P.O. Box 30449
Salt Lake City, UT 84130-0449

July 13, 2015

Re: Action Required – Review of Participation Agreement

To Whom It May Concern:

We believe your group practice would benefit from executing a UnitedHealthcare Medical Group Participation Agreement, which **enables all physicians in your medical group to participate with UnitedHealthcare under one contract, one Tax Identification Number (TIN) and one fee schedule(s), and we ask that you consider this option for your group practice.**

The Agreement will replace and supersede all of the individual contracts and fee schedules currently in place between UnitedHealthcare and your medical group physicians. You can review additional details about our products and policies as referenced in the Agreement, including our Administrative Guide at ***UnitedHealthcareOnline.com > Tools & Resources > Policies, Protocols and Guides*.**

Electronic Signature of the Medical Group Participation Agreement
UnitedHealthcare offers electronic contracting to physicians and practitioners so that agreements can be easily signed and returned by email, which replaces the need to print, sign and mail the agreements back to us. This secure, paperless process meets all state and federal requirements for privacy and compliance. If you choose to transition your group to the Medical Group Participation Agreement, please follow the instructions provided in the attached Agreement to sign your Medical Group Participation Agreement within 90 calendar days from the date of this letter.

By signing the Medical Group Participation agreement, you are attesting that you have full authority to bind the above-referenced practice to the agreement. If you are not authorized to sign participation agreements for this practice, please forward the participation agreement to an authorized signer using the link provided in the email.

Since your medical group includes more than one physician, please verify, update and return the attached Physician Roster. Also included for your review and acceptance are the market-standard specifications and samples of the new fee schedule(s) for your group.

To implement to the Medical Group Participation Agreement for your group practice, please do the following:

1. Sign both contracts
2. Verify and Update Appendix 3 – Physician Roster
3. Complete Appendix 4 – Your Practice Locations

4. Click “Send” to return your contract.

This option is valid for 90 days from the date of this letter and will expire after that date. We hope you will consider it. Please call Network Management at Texas at 866-574-6088 with any questions. Thank you.

Sincerely,

UnitedHealthcare

Enclosures

Insurance coverage provided by UnitedHealthcare Insurance Company or its affiliates. Health plan coverage provided by UnitedHealthcare of Arizona, Inc.; UnitedHealthcare of California, UnitedHealthcare of Colorado, Inc.; UnitedHealthcare of Oregon, Inc.; UnitedHealthcare of Utah, Inc.; and UnitedHealthcare of Washington, Inc. or other affiliates. Administrative services provided by United HealthCare Services, Inc. or its affiliates.

Doc#: UHC2047a.1_20 130311

Participation Agreement Check List

Below is a checklist of actions to be completed prior to returning your Medical Group Participation Agreement to UnitedHealthcare within 90 days of the date of this letter:

- ❒ Review the Medical Group Participation Agreement
- ❒ Have your practice's authorized signatory sign and date all designated signature block(s) in the Agreement
- ❒ Complete any other designated areas of the Agreement that applies to your practice.
- ❒ Complete the Demographic Form, for your practice

If you received a paper Agreement, then complete the following items:

- ❒ Confirm that your Tax Identification Number (TIN) on the signature page is accurate. If it is not accurate, please enter the correct TIN and initial the change. Please include an updated W-9 to confirm the change in your TIN.
- ❒ Return both copies of the signed Agreement including regulatory appendices, fee schedule, group roster, practice location page and the W-9 in the return envelope and mail to:

  UnitedHealthcare Physician Contract Support and Network Depiction
  1311 West President George Bush Hwy.
  Richardson, TX 75080

Please do NOT enter an effective date on the Agreement or make any handwritten comments or markings on the contract or fee schedules.

Once the Agreement is fully executed by both parties, we will send you a copy of the signed Agreement with the effective date.

For commercial products in the West Region: Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Health Plan coverage provided by or through UnitedHealthcare of Arizona, Inc., UnitedHealthcare of California, UnitedHealthcare of Colorado, Inc., UnitedHealthcare of Oregon, Inc., UnitedHealthcare of Utah, Inc., and UnitedHealthcare of Washington, Inc.
Administrative services provided by United HealthCare Services, Inc. or its affiliates.

INTRODUCTION

Our agreement consists of this contract, the appendices, and the additional materials we reference in the attached Appendix 1.

Guiding principles

We strive to operate in accordance with the following principles:

- *We want to work together with America's best physicians to improve the health care experience of our customers.*
- *We respect and support the physician/patient relationship while adhering fairly to the contract for benefits we provide our customers.*
- *Whether a particular treatment is covered under a benefit contract should not determine if the treatment is provided. Physicians and health care professionals should provide the care they believe is necessary regardless of coverage.*
- *You should discuss treatment options with patients regardless of coverage. We encourage that communication.*
- *Physicians should describe any factors that could affect their ability to render appropriate care. Matters such as professional training, financial incentives, availability constraints, religious or philosophical beliefs, and similar matters are all things that a physician should consider discussing with a patient. We encourage these communications. We urge full disclosure.*
- *Fairness and efficiency will govern the ways in which we administer our products. We will make our determinations promptly. Our commitments to our customers will be clear. We will honor our agreements. When it comes to coverage determinations, the language of the benefit contract will take precedence.*

Next steps

Please read this agreement. If you have questions, write to or call:

UnitedHealthcare
Network Contract Support
780 Shiloh Road, MS-1.700
Plano, TX 75074
(866) 574-6088

You can visit our website at www.unitedhealthcareonline.com (UnitedHealthcare Online®) for additional details on items described in the agreement. If the agreement is acceptable to you, please sign both of the enclosed copies of the contract, and send both copies to the address above.

MEDICAL GROUP CONTRACT

UnitedHealthcare Insurance Company is entering into this agreement with you. It is doing so on behalf of itself, UnitedHealthcare of Texas, Inc. and its other affiliates 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 to your professional staff (the physicians and other professionals who are your employees, or your independent contractors providing services to your patients, and who are subject to credentialing by us) and the services you provide at the locations in the attached Appendix 4. When this agreement refers to "you", it also refers to your professional staff. Your professional staff is bound to the same requirements of this agreement as you are. You represent to us that you have the authority to bind your professional staff to this agreement.

What you will do

You need to be credentialed in accordance with our Credentialing Plan, as referenced in Appendix 1, for the duration of this agreement.

You must notify us in a timely manner about certain services you provide in accordance with our Administrative Guide so that we can provide our customers with the services we have committed to provide. If you do not so notify us about these services, you will not be reimbursed for the services, and you may not charge our customer.

Within one year of the effective date of this agreement, you must conduct business with us entirely 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 in UnitedHealthcare Online® functionality as they become available and will make information available to you as to which products are supported by UnitedHealthcare Online.

You must submit your claims within 90 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. For laboratory services, you will only be reimbursed for the services that you are certified through the Clinical Laboratory Improvement Amendments (CLIA) to perform, and you must not bill our customers for laboratory services for which you are not certified.

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 the services you provide are denied for reason of not being medically necessary, you may not charge our customer unless our customer has, with knowledge of our determination of a lack of medical necessity, agreed in writing to be responsible for payment of those charges. If the services you provide are not covered under our customer's benefit contract, you may, of course, bill our customer directly. You will not require a customer to pay a "membership fee" or other fee in order to access you for covered services (except for co-payments, coinsurance and/or deductibles provided for under the customer's benefit contract) and will not discriminate against any customer based on the failure to pay such a fee.

You will cooperate with our reasonable requests to provide information that we need. 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 or the participating entity.

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 in a timely manner a payment obligation to you. 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.

The applicable participating entity will reimburse you for the services you deliver that our customer's benefit contract covers. The amount you receive will be based on the lesser of your billed charges or our fee schedule, which is described at Appendix 1 and is subject to the reimbursement (coding) policies and methodologies of us and the participating entities. Our reimbursement policies and methodologies are updated periodically and will be made available to you online or upon request. To request a copy of our reimbursement policies and methodologies, write to UnitedHealthcare, Network Contract Support, 780 Shiloh Road, MS-1.700, Plano, TX 75074. Your reimbursement is also subject to our rules concerning retroactive eligibility, subrogation and coordination of benefits (as described in the Administrative Guide). We recognize CPT reporting guidelines as developed by the American Medical Association, as well as ICD diagnostic codes and hospital-based revenue codes. Following these guidelines does not imply a right to reimbursement for all services as coded or reported.

Ordinarily, fee amounts listed in the Payment Appendix(ices) are based upon primary fee sources. We reserve the right to use gap-fill fee sources where primary fee sources are not available.

We routinely update our fee schedule in response to additions, deletions and changes to CPT codes by the

American Medical Association, price changes for immunizations and injectable medications, and in response to similar changes (additions and revisions) to other service coding and reporting conventions that are widely used in the health care industry, such as those maintained by the Centers for Medicare and Medicaid Services (for example, HCPCS). Ordinarily, our fee schedule is updated using similar methodologies for similar services. We will not generally attempt to communicate routine maintenance of this nature and will generally implement updates within 90 days from the date of publication.

We will give you 90 days written or electronic notice of non-routine fee schedule changes which will substantially alter the overall methodology or reimbursement level of the fee schedule. In the event such changes will reduce your overall reimbursement under this agreement, you may terminate this agreement by giving 60 days written notice to us, provided that the notice is given by you within 30 days after the notice of the fee schedule change.

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.

Your professional staff and Practice Locations

You represent to us that all of the members of your professional staff, as of the date you executed this agreement, are listed in Appendix 3. All of the members of your professional staff will participate in our network through this agreement, except in cases in which one of your professional staff is not accepted for participation or is removed from participation under our credentialing program, or removed from participation by us immediately due to that professional being sanctioned by any governmental agency or authority (including Medicare or Medicaid), or having lost a license to provide all or some of the professional services under this agreement, or no longer having hospital admitting privileges in any participating hospital. Your professional staff will cooperate with our credentialing program.

If a new professional joins your professional staff, you will give us 60 days notice and provide the information included in Appendix 3. You will assure that the new professional will promptly submit a credentialing application to us (unless the new professional is already credentialed with us) and cooperate with our credentialing program.

You will assure that a member of your professional staff who has not been approved or is not in good standing under our credentialing program will not provide covered services to our customers. In the event that professional does provide covered services, you will not bill us, our customer, or anyone acting on our customer's behalf for the service, and you will assure that the professional also does not bill for the service.

If a professional leaves your professional staff, you will notify us within ten business days after you become aware that the professional will leave. The notice will include the date that the professional will depart from your professional staff. If you know the future contact information for the professional and whether the professional will continue to practice after leaving your professional staff, you will make reasonable commercial efforts to include that information in the notice and will provide that information to us if we request it.

This agreement applies to your practice locations identified in Appendix 4. If you begin providing services at other locations (either by opening such locations yourself, or by acquiring, merging or coming

under common ownership and control with an existing provider of services that was not already under contract with us or one of our affiliates to participate in a network of health care providers), those additional locations will become subject to this agreement 30 days after we receive notice from you.

If you acquire or 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 a 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.

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.

We can amend this agreement or any of the appendices on 90 days written or electronic notice by sending you a copy of the amendment. 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 60 days written notice to us so long as you send this termination notice within 30 days of your receipt of the amendment.

In addition, this agreement has an initial term of three years, and it will automatically renew after the initial term, for renewal terms of one year each. Either you or we can terminate this agreement, effective at the end of the initial term or effective at the end of any renewal term, by providing at least 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 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 if any governmental agency or authority (including Medicare or Medicaid) sanctions you.

We both agree that termination notices under this agreement must be sent by certified mail, return receipt requested, to UnitedHealthcare, Network Contract Support, 780 Shiloh Road, MS-1.700, Plano, TX 75074, or to the post office address you provided 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

We will resolve all disputes between us by following the dispute procedures set out in our Administrative Guide. If either of us wishes to pursue the dispute beyond those procedures, they will submit the dispute to binding arbitration in accordance with the Commercial Dispute Procedures of the American Arbitration Association (see http://www.adr.org) within one year.

We both expressly intend that any dispute between us be resolved on an individual basis so that no other dispute with any third party(ies) may be consolidated or joined with our dispute. We both agree that any arbitration ruling by an arbitrator allowing class action arbitration or requiring consolidated arbitration involving any third party(ies) would be contrary to our intent and would require immediate judicial review of such ruling. The arbitrator will not vary the terms of this agreement and will be bound by governing law. We both acknowledge that this agreement involves interstate commerce, and is governed by the Federal Arbitration Act, 9 U.S.C. § 1 et seq. The arbitrator will not have the authority to award punitive or exemplary damages against either of us, except in connection with a statutory claim that explicitly provides for such relief. Arbitration will be conducted in Dallas County, TX.

If a court allows any litigation of a dispute to go forward, we both waive rights to a trial by jury with respect to that litigation, and the judge will be the finder of fact. Any provision of this agreement that is invalid or unenforceable shall not affect the validity or enforceability of the remaining provisions of this agreement or the validity or enforceability of the offending provision in any other situation or in any other jurisdiction. This section of the agreement shall survive and govern 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. It also means that you make independent health care treatment decisions. We do not. We do not reserve any right to control those treatment decisions. It further means that each of us is responsible for the costs, damages, claims, and liabilities that result from our own acts.

You will look to the applicable participating entity for reimbursement for the products and services under our agreement. This means that we are not financially responsible for claims payment for groups that are self-funded or that are not affiliated with us.

We may assign this agreement to any entity that is an affiliate of UnitedHealthcare Insurance Company 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:

Medical Group :	Address to be used for giving notice under the agreement:
DBA (if applicable):	Street:
Signature:	City:
Print Name: ________	State:
Title: ________	Zip Code:
Date: ________	TIN:
E-Mail: ________	National Provider Identification (NPI) Number:

UnitedHealthcare Insurance Company, on behalf of itself, UnitedHealthcare of Texas, 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 Appendices	**Fee Information Document includes**: Fee Specifications Document, Fee Schedule Sample, and Additional Information About Your Fee Schedule. Further information about the fee schedule (such as additional fee samples) can be requested by writing to UnitedHealthcare, Network Contract Support, 780 Shiloh Road, MS-1.700, Plano, TX 75074 or through our website at www.unitedhealthcareonline.com.
Appendix 3	This document provides information about the members of your professional staff.
Appendix 4	This document provides information about your practice locations.
State Regulatory Requirements Appendix	In some instances, states add requirements to our agreement that are 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.
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 these appendix(ices).
Administrative Guide	Our Administrative Guide governs the mechanics of our relationship. Our Administrative Guide may be viewed by going to www.unitedhealthcareonline.com, and it will also be made available to you upon request. We may make changes to the Administrative Guide or other administrative protocols upon 30 days electronic or written notice to you. Additionally, for some of the benefit contracts for which you may provide covered services under this agreement, you are subject to additional requirements of 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. An Additional Manual may be a separate document or it may be a supplement to the UnitedHealthcare Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide ("UnitedHealthcare Administrative Guide"). For benefit contracts subject to an Additional Manual, the Additional Manual controls if it conflicts with any of the following: (1) a provision of this agreement or of the UnitedHealthcare Administrative Guide; or (2) a United protocol or reimbursement policy. However, the Additional Manual does not control where it conflicts with applicable statutes or regulations.

	The Additional Manuals will be made available to you on a designated website and upon request. The names of the Additional Manuals, the websites to view and download them, and the benefit contracts to which they apply, are listed in Table 1 below. We may change the location of a website or the customer identification card identifier used to identify customers subject to a given Additional Manual; if we do so, we will inform you. We may make changes to the Additional Manuals subject to this provision in accordance with the provisions of this agreement relating to protocol and reimbursement policy changes.

Table 1.

Benefit Contract	**Description of Applicable Additional Manual**	**Website**
No Additional Manuals Apply		
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This row intentionally left blank	________	________
This row intentionally left blank	________	________

Credentialing Plan	To review our credentialing plan, visit www.unitedhealthcareonline.com. This plan requires your professional staff to be covered by malpractice insurance in amounts with carriers and on terms and conditions that are customary for professionals like them in your community. To request access to, or a copy of, our credentialing plan, write to UnitedHealthcare, Network Contract Support, 780 Shiloh Road, MS-1.700, Plano, TX 75074.

Appendix 2
Definitions, Products and Services

Section 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.

Section 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.

Section 3. Products and services.

a. We may allow participating entities to access your services under this agreement for the benefit contract types described in each line item below, unless otherwise specified in section 3b of this Appendix 2:

- Benefit contracts where customers are offered a network of participating providers and must select a primary physician, who in some cases must approve any care provided by other health care providers. Such benefit contracts may or may not include an out-of-network benefit.

- Benefit contracts where customers are offered a network of participating providers but are not required to select a primary physician. Such benefit contracts may or may not include an out-of-network benefit.

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- Medicare Advantage Benefit Contracts.

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- Additional Network Benefit Contracts. As used here Additional Network Benefit Contracts means commercial narrow network benefit contract types in which you do not participate, as described in section 3b of this Appendix 2, but that provide for an additional network of providers for outpatient emergency services, inpatient services following an emergency admission, urgent care services and services pre-approved by United. Additional Network Benefit Contract types will be identified by the notation "W500" on the customer's ID card. We may modify this ID card notation in the future, and will provide you with the updated information.

b. Notwithstanding the above section 3a of this Appendix 2, this agreement will not apply to the benefit contract types described in the following line items:

- Benefit contracts where customers are not offered a network of participating providers from which they may receive covered services.

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- Texas Medicare and Medicaid Enrollees (MME) Benefit Contracts.
- Medicare and Medicaid Enrollees (MME) Benefit Contracts other than those separately addressed in this Appendix 2.
- STAR+PLUS Medicaid Benefit Contracts.
- STAR Medicaid Benefit Contracts.
- STAR Health Medicaid Benefit Contracts.
- STAR Kids Medicaid Benefit Contracts.
- Texas CHIP Benefit Contracts.
- New Mexico Centennial Care Benefit Contracts.
- Benefit Contracts for Medicare Select.
- Medicare Advantage Private Fee-For-Service Benefit Contracts and Medicare Advantage Medical Savings Account Benefit Contracts.
- Medicaid or CHIP Benefit Contracts other than those separately addressed in this Appendix 2.
- Other Governmental Benefit Contracts.
- Benefit contracts accessing a network administered by OneNet PPO, LLC, other than workers' compensation benefit contracts.

- Benefit contracts for workers' compensation programs accessing a network administered by OneNet PPO, LLC.

- Benefit contracts for workers' compensation benefit programs other than those accessing a network administered by OneNet PPO, LLC.

- TRICARE Benefit Contracts.

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- UnitedHealthcare Core Benefit Contracts. As used here, UnitedHealthcare Core Benefit Contracts means commercial narrow network benefit contracts marketed under a name that includes the word "Core". References to "UnitedHealthcare Core" also apply to any brand name adopted by us in the future to supplement and/or replace "UnitedHealthcare Core".

- UnitedHealthcare Charter Benefit Contracts. As used here, UnitedHealthcare Charter Benefit Contracts means commercial narrow network benefit contracts for which the customer selects or is assigned a primary care physician to manage the customer's health care needs and referrals to network specialists, and that are marketed under a name that includes the word "Charter." References to "UnitedHealthcare Charter" also apply to any brand name adopted by us in the future to supplement and/or replace "UnitedHealthcare Charter."

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Note: Excluding certain benefit contracts or programs from this Agreement does not preclude the parties or their affiliates from having or entering into a separate agreement providing for your participation in a network for such benefit contracts or programs.

Section 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, section 3a or section 3b of 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.

MEDICARE:

- **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 Contract** 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.

MEDICAID, CHIP AND OTHER STATE PROGRAMS:

- **Medicaid Benefit Contracts** means benefit contracts that offer coverage to beneficiaries of a program that is authorized by Title XIX of the federal Social Security Act, and jointly financed by the federal and state governments and administered by the state.

- **STAR Medicaid Benefit Contracts** means Medicaid benefit contracts issued in Texas that include a reference to "UnitedHealthcare Community Plan" or "Texas STAR" on the identification card of any customer eligible for and enrolled in that benefit contract.

- **STAR+PLUS Medicaid Benefit Contracts** means long term care Medicaid benefit contracts issued in Texas that include a reference to "UnitedHealthcare Community Plan" or "STAR+PLUS" on the valid identification card of any customer eligible for and enrolled in that benefit contract.

- **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.

- **Texas CHIP Benefit Contracts** means CHIP benefit contracts issued in Texas that include a reference to "UnitedHealthcare Community Plan" on the valid identification card of any customer eligible for and enrolled in that benefit contract.

- **Other Governmental Benefit Contracts** means benefit contracts that are funded wholly or substantially by a state or district government or a subdivision of a state (such as a city or county), but do not include benefit contracts for:
  - i) employees of a state government or a subdivision of a state and their dependents;
  - ii) students at a public university, college or school;
  - iii) employer-based coverage of private sector employees, even if the employer receives a government subsidy to help fund the coverage;
  - iv) Medicaid beneficiaries;
  - v) Children's Health Insurance Program (CHIP) beneficiaries; and,
  - vi) Medicare and Medicaid Enrollees (MME).

Payment Appendix - All Payer for Physicians

All Payer Fee Information Document for Physicians: REGN 97284/97285

Unless another Payment Appendix to this agreement applies specifically to a particular benefit contract as it covers a particular customer, the provisions of this Payment Appendix apply to covered services rendered by you to customers covered by benefit contracts sponsored, issued or administered by all participating entities.

____

____

Print Name: ________
Provider signature (in compliance with Texas Insurance Code Chapter 1458)

Payment Appendix - All Payer for Non-Physician Professionals

All Payer Fee Information Document for Non-Physician Professionals: REGN 93434/93435

Unless another Payment Appendix to this agreement applies specifically to a particular benefit contract as it covers a particular customer, the provisions of this Payment Appendix apply to covered services rendered by you to customers covered by benefit contracts sponsored, issued or administered by all participating entities.

____

____

You will list the non-physician professional as the provider of service on claims when the non-physician professional provides a service to a customer. In the event that both a non-physician professional and a physician provide services to the same customer during the same encounter, then, subject to applicable reimbursement policies (for example the anesthesia reimbursement policy), either but not both the non-physician professional or the physician may bill as the provider of service on the claim in accordance with CMS.

Print Name: ________
Provider signature (in compliance with Texas Insurance Code Chapter 1458)

Payment Appendix - Medicare Advantage for Physicians

Medicare Advantage Fee Information Document for Physicians: REGN 7593/7594

Unless another Payment Appendix to this agreement applies specifically to a particular Medicare Advantage Benefit Contract as it covers a particular customer, the provisions of this Payment Appendix apply to covered services rendered by you to customers covered by all Medicare Advantage Benefit Contracts, as described in this agreement.

____

Print Name: ________
Provider signature (in compliance with Texas Insurance Code Chapter 1458)

Payment Appendix - Medicare Advantage for Non-Physician Professionals

Medicare Advantage Fee Information Document for Non-Physician Professionals: REGN 7509/7510

Unless another Payment Appendix to this agreement applies specifically to a particular Medicare Advantage Benefit Contract as it covers a particular customer, the provisions of this Payment Appendix apply to covered services rendered by you to customers covered by all Medicare Advantage Benefit Contracts, as described in this agreement.

____

You will list the non-physician professional as the provider of service on claims when the non-physician professional provides a service to a customer. In the event that both a non-physician professional and a physician provide services to the same customer during the same encounter, then, subject to applicable reimbursement policies (for example the anesthesia reimbursement policy), either but not both the non-physician professional or the physician may bill as the provider of service on the claim in accordance with CMS.

Print Name: ________
Provider signature (in compliance with Texas Insurance Code Chapter 1458)

Appendix 4
Your Practice Locations

Medical Group attests that this Appendix identifies all services and locations covered under this agreement.

BILLING ADDRESS

All sites of service billing under all TINs listed in Appendix 4 must be included as par providers. Identify only if a common name and address appears on all medical group practice location bills that utilize the medical group's Tax ID under the Agreement.

