

Home and Community Based Services Provider Agreement

UnitedHealthcare Insurance Company is entering into this agreement with you, **[provider name]**. It is doing so on behalf of itself, UnitedHealthcare of Ohio, Inc., UnitedHealthcare Community Plan of Ohio, Inc. and its other affiliates (collectively referred to as “United”) for certain products and services we offer our customers, all of which we describe in the attached Appendix 2

This agreement applies to you and the services you provide in all of your practice arrangements and for all of your tax identification numbers.

What you will do

You need to be credentialed in accordance with our credentialing plan for Home and Community Based Services providers for the duration of this agreement.

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

You must submit your claims for reimbursement (whether by claim form, invoice or other method, as set forth in this agreement) within 180 days of the date of service. After we receive your claim, if we request additional information in order to process your claim, you must submit this additional information within 90 days of our request. If your claim or the additional information is not submitted within these timeframes, you will not be reimbursed for the services, and you may not charge our customer.

You will submit claims only for services performed by you or your staff. Pass through billing is not payable under this agreement and may not be billed to our customer.

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

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

You will not charge our customers anything for the services you provide, if those services are covered services under their benefit contract, but the applicable co-pay, coinsurance or deductible amount. If the services you provide are denied or otherwise not paid due to your failure to notify us, to file a timely claim, to submit a complete claim, to respond to our request for information, or based on our reimbursement policies and methodologies, you may not charge our customer. If you collect payment from, bring a collection action against, or assert a lien against a customer for covered services rendered (other than for the applicable co-payment, deductible or coinsurance), you will be in breach of this agreement and we may deduct, from any amounts otherwise due you, the amount wrongfully collected from customers, and may also deduct an amount equal to any costs or expenses incurred by us, or the customer.

If the services you provide are not covered under our customer’s benefit contract, you may only bill our customer directly if that is permissible under 42 CFR Section 447.15, as well as state laws, regulations and

the applicable state Medicaid contract.

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

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

You will hold all applicable registrations, permits, licenses, and other approvals and consents required under applicable law in order to perform your obligations under this agreement and will comply with all applicable regulatory requirements, including but not limited to those relating to confidentiality of customer medical information.

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

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

You will ensure that anyone rendering services in connection with this agreement adheres to the requirements of this agreement. You are solely responsible for all services rendered in connection with this agreement.

To the extent applicable, during the term of this agreement, you will maintain and will require your subcontractors to maintain, at your (or your subcontractor's) sole cost and expense:

- a) commercial general liability insurance and/or umbrella liability insurance, in the amount of \$1,000,000 per occurrence and \$3,000,000 aggregate; and
- b) coverage for medical malpractice and/or professional liability insurance, in the amount of \$1,000,000 per occurrence and \$2,000,000 in aggregate.

In addition, you attest that you maintain, and at all times during the term of this agreement will continue to maintain, at your sole cost and expense: (i) workers' compensation and/or employer's liability insurance to the full extent required by applicable state law; and, (ii) if transportation services are provided as part of this agreement, business automobile liability insurance to the full extent required by applicable state law.

Our approval or acceptance of your insurance does not, in any way, represent that such insurance is sufficient or adequate to protect your interests or liabilities and such insurance coverage will be considered the minimum acceptable coverage.

Upon written request, you will submit to us, in writing, evidence of insurance coverage. You will give us ten (10) days written notice in the event of any termination, cancellation or material change in your insurance.

You will also give notice to us within ten (10) days after any event that causes you to be out of compliance

with licensure, or of any change in your name or Taxpayer Identification Number. In addition, you will give us forty-five (45) days prior written notice of changes in existing remit address(es) and other demographic information.

You acknowledge that you have been given the opportunity to review, and will cooperate with, our protocols which will be made available to you online or upon request. Some or all protocols also may be disseminated in the form of an Administrative Guide, or in other communications. We may change the protocols from time to time and will use reasonable commercial efforts to inform you at least thirty (30) days in advance of any material changes.

