

- [Medical malpractice and/or professional liability: $1,000,000 per occurrence/claim and $3,000,000 aggregate
- Commercial General/Umbrella: $1,000,000 per occurrence/claim and $1,000,000 aggregate]

Note to regulator: These liability levels are included when the provider is an ambulance provider

- [Medical malpractice and/or professional liability: $1,000,000 per occurrence/claim and $3,000,000 aggregate
- Commercial General/Umbrella: $1,000,000 per occurrence/claim and $2,000,000 aggregate
- Automobile: $5,000,000, combined single limit]

Note to regulator: These liability levels are included when the provider is an ancillary provider other than a durable medical equipment provider, SNF, birthing center, or ambulance provider

- [Medical malpractice and/or professional liability: $1,000,000 per occurrence/claim and $3,000,000 aggregate
- Commercial General/Umbrella: $1,000,000 per occurrence/claim and $2,000,000 aggregate]

In lieu of purchasing the insurance coverage required in this section, [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] may self-insure any of the required insurance. [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] will maintain a separate reserve for its self-insurance. Prior to the Effective Date, [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] 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] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] 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] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] will assure that its self-insurance fund will comply with applicable laws and regulations.

[[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] represents and warrants that [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] and [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] professionals have been deemed to be federal employees and as such are covered for medical liability protection under the Federal Tort Claims Act ("FTCA"). [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] will use reasonable commercial efforts to maintain its deemed status throughout the term of this Agreement. To the extent that such FTCA coverage applies, then the above requirements to maintain medical malpractice and/or professional liability insurance will not apply. [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] will be required to maintain the above insurance with respect to general liability and, to the extent not covered by the FTCA,

medical malpractice and/or professional liability insurance (for example, when providing services outside the scope of any approved projects). In the event that [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] loses its deemed status, then [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] will maintain the above referenced medical malpractice and/or professional liability insurance for all Covered Services rendered by [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] and [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] Professionals under this Agreement.

2.8 **Notice of certain events**. Either party will give notice to the other party within 10 days after any event that causes the noticing party to be out of compliance with the licensure and insurance provisions of this Agreement. [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] will give notice to United at least 30 days prior to any change in [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]]'s name, ownership, control, National Provider Identifier (NPI), or Taxpayer Identification Number.

Note to Regulator: The remainder of section 2.8 is included when the provider is a medical group, FQHC, RHC, IHCP

[In addition, [[Medical Group] [FQHC] [RHC] [IHCP]] will give written notice to United within 10 days after it learns of any of the following:

- any suspension, revocation, condition, limitation, qualification or other material restriction on a [[Medical Group] [FQHC] [RHC] [IHCP]] Professional's licenses, certifications and permits by any government agency under which a [[Medical Group] [FQHC] [RHC] [IHCP]] Professional is authorized to provide health care services
- any suspension, revocation, condition, limitation, qualification or other material restriction of a [[Medical Group] [FQHC] [RHC] [IHCP]] Physician's staff privileges at any hospital, nursing home or other facility at which a [[Medical Group] [FQHC] [RHC] [IHCP]] Physician has staff privileges during the term of this Agreement]

Note to Regulator: This language is added when the provider is a Medical group

- [the departure of any Medical Group Professional from Medical Group**]**

2.9 **Compliance with law**. Each party will comply with applicable statutes, regulations and other regulatory requirements, including but not limited to those relating to confidentiality of Member medical information. Additionally, United will comply with applicable prompt payment of claims requirements.

2.10 **Electronic connectivity**. When made available by United, [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] will do business with United electronically. [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] will use the UnitedHealthcare LINK (LINK) service tool (or its successor tool), found at www.UHCprovider.com (or its successor site), Point of Care Assist (or its successor tool) 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] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] 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] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] that these functionalities have become available for the applicable Member.

Note to Regulator: This paragraph is included in section 2.10 if the provider is a hospital or SNF

[In addition to the accessibility of medical records requirements set forth elsewhere in this Agreement, upon United's request, [[Facility] [Ancillary Provider]] will work with United to develop a plan to provide United with real-time data interoperability for [[Facility] [Ancillary Provider]] Records in [[Facility] [Ancillary Provider]]'s EHR, including HL7 admission discharge and transfer (ADT) or HL7 FHIR (or their successor protocols), in accordance with applicable Protocols.]

Note to Regulator: This paragraph is included in section 2.10 if the provider is not a hospital or SNF

[In addition to the accessibility of medical records requirements set forth elsewhere in this Agreement, upon United's request, [[Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] will work with United to develop a plan to provide United with real-time data interoperability for Members' medical records in [[Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]]'s EHR, in accordance with applicable Protocols.]

2.11 Protocols

i) **Compliance with Protocols**. [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] will comply with all Protocols. [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] acknowledges that it has had the opportunity to review the Protocols in effect as of the first day of the Initial Term or Renewal Term, as applicable. United will ensure that Payer's Protocols are generally consistent with United's and are available to [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]].

Note to Regulator: This subsection (ii) introductory paragraph is included in section 2.11 when the provider is a hospital or ancillary provider.

ii) **[New or Revised Protocols.** From time to time, United may establish new or revised Protocols. United will use reasonable commercial efforts to provide [[Facility] [Ancillary Provider]] with notice at least 30 days in advance of a new or revised Protocol. United may implement a new or revised Protocol without [[Facility] [Ancillary Provider]]'s consent if the new or revised Protocol applies to substantially all participating providers of the same type offering similar services as [[Facility] [Ancillary Provider]] located in[[Facility] [Ancillary Provider]]'s state.]

Note to Regulator: This subsection (ii) introductory paragraph is included in section 2.11 when the provider is not a hospital or ancillary provider.

ii) **[New or Revised Protocols.** From time to time, United may establish new or revised Protocols. United will use reasonable commercial efforts to provide [[Medical Group] [FQHC] [RHC] [IHCP]] with notice at least 30 days in advance of a new or revised Protocol. United may implement a new or revised Protocol without [[Medical Group] [FQHC] [RHC] [IHCP]]'s consent if the new or revised Protocol applies to substantially all participating providers of the same type and specialty offering similar services as [[Medical Group] [FQHC] [RHC] [IHCP]] located in [[Medical Group] [FQHC] [RHC] [IHCP]]'s state.]

Note to Regulator: This subsection (ii) paragraph is included in section 2.11 for all provider types.

In the event [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] believes that a new or revised Protocol would result in significantly increased costs for [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]], [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] may, no later than 90] days after the effective date of the new or revised Protocol, provide written notice to United of that

belief. The notice must explain and quantify the projected significantly increased costs to [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] resulting from the new or revised Protocol. If [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] sends such a notice, the parties will consult together about the issue. Both parties will work together in good faith to address and resolve the issue in a mutually satisfactory manner. If the issue is not resolved to [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]]'s satisfaction within 90 days following such notice, [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] may initiate dispute resolution pursuant to the dispute resolution provisions of this Agreement. In the event the issue is arbitrated, the arbitration's scope will be limited to quantifying the significantly increased costs to [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] resulting from the new or revised Protocol, and the arbitrator may award no more than the amount necessary to cover [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]]'s significantly increased costs resulting from the new or revised Protocol for the Initial Term or then-current Renewal Term. The new or revised Protocol may be implemented while the dispute resolution process is proceeding, and the arbitrator cannot order that the new or revised Protocol not take place or be reversed.

Note to Regulator: This subsection (iii) is included in section 2.11 when the provider is a hospital.

iii) **[Certain Protocols Concerning Referral to and Use of Participating Providers**.

a) **Non-Emergency Services**. For non-emergency Covered Services, Facility will assist Members to maximize their benefits by referring or directing Members 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-based Providers**. Facility will assist United in contracting with facility-based providers if requested by United to do so. In the event Facility enters a new contract with a facility-based provider, Facility will provide written notice to United of the new contract. United has no responsibility for the credentialing of any employed or subcontracted facility-based provider.]

Note to Regulator: This subsection (iii) is included in section 2.11 when the provider is not a hospital.

iii) **[Certain Protocols Concerning Referral to and Use of Participating Providers**.

a) **Non-Emergency Services.** For non-emergency Covered Services, [[Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] will assist Members to maximize their benefits by referring or directing Members 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) **PCP Notification**. If the Member's Benefit Plan requires the Member to receive certain Covered Services from or upon referral by a primary care physician, Medical Group Professionals must adhere to the following additional protocols:

1) Notify Member'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 Member's primary care physician.

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

c) **Cooperation With Requests for Clinical Information**. [[Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]]will provide notification for certain Covered Services, accept and return telephone calls from United staff, and respond to United requests for clinical information, as required by United or Payer as described in the Protocols.]

2.12 Nondiscrimination. [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] will not discriminate against any patient because of their status as a Member, regarding (i) quality of care or (ii) accessibility of services. Additionally, [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] will not discriminate against any Member based on the following: (i) race; (ii) ethnicity; (iii) national origin; (iv) religion; (v) sex or gender; (vi) age; (vii) mental or physical disability; (viii) mental health or medical condition; (ix) sexual orientation; (x) gender identity; (xi) medical history; (xii) genetic information; (xiii) type of health insurance; (xiv) claims experience; or (xv) type of payment. [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] will maintain policies and procedures to demonstrate [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] does not discriminate in the delivery of Covered Services.

Note to Regulator: This section 2.13 is included when the provider is a hospital or SNF.

2.13 [Accessibility. [[Facility] [Ancillary Provider]] will be open 24 hours a day, seven days a week. Certain services may routinely be provided by [[Facility] [Ancillary Provider]] on a more limited schedule, in a manner that appropriately provides timely and efficient care to patients.]

Note to Regulator: This section 2.13 is included when the provider is not a hospital or ancillary provider.

2.13 [**Accessibility**. [[Medical Group] [FQHC] [RHC] [IHCP]] will be open during normal business hours and will provide or arrange for the provision of advice and assistance to Members in emergency situations 24 hours a day, seven days a week.]

Note to Regulator: This section 2.13 is included when the provider is an ancillary provider but not a skilled nursing facility.

2.13 [Accessibility. At a minimum, Ancillary Provider will be open during normal business hours, Monday through Friday.]

2.14 Maintenance of and access to records

i) **Maintenance.** [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] will maintain [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] Records for at least 10 years following the end of the calendar year in which the Covered Services were provided unless a longer retention period is required by applicable law.

ii) **Access to Agencies**. [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] will provide access to [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] 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] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]], United or Payers.

iii) **Access to United.** [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] will provide United or its designees access to [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] 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]

[Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]]'s compliance with the provisions of this Agreement and appropriate billing practices.

[[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] will provide access to [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] Records by providing United electronic medical records ("EMR") access and electronic file transfer. When the requested [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] Records are not available through EMR access and electronic file transfer, [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] will submit those [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] 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] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] Records.

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

[[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] may meet the requirements of this section directly or through a Subcontractor.

iv) **Audits.** Pursuant to paragraph (iii) above, United may request [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] Records from [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] for purposes of performing an audit of [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]]'s compliance with this Agreement, [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] billing practices, or United's health care operations, including without limitation claims payments. In addition, United may perform audits at [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]]'s locations upon 14 days' prior notice. [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] 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) **Duplicative requests**. When [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] has provided records through EMR access or electronic file transfer, United will not request duplicative paper records from [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]].

vi) **Cost of records**. [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] will provide [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] Records free of charge**.**

2.15 Quality improvement and patient safety programs. [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] will implement programs recommended by nationally recognized independent third parties related to quality improvement and patient safety. [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] may also implement its own quality improvement and patient safety programs. If [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] implements its own programs, [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] will provide a summary of those programs to United upon request.

Note to Regulator: This paragraph of section 2.15 is not included when the provider is an ancillary provider other than a SNF.

[[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] will provide United with reporting regarding the metrics and outcomes of its quality improvement and patient safety programs on request by United; provided, however, if [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] places such data in the public domain, United will obtain it directly from the public source. United may share this data with United's current and potential clients and with Members.]

[[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] agrees to participate in The Leapfrog Group's annual patient safety survey if requested by the Leapfrog Group.

Note to Regulator: This paragraph of section is included only when the provider is a durable medical equipment supplier

[2.[x] Warranty and Liability. Ancillary Provider will provide United with a copy of its manufacturer's warranty for any product provided under this Agreement which is listed in the Manufacturer's Warranty Appendix to this Agreement. The warranty must state that the beneficiary of the warranty is United and the end user, i.e., Member.

Ancillary Provider will indemnify, defend and hold harmless United, and Payers, and each of their respective officers, directors, employees, and shareholders (each an "Indemnitee") from, against and in respect of all demands, claims, actions, assessments, losses, damages, liabilities, interest and penalties, costs and expenses (including, without limitation, reasonable legal fees and disbursements) resulting from, arising out of, or imposed upon or incurred by any Indemnitee hereunder by reason of (i) any breach of the manufacturer's warranty for a product provided under this Agreement, and (ii) any liability, claim or expense, including but not limited to reasonable attorneys' fees and medical expenses, arising in whole or in part out of claims of any and all third parties for personal injury or loss of or damage to property arising out of the design, materials or workmanship of the products provided under this Agreement, whether based on strict liability in tort, negligent manufacture of product, or any other allegation of liability arising from the design, testing, manufacture, packaging, or labeling (including instructions for use) of the products provided under this Agreement.]

