UnitedHealthcare

MEDICAL CONDITION ASSESSMENT INCENTIVE PROGRAM TERMS AND CONDITIONS FOR OUT OF NETWORK PROVIDERS EFFECTIVE JANUARY 1, 2027

These Medical Condition Assessment Incentive Program Terms and Conditions for Out of Network Providers[1] ("Terms and Conditions") govern the Medical Condition Assessment Incentive Program ("MCAIP"). Provider must have received a unilateral amendment or executed and timely returned a bilateral amendment or bilateral acknowledgement (collectively "Participation Document") to participate in this Program.

The parties acknowledge that Provider is participating in MA-PCPi for the 2027 MA-PCPi Term.

A Provider that participates in the MCAIP will receive payment from United if the requirements and conditions described in these Terms and Conditions are met.

1. **Eligibility:** With respect to the MCAIP Term, to be eligible to receive a Bonus under these Terms and Conditions, Provider must have access to Practice Assist or any comparable platform identified by United.

   Notwithstanding anything in these Terms and Conditions to the contrary, if at the time any Bonus is due and the Agreement is no longer in effect, Provider's eligibility to receive any of the Bonuses in these Terms and Conditions is at United's discretion.

2. **MCAIP Assessment Bonus**: Provider will be eligible to receive a MCAIP Assessment Bonus payment for submitting an Assessment with a Compliant Medical Record. The Compliant Medical Record must document one or more face-to-face comprehensive exams in 2027 that occurs after Provider's office received the member's assessment/gap information from Optum. United will pay Provider $25 for Assessments with Compliant Medical Records returned within 60 days of the comprehensive exam. Assessments with Compliant Medical Records received by United more than 60 days after the comprehensive exam, but before January 31, 2028 will be eligible for $15.

   Assessments documenting one or more comprehensive exams from January 1, 2027 through December 31, 2027, that occur prior to providers receipt of assessment/gap information from Optum will be eligible for an adjusted MCAIP Assessment Bonus of $15.

   Compensation for the Medical Condition Assessment Bonus will be limited to a single returned Assessment per member per year.

   Submissions received after January 31, 2028 will not be eligible for the MCAIP Assessment Bonus.

3. **Fully Assessed Bonus:** **Provider** will be eligible to receive the Fully Assessed Bonus for each MCAIP Customer whose Suspect Medical Conditions are assessed by a Provider Physician during a comprehensive visit within the MCAIP Term, as documented on the Assessment as described below:

   a. Provider must provide documentation of one or more face-to-face comprehensive exams in 2027.

   b. Provider must complete and return all elements of the Assessment and a Compliant Medical Record to support any existing chronic conditions and co-morbid factors, documented to the highest level of specificity.

[1] This version of the MCAIP program is for use with providers who are not participating in United's network for Medicare Advantage benefit plans.

c. An Assessment must have a documented action for all conditions included on the Assessment to be considered Fully Assessed. Eligible actions in the Assessment are defined as:

   i. Assessed and Present – Must be documented to the highest degree of specificity in the medical record submitted to Optum.

   ii. Assessed and Unable to Diagnose at this Time – Provider has assessed the MCAIP Customer for the suspected condition and does not find evidence of it. Please submit an Assessed and Unable to Diagnose at this Time response, where applicable, and complete the Evaluating Practitioner Name and Date of Service.

   iii. Referred – MCAIP Customer is assessed and referred to another provider for further evaluation and/or management of the condition. Please submit a referral response, where applicable.

d. A valid submission of the Assessment and Compliant Medical Records will include documented action for 100% of the Suspected Medical Conditions for a MCAIP Customer. Eligible dates of service are limited to January 1, 2027 through December 31, 2027 and can be submitted through January 31, 2028. Rejected assessments can be resubmitted by February 29, 2028. Submissions may be submitted through Practice Assist or any comparable platform identified by United. Submissions will also be counted if received through one of the approved options below:

   i. Traceable carrier (any commercial carrier with traceable delivery): Optum Prospective Programs Processing, 1 E. Washington St., Ste. 900, Phoenix, AZ 85004

   ii. Email: ioa@optum.com

   iii. Secure fax: 1-877-273-3868

If, for a given MCAIP Term, Provider qualifies for the Fully Assessed Bonus, United will calculate Provider's Fully Assessed Bonus as $150 per MCAIP Customer for whom every Suspect Medical Condition was assessed by a Provider Physician during a comprehensive visit and for whom an Assessment and Compliant Medical Record was submitted as defined in Section 3.