What we will do

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

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

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

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

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

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

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

In addition, either you or we can terminate this agreement, effective on an anniversary of the date this

agreement begins, by providing at least ninety (90) days prior written notice. Either you or we can terminate this agreement at any time if the other party has materially breached this agreement, by providing sixty (60) days written notice, except that if the breach is cured before our agreement ends, the agreement will continue.

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

Finally, we can immediately terminate this agreement for the following reasons: (1) if we become aware of any criminal charge related to your services or an indictment, arrest, or conviction for a felony; (2) your failure to meet our credentialing program requirements to the extent that those requirements apply to you; (3) if any governmental agency or authority (including Medicare or Medicaid) sanctions you; or (4) if you lose applicable accreditation, licensure, permit or other approval required to provide services under this agreement.

We both agree that termination notices under this agreement must be sent by certified mail, return receipt requested, to 9700 Healthcare Lane, ATTN: National Ancillary VP, Minnetonka, MN 55343, or to the post office address you provided to us. We both will treat termination notices as “received” on the third business day after they are sent.

About data and confidentiality

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

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

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

What if we do not agree

The parties will work together in good faith to resolve any and all disputes between them (“Disputes”) following the dispute procedures set out in our Administrative Guide. Disputes may include, but are not limited to the existence, validity, scope or termination of this agreement or any term thereof, and all

questions of arbitrability, with the exception of any question regarding the availability of class arbitration or consolidated arbitration, which is expressly waived below. Disputes also include any dispute in which you are acting as the assignee of one or more customer. In such cases, these procedures will apply, including, without limitation, the requirement for arbitration.

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

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

If the parties are unable to resolve any Dispute within 60 days after notice, either party may submit the Dispute to binding arbitration conducted by the American Arbitration Association (“AAA”). The arbitrators will use the AAA Healthcare Payor Provider Arbitration Rules, as amended. However, if a case involves a Dispute in which a party seeks an award of \$1,000,000 or greater or seeks termination of this agreement, a panel of three arbitrators will be used. The arbitrator(s) will be selected from the AAA National Healthcare Roster or the AAA’s National Roster of Arbitrators. Unless otherwise agreed in writing, arbitration must be initiated within one year after the date on which written notice of the Dispute was given, or any appeal process described in the Administrative Guide, whichever is later. If arbitration is not initiated in that time frame, the right to pursue the Dispute in any forum is waived.

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

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

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

The decision of the arbitrator(s) on the points in dispute will be binding. The parties acknowledge that because this agreement affects interstate commerce, the Federal Arbitration Act applies. In the event any court determines that this arbitration procedure is not binding or otherwise allows litigation involving a Dispute to proceed, the parties hereby waive any and all right to trial by jury in, or with respect to, the litigation. The litigation would instead proceed with the judge as the finder of fact.

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

This provision will survive any termination of this agreement.

What is our relationship to one another

You are an independent contractor. This means we do not have an employer-employee, principal-agent, partnership, joint venture, or similar arrangement.

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

This is it

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

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

Conclusion

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

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

AGREED BY:

PROVIDER

Address to be used for giving notice under the agreement:

Signature: _____

Street: _____

Print Name: _____

City: _____

DBA (if applicable): _____

State: _____

Date: _____

Zip Code: _____

Email: _____

TIN: _____

National Provider Identification (NPI) Number: _____

UnitedHealthcare Insurance Company contracting on behalf of itself, UnitedHealthcare of Ohio, Inc., UnitedHealthcare Community Plan of Ohio, Inc. and its other affiliates, as signed by its authorized representative:

Signature _____

Print Name _____

Date _____

For office use only:

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

Appendix 1

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

Appendix 2	Definitions, Products and Services This appendix sets forth definitions for our “customer” and “participating entities” as well as lists the type of benefit contracts offered to our customers.
Payment Appendix(ices)	Fee Information Document. This document sets forth the fees that will be paid for your services.
Appendix 3	Locations. This document provides information about your office, billing, and mailing locations. Please remember that, as described on page 2, this agreement applies to all of your locations even if you do not list all of your current locations or if you add a location in the future.
State Regulatory Requirements Appendix	In some instances, states add requirements to our agreement that are set forth in this appendix.
Medicaid and/or CHIP Regulatory Requirements Appendix(ices)	(These appendix(ices) apply only if you are in our Medicaid and/or CHIP network). Your participation in our network for customers with Medicaid or CHIP benefit contracts is subject to additional requirements set forth in this appendix.
Medicare Regulatory Requirements Appendix	(This appendix applies only if you are in our Medicare network.) Your participation in our network for customers with Medicare benefit contracts is subject to additional Medicare requirements set forth in this appendix.