Note to Regulator: This paragraph of section regarding never events is only included when the provider is a hospital.

[2.[x] Never events. If a "never event" occurs in connection with Facility rendering services to a Member, Facility will take then current steps recommended by the Leapfrog Group as follows:

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

ii) Report the event to United, if required by applicable law, 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. Interview the impacted Member and/or families who are willing and able, to gather evidence for the root cause analysis. Inform the Member and/or their 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.

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

For purposes of this section, 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.]

Note to Regulator: Except as noted below this section is included when the provider is a medical group, FQHC, RHC, or IHCP.

[2.[x] [[Medical Group] [FQHC] [RHC] [IHCP]] **Professionals** [[Medical Group] [FQHC] [RHC] [IHCP]] represents that it has provided United with a [[Medical Group] [FQHC] [RHC] [IHCP]] Professional Roster, and will provide updated rosters, that includes all of the following data elements for each [[Medical Group] [FQHC] [RHC] [IHCP]] Professional:

- 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)
- Address(es) on the Service Locations Appendix at which professional primarily sees patients

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

Note to Regulator: This paragraph is included when the provider is a medical group.

Medical Group has the authority to bind, and will bind, Medical Group Professionals to the obligations of this Agreement**.** Medical Group will provide to United the information described in the Medical Group Professional Roster to this Agreement. All Medical Group Professionals must participate in United's network, other than:

i) A Medical Group Professional who is required to be credentialed and who has (a) failed to meet the requirements of United's credentialing program, (b) not submitted a credentialing application or (c) a credentialing application pending; or

ii) A Medical Group Professional who has been terminated from participation in United's network under this Agreement or any other agreement with United through which the Medical Group Professional participated in United's network.

Note to Regulator: This section is included when the provider is a medical group, FQHC, RHC, or IHCP.

2.[x] New [[Medical Group] [FQHC] [RHC] [IHCP]]Professionals. [[Medical Group] [FQHC] [RHC] [IHCP]] will notify United at least 30 days before a physician or other healthcare professional becomes a [[Medical Group] [FQHC] [RHC] [IHCP]] Professional. If [[Medical Group] [FQHC] [RHC] [IHCP]]'s agreement with the new [[Medical Group] [FQHC] [RHC] [IHCP]] Professional provides for a starting date that would make it impossible for [[Medical Group] [FQHC] [RHC] [IHCP]] to provide 30 days advance notice to United, then [[Medical Group] [FQHC] [RHC] [IHCP]] will give notice to United as soon as reasonably possible but no later than five business days after reaching agreement with the new [[Medical Group] [FQHC] [RHC] [IHCP]] Professional. In either case, the new [[Medical Group] [FQHC] [RHC] [IHCP]] Professional will submit a credentialing application to United or its delegate within 30 days of the new [[Medical Group] [FQHC] [RHC] [IHCP]] Professional's agreement to join [[Medical Group] [FQHC] [RHC] [IHCP]], unless United's credentialing program does not apply to the new [[Medical Group] [FQHC] [RHC] [IHCP]] Professional. In addition, [[Medical Group] [FQHC] [RHC] [IHCP]] will provide to United the information described in the [[Medical Group] [FQHC] [RHC] [IHCP]] Professional Roster to this Agreement with respect to the new [[Medical Group] [FQHC] [RHC] [IHCP]] Professional.

Note to Regulator: this section is included when the provider is a medical group, FQHC, RHC, or IHCP.

2.[x] Termination of a [[Medical Group] FQHC] [RHC] [IHCP]] Professional from United's network. United may terminate a [[Medical Group] [FQHC] [RHC] [IHCP]] Professional's participation in United's network, without terminating this Agreement, immediately, upon becoming aware of any of the following:

i) the material breach of this Agreement by the [[Medical Group] [FQHC] [RHC] [IHCP]] Professional that is not cured by [[Medical Group] [FQHC] [RHC] [IHCP]] and/or the [[Medical Group] [FQHC] [RHC] [IHCP]] Professional within 30 days after United provided notice to [[Medical Group] [FQHC] [RHC] [IHCP]] of the breach;

ii) the suspension, revocation, condition, limitation, qualification or other material restriction on a [Medical Group] [FQHC] [RHC] [IHCP]] Professional's license, certification and/or permit by any government agency under which the [[Medical Group] [FQHC] [RHC] [IHCP]] Professional is authorized to provide health care services;

iii) the suspension, revocation, condition, limitation, qualification or other material restriction of a [[Medical Group] [FQHC] [RHC] [IHCP]] Physician's staff privileges at any licensed hospital, nursing home or other facility at which the [[Medical Group] [FQHC] [RHC] [IHCP]] Physician has staff privileges during the term of this Agreement;

iv) for any criminal charge related to the practice of [[Medical Group] [FQHC] [RHC] [IHCP]] Professional's profession or for an indictment, arrest, or conviction for a felony;

v) a sanction imposed by any governmental agency or authority, including Medicare or Medicaid; or

vi) the failure to meet the requirements of United's credentialing program to the extent that those requirements apply to the [[Medical Group] [FQHC] [RHC] [IHCP]] Professional.

United will notify [[Medical Group] [FQHC] [RHC] [IHCP]] of the [[Medical Group] [FQHC] [RHC] [IHCP]] Professional's termination according to the notice of certain events provision set forth in this Agreement.

Note to Regulator: This section is included when the provider is a medical group, FQHC, RHC, or IHCP.

[2.[x] Covered Services by [[Medical Group] [FQHC] [RHC] [IHCP]] **Professionals who are not participating providers.** [[Medical Group] [FQHC] [RHC] [IHCP]] will staff its service locations so that Covered Services can appropriately be rendered to Members by [[Medical Group] [FQHC] [RHC] [IHCP]] Professionals who participate in United's network. A [[Medical Group] [FQHC] [RHC] [IHCP]] Professional who does not participate in United's network pursuant to this Agreement, will not render Covered Services to a Member.

In the event Covered Services are rendered by a [[Medical Group] [FQHC] [RHC] [IHCP]] Professional who does not participate in United's network, neither [[Medical Group] [FQHC] [RHC] [IHCP]] nor the [[Medical Group] [FQHC] [RHC] [IHCP]] Professional will submit a claim or other request for payment to United or Payer and will not seek or accept payment from the Member.]

Note to Regulator: This section is included when the provider is a medical group.

[2.[x] Laboratory Services. Medical Group will be reimbursed for Covered Services that are laboratory services only if, (i) Medical Group is certified through the Clinical Laboratory Improvement Amendments (CLIA) to perform those services, or (ii) those services have "waived" status under CLIA and Medical Group is performing those services pursuant to a CLIA Certificate of Waiver. Medical Group must not bill Members for any other laboratory services.]

Note to Regulator: This section is included when the provider is an RHC.

[2.[x] Laboratory Services. For laboratory services, RHC must comply with the Clinical Laboratory Improvement Amendments (CLIA) for those laboratory services that are RHC services, as defined by CMS.]

Note to Regulator: This section is included when the provider is a medical group whose professional staff includes hospital-based providers.

[2.[#] Services rendered by Facility-Based Medical Group Professionals.

i) **Definition and applicability.** For purposes of this section, "Facility-Based Medical Group Professional" means a Medical Group Professional who provides substantially all of his or her professional services in a facility setting (such as, a hospital inpatient, hospital outpatient, or ambulatory surgical center). Facility-Based Medical Group 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, apply to services rendered by Medical Group Professionals who are not acting as Facility-Based Medical Group Professionals at the time the services are rendered.

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

a) the requirement that Medical Group purchase commercial general and/or umbrella liability insurance.

b) the requirement that Medical Group obtains the Member's consent to provide access to data.

c) the requirement to maintain Medical Group Records.

d) the requirement to collect and review certain quality data.

e) the requirement to obtain the Member's written consent prior to providing services that are not Covered Services.

f) the requirement to request the patient to present his or her Member identification card.

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

a) the requirement to direct Members only to other participating providers.

b) the requirement to notify Members' 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 Member's primary care physician, but only if Facility-Based Medical Group Professionals do not have hospital admitting privileges.

c) the requirement to notify Members' primary care physicians of admissions.

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

Note to Regulator: This section is included when the provider is an ancillary provider of emergency transport and related services.

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

i) the requirement that Ancillary Provider first obtain the Member's written consent in order to seek and collect payment from a Member for non-covered services (however, Ancillary Provider will obtain the Member's consent as soon as it is reasonable to do so consistent with Ancillary Provider's legal obligations regarding the provision of emergency transport and other related health care services when taking Member to the nearest emergency facility in an

emergent situation in order for Member to be stabilized and to receive screening examinations and then, only if the consent is not obtained by the admissions personnel of the emergency facility to which the Member is brought);

ii) the statement that the decision regarding what care is to be provided remains with Ancillary Provider and with Members and their physicians. Instead the decision regarding what care is to be provided remains with Ancillary Provider and with Members to the extent they are able to discuss the care to be provided by Ancillary Provider;

iii) the requirements regarding accessibility; however, Ancillary Provider will provide services 24 hours per day, seven days per week;

iv) the requirement to direct Members only to other participating providers for non-emergent care;

v) the requirements regarding medical records (but only if Ancillary Provider does not keep medical records because medical records are instead kept by the emergency facility to which the Member is brought); and

vi) the requirements regarding certain quality data (but only if Ancillary Provider does not collect and review that quality data because the collection and review of that quality data is instead done by the emergency facility to which the Member is brought).]

[2.[#] Service Standards. [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] will comply with the additional requirements in the attached Service Standards Appendix.]

Article III
Covered Services and Claims

3.1 Provide Covered Services. [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] will provide Covered Services to Members. To extent [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] is subject to credentialing by United, [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] must be credentialed by United or its delegate prior to furnishing any Covered Services to Members under this Agreement.

[[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] and [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] Professionals will participate in and cooperate with United's credentialing program to the extent that program applies to [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] and [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] Professionals. To the extent [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] and [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] Professionals are subject to credentialing, [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] and [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] Professionals must be credentialed by United or its delegate prior to furnishing any Covered Services under this Agreement.

i) **Form and content of claims**.

Each submission of a claim by [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] pursuant to this Agreement is a representation and warranty by [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] to United that [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] has complied with the requirements of this Agreement with respect to the Covered Services involved and the submission of the claim, the charge amount set forth on the claim is the Customary Charge,

and the claim is a valid claim. [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] must submit claims for Covered Services as described in the Protocols, using current, correct and applicable coding.

Note to Regulator: This paragraph is included when the provider is a medical group.

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

ii) **Electronic filing of claims**. [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] will submit claims electronically to the extent United can accept claims and attachments electronically.

iii) **Time to file claims**. Unless a longer timeframe is required under applicable law, [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] will submit claims, inclusive of all information necessary to process a claim, within 90 days from the date of service for Covered Services. If Payer is the secondary payer for a claim and [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] is pursuing payment from the primary payer, [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] will submit claims within 90 days of the date [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] receives the claim response from the primary payer. For purposes of this section, the date of service for an inpatient admission is the date of discharge.

3.3 Claims Payment; Reimbursement Policies

i) **Claims Payment.** Payer will pay claims for Covered Services in accordance with the applicable Payment Appendix(ices) to this Agreement, Reimbursement Policies, and the applicable Benefit Plan. United does not prioritize fully insured claims over self-funded claims in its claims adjudication or payment process. Claims for Covered Services subject to coordination of benefits will be paid in accordance with the Member's Benefit Plan and applicable law.

ii) **Reimbursement Policies.** United will make its Reimbursement Policies available to [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] online and upon request. [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] acknowledges it has had the opportunity to review the Reimbursement Policies in effect as of the first day of the Initial Term or Renewal Term, as applicable.

iii) **New or Revised Reimbursement Policies.** From time to time, United may establish new or revised Reimbursement Policies. United will provide [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] with notice at least 30 days in advance of the new or revised Reimbursement Policy.

iv) **Over and under payments.** If [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] 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, or through dispute resolution under Article IV of this Agreement or in any other forum.

In seeking correction of a given claim payment or denial under this section, [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] must provide United with a written or electronic request. Such written or electronic request must contain all information and documentation that United reasonably needs to complete review of the request and render a decision thereon. Such information and documentation may include, without limitation,

one or more of the following: (i) an explanation of [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]]'s basis for seeking correction; (ii) member identification number; (iii) date of service; (iv) United's claim number; (v) CPT or billing code and claim level detail; (vi) date and content of United's payment or denial decision; (vii) date and outcomes of all reconsiderations and appeals (as applicable); and (viii) specific basis for [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]]'s dispute of United's reconsideration or appeal decision(s). [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]]'s failure to provide a timely written or electronic request consistent with the requirements of this section will constitute a waiver of [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]]'s right to seek further review of the claim payment or denial under this, or through dispute resolution pursuant to the dispute resolution provisions of this Agreement or in any other forum.