Practice Name
Street Address
City
Tax ID Number
National Provider ID

PRACTICE LOCATIONS (complete one for each service location)		
Clinic Name	**Clinic Name**	**Clinic Name**
Street Address	**Street Address**	**Street Address**
City	**City**	**City**
State and Zip Code	**State and Zip Code**	**State and Zip Code**
Phone Number	**Phone Number**	**Phone Number**
TIN (*If different from above*)	**TIN (*If different from above*)**	**TIN (*If different from above*)**
National Provider ID (NPI)	**National Provider ID (NPI)**	**National Provider ID (NPI)**

PRACTICE LOCATIONS (complete one for each service location)		
Clinic Name	**Clinic Name**	**Clinic Name**
Street Address	**Street Address**	**Street Address**
City	**City**	**City**
State and Zip Code	**State and Zip Code**	**State and Zip Code**
Phone Number	**Phone Number**	**Phone Number**
TIN (*If different from above*)	**TIN (*If different from above*)**	**TIN (*If different from above*)**

National Provider ID (NPI)	National Provider ID (NPI)	National Provider ID (NPI)
____	____	____

Payment Appendix

All Payer Fee Information Document

Representative Fee Schedule Sample : as of 07/01/2015

Report Date: 07/13/2015

Fee Schedule ID: DAL 97284 - NonFacility

Linked Fee Schedule ID: DAL 97285 - Facility

Type Of Service Description	Primary Fee Source	Pricing Level
EVALUATION & MANAGEMENT	2012 CMS RBRVS Carrier Locality (0000000)	112.000%
EVALUATION & MANAGEMENT - NEONATAL	2012 CMS RBRVS Carrier Locality (0000000)	112.000%
EVALUATION & MANAGEMENT - PREVENTIVE	2012 CMS RBRVS Carrier Locality (0000000)	112.000%
EVALUATION & MANAGEMENT - NURSING FACILITY SVCS	2012 CMS RBRVS Carrier Locality (0000000)	112.000%
SURGERY - INTEGUMENTARY	2012 CMS RBRVS Carrier Locality (0000000)	130.000%
SURGERY - MUSCULOSKELETAL	2012 CMS RBRVS Carrier Locality (0000000)	130.000%
SURGERY - RESPIRATORY	2012 CMS RBRVS Carrier Locality (0000000)	130.000%
SURGERY - CARDIOVASCULAR	2012 CMS RBRVS Carrier Locality (0000000)	130.000%
SURGERY - HEMIC & LYMPHATIC	2012 CMS RBRVS Carrier Locality (0000000)	130.000%
SURGERY - MEDIASTINUM & DIAPHRAGM	2012 CMS RBRVS Carrier Locality (0000000)	130.000%
SURGERY - DIGESTIVE	2012 CMS RBRVS Carrier Locality (0000000)	130.000%
SURGERY - URINARY	2012 CMS RBRVS Carrier Locality (0000000)	130.000%
SURGERY - MALE GENITAL	2012 CMS RBRVS Carrier Locality (0000000)	130.000%
SURGERY - FEMALE GENITAL	2012 CMS RBRVS Carrier Locality (0000000)	130.000%
SURGERY - MATERNITY & DELIVERY	2012 CMS RBRVS Carrier Locality (0000000)	130.000%
SURGERY - ENDOCRINE	2012 CMS RBRVS Carrier Locality (0000000)	130.000%
SURGERY - NERVOUS	2012 CMS RBRVS Carrier Locality (0000000)	130.000%
SURGERY - EYE & OCULAR ADNEXA	2012 CMS RBRVS Carrier Locality (0000000)	130.000%
SURGERY - AUDITORY	2012 CMS RBRVS Carrier Locality (0000000)	130.000%
RADIOLOGY	2012 CMS RBRVS Carrier Locality (0000000)	95.000%
RADIOLOGY - BONE DENSITY	2012 CMS RBRVS Carrier Locality (0000000)	100.000%
RADIOLOGY - CT	2012 CMS RBRVS Carrier Locality (0000000)	100.000%
RADIOLOGY - MAMMOGRAPHY	2012 CMS RBRVS Carrier Locality (0000000)	105.000%
RADIOLOGY - MRI	2012 CMS RBRVS Carrier Locality (0000000)	100.000%
RADIOLOGY - MRA	2012 CMS RBRVS Carrier Locality (0000000)	100.000%
RADIOLOGY - NUCLEAR MEDICINE	2012 CMS RBRVS Carrier Locality (0000000)	105.000%
RADIOLOGY - PET SCANS	2012 CMS RBRVS Carrier Locality (0000000)	125.000%
RADIOLOGY - RADIATION THERAPY	2012 CMS RBRVS Carrier Locality (0000000)	125.000%
RADIOLOGY - ULTRASOUND	2012 CMS RBRVS Carrier Locality (0000000)	105.000%
LAB - PATHOLOGY	2012 CMS RBRVS Carrier Locality (0000000)	60.000%
OFFICE LAB	2012 CMS Clinical Lab Schedule National Limit	60.000%
CLINICAL LABORATORY	2012 CMS Clinical Lab Schedule National Limit	42.000%
MEDICINE - OPHTHALMOLOGY	2012 CMS RBRVS Carrier Locality (0000000)	115.000%
MEDICINE - CARDIOVASCULAR	2012 CMS RBRVS Carrier Locality (0000000)	115.000%
MEDICINE - ALLERGY & CLINICAL IMMUNOLOGY	2012 CMS RBRVS Carrier Locality (0000000)	120.000%
MEDICINE - CHIROPRACTIC MANIPULATIVE TREATMENT	2012 CMS RBRVS Carrier Locality (0000000)	115.000%
MEDICINE - PHYSICAL MED AND REHAB - MODALITIES	2012 CMS RBRVS Carrier Locality (0000000)	85.000%
MEDICINE - PHYSICAL MED AND REHAB -THERAPIES&OTHER	2012 CMS RBRVS Carrier Locality (0000000)	85.000%
MEDICINE - ENTERAL FORMULA	2012 CMS RBRVS Carrier Locality (0000000)	125.000%
MEDICINE - OTHER	2012 CMS RBRVS Carrier Locality (0000000)	125.000%
MEDICINE - IMMUNIZATION ADMINISTRATION	2012 CMS RBRVS Carrier Locality (0000000)	120.000%
MEDICINE - CHEMO ADMIN	2012 CMS RBRVS Carrier Locality (0000000)	120.000%
OBSTETRICS - GLOBAL	2012 CMS RBRVS Carrier Locality (0000000)	112.000%
IMMUNIZATIONS	UHC Immunization Fee Schedule	118.000%
INJECTABLES/OTHER DRUGS	CMS Drug Pricing	100.000%
INJECTABLES – ONCOLOGY/THERAPEUTIC CHEMO DRUGS	UHC Chemotherapy Fee Schedule	100.000%
INJECTABLES - IVIG	CMS Drug Pricing	112.000%
INJECTABLES-SALINE & DEXTROSE SOLUTIONS	CMS Drug Pricing	100.000%
DME & SUPPLIES	2012 CMS DME Floor	60.000%
DME & SUPPLIES - RESPIRATORY	2012 CMS DME Floor	60.000%
DME & SUPPLIES - ORTHOTICS	2012 CMS DME Floor	60.000%
DME & SUPPLIES - PROSTHETICS	2012 CMS DME Floor	60.000%
DME & SUPPLIES - OSTOMY	2012 CMS DME Floor	60.000%
AMBULANCE	2012 CMS Ambulance Schedule - Urban (0000000)	112.000%

Default Percent of Eligible Charges: 40.00 %
Professional/Technical Modifier Pricing: Fee Source-Based

Site of Service Price Differential: Site of Service applies. CMS Assignment (ASC POS 24 = F)
Anesthesia Conversion Factor (Based on a 15 minute Anesthesia Time Unit Value): $ 55.00
Calculation of Anesthesia Partial Units: Proration
Schedule Type: FFS

Last Routine Maintenance Update: 07-01-2015

Fixed Fees: 36415 - $ 3.00 36416 - $ 3.00 84030 - $ 33.00 87804 - $ 14.00 S3620 - $ 38.00 V5242 - $ 2500.00 V5243 - $ 2500.00 V5244 - $ 2500.00 V5245 - $ 2500.00 V5246 - $ 2500.00 V5247 - $ 2500.00 V5248 - $ 5000.00 V5249 - $ 5000.00 V5250 - $ 5000.00 V5251 - $ 5000.00 V5252 - $ 5000.00 V5253 - $ 5000.00 V5254 - $ 2500.00 V5255 - $ 2500.00 V5256 - $ 2500.00 V5257 - $ 2500.00 V5258 - $ 5000.00 V5259 - $ 5000.00 V5260 - $ 5000.00 V5261 - $

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Payment Appendix
All Payer Fee Information Document
Representative Fee Schedule Sample : as of 07/01/2015
Report Date: 07/13/2015

Fee Schedule ID: DAL 97284 - NonFacility

Linked Fee Schedule ID: DAL 97285 - Facility

5000.00 V5262 - $ 2500.00 V5263 - $ 5000.00

Payment Appendix
All Payer Fee Information Document

Representative Fee Schedule Sample for Otolaryngology : as of 07/01/2015
Report Date: 07/13/2015

Fee Schedule ID: DAL 97284 - NonFacility

Linked Fee Schedule ID: DAL 97285 - Facility

CPT/HCPCS	Modifier	CPT/HCPCS Description	Type of Service Description	Place of Service	Fee Amount
14060	00	ADJT TIS TRNSFR/	SURGERY - INTEGUMENTARY	NonFacility	$ 1017.28
30140	00	SBMCSL RESCJ INF	SURGERY - RESPIRATORY	NonFacility	$ 583.21
30520	00	SEPTOPLASTY/SUBM	SURGERY - RESPIRATORY	NonFacility	$ 821.26
31231	00	NASAL ENDO DX UN	SURGERY - RESPIRATORY	NonFacility	$ 256.20
31237	00	NASAL/SINUS NDSC	SURGERY - RESPIRATORY	NonFacility	$ 432.76
31238	00	NASAL/SINUS NDSC	SURGERY - RESPIRATORY	NonFacility	$ 444.26
31255	00	NASAL/SINUS ENDO	SURGERY - RESPIRATORY	NonFacility	$ 530.10
31256	00	NASL/SINUS ENDO	SURGERY - RESPIRATORY	NonFacility	$ 261.95
31267	00	NASL/SINUS ENDO;	SURGERY - RESPIRATORY	NonFacility	$ 420.37
31276	00	NASAL/SINUS NDSC	SURGERY - RESPIRATORY	NonFacility	$ 669.05
31295	00	NASAL/SINUS NDSC	SURGERY - RESPIRATORY	NonFacility	$ 2810.25
31296	00	NASAL/SINUS NDSC	SURGERY - RESPIRATORY	NonFacility	$ 2848.30
31297	00	NASAL/SINUS NDSC	SURGERY - RESPIRATORY	NonFacility	$ 2800.95
31575	00	LARYNGSCPY FLEXI	SURGERY - RESPIRATORY	NonFacility	$ 152.22
31579	00	LARYNGSCPY FLEX/	SURGERY - RESPIRATORY	NonFacility	$ 283.63
38724	00	CERVICAL LYMPHAD	SURGERY - HEMIC & LYMPHATIC	NonFacility	$ 1912.44
41530	00	SUBMUCOSAL ABLTJ	SURGERY - DIGESTIVE	NonFacility	$ 4397.46
42415	00	EXC PRTD TUM/PRT	SURGERY - DIGESTIVE	NonFacility	$ 1410.66
42820	00	TONSILLECTOMY &	SURGERY - DIGESTIVE	NonFacility	$ 388.06
42826	00	TONSILLECTOMY ON	SURGERY - DIGESTIVE	NonFacility	$ 337.18
60220	00	TOTAL THYROID LO	SURGERY - ENDOCRINE	NonFacility	$ 930.11
60240	00	THYROIDECTOMY TO	SURGERY - ENDOCRINE	NonFacility	$ 1202.68
61782	00	STRTCTC CPTR ASS	SURGERY - NERVOUS	NonFacility	$ 253.55
69210	00	REMOVAL IMPACTED	SURGERY - AUDITORY	NonFacility	$ 66.82
69433	00	TYMPANOSTOMY LOC	SURGERY - AUDITORY	NonFacility	$ 268.59
69436	00	TYMPANOSTOMY GEN	SURGERY - AUDITORY	NonFacility	$ 215.49
69631	00	TYMPANOPLASTY W/	SURGERY - AUDITORY	NonFacility	$ 1181.00
69801	00	LABYRINTHOTOMY;	SURGERY - AUDITORY	NonFacility	$ 265.06
70486	00	CT MAXILLOFACIAL	RADIOLOGY - CT	NonFacility	$ 250.86
70486	26	CT MAXILLOFACIAL	RADIOLOGY - CT	NonFacility	$ 55.48
70486	TC	CT MAXILLOFACIAL	RADIOLOGY - CT	NonFacility	$ 195.38
92504	00	BINOCULAR MICROS	MEDICINE - OTHER	NonFacility	$ 38.71
92511	00	NASOPHARYNGOSCOP	MEDICINE - OTHER	NonFacility	$ 180.83
92557	00	COMPRE AUDIOMETR	MEDICINE - OTHER	NonFacility	$ 48.93
92567	00	TYMPANOMETRY	MEDICINE - OTHER	NonFacility	$ 18.73
95004	00	PERCUTANEOUS TES	MEDICINE - ALLERGY & CLINICAL IMMUNOLOGY	NonFacility	$ 7.76
95024	00	INTRACUTANEOUS T	MEDICINE - ALLERGY & CLINICAL IMMUNOLOGY	NonFacility	$ 9.40
95165	00	PREPJ& ALLERGEN	MEDICINE - ALLERGY & CLINICAL IMMUNOLOGY	NonFacility	$ 15.52
99202	00	OFFICE OUTPATIEN	EVALUATION & MANAGEMENT	NonFacility	$ 81.20
99203	00	OFFICE OUTPATIEN	EVALUATION & MANAGEMENT	NonFacility	$ 117.80
99204	00	OFFICE OUTPATIEN	EVALUATION & MANAGEMENT	NonFacility	$ 179.94
99205	00	OFFICE OUTPATIEN	EVALUATION & MANAGEMENT	NonFacility	$ 223.40
99212	00	OFFICE OUTPATIEN	EVALUATION & MANAGEMENT	NonFacility	$ 47.66
99213	00	OFFICE OUTPATIEN	EVALUATION & MANAGEMENT	NonFacility	$ 78.92
99214	00	OFFICE OUTPATIEN	EVALUATION & MANAGEMENT	NonFacility	$ 116.66
99215	00	OFFICE OUTPATIEN	EVALUATION & MANAGEMENT	NonFacility	$ 156.68
99243	00	OFFICE CONSULTAT	EVALUATION & MANAGEMENT	NonFacility	$ 134.19
99244	00	OFFICE CONSULTAT	EVALUATION & MANAGEMENT	NonFacility	$ 198.24
V5257	00	HEARING AID, DIG	MEDICINE - OTHER	NonFacility	$ 2500.00
V5261	00	HEARING AID, DIG	MEDICINE - OTHER	NonFacility	$ 5000.00

Default Percent of Eligible Charges: 40.00 %
Professional/Technical Modifier Pricing: Fee Source-Based
Site of Service Price Differential: Site of Service applies. CMS Assignment (ASC POS 24 = F)
Anesthesia Conversion Factor (Based on a 15 minute Anesthesia Time Unit Value): $ 55.00
Calculation of Anesthesia Partial Units: Proration
Schedule Type: FFS
Last Routine Maintenance Update: 07-01-2015

UnitedHealthcare

Payment Appendix
All Payer Fee Information Document

Representative Fee Schedule Sample for Otolaryngology : as of 07/01/2015
Report Date: 07/13/2015

Fee Schedule ID: DAL 97284 - NonFacility

Linked Fee Schedule ID: DAL 97285 - Facility

CPT/HCPCS	Modifier	CPT/HCPCS Description	Type of Service Description	Place of Service	Fee Amount
14060	00	ADJT TIS TRNSFR/	SURGERY - INTEGUMENTARY	Facility	$ 891.62
30140	00	SBMCSL RESCJ INF	SURGERY - RESPIRATORY	Facility	$ 583.21
30520	00	SEPTOPLASTY/SUBM	SURGERY - RESPIRATORY	Facility	$ 821.26
31231	00	NASAL ENDO DX UN	SURGERY - RESPIRATORY	Facility	$ 101.34
31237	00	NASAL/SINUS NDSC	SURGERY - RESPIRATORY	Facility	$ 239.82
31238	00	NASAL/SINUS NDSC	SURGERY - RESPIRATORY	Facility	$ 260.18
31255	00	NASAL/SINUS ENDO	SURGERY - RESPIRATORY	Facility	$ 530.10
31256	00	NASL/SINUS ENDO	SURGERY - RESPIRATORY	Facility	$ 261.95
31267	00	NASL/SINUS ENDO;	SURGERY - RESPIRATORY	Facility	$ 420.37
31276	00	NASAL/SINUS NDSC	SURGERY - RESPIRATORY	Facility	$ 669.05
31295	00	NASAL/SINUS NDSC	SURGERY - RESPIRATORY	Facility	$ 223.46
31296	00	NASAL/SINUS NDSC	SURGERY - RESPIRATORY	Facility	$ 266.38
31297	00	NASAL/SINUS NDSC	SURGERY - RESPIRATORY	Facility	$ 219.04
31575	00	LARYNGSCPY FLEXI	SURGERY - RESPIRATORY	Facility	$ 100.89
31579	00	LARYNGSCPY FLEX/	SURGERY - RESPIRATORY	Facility	$ 187.62
38724	00	CERVICAL LYMPHAD	SURGERY - HEMIC & LYMPHATIC	Facility	$ 1912.44
41530	00	SUBMUCOSAL ABLTJ	SURGERY - DIGESTIVE	Facility	$ 543.82
42415	00	EXC PRTD TUM/PRT	SURGERY - DIGESTIVE	Facility	$ 1410.66
42820	00	TONSILLECTOMY &	SURGERY - DIGESTIVE	Facility	$ 388.06
42826	00	TONSILLECTOMY ON	SURGERY - DIGESTIVE	Facility	$ 337.18
60220	00	TOTAL THYROID LO	SURGERY - ENDOCRINE	Facility	$ 930.11
60240	00	THYROIDECTOMY TO	SURGERY - ENDOCRINE	Facility	$ 1202.68
61782	00	STRTCTC CPTR ASS	SURGERY - NERVOUS	Facility	$ 253.55
69210	00	REMOVAL IMPACTED	SURGERY - AUDITORY	Facility	$ 42.48
69433	00	TYMPANOSTOMY LOC	SURGERY - AUDITORY	Facility	$ 174.34
69436	00	TYMPANOSTOMY GEN	SURGERY - AUDITORY	Facility	$ 215.49
69631	00	TYMPANOPLASTY W/	SURGERY - AUDITORY	Facility	$ 1181.00
69801	00	LABYRINTHOTOMY;	SURGERY - AUDITORY	Facility	$ 280.10
70486	00	CT MAXILLOFACIAL	RADIOLOGY - CT	Facility	$ 250.86
70486	26	CT MAXILLOFACIAL	RADIOLOGY - CT	Facility	$ 55.48
70486	TC	CT MAXILLOFACIAL	RADIOLOGY - CT	Facility	$ 195.38
92504	00	BINOCULAR MICROS	MEDICINE - OTHER	Facility	$ 11.91
92511	00	NASOPHARYNGOSCOP	MEDICINE - OTHER	Facility	$ 62.11
92557	00	COMPRE AUDIOMETR	MEDICINE - OTHER	Facility	$ 42.98
92567	00	TYMPANOMETRY	MEDICINE - OTHER	Facility	$ 14.46
95004	00	PERCUTANEOUS TES	MEDICINE - ALLERGY & CLINICAL IMMUNOLOGY	Facility	$ 7.76
95024	00	INTRACUTANEOUS T	MEDICINE - ALLERGY & CLINICAL IMMUNOLOGY	Facility	$ 1.22
95165	00	PREPJ& ALLERGEN	MEDICINE - ALLERGY & CLINICAL IMMUNOLOGY	Facility	$ 4.08
99202	00	OFFICE OUTPATIEN	EVALUATION & MANAGEMENT	Facility	$ 54.89
99203	00	OFFICE OUTPATIEN	EVALUATION & MANAGEMENT	Facility	$ 83.87
99204	00	OFFICE OUTPATIEN	EVALUATION & MANAGEMENT	Facility	$ 142.20
99205	00	OFFICE OUTPATIEN	EVALUATION & MANAGEMENT	Facility	$ 182.22
99212	00	OFFICE OUTPATIEN	EVALUATION & MANAGEMENT	Facility	$ 28.21
99213	00	OFFICE OUTPATIEN	EVALUATION & MANAGEMENT	Facility	$ 55.65
99214	00	OFFICE OUTPATIEN	EVALUATION & MANAGEMENT	Facility	$ 85.39
99215	00	OFFICE OUTPATIEN	EVALUATION & MANAGEMENT	Facility	$ 120.09
99243	00	OFFICE CONSULTAT	EVALUATION & MANAGEMENT	Facility	$ 105.59
99244	00	OFFICE CONSULTAT	EVALUATION & MANAGEMENT	Facility	$ 166.97
V5257	00	HEARING AID, DIG	MEDICINE - OTHER	Facility	$ 2500.00
V5261	00	HEARING AID, DIG	MEDICINE - OTHER	Facility	$ 5000.00

Default Percent of Eligible Charges: 40.00 %
Professional/Technical Modifier Pricing: Fee Source-Based
Site of Service Price Differential: Site of Service applies. CMS Assignment (ASC POS 24 = F)
Anesthesia Conversion Factor (Based on a 15 minute Anesthesia Time Unit Value): $ 55.00
Calculation of Anesthesia Partial Units: Proration
Schedule Type: FFS
Last Routine Maintenance Update: 07-01-2015

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Payment Appendix
All Payer Fee Information Document
Additional Information About This Fee Schedule

Fee Schedule ID: DAL 97284 - NonFacility

Linked Fee Schedule ID: DAL 97285 - Facility

Section 1. Definition of Terms

Unless otherwise defined in this document, capitalized terms will have the meanings ascribed to them in the Agreement.

AMA: American Medical Association located at: www.ama-assn.org .

Anesthesia Conversion Factor: The dollar amount that will be used in the calculation of time-based and non-time based Anesthesia Management fees in accordance with the Anesthesia Payment Policy. Unless specifically stated otherwise, the Anesthesia Conversion Factor indicated is fixed and will not change. The Anesthesia Conversion Factor is based on an anesthesia time unit value of 15 minutes. In the event that any of United's claims systems cannot administer a 15 minute anesthesia time unit value, then the Anesthesia Conversion Factor will be calculated as follows:

[(Value of 15 minute Anesthesia Conversion Factor / 15) * anesthesia time unit value]

For example, an Anesthesia Conversion Factor of $60.00 (based on a 15-minute anesthesia time unit value) would be calculated to an Anesthesia Conversion Factor of $40.00 (based on a 10-minute anesthesia time unit value).

Example: [($60.00 / 15) * 10 = $40.00]

Anesthesia Management: The management of anesthesia services related to medical, surgical or scopic procedures, as described in the current Anesthesia Management Codes list attached to the Anesthesia Payment Policy located at www.unitedhealthcareonline.com .

Calculation of Anesthesia Partial Units:
Proration: Partial time units will be prorated and calculated to one decimal place rounded to the nearest tenth. For example, if the anesthesia time unit value is based on 15 minutes and if 17 minutes of actual time is submitted on a claim, then the 17 minutes will be divided by 15. The resulting figure of 1.1333 will be rounded to the nearest tenth and the total time units for the claim will be 1.1 time units.

In the event that any of United's claims systems cannot administer the calculation of partial units as indicated above, a different calculation method will be used until such time as the appropriate system enhancements can be programmed and implemented. That different calculation method will result in a Fee Amount that is no less than the Fee Amount that would apply under the Proration method described above.

CMS: Centers for Medicare and Medicaid Services located at: www.cms.hhs.gov .

CMS OPPSCap Rate: The Outpatient Prospective Payment System (OPPS) Cap Rate as defined in Section 5102(b) of the Deficit Reduction Act of 2005.

Conversion Factor: A multiplier, expressed in dollars per relative value unit, which converts relative values into Fee Basis amounts.

CPT/HCPCS: A set of codes that describe procedures and services, including supplies and materials, performed or provided by physicians and other health care professionals. Each procedure or service is identified with a 5 digit code. The use of CPT/HCPCS simplifies the reporting of services.

CPT/HCPCS Description: The descriptor associated with each CPT/HCPCS code.

Default Percent of Eligible Charges: In the event that a Fee Basis amount is not sourced by either a primary or alternate Fee Source, such as services submitted using unlisted, unclassified or miscellaneous codes, the codes are subject to correct coding review and will be priced at the contracted percentage indicated within this document.

Expired Code: An existing CPT or HCPCS code that will be expired by the entity that published the code (for example, CMS or the AMA).

Fee Amount: The contract rate for each CPT/HCPCS. The calculation of the Fee Amount is impacted by a variety of factors explained within this document including, but not limited to, Professional/Technical Modifier Pricing, Carrier Locality, CMS year, Place of Service and Pricing Level. The Fee Amount is calculated by multiplying the Fee Basis times the Pricing Level for each specific Type of Service.

Fee Basis: The amount published by the Fee Source upon which the Pricing Level will be applied to derive the Fee Amount.

Fee Schedule ID: United's proprietary naming/numbering convention that is used to identify the specific fee schedule which supports the terms of the

contractual agreement. This is the fee schedule for services performed in nonfacility Places of Service.

Fee Schedule Specifications: Documentation of the underlying calculation methodology and criteria used to derive the Fee Amounts contained within the fee schedule.

Fee Source: The primary or alternate entity or publication that is supplying the Fee Basis.

Fixed Fees: Fee Amounts that are set at amounts which do not change. The Fee Amounts listed are intended for pricing purposes only and are subject to other matters described in this Agreement, such as the Payment Policies.

Flat Rate Fee: An amount published by a Fee Source and used as a Fee Basis that is other than a RVU, such as an amount for durable medical equipment or laboratory services.

Future Payment Terms: The general description of any pricing terms which will be implemented on a scheduled future effective date.

Last Routine Maintenance Update: The effective date on which this fee schedule was most recently updated. Please refer to the Routine Maintenance section of this document for more information about Routine Maintenance updates.

Linked Fee Schedule ID: United's proprietary naming/numbering convention that is used to identify the specific fee schedule for each specific contractual agreement. This is the fee schedule for services performed in facility Places of Service.

Modifier: A Modifier provides the means to report or indicate that a service or procedure has been altered by some specific circumstance but not changed in its definition or code.

Place of Service: The facility or nonfacility setting in which the service is performed. This may also be referred to by CMS as Payment Type.

Pricing Level: The contracted percentage or amount that will be multiplied times the primary or alternate Fee Basis amount in order to derive the Fee Amount.

Primary Fee Source (Carrier Locality): The main Fee Source used to supply the Fee Basis amount for deriving the Fee Amount within each Type of Service category. For instance, if the Fee Amounts for a given category of codes are derived by applying a particular Pricing Level to the CMS Resource-Based Relative Value Scale (RBRVS), then CMS RBRVS is the Primary Fee Source. The Carrier Locality is designated to indicate the exact CMS geographic region upon which the Fee Amounts are based.

Professional/Technical Modifier Pricing: Fee Source-Based: Fee Amounts for Modifiers (for example, -TC or -26 Modifiers) are derived using the Fee Basis amount as published by the primary or alternate Fee Source.

RVU: Relative Value Unit as published by CMS. United uses the RVU that is used by CMS. For example, if CMS uses a transitional RVU, then United will as well.

Replacement Code: One or more new CPT or HCPCS codes that are the exact same services or descriptions and will replace one or more Expired Codes within the same Type of Service category.

Report Date: The actual date that this document was produced.

Representative Fee Schedule Sample: A representative listing of the most commonly used CPT/HCPCS codes and fees, along with other relevant pricing information, for each specific Fee Schedule ID. The Fee Amounts listed are intended for pricing purposes only and are subject to other matters described in this Agreement, such as the Payment Policies.

Schedule Type: FFS: This is a fee-for-service fee schedule. Unless stated otherwise, the Fee Amount indicated will be used to calculate payment to you as further described within this document.

Site of Service Price Differential: Site of Service applies. CMS Assignment (ASC POS 24 =F): This fee schedule follows CMS guidelines for determining when services are priced at the facility or nonfacility fee schedule (with the exception of services performed at Ambulatory Surgery Centers,

POS 24, which will be priced at the facility fee schedule). CMS guidelines can be located at: www.cms.hhs.gov .

In the event that any of United's claims systems cannot administer the calculation of Site of Service Differential pricing as indicated above, a different calculation method will be used until such time as the appropriate system enhancements can be programmed and implemented. That different calculation method will result in a Fee Amount that is no less than the Fee Amount that would apply under the method described above.

Type of Service: A general categorization of related CPT/HCPCS codes. Type of Service categories are intended to closely align with the CPT groupings in the Current Procedural Terminology code book (as published by the AMA) and the HCPCS groupings (as published by CMS). The Office Lab Type of Service category represents those lab tests, as determined by United, in which the lab test result is necessary to make an informed treatment decision while the patient is in the office. A partial or complete crosswalk mapping of CPT/HCPCS to Type of Service categories is available to you upon request.

United: UnitedHealthcare Insurance Company or one of its affiliates which is a party to the Agreement.

Section 2. Alternate Fee Sources

In the event the Primary Fee Source contains no published Fee Basis amount alternate (or 'gap fill') Fee Sources may be used to supply the Fee Basis amount for deriving the Fee Amount. For example, if a new CPT/HCPCS code has been created within the Type of Service category of codes described above, and CMS has not yet established an RBRVS value for the code, we use Fee Sources that exist within the industry to fill that gap. For that CPT/HCPCS code, we adopt the RBRVS value established by the gap-fill Fee Source, and determine the Fee Amount for that CPT/HCPCS code by applying to the gap-fill RBRVS the same Conversion Factor and Pricing Level that we apply to the CMS RBRVS for those CPT/HCPCS code that have CMS RBRVS values. At such time in the future as CMS publishes its own RBRVS value for that CPT/HCPCS code, we would begin using the Primary Fee Source, CMS, to derive the Fee Amount for that code and no longer use the alternate Fee Source. Information about our Alternate and Primary Fee Sources can be located at www.unitedhealthcareonline.com >> Claims & Payments >> Fee Schedule Lookup >> Related Links.

Section 3. Routine Updates

Routine updates occur when United mechanically incorporates revised information created by the Fee Source, and as described below, to update the Fee Amounts calculated in accordance with this Fee Information Document. United routinely updates its fee schedule: (1) to stay current with applicable coding practices; (2) in response to price changes for immunizations and injectable medications; and (3) to remain in compliance with HIPAA requirements. United will not generally attempt to communicate routine updates of this nature.

The types of routine updates, and their respective effective dates, are described below.

a. Annual Changes to Relative Value Units, Conversion Factors, or Flat Rate Fees

This fee schedule follows a "stated year" construction methodology. The 2012 RVU, the 2012 Conversion Factor, and the 2012 Flat Rate Fee will be locked in as the basis for deriving Fee Amounts.

Generally, any RVU, Conversion Factor, or Flat Rate Fee changes published in subsequent years by the Primary Fee Sources will not be reflected in this fee schedule except, for example, to add Fee Amounts for new codes or to replace alternate Fee Basis amounts. United will use reasonable commercial efforts to implement the updates in its systems on or before the later of (i) 90 days after the effective date of any modification made by the Fee Source or (ii) 90 days after the date on which the Fee Source initially places information regarding such modification in the public domain (for example, when CMS distributes program memoranda to providers). United will make the updates effective in its system on the effective date of the change by the Fee Source. However, claims already processed prior to the change being implemented by United will not be reprocessed unless otherwise required by law.

