UnitedHealthcare®

INTEGRATED QUALITY CARE INCENTIVE PROGRAM
FOR OUT OF NETWORK PROVIDERS TERMS AND CONDITIONS
EFFECTIVE JANUARY 1, 2026

The Integrated Quality Care Incentive Program for Out of Network Providers[1] Terms and Conditions ("Terms and Conditions") govern the Integrated Quality Care Incentive (I-QCi) Program. As a precondition for the Provider to participate in the I-QCi Program pursuant to these Terms and Conditions and to be eligible for the bonus opportunities described below, one of the following must have occurred: (a) UnitedHealthcare ("United") presented an I-QCi Program Participation Acknowledgement or I-QCi Program Participation Amendment (collectively "Participation Document") to Provider and Provider signed and returned the Participation Document to United in accordance with the deadline established by United, or (b) United notified Provider of Provider's enrollment in the I-QCi Program via a unilateral amendment to Provider's participation agreement with United (also a "Participation Document).

A provider that participates in the I-QCi Program will receive bonus payments from United if the requirements and conditions described in these Terms and Conditions are met.

Article 1
Quality Care Bonus Opportunities

1. To recognize Provider's effort to prioritize and address the specific open care opportunities shown in the Quality Care Measure Table, United will compensate Provider upon meeting the performance criteria outlined below.

Quality Care Measure Table

2026 Star ID*	Quality Care Measure Name*	Description*	Payment Eligibility	Eligible Payment Per Care Measure Closure
C01	Breast Cancer Screening (BCS)	Female I-QCi Customers 40-74 years of age who had a mammogram during the past two years	Quarterly	$20
C10	Osteoporosis Management in Women who had a fracture (OMW)	I-QCi Customers 67-85 years of age who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after the fracture.	Quarterly	$20
C12	Glycemic Status Assessment for Patients with Diabetes (GSD)	I-QCi Customers 18-75 years of age with diabetes who had HbA1c control (≤ 9.0%) based on LAST documented measurement of the year	Annual	$20
C13	Kidney Health Evaluation for Patients with Diabetes (KED)	I-QCi Customers 18–85 years of age with diabetes (Types 1 and 2) who had a kidney health evaluation in the measurement year. Both an eGFR and a uACR test are required on same or different dates of service. • At least 1 estimated glomerular filtration rate (eGFR); AND • At least 1 urine albumin-creatinine ratio (uACR) test identified by one of the following:	Quarterly	$20

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		– A quantitative urine albumin test AND a urine creatinine test 4 or less days apart; OR – A uACR		
C14	Controlling High Blood Pressure (CBP)	I-QCi Customers 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/<90 mm HG) based on LAST documented measurement of the year	Annual	$20
C19	Statin Therapy for Patients with Cardiovascular Disease (SPC)	I-QCi Customers, males 21-75 years of age and females 40-75 years of age, who were identified as having atherosclerotic cardiovascular disease (ASCVD) AND were dispensed at least one high or moderate intensity statin medication during the measurement period.	Quarterly	$30
D08	Medication Adherence for Diabetes Medications (MAD)	I-QCi Customers 18 years of age or older with at least 2+ prescription fill for diabetes medication (excluding insulin) who fill their prescription often enough to cover having diabetes medication(s) on hand at least 80% of the time during the measurement period	Annual	$20
D09	Medication Adherence for Hypertension (RAS antagonists) (MAH)	I-QCi Customers 18 years of age or older with at least 2+ prescription fills for RAS Antagonist who fill their prescription often enough to cover having their blood pressure medication on hand at least 80% of the time during the measurement period	Annual	$20
D10	Medication Adherence for Cholesterol (Statins) (MAC)	I-QCi Customers 18 years of age or older with at least 2+ prescription fills for Statin medication who fill their prescription often enough to cover having their Statin medication on hand at least 80% of the time during the measurement period	Annual	$20
D12	Statin Use in Persons with Diabetes (SUPD)	I-QCi Customers 40-75 years of age who were dispensed at least two diabetes medication fills AND who received at least one fill of a statin medication in the measurement period.	Quarterly	$30
N/A	Annual Care Visit (ACV)	I-QCi Customers that have completed an ACV between **January 1st and December 31st of the measurement year.**	Quarterly	$25

** The information in these columns is subject to change from time to time at CMS' discretion. If CMS retires a Quality Care Measure or moves it to "display status," United reserves the right to remove it from this bonus opportunity. Compensation for care measure closures will be limited to a single compliant closure per member per year.*

On a quarterly basis for each Quality Care Measure eligible for a quarterly payment and on an annual basis for each Quality Care Measure eligible for annual payment, United will calculate Provider's Quality Care Bonus as the total number of Quality Care Measures addressed for I-QCi Customers during the applicable period multiplied by the appropriate payment from the table above. United will pay the Quality Care Bonus to Provider as set forth in the table below.

Dates of Service	Payment Date*	Payment Eligibility
January 1 – March 31	7/31/2026	Quarterly
April 1 – June 30	10/31/2026	Quarterly
July 1 – September 30	1/31/2027	Quarterly
October 1 – December 31	5/31/2027	Quarterly
April 1 – December 31	5/31/2027	Annual

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

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Article 2
General Provisions that Apply to all Bonus Opportunities

2.1 Reporting: United will make available periodic reporting for all applicable bonus opportunities to demonstrate Provider's performance.