[[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] will repay overpayments within 30 days of notice of the overpayment. [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] 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.

v) **Correction of Member eligibility.** Except in the case of emergency services, [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] will check Member's eligibility prior to rendering services. A Member's eligibility is subject to change retroactively if:

a) United receives a change in eligibility from a Payer;

b) Member's coverage under a Benefit Plan is terminated for any reason including, but not limited to, non-payment of premium;

c) Member does not elect continuation of coverage pursuant to state and federal laws (e.g., COBRA continuation coverage); or

d) United determines a Member was not eligible because false information was provided with respect to eligibility.

This Agreement does not apply to services rendered to patients who are not Members at the time the services were rendered. If Member was not eligible on the date of service, any payments made with regard to those services may be recovered as overpayments as described in this section. [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] may directly bill the individual, or other responsible party, for those services. United will make reasonable commercial efforts to cause Payers to process eligibility changes within 120 days.

Note to Regulator: Subsections vi-viii are included when the provider is a medical group, FQHC, RHC, or IHCP.

vi) **[Fee Sources.** Ordinarily, fee amounts listed in the Payment Appendix(ices) are based upon primary fee sources. United reserves the right to use gap-fill fee sources where primary fee sources are not available.]

vii) **Payment Appendix Updates.** United routinely updates its payment appendices: (1) to remain current with applicable coding practices; (2) in response to price changes for immunizations and injectable medications; and (3) 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.

viii) **Non-routine Fee Schedule Changes.** United will give [[Medical Group] [FQHC] [RHC] [IHCP]] 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 [[Medical Group] [FQHC] [RHC] [IHCP]]'s overall reimbursement under this Agreement, [[Medical Group] [FQHC] [RHC] [IHCP]] may terminate this Agreement by giving 60 days written notice to United, provided that the notice is given by [[Medical Group] [FQHC] [RHC] [IHCP]] within 30 days after the notice of the fee schedule change.

3.4 Denial of claims.

Note to Regulator: This subsection is included when the provider is not a hospital.

i) **[Payment and Denial of Claims.** Coverage for the service under the Member's Benefit Plan (including Medical Necessity), timely claim filing, and [[Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]]'s compliance with Protocols are conditions precedent to payment under this Agreement. Accordingly, at its discretion, United will deny payment in whole or in part for the following reasons:

a) **Failure to File Timely Claims**. [[Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] fails to file a timely claim in accordance with this Agreement.

b) **Protocol Noncompliance**. [[Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] fails to comply with a Protocol (including, without limitation, a Protocol regarding notification or prior authorization).

c) **Services Not Medically Necessary or Otherwise Not Covered Under the Member's Benefit Plan**. United determines prospectively, concurrently, or retrospectively that the service is not or was not Medically Necessary or that the Member's Benefit Plan otherwise excludes coverage for the service.

d) **Failure to Provide Information**. United cannot determine whether a service is Medically Necessary because [[Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] omitted information or failed to respond timely to United's request for information ("Failure to Provide Information Denial").

e) **Other Permitted Reasons**. Any other reason permitted under this Agreement.]

Note to Regulator: This subsection is included when the provider is a hospital.

i) **[Payment and Denial of Claims.** Coverage for the service under the Member's Benefit Plan (including Medical Necessity), timely claim filing, and Facility's compliance with Protocols are conditions precedent to payment under this Agreement. Accordingly, at its discretion, United will deny payment in whole or in part for the following reasons:

a) **Failure to File Timely Claims**. Facility fails to file a timely claim in accordance with this Agreement.

b) **Protocol Noncompliance**. Facility fails to comply with a Protocol (including, without limitation, a Protocol regarding notification or prior authorization).

c) **Services Not Medically Necessary or Otherwise Not Covered Under the Member's Benefit Plan**. United determines prospectively, concurrently, or retrospectively that the

service is not or was not Medically Necessary or that the Member's Benefit Plan otherwise excludes coverage for the service.

d) **Failure to Provide Information**. United cannot determine whether a service is Medically Necessary because Facility omitted information or failed to respond timely to United's request for information ("Failure to Provide Information Denial").]

e) **Delay in Service**. 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 Member's inpatient stay was lengthened ("Delay in Service Denial"). Pursuant to a Delay in Service Denial, 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(s)), and process the claim based on the contract rate that would apply without such day(s). However, United will not reduce payment based on a Delay in Service Denial if the applicable contact rate is not impacted by the length of stay because such rate is determined by an MS-DRG (or similar) methodology and lacks an inpatient outlier provision. This subsection does not apply to delays in executing discharge orders.]

f) **Other Permitted Reasons**. Any other reason permitted under this Agreement.

Note to Regulator: This subsection is included when the provider is not a hospital.

ii) **[Limitations on Member Billing for Certain Denials**.

a) **Services not Covered under the Applicable Benefit Plan**. Services not covered under the applicable Benefit Plan are not subject to the rates or discounts of this Agreement. [[Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] may seek and collect payment from a Member for such services, but only if [[Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] obtained the Member's written consent. The preceding sentence does not apply to Prior Authorization Denials.

b) **Prior Authorization Denials**. If United determines through the prior authorization process that a service is not Medically Necessary ("Prior Authorization Denial"), [[Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] may seek or collect payment from the Member only if, prior to receiving the service, the Member had knowledge of the determination of non-coverage and specifically agreed in writing to be responsible for payment of those charges.

c) **Failure to Provide Information Denials**. If United denies payment based on a Failure to Provide Information Denial, [[Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] will not seek or collect payment from the Member for the services for which United denied payment.

d) **Other Member Billing Protections Not Affected**. This section supplements the other Member billing requirements and restrictions set forth in this Agreement.]

Note to Regulator: This subsection is included when the provider is a hospital.

ii) **[Limitations on Member Billing for Certain Denials**.

a) **Services not Covered under the Applicable Benefit Plan**. 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 Member for such services, but only if Facility obtained the Member's written consent. The preceding sentence does not apply

to Prior Authorization Denials, Length of Stay Denials, Level of Care Denials, Failure to Provide Information Denials, and Delay in Service Denials as each are defined below.

If United determines that an inpatient service is not a Covered Service because a discharge order has been written by a physician treating the Member but the Member has elected to remain an inpatient, Facility may seek and collect payment from the Member for those non-Covered Services only if: (a) prior to receiving the service, the Member 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 Member's refusal to agree in writing to be responsible for those charges.]

a) **Prior Authorization Denials**. If United determines through the prior authorization process that a service is not Medically Necessary ("Prior Authorization Denial"), Facility may seek or collect payment from the Member only if, prior to receiving the service, the Member had knowledge of the determination of non-coverage and specifically agreed in writing to be responsible for payment of those charges.

b) **Failure to Provide Information Denials**. If United denies payment based on a Failure to Provide Information Denial, Facility will not seek or collect payment from the Member for the services for which United denied payment.

c) **Length of Stay Denials**. If United determines after a Member becomes an inpatient that services are not Medically Necessary ("Length of Stay Denial"), 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, Facility must not seek or collect payment from the Member with regard to services that are denied for lack of Medical Necessity (including room, board, and other services for a given day). However, Facility may collect from the Member the applicable copayment, deductible, or coinsurance for the part of the admission that United determined to be Medically Necessary.

d) **Level of Care Denials**. If United determines that the level of care provided for a 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) ("Level of Care Denial"), Facility will not seek or collect payment from the Member for the level of care denied for lack of Medical Necessity. However, Facility may, to the extent permitted under this Agreement and applicable law, resubmit the denied claim at the appropriate level of care and bill the Member for the copayment, deductible, or coinsurance that was calculated by United when it processed the resubmitted claim.

e) **Failure to Provide Information Denials**. If United denies payment based on a Failure to Provide Information Denial, Facility will not seek or collect payment from the Member for the services for which United denied payment.

f) **Delay in Service Denials**. If United denies or reduces payment based on a Delay in Service Denial, Facility will not seek or collect payment from the Member in excess of the coinsurance, copayment, or deductible associated with the claim as processed by United.

g) **Other Member Billing Protections Not Affected**. This section supplements the other Member billing requirements and restrictions set forth in this Agreement.

Note to Regulator: This subsection is included when the provider is not a hospital.

iii) **[Review of Certain Denials**

a) **Protocol Noncompliance Denials (Notification or Prior Authorization)**. This section does not apply to the following Benefit Plans: UnitedHealthcare Community Plan Medicaid, CHIP and Uninsured; UnitedHealthcare West; NHP; Oxford; River Valley; MDIPA; and Rocky Mountain Health Plan (RMHP).

[[Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] may appeal a denial for [[Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]]'s failure to comply with a Protocol regarding notification or prior authorization. The denial will be reversed only if [[Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]]:

1. Submits the appeal within the applicable timeframes set forth in the regulatory appendix(ices) attached to this Agreement and in the applicable Administrative Guide Supplement(s); and

2. Shows one or more of the following:

   A. The denial was incorrect because [[Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] complied with the Protocol,

   B. The service was Medically Necessary, or

   C. At the time the Protocol required notification or prior authorization, [[Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] did not know and was unable to reasonably determine that the patient was a Member, but [[Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] took reasonable steps to learn that the patient was a Member and promptly submitted a claim after learning the patient was a Member.

A denial that is upheld on appeal is not be eligible for additional review by United. Reversal of a denial under this subsection does not preclude United from upholding the denial for another permitted reason under this Agreement.

b) **Failure to File Timely Claims**. [[Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] may request reconsideration of a denial for [[Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]]'s failure to file a timely claim in accordance with this Agreement. The denial will be reversed only if [[Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]]:

1. Submits the reconsideration request within the applicable timeframes set forth in the regulatory appendix (ices) attached to this Agreement and in the applicable Administrative Guide Supplement(s);

2. Shows one or more of the following:

   A. The denial was incorrect because [[Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] filed a timely claim, or

   B. [[Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] did not know and was unable to reasonably determine at the time by which a claim filing was required that the patient was a Member, but [[Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] took reasonable steps to learn that the patient

was a Member and promptly filed the claim after learning the patient was a Member.

Reversal of a denial under this subsection does not preclude United from upholding the denial for another permitted reason under this Agreement.]

Note to Regulator: This subsection is included when the provider is a hospital.

iii) **[Review of Certain Denials**.

a) **Certain Medical Necessity Denials**. Facility may appeal a Prior Authorization Denial, Length of Stay Denial, or Level of Care Denial. Such denial will be reversed only if: (a) Facility submits the appeal within the applicable timeframes set forth in this Agreement and in the UnitedHealthcare Administrative Guide or Supplement; and (b) Facility shows that the service was Medically Necessary. A denial that is upheld on appeal is not eligible for additional review by United. Reversal of a denial under this subsection does not preclude United from upholding the denial for another permitted reason under this Agreement.

b) **Failure to Provide Information Denials.** Facility may appeal a Failure to Provide Information Denial that was made with respect to a length of stay review or a level of care review as described in this section. The denial will be reversed only if: (a) Facility submits the appeal within the applicable timeframes set forth in the correction of claim payments provision in this Agreement and in the applicable Administrative Guide; and (b) Facility shows that the service was Medically Necessary. A denial that is upheld on appeal is not eligible for additional review by United. Reversal of a denial under this subsection does not preclude United from upholding the denial for another permitted reason under this Agreement.

c) **Protocol Noncompliance Denials (Notification or Prior Authorization)**. This section does not apply to the following Benefit Plans: UnitedHealthcare Community Plan Medicaid, CHIP and Uninsured; UnitedHealthcare West; NHP; Oxford; River Valley; MDIPA; and Rocky Mountain Health Plan (RMHP).

Facility may appeal a denial for Facility's failure to comply with a Protocol regarding notification or prior authorization. The denial will be reversed only if Facility:

1. Submits the appeal within the applicable timeframes set forth in the regulatory appendix(ices) attached to this Agreement and in the applicable Administrative Guide Supplement(s); and

2. Shows one or more of the following:

   A. The denial was incorrect because Facility complied with the Protocol,

   B. The service was Medically Necessary, or

   C. At the time the Protocol required notification or prior authorization, Facility did not know and was unable to reasonably determine that the patient was a Member, but Facility took reasonable steps to learn that the patient was a Member and promptly submitted a claim after learning the patient was a Member.

A denial that is upheld on appeal is not be eligible for additional review by United. Reversal of a denial under this subsection does not preclude United from upholding the denial for another permitted reason under this Agreement.

d) **Failure to File Timely Claims**. Facility may request reconsideration of a denial for Facility's failure to file a timely claim in accordance with this Agreement. The denial will be reversed only if Facility:

1) Submits the reconsideration request within the applicable timeframes set forth in the regulatory appendix(ices) attached to this Agreement and in the applicable Administrative Guide Supplement(s);

2) Shows one or more of the following:

A. The denial was incorrect because Facility filed a timely claim, or

B. Facility did not know and was unable to reasonably determine at the time by which a claim filing was required that the patient was a Member, but Facility took reasonable steps to learn that the patient was a Member and promptly filed the claim after learning the patient was a Member.

Reversal of a denial under this subsection does not preclude United from upholding the denial for another permitted reason under this Agreement.]

