Ntent

UNITED HEALTHCARE OF TEXAS, INC.
MEDICAL GROUP PARTICIPATION AGREEMENT

THIS AGREEMENT, effective on the date specified at the signature portion of this Agreement ("Effective Date"), is between United HealthCare of Texas, Inc., United HealthCare Insurance Company, and United HealthCare Services, Inc. (collectively "Plan") and North Texas Ear, Nose & Throat Associates ("Medical Group") and sets forth the terms and conditions under which Medical Group shall provide services to Plan. United HealthCare of Texas, Inc. shall negotiate and sign this agreement on behalf of United HealthCare Insurance Company and United HealthCare Services, Inc. For services rendered on or after its Effective Date, this Agreement supersedes and replaces any existing agreements between the parties relating to the same subject matter. This Agreement also supersedes and replaces any existing agreements between Medical Group and the following entities to the extent such agreements relate to the provision of health care services to Members, and to the extent such entities sponsor, issue or administer a Benefit Contract, as defined in this Agreement: The MetraHealth Insurance Company, The Travelers Insurance Company, Metropolitan Life Insurance Company, Principal Health Care of Texas, Inc., Coastal Bend Health Plan, and United Health and Life Insurance Company.

SECTION 1
Definitions

Benefit Contract: A benefit plan that includes health care coverage, is sponsored, issued or administered by Payor and contains the terms and conditions of a Member's coverage.

Customary Charge: The fee for health care services charged by Medical Group that does not exceed the fee Medical Group would charge any other person regardless of whether the person is a Member.

Health Services: The health care services and supplies covered by the Member's Benefit Contract. Upon prior notice by Plan, certain Health Services may not be eligible for payment under this Agreement.

Medical Group Physician: A Doctor of Medicine ("M.D."), or a Doctor of Osteopathy ("D.O.") duly licensed and qualified under the laws of the jurisdiction in which Health Services are provided, who practices as a shareholder, partner or employee of Medical Group, and who has executed a Medical Group Physician Participation Addendum, the form of which is attached to this Agreement.

Member: An individual who is properly covered under a Benefit Contract.

? evergreen clause?

Member Expenses: Any amounts that are the Member's responsibility to pay Medical Group in accordance with the Member's Benefit Contract, including copayments, coinsurance and deductibles.

Participating Provider: A health care professional or facility, including Medical Group, that has a written participation agreement in effect with Plan, directly or through another entity, to provide Health Services to selected groups of Members.

Payor: The entity or person authorized by Plan to access one or more networks of Participating Providers developed by Plan and that has the financial responsibility for payment of Health Services covered by a Benefit Contract.

Primary Care Physician: A Doctor of Medicine ("M.D."), Doctor of Osteopathy ("D.O.") or another health care professional as required by applicable statutes and regulations, who is duly licensed and qualified under the laws of the jurisdiction in which Health Services are rendered and is a Participating Provider of primary care Health Services.

Referral Authorization: The approval by a Member's Primary Care Physician in a format determined by Payor, which may be an electronic format, for a health care professional or facility to render certain Health Services to the Member.

Referral Physician: An M.D. or a D.O. (1) who is a Participating Provider, (2) who is not a Primary Care Physician, and (3) to whom a Member is referred by a Primary Care Physician for the provision of certain Health Services.

SECTION 2
Networks of Participating Providers

Medical Group shall provide Health Services to Members covered under the Benefit Contract types described in Exhibit 1, which may be modified from time to time by Plan, and which includes, but is not limited to, Benefit Contracts which offer a network of Participating Providers. When appropriate, Medical Group will be listed in the applicable provider directories.

When Benefit Contracts offer a network of Participating Providers the product name will appear on the Member's identification card and the Members will receive a provider directory listing all Participating Providers. Members covered under these Benefit Contract types are incented to receive services from Participating Providers. Such incentives may include, but are not limited to, a higher level of coverage and/or the potential reduction or elimination Member Expenses.

SECTION 3
Duties of Medical Group

3.1 Member Status. To determine whether an individual is a Member and, therefore entitled to receive Health Services, Medical Group shall ask the individual to present his or her identification card, which shall be provided to all Members by Payors, unless because of the type of Benefit Contract under which the Member has coverage no identification card applies. In addition, Medical Group may contact Plan to obtain Plan's most current information on the individual as a Member. However, Medical Group acknowledges that such information is subject to change retroactively (1) if Plan does not receive proper and timely notification regarding termination of a Member's coverage; (2) as a result of the Member's final decision regarding continuation of coverage pursuant to state and federal laws; or (3) if eligibility information Plan receives on the individual is later proven to be false. If Medical Group provides health care services to an individual, and it is later determined the individual was not a Member at the time the health care services were provided, those services shall not be eligible for payment under this Agreement. Medical Group may then directly bill the responsible party for such services.