In the event that a code contains a status code of "C" (indicating the code is carrier priced), United will establish Fee Amounts using the following methodology:

1) If CMS' multiple procedure indicator is other than "4" and United's multiple imaging reductions do not apply, United will establish Fee Amounts for those codes and modifiers using the CMS OPPSCap Rate, if available.
2) In all other cases (including if a CMS OPPSCap Rate is not available), United will use reasonable commercial efforts to establish Fee Amounts for all modifiers associated with the code based on fee information available and published by (in order of preference) CMS, the local fiscal intermediary or fiscal intermediaries from other locations.

Payment Appendix
All Payer Fee Information Document
Additional Information About This Fee Schedule

Fee Schedule ID: DAL 97284 - NonFacility

Linked Fee Schedule ID: DAL 97285 - Facility

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b. Quarterly Updates in Response to Changes Published by Primary and Alternate Fee Sources
United updates its fee schedule in response to changes published by Primary Fee Sources as a result of additions, deletions, and changes to CPT codes by the AMA or HCPCS codes by CMS and any subsequent changes to CMS' annual update. United updates its fee schedules for new CPT/HCPCS codes using the applicable Conversion Factor and Pricing Level of the original construction methodology along with the then-current RVU of the published CPT/HCPCS code. The effective date of the updates described in this subsection b. will be no later than the first day of the next calendar quarter after final publication by the Fee Source, except that if that quarter begins less than 60 days after final publication, the effective date will be no later than the first day of the calendar quarter following the next calendar quarter. For example, if final publication by the Fee Source is on April 10, the fee update under this subsection b. will be effective no later than July 1, and if final publication by the Fee Source is on June 10, the fee update under this subsection b. will be effective no later than October 1.

In the event that a code contains a status code of "C" (indicating the code is carrier priced), United will establish Fee Amounts using the following methodology:

1) If CMS' multiple procedure indicator is other than "4" and United's multiple imaging reductions do not apply, United will establish Fee Amounts for those codes and modifiers using the CMS OPPSCap Rate, if available.
2) In all other cases (including if a CMS OPPSCap Rate is not available), United will use reasonable commercial efforts to establish Fee Amounts for all modifiers associated with the code based on fee information available and published by (in order of preference) CMS, the local fiscal intermediary or fiscal intermediaries from other locations.

However, in the event that the code source has expired a CPT/HCPCS code and replaced it with a Replacement Code, United will crosswalk the fee from the Expired Code to its Replacement Code as further described below:

Based on information published by the code source (AMA Current Procedural Terminology and The HCPCS Level II), when one Expired Code is replaced by one Replacement Code, United will apply the Expired Code's Fee Amount to the Replacement Code; provided, however, if the Expired Code's Fee Amount was determined by an alternate Fee Source and a Primary Fee Source becomes available, the Replacement Code's Fee Amount will be determined using the Primary Fee Source.

Based on information published by the code source (AMA Current Procedural Terminology and The HCPCS Level II) and United's claims data, when several Expired Codes that are always done in conjunction with each other are replaced by one Replacement Code, United will apply the sum of these Expired Code's Fee Amounts to the Replacement Code; provided, however, if the Expired Code's Fee Amount was determined by an alternate Fee Source and a Primary Fee Source becomes available, the Replacement Code's Fee Amount will be determined using the Primary Fee Source.

The following types of codes are not included in our direct crosswalk methodology as described above:

- ☐ Temporary HCPCS codes, such as G, K, Q, and S codes
- ☐ Temporary CPT codes, such as Category III codes
- ☐ Informational codes, such as CPT Category II codes
- ☐ HCPC-C Codes, which are only used by hospitals
- ☐ Codes categorized as immunizations and injectables

If any types of codes not currently listed in the exclusions above are developed in the future, United reserves the right to make a crosswalk determination at that time.

c. Price Changes for Immunizations and Injectables
United routinely updates the Fee Amounts in response to price changes for immunizations and injectables published by the Fee Sources. In addition, United's Executive Drug Pricing Forum (EDPF) meets on a quarterly basis to review and evaluate the drug prices that will be used in each quarterly update. The EDPF may address topics including pricing for emerging drugs, anticipated manufacturer price changes, and special circumstances (for example, H1N1 vaccine). Based on supporting information provided by the drug manufacturer or the Fee Source, United's EDPF may elect to establish a Fee Amount or override a Fee Amount, as published by the Fee Source, in favor of a Fee Amount that is more appropriate and reasonable for a particular vaccine or drug. These Fee Amount updates will be effective as described below.

Payment Appendix
All Payer Fee Information Document
Additional Information About This Fee Schedule

Fee Schedule ID: DAL 97284 - NonFacility

Linked Fee Schedule ID: DAL 97285 - Facility

For Injectable Oncology/Therapeutic Chemotherapy Drugs, United applies the UHC Chemotherapy Fee Schedule, which uses a third party vendor as the Primary Fee Source to determine the acquisition cost information provided. The Fee Amount will be the Fee Basis multiplied by the Pricing Level on the Specifications document under the Type of Service – Injectables-Oncology/Therapeutic Chemo Drugs. The Fee Basis amounts are determined as follows:

- For J codes for which there is no generic available, the Fee Basis will be xxx% of Average Sales Price.
- For J codes containing brand and generic drug(s) or generic drug(s) only, the Fee Basis will be calculated using the formula: xx% of the Average Wholesale Price (AWP) for the brand drug plus the lower of: i) the acquisition cost for the brand drug(s) or ii) the average acquisition cost of the generic drug(s). In no event will the Fee Basis for J codes containing brand and generic drug(s) or generic drug(s) only be less than xx% of Average Sales Price.

More information about the UHC Chemotherapy Fee Schedule can be located at: www.unitedhealthcareonline.com >> Claims & Payments > Fee Schedule Lookup > Related Links "Acquisition Cost List"

For Immunizations, United applies the UHC Immunization Fee Schedule. The Centers for Disease Control and Prevention Private Sector Selling Price (CDC PSSP) is the Primary Fee Source used to obtain the Fee Basis amounts. In the event that more than one Fee Basis amount is published by the CDC PSSP for a specific CPT/HCPCS code, an average of the published amounts will be used.

More information about the UHC Immunization Fee Schedule can be located at: www.unitedhealthcareonline.com >> Claims & Payments > Fee Schedule Lookup > Related Links "UHC Immunization Fee Schedule"

The effective date of updates under this subsection c. will be no later than the first day of the next calendar quarter after final publication by the Fee Source, except that if that quarter begins less than 60 days after final publication, the effective date will be no later than the first day of the calendar quarter following the next calendar quarter. For example, if final publication by the Fee Source is on April 10, the fee update under this subsection c. will be effective no later than July 1, and if final publication by the Fee Source is on June 10, the fee update under this subsection c. will be effective no later than October 1.

d. Other Updates

United reserves the right, but not the obligation, to perform other updates as may be necessary to remain consistent with a Primary Fee Source. United also will perform other updates as may be required by applicable law from time to time. United will use reasonable commercial efforts to implement the updates in its systems on or before the later of (i) 90 days after the effective date of any modification made by the Fee Source or (ii) 90 days after the date on which the Fee Source initially places information regarding such modification in the public domain (for example, when CMS distributes program memoranda to providers). United will make the updates effective in its system on the effective date of the change by the Fee Source. However, claims already processed prior to the change being implemented by United will not be reprocessed unless otherwise required by law.

Section 4. Miscellaneous

Claims must be submitted using a CMS 1500, its successor form or its electronic equivalent. All claims submitted under this Appendix must use CPT Codes, HCPCS Codes, ICD-9 codes or its successor and other codes in compliance with HIPAA standard data set requirements. Claims submitted without HIPAA standard data set requirements may be denied.

Fee Amounts listed in the fee schedule are all-inclusive, including without limitation any applicable taxes. Unless specifically indicated otherwise, Fee Amounts represent global fees and may be subject to reductions based on appropriate Modifier (for example, professional and technical modifiers.) As used in the previous sentence, “global fees” refers to services billed without a Modifier, for which the Fee Amount includes both the professional component and the technical component. Any co-payment, deductible or coinsurance that the customer is responsible to pay under the customer’s benefit contract will be subtracted from the listed Fee Amount in determining the amount to be paid by the payer. The actual payment amount is also subject to matters described in this agreement, such as the Payment Policies.

No payments will be made for any CMS additional compensation programs under this Payment Appendix, including without limitation value based modifiers, incentive programs or other bonus payment programs.

Section 5. Services Covered or Provided by Another Program

If an applicable state, federal or other program is available to provide items or payment directly to provider for specific covered services for customers

subject to this Appendix that would otherwise be payable under this Appendix, the applicable program will apply and not this Appendix. (For example, the Vaccines For Children program currently provides vaccines free of charge, and therefore no amount will be payable under this Appendix for vaccines within the Vaccines For Children program.)

For More Information United is committed to providing transparency related to our fee schedules. If you have questions about this fee schedule, please contact Network Management at the address and phone number on your contract or participation agreement. Alternatively, you may use our fee schedule look-up function on the web at: www.unitedhealthcareonline.com or contact our Voice Enabled Telephonic Self Service line at (877) 842-3210.

Payment Appendix

Medicare Advantage Fee Information Document

Representative Fee Schedule Sample : as of 07/01/2015

Report Date: 07/13/2015

Fee Schedule ID: DAL 7593 - NonFacility

Linked Fee Schedule ID: DAL 7594 - Facility

Type Of Service Description	Primary Fee Source	Pricing Level
EVALUATION & MANAGEMENT	Current Year CMS RBRVS Carrier Locality (0441228)	100.000%
EVALUATION & MANAGEMENT - NEONATAL	Current Year CMS RBRVS Carrier Locality (0441228)	100.000%
EVALUATION & MANAGEMENT - PREVENTIVE	Current Year CMS RBRVS Carrier Locality (0441228)	100.000%
EVALUATION & MANAGEMENT - NURSING FACILITY SVCS	Current Year CMS RBRVS Carrier Locality (0441228)	100.000%
SURGERY - INTEGUMENTARY	Current Year CMS RBRVS Carrier Locality (0441228)	100.000%
SURGERY - MUSCULOSKELETAL	Current Year CMS RBRVS Carrier Locality (0441228)	100.000%
SURGERY - RESPIRATORY	Current Year CMS RBRVS Carrier Locality (0441228)	100.000%
SURGERY - CARDIOVASCULAR	Current Year CMS RBRVS Carrier Locality (0441228)	100.000%
SURGERY - HEMIC & LYMPHATIC	Current Year CMS RBRVS Carrier Locality (0441228)	100.000%
SURGERY - MEDIASTINUM & DIAPHRAGM	Current Year CMS RBRVS Carrier Locality (0441228)	100.000%
SURGERY - DIGESTIVE	Current Year CMS RBRVS Carrier Locality (0441228)	100.000%
SURGERY - URINARY	Current Year CMS RBRVS Carrier Locality (0441228)	100.000%
SURGERY - MALE GENITAL	Current Year CMS RBRVS Carrier Locality (0441228)	100.000%
SURGERY - FEMALE GENITAL	Current Year CMS RBRVS Carrier Locality (0441228)	100.000%
SURGERY - MATERNITY & DELIVERY	Current Year CMS RBRVS Carrier Locality (0441228)	100.000%
SURGERY - ENDOCRINE	Current Year CMS RBRVS Carrier Locality (0441228)	100.000%
SURGERY - NERVOUS	Current Year CMS RBRVS Carrier Locality (0441228)	100.000%
SURGERY - EYE & OCULAR ADNEXA	Current Year CMS RBRVS Carrier Locality (0441228)	100.000%
SURGERY - AUDITORY	Current Year CMS RBRVS Carrier Locality (0441228)	100.000%
RADIOLOGY	Current Year CMS RBRVS Carrier Locality (0441228)	70.000%
RADIOLOGY - BONE DENSITY	Current Year CMS RBRVS Carrier Locality (0441228)	70.000%
RADIOLOGY - CT	Current Year CMS RBRVS Carrier Locality (0441228)	70.000%
RADIOLOGY - MAMMOGRAPHY	Current Year CMS RBRVS Carrier Locality (0441228)	70.000%
RADIOLOGY - MRI	Current Year CMS RBRVS Carrier Locality (0441228)	70.000%
RADIOLOGY - MRA	Current Year CMS RBRVS Carrier Locality (0441228)	70.000%
RADIOLOGY - NUCLEAR MEDICINE	Current Year CMS RBRVS Carrier Locality (0441228)	70.000%
RADIOLOGY - PET SCANS	Current Year CMS RBRVS Carrier Locality (0441228)	70.000%
RADIATION THERAPY	Current Year CMS RBRVS Carrier Locality (0441228)	70.000%
RADIOLOGY - ULTRASOUND	Current Year CMS RBRVS Carrier Locality (0441228)	70.000%
LAB - PATHOLOGY	Current Year CMS RBRVS Carrier Locality (0441228)	60.000%
OFFICE LAB	Current Year CMS Clinical Lab Schedule TX	60.000%
CLINICAL LABORATORY	Current Year CMS Clinical Lab Schedule TX	42.000%
MEDICINE - OPHTHALMOLOGY	Current Year CMS RBRVS Carrier Locality (0441228)	100.000%
MEDICINE - CARDIOVASCULAR	Current Year CMS RBRVS Carrier Locality (0441228)	100.000%
MEDICINE - ALLERGY & CLINICAL IMMUNOLOGY	Current Year CMS RBRVS Carrier Locality (0441228)	100.000%
MEDICINE - CHIROPRACTIC MANIPULATIVE TREATMENT	Current Year CMS RBRVS Carrier Locality (0441228)	100.000%
MEDICINE - PHYSICAL MED AND REHAB - MODALITIES	Current Year CMS RBRVS Carrier Locality (0441228)	100.000%
MEDICINE - PHYSICAL MED AND REHAB -THERAPIES&OTHER	Current Year CMS RBRVS Carrier Locality (0441228)	100.000%
MEDICINE - ENTERAL FORMULA	Current Year CMS RBRVS Carrier Locality (0441228)	100.000%
MEDICINE - OTHER	Current Year CMS RBRVS Carrier Locality (0441228)	100.000%
MEDICINE - IMMUNIZATION ADMINISTRATION	Current Year CMS RBRVS Carrier Locality (0441228)	100.000%
MEDICINE - CHEMO ADMIN	Current Year CMS RBRVS Carrier Locality (0441228)	100.000%
OBSTETRICS - GLOBAL	Current Year CMS RBRVS Carrier Locality (0441228)	100.000%
IMMUNIZATIONS	CMS Drug Pricing	100.000%
INJECTABLES/OTHER DRUGS	CMS Drug Pricing	100.000%
INJECTABLES – ONCOLOGY/THERAPEUTIC CHEMO DRUGS	CMS Drug Pricing	100.000%
INJECTABLES - IVIG	CMS Drug Pricing	100.000%
INJECTABLES-SALINE & DEXTROSE SOLUTIONS	CMS Drug Pricing	100.000%
DME & SUPPLIES	Current Year CMS DME TX	65.000%
DME & SUPPLIES - RESPIRATORY	Current Year CMS DME TX	65.000%
DME & SUPPLIES - ORTHOTICS	Current Year CMS DME TX	65.000%
DME & SUPPLIES - PROSTHETICS	Current Year CMS DME TX	65.000%
DME & SUPPLIES - OSTOMY	Current Year CMS DME TX	65.000%
AMBULANCE	Current Year CMS Ambulance Schedule - Urban (0441228)	100.000%

Default Percent of Eligible Charges: 35.00 %
Professional/Technical Modifier Pricing: Fee Source-Based
Site of Service Price Differential: Site of Service applies. CMS Assignment (ASC POS 24 = F)
Anesthesia Conversion Factor (Based on a 15 minute Anesthesia Time Unit Value): $ 16.23
Calculation of Anesthesia Partial Units: Proration
Schedule Type: FFS

Last Routine Maintenance Update: 07-01-2015

Fixed Fees: 84030 - $ 33.00 87804 - $ 14.00 S3620 - $ 38.00 V5242 - $ 2500.00 V5243 - $ 2500.00 V5244 - $ 2500.00 V5245 - $ 2500.00 V5246 - $ 2500.00 V5247 - $ 2500.00 V5248 - $ 5000.00 V5249 - $ 5000.00 V5250 - $ 5000.00 V5251 - $ 5000.00 V5252 - $ 5000.00 V5253 - $ 5000.00 V5254 - $ 2500.00 V5255 - $ 2500.00 V5256 - $ 2500.00 V5257 - $ 2500.00 V5258 - $ 5000.00 V5259 - $ 5000.00 V5260 - $ 5000.00 V5261 - $ 5000.00 V5262 - $ 2500.00

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Payment Appendix

Medicare Advantage Fee Information Document

Representative Fee Schedule Sample : as of 07/01/2015

Report Date: 07/13/2015

Fee Schedule ID: DAL 7593 - NonFacility

Linked Fee Schedule ID: DAL 7594 - Facility

V5263 - $ 5000.00

Payment Appendix
Medicare Advantage Fee Information Document

Representative Fee Schedule Sample for Otolaryngology : as of 07/01/2015
Report Date: 07/13/2015

Fee Schedule ID: DAL 7593 - NonFacility

Linked Fee Schedule ID: DAL 7594 - Facility

CPT/HCPCS	Modifier	CPT/HCPCS Description	Type of Service Description	Place of Service	Fee Amount
14060	00	ADJT TIS TRNSFR/	SURGERY - INTEGUMENTARY	NonFacility	$ 775.68
30140	00	SBMCSL RESCJ INF	SURGERY - RESPIRATORY	NonFacility	$ 443.96
30520	00	SEPTOPLASTY/SUBM	SURGERY - RESPIRATORY	NonFacility	$ 626.83
31231	00	NASAL ENDO DX UN	SURGERY - RESPIRATORY	NonFacility	$ 211.51
31237	00	NASAL/SINUS NDSC	SURGERY - RESPIRATORY	NonFacility	$ 260.17
31238	00	NASAL/SINUS NDSC	SURGERY - RESPIRATORY	NonFacility	$ 259.63
31255	00	NASAL/SINUS ENDO	SURGERY - RESPIRATORY	NonFacility	$ 404.46
31256	00	NASL/SINUS ENDO	SURGERY - RESPIRATORY	NonFacility	$ 200.49
31267	00	NASL/SINUS ENDO;	SURGERY - RESPIRATORY	NonFacility	$ 321.45
31276	00	NASAL/SINUS NDSC	SURGERY - RESPIRATORY	NonFacility	$ 509.71
31295	00	NASAL/SINUS NDSC	SURGERY - RESPIRATORY	NonFacility	$ 2074.34
31296	00	NASAL/SINUS NDSC	SURGERY - RESPIRATORY	NonFacility	$ 2103.09
31297	00	NASAL/SINUS NDSC	SURGERY - RESPIRATORY	NonFacility	$ 2065.59
31575	00	LARYNGSCPY FLEXI	SURGERY - RESPIRATORY	NonFacility	$ 115.45
31579	00	LARYNGSCPY FLEX/	SURGERY - RESPIRATORY	NonFacility	$ 212.34
38724	00	CERVICAL LYMPHAD	SURGERY - HEMIC & LYMPHATIC	NonFacility	$ 1473.17
41530	00	SUBMUCOSAL ABLTJ	SURGERY - DIGESTIVE	NonFacility	$ 3284.91
42415	00	EXC PRTD TUM/PRT	SURGERY - DIGESTIVE	NonFacility	$ 1074.19
42820	00	TONSILLECTOMY &	SURGERY - DIGESTIVE	NonFacility	$ 295.40
42826	00	TONSILLECTOMY ON	SURGERY - DIGESTIVE	NonFacility	$ 256.16
60220	00	TOTAL THYROID LO	SURGERY - ENDOCRINE	NonFacility	$ 712.81
60240	00	THYROIDECTOMY TO	SURGERY - ENDOCRINE	NonFacility	$ 925.69
61782	00	STRTCTC CPTR ASS	SURGERY - NERVOUS	NonFacility	$ 178.59
69210	00	REMOVAL IMPACTED	SURGERY - AUDITORY	NonFacility	$ 49.47
69433	00	TYMPANOSTOMY LOC	SURGERY - AUDITORY	NonFacility	$ 204.36
69436	00	TYMPANOSTOMY GEN	SURGERY - AUDITORY	NonFacility	$ 163.04
69631	00	TYMPANOPLASTY W/	SURGERY - AUDITORY	NonFacility	$ 897.48
69801	00	LABYRINTHOTOMY;	SURGERY - AUDITORY	NonFacility	$ 197.85
70486	00	CT MAXILLOFACIAL	RADIOLOGY - CT	NonFacility	$ 97.55
70486	26	CT MAXILLOFACIAL	RADIOLOGY - CT	NonFacility	$ 30.12
70486	TC	CT MAXILLOFACIAL	RADIOLOGY - CT	NonFacility	$ 67.43
92504	00	BINOCULAR MICROS	MEDICINE - OTHER	NonFacility	$ 30.22
92511	00	NASOPHARYNGOSCOP	MEDICINE - OTHER	NonFacility	$ 136.87
92557	00	COMPRE AUDIOMETR	MEDICINE - OTHER	NonFacility	$ 37.41
92567	00	TYMPANOMETRY	MEDICINE - OTHER	NonFacility	$ 14.58
95004	00	PERCUTANEOUS TES	MEDICINE - ALLERGY & CLINICAL IMMUNOLOGY	NonFacility	$ 6.33
95024	00	INTRACUTANEOUS T	MEDICINE - ALLERGY & CLINICAL IMMUNOLOGY	NonFacility	$ 7.75
95165	00	PREPJ& ALLERGEN	MEDICINE - ALLERGY & CLINICAL IMMUNOLOGY	NonFacility	$ 12.75
99202	00	OFFICE OUTPATIEN	EVALUATION & MANAGEMENT	NonFacility	$ 74.48
99203	00	OFFICE OUTPATIEN	EVALUATION & MANAGEMENT	NonFacility	$ 107.82
99204	00	OFFICE OUTPATIEN	EVALUATION & MANAGEMENT	NonFacility	$ 164.19
99205	00	OFFICE OUTPATIEN	EVALUATION & MANAGEMENT	NonFacility	$ 206.23
99212	00	OFFICE OUTPATIEN	EVALUATION & MANAGEMENT	NonFacility	$ 43.61
99213	00	OFFICE OUTPATIEN	EVALUATION & MANAGEMENT	NonFacility	$ 72.44
99214	00	OFFICE OUTPATIEN	EVALUATION & MANAGEMENT	NonFacility	$ 107.53
99215	00	OFFICE OUTPATIEN	EVALUATION & MANAGEMENT	NonFacility	$ 144.98
99243	00	OFFICE CONSULTAT	EVALUATION & MANAGEMENT	NonFacility	$ 124.19
99244	00	OFFICE CONSULTAT	EVALUATION & MANAGEMENT	NonFacility	$ 184.04
V5257	00	HEARING AID, DIG	MEDICINE - OTHER	NonFacility	$ 2500.00
V5261	00	HEARING AID, DIG	MEDICINE - OTHER	NonFacility	$ 5000.00

Default Percent of Eligible Charges: 35.00 %
Professional/Technical Modifier Pricing: Fee Source-Based
Site of Service Price Differential: Site of Service applies. CMS Assignment (ASC POS 24 = F)
Anesthesia Conversion Factor (Based on a 15 minute Anesthesia Time Unit Value): $ 16.23
Calculation of Anesthesia Partial Units: Proration
Schedule Type: FFS
Last Routine Maintenance Update: 07-01-2015

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Payment Appendix
Medicare Advantage Fee Information Document

Representative Fee Schedule Sample for Otolaryngology : as of 07/01/2015
Report Date: 07/13/2015

Fee Schedule ID: DAL 7593 - NonFacility

Linked Fee Schedule ID: DAL 7594 - Facility

CPT/HCPCS	Modifier	CPT/HCPCS Description	Type of Service Description	Place of Service	Fee Amount
14060	00	ADJT TIS TRNSFR/	SURGERY - INTEGUMENTARY	Facility	$ 678.56
30140	00	SBMCSL RESCJ INF	SURGERY - RESPIRATORY	Facility	$ 443.96
30520	00	SEPTOPLASTY/SUBM	SURGERY - RESPIRATORY	Facility	$ 626.83
31231	00	NASAL ENDO DX UN	SURGERY - RESPIRATORY	Facility	$ 66.00
31237	00	NASAL/SINUS NDSC	SURGERY - RESPIRATORY	Facility	$ 163.05
31238	00	NASAL/SINUS NDSC	SURGERY - RESPIRATORY	Facility	$ 171.05
31255	00	NASAL/SINUS ENDO	SURGERY - RESPIRATORY	Facility	$ 404.46
31256	00	NASL/SINUS ENDO	SURGERY - RESPIRATORY	Facility	$ 200.49
31267	00	NASL/SINUS ENDO;	SURGERY - RESPIRATORY	Facility	$ 321.45
31276	00	NASAL/SINUS NDSC	SURGERY - RESPIRATORY	Facility	$ 509.71
31295	00	NASAL/SINUS NDSC	SURGERY - RESPIRATORY	Facility	$ 169.25
31296	00	NASAL/SINUS NDSC	SURGERY - RESPIRATORY	Facility	$ 201.91
31297	00	NASAL/SINUS NDSC	SURGERY - RESPIRATORY	Facility	$ 165.48
31575	00	LARYNGSCPY FLEXI	SURGERY - RESPIRATORY	Facility	$ 77.74
31579	00	LARYNGSCPY FLEX/	SURGERY - RESPIRATORY	Facility	$ 143.33
38724	00	CERVICAL LYMPHAD	SURGERY - HEMIC & LYMPHATIC	Facility	$ 1473.17
41530	00	SUBMUCOSAL ABLTJ	SURGERY - DIGESTIVE	Facility	$ 425.32
42415	00	EXC PRTD TUM/PRT	SURGERY - DIGESTIVE	Facility	$ 1074.19
42820	00	TONSILLECTOMY &	SURGERY - DIGESTIVE	Facility	$ 295.40
42826	00	TONSILLECTOMY ON	SURGERY - DIGESTIVE	Facility	$ 256.16
60220	00	TOTAL THYROID LO	SURGERY - ENDOCRINE	Facility	$ 712.81
60240	00	THYROIDECTOMY TO	SURGERY - ENDOCRINE	Facility	$ 925.69
61782	00	STRTCTC CPTR ASS	SURGERY - NERVOUS	Facility	$ 178.59
69210	00	REMOVAL IMPACTED	SURGERY - AUDITORY	Facility	$ 33.10
69433	00	TYMPANOSTOMY LOC	SURGERY - AUDITORY	Facility	$ 134.27
69436	00	TYMPANOSTOMY GEN	SURGERY - AUDITORY	Facility	$ 163.04
69631	00	TYMPANOPLASTY W/	SURGERY - AUDITORY	Facility	$ 897.48
69801	00	LABYRINTHOTOMY;	SURGERY - AUDITORY	Facility	$ 127.76
70486	00	CT MAXILLOFACIAL	RADIOLOGY - CT	Facility	$ 97.55
70486	26	CT MAXILLOFACIAL	RADIOLOGY - CT	Facility	$ 30.12
70486	TC	CT MAXILLOFACIAL	RADIOLOGY - CT	Facility	$ 67.43
92504	00	BINOCULAR MICROS	MEDICINE - OTHER	Facility	$ 9.59
92511	00	NASOPHARYNGOSCOP	MEDICINE - OTHER	Facility	$ 48.99
92557	00	COMPRE AUDIOMETR	MEDICINE - OTHER	Facility	$ 32.43
92567	00	TYMPANOMETRY	MEDICINE - OTHER	Facility	$ 11.02
95004	00	PERCUTANEOUS TES	MEDICINE - ALLERGY & CLINICAL IMMUNOLOGY	Facility	$ 6.33
95024	00	INTRACUTANEOUS T	MEDICINE - ALLERGY & CLINICAL IMMUNOLOGY	Facility	$ 0.99
95165	00	PREPJ& ALLERGEN	MEDICINE - ALLERGY & CLINICAL IMMUNOLOGY	Facility	$ 3.14
99202	00	OFFICE OUTPATIEN	EVALUATION & MANAGEMENT	Facility	$ 49.94
99203	00	OFFICE OUTPATIEN	EVALUATION & MANAGEMENT	Facility	$ 76.51
99204	00	OFFICE OUTPATIEN	EVALUATION & MANAGEMENT	Facility	$ 129.68
99205	00	OFFICE OUTPATIEN	EVALUATION & MANAGEMENT	Facility	$ 168.52
99212	00	OFFICE OUTPATIEN	EVALUATION & MANAGEMENT	Facility	$ 25.47
99213	00	OFFICE OUTPATIEN	EVALUATION & MANAGEMENT	Facility	$ 50.74
99214	00	OFFICE OUTPATIEN	EVALUATION & MANAGEMENT	Facility	$ 78.36
99215	00	OFFICE OUTPATIEN	EVALUATION & MANAGEMENT	Facility	$ 111.19
99243	00	OFFICE CONSULTAT	EVALUATION & MANAGEMENT	Facility	$ 97.51
99244	00	OFFICE CONSULTAT	EVALUATION & MANAGEMENT	Facility	$ 154.87
V5257	00	HEARING AID, DIG	MEDICINE - OTHER	Facility	$ 2500.00
V5261	00	HEARING AID, DIG	MEDICINE - OTHER	Facility	$ 5000.00

Default Percent of Eligible Charges: 35.00 %
Professional/Technical Modifier Pricing: Fee Source-Based
Site of Service Price Differential: Site of Service applies. CMS Assignment (ASC POS 24 = F)
Anesthesia Conversion Factor (Based on a 15 minute Anesthesia Time Unit Value): $ 16.23
Calculation of Anesthesia Partial Units: Proration
Schedule Type: FFS
Last Routine Maintenance Update: 07-01-2015

UnitedHealthcare

Payment Appendix

Medicare Advantage Fee Information Document
Additional Information About This Fee Schedule

Fee Schedule ID: DAL 7593 - NonFacility

Linked Fee Schedule ID: DAL 7594 - Facility

Section 1. Definition of Terms

Unless otherwise defined in this document, capitalized terms will have the meanings ascribed to them in the Agreement.