Note to Regulator: This subsection is included when the provider is not a hospital.

iv) **[Medical Necessity**. For purposes of prior authorization, Medically Necessary or Medical Necessity will be defined in accordance with the applicable Benefit Plan and applicable law or regulatory requirements.]

Note to Regulator: This subsection is included when the provider is a hospital.

iv) **[Medical Necessity**.

a) **Definition**. Medically Necessary or Medical Necessity will be defined in accordance with this subsection. For purposes of prior authorization, appeals of Prior Authorization Denials, and appeals of denials for Facility's failure to comply with Protocols regarding notification or prior authorization, Medically Necessary or Medical Necessity will be defined in accordance with the applicable Benefit Plan and applicable law or regulatory requirements. For all other purposes not described in the preceding sentence, Medically Necessary or Medical Necessity is defined as 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 Member's sickness, injury, substance use disorder, disease or its symptoms.
- Not mainly for the Member's convenience or that of the Member's physician or other health care provider.

- [Not more costly than an alternative drug, service(s), service site, or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Member'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) **Limitations on Certain Denials**.

Length of stay denials. United will not reduce payment based on a Length of Stay Denial if the applicable contact rate is not impacted by the length of stay because such rate is determined by an MS-DRG (or similar) methodology and lacks an inpatient outlier provision.

3.5 Payment in full. Payment provided pursuant to this Agreement, together with any Member cost-sharing under the Benefit Plan, is payment in full for a Covered Service. Nothing in this Agreement prevents [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] from collecting any Member co-payment, deductible, or coinsurance at the time the Covered Service is provided. [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] will use reasonable commercial efforts to determine or estimate the amount of Member liability before collection. [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] will submit a claim for its services regardless of whether [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] has collected from the Member as permitted under this section. If [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] learns it has collected an amount in excess of the Member's liability, [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] will promptly remit to Member the overpayment within 20days from the date that [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] first learned of the Member overpayment.

3.6 Member hold harmless; payer default.

i) **Member hold harmless**

a) **Requirement to hold harmless**. [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] will not bill or collect payment from the Member, or seek to impose a lien, for the difference between the amount paid under this Agreement and [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]]'s Customary Charge, or for any amounts denied or not paid under this Agreement due to:

1. [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]]'s failure to comply with the Protocols,

2. [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]]'s failure to file a timely claim,

3. Application of Reimbursement Policies,

4. Inaccurate or incorrect claim processing,

5. Insolvency or other failure by Payer to maintain its obligation to fund claims payments if Payer is an entity required by applicable law to assure that its Members not be billed in these circumstances, or

6. 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 the denial of claims provisions of this Agreement.

If [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] believes one or more claim is paid incorrectly, [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] may pursue remedies under this Agreement, but must still hold the Member harmless.

b) **Failure to hold harmless**. Failure to comply with the Member protection provisions of this section is a breach of this Agreement. Except as otherwise provided in this Agreement, this section applies regardless of whether the Member or anyone purporting to act on the Member's behalf has executed a waiver or other document of any kind purporting to allow [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] to collect payment from the Member.

In the event of such a breach, Payer may deduct the amount wrongfully collected from Members from any amounts otherwise due [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]]. Payer may also deduct an amount equal to any costs or expenses incurred by the Member, United or Payer in defending the Member and otherwise enforcing this section. United will give [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] 30 days' notice prior to any deduction under this section and will provide [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] documentation to substantiate the deduction.

Any amounts deducted by Payer in accordance with this provision will be used to reimburse the Member 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.

ii) **Payer default**

a) **United's evaluation of Payers**. United will make reasonable commercial efforts to evaluate a Payer's financial ability to meet its claims payment obligations and to terminate or bring into compliance a Payer that has defaulted. A default is a systematic failure by a Payer to fund claims payments for Covered Services under Benefit Plans sponsored by the Payer. A default is not a dispute as to whether certain claims should be paid or the payment amount for certain claims.

b) **Payer Default; non-application of agreement.** This Agreement does not apply to services rendered to Members covered by a Benefit Plan sponsored by a Payer in default, other than a default described immediately above. After confirming with United a Payer

is in default, [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] may seek payment directly from the Payer or from Members.

This section will survive the termination of this Agreement, regarding Covered Services rendered prior to when the termination takes effect.

Note to Regulator: This subsection is included when the provider is not a facility or ancillary provider

[3.7 Claims payment issues arising from departure of [[Medical Group] [FQHC] [RHC] [IHCP]] Professionals from [[Medical Group] [FQHC] [RHC] [IHCP]]. In the event a [[Medical Group] [FQHC] [RHC] [IHCP]] Professional departs from [[Medical Group] [FQHC] [RHC] [IHCP]], and uncertainty arises as to whether [[Medical Group] [FQHC] [RHC] [IHCP]] or some other entity is entitled to receive payment for certain services rendered by such former [[Medical Group] [FQHC] [RHC] [IHCP]] Professional, the parties will cooperate with each other in good faith in an attempt to resolve the situation appropriately.

In the event [[Medical Group] [FQHC] [RHC] [IHCP]]'s failure to give timely notice under this Agreement resulted in claims payments being made incorrectly to [[Medical Group] [FQHC] [RHC] [IHCP]], [[Medical Group] [FQHC] [RHC] [IHCP]] will promptly notify United and return such payments to United. In the event [[Medical Group] [FQHC] [RHC] [IHCP]] fails to do so, United may hold [[Medical Group] [FQHC] [RHC] [IHCP]] liable for any attorneys' fees, costs, or administrative expenses incurred by United as a result.

In the event both [[Medical Group] [FQHC] [RHC] [IHCP]] and some other entity assert a right to payment for the same service rendered by the former [[Medical Group] [FQHC] [RHC] [IHCP]] 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, [[Medical Group] [FQHC] [RHC] [IHCP]] will waive any right to receive interest or penalties under any applicable law relating to the prompt payment of claims.]

Article IV
Dispute Resolution

4.1 Resolution of Disputes; Scope and Applicability. Every dispute or disagreement between the parties (each a "Dispute") is subject to the provisions of this Article IV, except Disputes concerning arbitrability or Disputes concerning the availability of class or consolidated arbitration, the right to which the parties expressly waive below in Section 4.4 (vii). Examples of the types of disputes and disagreements that constitute Disputes include: those in any way relating to, arising out of or in connection with, or involving the performance, enforcement, breach, existence, validity, scope, interpretation, or termination of this Agreement or any term thereof or any right or obligation thereunder; and those in which [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] is acting as the assignee of one or more Member(s).

4.2 Compliance with United Policies and Procedures. A party may not invoke the provisions of this Article IV unless and until it has timely and successfully complied with and exhausted all United policies and procedures applicable to the subject(s) of the Dispute. Examples of such United policies and procedures include: claim reconsideration and appeal processes; claims underpayments and denial correction processes (e.g., Claims Payment and Reimbursement Policies Section of this Agreement); grievance and complaints processes; processes governing medical/utilization management determinations, reviews, and appeals; medical and drug policies and guidelines; reconsideration rights under a provision of this Agreement (e.g., Denial of Claims Section of this Agreement); review and appeal processes mandated by law; and credentialing or quality improvement plans. United policies and procedures may be set forth in this Agreement, applicable administrative guide supplements, Reimbursement Policies, Protocols, medical and

drug policies and guidelines, and Benefit Plans. United policies and procedures may change from time to time and may be issued and maintained in electronic and internet-based media or formats.

4.3 Informal Dispute Resolution; Notice Requirements. The parties will initially attempt to resolve a Dispute through the good-faith negotiation process described in this section. Disputes over the validity of a purported termination for uncured material breach will not be subject to this section and instead will be governed by and resolved through the arbitration process set forth below.

i) **Written Notice of Dispute**. The party invoking this section for a Dispute must send written notice of the Dispute to the other party. Such written notice must: (i) state that the noticing party is invoking this Agreement's dispute-resolution process; and (ii) explain the circumstances giving rise to and underlying the Dispute (including, to the extent applicable, the information and documentation required under the corrections of claim underpayments and denials provisions) and the basis for the noticing party's position regarding the Dispute.

ii) **Timely Provision of Written Notice of Dispute**. Any written notice of Dispute that is required to be provided under this section must be sent within the following time frames:

a) For a Dispute involving a matter that is subject to United policies or procedures, no later than the 60th day following the exhaustion of all such applicable United policies and procedures; and

b) For a Dispute involving matters not subject to United policies or procedures, no later than the 60th day following the noticing party's discovery of the action or omission that is the subject of the Dispute.

In the event one party fails to exhaust all applicable United policies and procedures for a Dispute, written notice of the Dispute by the other party is timely if sent no later than the 60th day following the final day by which exhaustion of all applicable United policies and procedures was required.

Nothing in this section shortens the period under applicable law or this Agreement during which United may pursue and complete recovery of an overpayment.

iii) **Negotiation Period**. A party that receives a valid written notice of a Dispute will promptly contact the noticing party to arrange for discussions (which may be virtual or telephonic) during which the parties will make reasonable commercial efforts to negotiate and resolve the Dispute. If the parties fail to resolve the Dispute by the 90th day following the other party's receipt of written notice (or by such other date to which the parties may mutually agree), either party may initiate formal dispute resolution pursuant to the next section of this Agreement.

4.4 Arbitration. The sole and exclusive means for settling any Dispute not successfully resolved is binding arbitration conducted by the American Arbitration Association ("AAA") in accordance with the AAA Commercial Arbitration Rules, as they may be amended from time to time (see http://www.adr.org).

i) **Timely Initiation of Arbitration.** Unless applicable law provides otherwise, a party submitting a Dispute to arbitration must initiate arbitration no later than 12 months following the date on which written notice of the Dispute was made pursuant to this Article. A party seeking resolution of a Dispute over the validity of a purported termination for uncured material breach must initiate arbitration no later than the 60th day following the initial

termination notice, and unless the parties agree otherwise, the purported termination will be deferred the through the conclusion of the arbitration.

ii) **Arbitrator(s)/Panel Selection**. The arbitrator(s) will be selected from the AAA National Roster (as described in the AAA Commercial Arbitration Rules and Mediation Procedures). In an arbitration of a Dispute in which a party seeks an award of $1,000,000 or greater or termination of this Agreement, a panel of three arbitrators will be used.

iii) **Location**. Arbitration of a Dispute will be conducted in [county]/[city], [state]/[territory]/[District of Columbia].

iv) **Authority of Arbitrator(s); Burden of Proof.** The arbitrator(s) will be bound by controlling law and may construe or interpret—but must not vary or ignore—the terms of this Agreement. The arbitrator(s) will have no authority to award punitive, exemplary, indirect, or special damages, except in connection with a statutory claim that explicitly provides for that relief. In any arbitration of a Dispute involving disagreement over one or more claim underpayments or denials, the arbitrator(s) must construe or interpret the applicable United policies and procedures, unless otherwise required by law. Any prejudgment interest awarded by the arbitrator(s) shall not exceed 3 percent per year. The burden of proof in any arbitration shall be on the party asserting the claims or defenses in the arbitration.

v) **Class Actions, Joinder, Consolidation.** 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 ruling by a court allowing class action proceedings or requiring consolidated litigation involving any third party(ies) would be contrary to their intent and would require immediate judicial review of such ruling.

vi) **Arbitration Decision.** The decision(s) and award(s) of the arbitrator(s) on the Dispute will be final and binding and will not be subject to further review in any forum (including judicial review)

vii) **FAA.** The parties acknowledge that because this Agreement affects interstate commerce the Federal Arbitration Act applies in addition to any applicable state or federal law.

viii) **Waiver of Jury Trial.** In the event a court determines that the arbitration procedure set forth in this section is not binding or otherwise allows litigation involving a Dispute to proceed, the parties hereby waive any 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.

4.5 **Waiver**. Failure to timely comply with and exhaust the requirements and processes described in this Article will constitute a waiver of the party's right to review of the Dispute, through any judicial, administrative, or regulatory process, through United's internal processes, or in any other forum (including arbitration and litigation), except as otherwise required by law.

4.6 **Survival**. This Article will survive any termination of this Agreement

Article V
Term and Termination

5.1 **Term**. This Agreement will have an initial term beginning on the Effective Date and ending as set forth below (each, an "Initial Term"). Unless otherwise terminated pursuant to this Article, this Agreement will renew for successive one-year terms (each, an "Renewal Term") upon the expiration of an Initial Term.

a) The Initial Term for Medicare Advantage Benefit Plans will end on [May 31][June 30][July 31], 20[XX].

b) The Initial Term for State Government Program Benefit Plans will end on [*Month Day, Year*].

c) The Initial Term for Individual Exchange Benefit Plans will end on [*Month Day, Year*].

d) The Initial Term for Non-Governmental Benefit Plans will end on [*Month Day, Year*].

e) The Initial Term for VA CCN Benefit Plans will end on [*Month Day, Year*].

5.2 Termination. This Agreement or a Participating Benefit Plan set forth on Network Participation Appendix may be terminated under any of the following circumstances:

Note to regulator: This subsection (i) is included if the parties agree to only one termination without cause notice period for all benefit plan categories.

i) [By either party for Participating Benefit Plans upon at least 270 [240][210][180] days' prior written notice to the other party to be effective upon the expiration of the Initial Term or the then current Renewal Term.]