United will pay the MCAIP Assessment Bonus and the Fully Assessed Bonus to Provider as set forth in the table below:

MCAIP Quarter	**Assessment Forms Received and Processed Through**	**Payment Date***
Quarter 1	May 31, 2027	July 31, 2027
Quarter 2	August 31, 2027	October 31, 2027
Quarter 3	November 30, 2027	January 31, 2028
Quarter 4	February 29, 2028	May 31, 2028

**To ensure Provider is reimbursed as outlined above, United will review Provider's submissions for the previous quarter(s) and make additional payments, if applicable.*

4. **Medical Condition Assessment Superior Bonus:** Provider will be eligible to receive a Medical Condition Assessment Superior Bonus if Provider i) earns at least 55 Performance Points within MA-PCPi and ii) submits an Assessment and Compliant Medical Record that comply with the requirements in Section 2 for at least 70% of MCAIP Customers during the MCAIP Term, rounded to the nearest whole percent. United will calculate Provider's Medical Condition Assessment Superior Bonus as the applicable payment amount from the table below multiplied by the total number of Assessments (including Compliant Medical Record) received as identified on the final report. United will pay the Suspect Medical Condition Assessment Superior Bonus no later than 150 days after the end of the MCAIP Term. United will review Provider's eligibility for a Medical Condition Assessment Superior Bonus if an approved reconsideration in the MA-PCPi program increases the total number of Performance Points earned in MA-PCPi. If Provider is due an additional payment relative to the Medical Condition Assessment Superior Bonus, that payment will be made no later than 180 days of the approved MA-PCPi reconsideration.

Percentage of MCAIP Customers Assessed	**Medical Condition Assessment Superior Bonus** *(Per Valid Assessment noted in the final reporting)*
90% - 100%	$200.00
80% - 89%	$150.00
70% - 79%	$100.00
69% and below	$0.00

5. **Reporting:** United will make available, on a monthly basis, reporting to reflect Provider's activity in returning Assessments [and Compliant Medical Records], and to assess a MCAIP Customer's Suspect Medical Conditions as described in Section 3.c for the Fully Assessed Bonus.

   No later than 120 days after the end of the MCAIP Term, United will make available to Provider the final report for that MCAIP Term.

6. **Quality Review:** United reserves the right to conduct quality reviews and withhold payment for Assessments if United determines that the Provider Physician has failed to conduct the Assessments or if Provider has not complied with relevant risk adjustment standards and requirements related to accurate and complete coding. If Provider fails to timely comply with the requirements of these Terms and Conditions, United reserves the right to reduce or withhold payment under the MCAIP.

7. **Overpayment:** If United notifies Provider of an overpayment under the MCAIP, Provider will repay overpayments within 30 days of written or electronic notice. In addition, Provider will promptly report any overpayment under the MCAIP and will return the overpayment to United within 30 days of discovery. If Provider fails to repay overpayments as specified above, United may recover overpayments by offsets against future payments.

8. **Termination:**

   a. Provider has the right to terminate Provider's participation in the MCAIP, effective for the next MCAIP Term, by giving notice electronically or in writing within 60 days after the Terms & Conditions for the next MCAIP Term have been communicated. Such termination will not affect the MCAIP payment determination for the MCAIP Term in effect prior to such termination.

b. United has the right to terminate Provider's participation in the MCAIP, effective for the next MCAIP Term, by giving notice electronically or in writing at least 30 days prior to the start of the next MCAIP Term. Such termination will not affect the MCAIP payment determination for the MCAIP Term in effect prior to such termination.

c. United and Provider each have the right to terminate Provider's participation in the MCAIP immediately upon notice, electronically or in writing, to the other if the other party fails to comply with any requirement of these Terms and Conditions.

d. United has the right to terminate Provider's participation in the MCAIP immediately upon notice, electronically or in writing, if Provider no longer meets United's requirements to participate in the MCAIP.

e. Unless otherwise authorized by United, if Provider participates in any other incentive program with United or United's Affiliates for the same Medicare Advantage Benefit Plans that are within the scope of the MCAIP, Provider's participation in the MCAIP will continue at United's sole discretion. If United terminates the MCAIP during a MCAIP Term under paragraph 8, Provider will not be entitled to payment under the MCAIP for that Term.