AMA: American Medical Association located at: www.ama-assn.org .

Anesthesia Conversion Factor: The dollar amount that will be used in the calculation of time-based and non-time based Anesthesia Management fees in accordance with the Anesthesia Payment Policy. Unless specifically stated otherwise, the Anesthesia Conversion Factor indicated is fixed and will not change. The Anesthesia Conversion Factor is based on an anesthesia time unit value of 15 minutes. In the event that any of United's claims systems cannot administer a 15 minute anesthesia time unit value, then the Anesthesia Conversion Factor will be calculated as follows:

[(Value of 15 minute Anesthesia Conversion Factor / 15) * anesthesia time unit value]

For example, an Anesthesia Conversion Factor of $60.00 (based on a 15-minute anesthesia time unit value) would be calculated to an Anesthesia Conversion Factor of $40.00 (based on a 10-minute anesthesia time unit value).

Example: [($60.00 / 15) * 10 = $40.00]

Anesthesia Management: The management of anesthesia services related to medical, surgical or scopic procedures, as described in the current Anesthesia Management Codes list attached to the Anesthesia Payment Policy located at www.unitedhealthcareonline.com .

Calculation of Anesthesia Partial Units:
Proration: Partial time units will be prorated and calculated to one decimal place rounded to the nearest tenth. For example, if the anesthesia time unit value is based on 15 minutes and if 17 minutes of actual time is submitted on a claim, then the 17 minutes will be divided by 15. The resulting figure of 1.1333 will be rounded to the nearest tenth and the total time units for the claim will be 1.1 time units.

In the event that any of United's claims systems cannot administer the calculation of partial units as indicated above, a different calculation method will be used until such time as the appropriate system enhancements can be programmed and implemented. That different calculation method will result in a Fee Amount that is no less than the Fee Amount that would apply under the Proration method described above.

CMS: Centers for Medicare and Medicaid Services located at: www.cms.hhs.gov .

CMS OPPSCap Rate: The Outpatient Prospective Payment System (OPPS) Cap Rate as defined in Section 5102(b) of the Deficit Reduction Act of 2005.

Conversion Factor: A multiplier, expressed in dollars per relative value unit, which converts relative values into Fee Basis amounts.

CPT/HCPCS: A set of codes that describe procedures and services, including supplies and materials, performed or provided by physicians and other health care professionals. Each procedure or service is identified with a 5 digit code. The use of CPT/HCPCS simplifies the reporting of services.

CPT/HCPCS Description: The descriptor associated with each CPT/HCPCS code.

Default Percent of Eligible Charges: In the event that a Fee Basis amount is not sourced by either a primary or alternate Fee Source, such as services submitted using unlisted, unclassified or miscellaneous codes, the codes are subject to correct coding review and will be priced at the contracted percentage indicated within this document.

Expired Code: An existing CPT or HCPCS code that will be expired by the entity that published the code (for example, CMS or the AMA).

Fee Amount: The contract rate for each CPT/HCPCS. The calculation of the Fee Amount is impacted by a variety of factors explained within this document including, but not limited to, Professional/Technical Modifier Pricing, Carrier Locality, CMS year, Place of Service and Pricing Level. The Fee Amount is calculated by multiplying the Fee Basis times the Pricing Level for each specific Type of Service.

Fee Basis: The amount published by the Fee Source upon which the Pricing Level will be applied to derive the Fee Amount.

Fee Schedule ID: United's proprietary naming/numbering convention that is used to identify the specific fee schedule which supports the terms of the

contractual agreement. This is the fee schedule for services performed in nonfacility Places of Service.

Fee Schedule Specifications: Documentation of the underlying calculation methodology and criteria used to derive the Fee Amounts contained within the fee schedule.

Fee Source: The primary or alternate entity or publication that is supplying the Fee Basis.

Fixed Fees: Fee Amounts that are set at amounts which do not change. The Fee Amounts listed are intended for pricing purposes only and are subject to other matters described in this Agreement, such as the Payment Policies.

Flat Rate Fee: An amount published by a Fee Source and used as a Fee Basis that is other than a RVU, such as an amount for durable medical equipment or laboratory services.

Future Payment Terms: The general description of any pricing terms which will be implemented on a scheduled future effective date.

Last Routine Maintenance Update: The effective date on which this fee schedule was most recently updated. Please refer to the Routine Maintenance section of this document for more information about Routine Maintenance updates.

Linked Fee Schedule ID: United's proprietary naming/numbering convention that is used to identify the specific fee schedule for each specific contractual agreement. This is the fee schedule for services performed in facility Places of Service.

Modifier: A Modifier provides the means to report or indicate that a service or procedure has been altered by some specific circumstance but not changed in its definition or code.

Place of Service: The facility or nonfacility setting in which the service is performed. This may also be referred to by CMS as Payment Type.

Pricing Level: The contracted percentage or amount that will be multiplied times the primary or alternate Fee Basis amount in order to derive the Fee Amount.

Primary Fee Source (Carrier Locality): The main Fee Source used to supply the Fee Basis amount for deriving the Fee Amount within each Type of Service category. For instance, if the Fee Amounts for a given category of codes are derived by applying a particular Pricing Level to the CMS Resource-Based Relative Value Scale (RBRVS), then CMS RBRVS is the Primary Fee Source. The Carrier Locality is designated to indicate the exact CMS geographic region upon which the Fee Amounts are based.

Professional/Technical Modifier Pricing: Fee Source-Based: Fee Amounts for Modifiers (for example, -TC or -26 Modifiers) are derived using the Fee Basis amount as published by the primary or alternate Fee Source.

RVU: Relative Value Unit as published by CMS. United uses the RVU that is used by CMS. For example, if CMS uses a transitional RVU, then United will as well.

Replacement Code: One or more new CPT or HCPCS codes that are the exact same services or descriptions and will replace one or more Expired Codes within the same Type of Service category.

Report Date: The actual date that this document was produced.

Representative Fee Schedule Sample: A representative listing of the most commonly used CPT/HCPCS codes and fees, along with other relevant pricing information, for each specific Fee Schedule ID. The Fee Amounts listed are intended for pricing purposes only and are subject to other matters described in this Agreement, such as the Payment Policies.

Schedule Type: FFS: This is a fee-for-service fee schedule. Unless stated otherwise, the Fee Amount indicated will be used to calculate payment to you as further described within this document.

Site of Service Price Differential: Site of Service applies. CMS Assignment (ASC POS 24 =F): This fee schedule follows CMS guidelines for determining when services are priced at the facility or nonfacility fee schedule (with the exception of services performed at Ambulatory Surgery Centers,

POS 24, which will be priced at the facility fee schedule). CMS guidelines can be located at: www.cms.hhs.gov .

In the event that any of United's claims systems cannot administer the calculation of Site of Service Differential pricing as indicated above, a different calculation method will be used until such time as the appropriate system enhancements can be programmed and implemented. That different calculation method will result in a Fee Amount that is no less than the Fee Amount that would apply under the method described above.

Type of Service: A general categorization of related CPT/HCPCS codes. Type of Service categories are intended to closely align with the CPT groupings in the Current Procedural Terminology code book (as published by the AMA) and the HCPCS groupings (as published by CMS). The Office Lab Type of Service category represents those lab tests, as determined by United, in which the lab test result is necessary to make an informed treatment decision while the patient is in the office. A partial or complete crosswalk mapping of CPT/HCPCS to Type of Service categories is available to you upon request.

United: UnitedHealthcare Insurance Company or one of its affiliates which is a party to the Agreement.

Section 2. Alternate Fee Sources

In the event the Primary Fee Source contains no published Fee Basis amount alternate (or 'gap fill') Fee Sources may be used to supply the Fee Basis amount for deriving the Fee Amount. For example, if a new CPT/HCPCS code has been created within the Type of Service category of codes described above, and CMS has not yet established an RBRVS value for the code, we use Fee Sources that exist within the industry to fill that gap. For that CPT/HCPCS code, we adopt the RBRVS value established by the gap-fill Fee Source, and determine the Fee Amount for that CPT/HCPCS code by applying to the gap-fill RBRVS the same Conversion Factor and Pricing Level that we apply to the CMS RBRVS for those CPT/HCPCS code that have CMS RBRVS values. At such time in the future as CMS publishes its own RBRVS value for that CPT/HCPCS code, we would begin using the Primary Fee Source, CMS, to derive the Fee Amount for that code and no longer use the alternate Fee Source. Information about our Alternate and Primary Fee Sources can be located at www.unitedhealthcareonline.com >> Claims & Payments >> Fee Schedule Lookup >> Related Links.

Section 3. Routine Updates

Routine updates occur when United mechanically incorporates revised information created by the Fee Source, and as described below, to update the Fee Amounts calculated in accordance with this Fee Information Document. United routinely updates its fee schedule: (1) to stay current with applicable coding practices; (2) in response to price changes for immunizations and injectable medications; and (3) to remain in compliance with HIPAA requirements. United will not generally attempt to communicate routine updates of this nature.

The types of routine updates, and their respective effective dates, are described below.

a. Annual Changes to Relative Value Units, Conversion Factors, or Flat Rate Fees

This fee schedule follows a "current year" construction methodology and it will remain current with RVU, Conversion Factor, and Flat Rate Fee changes as the basis for deriving Fee Amounts. Therefore, the annual publication of RVUs, Conversion Factors and Flat Rate Fees by CMS will affect this fee schedule. United will use reasonable commercial efforts to implement the updates in its systems on or before the later of (i) 90 days after the effective date of any modification made by the Fee Source or (ii) 90 days after the date on which the Fee Source initially places information regarding such modification in the public domain (for example, when CMS distributes program memoranda to providers). United will make the updates effective in its system on the effective date of the change by the Fee Source. However, claims already processed prior to the change being implemented by United will not be reprocessed unless otherwise required by law. Unless specifically stated otherwise, for those anesthesia services that are contracted on a time-based methodology, the Anesthesia Conversion Factor indicated within this document is fixed and will not change. Please refer to the Anesthesia Conversion Factor section above.

In the event that a code contains a status code of "C" (indicating the code is carrier priced), United will establish Fee Amounts using the following methodology:

1) If CMS' multiple procedure indicator is other than "4" and United's multiple imaging reductions do not apply, United will establish Fee Amounts for those codes and modifiers using the CMS OPPSCap Rate, if available.
2) In all other cases (including if a CMS OPPSCap Rate is not available), United will use reasonable commercial efforts to establish Fee Amounts for all modifiers associated with the code based on fee information available and published by (in order of preference) CMS, the local fiscal intermediary or fiscal intermediaries from other locations.

b. Quarterly Updates in Response to Changes Published by Primary and Alternate Fee Sources
United updates its fee schedule in response to changes published by Primary Fee Sources as a result of additions, deletions, and changes to CPT codes by the AMA or HCPCS codes by CMS and any subsequent changes to CMS' annual update. United updates its fee schedules for new CPT/HCPCS codes using the applicable Conversion Factor and Pricing Level of the original construction methodology along with the then-current RVU of the published CPT/HCPCS code. The effective date of the updates described in this subsection b. will be no later than the first day of the next calendar quarter after final publication by the Fee Source, except that if that quarter begins less than 60 days after final publication, the effective date will be no later than the first day of the calendar quarter following the next calendar quarter. For example, if final publication by the Fee Source is on April 10, the fee update under this subsection b. will be effective no later than July 1, and if final publication by the Fee Source is on June 10, the fee update under this subsection b. will be effective no later than October 1.

In the event that a code contains a status code of "C" (indicating the code is carrier priced), United will establish Fee Amounts using the following methodology:

1) If CMS' multiple procedure indicator is other than "4" and United's multiple imaging reductions do not apply, United will establish Fee Amounts for those codes and modifiers using the CMS OPPSCap Rate, if available.
2) In all other cases (including if a CMS OPPSCap Rate is not available), United will use reasonable commercial efforts to establish Fee Amounts for all modifiers associated with the code based on fee information available and published by (in order of preference) CMS, the local fiscal intermediary or fiscal intermediaries from other locations.

c. Price Changes for Immunizations and Injectables
United routinely updates the Fee Amounts in response to price changes for immunizations and injectables published by the Fee Sources. In addition, United's Executive Drug Pricing Forum (EDPF) meets on a quarterly basis to review and evaluate the drug prices that will be used in each quarterly update. The EDPF may address topics including pricing for emerging drugs, anticipated manufacturer price changes, and special circumstances (for example, H1N1 vaccine). Based on supporting information provided by the drug manufacturer or the Fee Source, United's EDPF may elect to establish a Fee Amount or override a Fee Amount, as published by the Fee Source, in favor of a Fee Amount that is more appropriate and reasonable for a particular vaccine or drug. These Fee Amount updates will be effective as described below.

The effective date of updates under this subsection c. will be no later than the first day of the next calendar quarter after final publication by the Fee Source, except that if that quarter begins less than 60 days after final publication, the effective date will be no later than the first day of the calendar quarter following the next calendar quarter. For example, if final publication by the Fee Source is on April 10, the fee update under this subsection c. will be effective no later than July 1, and if final publication by the Fee Source is on June 10, the fee update under this subsection c. will be effective no later than October 1.

d. Other Updates
United reserves the right, but not the obligation, to perform other updates as may be necessary to remain consistent with a Primary Fee Source. United also will perform other updates as may be required by applicable law from time to time. United will use reasonable commercial efforts to implement the updates in its systems on or before the later of (i) 90 days after the effective date of any modification made by the Fee Source or (ii) 90 days after the date on which the Fee Source initially places information regarding such modification in the public domain (for example, when CMS distributes program memoranda to providers). United will make the updates effective in its system on the effective date of the change by the Fee Source. However, claims already processed prior to the change being implemented by United will not be reprocessed unless otherwise required by law.

Section 4. Miscellaneous
Claims must be submitted using a CMS 1500, its successor form or its electronic equivalent. All claims submitted under this Appendix must use CPT Codes, HCPCS Codes, ICD-9 codes or its successor and other codes in compliance with HIPAA standard data set requirements. Claims submitted without HIPAA standard data set requirements may be denied.

Fee Amounts listed in the fee schedule are all-inclusive, including without limitation any applicable taxes. Unless specifically indicated otherwise, Fee Amounts represent global fees and may be subject to reductions based on appropriate Modifier (for example, professional and technical modifiers.) As used in the previous sentence, "global fees" refers to services billed without a Modifier, for which the Fee Amount includes both the professional component and the technical component. Any co-payment, deductible or coinsurance that the customer is responsible to pay under the customer's

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benefit contract will be subtracted from the listed Fee Amount in determining the amount to be paid by the payer. The actual payment amount is also subject to matters described in this agreement, such as the Payment Policies.

No payments will be made for any CMS additional compensation programs under this Payment Appendix, including without limitation value based modifiers, incentive programs or other bonus payment programs.

Section 5. Services Covered or Provided by Another Program
If an applicable state, federal or other program is available to provide items or payment directly to provider for specific covered services for customers subject to this Appendix that would otherwise be payable under this Appendix, the applicable program will apply and not this Appendix. (For example, the Vaccines For Children program currently provides vaccines free of charge, and therefore no amount will be payable under this Appendix for vaccines within the Vaccines For Children program.)

For More Information United is committed to providing transparency related to our fee schedules. If you have questions about this fee schedule, please contact Network Management at the address and phone number on your contract or participation agreement. Alternatively, you may use our fee schedule look-up function on the web at: www.unitedhealthcareonline.com or contact our Voice Enabled Telephonic Self Service line at (877) 842-3210.

Payment Appendix
All Payer Fee Information Document
Representative Fee Schedule Sample : as of 07/01/2015
Report Date: 07/07/2015

Fee Schedule ID: REGN 93434 - NonFacility

Linked Fee Schedule ID: REGN 93435 - Facility

Type Of Service Description	Primary Fee Source	Pricing Level
EVALUATION & MANAGEMENT	2012 CMS RBRVS Carrier Locality (0000000)	100.000%
EVALUATION & MANAGEMENT - NEONATAL	2012 CMS RBRVS Carrier Locality (0000000)	100.000%
EVALUATION & MANAGEMENT - PREVENTIVE	2012 CMS RBRVS Carrier Locality (0000000)	100.000%
EVALUATION & MANAGEMENT - NURSING FACILITY SVCS	2012 CMS RBRVS Carrier Locality (0000000)	100.000%
SURGERY - INTEGUMENTARY	2012 CMS RBRVS Carrier Locality (0000000)	100.000%
SURGERY - MUSCULOSKELETAL	2012 CMS RBRVS Carrier Locality (0000000)	100.000%
SURGERY - RESPIRATORY	2012 CMS RBRVS Carrier Locality (0000000)	100.000%
SURGERY - CARDIOVASCULAR	2012 CMS RBRVS Carrier Locality (0000000)	100.000%
SURGERY - HEMIC & LYMPHATIC	2012 CMS RBRVS Carrier Locality (0000000)	100.000%
SURGERY - MEDIASTINUM & DIAPHRAGM	2012 CMS RBRVS Carrier Locality (0000000)	100.000%
SURGERY - DIGESTIVE	2012 CMS RBRVS Carrier Locality (0000000)	100.000%
SURGERY - URINARY	2012 CMS RBRVS Carrier Locality (0000000)	100.000%
SURGERY - MALE GENITAL	2012 CMS RBRVS Carrier Locality (0000000)	100.000%
SURGERY - FEMALE GENITAL	2012 CMS RBRVS Carrier Locality (0000000)	100.000%
SURGERY - MATERNITY & DELIVERY	2012 CMS RBRVS Carrier Locality (0000000)	100.000%
SURGERY - ENDOCRINE	2012 CMS RBRVS Carrier Locality (0000000)	100.000%
SURGERY - NERVOUS	2012 CMS RBRVS Carrier Locality (0000000)	100.000%
SURGERY - EYE & OCULAR ADNEXA	2012 CMS RBRVS Carrier Locality (0000000)	100.000%
SURGERY - AUDITORY	2012 CMS RBRVS Carrier Locality (0000000)	100.000%
RADIOLOGY	2012 CMS RBRVS Carrier Locality (0000000)	95.000%
RADIOLOGY - BONE DENSITY	2012 CMS RBRVS Carrier Locality (0000000)	100.000%
RADIOLOGY - CT	2012 CMS RBRVS Carrier Locality (0000000)	100.000%
RADIOLOGY - MAMMOGRAPHY	2012 CMS RBRVS Carrier Locality (0000000)	100.000%
RADIOLOGY - MRI	2012 CMS RBRVS Carrier Locality (0000000)	100.000%
RADIOLOGY - MRA	2012 CMS RBRVS Carrier Locality (0000000)	100.000%
RADIOLOGY - NUCLEAR MEDICINE	2012 CMS RBRVS Carrier Locality (0000000)	100.000%
RADIOLOGY - PET SCANS	2012 CMS RBRVS Carrier Locality (0000000)	100.000%
RADIOLOGY - RADIATION THERAPY	2012 CMS RBRVS Carrier Locality (0000000)	100.000%
RADIOLOGY - ULTRASOUND	2012 CMS RBRVS Carrier Locality (0000000)	100.000%
LAB - PATHOLOGY	2012 CMS RBRVS Carrier Locality (0000000)	60.000%
OFFICE LAB	2012 CMS Clinical Lab Schedule National Limit	60.000%
CLINICAL LABORATORY	2012 CMS Clinical Lab Schedule National Limit	42.000%
MEDICINE - OPHTHALMOLOGY	2012 CMS RBRVS Carrier Locality (0000000)	100.000%
MEDICINE - CARDIOVASCULAR	2012 CMS RBRVS Carrier Locality (0000000)	100.000%
MEDICINE - ALLERGY & CLINICAL IMMUNOLOGY	2012 CMS RBRVS Carrier Locality (0000000)	100.000%
MEDICINE - CHIROPRACTIC MANIPULATIVE TREATMENT	2012 CMS RBRVS Carrier Locality (0000000)	100.000%
MEDICINE - PHYSICAL MED AND REHAB - MODALITIES	2012 CMS RBRVS Carrier Locality (0000000)	85.000%
MEDICINE - PHYSICAL MED AND REHAB -THERAPIES&OTHER	2012 CMS RBRVS Carrier Locality (0000000)	85.000%
MEDICINE - ENTERAL FORMULA	2012 CMS RBRVS Carrier Locality (0000000)	100.000%
MEDICINE - OTHER	2012 CMS RBRVS Carrier Locality (0000000)	100.000%
MEDICINE - IMMUNIZATION ADMINISTRATION	2012 CMS RBRVS Carrier Locality (0000000)	100.000%
MEDICINE - CHEMO ADMIN	2012 CMS RBRVS Carrier Locality (0000000)	100.000%
OBSTETRICS - GLOBAL	2012 CMS RBRVS Carrier Locality (0000000)	100.000%
IMMUNIZATIONS	UHC Immunization Fee Schedule	118.000%
INJECTABLES/OTHER DRUGS	CMS Drug Pricing	100.000%
INJECTABLES – ONCOLOGY/THERAPEUTIC CHEMO DRUGS	UHC Chemotherapy Fee Schedule	100.000%
INJECTABLES - IVIG	CMS Drug Pricing	112.000%
INJECTABLES-SALINE & DEXTROSE SOLUTIONS	CMS Drug Pricing	100.000%
DME & SUPPLIES	2012 CMS DME Ceiling	60.000%
DME & SUPPLIES - RESPIRATORY	2012 CMS DME Ceiling	60.000%
DME & SUPPLIES - ORTHOTICS	2012 CMS DME Ceiling	60.000%
DME & SUPPLIES - PROSTHETICS	2012 CMS DME Ceiling	60.000%
DME & SUPPLIES - OSTOMY	2012 CMS DME Ceiling	60.000%
AMBULANCE	2012 CMS Ambulance Schedule - Urban (0000000)	100.000%

Default Percent of Eligible Charges: 40.00 %
Professional/Technical Modifier Pricing: Fee Source-Based
Site of Service Price Differential: Site of Service applies. CMS Assignment (ASC POS 24 = F)
Anesthesia Conversion Factor (Based on a 15 minute Anesthesia Time Unit Value): $ 55.00
Calculation of Anesthesia Partial Units: Proration
Schedule Type: FFS

Last Routine Maintenance Update: 07-01-2015

Fixed Fees: 36415 - $ 3.00 36416 - $ 3.00 84030 - $ 33.00 87804 - $ 14.00 S3620 - $ 38.00 V5242 - $ 2500.00 V5243 - $ 2500.00 V5244 - $ 2500.00 V5245 - $ 2500.00 V5246 - $ 2500.00 V5247 - $ 2500.00 V5248 - $ 5000.00 V5249 - $ 5000.00 V5250 - $ 5000.00 V5251 - $ 5000.00 V5252 - $ 5000.00 V5253 - $ 5000.00 V5254 - $ 2500.00 V5255 - $ 2500.00 V5256 - $ 2500.00 V5257 - $ 2500.00 V5258 - $ 5000.00 V5259 - $ 5000.00 V5260 - $ 5000.00 V5261 - $