Note to regulator: This subsection (i) is included if the parties agree to two termination without cause different notice periods.

i) [By either party for Participating Benefit Plans that are:

a) [Medicare Advantage Benefit Plans,] [and] [State Government Program Benefit Plans,] [and] [Individual Exchange Benefit Plans,] [and] [Non-Governmental Benefit Plans,] and] [VA CCN Benefit Plans]], upon at least 270 [240][210][180] days' prior written notice;

b) [Medicare Advantage Benefit Plans,] [and] [State Government Program Benefit Plans,] [and] [Individual Exchange Benefit Plans,] [and] [Non-Governmental Benefit Plans] upon at least 240[210][180] days' prior written notice,

to the other party to be effective upon the expiration of the Initial Term or the then current Renewal Term.]

ii) by either party, upon 60 days' prior written notice, in the event of a material breach of this Agreement by the other party; the notice must include a specific description of the alleged material breach; however, the termination will not take effect if the breach is cured within 60 days after notice of the termination; moreover, termination may be deferred as further described in the dispute resolution provisions of this Agreement.

iii) 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 by this Agreement.

iv) by United, upon 10 days' prior written notice, in the event [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] loses accreditation.

v) by United, immediately upon written notice, if:

a) [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] loses approval for participation under United's credentialing plan, or

b) [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] does not successfully complete United's re-credentialing process as required by the credentialing plan.

Note to Regulator: This subsection will only be used if United has an IEX benefit plan in this state. It is a variable for future IEX expansion.

[[x] During the first year of the Initial Term for Individual Exchange Benefit Plans, by United upon at least 90 days' prior written notice, to be effective as of December 31 of the calendar year in which notice is given, if United's silver plans' approved premium in the market is [%] higher than the lowest competitor silver plan approved premium in the same market.]

Note to Regulator: This subsection will be included only when the provider is a lab.

[[x] by United, upon 10 days' prior written notice to Ancillary Provider in the event there is any change in the controlling interest of Ancillary Provider modifying the percentage ownership interest outlined in the Lab Attestation Appendix to this Agreement.]

Note to Regulator: This subsection will be included only when the provider is a medical group, FQHC, RHC, IHCP.

[[x] by [[Medical Group] [FQHC] [RHC] [IHCP]]in the event of a non-routine fee schedule change as described in this Agreement.]

For the subparagraph on termination upon notice [and the subparagraph at the end of the first contract year for Individual Exchange Benefit Plans], each Participating Benefit Plan must be terminated separately in the timeframes listed. Termination of one Participating Benefit Plan will not result in termination of this Agreement or terminations of any other Participating Benefit Plan. This Agreement will automatically terminate on the date no Participating Benefit Plan remains in effect. United may update the Network Participation Appendix without amendment to accurately reflect the Participating Benefit Plans upon termination of any Participating Benefit Plan pursuant to this section.

Note to Regulator: This section will be included when the provider is not a lab.

[5.3 Ongoing Services. This Section applies when a Member ceases to have network access to [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] because of a termination of this Agreement or because of a change in relationship between United and [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]], Payer and [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]], Member and [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]], or United and Member. If the Member is receiving any of the Covered Services listed below as of the effective date of the termination or change in relationship, then for the length of time reflected below [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] will continue to render those Covered Services to that Member and this Agreement will continue to apply to those Covered Services.

- **Institutional Inpatient Covered Services** : The earlier of 90 days or discharge
- **Pregnancy** : The earlier of 90 days or through postpartum treatment
- **Terminally Ill per Social Security Act** : The earlier of 90 days or the completion of course of treatment

- **Serious and Complex Medical Conditions** : The earlier of 90 days or the completion of course of treatment for the condition

- **Any other conditions where a Payer is required to provide coverage for continued care by care provider after Member loses access to care provider due to a qualifying event under the federal Consolidated Appropriations Act, 2021 as may be subsequently amended, or applicable law or regulation**: As required by state regulatory appendix or applicable state or federal regulation or law

- **Ongoing Services to State Government Program Benefit Plan Members** : As required by the state regulatory appendix or United's contract with the state's Medicaid agency or state law]

Note to Regulator: This section will be included only when the provider is a lab.

[5.3 Ongoing Services. This Section applies when a Member ceases to have network access to Ancillary Provider because of a termination of this Agreement or because of a change in relationship between United and [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]], Payer and [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]], Member and [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]], or United and Member. If the Member is receiving any Covered Services as of the effective date of the termination or change in relationship, then [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] will continue to render those Covered Services to that Member and this Agreement will continue to apply to those Covered Services until the earlier of the Covered Services' completion or the 31st day after the termination or change in relationship.]

Article VI
Miscellaneous Provisions

6.1 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.

Note to Regulator: This subsection will be included when the provider is a facility.

6.2 [**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.

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.]

Note to Regulator: This subsection will be included when the provider is not a facility.

6.2 [Amendment. United may amend this Agreement or any of the appendices on 90 days' written or electronic notice by sending [[Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] a copy of the amendment.

Additionally, United may amend this Agreement upon written notice to [[Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] 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 medical groups in United's network that would be similarly impacted by the regulation in question. United will provide at least 30 days' notice of any such regulatory amendment unless a shorter notice period is necessary in order to comply with regulatory requirements.

[[Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]]'s signature is not required to make the amendment effective. However, if the amendment is not required by law or regulation and would impose a material adverse impact on [[Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]], then [[Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] may terminate this Agreement on 60 days' written notice to United by sending a termination notice within 30 days after receipt of the amendment.]

6.3 **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.

6.4 **Assignment.** This Agreement may not be assigned in whole or in part by either party without the written consent of the other party, except that this Agreement may be assigned by a party to an entity which is an affiliate of the party so long as the assignee is not a competitor of the other party.

Any partial assignment will not impact the relationship of the parties with respect to the remainder of this Agreement.

6.5 **Confidentiality.** Neither party may disclose, directly or indirectly, to a Member, other health care provider, or other third party any of the following information (except as required by an agency of the government, court order, other third party, or applicable laws or regulations):

i) any proprietary business information, not available to the general public, obtained by the party or its representative from the other party or its representative;

ii) the specific terms, including reimbursement amounts, of this Agreement, except for purposes of administration of benefits, including Informing Members, 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.

For the avoidance of doubt, nothing in this Agreement will constitute a gag clause prohibited by the Consolidated Appropriations Act, 2021, as it may be amended from time to time. In addition, this section does not preclude the disclosure of information by United to a third party as part of a process by which the third party is evaluating administration of benefits or considering whether to purchase services from United.

During the term of this Agreement, United grants to [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] a limited, non-sublicensable, non-transferable, and non-exclusive license to use within the United States the UNITEDHEALTHCARE name and logo (the "Licensed Marks") solely for the purposes of (i) using or displaying the Licensed Marks alongside names or logos of other insurance carriers with whom [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] has a network participation agreement, or (ii) communicating verbally or in writing to [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]]'s prospective or existing patients that [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] has an agreement with United to provide health care services to Members. [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] will comply with all requirements made available by United regarding the use of United's names, logos, trademarks, trade names, or other marks of United including those located

in the Protocols. United may at any time withdraw its permission for [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] to use any Licensed Marks, effective upon written notice to [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]]. All other uses of any names, logos, trademarks, trade names, or other marks of United require the advance written consent of United.

[[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] will not issue a press release or public disclosure related to this Agreement without the advanced written consent of United. Without limiting the generality of the foregoing, in the event either party issues a press release or other public disclosure about the business relationship between the parties, that party will ensure the content of such material does not (a) mischaracterize the nature of the relationship between the parties, (b) suggest any endorsement or promotion of the other party, or (c) disclose or describe information subject to the confidentiality obligations in this Agreement.

6.6 Notice procedures. Except as specified below, when notice is required under this Agreement, it will be provided in writing. Written notice may be delivered by any of the following methods: i) email; ii) in person; iii) first class mail, certified mail; iv) other method as specified in a Protocol; or v) overnight delivery by a carrier service with proof of delivery. New or revised Reimbursement Policies and Protocols may be noticed online at www.uhcprovider.com or its successor, unless otherwise required by law. All notices of termination of all or part of this Agreement or Dispute by either party must be delivered in person; by first class, certified mail; or overnight delivery and must be clearly marked as notice of termination or Dispute. A party may update its notice contact information by providing proper notice under this section. 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.

As of the Effective Date of this Agreement, the notice contact information for each party is as follows:

United:

Attn: [insert]

[address]

[email]

[phone]

For notice of termination or Dispute, copy to:

Attn: Network Legal Department

UnitedHealth Group

9900 Bren Road East

MN008-T502 – Legal Intake

Minnetonka, MN 55343

[*provider*]:

Attn: [insert]

[address]

[email]

[phone]

For notice of termination or Dispute, copy to:

Attn: Legal Department

[address]

[phone]

6.7 **No third-party beneficiaries**. United and [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] 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.

6.8 **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.

6.9 **Governing law.** This Agreement will be governed by and construed in accordance with the laws of the state in which [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] renders Covered Services, and any other applicable law.

6.9 [**Governing law.** This Agreement will be governed by and construed in accordance with the laws of the state of Minnesota, and any other applicable law.]

6.10 **Regulatory appendices**. One or more regulatory appendices are attached to this Agreement, setting forth additional provisions included in this Agreement 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.

6.11 **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.

6.12 **Survival**. In addition to any other provisions relating to survival, this Agreement will continue to apply to Covered Services rendered while this Agreement was in effect and in relation to confidentiality.

6.13 **Fines; Penalties**. United will be responsible for any fines or penalties that may be assessed against [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] by any government agency that arise from the United's failure to execute, deliver or perform its obligations under this Agreement. [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] will be responsible for any fines or penalties that may be assessed against United by any government agency that arise from [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]]'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.

[Provider Name inserted here]**, as signed by its authorized representative:**	**[**Applicable United Legal entity inserted here**], as signed by its authorized representative:**
Signature:	Signature:
Name:	Name:
Title:	Title:
Date:	Date:

Service Location Appendix

(As of the Effective Date of this Agreement)

See attached or embedded list.

Capitation Arrangements and Financial Responsibility Appendix

This Appendix applies when United has a Capitation arrangement in place with one or more Capitated Organizations.

For the purposes of this Appendix, the following definitions will also apply:

Capitated Member is a Member who is assigned to a Capitated Organization. Capitated Members can be identified through a reference to the Capitated Organization on the Member's valid identification card.

Capitated Organization is a medical group, an IPA, a hospital, a management services organization, or other provider organization that has financial responsibility for certain designated Covered Services rendered to Capitated Members by accepting Capitation from United.

Capitation is when United pays a Capitated Organization a set amount for each Capitated Member per period of time (for example, an amount per Member per month). Payment is made whether or not the Capitated Member seeks care or services from the Capitated Organization.

The following paragraphs identify the entity with the financial responsibility and the reimbursement for the designated Covered Services under the Capitation arrangement:

- When [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] is part of a network for both United and a Capitated Organization, and [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] provides or arranges for certain designated Covered Services to be provided to Capitated Members assigned to that Capitated Organization, the obligation for payment will be solely that of the Capitated Organization, and not that of United. The reimbursement to [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] will be according to the agreement [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] has with the Capitated Organization.
- When [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] is part of a network for United but not part of a network for a Capitated Organization, and [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] provides or arranges for certain designated Covered Services to be provided to Capitated Members assigned to that Capitated Organization, the obligation for payment will be solely that of the Capitated Organization and not that of United. The reimbursement to [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] will be according to this Agreement. Provided, however, for Capitated Members covered under a Medicare Advantage Benefit Plan, the reimbursement to [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] will be the lesser of 100% of CMS or the rates set forth in this Agreement for Medicare Advantage Benefit Plans.
- When [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] is part of a network for both United and a Capitated Organization, and [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] provides or arranges for Covered Services to be provided to Members who are not Capitated Members, the obligation for payment will be solely that of United or the participating entity that has the financial obligation and not that of the Capitated Organization. The reimbursement to [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP]] will be according to this Agreement.

Administrative Guide Supplements Appendix

For some of the Benefit Plans for which [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP] [Provider]] may provide Covered Services under this Agreement, [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP] [Provider]]is subject to additional requirements of one or more additional provider manuals (each, a "Supplement" and, collectively, the "Supplements"). When this Agreement refers to Protocols or Reimbursement Policies, it is also referring to the Supplements. A Supplement may be a separate document, or it may be included in the UnitedHealthcare Care Provider Administrative Guide ("UnitedHealthcare Administrative Guide").

For Benefit Plans subject to a Supplement, the Supplement 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 Reimbursement Policy. However, the Supplement does not control where it conflicts with applicable statutes or regulations.

The Supplements listed below will be made available to [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP] [Provider]] on www.UHCProvider.com (or successor site) and upon request.

United may make changes to the Supplements subject to this Appendix in accordance with the provisions of this Agreement, subject to Protocol and Reimbursement Policy changes.