9. **Amendment of the MCAIP Terms and Conditions:** United, in its sole discretion, may amend these Terms and Conditions for any future MCAIP Term by providing to Provider a copy of and/or electronic access to the new Terms and Conditions no later than 30 days prior to the first day of the MCAIP Term to which the new Terms and Conditions will apply. If Provider does not wish to continue participation in the MCAIP after review of the new Terms and Conditions, Provider has the option to terminate participation in the MCAIP as set forth in paragraph 8 above.

   To allow United to efficiently implement new incentive programs or bonus opportunities that allow Provider a chance to earn additional compensation, United will provide notice of new bonus opportunities under the MCAIP and Provider will participate in those programs without amendment to these Terms & Conditions so long as those programs provide only the opportunity for increased compensation.

10. **Agreement:** If Provider and United are parties to a participation agreement, United and Provider agree and acknowledge that the terms of the participation agreement are separate and distinct from the terms of the Program. The terms of the participation agreement do not apply to and have no impact on the terms of the Program and are not binding on the parties with respect to the Program. Conversely, the terms of the Program do not apply to and have no impact on the terms of the participation agreement and are not binding on the parties with respect to the participation agreement.

    When Provider and United are not parties to an Agreement when Provider begins participating in the MCAIP, Provider agrees and acknowledges that it is subject to the additional Terms and Conditions in paragraph 12 of these Terms and Conditions. Further, Provider acknowledges that each Provider Physician is subject to the terms of the participation agreement or provider contract under which the Provider Physician participates in United's network for Medicare Advantage Benefit Plans.

11. **Defined Terms:** As used in these Terms and Conditions, these capitalized terms have the following meanings:

    Agreement: The participation agreement or provider contract to which Provider and United are parties and under which Provider has agreed to participate in United's network for Medicare Advantage Benefit Plans.

Assessment: The assessment document provided by Optum to Provider for the comprehensive assessment of Suspect Medical Conditions as completed by the Provider.

Benefit Plan: A certificate of coverage, summary plan description, or other document or agreement, whether delivered in paper, electronic, or other format, under which United is obligated to provide coverage for a Customer.

Compliant Medical Record: A medical record that is in compliance with CMS and /or NCQA documentation requirements, including date of service. Provider name, credentials, and a valid signature must appear at the end of each documented MCAIP Customer visit. MCAIP Customer's name and date of birth must be present on all pages of the medical record. If printing from EMR, appropriate authentication language, such as "Signed by" or "Authenticated by" and EMR signature date within 180 days of the date of service must be present.

Customer: A person eligible for, enrolled in and entitled to receive coverage from United for a health care service or product, according to the terms of the United Benefit Plan.

MCAIP Customer: Each Customer eligible for and enrolled in a Medicare Advantage Benefit Plan who is assigned and/or attributed, for a given MCAIP Term, by United to one of Provider Physicians and identified by United on the PCOR as eligible for an Assessment as described in these Terms and Conditions.

MCAIP Term: A calendar year during which Provider is eligible to participate in the MCAIP as described in these Terms and Conditions (for example, January 1, 2027 through December 31, 2027).

PCOR: The Patient Care Opportunity Report, or any successor reporting, generated by United on a monthly basis that summarizes performance data for MCAIP Customers using United data available at the time the report is generated.

Practice Assist: A workflow management tool that enables providers to manage patient care opportunities and suspects across multiple health plans.

Provider: Either (i) a physician, medical group, clinic, IPA, or PHO, that is a party to an Agreement and has met the requirements set forth in the opening paragraph of these Terms and Conditions, or (ii) a medical group or clinic that is not a party to an Agreement, but employs or contracts with Provider Physicians, and has met the requirements set forth in the opening paragraph of these Terms and Conditions. Provider TINs must be reported to United no later than March 31 of each calendar year for inclusion in that program term.