3.2 Provision of Health Services. Medical Group shall provide Health Services to all Members as Medical Group's patient load and appointment calendar permit and shall accept Members as new patients on the same basis as Medical Group is accepting non-Members as new patients without regard to race, religion, gender, color, national origin, age or physical or mental health status, or on any other basis deemed unlawful under federal, state or local law. Medical Group warrants and represents that it has the authority to enter into this Agreement on behalf of all Medical Group Physicians. At all times, Medical Group shall require employed or subcontracted health care professionals and facilities including, but not limited to, Medical Group Physicians to comply with the protocols and requirements of Plan and Payor and the requirements of all applicable regulatory authorities. Such requirements include, but are not limited to, not billing Members for any amounts except Member Expenses and charges for services not covered under the Member's Benefit Contract.

3.3 Selection of a Primary Care Physician. If a Member does not select a Primary Care Physician, Plan or Payor may assign the Member to a Primary Care Physician located within the zip code nearest to the Member's residence or place of employment. Reasonable attempts will be made to ensure such assignments result in a fair and equal distribution of Members among the Plan's Primary Care Physicians. Plan or Payor will notify the Primary Care Physician within 30 working days of the selection or assignment of a Member to that Primary Care Physician.

3.4 Utilization Management, Quality Improvement and Other Plan or Payor Programs. Medical Group shall cooperate with all credentialing and recredentialing processes and all utilization management, quality improvement, peer review, Member grievance, on site review, or other similar Plan or Payor programs.

3.5 **Protocols.** Medical Group shall comply with protocols of Plan or Payor, including, but not limited to the following:

1. Refer Members only to other Participating Providers unless otherwise authorized by Plan or Payor.
2. Be bound by any provider manual and credentialing plan, as modified from time to time by Plan or Payor.
3. Obtain prior authorization for certain Health Services as defined by Plan or Payor.
4. Follow approved billing procedures of Plan or Payor, as appropriate.
5. If Medical Group is composed of one or more Primary Care Physicians, Medical Group shall provide or arrange for the provision of advice and assistance to Members in emergency situations 24 hours per day, 7 days per week.
6. If the Member's Benefit Contract requires the Member to receive certain Health Services from or upon referral by a Primary Care Physician, all Referral Physicians must adhere to the following additional protocols when those Health Services are provided:
   a) Referrals to other Participating or non-Participating Providers must first be authorized by the Member's Primary Care Physician.
   b) Health Services must be provided pursuant to the terms and limitations of the Referral Authorization issued by or on behalf of the Member's Primary Care Physician.
7. Medical Group shall comply with the following requirements when admitting Members to a hospital:
   a) Admit Members on the day of surgery, unless the Member's medical condition requires otherwise and Medical Group has obtained prior authorization from Plan or Payor, as appropriate.
   b) Notify Plan or Payor, as appropriate, by telephone at least 48 hours prior to a scheduled admission of a Member.
   c) Notify Plan or Payor, as appropriate, immediately (within one business day) if Medical Group admits a Member to a hospital for an emergency or for observation.
   d) If the Medical Group Physician providing the Health Services is a Referral Physician, the Medical Group Physician must also notify the Member's Primary Care Physician of all admissions in accordance with the above time frames.

Failure to comply with the above may result in denial of payment to Medical Group and/or termination of this Agreement. If any payment to Medical Group is denied due to Medical Group's failure to comply with the above protocols, Medical Group shall not bill the Member for the denied amounts.

Failure to obtain prior authorization as required will result in denial of payment to Medical Group.

3.6 Medical Group Physicians. Acceptance of Medical Group as a Participating Provider is subject to the requirement that all physicians that join Medical Group become Participating Providers. However, Medical Group understands that all current and future physicians that join Medical Group must go through the Plan credentialing process before they are accepted as Participating Providers. Medical Group also understands that Medical Group Physicians may be individually terminated as Participating Providers pursuant to section 9.3 of this Agreement. Medical Group shall notify Plan of all Medical Group Physicians who are added to the staff of Medical Group as well as those who are no longer on the staff of Medical Group.

SECTION 4
Payment Provisions

4.1 Payment. For the provision of Health Services to a Member, Payor shall pay Medical Group the applicable amounts stated in the attached Appendices. The obligation for payment under this Agreement for Health Services rendered to a Member is solely that of Payor.

If the payment method under this Agreement is capitated, capitation payment will begin, calculated from the date of enrollment, no later than 60 days following the date a Member has selected or has been assigned to a Primary Care Physician. If selection or assignment does not occur at the time of enrollment, capitation which would otherwise have been paid to a selected Primary Care Physician, had a selection been made, will be reserved as a capitation payable until such time as a Member makes a selection or Plan assigns a Primary Care Physician.