- Benefit Plan: [Name of Supplement]

Network Participation Appendix
Benefit Plan Descriptions

Section 1. United may allow Payers to access [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP] [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 Network Participation Appendix:

Note to regulator: The list of Benefit Plan types for the network in which the provider agrees to participate will appear here.

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

Note to regulator: The list of Benefit Plan types for the network in which the provider does not agree to participate will appear here.

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] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP] [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 Network Participation Appendix regarding Member identification cards. If that happens, section 1 or section 2 of this Network Participation Appendix will continue to apply to those Benefit Plans as it did previously, and United will provide [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP] [Provider]] with the updated information. Additionally, United may revise the definitions in this Network Participation Appendix to reflect changes in the names or roles of United's business units, provided that doing so does not change [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP] [Provider]]'s participation status in Benefit Plans impacted by that change, and further provided that United provides [[Facility] [Medical Group] [Ancillary Provider] [FQHC] [RHC] [IHCP] [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. The Member identification card will include a reference to "PPO".

- **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. The Member identification card will include a reference to "UnitedHealthcare Group Medicare Advantage (PPO)".]

- **Local PPO Medicare Advantage Benefit Plans** means PPO Medicare Advantage Benefit Plans other than Group PPO Medicare Advantage Benefit Plans and Regional PPO Medicare Advantage Benefit Plans. The Member identification card will include a reference to "PPO" other than "Regional PPO" or "UnitedHealthcare Group Medicare Advantage (PPO)."

- **Regional PPO Medicare Advantage Benefit Plans** means PPO Medicare Advantage Benefit Plans that serve one or more entire regions as established by CMS. The Member identification card will include a reference to "Regional PPO".

- **D-SNP Medicare Advantage Benefit Plans** means Medicare Advantage Benefit Plans for special needs individuals (as that term is defined in the Code of Federal Regulations currently codified at 42 CFR 422.2) and who are entitled to both Medicare and medical assistance from a State plan under Title XIX. The Member identification card will include a reference to "D-SNP".

- **I-SNP Medicare Advantage Benefit Plans** means Medicare Advantage Benefit Plans that (A) are specialized Medicare Advantage plans for special needs individuals (as that term is defined in the Code of Federal Regulations provision currently codified at 42 CFR 422.2) and (B) exclusively enroll special needs individuals who are institutionalized (as that term is defined the Code of Federal Regulations provision currently codified at in 42 CFR 422.2). The Member identification card will include a reference to "I-SNP".

- **IE-SNP Medicare Advantage Benefit Plans** means Medicare Advantage Benefit Plans that (A) are specialized Medicare Advantage plans for special needs individuals (as that term is defined in the Code of Federal Regulations provision currently codified at 42 CFR 422.2) and (B) exclusively enroll special needs individuals who are institutionalized-equivalent (as that term is defined the Code of Federal Regulations provision currently codified at in 42 CFR 422.2). The Member identification card will include a reference to "I-SNP" on the face of the card.

- **Erickson Advantage Medicare Advantage Benefit Plans** means Medicare Advantage Benefit Plans underwritten by a United Affiliate that are (A) senior housing facility Medicare Advantage plans (as that term is defined in the Code of Federal Regulations provision currently codified at 42 CFR 422.2) and (B) associated with Erickson Senior Living communities. The Member identification card will include a reference to "Erickson".

- **C-SNP Medicare Advantage Benefit Plans** means Medicare Advantage Benefit Plans that (A) are specialized Medicare Advantage plans for special needs individuals (as that term is defined in the Code of Federal Regulations provision currently codified at 42 CFR 422.2) and (B) exclusively enroll special needs individuals who have a severe or disabling chronic condition(s) (as that term is defined the Code of Federal Regulations provision currently codified at in 42 CFR 422.2). The Member identification card will include a reference to "C-SNP".

- **Mosaic Medicare Advantage Benefit Plans** means Medicare Advantage Benefit Plans offered in a limited service area that address the cultural and language needs of a specific subset of Medicare beneficiaries while providing access to health care. The Member identification card will include a reference to ""Mosaic".

- **UnitedHealthcare FOCUS Medicare Advantage Benefit Plans** means Medicare Advantage Benefit Plans that limit a Customer to a subset of contracted providers located within the service area. The Member identification card will include a reference to "FOCUS".

- **UnitedHealthcare FOCUS Dual Complete Medicare Advantage Benefit Plans** means UnitedHealthcare FOCUS Medicare Advantage Benefit Plans for special needs individuals (as that term is defined in the Code of Federal Regulations currently codified at 42 CFR 422.2) and who are entitled to both Medicare and medical assistance from a State plan under title XIX. The Member identification card will include references to "FOCUS" and "D-SNP".

- **UnitedHealthcare Ally Medicare Advantage Benefit Plans** means Medicare Advantage Benefit Plans that limit a Member to a subset of contracted providers located within the service area. The Member identification card will include a reference to "Ally".

- **UnitedHealthcare ACCESS Medicare Advantage Benefit Plans** means Medicare Advantage Benefit Plans that limit a Member to a subset of contracted providers located within the service area. The Member identification card will include a reference to "ACCESS".

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.

- **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.

- **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.

- **<State name> Medicaid Benefit Plans** means Benefit Plans issued in <State name> that offer coverage to beneficiaries of a program that is authorized by Title XIX of the federal Social Security Act and is jointly financed by the federal and state governments and administered by the

state. These Benefit Plans include a reference to "UnitedHealthcare Community Plan on the Member identification card.

- **<State name> CHIP Benefit Plans** means Benefit Plans issued in <State name> 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. These Benefit Plans include a reference to "UnitedHealthcare Community Plan" on the Member identification card.

- **<State name> Benefit Plans for the Uninsured** means Benefit Plans issued in <State name> under the <name of program> program. Such Benefit Plans will include a reference to "UnitedHealthcare Community Plan" on the Member identification card.

- **[State name] Medicaid Long Term Care Benefit Plans** means long term care Medicaid Benefit Plans issued in <State name> that include a reference to ["_____"] on the Member identification card.

- **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:
  iii) employees of a state government or a subdivision of a state and their dependents;
  iv) students at a public university, college or school;
  v) employer-based coverage of private sector employees, even if the employer receives a government subsidy to help fund the coverage;
  iv) Medicaid beneficiaries;
  vi) Children's Health Insurance Program (CHIP) beneficiaries; and
  vi) Medicare and Medicaid Enrollees (MME).

VACCN:

- **VA CCN Benefit Plans** means Benefit Plans sponsored, issued, or administered by the VA for veterans enrolled in the patient enrollment system established and operated by the VA under 38 U.S.C. Section 1705.

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.)

- **Anchor Individual Exchange Benefit Plans** means narrow network Individual Exchange Benefit Plans for which the Member selects or is assigned a primary care physician to manage the Member's health care needs.

- **Virtual First Individual Exchange Benefit Plans** means Individual Exchange Benefit Plans that are to offer access to virtual primary and specialist care coordinated through an assigned virtual primary care provider.

OHIO MEDICAID AND CHIP

REGULATORY REQUIREMENTS APPENDIX

PROVIDER

THIS OHIO MEDICAID AND CHIP REGULATORY REQUIREMENTS APPENDIX (this "Appendix") supplements and is made part of the provider agreement (the "Agreement") between UnitedHealthcare Insurance Company or one of its Affiliates ("United") and the party named in the Agreement ("Provider").

SECTION 1
APPLICABILITY

This Appendix applies to benefit plans sponsored, issued or administered by United under the State's Medicaid program, CHIP program and, as applicable, benefit plans for other state-based healthcare programs (the "State Program") as governed by the State's designated agencies. In the event of a conflict between this Appendix and other appendices or any provision of the Agreement, the provisions of this Appendix shall control except with regard to benefit plans outside the scope of this Appendix or unless otherwise required by law.

SECTION 2
DEFINITIONS

Unless otherwise defined in this Appendix, all capitalized terms shall be as defined in the Agreement. For purposes of this Appendix, the following terms shall have the meanings set forth below; provided, however, in the event any definition set forth in this Appendix or the Agreement is inconsistent with any definitions under the applicable State Program, the definitions shall have the meaning set forth under the applicable State Program.

2.1 **Covered Service** means health care service or product for which a Customer is enrolled with United to receive coverage under the State Program.

2.2 **Medicaid Agency** or Agency means the single State agency of administering or supervising the administration of the State Program.

2.3 **State** is the State of Ohio.

2.4 **State Contract** is the contract between United and the Medicaid Agency for the purpose of providing and paying for Covered Services to Customers enrolled in the State Program.

SECTION 3
PROVIDER REQUIREMENTS

The State Program, through contractual requirements and federal and State statutes and regulations, requires the Agreement to contain certain conditions that United and Provider agree to undertake, which include the following:

3.1 **Definitions Related to the Provision of Covered Services.** Provider shall follow the applicable State Program requirements for the provision of Covered Services. Provider's decisions affecting

the delivery of acute or chronic care services to Customers shall be made on an individualized basis and in accordance with the following definitions:

i) **Emergency Medical Condition** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: (a) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (b) serious impairment to body functions; or (c) serious dysfunction of any body organ or part.

ii) **Emergency Services** means inpatient and outpatient Covered Services furnished by a provider qualified to furnish those health services and that are needed to evaluate or stabilize an Emergency Medical Condition.

iii) **Medically Necessary or Medical Necessity** has the same meaning as contained in 42 C.F.R. § 438.210(a)(5) and as indicated in State statutes and regulations, the State Contract, and other State policy and procedures.

iv) **Poststabilization Care Services** means covered services, related to an emergency medical condition that are provided after an enrollee is stabilized to maintain the stabilized condition, or, under circumstances described in condition that are provided after an enrollee is stabilized to maintain the stabilized condition, or, under the circumstances described in 42 C.F.R. § 422.113(c), to improve or resolve the enrollee's condition.

3.2 Provider Participation Requirements. Provider hereby acknowledges and certifies to the best of its knowledge the following:

i) **State Program Participation.** Provider is enrolled as, or has applied to enroll as, a participating provider with the State Program. United may terminate Provider from its State Program Provider network immediately upon notification from the State that Provider cannot be enrolled or has been terminated from the State Program, or the expiration of one 120 day period without enrollment of Provider.

ii) **Licensure.** Provider has all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated to Provider by United under the Agreement and will maintain such necessary licenses, certifications, registrations and permits at all times throughout the term of the Agreement. If at any time during the term of the Agreement, Provider is not in compliance with this Section, Provider shall discontinue providing services to Customers. Additionally, payment will not be made for any items or Covered Services provided during any time period of noncompliance with this Section.

iii) **Excluded Individuals and Entities**. Provider nor any of its employees, principals, nor any providers, subcontractors or consultants or persons with an ownership or controlling interest in the Provider are: (a) debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; or b)

excluded from participation in federal health care programs under either 42 U.S.C. §§ 1320a–7 or 1320a–7a. Provider acknowledges and agrees that payment will not be made for any items or Covered Services provided by an excluded individual or entity pursuant to 42 C.F.R. § 1001.1901(b).

3.3 Compliance with Law. Provider shall comply with all federal and State laws and regulations applicable to Provider in performance of the Agreement, including but not limited to, the following:

i) **Civil Rights.** Provider shall comply with Title VI of the Civil Rights Act of 1964; the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; Title IX of the Education Amendments of 1972; Titles II and III of the Americans with Disabilities Act; and section 1557 of the Patient Protection and Affordable Care Act (see 42 CFR 438.3; 42 CFR 438.100(d)).

ii) **Lobbying.** Provider certifies to the best of Provider's knowledge and belief, pursuant to 31 U.S.C. § 1352 and 45 C.F.R. § 93.100 et seq. that no federally appropriated funds have been paid or will be paid to any person by or on Provider's behalf for the purpose of influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

iii) **Medicaid Laws and Regulations.** Provider agrees to abide by all federal and state Medicaid laws, regulations and State Program requirements, including but not limited to:

a. 5 C.F.R. § 900.601 et seq., Administration of the Standards for a Merit System of Personnel Administration.

b. The following HHS Regulations in 45 C.F.R. subtitle A:

i. 45 C.F.R. § 16.1 et seq., Procedures of the Departmental Appeals Board;

ii. 45 C.F.R. § 75.1 et seq., Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards;

iii. 45 C.F.R. § 80.1 et seq., Nondiscrimination Under Programs Receiving Federal Assistance Through the Department of Health and Human Services: Effectuation of Title VI of the Civil Rights Act of 1964;

iv. 45 C.F.R. § 81.1 et seq., Practice and Procedure for Hearings Under 45 C.F.R. § 80.1 et seq.;

v. 45 C.F.R. § 84.1 et seq., Nondiscrimination on the Basis of Handicap in Programs and Activities Receiving or Benefiting from Federal Financial Assistance.