Payment Appendix

All Payer Fee Information Document

Representative Fee Schedule Sample : as of 07/01/2015

Report Date: 07/07/2015

Fee Schedule ID: REGN 93434 - NonFacility

Linked Fee Schedule ID: REGN 93435 - Facility

5000.00 V5262 - $ 2500.00 V5263 - $ 5000.00

Payment Appendix

All Payer Fee Information Document

Representative Fee Schedule Sample : as of 07/01/2015
Report Date: 07/07/2015

Fee Schedule ID: REGN 93434 - NonFacility

Linked Fee Schedule ID: REGN 93435 - Facility

CPT/HCPCS	Modifier	CPT/HCPCS Description	Type of Service Description	Place of Service	Fee Amount
59400	00	OB CARE ANTEPART	OBSTETRICS - GLOBAL	Facility	$ 2120.54
59510	00	OB ANTEPARTUM CA	OBSTETRICS - GLOBAL	Facility	$ 2351.32
66984	00	CATARACT REMOVAL	SURGERY - EYE & OCULAR ADNEXA	Facility	$ 760.74
88305	00	LEVEL IV SURG PA	LAB - PATHOLOGY	Facility	$ 63.52
88305	26	LEVEL IV SURG PA	LAB - PATHOLOGY	Facility	$ 21.65
88305	TC	LEVEL IV SURG PA	LAB - PATHOLOGY	Facility	$ 41.87
90460	00	IM ADM THRU 18YR	MEDICINE - IMMUNIZATION ADMINISTRATION	Facility	$ 24.51
90649	00	HPV4 VACCINE 3 D	IMMUNIZATIONS	Facility	$ 173.47
90670	00	PCV13 VACCINE FO	IMMUNIZATIONS	Facility	$ 179.37
92014	00	OPHTH MEDICAL XM	MEDICINE - OPHTHALMOLOGY	Facility	$ 78.29
93306	00	ECHO TTHRC R-T 2	MEDICINE - CARDIOVASCULAR	Facility	$ 213.08
93306	26	ECHO TTHRC R-T 2	MEDICINE - CARDIOVASCULAR	Facility	$ 64.68
93306	TC	ECHO TTHRC R-T 2	MEDICINE - CARDIOVASCULAR	Facility	$ 148.40
99203	00	OFFICE OUTPATIEN	EVALUATION & MANAGEMENT	Facility	$ 74.88
99204	00	OFFICE OUTPATIEN	EVALUATION & MANAGEMENT	Facility	$ 126.96
99205	00	OFFICE OUTPATIEN	EVALUATION & MANAGEMENT	Facility	$ 162.70
99212	00	OFFICE OUTPATIEN	EVALUATION & MANAGEMENT	Facility	$ 25.19
99213	00	OFFICE OUTPATIEN	EVALUATION & MANAGEMENT	Facility	$ 49.69
99214	00	OFFICE OUTPATIEN	EVALUATION & MANAGEMENT	Facility	$ 76.24
99215	00	OFFICE OUTPATIEN	EVALUATION & MANAGEMENT	Facility	$ 107.22
99222	00	INITIAL HOSPITAL	EVALUATION & MANAGEMENT	Facility	$ 133.09
99223	00	INITIAL HOSPITAL	EVALUATION & MANAGEMENT	Facility	$ 195.38
99232	00	SBSQ HOSPITAL CA	EVALUATION & MANAGEMENT	Facility	$ 69.78
99233	00	SBSQ HOSPITAL CA	EVALUATION & MANAGEMENT	Facility	$ 100.07
99244	00	OFFICE CONSULTAT	EVALUATION & MANAGEMENT	Facility	$ 149.08
99283	00	EMERGENCY DEPART	EVALUATION & MANAGEMENT	Facility	$ 60.25
99284	00	EMERGENCY DEPART	EVALUATION & MANAGEMENT	Facility	$ 114.71
99285	00	EMERGENCY DEPT V	EVALUATION & MANAGEMENT	Facility	$ 168.15
99291	00	CRITICAL CARE IL	EVALUATION & MANAGEMENT	Facility	$ 217.16
99308	00	SBSQ NURSING FAC	EVALUATION & MANAGEMENT - NURSING FACILITY SVCS	Facility	$ 66.03
99309	00	SBSQ NURSING FAC	EVALUATION & MANAGEMENT - NURSING FACILITY SVCS	Facility	$ 86.80
99391	00	PERIODIC PREVENT	EVALUATION & MANAGEMENT - PREVENTIVE	Facility	$ 67.73
99392	00	PERIODIC PREVENT	EVALUATION & MANAGEMENT - PREVENTIVE	Facility	$ 74.20
99395	00	PERIODIC PREVENT	EVALUATION & MANAGEMENT - PREVENTIVE	Facility	$ 86.12
99396	00	PERIODIC PREVENT	EVALUATION & MANAGEMENT - PREVENTIVE	Facility	$ 93.94
99397	00	PERIODIC PREVENT	EVALUATION & MANAGEMENT - PREVENTIVE	Facility	$ 99.73
G0202	00	SCR MAMMO PRODUC	RADIOLOGY - MAMMOGRAPHY	Facility	$ 139.89
G0202	26	SCR MAMMO PRODUC	RADIOLOGY - MAMMOGRAPHY	Facility	$ 34.72
G0202	TC	SCR MAMMO PRODUC	RADIOLOGY - MAMMOGRAPHY	Facility	$ 105.17
J0178	00	INJECTION AFLIBE	INJECTABLES/OTHER DRUGS	Facility	$ 980.50
J1745	00	INJECTION INFLIX	INJECTABLES-ONCOLOGY/THERAPEUTIC CHEMO DRUGS	Facility	$ 85.17
J2323	00	INJECTION NATAL	INJECTABLES/OTHER DRUGS	Facility	$ 15.82
J2505	00	INJECTION PEGFIL	INJECTABLES-ONCOLOGY/THERAPEUTIC CHEMO DRUGS	Facility	$ 3896.89
J2778	00	INJECTION RANIBI	INJECTABLES/OTHER DRUGS	Facility	$ 395.54
J7302	00	LEVONORGESTREL I	INJECTABLES/OTHER DRUGS	Facility	$ 810.51
J9035	00	INJECTION BEVACI	INJECTABLES-ONCOLOGY/THERAPEUTIC CHEMO DRUGS	Facility	$ 76.23
J9263	00	INJECTION OXALIP	INJECTABLES-ONCOLOGY/THERAPEUTIC CHEMO DRUGS	Facility	$ 3.02
J9305	00	INJECTION PEMETR	INJECTABLES-ONCOLOGY/THERAPEUTIC CHEMO DRUGS	Facility	$ 67.73
J9310	00	INJECTION, RITUX	INJECTABLES-ONCOLOGY/THERAPEUTIC CHEMO DRUGS	Facility	$ 814.85
J9355	00	INJECTION, TRAST	INJECTABLES-ONCOLOGY/THERAPEUTIC CHEMO DRUGS	Facility	$ 94.87

Default Percent of Eligible Charges: 40.00 %
Professional/Technical Modifier Pricing: Fee Source-Based
Site of Service Price Differential: Site of Service applies. CMS Assignment (ASC POS 24 = F)
Anesthesia Conversion Factor (Based on a 15 minute Anesthesia Time Unit Value): $ 55.00
Calculation of Anesthesia Partial Units: Proration
Schedule Type: FFS
Last Routine Maintenance Update: 07-01-2015

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UnitedHealthcare

Payment Appendix
All Payer Fee Information Document

Representative Fee Schedule Sample : as of 07/01/2015
Report Date: 07/07/2015

Fee Schedule ID: REGN 93434 - NonFacility

Linked Fee Schedule ID: REGN 93435 - Facility

CPT/HCPCS	Modifier	CPT/HCPCS Description	Type of Service Description	Place of Service	Fee Amount
59400	00	OB CARE ANTEPART	OBSTETRICS - GLOBAL	NonFacility	$ 2120.54
59510	00	OB ANTEPARTUM CA	OBSTETRICS - GLOBAL	NonFacility	$ 2351.32
66984	00	CATARACT REMOVAL	SURGERY - EYE & OCULAR ADNEXA	NonFacility	$ 760.74
88305	00	LEVEL IV SURG PA	LAB - PATHOLOGY	NonFacility	$ 63.52
88305	26	LEVEL IV SURG PA	LAB - PATHOLOGY	NonFacility	$ 21.65
88305	TC	LEVEL IV SURG PA	LAB - PATHOLOGY	NonFacility	$ 41.87
90460	00	IM ADM THRU 18YR	MEDICINE - IMMUNIZATION ADMINISTRATION	NonFacility	$ 24.51
90649	00	HPV4 VACCINE 3 D	IMMUNIZATIONS	NonFacility	$ 173.47
90670	00	PCV13 VACCINE FO	IMMUNIZATIONS	NonFacility	$ 179.37
92014	00	OPHTH MEDICAL XM	MEDICINE - OPHTHALMOLOGY	NonFacility	$ 119.81
93306	00	ECHO TTHRC R-T 2	MEDICINE - CARDIOVASCULAR	NonFacility	$ 213.08
93306	26	ECHO TTHRC R-T 2	MEDICINE - CARDIOVASCULAR	NonFacility	$ 64.68
93306	TC	ECHO TTHRC R-T 2	MEDICINE - CARDIOVASCULAR	NonFacility	$ 148.40
99203	00	OFFICE OUTPATIEN	EVALUATION & MANAGEMENT	NonFacility	$ 105.18
99204	00	OFFICE OUTPATIEN	EVALUATION & MANAGEMENT	NonFacility	$ 160.66
99205	00	OFFICE OUTPATIEN	EVALUATION & MANAGEMENT	NonFacility	$ 199.46
99212	00	OFFICE OUTPATIEN	EVALUATION & MANAGEMENT	NonFacility	$ 42.55
99213	00	OFFICE OUTPATIEN	EVALUATION & MANAGEMENT	NonFacility	$ 70.46
99214	00	OFFICE OUTPATIEN	EVALUATION & MANAGEMENT	NonFacility	$ 104.16
99215	00	OFFICE OUTPATIEN	EVALUATION & MANAGEMENT	NonFacility	$ 139.89
99222	00	INITIAL HOSPITAL	EVALUATION & MANAGEMENT	NonFacility	$ 133.09
99223	00	INITIAL HOSPITAL	EVALUATION & MANAGEMENT	NonFacility	$ 195.38
99232	00	SBSQ HOSPITAL CA	EVALUATION & MANAGEMENT	NonFacility	$ 69.78
99233	00	SBSQ HOSPITAL CA	EVALUATION & MANAGEMENT	NonFacility	$ 100.07
99244	00	OFFICE CONSULTAT	EVALUATION & MANAGEMENT	NonFacility	$ 177.00
99283	00	EMERGENCY DEPART	EVALUATION & MANAGEMENT	NonFacility	$ 60.25
99284	00	EMERGENCY DEPART	EVALUATION & MANAGEMENT	NonFacility	$ 114.71
99285	00	EMERGENCY DEPT V	EVALUATION & MANAGEMENT	NonFacility	$ 168.15
99291	00	CRITICAL CARE IL	EVALUATION & MANAGEMENT	NonFacility	$ 267.20
99308	00	SBSQ NURSING FAC	EVALUATION & MANAGEMENT - NURSING FACILITY SVCS	NonFacility	$ 66.03
99309	00	SBSQ NURSING FAC	EVALUATION & MANAGEMENT - NURSING FACILITY SVCS	NonFacility	$ 86.80
99391	00	PERIODIC PREVENT	EVALUATION & MANAGEMENT - PREVENTIVE	NonFacility	$ 95.99
99392	00	PERIODIC PREVENT	EVALUATION & MANAGEMENT - PREVENTIVE	NonFacility	$ 102.79
99395	00	PERIODIC PREVENT	EVALUATION & MANAGEMENT - PREVENTIVE	NonFacility	$ 114.37
99396	00	PERIODIC PREVENT	EVALUATION & MANAGEMENT - PREVENTIVE	NonFacility	$ 122.19
99397	00	PERIODIC PREVENT	EVALUATION & MANAGEMENT - PREVENTIVE	NonFacility	$ 132.07
G0202	00	SCR MAMMO PRODUC	RADIOLOGY - MAMMOGRAPHY	NonFacility	$ 139.89
G0202	26	SCR MAMMO PRODUC	RADIOLOGY - MAMMOGRAPHY	NonFacility	$ 34.72
G0202	TC	SCR MAMMO PRODUC	RADIOLOGY - MAMMOGRAPHY	NonFacility	$ 105.17
J0178	00	INJECTION AFLIBE	INJECTABLES/OTHER DRUGS	NonFacility	$ 980.50
J1745	00	INJECTION INFLIX	INJECTABLES-ONCOLOGY/THERAPEUTIC CHEMO DRUGS	NonFacility	$ 85.17
J2323	00	INJECTION NATAL	INJECTABLES/OTHER DRUGS	NonFacility	$ 15.82
J2505	00	INJECTION PEGFIL	INJECTABLES-ONCOLOGY/THERAPEUTIC CHEMO DRUGS	NonFacility	$ 3896.89
J2778	00	INJECTION RANIBI	INJECTABLES/OTHER DRUGS	NonFacility	$ 395.54
J7302	00	LEVONORGESTREL I	INJECTABLES/OTHER DRUGS	NonFacility	$ 810.51
J9035	00	INJECTION BEVACI	INJECTABLES-ONCOLOGY/THERAPEUTIC CHEMO DRUGS	NonFacility	$ 76.23
J9263	00	INJECTION OXALIP	INJECTABLES-ONCOLOGY/THERAPEUTIC CHEMO DRUGS	NonFacility	$ 3.02
J9305	00	INJECTION PEMETR	INJECTABLES-ONCOLOGY/THERAPEUTIC CHEMO DRUGS	NonFacility	$ 67.73
J9310	00	INJECTION, RITUX	INJECTABLES-ONCOLOGY/THERAPEUTIC CHEMO DRUGS	NonFacility	$ 814.85
J9355	00	INJECTION, TRAST	INJECTABLES-ONCOLOGY/THERAPEUTIC CHEMO DRUGS	NonFacility	$ 94.87

Default Percent of Eligible Charges: 40.00 %
Professional/Technical Modifier Pricing: Fee Source-Based
Site of Service Price Differential: Site of Service applies. CMS Assignment (ASC POS 24 = F)
Anesthesia Conversion Factor (Based on a 15 minute Anesthesia Time Unit Value): $ 55.00
Calculation of Anesthesia Partial Units: Proration
Schedule Type: FFS
Last Routine Maintenance Update: 07-01-2015

UnitedHealthcare

Payment Appendix
All Payer Fee Information Document
Additional Information About This Fee Schedule

Fee Schedule ID: REGN 93434 - NonFacility

Linked Fee Schedule ID: REGN 93435 - Facility

Section 1. Definition of Terms

Unless otherwise defined in this document, capitalized terms will have the meanings ascribed to them in the Agreement.

AMA: American Medical Association located at: www.ama-assn.org .

Anesthesia Conversion Factor: The dollar amount that will be used in the calculation of time-based and non-time based Anesthesia Management fees in accordance with the Anesthesia Payment Policy. Unless specifically stated otherwise, the Anesthesia Conversion Factor indicated is fixed and will not change. The Anesthesia Conversion Factor is based on an anesthesia time unit value of 15 minutes. In the event that any of United's claims systems cannot administer a 15 minute anesthesia time unit value, then the Anesthesia Conversion Factor will be calculated as follows:

[(Value of 15 minute Anesthesia Conversion Factor / 15) * anesthesia time unit value]

For example, an Anesthesia Conversion Factor of $60.00 (based on a 15-minute anesthesia time unit value) would be calculated to an Anesthesia Conversion Factor of $40.00 (based on a 10-minute anesthesia time unit value).

Example: [($60.00 / 15) * 10 = $40.00]

Anesthesia Management: The management of anesthesia services related to medical, surgical or scopic procedures, as described in the current Anesthesia Management Codes list attached to the Anesthesia Payment Policy located at www.unitedhealthcareonline.com .

Calculation of Anesthesia Partial Units:
Proration: Partial time units will be prorated and calculated to one decimal place rounded to the nearest tenth. For example, if the anesthesia time unit value is based on 15 minutes and if 17 minutes of actual time is submitted on a claim, then the 17 minutes will be divided by 15. The resulting figure of 1.1333 will be rounded to the nearest tenth and the total time units for the claim will be 1.1 time units.

In the event that any of United's claims systems cannot administer the calculation of partial units as indicated above, a different calculation method will be used until such time as the appropriate system enhancements can be programmed and implemented. That different calculation method will result in a Fee Amount that is no less than the Fee Amount that would apply under the Proration method described above.

CMS: Centers for Medicare and Medicaid Services located at: www.cms.hhs.gov .

CMS OPPSCap Rate: The Outpatient Prospective Payment System (OPPS) Cap Rate as defined in Section 5102(b) of the Deficit Reduction Act of 2005.

Conversion Factor: A multiplier, expressed in dollars per relative value unit, which converts relative values into Fee Basis amounts.

CPT/HCPCS: A set of codes that describe procedures and services, including supplies and materials, performed or provided by physicians and other health care professionals. Each procedure or service is identified with a 5 digit code. The use of CPT/HCPCS simplifies the reporting of services.

CPT/HCPCS Description: The descriptor associated with each CPT/HCPCS code.

Default Percent of Eligible Charges: In the event that a Fee Basis amount is not sourced by either a primary or alternate Fee Source, such as services submitted using unlisted, unclassified or miscellaneous codes, the codes are subject to correct coding review and will be priced at the contracted percentage indicated within this document.

Expired Code: An existing CPT or HCPCS code that will be expired by the entity that published the code (for example, CMS or the AMA).

Fee Amount: The contract rate for each CPT/HCPCS. The calculation of the Fee Amount is impacted by a variety of factors explained within this document including, but not limited to, Professional/Technical Modifier Pricing, Carrier Locality, CMS year, Place of Service and Pricing Level. The Fee Amount is calculated by multiplying the Fee Basis times the Pricing Level for each specific Type of Service.

Fee Basis: The amount published by the Fee Source upon which the Pricing Level will be applied to derive the Fee Amount.

Fee Schedule ID: United's proprietary naming/numbering convention that is used to identify the specific fee schedule which supports the terms of the

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contractual agreement. This is the fee schedule for services performed in nonfacility Places of Service.

Fee Schedule Specifications: Documentation of the underlying calculation methodology and criteria used to derive the Fee Amounts contained within the fee schedule.

Fee Source: The primary or alternate entity or publication that is supplying the Fee Basis.

Fixed Fees: Fee Amounts that are set at amounts which do not change. The Fee Amounts listed are intended for pricing purposes only and are subject to other matters described in this Agreement, such as the Payment Policies.

Flat Rate Fee: An amount published by a Fee Source and used as a Fee Basis that is other than a RVU, such as an amount for durable medical equipment or laboratory services.

Future Payment Terms: The general description of any pricing terms which will be implemented on a scheduled future effective date.

Last Routine Maintenance Update: The effective date on which this fee schedule was most recently updated. Please refer to the Routine Maintenance section of this document for more information about Routine Maintenance updates.

Linked Fee Schedule ID: United's proprietary naming/numbering convention that is used to identify the specific fee schedule for each specific contractual agreement. This is the fee schedule for services performed in facility Places of Service.

Modifier: A Modifier provides the means to report or indicate that a service or procedure has been altered by some specific circumstance but not changed in its definition or code.

Place of Service: The facility or nonfacility setting in which the service is performed. This may also be referred to by CMS as Payment Type.

Pricing Level: The contracted percentage or amount that will be multiplied times the primary or alternate Fee Basis amount in order to derive the Fee Amount.

Primary Fee Source (Carrier Locality): The main Fee Source used to supply the Fee Basis amount for deriving the Fee Amount within each Type of Service category. For instance, if the Fee Amounts for a given category of codes are derived by applying a particular Pricing Level to the CMS Resource-Based Relative Value Scale (RBRVS), then CMS RBRVS is the Primary Fee Source. The Carrier Locality is designated to indicate the exact CMS geographic region upon which the Fee Amounts are based.

Professional/Technical Modifier Pricing: Fee Source-Based: Fee Amounts for Modifiers (for example, -TC or -26 Modifiers) are derived using the Fee Basis amount as published by the primary or alternate Fee Source.

RVU: Relative Value Unit as published by CMS. United uses the RVU that is used by CMS. For example, if CMS uses a transitional RVU, then United will as well.

Replacement Code: One or more new CPT or HCPCS codes that are the exact same services or descriptions and will replace one or more Expired Codes within the same Type of Service category.

Report Date: The actual date that this document was produced.

Representative Fee Schedule Sample: A representative listing of the most commonly used CPT/HCPCS codes and fees, along with other relevant pricing information, for each specific Fee Schedule ID. The Fee Amounts listed are intended for pricing purposes only and are subject to other matters described in this Agreement, such as the Payment Policies.

Schedule Type: FFS: This is a fee-for-service fee schedule. Unless stated otherwise, the Fee Amount indicated will be used to calculate payment to you as further described within this document.

Site of Service Price Differential: Site of Service applies. CMS Assignment (ASC POS 24 =F): This fee schedule follows CMS guidelines for determining when services are priced at the facility or nonfacility fee schedule (with the exception of services performed at Ambulatory Surgery Centers,

POS 24, which will be priced at the facility fee schedule). CMS guidelines can be located at: www.cms.hhs.gov .

In the event that any of United's claims systems cannot administer the calculation of Site of Service Differential pricing as indicated above, a different calculation method will be used until such time as the appropriate system enhancements can be programmed and implemented. That different calculation method will result in a Fee Amount that is no less than the Fee Amount that would apply under the method described above.

Type of Service: A general categorization of related CPT/HCPCS codes. Type of Service categories are intended to closely align with the CPT groupings in the Current Procedural Terminology code book (as published by the AMA) and the HCPCS groupings (as published by CMS). The Office Lab Type of Service category represents those lab tests, as determined by United, in which the lab test result is necessary to make an informed treatment decision while the patient is in the office. A partial or complete crosswalk mapping of CPT/HCPCS to Type of Service categories is available to you upon request.

United: UnitedHealthcare Insurance Company or one of its affiliates which is a party to the Agreement.

Section 2. Alternate Fee Sources

In the event the Primary Fee Source contains no published Fee Basis amount alternate (or 'gap fill') Fee Sources may be used to supply the Fee Basis amount for deriving the Fee Amount. For example, if a new CPT/HCPCS code has been created within the Type of Service category of codes described above, and CMS has not yet established an RBRVS value for the code, we use Fee Sources that exist within the industry to fill that gap. For that CPT/HCPCS code, we adopt the RBRVS value established by the gap-fill Fee Source, and determine the Fee Amount for that CPT/HCPCS code by applying to the gap-fill RBRVS the same Conversion Factor and Pricing Level that we apply to the CMS RBRVS for those CPT/HCPCS code that have CMS RBRVS values. At such time in the future as CMS publishes its own RBRVS value for that CPT/HCPCS code, we would begin using the Primary Fee Source, CMS, to derive the Fee Amount for that code and no longer use the alternate Fee Source. Information about our Alternate and Primary Fee Sources can be located at www.unitedhealthcareonline.com >> Claims & Payments >> Fee Schedule Lookup >> Related Links.

Section 3. Routine Updates

Routine updates occur when United mechanically incorporates revised information created by the Fee Source, and as described below, to update the Fee Amounts calculated in accordance with this Fee Information Document. United routinely updates its fee schedule: (1) to stay current with applicable coding practices; (2) in response to price changes for immunizations and injectable medications; and (3) to remain in compliance with HIPAA requirements. United will not generally attempt to communicate routine updates of this nature.

The types of routine updates, and their respective effective dates, are described below.

a. Annual Changes to Relative Value Units, Conversion Factors, or Flat Rate Fees

This fee schedule follows a "stated year" construction methodology. The 2012 RVU, the 2012 Conversion Factor, and the 2012 Flat Rate Fee will be locked in as the basis for deriving Fee Amounts.

Generally, any RVU, Conversion Factor, or Flat Rate Fee changes published in subsequent years by the Primary Fee Sources will not be reflected in this fee schedule except, for example, to add Fee Amounts for new codes or to replace alternate Fee Basis amounts. United will use reasonable commercial efforts to implement the updates in its systems on or before the later of (i) 90 days after the effective date of any modification made by the Fee Source or (ii) 90 days after the date on which the Fee Source initially places information regarding such modification in the public domain (for example, when CMS distributes program memoranda to providers). United will make the updates effective in its system on the effective date of the change by the Fee Source. However, claims already processed prior to the change being implemented by United will not be reprocessed unless otherwise required by law.

In the event that a code contains a status code of "C" (indicating the code is carrier priced), United will establish Fee Amounts using the following methodology:

1) If CMS' multiple procedure indicator is other than "4" and United's multiple imaging reductions do not apply, United will establish Fee Amounts for those codes and modifiers using the CMS OPPSCap Rate, if available.
2) In all other cases (including if a CMS OPPSCap Rate is not available), United will use reasonable commercial efforts to establish Fee Amounts for all modifiers associated with the code based on fee information available and published by (in order of preference) CMS, the local fiscal intermediary or fiscal intermediaries from other locations.

b. Quarterly Updates in Response to Changes Published by Primary and Alternate Fee Sources
United updates its fee schedule in response to changes published by Primary Fee Sources as a result of additions, deletions, and changes to CPT codes by the AMA or HCPCS codes by CMS and any subsequent changes to CMS' annual update. United updates its fee schedules for new CPT/HCPCS codes using the applicable Conversion Factor and Pricing Level of the original construction methodology along with the then-current RVU of the published CPT/HCPCS code. The effective date of the updates described in this subsection b. will be no later than the first day of the next calendar quarter after final publication by the Fee Source, except that if that quarter begins less than 60 days after final publication, the effective date will be no later than the first day of the calendar quarter following the next calendar quarter. For example, if final publication by the Fee Source is on April 10, the fee update under this subsection b. will be effective no later than July 1, and if final publication by the Fee Source is on June 10, the fee update under this subsection b. will be effective no later than October 1.

In the event that a code contains a status code of “C” (indicating the code is carrier priced), United will establish Fee Amounts using the following methodology:

1) If CMS' multiple procedure indicator is other than “4” and United's multiple imaging reductions do not apply, United will establish Fee Amounts for those codes and modifiers using the CMS OPPSCap Rate, if available.
2) In all other cases (including if a CMS OPPSCap Rate is not available), United will use reasonable commercial efforts to establish Fee Amounts for all modifiers associated with the code based on fee information available and published by (in order of preference) CMS, the local fiscal intermediary or fiscal intermediaries from other locations.

However, in the event that the code source has expired a CPT/HCPCS code and replaced it with a Replacement Code, United will crosswalk the fee from the Expired Code to its Replacement Code as further described below:

Based on information published by the code source (AMA Current Procedural Terminology and The HCPCS Level II), when one Expired Code is replaced by one Replacement Code, United will apply the Expired Code's Fee Amount to the Replacement Code; provided, however, if the Expired Code's Fee Amount was determined by an alternate Fee Source and a Primary Fee Source becomes available, the Replacement Code's Fee Amount will be determined using the Primary Fee Source.

Based on information published by the code source (AMA Current Procedural Terminology and The HCPCS Level II) and United's claims data, when several Expired Codes that are always done in conjunction with each other are replaced by one Replacement Code, United will apply the sum of these Expired Code's Fee Amounts to the Replacement Code; provided, however, if the Expired Code's Fee Amount was determined by an alternate Fee Source and a Primary Fee Source becomes available, the Replacement Code's Fee Amount will be determined using the Primary Fee Source.

The following types of codes are not included in our direct crosswalk methodology as described above:

- ☐ Temporary HCPCS codes, such as G, K, Q, and S codes
- ☐ Temporary CPT codes, such as Category III codes
- ☐ Informational codes, such as CPT Category II codes
- ☐ HCPC-C Codes, which are only used by hospitals
- ☐ Codes categorized as immunizations and injectables

If any types of codes not currently listed in the exclusions above are developed in the future, United reserves the right to make a crosswalk determination at that time.

c. Price Changes for Immunizations and Injectables
United routinely updates the Fee Amounts in response to price changes for immunizations and injectables published by the Fee Sources. In addition, United's Executive Drug Pricing Forum (EDPF) meets on a quarterly basis to review and evaluate the drug prices that will be used in each quarterly update. The EDPF may address topics including pricing for emerging drugs, anticipated manufacturer price changes, and special circumstances (for example, H1N1 vaccine). Based on supporting information provided by the drug manufacturer or the Fee Source, United's EDPF may elect to establish a Fee Amount or override a Fee Amount, as published by the Fee Source, in favor of a Fee Amount that is more appropriate and reasonable for a particular vaccine or drug. These Fee Amount updates will be effective as described below.

Payment Appendix
All Payer Fee Information Document
Additional Information About This Fee Schedule

Fee Schedule ID: REGN 93434 - NonFacility

Linked Fee Schedule ID: REGN 93435 - Facility

For Injectable Oncology/Therapeutic Chemotherapy Drugs, United applies the UHC Chemotherapy Fee Schedule, which uses a third party vendor as the Primary Fee Source to determine the acquisition cost information provided. The Fee Amount will be the Fee Basis multiplied by the Pricing Level on the Specifications document under the Type of Service – Injectables-Oncology/Therapeutic Chemo Drugs. The Fee Basis amounts are determined as follows:

- For J codes for which there is no generic available, the Fee Basis will be 118% of Average Sales Price.
- For J codes containing brand and generic drug(s) or generic drug(s) only, the Fee Basis will be calculated using the formula: xx% of the Average Wholesale Price (AWP) for the brand drug plus the lower of: i) the acquisition cost for the brand drug(s) or ii) the average acquisition cost of the generic drug(s). In no event will the Fee Basis for J codes containing brand and generic drug(s) or generic drug(s) only be less than xx% of Average Sales Price.