Provider Physician: A physician who is a doctor of medicine or osteopathy, duly licensed and qualified under the laws of the jurisdiction in which he/she provides health services to Customers, or a registered nurse practitioner or physician assistant as permitted by United's credentialing plan and state law, who meets one of the following: (i) is a Provider who is a party to an Agreement, or (ii) practices as a shareholder, partner, employee, or subcontractor of a Provider that is a party to an Agreement, or (iii) where the Provider is not a party to an Agreement, is a party to a United participation agreement or provider contract under which he/she participates in United's network for Medicare Advantage Benefit Plans and is a practicing shareholder, partner, employee, or subcontractor of that Provider. Each Provider Physician is assigned to a specific Provider based on the criteria above.

Suspect Medical Condition: A potential condition that United believes that a MCAIP Customer has but that has not been reported during the MCAIP Term on a claim or encounter.

United: UnitedHealthcare Insurance Company and/or the UnitedHealthcare Insurance Company affiliate(s) as named or identified in the Agreement (if Provider is a party to an Agreement), or in the MCAIP Participation Amendment (if Provider is not a party to an Agreement).

12. **Additional Terms and Conditions:** The additional terms and conditions of this Paragraph only apply when Provider and United are **NOT** parties to an Agreement, as set forth in paragraph 10 above.

    a. Authority to Contract. Provider agrees and acknowledges that it (i) has all requisite corporate power and authority to conduct its business as presently conducted, and to agree to be bound by these Terms and Conditions, and (ii) has the unqualified authority to bind, and does bind, itself and its Provider Physicians to all of these Terms and Conditions.

    b. Compliance with Laws and Regulations. Provider and United will comply with applicable state and federal laws and regulations, including but not limited to the requirements set forth in the Medicare Advantage Regulatory Requirements Appendix attached to these Terms and Conditions and those laws and regulations relating to confidentiality of individually identifiable health information derived from or obtained during the course of the performance of the MCAIP.

    c. Confidentiality. Except as required by an agency of the government or by law, neither United nor Provider will disclose to any third party, including Customers, (i) any proprietary business information, not available to the general public, that it obtains from the other party; or (ii) the specific initiatives and related payment provided for under the MCAIP. Provider will assure that its Provider Physicians are likewise bound by this confidentiality obligation.

    d. Dispute Resolution. The party invoking this provision, whether it be United or Provider, with its Provider Physicians, must provide written notice of any dispute within 180 days of the receipt of final payment under this Program for the MCAIP Term, or within the 60th day following the noticing party's discovery of the action or omission that is the subject of the Dispute, whichever is earlier. Nothing in this section shortens the period under applicable law or this Terms and Conditions during which United may pursue and complete recovery of an overpayment.

       Such written notice must: (i) state that the noticing party is invoking this Terms and Conditions' dispute-resolution process; and (ii) explain the circumstances giving rise to the Disputes and the basis for the noticing party's position regarding the Dispute. A party that receives a valid written notice of a Dispute will promptly arrange for discussions (which may be virtual or telephonic), during which United and Provider, with its Provider Physicians, will work together in good faith to resolve any and all disputes between them (hereinafter referred to as "Disputes") relating to the MCAIP Program. The parties will make reasonable commercial efforts to negotiate and resolve the Disputes. If the parties are unable to resolve any such Dispute within 90 days following the date one party sent written notice of the Dispute to the other party, and if either party wishes to pursue the Dispute, 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). Unless otherwise agreed to in writing by the parties, the party wishing to pursue the Dispute must initiate the arbitration within one year after the date on which notice of the Dispute was given or will be deemed to have waived its right to pursue the Dispute in any forum.

       Any arbitration proceeding under the MCAIP Program will be conducted in Hennepin County, Minnesota. 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, a panel of three arbitrators will be used. The arbitrator(s) may construe or interpret but will not vary or ignore the terms of the MCAIP Program and will be bound by controlling law. 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 such relief. The decisions and awards 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), and judgment on the award may be entered in any court having jurisdiction thereof. The parties acknowledge that because the MCAIP Program affects interstate commerce the Federal Arbitration Act applies in addition to any applicable state or federal law. Any prejudgment interest awarded by the arbitrator(s) will not exceed 3 percent per year and will only be available when required by applicable law or these Terms and Conditions. The burden of proof in any arbitration will be on the party asserting the claims or defenses in the arbitration.