c. **Availability of Services.** Provider will comply with 42 C.F.R. § 438.206 and any applicable State Program regulations and requirements related to availability of services to Customers including, but not limited to, meeting State Program standards for timely access to care and services, taking into account the urgency of the need for services. Additionally, Provider shall offer hours of operation that are no less than the hours of operation offered to commercial beneficiaries or comparable to Medicaid fee-for-service beneficiaries, if Provider serves only Medicaid beneficiaries. As applicable, Provider will make Covered Services available 24 hours a day, 7 days a week when medically necessary. In addition, Provider will provide physical access, reasonable accommodations and accessible equipment for Customers with physical or mental disabilities.

d. **Claims Information.** Provider shall promptly submit to United the information needed to make payment and shall identify third party liability coverage, including Medicare and other insurance, and if applicable seek such third-party liability payment before submitting claims to United.

e. **Continuity of Care.** Provider shall cooperate with United and provide Customers with continuity of treatment, including coordination of care to the extent required under law and according to the terms of the Agreement, in the event Provider's participation with United terminates during the course of a Customer's treatment by Provider, except in the case of adverse reasons on the part of Provider.

f. **Cultural Competency and Access.** Provider shall participate in United's and the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of sex, and shall provide interpreter services in a Customer's primary language and for the hearing impaired for all appointments and emergency services. Provider shall provide information to Customers regarding treatment options and alternatives, as well as information on complaints and appeals, in a manner appropriate to the Customer's condition and ability to understand. Provider shall provide physical access, reasonable accommodations, and accessible equipment for Customers with physical or mental disabilities.

g. **Data; Reports.** Provider agrees to cooperate with and release to United any information necessary for United to comply with the State Contract and federal and state law, to the extent applicable to Provider in performance of the Agreement. Such information includes timely submission of reports including child health check-up reporting, EPSDT encounters, and cancer screening encounters, if applicable, as well as complete and accurate encounter data in accordance with the requirements of United and the State. By submitting data to United, Provider represents and attests to United and the State that the data is accurate, complete and truthful, and upon United's request Provider shall certify in writing, that the data is accurate, complete, and truthful, based on Provider's best knowledge, information and belief.

h. **Fraud, Waste, and Abuse.** Provider understands and agrees that each claim the Provider submits to United constitutes a certification that the Provider has

complied with all applicable Medicaid laws, regulations and program instructions in connection with such claims and the services provided therein. Provider's payment of a claim will be denied if Provider is terminated or excluded from participation in federal healthcare programs. Provider's payment of a claim may be temporarily suspended if the State or United provides notice that a credible allegation of fraud exists and there is a pending investigation. Provider's payment of a claim may also be temporarily suspended or adjusted if the Provider bills a claim with a code that does not match the service provided. United performs coding edit procedures based primarily on National Correct Coding Initiative (NCCI) policies and other nationally recognized and validated policies. Provider agrees that it will provide medical records to United upon its request in order to determine appropriateness of coding. Further, when Provider has received an overpayment, Provider will return the overpayment to United within 60 calendar days after the date on which the overpayment was identified, and to notify United in writing of the reason for the overpayment.

i. **Government Audit; Investigations.** Provider acknowledges and agrees that the State, CMS, the Office of Inspector General, the Comptroller General, and the U.S. Department of Health and Human Services and their designees or their authorized representatives shall at any time, have the right to inspect, audit or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the State Contract and any other applicable rules, including the right to inspect and audit any records or documents of Provider and its subcontractors, and the right to inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. The right to audit under this section exists for 10 years from the end date of the State Contract or from the date of completion of any audit, whichever is later. There shall be no restrictions on the right of the State or federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services provided pursuant to the State Contract and the reasonableness of their costs.

j. **Hold Harmless.** Provider will accept, as payment in full, the amounts paid by United to Provider for Covered Services to Customers, plus any deductible, coinsurance or copayment required to be paid by the Customer, and will hold Customers harmless in the event that United cannot or will not pay for such Covered Services. If a service is not a Covered Services, prior to providing the service, Provider shall inform the Customer the service is not a Covered Service and have the Customer acknowledge the information. If the Customer still requests the service, Provider shall obtain such acknowledgement in writing prior to rendering the service. If United determines a Customer was charged for Covered Services inappropriately, such payment may be recovered, as applicable. This provision shall survive any termination of the Agreement, including breach of the Agreement due to insolvency.

k. **Marketing.** Provider will comply with 42 C.F.R. § 438.104 and any applicable State Program guidance and regulations related to marketing materials including, but not limited to, seeking approval from the Medicaid Agency prior to distributing any marketing materials to Customers.

l. **Physician Incentive Plans.** If Provider participates in a physician incentive program ("PIP"), Provider must comply with the requirements set forth in 42 C.F.R. §§ 422.208 and 422.210, including but not limited to the following: a) Provider will not make specific payment, directly or indirectly, to a physician or physician group as an inducement to reduce or limit Medically Necessary services furnished to any Customer; and b) if the PIP places Provider at substantial financial risk for services that Provider does not furnish itself, Provider must have stop-loss protection in accordance with 42 C.F.R. § 422.208(f).

m. **Preventable Conditions.** No payment will be made by United to a Provider for provider preventable conditions, as identified in the State Program. Provider shall identify and report to United any provider preventable conditions in accordance with 42 C.F.R. §§ 434.6(a)(12)(i) and (ii) and 42 C.F.R. § 447.26(d).

n. **Privacy; Confidentiality.** Provider shall safeguard Customer privacy and confidentiality including, but not limited to, the privacy and confidentiality of any information that identifies a particular Customer and shall comply with all federal and state laws and State Program requirements regarding confidentiality and disclosure of medical records or other health and enrollment information.

o. **Quality; Utilization Management.** Provider agrees to cooperate with United's quality improvement and utilization review and management activities. This shall include, but not be limited to, participation in any internal and external quality assurance, utilization review, peer review, and grievance procedures established by United or as required under the State Contract to ensure that Customers have due process for their complaints, grievances, appeals, fair hearings or requests for external review of adverse decisions made by United or Provider. Provider shall adhere to the quality assurance and utilization review standards of the State Program and shall monitor quality and initiate corrective action to improve quality consistent with the generally accepted level of care.

p. **Records.** As required under State or federal law or the State Contract, Provider shall maintain an adequate record keeping system for recording services, charges, dates and all other commonly accepted information elements for services rendered to Customers. Medical records and supporting management systems shall include all pertinent information related to the medical management of each Customer. Other records shall be maintained as necessary to clearly reflect all actions taken by Provider related to services provided under the State Contract. Provider shall retain all records including, as applicable, grievance and appeal records and any other records related to data, information, and documentation for a period of not less than 10 years from the close of the Agreement, or such other period as required by law.

Provider acknowledges and agrees that the State, the U.S. Department of Health and Human Services and other authorized federal and state personnel shall have complete access to all records pertaining to services provided to Customers. Provider shall provide immediate access to facilities, records and supportive materials pertinent to the State Contract for State or Federal fraud investigators.

iv) **Stark Law and the Anti-Kickback Statute.** Provider shall not make inappropriate referrals for designated health services to health care entities with which Provider or a member of Provider's family has a financial relationship, pursuant to federal anti-kickback and physician self-referral laws that prohibit such referrals (see, 42 U.S.C. 1395nn; 42 U.S.C. 1320a–7b; 42 C.F.R. § 411.350).

3.4 Requirements for Specific Provider Types. The following provisions apply to certain provider types as indicated:

i) **Advance Directives.** When applicable, Provider shall comply with the advance directives requirements for hospitals, nursing facilities, providers of home and health care and personal care services, hospices, and HMOs as specified in 42 C.F.R. §§ 417.436(d), 422.128, and 438.3(j).

ii) **Clinical Laboratory Improvements Act (CLIA) certification or waiver.** As applicable, if Provider performs any laboratory tests on human specimens for the purpose of diagnosis and/or treatment, Provider agrees to acquire and maintain the appropriate CLIA certification or waiver for the type of laboratory testing performed. Provider further agrees to provide a copy of the certification if requested by United. A State authorized license or permit that meets the CLIA requirements may be substituted for the CLIA certificate pursuant to State law. Medicare and Medicaid programs require the applicable CLIA certification or waiver for the type of services performed as a condition of payment. Provider must include the appropriate CLIA certificate or waiver number on claims submitted for payment for laboratory services.

iii) **Electronic Visit Verification (EVV).** Provider shall cooperate with State requirements for electronic visit verification for personal care services and home health services, as applicable.

iv) **Long-Term Services and Supports (LTSS) Providers.** Any LTSS Covered Services under the State Contract that could be authorized through a waiver under section 1915(c) of the Social Security Act (the "Act") or a State Program amendment authorized through sections 1915(i) or 1915(k) of the Act must be delivered in settings consistent with 42 C.F.R. § 441.301(c)(4).

3.5 Termination. In the event of termination of the Agreement, Provider shall promptly supply to United all information necessary for the reimbursement of any outstanding Medicaid claims.

SECTION 4
UNITED REQUIREMENTS

4.1 Prompt Payment. United shall pay Provider pursuant to the State Contract and applicable State and federal law and regulations, including but not limited to 42 C.F.R. § 447.46. If a third party liability exists, payment of claims shall be determined in accordance with federal and/or State third party liability law and the terms of the State Contract. Unless United otherwise requests assistance from Provider, United will be responsible for third party collections in accordance with the terms of the State Contract.

4.2 Provider Discrimination Prohibition. United will not discriminate in the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her

license or certification under applicable State law, solely on the basis of that license or certification. In addition, United will not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment. This provision shall not be construed as prohibiting United from limiting a provider's participation to the extent necessary to meet the needs of Customers. This provision also is not intended and shall not interfere with measures established by United that are designed to maintain quality of care practice standards and control costs.

4.3 Provider-Customer Communications. United may not prohibit, or otherwise restrict, Provider when acting within the lawful scope of practice, from advising or advocating on behalf of a Customer for the following: (i) the Customer's health status, medical care, or treatment options, including any alternative treatment that may be self-administered; (ii) any information the Customer needs in order to decide among all relevant treatment options; (iii) the risks, benefits, and consequences of treatment or non-treatment; or (iv) the Customer's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

United also shall not prohibit a Provider from advocating on behalf of a Customer in any grievance system, utilization review process, or individual authorization process to obtain necessary health care services.

SECTION 5
OTHER REQUIREMENTS

5.1 Compliance with State Contract. All tasks performed under the Agreement shall be performed in accordance with the requirements of the applicable State Contract. The provisions of the State Contract applicable to Provider are incorporated into the Agreement by reference. Nothing in the Agreement relieves United of its responsibility under the State Contract. If any provision of the Agreement is in conflict with provisions of the State Contract, the terms of the State Contract shall control and the terms of the Agreement in conflict with those of the State Contract will be considered waived.

5.2 Monitoring. United shall perform ongoing monitoring (announced or unannounced) of services rendered by Provider under the Agreement and shall perform periodic formal reviews of Provider according to a schedule established by the State, consistent with industry standards or State managed care organization laws and regulations or requirements under the State Contract. As a result of such monitoring activities, United shall identify to Provider any deficiencies or areas for improvement mandated under the State Contract and Provider and United shall take appropriate corrective action. Provider shall comply with any corrective action plan initiated by United and/or required by the State Program.

5.3 No Exclusivity. Nothing in the Agreement or this Appendix shall be construed as prohibiting or penalizing Provider for contracting with a managed care organization other than United or as prohibiting or penalizing United for contracting with other providers

5.4 Delegation. Any delegated duties and reporting responsibilities shall be set forth in the Agreement or other written delegation agreement or addendum between the parties.

5.5 Regulatory Amendment. United may unilaterally amend this Appendix to comply with applicable laws and regulations and the requirements of applicable regulatory authorities

including, but not limited to, Medicaid Agency. Unless such laws, regulations, or regulatory authority(ies) direct otherwise, the signature of Provider will not be required in order for the amendment to take effect.

SECTION 6
STATE SPECIFIC REQUIREMENTS

6.1 Medically Necessary or Medical Necessity. In addition to Section 3.1(iii) and as required by the State Contract, Medically Necessary or Medical Necessity means ODM requirements as stated in OAC Chapter 5160.

6.2 HealthChek. The parties agree to comply with all HealthChek requirements as specified in OAC Chapter 5160.

6.3 Timely Filing. United must accept claims for 365 calendar days from the date of service, as described in Ohio Admin. Code 5160-1-19. In addition, United must follow the overpaid claims and timely filing exceptions described in the rule.

6.4 Health Information Exchanges. As applicable, Provider must provide admission, discharge, and transfer (ADT) data to Ohio's HIEs.

Ohio Department of Medicaid

United Healthcare

MEDICAID ADDENDUM

This Addendum supplements the Base Contract or Agreement between United Healthcare and _____ effective date _____ and runs concurrently with the terms of the Base Contract or Agreement *(hereinafter referred to as "Base Contract")*. This Addendum is limited to the terms and conditions governing the provision of and payment for health services provided to Medicaid members.