More information about the UHC Chemotherapy Fee Schedule can be located at: www.unitedhealthcareonline.com >> Claims & Payments > Fee Schedule Lookup > Related Links "Acquisition Cost List"

For Immunizations, United applies the UHC Immunization Fee Schedule. The Centers for Disease Control and Prevention Private Sector Selling Price (CDC PSSP) is the Primary Fee Source used to obtain the Fee Basis amounts. In the event that more than one Fee Basis amount is published by the CDC PSSP for a specific CPT/HCPCS code, an average of the published amounts will be used.

More information about the UHC Immunization Fee Schedule can be located at: www.unitedhealthcareonline.com >> Claims & Payments > Fee Schedule Lookup > Related Links "UHC Immunization Fee Schedule"

The effective date of updates under this subsection c. will be no later than the first day of the next calendar quarter after final publication by the Fee Source, except that if that quarter begins less than 60 days after final publication, the effective date will be no later than the first day of the calendar quarter following the next calendar quarter. For example, if final publication by the Fee Source is on April 10, the fee update under this subsection c. will be effective no later than July 1, and if final publication by the Fee Source is on June 10, the fee update under this subsection c. will be effective no later than October 1.

d. Other Updates
United reserves the right, but not the obligation, to perform other updates as may be necessary to remain consistent with a Primary Fee Source. United also will perform other updates as may be required by applicable law from time to time. United will use reasonable commercial efforts to implement the updates in its systems on or before the later of (i) 90 days after the effective date of any modification made by the Fee Source or (ii) 90 days after the date on which the Fee Source initially places information regarding such modification in the public domain (for example, when CMS distributes program memoranda to providers). United will make the updates effective in its system on the effective date of the change by the Fee Source. However, claims already processed prior to the change being implemented by United will not be reprocessed unless otherwise required by law.

Section 4. Miscellaneous
Claims must be submitted using a CMS 1500, its successor form or its electronic equivalent. All claims submitted under this Appendix must use CPT Codes, HCPCS Codes, ICD-9 codes or its successor and other codes in compliance with HIPAA standard data set requirements. Claims submitted without HIPAA standard data set requirements may be denied.

Fee Amounts listed in the fee schedule are all-inclusive, including without limitation any applicable taxes. Unless specifically indicated otherwise, Fee Amounts represent global fees and may be subject to reductions based on appropriate Modifier (for example, professional and technical modifiers.) As used in the previous sentence, "global fees" refers to services billed without a Modifier, for which the Fee Amount includes both the professional component and the technical component. Any co-payment, deductible or coinsurance that the customer is responsible to pay under the customer's benefit contract will be subtracted from the listed Fee Amount in determining the amount to be paid by the payer. The actual payment amount is also subject to matters described in this agreement, such as the Payment Policies.

No payments will be made for any CMS additional compensation programs under this Payment Appendix, including without limitation value based modifiers, incentive programs or other bonus payment programs.

Section 5. Services Covered or Provided by Another Program
If an applicable state, federal or other program is available to provide items or payment directly to provider for specific covered services for customers

subject to this Appendix that would otherwise be payable under this Appendix, the applicable program will apply and not this Appendix. (For example, the Vaccines For Children program currently provides vaccines free of charge, and therefore no amount will be payable under this Appendix for vaccines within the Vaccines For Children program.)

For More Information United is committed to providing transparency related to our fee schedules. If you have questions about this fee schedule, please contact Network Management at the address and phone number on your contract or participation agreement. Alternatively, you may use our fee schedule look-up function on the web at: www.unitedhealthcareonline.com or contact our Voice Enabled Telephonic Self Service line at (877) 842-3210.

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Payment Appendix

Medicare Advantage Fee Information Document

Representative Fee Schedule Sample : as of 07/01/2015
Report Date: 07/06/2015

Fee Schedule ID: DAL 7509 - NonFacility

Linked Fee Schedule ID: DAL 7510 - Facility

Type Of Service Description	Primary Fee Source	Pricing Level
EVALUATION & MANAGEMENT	Current Year CMS RBRVS Carrier Locality (0441299)	100.000%
EVALUATION & MANAGEMENT - NEONATAL	Current Year CMS RBRVS Carrier Locality (0441299)	100.000%
EVALUATION & MANAGEMENT - PREVENTIVE	Current Year CMS RBRVS Carrier Locality (0441299)	100.000%
EVALUATION & MANAGEMENT - NURSING FACILITY SVCS	Current Year CMS RBRVS Carrier Locality (0441299)	100.000%
SURGERY - INTEGUMENTARY	Current Year CMS RBRVS Carrier Locality (0441299)	90.000%
SURGERY - MUSCULOSKELETAL	Current Year CMS RBRVS Carrier Locality (0441299)	90.000%
SURGERY - RESPIRATORY	Current Year CMS RBRVS Carrier Locality (0441299)	90.000%
SURGERY - CARDIOVASCULAR	Current Year CMS RBRVS Carrier Locality (0441299)	90.000%
SURGERY - HEMIC & LYMPHATIC	Current Year CMS RBRVS Carrier Locality (0441299)	90.000%
SURGERY - MEDIASTINUM & DIAPHRAGM	Current Year CMS RBRVS Carrier Locality (0441299)	90.000%
SURGERY - DIGESTIVE	Current Year CMS RBRVS Carrier Locality (0441299)	90.000%
SURGERY - URINARY	Current Year CMS RBRVS Carrier Locality (0441299)	90.000%
SURGERY - MALE GENITAL	Current Year CMS RBRVS Carrier Locality (0441299)	90.000%
SURGERY - FEMALE GENITAL	Current Year CMS RBRVS Carrier Locality (0441299)	90.000%
SURGERY - MATERNITY & DELIVERY	Current Year CMS RBRVS Carrier Locality (0441299)	90.000%
SURGERY - ENDOCRINE	Current Year CMS RBRVS Carrier Locality (0441299)	90.000%
SURGERY - NERVOUS	Current Year CMS RBRVS Carrier Locality (0441299)	90.000%
SURGERY - EYE & OCULAR ADNEXA	Current Year CMS RBRVS Carrier Locality (0441299)	90.000%
SURGERY - AUDITORY	Current Year CMS RBRVS Carrier Locality (0441299)	90.000%
RADIOLOGY	Current Year CMS RBRVS Carrier Locality (0441299)	70.000%
RADIOLOGY - BONE DENSITY	Current Year CMS RBRVS Carrier Locality (0441299)	70.000%
RADIOLOGY - CT	Current Year CMS RBRVS Carrier Locality (0441299)	70.000%
RADIOLOGY - MAMMOGRAPHY	Current Year CMS RBRVS Carrier Locality (0441299)	70.000%
RADIOLOGY - MRI	Current Year CMS RBRVS Carrier Locality (0441299)	70.000%
RADIOLOGY - MRA	Current Year CMS RBRVS Carrier Locality (0441299)	70.000%
RADIOLOGY - NUCLEAR MEDICINE	Current Year CMS RBRVS Carrier Locality (0441299)	70.000%
RADIOLOGY - PET SCANS	Current Year CMS RBRVS Carrier Locality (0441299)	70.000%
RADIATION THERAPY	Current Year CMS RBRVS Carrier Locality (0441299)	70.000%
RADIOLOGY - ULTRASOUND	Current Year CMS RBRVS Carrier Locality (0441299)	70.000%
LAB - PATHOLOGY	Current Year CMS RBRVS Carrier Locality (0441299)	60.000%
OFFICE LAB	Current Year CMS Clinical Lab Schedule TX	60.000%
CLINICAL LABORATORY	Current Year CMS Clinical Lab Schedule TX	42.000%
MEDICINE - OPHTHALMOLOGY	Current Year CMS RBRVS Carrier Locality (0441299)	90.000%
MEDICINE - CARDIOVASCULAR	Current Year CMS RBRVS Carrier Locality (0441299)	90.000%
MEDICINE - ALLERGY & CLINICAL IMMUNOLOGY	Current Year CMS RBRVS Carrier Locality (0441299)	90.000%
MEDICINE - CHIROPRACTIC MANIPULATIVE TREATMENT	Current Year CMS RBRVS Carrier Locality (0441299)	90.000%
MEDICINE - PHYSICAL MED AND REHAB - MODALITIES	Current Year CMS RBRVS Carrier Locality (0441299)	90.000%
MEDICINE - PHYSICAL MED AND REHAB -THERAPIES&OTHER	Current Year CMS RBRVS Carrier Locality (0441299)	90.000%
MEDICINE - ENTERAL FORMULA	Current Year CMS RBRVS Carrier Locality (0441299)	90.000%
MEDICINE - OTHER	Current Year CMS RBRVS Carrier Locality (0441299)	90.000%
MEDICINE - IMMUNIZATION ADMINISTRATION	Current Year CMS RBRVS Carrier Locality (0441299)	90.000%
MEDICINE - CHEMO ADMIN	Current Year CMS RBRVS Carrier Locality (0441299)	90.000%
OBSTETRICS - GLOBAL	Current Year CMS RBRVS Carrier Locality (0441299)	90.000%
IMMUNIZATIONS	CMS Drug Pricing	100.000%
INJECTABLES/OTHER DRUGS	CMS Drug Pricing	100.000%
INJECTABLES – ONCOLOGY/THERAPEUTIC CHEMO DRUGS	CMS Drug Pricing	100.000%
INJECTABLES - IVIG	CMS Drug Pricing	100.000%
INJECTABLES-SALINE & DEXTROSE SOLUTIONS	CMS Drug Pricing	100.000%
DME & SUPPLIES	Current Year CMS DME TX	65.000%
DME & SUPPLIES - RESPIRATORY	Current Year CMS DME TX	65.000%
DME & SUPPLIES - ORTHOTICS	Current Year CMS DME TX	65.000%
DME & SUPPLIES - PROSTHETICS	Current Year CMS DME TX	65.000%
DME & SUPPLIES - OSTOMY	Current Year CMS DME TX	65.000%
AMBULANCE	Current Year CMS Ambulance Schedule - Urban (0441299)	100.000%

Default Percent of Eligible Charges: 35.00 %
Professional/Technical Modifier Pricing: Fee Source-Based
Site of Service Price Differential: Site of Service applies. CMS Assignment (ASC POS 24 = F)
Anesthesia Conversion Factor (Based on a 15 minute Anesthesia Time Unit Value): $ 16.08
Calculation of Anesthesia Partial Units: Proration
Schedule Type: FFS

Last Routine Maintenance Update: 07-01-2015

Fixed Fees: 84030 - $ 33.00 87804 - $ 14.00 S3620 - $ 38.00 V5242 - $ 2500.00 V5243 - $ 2500.00 V5244 - $ 2500.00 V5245 - $ 2500.00 V5246 - $ 2500.00 V5247 - $ 2500.00 V5248 - $ 5000.00 V5249 - $ 5000.00 V5250 - $ 5000.00 V5251 - $ 5000.00 V5252 - $ 5000.00 V5253 - $ 5000.00 V5254 - $ 2500.00 V5255 - $ 2500.00 V5256 - $ 2500.00 V5257 - $ 2500.00 V5258 - $ 5000.00 V5259 - $ 5000.00 V5260 - $ 5000.00 V5261 - $ 5000.00 V5262 - $ 2500.00

Payment Appendix

Medicare Advantage Fee Information Document

Representative Fee Schedule Sample : as of 07/01/2015

Report Date: 07/06/2015

Fee Schedule ID: DAL 7509 - NonFacility

Linked Fee Schedule ID: DAL 7510 - Facility

V5263 - $ 5000.00

Payment Appendix

Medicare Advantage Fee Information Document

Representative Fee Schedule Sample : as of 07/01/2015
Report Date: 07/06/2015

Fee Schedule ID: DAL 7509 - NonFacility

Linked Fee Schedule ID: DAL 7510 - Facility

CPT/HCPCS	Modifier	CPT/HCPCS Description	Type of Service Description	Place of Service	Fee Amount
59400	00	OB CARE ANTEPART	OBSTETRICS - GLOBAL	NonFacility	$ 1851.43
59510	00	OB ANTEPARTUM CA	OBSTETRICS - GLOBAL	NonFacility	$ 2045.00
66984	00	CATARACT REMOVAL	SURGERY - EYE & OCULAR ADNEXA	NonFacility	$ 555.86
88305	00	LEVEL IV SURG PA	LAB - PATHOLOGY	NonFacility	$ 41.51
88305	26	LEVEL IV SURG PA	LAB - PATHOLOGY	NonFacility	$ 22.78
88305	TC	LEVEL IV SURG PA	LAB - PATHOLOGY	NonFacility	$ 18.73
90460	00	IM ADM THRU 18YR	MEDICINE - IMMUNIZATION ADMINISTRATION	NonFacility	$ 21.43
90649	00	HPV4 VACCINE 3 D	IMMUNIZATIONS	NonFacility	$ 155.83
90670	00	PCV13 VACCINE FO	IMMUNIZATIONS	NonFacility	$ 173.15
92014	00	OPHTH MEDICAL XM	MEDICINE - OPHTHALMOLOGY	NonFacility	$ 106.23
93306	00	ECHO TTHRC R-T 2	MEDICINE - CARDIOVASCULAR	NonFacility	$ 192.63
93306	26	ECHO TTHRC R-T 2	MEDICINE - CARDIOVASCULAR	NonFacility	$ 56.22
93306	TC	ECHO TTHRC R-T 2	MEDICINE - CARDIOVASCULAR	NonFacility	$ 136.41
99203	00	OFFICE OUTPATIEN	EVALUATION & MANAGEMENT	NonFacility	$ 103.86
99204	00	OFFICE OUTPATIEN	EVALUATION & MANAGEMENT	NonFacility	$ 158.81
99205	00	OFFICE OUTPATIEN	EVALUATION & MANAGEMENT	NonFacility	$ 199.83
99212	00	OFFICE OUTPATIEN	EVALUATION & MANAGEMENT	NonFacility	$ 41.69
99213	00	OFFICE OUTPATIEN	EVALUATION & MANAGEMENT	NonFacility	$ 69.67
99214	00	OFFICE OUTPATIEN	EVALUATION & MANAGEMENT	NonFacility	$ 103.61
99215	00	OFFICE OUTPATIEN	EVALUATION & MANAGEMENT	NonFacility	$ 140.01
99222	00	INITIAL HOSPITAL	EVALUATION & MANAGEMENT	NonFacility	$ 134.03
99223	00	INITIAL HOSPITAL	EVALUATION & MANAGEMENT	NonFacility	$ 198.47
99232	00	SBSQ HOSPITAL CA	EVALUATION & MANAGEMENT	NonFacility	$ 70.76
99233	00	SBSQ HOSPITAL CA	EVALUATION & MANAGEMENT	NonFacility	$ 101.94
99244	00	OFFICE CONSULTAT	EVALUATION & MANAGEMENT	NonFacility	$ 178.62
99283	00	EMERGENCY DEPART	EVALUATION & MANAGEMENT	NonFacility	$ 60.98
99284	00	EMERGENCY DEPART	EVALUATION & MANAGEMENT	NonFacility	$ 116.02
99285	00	EMERGENCY DEPT V	EVALUATION & MANAGEMENT	NonFacility	$ 171.71
99291	00	CRITICAL CARE IL	EVALUATION & MANAGEMENT	NonFacility	$ 267.06
99308	00	SBSQ NURSING FAC	EVALUATION & MANAGEMENT - NURSING FACILITY SVCS	NonFacility	$ 66.59
99309	00	SBSQ NURSING FAC	EVALUATION & MANAGEMENT - NURSING FACILITY SVCS	NonFacility	$ 88.33
99391	00	PERIODIC PREVENT	EVALUATION & MANAGEMENT - PREVENTIVE	NonFacility	$ 95.71
99392	00	PERIODIC PREVENT	EVALUATION & MANAGEMENT - PREVENTIVE	NonFacility	$ 102.29
99395	00	PERIODIC PREVENT	EVALUATION & MANAGEMENT - PREVENTIVE	NonFacility	$ 114.78
99396	00	PERIODIC PREVENT	EVALUATION & MANAGEMENT - PREVENTIVE	NonFacility	$ 122.71
99397	00	PERIODIC PREVENT	EVALUATION & MANAGEMENT - PREVENTIVE	NonFacility	$ 131.87
G0202	00	SCR MAMMO PRODUC	RADIOLOGY - MAMMOGRAPHY	NonFacility	$ 88.09
G0202	26	SCR MAMMO PRODUC	RADIOLOGY - MAMMOGRAPHY	NonFacility	$ 24.10
G0202	TC	SCR MAMMO PRODUC	RADIOLOGY - MAMMOGRAPHY	NonFacility	$ 63.99
J0178	00	INJECTION AFLIBE	INJECTABLES/OTHER DRUGS	NonFacility	$ 980.50
J1745	00	INJECTION INFLIX	INJECTABLES-ONCOLOGY/THERAPEUTIC CHEMO DRUGS	NonFacility	$ 76.51
J2323	00	INJECTION NATAL	INJECTABLES/OTHER DRUGS	NonFacility	$ 15.82
J2505	00	INJECTION PEGFIL	INJECTABLES-ONCOLOGY/THERAPEUTIC CHEMO DRUGS	NonFacility	$ 3500.59
J2778	00	INJECTION RANIBI	INJECTABLES/OTHER DRUGS	NonFacility	$ 395.54
J7302	00	LEVONORGESTREL I	INJECTABLES/OTHER DRUGS	NonFacility	$ 810.51
J9035	00	INJECTION BEVACI	INJECTABLES-ONCOLOGY/THERAPEUTIC CHEMO DRUGS	NonFacility	$ 68.48
J9263	00	INJECTION OXALIP	INJECTABLES-ONCOLOGY/THERAPEUTIC CHEMO DRUGS	NonFacility	$ 0.52
J9305	00	INJECTION PEMETR	INJECTABLES-ONCOLOGY/THERAPEUTIC CHEMO DRUGS	NonFacility	$ 60.84
J9310	00	INJECTION, RITUX	INJECTABLES-ONCOLOGY/THERAPEUTIC CHEMO DRUGS	NonFacility	$ 731.98
J9355	00	INJECTION, TRAST	INJECTABLES-ONCOLOGY/THERAPEUTIC CHEMO DRUGS	NonFacility	$ 85.22

Default Percent of Eligible Charges: 35.00 %
Professional/Technical Modifier Pricing: Fee Source-Based
Site of Service Price Differential: Site of Service applies. CMS Assignment (ASC POS 24 = F)
Anesthesia Conversion Factor (Based on a 15 minute Anesthesia Time Unit Value): $ 16.08
Calculation of Anesthesia Partial Units: Proration
Schedule Type: FFS
Last Routine Maintenance Update: 07-01-2015

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Payment Appendix
Medicare Advantage Fee Information Document

Representative Fee Schedule Sample : as of 07/01/2015
Report Date: 07/06/2015

Fee Schedule ID: DAL 7509 - NonFacility

Linked Fee Schedule ID: DAL 7510 - Facility

CPT/HCPCS	Modifier	CPT/HCPCS Description	Type of Service Description	Place of Service	Fee Amount
59400	00	OB CARE ANTEPART	OBSTETRICS - GLOBAL	Facility	$ 1851.43
59510	00	OB ANTEPARTUM CA	OBSTETRICS - GLOBAL	Facility	$ 2045.00
66984	00	CATARACT REMOVAL	SURGERY - EYE & OCULAR ADNEXA	Facility	$ 555.86
88305	00	LEVEL IV SURG PA	LAB - PATHOLOGY	Facility	$ 41.51
88305	26	LEVEL IV SURG PA	LAB - PATHOLOGY	Facility	$ 22.78
88305	TC	LEVEL IV SURG PA	LAB - PATHOLOGY	Facility	$ 18.73
90460	00	IM ADM THRU 18YR	MEDICINE - IMMUNIZATION ADMINISTRATION	Facility	$ 21.43
90649	00	HPV4 VACCINE 3 D	IMMUNIZATIONS	Facility	$ 155.83
90670	00	PCV13 VACCINE FO	IMMUNIZATIONS	Facility	$ 173.15
92014	00	OPHTH MEDICAL XM	MEDICINE - OPHTHALMOLOGY	Facility	$ 70.11
93306	00	ECHO TTHRC R-T 2	MEDICINE - CARDIOVASCULAR	Facility	$ 192.63
93306	26	ECHO TTHRC R-T 2	MEDICINE - CARDIOVASCULAR	Facility	$ 56.22
93306	TC	ECHO TTHRC R-T 2	MEDICINE - CARDIOVASCULAR	Facility	$ 136.41
99203	00	OFFICE OUTPATIEN	EVALUATION & MANAGEMENT	Facility	$ 74.92
99204	00	OFFICE OUTPATIEN	EVALUATION & MANAGEMENT	Facility	$ 126.90
99205	00	OFFICE OUTPATIEN	EVALUATION & MANAGEMENT	Facility	$ 164.96
99212	00	OFFICE OUTPATIEN	EVALUATION & MANAGEMENT	Facility	$ 24.92
99213	00	OFFICE OUTPATIEN	EVALUATION & MANAGEMENT	Facility	$ 49.60
99214	00	OFFICE OUTPATIEN	EVALUATION & MANAGEMENT	Facility	$ 76.64
99215	00	OFFICE OUTPATIEN	EVALUATION & MANAGEMENT	Facility	$ 108.76
99222	00	INITIAL HOSPITAL	EVALUATION & MANAGEMENT	Facility	$ 134.03
99223	00	INITIAL HOSPITAL	EVALUATION & MANAGEMENT	Facility	$ 198.47
99232	00	SBSQ HOSPITAL CA	EVALUATION & MANAGEMENT	Facility	$ 70.76
99233	00	SBSQ HOSPITAL CA	EVALUATION & MANAGEMENT	Facility	$ 101.94
99244	00	OFFICE CONSULTAT	EVALUATION & MANAGEMENT	Facility	$ 151.65
99283	00	EMERGENCY DEPART	EVALUATION & MANAGEMENT	Facility	$ 60.98
99284	00	EMERGENCY DEPART	EVALUATION & MANAGEMENT	Facility	$ 116.02
99285	00	EMERGENCY DEPT V	EVALUATION & MANAGEMENT	Facility	$ 171.71
99291	00	CRITICAL CARE IL	EVALUATION & MANAGEMENT	Facility	$ 219.69
99308	00	SBSQ NURSING FAC	EVALUATION & MANAGEMENT - NURSING FACILITY SVCS	Facility	$ 66.59
99309	00	SBSQ NURSING FAC	EVALUATION & MANAGEMENT - NURSING FACILITY SVCS	Facility	$ 88.33
99391	00	PERIODIC PREVENT	EVALUATION & MANAGEMENT - PREVENTIVE	Facility	$ 68.73
99392	00	PERIODIC PREVENT	EVALUATION & MANAGEMENT - PREVENTIVE	Facility	$ 75.32
99395	00	PERIODIC PREVENT	EVALUATION & MANAGEMENT - PREVENTIVE	Facility	$ 88.14
99396	00	PERIODIC PREVENT	EVALUATION & MANAGEMENT - PREVENTIVE	Facility	$ 96.06
99397	00	PERIODIC PREVENT	EVALUATION & MANAGEMENT - PREVENTIVE	Facility	$ 100.95
G0202	00	SCR MAMMO PRODUC	RADIOLOGY - MAMMOGRAPHY	Facility	$ 88.09
G0202	26	SCR MAMMO PRODUC	RADIOLOGY - MAMMOGRAPHY	Facility	$ 24.10
G0202	TC	SCR MAMMO PRODUC	RADIOLOGY - MAMMOGRAPHY	Facility	$ 63.99
J0178	00	INJECTION AFLIBE	INJECTABLES/OTHER DRUGS	Facility	$ 980.50
J1745	00	INJECTION INFLIX	INJECTABLES-ONCOLOGY/THERAPEUTIC CHEMO DRUGS	Facility	$ 76.51
J2323	00	INJECTION NATAL	INJECTABLES/OTHER DRUGS	Facility	$ 15.82
J2505	00	INJECTION PEGFIL	INJECTABLES-ONCOLOGY/THERAPEUTIC CHEMO DRUGS	Facility	$ 3500.59
J2778	00	INJECTION RANIBI	INJECTABLES/OTHER DRUGS	Facility	$ 395.54
J7302	00	LEVONORGESTREL I	INJECTABLES/OTHER DRUGS	Facility	$ 810.51
J9035	00	INJECTION BEVACI	INJECTABLES-ONCOLOGY/THERAPEUTIC CHEMO DRUGS	Facility	$ 68.48
J9263	00	INJECTION OXALIP	INJECTABLES-ONCOLOGY/THERAPEUTIC CHEMO DRUGS	Facility	$ 0.52
J9305	00	INJECTION PEMETR	INJECTABLES-ONCOLOGY/THERAPEUTIC CHEMO DRUGS	Facility	$ 60.84
J9310	00	INJECTION, RITUX	INJECTABLES-ONCOLOGY/THERAPEUTIC CHEMO DRUGS	Facility	$ 731.98
J9355	00	INJECTION, TRAST	INJECTABLES-ONCOLOGY/THERAPEUTIC CHEMO DRUGS	Facility	$ 85.22

Default Percent of Eligible Charges: 35.00 %
Professional/Technical Modifier Pricing: Fee Source-Based
Site of Service Price Differential: Site of Service applies. CMS Assignment (ASC POS 24 = F)
Anesthesia Conversion Factor (Based on a 15 minute Anesthesia Time Unit Value): $ 16.08
Calculation of Anesthesia Partial Units: Proration
Schedule Type: FFS
Last Routine Maintenance Update: 07-01-2015

Payment Appendix
Medicare Advantage Fee Information Document
Additional Information About This Fee Schedule

Fee Schedule ID: DAL 7509 - NonFacility

Linked Fee Schedule ID: DAL 7510 - Facility

Section 1. Definition of Terms

Unless otherwise defined in this document, capitalized terms will have the meanings ascribed to them in the Agreement.

AMA: American Medical Association located at: www.ama-assn.org .

Anesthesia Conversion Factor: The dollar amount that will be used in the calculation of time-based and non-time based Anesthesia Management fees in accordance with the Anesthesia Payment Policy. Unless specifically stated otherwise, the Anesthesia Conversion Factor indicated is fixed and will not change. The Anesthesia Conversion Factor is based on an anesthesia time unit value of 15 minutes. In the event that any of United's claims systems cannot administer a 15 minute anesthesia time unit value, then the Anesthesia Conversion Factor will be calculated as follows:

[(Value of 15 minute Anesthesia Conversion Factor / 15) * anesthesia time unit value]

For example, an Anesthesia Conversion Factor of $60.00 (based on a 15-minute anesthesia time unit value) would be calculated to an Anesthesia Conversion Factor of $40.00 (based on a 10-minute anesthesia time unit value).

Example: [($60.00 / 15) * 10 = $40.00]

Anesthesia Management: The management of anesthesia services related to medical, surgical or scopic procedures, as described in the current Anesthesia Management Codes list attached to the Anesthesia Payment Policy located at www.unitedhealthcareonline.com .

Calculation of Anesthesia Partial Units:
Proration: Partial time units will be prorated and calculated to one decimal place rounded to the nearest tenth. For example, if the anesthesia time unit value is based on 15 minutes and if 17 minutes of actual time is submitted on a claim, then the 17 minutes will be divided by 15. The resulting figure of 1.1333 will be rounded to the nearest tenth and the total time units for the claim will be 1.1 time units.

In the event that any of United's claims systems cannot administer the calculation of partial units as indicated above, a different calculation method will be used until such time as the appropriate system enhancements can be programmed and implemented. That different calculation method will result in a Fee Amount that is no less than the Fee Amount that would apply under the Proration method described above.

CMS: Centers for Medicare and Medicaid Services located at: www.cms.hhs.gov .

CMS OPPSCap Rate: The Outpatient Prospective Payment System (OPPS) Cap Rate as defined in Section 5102(b) of the Deficit Reduction Act of 2005.

Conversion Factor: A multiplier, expressed in dollars per relative value unit, which converts relative values into Fee Basis amounts.