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

2.2 Eligibility for Bonus Payments: Notwithstanding anything in these Terms and Conditions to the contrary, if at the time any bonus is due 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.

2.3 Medical Record, Chart Request and Provider Data Attestation: Without limiting any other data access rights set forth elsewhere in the Agreement, Provider will permit United or its designee to conduct chart reviews of Provider's records, specifically for the CMS required data submission, for any or all I-QCi Customers. On a quarterly basis, Provider will also attest to the accuracy of demographic data as described within the UnitedHealthcare Care Provider Administrative Guide. If charts or records are not furnished within the timeframe specified and/or are incomplete, or if Provider fails to attest to the accuracy of demographic data, United reserves the right to reduce or withhold payment under the I-QCi Program.

2.4 Training: United may offer training, at no cost to Provider, regarding required medical record documentation and appropriate coding. The purpose of the training is to improve the accuracy and completeness of United's information and the information United provides to CMS regarding the health status of I-QCi Customers. United will identify any Provider employees who United believes will benefit from this training and notify providers in writing that they have been identified and of the details of the required training. Identified individuals must attend a training session within the timeframe established by United. If the identified individuals fail to timely complete requested training, United reserves the right to reduce or withhold payment under this Program.

2.5 Overpayments: If United notifies Provider of an overpayment under the I-QCi Program, Provider will repay overpayments within 30 days of written or electronic notice. In addition, Provider will promptly report any overpayment under the I-QCi Program 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.

2.6 Termination:

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

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

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c. United and Provider each have the right to terminate Provider's participation in the I-QCi Program 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 I-QCi Program immediately upon notice electronically or in writing if Provider no longer meets United's requirements to participate in the Program.

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 this I-QCi Program, Provider's participation in I-QCi will continue at United's sole discretion. If United terminates I-QCi during an I-QCi Term under this Article 2.6 (e), Provider will not be entitled to payment under I-QCi for that Term.

2.7 Amendment of the I-QCi Terms and Conditions: United, in its sole discretion, may amend these Terms and Conditions for any future I-QCi 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 I-QCi Term to which the new Terms and Conditions will apply. If Provider does not wish to continue participation in the I-QCi Program after review of the new Terms and Conditions, Provider has the option to terminate participation in the I-QCi Program as set forth in Article 2.6.

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

2.8 Agreement: If Provider and United are parties to a participation agreement, United and Provider agree and acknowledge 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.

Article 3
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.

Annual Care Visit: A care visit with an I-QCi Customer for which a claim is appropriately submitted with a qualifying code as identified in the glossary tab of the PCOR. Refer to uhcprovider.com for the most up to date information on telehealth requirements.

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.

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.

I-QCi Customer: Each Customer eligible for and enrolled in a Medicare Advantage Benefit Plan who is assigned and/or attributed for a given I-QCi Term by United to a Provider Physician and identified by United in the PCOR as eligible for the Program described in these Terms and Conditions.

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I-QCi Term: A calendar year during which Provider is eligible to participate in the I-QCi Program described in these Terms and Conditions (for example, January 1, 2026 through December 31, 2026).

PCOR: The Patient Care Opportunity Report, or any successor reporting, generated by United on a monthly basis that summarizes performance data about various measures for I-QCi Customers, including measures that are part of the I-QCi Program, using United data available at the time the report is generated.

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 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.

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 I-QCi Program Participation document (if Provider is not a party to an Agreement).

Article 4
Additional Terms and Conditions

These additional terms and conditions of this Article apply to Provider because Provider is not party to a participation agreement to participate in a network for United's Medicare Advantage Benefit Plans.

4.1 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.

4.2 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 I-QCi Program.

4.3 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 I-QCi Program. Provider will assure that its Provider Physicians are likewise bound by this confidentiality obligation.

4.4 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 I-QCi 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.

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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 I-QCi 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 I-QCi 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 I-QCi 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 I-QCi 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.
Any arbitration proceeding under the I-QCi Program will be conducted in Hennepin County, Minnesota. The arbitrator(s) may construe or interpret but will not vary or ignore the terms of the I-QCi Program and will be bound

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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 decision of the arbitrator(s) on the points in dispute will be binding, and judgment on the award may be entered in any court having jurisdiction thereof. The parties acknowledge that because the I-QCi Program affects interstate commerce the Federal Arbitration Act applies.

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.

4.5 Entire Agreement. These Terms and Conditions and the Participation Document, as applicable, 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.

4.6 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.

4.7 Notice. Any notice required to be given under the I-QCi Program 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.

4.8 Governing Law. These Terms and Conditions and the Participation Document, as applicable, will be construed in accordance with the laws of the State of Minnesota.

4.9 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.

4.10 Non-Assignability. These Terms and Conditions may 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.

4.11 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.

4.12 Survival. Articles 4.2, 4.3, 4.4 and 4.8 of this Article will survive termination of the I-QCi Program.

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

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MEDICARE ADVANTAGE REGULATORY REQUIREMENTS APPENDIX

THIS MEDICARE ADVANTAGE REGULATORY REQUIREMENTS APPENDIX ("Appendix") supplements and is made part of the Medicare Advantage Primary Care Physician 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,

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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.

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(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.

3.11 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.

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

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