The provider will provide services to the following eligible Medicaid consumer populations as specified in United Healthcare 's Provider Agreement or contract with the Ohio Department of Medicaid **(select all that apply)**

- ☐ All Managed Care Organization (MCO) members
- ☐ All MyCare Ohio plan (MCOP) members
- ☐ All OhioRise members
- ☐ All Single Pharmacy Benefit Manager (SPBM) members
- ☐ Medicaid Managed Care Single Case Agreement
- ☐ MyCare Ohio Single Case Agreement
- ☐ OhioRISE Single Case Agreement

The provider agrees to provide services to the managed care entity's *(MCE's)* member(s) within the designated service area(s) as specified below **(select all that apply)**

☐ *Not applicable (out-of-state provider)*

MCO Service Area ☐ Statewide	**SPBM Service Area** ☐ Statewide	**OhioRISE Service Area** ☐ Statewide
MCOP Service Areas ☐ Central ☐ West Central ☐ East Central ☐ Northeast ☐ Northwest ☐ Southwest ☐ Northeast Central		

An ODM administered home and community based services (HCBS) waiver provider must be currently enrolled as an ODM providers with an active status in accordance with Ohio Administrative Code (OAC) Agency 5160 prior to rending services to any Medicaid eligible individual. Any other provider type must be either currently enrolled as an ODM provider and meet the qualifications specified in OAC rule 5160-26-05(C) or be in the process of enrolling as an ODM provider.

ADDENDUM PROVISIONS

The provisions of this Medicaid Addendum supersede any language to the contrary which may appear elsewhere in the Base Contract.

A. All providers providing health care services to United Healthcare 's members as specified above, including providers operating under a single case agreement, agree to abide by all of the following specific terms:

1. The provider, acting within their scope of practice, will provide all specialties as identified in their ODM enrollment or the specialties as enumerated in Attachment C of this Addendum. Any amendment to Attachment C must be agreed to by both parties.
    i. Attachment C is not required for pharmacy providers when contracting with the SPBM.
    ii. For single case agreements, Attachment C only needs to be completed if the Base Contract does not specify the service being provided.
2. The terms of the Base Contract relating to the beginning date and expiration date or automatic renewal clause, as well as the applicable methods of extension, renegotiation, and termination apply to this Addendum.

3. The Base Contract and Addendum are governed by, and are construed in accordance with all applicable laws, regulations, and contractual obligations of the Managed Care Entity (MCE).

    i. ODM will notify the MCE and the MCE shall notify the provider of any changes in applicable state or federal law, regulations, waiver, or contractual obligation of the MCE.

    ii. This Addendum shall be automatically amended to conform to such changes without the necessity for executing written amendments.

    iii. The MCE shall notify the provider of all applicable contractual obligations.

4. The procedures specified in the Base Contract to be employed upon the ending, nonrenewal, or termination of the Base Contract apply to this Addendum, including an agreement to promptly supply all records necessary for the settlement of outstanding medical claims.

5. The provider will serve members through the last day the Base Contract is in effect.

6. The provider shall be compensated pursuant to the method and in the amounts specified in the Base Contract.

7. The provider and all employees of the provider are duly registered, licensed, or certified under applicable state and federal statutes and regulations to provide the health care services that are the subject of the Base Contract, and that the provider and all employees of the provider are not excluded from participating in federally funded health care programs.

8. The provider, in performance of the subcontract or in the hiring of any employees for the performance of services under the contract, shall not by reason of race, color, religion, gender, sexual orientation, age disability, national origin, military status, genetic information, health status or ancestry, unlawfully discriminate against any citizen of Ohio in the employment of a person qualified and available to perform the services to which the subcontract relates.

9. The provider shall not in any manner unlawfully discriminate against, intimidate, or retaliate against any employee hired for the performance of services under the subcontract on account of race, color, religion, gender, sexual orientation, age, disability, national origin, military status, genetic information, health status, or ancestry.

10. The provider will abide by the MCE's written policies regarding the False Claims Act and the detection and prevention of fraud, waste and abuse.

11. The provider shall not unlawfully discriminate in the delivery of services based on the member's race, color, religion, gender, sexual orientation, age, disability, national origin, military status, genetic information, ancestry, health status, or need for health services.

12. With the exception of any member co-payments the MCE has elected to implement in accordance with OAC rule 5160-26-12, the MCE's payment constitutes payment in full for any covered service and the provider will not charge the member or ODM any co-payment, cost sharing, down-payment, or similar charge, refundable or otherwise. This agreement does not prohibit nursing facilities or home and community-based waiver providers from collecting patient liability payments from members as specified in OAC rules 5160:1-6-07 and 5160:1-6-07.1, or Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) from submitting claims for supplemental payments to ODM as specified in OAC Chapter 5160-28.

i. The MCE shall notify the provider whether the MCE elected to implement any member co-payments and, if applicable, under what circumstances member co-payments are imposed in accordance with OAC rule 5160-26-12.

ii. The provider agrees that member notification regarding any applicable co-payment amounts must be carried out in accordance with OAC rule 5160-26-12.

iii. In accordance with OAC rule 5160-26-12, members who are under the age of twenty-one are excluded from co-payment obligations.

13. The provider will not hold liable ODM or any member(s) in the event the MCE cannot or will not pay for covered services performed by the provider pursuant to the Base Contract with the exceptions that:
    i. FQHCs and RHCs may be reimbursed by ODM in the event of MCE insolvency.
    ii. The provider may bill the member when the MCE denied prior authorization or referral for the services and the conditions described in OAC rule 5160-1-13.1 are met.

14. The provider will not bill members for missed appointments.

15. In accordance with OAC rule 5160-26-05, the provider agrees to identify, and where indicated arrange, for the following at no cost to the member:
    i. Sign language services; and
    ii. Oral interpretation and oral translation services.

16. The provider shall be bound by the standards of confidentiality outlined in OAC rule 5160-1-32 and 45 CFR Parts 160 and 164, including standards for unauthorized uses of or disclosures of protected health information (PHI).

17. The provider will not identify the addressee as a Medicaid consumer on the outside of the envelope when contacting members by mail.

18. The provider will immediately forward any information regarding a member appeal or grievance, as defined in OAC 5160-26-08.4 or 5160-58-08.4, to the MCE for processing.

19. The provider will release to the MCE, ODM, or ODM's designee(s) any information necessary for the MCE to perform any of its obligations under the MCE's provider agreement or contract with ODM, including but not limited to, compliance with reporting and quality assurance requirements.

20. The provider will supply, upon request, the business transaction information required under 42 CFR. 455.105.

21. The provider will contact the MCE's designated twenty-four-hour post-stabilization services phone line to request authorization to provide post-stabilization services in accordance with OAC rule 5160-26-03 or OAC rule 5160-59-03.

22. All of the provider's applicable facilities and records will be open to inspection by the MCE, ODM, or ODM's designee(s), or other entities as specified in OAC rule 5160-26-06.

23. The provider agrees to comply with the provisions for record keeping and auditing in accordance with OAC Chapter 5160-26.

24. The provider will retain and allow the MCE access to all member medical records for a period of not fewer than ten years from the date of service or until any audit initiated within the ten year period is completed and allow access to all record keeping, audits, financial records, and medical records to ODM or its designee or other entities as specified in OAC rule 5160-26-06. At least three of the ten year-period of documentation must be readily available.

25. The provider will make medical records for Medicaid eligible individuals available for transfer to new providers at no cost to the individual.

B. All participating providers providing health care services to United Healthcare 's members as specified above, not including providers operating under a single case agreement, agree to abide by all of the following specific terms:

1. Notwithstanding item A.2 of this Addendum, the provider may non-renew or terminate the Base Contract if one of the following occurs:

   i. The provider gives the MCE at least 60 days prior notice in writing for the nonrenewal or termination of the Base Contract, or the termination of any services for which the provider is contracted. The effective date for the nonrenewal or termination of the Base Contract or any contracted services must be the last day of the month; or

   ii. ODM proposed action in accordance with OAC Chapter 5160, including rule 5160-26-10, regardless whether the action is appealed. The provider's nonrenewal or termination written notice must be received by the MCE within 15 working days prior to the end of the month in which the provider is proposing nonrenewal or termination. If the notice is not received by this date, the provider must extend the nonrenewal or termination date to the last day of the subsequent month.

2. The provider will cooperate with the MCE's quality assessment and performance improvement (QAPI) program in all the MCE's provider subcontracts and employment agreements for physician and non-physician providers.

3. The provider will cooperate with the ODM external quality review as required by 42 C.F.R. 438.358, ad on-site audits, as deemed necessary based on ODM's periodic analysis of financial, utilization, provider panel, and other information in OAC Chapter 5160.

C. If applicable based on the service(s) being provided to United Healthcare 's member(s) as specified above, the provider agrees to abide by the following specific terms:

1. ☐ If the provider is a primary care provider (PCP), the provider will participate in the care coordination requirements outlined in OAC rule 5160-26-03.1 or OAC rule 5160-59-03.2. All PCP providers must complete Attachment A and indicate the maximum member capacity agreed to be served at each service location where PCP services are offered.

2. ☐ Notwithstanding Items B.1 and C.4 of this Addendum, in the event of a hospital provider's proposed non-renewal or termination of the Base Contract, the hospital provider will notify in writing all providers who have admitting privileges at the hospital of the impending non-renewal or termination of the Base Contract and the last date the hospital will provide services to members under the Base Contract. This notice must be sent at least forty-five days prior to the effective date of the proposed non-renewal or termination. If the hospital provider issues fewer than forty-five days prior notice to the MCE, the notice to providers, who have admitting privileges at the hospital, must be sent within one working day of the hospital provider issuing notice of non-renewal or termination of the Base Contract.

3. ☐ All laboratory testing sites providing services to members must have either a current Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver, certificate of accreditation, certificate of compliance, or a certificate of registration along with a CLIA identification number.

4. ☐ If the provider is a home health provider, the provider must meet the eligible provider requirements specified in OAC Chapter 5160-12 and comply with the requirements for home care dependent adults as specified in section 121.36 of the Ohio Revised Code.
5. ☐ Any third party administrator (TPA) will include all elements of OAC rule 5160-26-05(D) in its subcontracts and will ensure that its subcontracted providers will forward information to ODM as requested.
6. ☐ Institutional providers will assure discharge planning begins upon the member's admission to the facility and discharge will not occur until there is a safe discharge plan in place, including identification of and arrangement for necessary community supports.
7. ☐ Organization and/or group providers agree all practitioners affiliated in the ODM provider network management system are available and will render services under this contract. In accordance with OAC rule 5160-1-17, any changes to the affiliated practitioners must be maintained in the ODM provider network management system.

   Any organization or group providers with affiliated practitioners in the ODM provider network management system who do not agree to render services under this MCE contract must complete Attachment A to identify which ODM-enrolled practitioners agree to render services under this MCE contract. Plans may also require Attachment A if the information needed to contract with the provider is not available in the ODM provider network management system. In accordance with OAC rule 5160-1-17, any changes to the affiliated practitioners must be maintained in the ODM provider network management system and, when applicable, submitted to the plan on Attachment A.

D. United Healthcare agrees to abide by the following specific terms:

1. The MCE shall disseminate written policies including detailed information about the False Claims Act and other provisions named in 42 U.S.C. Section 1396a(a)(68), any related State laws pertaining to civil or criminal penalties, whistleblower protections under such laws, as well as the MCE's policies and procedures for detecting and preventing fraud, waste and abuse.

2. The MCE will fulfill the provider's responsibility to mail or personally deliver notice of the member's right to request a state hearing whenever the provider bills a member due to the MCE's denial of payment of a Medicaid service, as specified in OAC rule 5160-26-08.4 and 5160-58-08.4, utilizing the procedures and forms as specified in OAC Chapter 5101:6-2.

3. The MCE will not prohibit, or otherwise restrict a provider, acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient, for the following:

   i. The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

   ii. Any information the member needs in order to decide among all relevant treatment options.

   iii. The risks, benefits, and consequences of treatment versus non-treatment.

   iv. The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

4. Not with standing item A.2 of this Addendum, and with the exception of single case agreements, the MCE must give the provider at least sixty days prior notice in writing for the nonrenewal or termination of the Base Contract except in cases where an adverse finding by a regulatory agency or health or safety risks dictate that the Base Contract be terminated sooner or when the Base Contract is temporary in accordance with 42 CFR 438.602 and the provider fails to enroll as an ODM provider within 120 calendar days.

Any changes to Attachments A and/or C may be made without renegotiation of the Base Contract or this Addendum.

SIGNATURES

MCE Name	Provider Name
Signature	Signature
Printed Name	Printed Name
Title	Title
Date	Date

[Lab Attestation Appendix

ATTESTATION OF [Provider name inserted here]

State of _____

County of [ ]

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

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

2. "I hereby certify that [ENTITY NAME or NAME OF LAB] has ___ % ownership of the [NAME OF THE LAB]."

3. "I hereby certify that the following entities have the following percentage ownership of the [NAME OF THE LAB]: [List all entities and percentage ownership]."

4. "I hereby certify that at no time will there be any change in the controlling interest modifying the current percentage ownership as set forth herein of the [NAME OF THE LAB]."

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

Signed this _____ day of ____, 20___.

_____

[Affiant signature]

Notary Stamp/Certification

_____

Notary Signature

_____

Date of Notary's Signature

_____

Expiration date of Notary authority]