Any payments made directly or indirectly to Medical Group under any provision of this Agreement are not made as an inducement to reduce or limit necessary services to any Member.

Medical Group shall accept as payment in full for Health Services rendered to Members such amounts as are paid by Payor pursuant to this Agreement, and shall not bill Members for non-covered charges which result from Payor's reimbursement methodologies. In no event shall Medical Group bill a Member for the difference between Customary Charges and the amount Medical Group has agreed to accept as full reimbursement under this Agreement. Medical Group may collect Member Expenses from the Member. If Payor denies payment for services rendered by Medical Group on grounds that the services are not medically necessary, as defined in the Member's Benefit Contract, Medical Group shall not collect payment from the Member for the services unless Medical Group first obtains the Member's written consent.

4.2 Submission of Claims. Medical Group shall submit claims for Health Services to Plan in a manner and format prescribed by Plan, which may be an electronic format. All information necessary to process the claims must be received by Plan no more than 90

days from the date the Health Services are rendered. Medical Group agrees that claims received after this time period may be rejected for payment, at Plan's and/or Payor's discretion.

Unless otherwise directed by Plan, Medical Group shall submit claims using current HCFA 1500 or UB92 forms, whichever is appropriate, with applicable coding including, but not limited to, ICD9, CPT, Revenue and HCPCS coding. Medical Group shall include in a claim the Member number, Customary Charges for the Health Services rendered to a Member during a single instance of service, Medical Group's Federal Tax I.D. number and/or other identifiers requested by Plan.

Medical Group shall not bill the Member for Health Services if Medical Group fails to submit claims in accordance with the above provisions.

Payor shall have the right to make, and Medical Group shall have the right to request, corrective adjustments to a previous payment, provided however, that Payor shall have no obligation to pay additional amounts after 12 months from the date the initial claim was paid. - time period?

4.3 Prompt Payment. For the provision of Health Services to a Member, Payor shall pay Medical Group the applicable amounts stated in the attached Appendices within 45 days of Plan's receipt of all information necessary to process the claim.

4.4 Coordination of Benefits. Medical Group shall be paid in accordance with Payor's coordination of benefits rules.

4.5 Financial Responsibility. Plan shall notify Medical Group in writing if Plan determines that a Payor has failed to maintain its responsibility to pay for services rendered. Any services which have been rendered by Medical Group prior to and after such notification, and which were not paid for by Payor, shall be considered ineligible for reimbursement under this Agreement, and Medical Group may bill the Member directly for such services.

4.6 Member Protection Provision. This provision supersedes and replaces the Financial Responsibility section when Plan is the Payor, when required by a specific Payor other than Plan, or when required pursuant to applicable statutes and regulations.

In no event, including, but not limited to, non-payment by Payor for Health Services rendered to Members by Medical Group, insolvency of Payor, or breach by Plan of any term or condition of this Agreement, shall Medical Group bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member or persons acting on behalf of the Member for Health Services eligible for reimbursement under this Agreement; provided, however, that Medical Group may collect from the Member, Member Expenses or charges for services not covered under the Member's Benefit Contract.

The provisions of this section shall (1) apply to all Health Services rendered while this Agreement is in force; (2) with respect to Health Services rendered while this Agreement is in force, survive the termination of this Agreement regardless of the cause of termination; (3) be construed to be for the benefit of the Members; and (4) supersede any oral or written agreement, existing or subsequently entered into, between Medical Group and a Member or person acting on a Member's behalf, that requires the Member to pay for such Health Services.

Any modification, addition or deletion to this section shall become effective on a date no earlier than 15 days after the commissioner of insurance has received written notice of such proposed changes.

SECTION 5
Liability of Parties, Laws, Regulations and Licenses

5.1 Medical Group Liability Insurance. Medical Group shall procure and maintain, at Medical Group's sole expense, (1) medical malpractice insurance in the amounts of Two Hundred Thousand Dollars ($200,000.00) per occurrence and Six Hundred Thousand Dollars ($600,000.00) aggregate, and (2) comprehensive general and/or umbrella liability insurance in the amount of Two Hundred Thousand Dollars ($200,000.00) per occurrence and aggregate. Medical Group shall also require that all health care professionals employed by or under contract with Medical Group to render Health Services to Members procure and maintain malpractice insurance, unless they are covered under Medical Group's insurance policies. Medical Group's and other health care professionals' medical malpractice insurance shall be either occurrence or claims made with an extended period reporting option under such terms and conditions as may be reasonably required by Plan. Prior to the Effective Date of this Agreement and at each policy renewal thereafter, Medical Group shall submit to Plan in writing evidence of insurance coverage.