CPT/HCPCS: A set of codes that describe procedures and services, including supplies and materials, performed or provided by physicians and other health care professionals. Each procedure or service is identified with a 5 digit code. The use of CPT/HCPCS simplifies the reporting of services.

CPT/HCPCS Description: The descriptor associated with each CPT/HCPCS code.

Default Percent of Eligible Charges: In the event that a Fee Basis amount is not sourced by either a primary or alternate Fee Source, such as services submitted using unlisted, unclassified or miscellaneous codes, the codes are subject to correct coding review and will be priced at the contracted percentage indicated within this document.

Expired Code: An existing CPT or HCPCS code that will be expired by the entity that published the code (for example, CMS or the AMA).

Fee Amount: The contract rate for each CPT/HCPCS. The calculation of the Fee Amount is impacted by a variety of factors explained within this document including, but not limited to, Professional/Technical Modifier Pricing, Carrier Locality, CMS year, Place of Service and Pricing Level. The Fee Amount is calculated by multiplying the Fee Basis times the Pricing Level for each specific Type of Service.

Fee Basis: The amount published by the Fee Source upon which the Pricing Level will be applied to derive the Fee Amount.

Fee Schedule ID: United's proprietary naming/numbering convention that is used to identify the specific fee schedule which supports the terms of the

contractual agreement. This is the fee schedule for services performed in nonfacility Places of Service.

Fee Schedule Specifications: Documentation of the underlying calculation methodology and criteria used to derive the Fee Amounts contained within the fee schedule.

Fee Source: The primary or alternate entity or publication that is supplying the Fee Basis.

Fixed Fees: Fee Amounts that are set at amounts which do not change. The Fee Amounts listed are intended for pricing purposes only and are subject to other matters described in this Agreement, such as the Payment Policies.

Flat Rate Fee: An amount published by a Fee Source and used as a Fee Basis that is other than a RVU, such as an amount for durable medical equipment or laboratory services.

Future Payment Terms: The general description of any pricing terms which will be implemented on a scheduled future effective date.

Last Routine Maintenance Update: The effective date on which this fee schedule was most recently updated. Please refer to the Routine Maintenance section of this document for more information about Routine Maintenance updates.

Linked Fee Schedule ID: United's proprietary naming/numbering convention that is used to identify the specific fee schedule for each specific contractual agreement. This is the fee schedule for services performed in facility Places of Service.

Modifier: A Modifier provides the means to report or indicate that a service or procedure has been altered by some specific circumstance but not changed in its definition or code.

Place of Service: The facility or nonfacility setting in which the service is performed. This may also be referred to by CMS as Payment Type.

Pricing Level: The contracted percentage or amount that will be multiplied times the primary or alternate Fee Basis amount in order to derive the Fee Amount.

Primary Fee Source (Carrier Locality): The main Fee Source used to supply the Fee Basis amount for deriving the Fee Amount within each Type of Service category. For instance, if the Fee Amounts for a given category of codes are derived by applying a particular Pricing Level to the CMS Resource-Based Relative Value Scale (RBRVS), then CMS RBRVS is the Primary Fee Source. The Carrier Locality is designated to indicate the exact CMS geographic region upon which the Fee Amounts are based.

Professional/Technical Modifier Pricing: Fee Source-Based: Fee Amounts for Modifiers (for example, -TC or -26 Modifiers) are derived using the Fee Basis amount as published by the primary or alternate Fee Source.

RVU: Relative Value Unit as published by CMS. United uses the RVU that is used by CMS. For example, if CMS uses a transitional RVU, then United will as well.

Replacement Code: One or more new CPT or HCPCS codes that are the exact same services or descriptions and will replace one or more Expired Codes within the same Type of Service category.

Report Date: The actual date that this document was produced.

Representative Fee Schedule Sample: A representative listing of the most commonly used CPT/HCPCS codes and fees, along with other relevant pricing information, for each specific Fee Schedule ID. The Fee Amounts listed are intended for pricing purposes only and are subject to other matters described in this Agreement, such as the Payment Policies.

Schedule Type: FFS: This is a fee-for-service fee schedule. Unless stated otherwise, the Fee Amount indicated will be used to calculate payment to you as further described within this document.

Site of Service Price Differential: Site of Service applies. CMS Assignment (ASC POS 24 =F): This fee schedule follows CMS guidelines for determining when services are priced at the facility or nonfacility fee schedule (with the exception of services performed at Ambulatory Surgery Centers,

POS 24, which will be priced at the facility fee schedule). CMS guidelines can be located at: www.cms.hhs.gov .

In the event that any of United's claims systems cannot administer the calculation of Site of Service Differential pricing as indicated above, a different calculation method will be used until such time as the appropriate system enhancements can be programmed and implemented. That different calculation method will result in a Fee Amount that is no less than the Fee Amount that would apply under the method described above.

Type of Service: A general categorization of related CPT/HCPCS codes. Type of Service categories are intended to closely align with the CPT groupings in the Current Procedural Terminology code book (as published by the AMA) and the HCPCS groupings (as published by CMS). The Office Lab Type of Service category represents those lab tests, as determined by United, in which the lab test result is necessary to make an informed treatment decision while the patient is in the office. A partial or complete crosswalk mapping of CPT/HCPCS to Type of Service categories is available to you upon request.

United: UnitedHealthcare Insurance Company or one of its affiliates which is a party to the Agreement.

Section 2. Alternate Fee Sources

In the event the Primary Fee Source contains no published Fee Basis amount alternate (or 'gap fill') Fee Sources may be used to supply the Fee Basis amount for deriving the Fee Amount. For example, if a new CPT/HCPCS code has been created within the Type of Service category of codes described above, and CMS has not yet established an RBRVS value for the code, we use Fee Sources that exist within the industry to fill that gap. For that CPT/HCPCS code, we adopt the RBRVS value established by the gap-fill Fee Source, and determine the Fee Amount for that CPT/HCPCS code by applying to the gap-fill RBRVS the same Conversion Factor and Pricing Level that we apply to the CMS RBRVS for those CPT/HCPCS code that have CMS RBRVS values. At such time in the future as CMS publishes its own RBRVS value for that CPT/HCPCS code, we would begin using the Primary Fee Source, CMS, to derive the Fee Amount for that code and no longer use the alternate Fee Source. Information about our Alternate and Primary Fee Sources can be located at www.unitedhealthcareonline.com >> Claims & Payments >> Fee Schedule Lookup >> Related Links.

Section 3. Routine Updates

Routine updates occur when United mechanically incorporates revised information created by the Fee Source, and as described below, to update the Fee Amounts calculated in accordance with this Fee Information Document. United routinely updates its fee schedule: (1) to stay current with applicable coding practices; (2) in response to price changes for immunizations and injectable medications; and (3) to remain in compliance with HIPAA requirements. United will not generally attempt to communicate routine updates of this nature.

The types of routine updates, and their respective effective dates, are described below.

a. Annual Changes to Relative Value Units, Conversion Factors, or Flat Rate Fees

This fee schedule follows a "current year" construction methodology and it will remain current with RVU, Conversion Factor, and Flat Rate Fee changes as the basis for deriving Fee Amounts. Therefore, the annual publication of RVUs, Conversion Factors and Flat Rate Fees by CMS will affect this fee schedule. United will use reasonable commercial efforts to implement the updates in its systems on or before the later of (i) 90 days after the effective date of any modification made by the Fee Source or (ii) 90 days after the date on which the Fee Source initially places information regarding such modification in the public domain (for example, when CMS distributes program memoranda to providers). United will make the updates effective in its system on the effective date of the change by the Fee Source. However, claims already processed prior to the change being implemented by United will not be reprocessed unless otherwise required by law. Unless specifically stated otherwise, for those anesthesia services that are contracted on a time-based methodology, the Anesthesia Conversion Factor indicated within this document is fixed and will not change. Please refer to the Anesthesia Conversion Factor section above.

In the event that a code contains a status code of "C" (indicating the code is carrier priced), United will establish Fee Amounts using the following methodology:

1) If CMS' multiple procedure indicator is other than "4" and United's multiple imaging reductions do not apply, United will establish Fee Amounts for those codes and modifiers using the CMS OPPSCap Rate, if available.
2) In all other cases (including if a CMS OPPSCap Rate is not available), United will use reasonable commercial efforts to establish Fee Amounts for all modifiers associated with the code based on fee information available and published by (in order of preference) CMS, the local fiscal intermediary or fiscal intermediaries from other locations.

b. Quarterly Updates in Response to Changes Published by Primary and Alternate Fee Sources
United updates its fee schedule in response to changes published by Primary Fee Sources as a result of additions, deletions, and changes to CPT codes by the AMA or HCPCS codes by CMS and any subsequent changes to CMS' annual update. United updates its fee schedules for new CPT/HCPCS codes using the applicable Conversion Factor and Pricing Level of the original construction methodology along with the then-current RVU of the published CPT/HCPCS code. The effective date of the updates described in this subsection b. will be no later than the first day of the next calendar quarter after final publication by the Fee Source, except that if that quarter begins less than 60 days after final publication, the effective date will be no later than the first day of the calendar quarter following the next calendar quarter. For example, if final publication by the Fee Source is on April 10, the fee update under this subsection b. will be effective no later than July 1, and if final publication by the Fee Source is on June 10, the fee update under this subsection b. will be effective no later than October 1.

In the event that a code contains a status code of "C" (indicating the code is carrier priced), United will establish Fee Amounts using the following methodology:

1) If CMS' multiple procedure indicator is other than "4" and United's multiple imaging reductions do not apply, United will establish Fee Amounts for those codes and modifiers using the CMS OPPSCap Rate, if available.
2) In all other cases (including if a CMS OPPSCap Rate is not available), United will use reasonable commercial efforts to establish Fee Amounts for all modifiers associated with the code based on fee information available and published by (in order of preference) CMS, the local fiscal intermediary or fiscal intermediaries from other locations.

c. Price Changes for Immunizations and Injectables
United routinely updates the Fee Amounts in response to price changes for immunizations and injectables published by the Fee Sources. In addition, United's Executive Drug Pricing Forum (EDPF) meets on a quarterly basis to review and evaluate the drug prices that will be used in each quarterly update. The EDPF may address topics including pricing for emerging drugs, anticipated manufacturer price changes, and special circumstances (for example, H1N1 vaccine). Based on supporting information provided by the drug manufacturer or the Fee Source, United's EDPF may elect to establish a Fee Amount or override a Fee Amount, as published by the Fee Source, in favor of a Fee Amount that is more appropriate and reasonable for a particular vaccine or drug. These Fee Amount updates will be effective as described below.

The effective date of updates under this subsection c. will be no later than the first day of the next calendar quarter after final publication by the Fee Source, except that if that quarter begins less than 60 days after final publication, the effective date will be no later than the first day of the calendar quarter following the next calendar quarter. For example, if final publication by the Fee Source is on April 10, the fee update under this subsection c. will be effective no later than July 1, and if final publication by the Fee Source is on June 10, the fee update under this subsection c. will be effective no later than October 1.

d. Other Updates
United reserves the right, but not the obligation, to perform other updates as may be necessary to remain consistent with a Primary Fee Source. United also will perform other updates as may be required by applicable law from time to time. United will use reasonable commercial efforts to implement the updates in its systems on or before the later of (i) 90 days after the effective date of any modification made by the Fee Source or (ii) 90 days after the date on which the Fee Source initially places information regarding such modification in the public domain (for example, when CMS distributes program memoranda to providers). United will make the updates effective in its system on the effective date of the change by the Fee Source. However, claims already processed prior to the change being implemented by United will not be reprocessed unless otherwise required by law.

Section 4. Miscellaneous
Claims must be submitted using a CMS 1500, its successor form or its electronic equivalent. All claims submitted under this Appendix must use CPT Codes, HCPCS Codes, ICD-9 codes or its successor and other codes in compliance with HIPAA standard data set requirements. Claims submitted without HIPAA standard data set requirements may be denied.

Fee Amounts listed in the fee schedule are all-inclusive, including without limitation any applicable taxes. Unless specifically indicated otherwise, Fee Amounts represent global fees and may be subject to reductions based on appropriate Modifier (for example, professional and technical modifiers.) As used in the previous sentence, "global fees" refers to services billed without a Modifier, for which the Fee Amount includes both the professional component and the technical component. Any co-payment, deductible or coinsurance that the customer is responsible to pay under the customer's

benefit contract will be subtracted from the listed Fee Amount in determining the amount to be paid by the payer. The actual payment amount is also subject to matters described in this agreement, such as the Payment Policies.

No payments will be made for any CMS additional compensation programs under this Payment Appendix, including without limitation value based modifiers, incentive programs or other bonus payment programs.

Section 5. Services Covered or Provided by Another Program
If an applicable state, federal or other program is available to provide items or payment directly to provider for specific covered services for customers subject to this Appendix that would otherwise be payable under this Appendix, the applicable program will apply and not this Appendix. (For example, the Vaccines For Children program currently provides vaccines free of charge, and therefore no amount will be payable under this Appendix for vaccines within the Vaccines For Children program.)

For More Information United is committed to providing transparency related to our fee schedules. If you have questions about this fee schedule, please contact Network Management at the address and phone number on your contract or participation agreement. Alternatively, you may use our fee schedule look-up function on the web at: www.unitedhealthcareonline.com or contact our Voice Enabled Telephonic Self Service line at (877) 842-3210.

Texas Regulatory Requirements Appendix

This Texas Regulatory Requirements Appendix (the "Appendix") is made part of the agreement ("Agreement") entered into by and among UnitedHealthcare Insurance Company, contracting on behalf of itself, the entities named in the Agreement, and the other entities that are United's Affiliates (collectively referred to as "United") and the health care professional or entity named in the Agreement ("Provider").

This Appendix applies to all products or benefit plans sponsored, issued or administered by or accessed through United, to the extent such products or benefit plans are regulated under Texas laws applicable to HMOs, managed care, insurance and/or preferred provider organizations; provided, however, that the requirements in this Appendix will not apply to: (1) the extent they are preempted by the Medicare Modernization Act, ERISA or other applicable law; (2) self-funded benefit plans that are administered by United; (3) any other fully insured benefit plans not regulated under the Texas laws mentioned above; (4) or to United in its role as a claims administrator or insurer for any self-funded benefit plans or any other fully insured benefit plans not regulated under the Texas laws mentioned above regardless of preemption.

United and Provider each agree to be bound by the terms and conditions contained in this Appendix. In the event of a conflict or inconsistency between this Appendix and any term or condition contained in the Agreement, this Appendix shall control, except with regard to Benefit Plans outside the scope of this Appendix.

If any of the capitalized terms in this Appendix are used or defined (or the equivalent terms are used or defined) in the Agreement, then the terms used in this Appendix will have the same meaning as the terms (or equivalent terms) used or defined in the Agreement. For example, "Benefit Plans," as used in this Appendix, will have the same meaning as "benefit contracts"; "Customer," as used in this Appendix, will have the same meaning as "member," "enrollee," or "covered person"; "Payer," as used in this Appendix, will have the same meaning as "participating entity"; "Provider," as used in this Appendix, will have the same meaning as "Facility," "Medical Group," "Ancillary Provider," "Physician," or "Practitioner." Additionally, if the Agreement uses pronouns to refer to the contracted entities, then "United" will have the same meaning as "we" or "us," and "Provider" will have the same meaning as "you" or "your."

This Appendix will be deemed to be updated to incorporate any changes to the laws and regulations referenced herein, including any changes to definitions referenced herein, effective as of the date of such changes.

Unless otherwise defined in this Appendix, all capitalized terms contained in the Appendix shall be defined as set forth in the Agreement.

Provisions applicable to fully insured Benefit Plans regulated under Texas HMO laws:

1. Payment. Any financial incentive used or payment made directly or indirectly to Provider under any provision of this Agreement is not made as an inducement to reduce or limit medically necessary services to any Customer.

2. Prompt Payment of Clean Claims. United or Payer, as applicable, will make payment to Provider pursuant to the provisions of the Texas law. For instance, unless a longer time is permitted under applicable Texas law, not later than 30 days from the date United receives an electronic clean claim and not later than 45 days from the date United receives a non-electronic clean claim, United or Payer will either: pay the total amount of the claim in accordance with this Agreement; pay the portion of the claim

MEDICARE ADVANTAGE REGULATORY REQUIREMENTS APPENDIX

THIS MEDICARE ADVANTAGE REGULATORY REQUIREMENTS APPENDIX (this "Appendix") supplements and is made part of the network participation agreement (the "Agreement") between United and the physician or provider named in the Agreement ("Provider").

SECTION 1
APPLICABILITY

This Appendix applies to the Covered Services Provider provides to Medicare Advantage Customers. In the event of a conflict between this Appendix and other appendices or any provision of the Agreement, the provisions of this Appendix shall control except: (1) with regard to Benefit Plans outside the scope of this Appendix; (2) as noted in Section 2 of this Appendix; or (3) 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 Agreement for the same or substantially similar term, the definition for such term in the Agreement shall control. All other capitalized terms not otherwise defined in this Appendix shall be as defined in the Agreement.

2.1 **Benefit Plan:** A certificate of coverage, summary plan description, or other document or agreement, whether delivered in paper, electronic, or other format, under which a Payer is obligated to provide coverage of Covered Services for a Customer. Benefit Plan may also be referred to as benefit contract, benefit document, plan, or other similar term under the Agreement.

2.2 **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.

2.3 **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 Agreement.

2.4 **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.

2.5 **Customer:** A person eligible and enrolled to receive coverage from a Payer for Covered Services. A Customer may also be referred to as an enrollee, member, patient, covered person, or other similar term under the Agreement.

2.6 **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.

2.7 **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).

2.8 **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 Agreement.

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

2.10 **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 Agreement.

2.11 **United:** UnitedHealthcare Insurance Company and/or one or more of its affiliates.

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 cooperate and comply with MA Organization's policies and procedures.

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 Agreement, 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 Agreement 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. This provision also does not prohibit Provider and an MA Customer from agreeing to the provision of services solely at the expense of the MA Customer, as long as Provider has clearly informed the MA Customer, in accordance with applicable law, that the MA Customer's Benefit Plan may not cover or continue to cover a specific service or services.

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 MA Customers who are 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 Agreement 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.

For the purpose of this provision, an "intermediary" is a person or entity authorized to negotiate and execute the Agreement on behalf of Provider or on behalf of a network through which Provider elects to participate.

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 Agreement, 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. This provision does not prohibit Provider and a Dual Eligible Customer from agreeing to the provision of services solely at the expense of the Dual Eligible Customer, as long as Provider has clearly informed the Dual Eligible Customer, in accordance with applicable law, that the Dual Eligible Customer's Benefit Plan may not cover or continue to cover a specific service or services.

3.5 **Eligibility.** Provider agrees to immediately notify MA Organization in the event Provider is or becomes excluded from participation in any federal or state health care program under Section 1128 or 1128A of the Social Security Act. 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 or state health care program under Section 1128 or 1128A of the Social Security Act.

3.6 **Laws.** Provider shall comply with all applicable federal and Medicare laws, regulations, and CMS instructions, including but not limited to: (a) federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including but not limited to, applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. §3729 et seq.), and the anti-kickback statute (§1128B of the Social Security Act); and (b) HIPAA administrative simplification rules at 45 CFR Parts 160, 162, and 164.

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 Agreement in a manner consistent with and in compliance with MA Organization's contractual obligations under the CMS Contract.

3.9 **Records.**

(a) Maintenance; Privacy and Confidentiality; Customer Access. Provider shall maintain records and information related to the services provided under the Agreement, 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 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.

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) Government Access to Records. Provider acknowledges and agrees that the Secretary of Health and Human Services, the Comptroller General, or their designees shall have the right to audit, evaluate and inspect any pertinent books, contracts, computer or other electronic systems (including medical records), patient care documentation and other records and information belonging to Provider that involve transactions related to the CMS Contract. This right shall extend through 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 records, at least ten (10) years from the later of the final date of the CMS Contract period in effect at the time the records were created or the date of completion of any audit, or longer in certain instances described in the applicable Medicare Advantage regulations.

For the purpose of conducting the above activities, Provider shall make available its premises, physical facilities and equipment, records relating to MA Customers, and any additional relevant information CMS may require.

(c) MA Organization Access to Records. Provider shall grant MA Organization or its designees such audit, evaluation, and inspection rights identified in subsection 3.9(b) 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 or inspection, and will conduct such audit, evaluation 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 the purpose of (i) CMS audits of risk adjustment data and (ii) for other purposes medical records from providers are used by MA Organization, as specified by CMS. Provision of medical records must be in the manner consistent with HIPAA privacy statute and regulations.

3.10 **MA Organization Accountability; Delegated Activities.** Provider acknowledges and agrees that MA Organization oversees and is accountable to CMS for any functions and responsibilities described in the CMS Contract and applicable Medicare Advantage regulations, including those that MA Organization may delegate to Provider or others. If MA Organization has delegated any of its functions and responsibilities under the CMS Contract to Provider pursuant to the Agreement, the following shall apply in addition to the other provisions of this Appendix:

(a) Provider shall perform those delegated activities specified in the Agreement, if any, and shall comply with any reporting responsibilities as set forth in the Agreement.

(b) If MA Organization has delegated to Provider any activities related to the credentialing of health care providers, Provider must comply with all applicable CMS requirements for credentialing, including but not limited to the requirement that the credentials of medical professionals must either be reviewed by MA Organization, or the credentialing process must be reviewed, pre-approved and audited on an ongoing basis by MA Organization.

(c) If MA Organization has delegated to Provider the selection of health care providers to be participating providers in MA Organization's Medicare Advantage network, MA Organization retains the right to approve, suspend or terminate the participation status of such health care providers.

(d) Provider acknowledges that MA Organization shall monitor Provider's performance of any delegated activities on an ongoing basis. If MA Organization or CMS determines that Provider has not performed satisfactorily, MA Organization may revoke any or all delegated activities and reporting requirements. Provider shall cooperate with MA Organization regarding the transition of any delegated activities or reporting requirements that have been revoked by MA Organization.

3.11 **Subcontracts.** If Provider has any arrangements, in accordance with the terms of the Agreement, 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 Agreement 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.** Unless previously authorized by MA Organization in writing, all services provided pursuant to the Agreement that are subject to this Appendix must be performed within the United States, the District of Columbia, or the United States territories.

SECTION 4
OTHER

4.1 **Payment.** MA Organization or its designee shall promptly process and pay or deny Provider's claim no later than sixty (60) days after MA Organization or its designee receives all appropriate information as described in MA Organization's administrative procedures. If Provider is responsible for making payment to subcontracted providers for services provided to MA Customers, Provider shall pay them no later than sixty (60) days after Provider receives request for payment for those services from subcontracted providers.

4.2 **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.

that is not in dispute and notify Provider in writing why the remaining portion of the claim is not being paid; pay the total amount of the claim in accordance with this Agreement but notify Provider that the claim is subject to audit; request additional information from Provider within 30 days of receipt of a clean claim, and then pay or deny the claim within the time required by law after United receives that information or Provider fails to timely provide it; or notify Provider in writing why United or Payer will not pay the claim.

If Provider submits claims that are not clean:

- United will notify Provider within 30 days of receiving an electronic claim or within 45 days of receiving a non-electronic claim that it is not a clean claim;
- Provider may be asked for additional information so that Provider's claim may be adjudicated; or
- Provider's claim may be denied and Provider will be notified of the denial and the reason for it; or
- United may in its discretion pay or have the claim paid by an applicable Payer based on the information that Provider gave in addition to the information United has.

A claim is complete or "clean" if it supplies all the information required by statute. The Administrative Guide contains additional important information about clean claims, an address to submit claims, a phone number and internet address where Provider can contact United with questions regarding claims Provider has submitted, information regarding any entity to whom United may have delegated claim payment functions, and the address and telephone number of any separate claims processing centers for specific types of claims or services.

United or Payer may not refuse to process or pay an electronically submitted clean claim, because the claim is submitted together with or in a batch submission with a claim that is not a clean claim.

3. Timely Filing of Claims. Provider must submit its claims within 95 days of the date of service. For a claim submitted by an institutional provider, the 95-day period does not begin until the date of discharge. For a claim for which coordination of benefits applies, the 95-day period does not begin for submission of the claim to the secondary payer until Provider receives notice of the payment or denial from the primary payer. If Provider's claim is not submitted within this time frame, Provider will not be reimbursed for the services and Provider may not charge its patient for them. If Provider's failure to timely submit the claim is the result of an information systems failure or a catastrophic event that substantially interferes with Provider's normal business operations for more than two consecutive business days and about which Provider notifies the Texas Department of Insurance as required by 28 Tex. Admin. Code §21.2819, United will extend the 95 day filing deadline by the number of days in which Provider's business was unable to operate. In the event that Provider seeks and receives a waiver from United's electronic filing requirements under 28 Tex. Admin. Code § 21.3701, Provider may submit non-electronic claims to the address shown in the Administrative Guide.

4. Duplicate Claims. Provider may not submit duplicate claims for claims, (defined as a claim for payment made for the same patient on the same date of service for the same services) that are not clean for: 1) 45 days after Provider files those claims non-electronically, and 2) 30 days after Provider files those claims electronically.

5. Penalties. If governing law requires United or Payer to pay interest, billed charges, fees, costs or another penalty for a failure to pay Provider's clean claim for covered services within a certain time frame, United will follow those requirements. The interest, billed charges, fees, costs or other penalty

required by law will be the only additional obligation for not satisfying in a timely manner a payment obligation to Provider. In addition, if United adjudicated a claim of Provider's that was not clean, there shall be no interest or other late payment obligation to Provider even if United subsequently adjusts the payment amount based on additional information that Provider provides or that United obtains. In accordance with Tex. Ins. Code § 843.342, United or Payer is not liable for a penalty for failure to pay a clean claim: (1) if the failure to pay the claim is a result of a catastrophic event that substantially interferes with the normal business operations of United or Payer; or (2) if the claim was paid in accordance with applicable law, but for less than the contracted rate, and: (A) Provider notifies the United of the underpayment after the 270th day after the date the underpayment was received; and (B) United or Payer pays the balance of the claim on or before the 30th day after the date United receives the notice.

Notwithstanding any other provision of this section, this subsection governs the payment of a penalty under this section. If Provider is not an institutional provider, for a penalty under this section relating to a clean claim submitted by Provider, United or Payer shall pay the entire penalty to the Provider, except for any interest computed under Tex. Ins. Code § 843.342(c), which shall be paid to the Texas Health Insurance Risk Pool. If Provider is an institutional provider, for a penalty under this section relating to a clean claim submitted by Provider, United or Payer shall pay fifty percent (50%) of the penalty amount computed under this section, including interest, to Provider and the remaining fifty percent (50%) of that amount to the Texas Health Insurance Risk Pool. In this section, "institutional provider" means a hospital or other medical or health-related service facility that provides care for the sick or injured or other care that may be covered in an evidence of coverage.

6. Corrective Adjustments for Overpayments.

(a) In accordance with TAC § 21.2818, United or Payer may recover a refund from Provider due to overpayment or completion of an audit, by adjusting future claim payments and/or by billing Provider for the amount of the overpayment, if: (i) United notifies Provider of the overpayment not later than the 180th day after the date of receipt of the overpayment; or (ii) United notifies Provider of the completion of an audit under TAC § 21.2809. Notification under subsection (i) of this section shall be in writing and shall include: (A) the specific claims and amounts for which a refund is due and for each claim the basis and specific reasons for the request for refund; (B) notice of Provider's right to appeal; and (C) the methods by which United intends to recover the refund.

(b) If Provider disagrees with a request for recovery of an overpayment, United shall provide Provider with an opportunity to appeal, in accordance with Tex. Ins. Code § 843.350 and 28 TAC § 21.2818, and United or Payer may not recover the overpayment until all appeal rights are exhausted.