Except as may be required by law, neither a party (including without limitation, the parties' agents, representatives, consultants and counsel), 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 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.

In the event that any portion of this Article or any part of the Terms and Conditions is deemed invalid or unenforceable, such unlawfulness, invalidity or unenforceability will not serve to invalidate any other part of this Article or the Terms and Conditions. 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, such litigation. Such litigation would instead proceed with the judge as the finder of fact.

Failure to timely comply with and exhaust the requirements and processes described in this dispute resolution provision 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.

e. Entire Agreement. These Terms and Conditions are the entire agreement between Provider and United with regard to the subject matter herein and supersede any prior written or unwritten agreements between Provider and United with regard to the same subject matter.

f. Relationship Between Parties. The relationship between United and Provider is solely that of independent contractors and nothing in the Terms and Conditions or otherwise will be construed or deemed to create any other relationship, including one of employment, agency or joint venture.

g. Notice. Any notice required to be given under the MCAIP will be in writing and will be deemed to have been given when delivered in person, by electronic communication, by facsimile or, if delivered by

first-class United States mail, on the date mailed, proper postage prepaid and properly addressed to Provider or to United, as appropriate.

h. Governing Law. These Terms and Conditions will be construed in accordance with the laws of the State of Minnesota.

i. Participation Status. Provider's participation in this Program does not change Provider's status as a non- participating provider in United's network for Medicare Advantage Benefit Plans. United will treat Provider as an out-of-network provider under all circumstances including, but not limited to, excluding Provider from all United Medicare Advantage Provider directories.

j. Non-Assignability. These Terms and Conditions will not be assigned, sublet, delegated or transferred by Provider without United's written consent. These Terms and Conditions may be assigned, sublet, delegated or transferred by United.

k. Severability. Any provision of these Terms and Conditions that is unlawful, invalid, or unenforceable by the binding decision of any court or administrative agency of competent jurisdiction will not affect the validity or enforceability of the remaining provisions of these Terms and Conditions or the lawfulness, validity or enforceability of the offending provision in any other situation or jurisdiction.

l. Survival. Subparagraphs B, C, D, and H of this section will survive termination of the MCAIP.

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

MEDICARE ADVANTAGE REGULATORY REQUIREMENTS APPENDIX

THIS MEDICARE ADVANTAGE REGULATORY REQUIREMENTS APPENDIX ("Appendix") supplements and is made part of the Medical Condition Assessment Incentive Program for Out of Network Providers Terms and Conditions (the "Terms and Conditions") between United and Provider.

SECTION 1
APPLICABILITY

This Appendix applies to the services performed by Provider pursuant to the Terms and Conditions as such services relate to the provision of Covered Services to Medicare Advantage Customers. In the event of a conflict between this Appendix and other appendices or any provision of the Terms and Conditions, the provisions of this Appendix shall control except: (1) as noted in Section 2 of this Appendix; or (2) as required by applicable law.

SECTION 2
DEFINITIONS

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 is in conflict with any definition in the Terms and Conditions for the same or substantially similar term, the definition for such term in the Terms and Conditions shall control. All other capitalized terms not otherwise defined in this Appendix shall be as defined in the Terms and Conditions.

2.1 CMS Contract: A contract between the Centers for Medicare & Medicaid Services ("CMS") and a Medicare Advantage Organization for the provision of Medicare benefits pursuant to the Medicare Advantage Program under Title XVIII, Part C of the Social Security Act.

2.2 Covered Service: A health care service or product for which a Customer is entitled to receive coverage from a Payer, pursuant to the terms of the Customer's Benefit Plan with that Payer. A Covered Service may also be referred to as a health service or other similar term under the Agreement.

2.3 Cost Sharing: Those costs, if any, under a Benefit Plan that are the responsibility of the Customer, including deductibles, coinsurance, and copayments. Cost Sharing may also be referred to as patient expenses or other similar term under the Terms and Conditions.

2.4 Dual Eligible Customer: A Medicare Advantage Customer who is: (a) eligible for Medicaid; and (b) for whom the state is responsible for paying Medicare Part A and B Cost Sharing.