<p>Administrative Guide</p>	<p>This guide governs the mechanics of our relationship. Our Administrative Guide may be viewed by going to www.UHCprovider.com. We may make changes to the Administrative Guide or other administrative protocols upon 30 days electronic or written notice to you.</p> <p>For services rendered to customers enrolled in certain benefit contracts that may be included under this agreement, you will be subject to additional requirements described in or made available to you through one or more additional provider manuals (“Additional Manuals”). When this agreement refers to protocols or reimbursement policies it is also referring to the Additional Manuals. The Additional Manuals will be made available to you on a designated website or upon request.</p> <p>In the event of any conflict between this agreement or the “UnitedHealthcare Care Provider Administrative Guide” or other UnitedHealthcare protocols and reimbursement policies, and any Additional Manual, in connection with any matter pertaining to customers enrolled in the benefit contracts to which the Additional Manual applies, that Additional Manual will govern, unless statutes and regulations dictate otherwise. We may make changes to the protocols and reimbursement policies subject to this Appendix in accordance with the provisions of the agreement relating to protocols and reimbursement policy changes.</p> <p>The benefit contracts, names of the Additional Manuals, and name of the website to view and download the manuals, when applicable, are set forth in the table below. We will notify you of any changes in the location of the Additional Manuals. You may request a copy of the Additional Manual.</p>		
	<p>Table 1.</p>		
	<p>Benefit Contract</p>	<p>Description of Applicable Additional Manual</p>	<p>Website</p>
	<p>Ohio Medicare and Medicaid Enrollees Benefit Plans</p>	<p>UnitedHealthcare Community Plan of Ohio Physician, Health Care Professional, Facility and Ancillary Provider Care Provider Manual: UnitedHealthcare Connected for MyCare Ohio</p>	<p>www.UHCprovider.com</p>

Appendix 2 Definitions, Products and Services

1. Customer. Individuals who are enrolled in benefit contracts insured or administered by us or any participating entity are included in our use of the phrase “customer” in this agreement.

2. Participating entities. The following entities have access to our agreement:

- UnitedHealthcare Insurance Company and its affiliates;
- Groups receiving administrative services from UnitedHealthcare Insurance Company or its affiliates or that have arranged for network access through an entity that has contracted with UnitedHealthcare Insurance Company or one of its affiliates.

3. Products and services.

You will participate in networks where our customers are enrolled in benefit contracts of the types generally described below.

- Ohio Medicare and Medicaid Enrollees (MME) Benefit Contracts.

This agreement does not apply to benefit contracts other than those described above.

4. Definitions.

Note: We may adopt a different name for a particular benefit contract, and/or may modify information referenced in the definitions in this Appendix 2 regarding customer identification cards. If that happens, this Appendix 2 will continue to apply to those benefit contracts as it did previously, and we will provide you with the updated information. Additionally, we may revise the definitions in this Appendix 2 to reflect changes in the names or roles of our business units, provided that doing so does not change your participation status in benefit contracts impacted by that change, and further provided that we provide you with the updated information.

- Medicaid Benefit Contracts means benefit contracts that offer coverage to beneficiaries of a program 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 Contracts means benefit contracts under the program authorized by Title XXI of the federal Social Security Act that are jointly financed by the federal and state governments and administered by the state.
- Medicare Advantage Benefit Contracts means benefit contracts 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.
- Medicare and Medicaid Enrollees (MME) Benefit Contracts 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 contract 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.

Appendix 3 - LOCATIONS

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

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

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

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

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