(c) United or Payer may recover overpayments beyond the 180-day time frame mentioned above if the overpayment occurred as a result of fraudulent billing practices or a material misrepresentation by Provider.

7. Information About and Limits on Using Fee Schedule and Reimbursement Methodology. Fee schedule or coding guideline changes which are intended to substantially alter the overall methodology or reimbursement level of the fee schedule or which result in a material change in payment to Provider for the same CPT Code, ICD diagnostic code or hospital-based revenue code will be treated as an amendment to the Agreement, and United will give Provider 90 days written notice of the changes. United will not make retroactive revisions to the coding guidelines and fee schedules. To request a written copy of United's reimbursement policies and methodologies that apply to specific procedures or services for which Provider will seek reimbursement under this Agreement, or any other information

Provider needs to determine that Provider is being paid according to this Agreement, Provider should send a written request to Network Management at the address for Notices provided in the Agreement. United will respond to Provider's request within 30 days of receiving it. United will, at request of Provider, provide the name, edition, and model version of the software that the United uses to determine bundling and unbundling of claims. If United discloses fee schedule or reimbursement methodology to Provider, Provider may not use or disclose it for any purposes other than management of Provider's practice, billing activities, for Provider's business operations or in communications with a governmental agency involved in the regulation of health care or insurance.

8. Customer Hold Harmless. As further described in this section, Provider shall hold a Customer harmless for payment of the cost of covered health services in the event that Payer or United fails to pay the Provider for such services. Provider hereby agrees that in no event, including, but not limited to non-payment by Payer or United, or United insolvency, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against Customer or persons other than United acting on Customer's behalf for services provided pursuant to this Agreement. This provision shall not prohibit collection of copayments, deductibles or coinsurance for which Customer is responsible in accordance with the terms of the Benefit Plan. Provider further agrees that: (a) this provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Customer; and that (b) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Customer or person acting on Customer's behalf. No amendment or modification of this provision shall be effective earlier than fifteen (15) days following the Commissioner of the Texas Department of Insurance's receipt of written notice of such proposed change.

9. Provisions Related to Termination.

(a) Notice of Termination to Provider. United shall provide written notification of termination of this Agreement to Provider at least ninety (90) days prior to the effective date of termination, except if termination is related to (i) imminent harm to Customer health, (ii) action against Provider's license to practice or (iii) fraud or malfeasance, in which cases termination may be immediate.

(b) Advisory Review Panel Review of Proposed Termination. Prior to termination of this Agreement, United shall give Provider a written explanation of the reasons for termination. Not later than 30 days following receipt of the written notice of termination Provider may request and shall receive a review of the proposed termination by an advisory review panel selected in accordance with the provisions of Tex. Ins. Code chpt. 843.306. Such review shall be conducted within sixty (60) days of Provider's request or, if requested by Provider, the review process shall be expedited. The decision of the advisory panel must be considered but is not binding on United. United shall provide Provider, upon request, a copy of the recommendation of the advisory review panel and United's determination. Notwithstanding the above provision, Provider is not entitled to and no review shall be provided in a case in which there is (a) imminent harm to Customer health, (b) an action by a state medical board, licensing board or other government agency that effectively impairs the Provider's ability to practice or (c) a case of fraud or malfeasance.

(c) Notice to Customers of Provider Deselection and Termination. United must provide reasonable advance notification of an impending termination of Provider to Customers receiving care from Provider. Notice given at least thirty (30) days before the effective date of the termination shall be deemed reasonable; provided, however, that if Provider is deselected or terminated for reasons related to imminent harm to Customers, notification of the deselection or

termination may be given to Customers immediately. If Provider is entitled to a review by United of its decision to deselect or terminate Provider pursuant to Texas Insurance Code chpts. 843.306 and/or 843.307, United will not notify Customers of Provider's impending deselection or termination until its effective date or until the time the review panel makes its formal recommendation.

(d) Continuation of Care for Customer Special Circumstance. Unless termination of this Agreement is based upon reasons of medical competence or professional behavior, United or Payer shall have a continuing obligation to reimburse Provider if Provider is treating a Customer with special circumstance at no less than the rate provided in this Agreement. For purposes of this section, "special circumstance" means a condition with regard to which Provider reasonably believes that discontinuing care by Provider and transferring the Customer's care to another provider could cause harm to the Customer, such as a disability, acute condition, life threatening illness, or pregnancy of more than twenty-four (24) weeks. Provider must identify the special circumstance and request that the Customer be permitted to continue treatment under the Provider's care. Provider must also agree not to seek payment from the Customer of any amounts for which the Customer would not be responsible if this Agreement were still in effect. Any dispute regarding the necessity for continued treatment by Provider shall be resolved pursuant to United's dispute resolution procedures contained in the appeal procedure for medical necessity determinations as described in the provider manual or administrative manual. The obligation of United or Payer to reimburse a terminated Provider for ongoing treatment of a Customer with special circumstance continues through: (a) the ninetieth (90th) day after the effective date of the termination; (b) nine (9) months following the effective date of the termination for a Customer who at the time of the termination has been diagnosed with a terminal illness; or (c) delivery of the child, immediate postpartum care, including a follow-up checkup within the first six (6) weeks of delivery, for a Customer who is past the twenty-fourth (24th) week of pregnancy at the effective date of the termination.

(e) Voluntary Termination by Provider. Provider may also terminate this Agreement upon 30 days' written notice if Provider provides United with such written notice within 30 days of receiving the information requested under Tex. Ins. Code chpt. 843.321, as described in section 7 above. Provider agrees to cooperate with United to give Customers the notice described in (c) above.

10. Posting of Complaint Procedure and Handling of Customer Complaints. Provider shall post in Provider's office a notice to Customers on the process for resolving complaints with United or Payer. Such notice shall include the Texas Department of Insurance's toll-free telephone number for filing complaints. United also provides a mechanism for the resolution of any complaints initiated by Customers which provides for reasonable due process, including, in an advisory role only, a review panel selected in compliance with the provisions of Tex. Ins. Code chpt. 843.255, as applicable.

11. No Retaliatory Action. United shall not engage in any retaliatory action, including termination of or refusal to renew this Agreement, against Provider because Provider has, on behalf of a Customer, reasonably filed a complaint against United or has appealed a decision of United.

12. Capitation Payments. If reimbursement to Provider contains capitation payments, United shall comply with the requirements of the Texas Ins. Code chpts. 843.315 and 843.316.

13. No Indemnification for Tort Liability. Provider and United agree that nothing in this Agreement shall be construed to require Provider to indemnify United for any tort liability resulting from acts or omissions of United.

14. Provider Communication with Customers. Nothing in this Agreement shall be construed to prohibit, attempt to prohibit, or discourage Provider from discussing with or communicating to a Customer, with respect to: (a) information or opinions regarding Customer's health care, including medical condition or treatment options; (b) information or opinions regarding the provisions, terms, requirements, or services of United as they relate to the Customer's medical needs; (c) the fact that this Agreement has terminated or that Provider shall otherwise no longer be providing medical care or health care services under United's products; or (d) the fact that, if medically necessary covered services are not available through providers contracting with United, then United must, upon the request of Provider and within time appropriate to the circumstances relating to the delivery of the services and the condition of the Customer, but in no event to exceed five (5) business days after receipt of reasonably requested documentation, allow referral to an appropriate provider. Further, United may not in any way penalize, terminate, or refuse to compensate (as provided under this Agreement) Provider for communicating with a current, prospective or former patient, or a party designated by a patient, in any way protected by this section.

15. Provisions Related to Emergency Services and Post-stabilization Care.

(a) Definition of Emergency Care. Provider agrees that for the purposes of providing health care services to Customers under United's Benefit Plans, "emergency care" shall mean health care services provided in a hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness or injury is of such a nature that failure to get immediate medical care could result in: (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part; (4) serious disfigurement; or (5) in the case of a pregnant woman, serious jeopardy to the health of her fetus.

(b) Post-stabilization Care Approval. If United requires prior approval of post-stabilization care requested by a treating physician or health care professional following emergency services, and if such health care services are for Customers covered under Benefit Plans regulated by Texas law, United will approve or deny such treatment within one hour of the time of the request.

16. Provisions Specific to Podiatrists. The provisions contained in this section apply only in the event that Provider is a podiatrist licensed by the Texas State Board of Podiatric Medical Examiners.

(a) Request for Coding Guidelines and Payment Schedules. Within thirty (30) days after the date of Provider's request, United shall provide a copy of the coding guidelines and payment schedules applicable to the compensation that the Provider shall receive under this Agreement.

(b) No Unilateral Material Retroactive Change. United may not unilaterally make material retroactive revisions to the coding guidelines and payment schedules.

(c) X-Rays and Orthotics. Provider may, practicing within the scope of the law regulating podiatry, furnish x-rays and nonprefabricated orthotics covered by a Benefit Plan.

17. Specialists Designated as Primary Care Physicians. If a Customer's Benefit Plan allows the Customer to apply to United for a physician specialist to be designated as the Customer's primary care physician, and if Provider is a physician specialist, Provider and United agree to comply with United's procedures for such designation.

18. Utilization Review. United, Payer or Provider, as applicable, shall comply with applicable sections of Texas laws and regulations as they relate to utilization review of health care services, including those set forth in Texas Insurance Code Chapter 4201 and Texas Administrative Code § 19.1701 - 19.1724, as applicable.

19. Agreement Requirements. United, Payer or Provider, as applicable, shall comply with applicable sections of Texas laws and regulations as they relate to provider agreement requirements, including those set forth in Texas Insurance Code Chapter 1458 and any related Texas Administrative Code sections, as applicable.

20. Agreement Access. United, Payer or Provider, as applicable, shall comply with applicable sections of Texas laws and regulations as they relate to access to provider agreements, including but not limited to health care services or contractual discounts under such agreements, including those set forth in Texas Insurance Code Chapter 1458 and any related Texas Administrative Code sections, as applicable.

21. Statement of Compliance. United, Payer or Provider, as applicable, shall comply with applicable sections of Texas laws and regulations as they relate to provider agreement renewal and notice thereof, including those set forth in Texas Insurance Code Chapter 1458, Section 2, as codified and any rules related thereto as promulgated by the Commissioner.

Provisions applicable to fully insured Benefit Plans regulated by the State of Texas but not subject to Texas HMO laws:

1. Other Contracts. Provider is not restricted from contracting with other insurers, preferred provider plans, preferred provider organizations, or HMOs.

2. Quality Care. Any term or condition of this Agreement that limits Provider's participation on the basis of quality shall be consistent with established standards of care for Provider's profession.

3. Provider Privileges.

(a) If Provider has hospital or institutional provider privileges and delivers a significant portion of care in a hospital or institutional provider setting, this Agreement may contain terms and conditions that include the possession of practice privileges at preferred hospitals or institutions. However, if no preferred hospital or institution offers privileges to members of a class of physicians or practitioners to which Provider belongs, then the lack of such hospital or institutional provider privileges may not be a basis for denial of Provider's participation as a preferred provider.

(b) A contract between United or Payer and a hospital or institutional provider shall not, as a condition of staff membership or privileges, require a Provider to enter into a preferred provider contract. However, this prohibition does not extend to requirements concerning practice conditions other than conditions of membership or privileges.

4. Provider Billing. This Agreement prohibits Provider from billing the Customer for unnecessary care if a physician or practitioner panel has determined the care was unnecessary. However, Provider shall not be required to pay hospital, institutional, laboratory, x-ray or like charges resulting from the provision of services lawfully ordered by Provider, even though such service may be determined to be unnecessary.

5. Customer Referrals. Nothing in this Agreement shall be construed as a restriction on the classes of physicians and practitioners who may refer a Customer to another physician or practitioner. In the event that Provider makes a referral for specialty care, nothing in this Agreement shall be construed to require Provider to bear the expenses of such referral in or out of the preferred provider panel. If Provider makes a referral out of the preferred provider panel, Provider must disclose to Customer (1) that the referred provider is out of the preferred provider panel (not a preferred provider) and (2) any ownership interest of the Provider in the referred facility. Such disclosure shall not limit or delay emergency care, nor shall it interrupt or delay medically necessary care. This disclosure shall not limit access to non- preferred (or out of preferred provider panel) providers.

6. No Inducement to Limit Medically Necessary Services. This Agreement does not contain any financial incentives to Provider that act directly or indirectly as an inducement to limit medically necessary services.

7. Customer or Provider Complaints. United provides a mechanism for the resolution of complaints initiated by a Customer or Provider which provides for reasonable due process including, in an advisory role only, a review panel selected in compliance with the provisions of Tex. Ins. Code § 1301.055 and 28 Tex. Admin. Code § 3.3706.

8. Limit on Indemnification. Provider shall not be required to indemnify or hold United harmless from tort liability resulting from acts or omissions of United.

9. Discounted Fee Arrangements. If this Agreement contains a discounted fee arrangement, the Customer may be billed only on the discounted fee and not the full charge.

10. Prompt Payment. United or Payer, as applicable, will make payment to Provider pursuant to the provisions of the Texas law. For instance, unless a longer time is permitted under applicable Texas law, not later than 30 days from the date United receives an electronic clean claim and not later than 45 days from the date United receives a non-electronic clean claim, United or Payer will either: pay the total amount of the claim in accordance with this Agreement; pay the portion of the claim that is not in dispute and notify Provider in writing why the remaining portion of the claim is not being paid; pay the total amount of the claim in accordance with this Agreement but notify Provider that the claim is subject to audit; request additional information from Provider within 30 days of receipt of a clean claim, and then pay or deny the claim within the time required by law after United receives that information or Provider fails to timely provide it; or notify Provider in writing why United or Payer will not pay the claim.

If Provider submits claims that are not clean,

- United will notify Provider within 30 days of receiving an electronic claim or within 45 days of receiving a non-electronic claim that it is not a clean claim;
- Provider may be asked for additional information so that Provider's claim may be adjudicated; or
- Provider's claim may be denied and Provider will be notified of the denial and the reason for it; or
- United may in its discretion pay or have the claim paid by an applicable Payer based on the information that Provider gave in addition to the information United has.

A claim is complete or "clean" if it supplies all the information required by statute. The Administrative Guide contains additional important information about clean claims, an address to submit claims, a phone number and internet address where Provider can contact United with questions regarding claims Provider

has submitted, information regarding any entity to whom United may have delegated claim payment functions, and the address and telephone number of any separate claims processing centers for specific types of claims or services.

11. Timely Filing of Claims. Provider must submit Provider's claims within 95 days of the date of service. For a claim submitted by an institutional provider, the 95-day period does not begin until the date of discharge. For a claim for which coordination of benefits applies, the 95-day period does not begin for submission of the claim to the secondary payer until Provider receives notice of the payment or denial from the primary payer. If Provider's claim is not submitted within this time frame, Provider will not be reimbursed for the services and Provider may not charge Provider's patient for them. If Provider's failure to timely submit the claim is the result of an information systems failure or catastrophic event that substantially interferes with Provider's normal business operations for more than two consecutive business days and about which Provider notifies the Texas Department of Insurance as required by 28 Tex. Admin. Code §21.2819, United will extend the 95 day filing deadline by the number of days in which Provider's business was unable to operate. In the event that Provider seeks and receives a waiver from United's electronic filing requirements under 28 Tex. Admin. Code § 21.3701, Provider may submit non-electronic claims to the address shown in the Administrative Guide.

12. Duplicate Claims. Provider may not submit duplicate claims for claims, (defined as a claim for payment made for the same patient on the same date of service for the same services) that are not clean for: 1) 45 days after Provider files those claims non-electronically, and 2) 30 days after Provider files those claims electronically.

13. Penalties. If governing law requires United or Payer to pay interest, billed charges, fees, costs or another penalty for a failure to pay Provider's clean claim for covered services within a certain time frame, United will follow those requirements. The interest, billed charges, fees, costs or other penalty required by law will be the only additional obligation for not satisfying in a timely manner a payment obligation to Provider. In addition, if United adjudicated a claim of Provider's that was not clean, there shall be no interest or other late payment obligation to Provider even if United subsequently adjusts the payment amount based on additional information that Provider provides or that United obtains. In accordance with Tex. Ins. Code § 1301.137, United or Payer is not liable for a penalty for failure to pay a clean claim: (1) if the failure to pay the claim is a result of a catastrophic event that substantially interferes with the normal business operations of United or Payer; or (2) if the claim was paid in accordance with applicable law, but for less than the contracted rate, and: (A) Provider notifies the United of the underpayment after the 270th day after the date the underpayment was received; and (B) United or Payer pays the balance of the claim on or before the 30th day after the date United receives the notice.

Notwithstanding any other provision of this section, this subsection governs the payment of a penalty under this section. If Provider is not an institutional provider, for a penalty under this section relating to a clean claim submitted by Provider, United or Payer shall pay the entire penalty to the Provider, except for any interest computed under Tex. Ins. Code § 1301.137(c), which shall be paid to the Texas Health Insurance Risk Pool. If Provider is an institutional provider, for a penalty under this section relating to a clean claim submitted by Provider, United or Payer shall pay fifty percent (50%) of the penalty amount computed under this section, including interest, to Provider and the remaining fifty percent (50%) of that amount to the Texas Health Insurance Risk Pool.

14. Overpayments

(a) **Corrective Adjustments for Overpayments by United or Payer.**

(i) In accordance with TAC § 21.2818, United or Payer may recover a refund from Provider due to overpayment or completion of an audit, by adjusting future claim payments and/or by billing Provider for the amount of the overpayment, if: (i) United notifies Provider of the overpayment not later than the 180th day after the date of receipt of the overpayment; or (ii) United notifies Provider of the completion of an audit under TAC § 21.2809. Notification under subsection (i) of this section shall be in writing and shall include: (A) the specific claims and amounts for which a refund is due and for each claim the basis and specific reasons for the request for refund; (B) notice of Provider's right to appeal; and (C) the methods by which United intends to recover the refund.

(ii) If Provider disagrees with a request for recovery of an overpayment, United shall provide Provider with an opportunity to appeal, in accordance with Tex. Ins. Code § 1301.132 and 28 TAC § 21.2818, and United or Payer may not recover the overpayment until all appeal rights are exhausted.

(iii) United or Payer may recover overpayments beyond the 180-day time frame mentioned above if the overpayment occurred as a result of fraudulent billing practices or a material misrepresentation by Provider.

(b) **Overpayments by Customer.** In accordance with Tex. Ins. Code §1661.005 and 28 TAC §3.3703(e)(25), if Provider receives an overpayment from a Customer that overpayment must be refunded to the Customer no later than the 30th day after the date Provider determines an overpayment was made. Provider must comply with all applicable requirements contained in Tex. Ins. Code § 1661.005 regarding Customer overpayments.

15. Information About and Limits on Using Fee Schedule and Reimbursement Methodology. Fee schedule or coding guideline changes which are intended to substantially alter the overall methodology or reimbursement level of the fee schedule or which result in a material change in payment to Provider for the same CPT Code, ICD diagnostic code or hospital-based revenue code will be treated as an amendment to the contract, and United will give Provider 90 days written notice of the changes. United will not make retroactive revisions to the coding guidelines and fee schedules. To request a written copy of United's reimbursement policies and methodologies that apply to specific procedures or services for which Provider will seek reimbursement under this Agreement, or any other information Provider needs to determine that Provider is being paid according to this Agreement, Provider should send a written request to Network Management at the address for Notices provided in the Agreement. United will respond to Provider's request within 30 days of receiving it. United will, on request of Provider, provide the name, edition, and model version of the software that the United uses to determine bundling and unbundling of claims. If United discloses fee schedule or reimbursement methodology to Provider, Provider may not use or disclose it for any purposes other than management of Provider's practice, to submit bills, for Provider's business operations or in communications with a governmental agency involved in the regulation of health care or insurance.

16. Protected Communications. Provider shall not be prohibited, penalized, retaliated against, or terminated for communicating items pursuant to Tex. Ins. Code Ann. § 1301.067.

17. Use of Economic Profiling. If United conducts, uses, or relies upon economic profiling to terminate Provider, Provider shall be informed of United's obligation to make available as requested by Provider, Provider's economic profile, including written criteria by which the Provider's performance was measured in accordance with Tex. Ins. Code Ann. § 1301.058.

18. Quality Assessment. If United engages in quality assessment, United shall do so through a panel of not less than three physicians selected by United from among a list of physicians contracting with United.

19. Immunization or Vaccination Protocol. Provider is not required to issue an immunization or vaccination protocol for an immunization or vaccination to be administered to a Customer by a pharmacist.

20. Administration of Immunizations or Vaccinations. This Agreement does not prohibit a pharmacist from administering immunizations or vaccinations if such immunizations or vaccinations are administered in accordance with the Texas Pharmacy Act art. 4542a-1 and rules promulgated thereunder.

21. Provisions Related to Emergency Services and Post-stabilization Care.

(a) Definition of Emergency Care. Provider agrees that for the purposes of providing health care services to Customers under Benefit Plans, "emergency care" shall mean health care services provided in a hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness or injury is of such a nature that failure to get immediate medical care could result in : (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part; (4) serious disfigurement; or (5) in the case of a pregnant woman, serious jeopardy to the health of her fetus.

(b) Post-stabilization Care Approval. If United requires prior approval of post-stabilization care requested by a treating physician or health care professional following emergency services, and if such health care services are for Customers covered under Benefit Plans regulated by Texas law, United will approve or deny such treatment within one hour of the time of the request.

22. Provisions Related to Termination.

(a) Notice of Termination to Provider. United shall provide written notification of termination of this Agreement to Provider at least ninety (90) days prior to the effective date of termination, except if termination is related to (i) imminent harm to Customer health, (ii) action against Provider's license to practice or (iii) fraud, in which cases termination may be immediate.

(b) Advisory Review Panel Review of Proposed Termination. Prior to termination of this Agreement, United shall give Provider a written explanation of the reasons for termination. If Provider is a physician or practitioner, in accordance with 28 TAC § 3.3706 and Tex. Ins. Code § 1301.053(b), Provider may request and shall receive a review of the proposed termination by a selected advisory review panel. Provider must make the request in writing to United within 20 business days of receipt of the notification of United's intent to terminate, which shall include any relevant documentation. Such review shall be conducted within sixty (60) days of Provider's request or, if requested by Provider pursuant to 28 TAC § 3.3706, the review process shall be expedited. The decision of the advisory panel must be considered but is not binding on United. United shall provide Provider, upon request, a copy of the recommendation of the advisory review panel and United's determination. Notwithstanding the above provision, Provider is not entitled to and no review shall be provided in a case in which there is (a) imminent harm to Customer health, (b) an action by a state medical board, licensing board or other government agency that effectively impairs the Provider's ability to practice or (c) a case of fraud or malfeasance.

(c) Notice of Provider Termination to Customers. United must provide reasonable advance notification of an impending termination of Provider to Customers receiving care from Provider. Notice given at least thirty (30) days before the effective date of the termination shall be deemed reasonable; provided, however, that if termination of Provider is for reasons related to imminent harm to Customers, notification of termination may be given to Customers immediately. If Provider is entitled to a review by United of its decision to terminate Provider pursuant to Tex. Ins. Code Ann. § 1301.057, United will not notify Customers of Provider's impending termination until its effective date or until the time the review panel makes its formal recommendation, whichever is later.

(d) Continuation of Care for Customer Special Circumstance. Unless termination of this Agreement is based upon reasons of medical competence or professional behavior, United or Payer shall have a continuing obligation to reimburse Provider if Provider is treating a Customer with special circumstance at no less than the rate provided in this Agreement. For purposes of this section, “special circumstance” means a condition with regard to which Provider reasonably believes that discontinuing care by Provider and transferring the Customer’s care to another provider could cause harm to the Customer, such as a disability, acute condition, life threatening illness, or pregnancy of more than twenty-four (24) weeks. Provider must identify the special circumstance and request that the Customer be permitted to continue treatment under the Provider’s care. Provider must also agree not to seek payment from the Customer of any amounts for which the Customer would not be responsible if this Agreement were still in effect. Any dispute regarding the necessity for continued treatment by Provider shall be resolved pursuant to United’s dispute resolution procedures contained in the appeal procedure for medical necessity determinations as described in the provider manual or administrative manual. The obligation of United or Payer to reimburse a terminated Provider for ongoing treatment of a Customer with special circumstance continues through: (a) the ninetieth (90th) day after the effective date of the termination; (b) nine (9) months following the effective date of the termination for a Customer who at the time of the termination has been diagnosed with a terminal illness; or (c) delivery of the child, immediate postpartum care, including a follow-up checkup within the first six (6) weeks of delivery, for a Customer who is past the twenty-fourth (24th) week of pregnancy at the effective date of the termination.

(e) Voluntary Termination by Provider. Provider may also terminate this Agreement upon 30 days’ written notice if Provider provides United with such written notice within 30 days of receiving the information requested under 28 Tex. Admin. Code § 3.3703(a)(20), as described in section 15 above. Provider agrees to cooperate with United to give Customers the notice described in (c) above.

(f) Termination of Agreement between Facility and Facility-Based Physician Group. If Provider is a “facility,” as defined in the Agreement, Provider must give notice to United as soon as reasonably practicable, but not later than the 5th business day following the termination of a contract between Provider and a facility-based physician group that is a preferred provider for United.

23. No Retaliatory Action. United shall not engage in any retaliatory action, including termination of or refusal to renew this Agreement, against Provider because Provider has, on behalf of a Customer, reasonably filed a complaint against United or has appealed a decision of United.

24. Provisions Specific to Podiatrists. The provisions contained in this section apply only in the event that Provider is a podiatrist licensed by the Texas State Board of Podiatric Medical Examiners.

(a) Request for Coding Guidelines and Payment Schedules. Within thirty (30) days after the date of Provider's request, United shall provide a copy of the coding guidelines and payment schedules applicable to the compensation that the Provider shall receive under this Agreement.

(b) No Unilateral Material Retroactive Change. United may not unilaterally make material retroactive revisions to the coding guidelines and payment schedules.

(c) X-Rays and Orthotics. Provider may, practicing within the scope of the law regulating podiatry, furnish x-rays and nonprefabricated orthotics covered by a Benefit Plan.

25. Utilization Review. United, Payer or Provider, as applicable, shall comply with applicable sections of Texas laws and regulations as they relate to utilization review of health care services, including those set forth in Texas Insurance Code Chapter 4201 and Texas Administrative Code § 19.1701 - 19.1724, as applicable.

26. Surgery Referrals. Except for instances of Emergency Care (as defined herein and under Texas Insurance Code §1301.155(a)), a physician or provider referring a Customer to a facility for surgery must: (a) notify Customer of the possibility that out-of-network providers may provide treatment and that Customer can contact United for more information; (b) notify United that surgery has been recommended; and, (c) notify United of the facility that has been recommended for the surgery.

27. Surgery Scheduling. Except for instances of Emergency Care (as defined herein and under Texas Insurance Code §1301.155(a)), a facility, when scheduling surgery for a Customer must: (a) notify Customer of the possibility that out-of-network providers may provide treatment and that Customer can contact United for more information; and, (b) notify Customer that surgery has been scheduled.

28. Agreement Requirements. United, Payer or Provider, as applicable, shall comply with applicable sections of Texas laws and regulations as they relate to provider agreement requirements, including those set forth in Texas Insurance Code Chapter 1458 and any related Texas Administrative Code sections, as applicable.

29. Agreement Access. United, Payer or Provider, as applicable, shall comply with applicable sections of Texas laws and regulations as they relate to access to provider agreements, including but not limited to health care services or contractual discounts under such agreements, including those set forth in Texas Insurance Code Chapter 1458 and any related Texas Administrative Code sections, as applicable.

30. Statement of Compliance. United, Payer or Provider, as applicable, shall comply with applicable sections of Texas laws and regulations as they relate to provider agreement renewal and notice thereof, including those set forth in Texas Insurance Code Chapter 1458, Section 2, as codified and any rules related thereto as promulgated by the Commissioner.