2.5 Medicare Advantage Benefit Plans: Benefit Plans sponsored, issued or administered by a Medicare Advantage Organization as part of the Medicare Advantage program or as part of 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).

2.6 Medicare Advantage Customer or MA Customer: A Customer eligible for and enrolled in a Medicare Advantage Benefit Plan in which Provider participates pursuant to the Terms and Conditions.

2.7 Medicare Advantage Organization or MA Organization: For purposes of this Appendix, MA Organization is either United or Payer.

2.8 Payer: An entity obligated to a Customer to provide reimbursement for Covered Services under the Customer's Benefit Plan and authorized by United to access Provider's services under the Agreement. A Payer may also be referred to as a payor, participating entity, or other similar term under the Terms and Conditions.

SECTION 3
PROVIDER REQUIREMENTS

3.1 Data. Provider shall submit to MA Organization all risk adjustment data as defined in 42 CFR § 422.310(a), and other Medicare Advantage program-related information as may be requested by MA Organization, within the timeframes specified and in a form that meets Medicare Advantage program requirements. By submitting data to MA Organization, Provider represents to MA Organization, and upon MA Organization's request Provider shall certify in writing, that the data is accurate, complete, and truthful, based on Provider's best knowledge, information, and belief.

3.2 Policies. Provider shall comply with MA Organization's policies and procedures to the extent communicated by the MA Organization to Provider.

3.3 Customer Protection. Provider agrees that in no event including, but not limited to, non-payment by MA Organization or an intermediary, insolvency of MA Organization or an intermediary, or breach by United of the Terms and Conditions, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any MA Customer or person (other than MA Organization or an intermediary) acting on behalf of the MA Customer for Covered Services provided pursuant to the Terms and Conditions or for any other fees that are the legal obligation of MA Organization under the CMS Contract. This provision does not prohibit Provider from collecting from MA Customers allowable Cost Sharing. For the purpose of this provision, an "intermediary" is a person or entity authorized to negotiate and execute the Terms and Conditions on behalf of Provider. In the event of MA Organization's or an intermediary's insolvency or other cessation of operations or termination of MA Organization's contract with CMS, Provider shall continue to provide Covered Services to an MA Customer through the later of the period for which premium has been paid to MA Organization on behalf of the MA Customer, or, in the case of an MA Customer who is hospitalized as of such period or date, the MA Customer's discharge.

This provision shall be construed in favor of the MA Customer, shall survive the termination of the Terms and Conditions regardless of the reason for termination, including MA Organization's insolvency, and shall supersede any contrary agreement, oral or written, between Provider and an MA Customer or the representative of an MA Customer if the contrary agreement is inconsistent with this provision.

3.4 Dual Eligible Customers. Provider agrees that in no event including, but not limited to, non-payment by a state Medicaid agency or other applicable regulatory authority, other state source, or breach by United of the Terms and Conditions, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Dual Eligible Customer, person acting on behalf of the Dual Eligible Customer, or MA Organization (unless notified otherwise) for Medicare Part A and B Cost Sharing. Instead, Provider will either: (a) accept payment made by or on behalf of MA Organization as payment in full; or (b) bill the appropriate state source for such Cost Sharing amount. If Provider imposes an excess charge on a Dual Eligible Customer, Provider is subject to any lawful sanction that may be imposed under Medicare or Medicaid.

3.5 Eligibility. Provider agrees to immediately notify MA Organization in the event Provider is or becomes excluded from participation in any federal health care program under Section 1128 or 1128A of the Social Security Act, or is or becomes included on the preclusion list under Part 422 of the Code of Federal Regulations. Provider shall not be eligible for payment from MA Organization after the date or during the time period specified by the applicable regulatory authorities. Provider also shall not employ or contract for the provision of health care services, utilization review, medical social work or administrative services, with or without compensation, with any individual or entity that is or becomes excluded from participation in any federal health care program under Section 1128 or 1128A of the Social Security Act or is or becomes included on the preclusion list under Part 422 of the Code of Federal Regulations. MA Customers shall not have any financial liability and Provider shall not pursue MA Customer for financial liability for services or items furnished by an individual or entity that is excluded from participation in any federal health care program under Section 1128 or 1128A of the Social Security Act or is included on the preclusion list under Part 422 of the Code of Federal Regulations. Provider shall be financially liable for those services or items after the date or during the time period specified by the applicable regulatory authorities.

3.6 Laws. Provider shall comply with all applicable federal and Medicare laws, regulations, and CMS instructions.

3.7 Federal Funds. Provider acknowledges and agrees that MA Organization receives federal payments under the CMS Contract and that payments Provider receives from or on behalf of MA Organization are, in whole or in part, from federal funds. Provider is therefore subject to certain laws that are applicable to individuals and entities receiving federal funds.

3.8 CMS Contract. Provider shall perform the services set forth in the Terms and Conditions in a manner consistent and compliant with MA Organization's contractual obligations under the CMS Contract.

3.9 Records.

(a) Privacy and Confidentiality; Customer Access. Provider shall safeguard MA Customer privacy and confidentiality including, but not limited to, the privacy and confidentiality of any information that identifies a particular MA Customer, and shall comply with all federal and state laws regarding confidentiality and disclosure of medical records or other health and enrollment information. Provider shall ensure that MA Customers have timely access to medical records and information that pertain to them, in accordance with applicable law.

(b) Retention. Provider shall maintain records and information related to the services provided under the Terms and Conditions including, but not limited to, MA Customer medical records and other health and enrollment information, in an accurate and timely manner. Provider shall maintain such records for the longer of the following periods:

(i) in the case of records containing information related to the medical loss ratio information reported to CMS by the MA Organization, including, for example, information related to incurred claims and quality improvement activities, at least ten (10) years from the date such medical loss ratio information is reported to CMS by the MA Organization, or

(ii) in the case of all other records, at least ten (10) years from the final date of the CMS Contract period in effect at the time the records were created, or such longer period as required by law.

(c) Government Access to Records. Provider acknowledges and agrees that the U.S. Department of Health and Human Services, the Comptroller General, or their designees shall have the right (directly or through the MA Organization) to audit, evaluate, collect, and inspect any pertinent books, contracts, computer or other electronic systems (including medical records and documentation), and other records and information of Provider related to the CMS Contract. Provider shall make available to its premises, physical facilities, and equipment, records relating to MA Customers and any additional relevant information CMS may require. This right shall extend through the longer of the time periods identified in subsection 3.9(b)(i) and (ii), or ten (10) years from date of completion of any audit, whichever is later in time.

(d) MA Organization Access to Records. Provider shall grant MA Organization or its designees such audit, evaluation, collection and inspection rights identified in subsection 3.9(c) as are necessary for MA Organization to comply with its obligations under the CMS Contract. Whenever possible, MA Organization will give Provider reasonable notice of the need for such audit, evaluation, collection, or inspection, and will conduct such audit, evaluation, collection, or inspection at a reasonable time and place. Provider shall submit medical records of MA Customers to the MA Organization as may be requested, within the timeframes specified, for (i) the purpose of CMS audits of risk adjustment data, and (ii) other purposes medical records from providers are used by MA Organization, as specified by CMS.

3.10 Subcontracts. If Provider has any arrangements, in accordance with the terms of the Terms and Conditions, with affiliates, subsidiaries, or any other subcontractors, directly or through another person or entity, to perform any of the services Provider is obligated to perform under the Terms and Conditions that are the subject of this Appendix, Provider shall ensure that all such arrangements are in writing, duly executed, and include all the terms contained in this Appendix. Provider shall provide proof of such to MA Organization upon request. Provider further agrees to promptly amend its agreements with such subcontractors, in a manner consistent with the changes made to this Appendix by MA Organization, to meet any additional CMS requirements that may apply to the services.

3.12 Offshoring. All services provided pursuant to the Terms and Conditions that are subject to this Appendix and that involve MA Customer's protected health information ("PHI") must be performed within the United States, the District of Columbia, or the United States territories, unless Provider previously notifies MA Organization in writing and submits required offshoring information to, and receives approval from, MA Organization.

SECTION 4
OTHER

4.1 Regulatory Amendment. MA Organization may unilaterally amend this Appendix to comply with applicable laws and regulations and the requirements of applicable regulatory authorities including, but not limited to, CMS. MA Organization shall provide written or electronic notice to Provider of such amendment and its effective date. 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.