5.2 Laws, Regulations and Licenses. Medical Group shall maintain all federal, state and local licenses, certifications and permits, without material restriction, which are required to provide health care services according to the laws of the jurisdiction in which Health Services are provided, and shall comply with all applicable statutes and regulations. Medical Group shall also require that all health care professionals employed by or under contract with Medical Group to render Health Services to Members, including covering physicians, comply with this provision.

SECTION 6
Notices

Medical Group shall notify Plan within 10 days of knowledge of the following:

1. Changes in liability insurance carriers, termination of, renewal of or any other material changes in Medical Group's liability insurance, including reduction of limits, erosion of aggregate, changes in retention or non-payment of premium.

2. Action which may result in the suspension, revocation, condition limitation, qualification or other material restriction on a Medical Group Physician's licenses, certifications and permits by any government under which a Medical Group Physician is authorized to provide health care services; and, of any suspension, revocation, condition, limitation, qualification or other material restriction of a Medical Group Physician's staff privileges at any licensed hospital, nursing home or other facility at which a Medical Group Physician has staff privileges during the term of this Agreement.

3. A change in Medical Group's name, ownership or Federal Tax I.D. number.

4. Indictment, arrest or conviction for a felony or for any criminal charge related to the practice of Medical Group's profession.

Unless otherwise specified in this Agreement, any notice or other communication required or permitted shall be in writing. All written notices or communication shall be deemed to have been given when delivered in person or by facsimile; or, if delivered by first-class United States mail, or the date mailed, proper postage prepaid and properly addressed to the appropriate party at the address set forth at the signature portion of this Agreement or to another more recent address of which the sending party has received written notice. The parties shall provide each other with proper addresses of all designees that should receive certain notices or communication instead of that party.

SECTION 7
Records

7.1 Confidentiality of Records. Plan and Medical Group shall maintain the confidentiality of all Member records in accordance with any applicable statutes and regulations.

7.2 Maintenance of and Plan Access to Records. Medical Group will maintain adequate medical, financial and administrative records related to Health Services rendered by Medical Group under this Agreement. In order to perform its utilization management and quality improvement activities, Plan shall have access to such information and records, including claims records, within 14 days from the date the request is made, except that, in the case of an audit by Plan such access shall be given at the time of the audit. If requested by Plan, Medical Group shall provide copies of such records at $.05 per copied page not to exceed $25 per record. Unless a longer time period is required by applicable statutes or regulations, Plan shall have access to and the right to audit information and records during the term of this Agreement and for 3 years

following its termination. It is Medical Group's responsibility to obtain any Member consent required in order to provide Plan with requested information and records or copies of records.

7.3 Government and Accrediting Agency Access to Records. The federal, state and local government, or accrediting agencies including, but not limited to, the National Committee for Quality Assurance (the "NCQA"), and any of their authorized representatives, shall have access to, and Plan and Medical Group are authorized to release, in accordance with applicable statutes and regulations, all information and records or copies of such, within the possession of Plan or Medical Group, which are pertinent to and involve transactions related to this Agreement if such access is necessary to comply with accreditation standards, statutes or regulations applicable to Plan, Payor or Medical Group.

SECTION 8
Resolution of Disputes

The parties will work together in good faith to resolve any disputes about their business relationship. If the parties are unable to resolve the dispute within 30 days following the date one party sent written notice of the dispute to the other party, and if either party wishes to pursue the dispute, it shall be submitted to binding arbitration in accordance with the rules of the American Arbitration Association. In no event may arbitration be initiated more than one year following the sending of written notice of the dispute. Any arbitration proceeding under this Agreement shall be conducted in Dallas County, Texas. The arbitrators may construe or interpret but shall not vary or ignore the terms of this Agreement, shall have no authority to award any extracontractual damages of any kind, including punitive or exemplary damages, and shall be bound by controlling law. If the dispute pertains to a matter which is generally administered by certain Plan procedures, such as a credentialing or quality improvement plan, the procedures set forth in that plan must be fully exhausted by Medical Group before Medical Group may invoke its right to arbitration under this section. The parties acknowledge that because this Agreement affects interstate commerce the Federal Arbitration Act applies. Notwithstanding the foregoing, the provision of this section 8 shall not apply to disputes arising under or relating to agreements other than this Agreement that were in place.

SECTION 9
Term and Termination

9.1 Term. This Agreement shall begin on the Effective Date and it shall remain in effect for one year, and shall automatically renew for successive 1-year terms until it is terminated as provided below.

9.2 Termination. This Agreement may be terminated as follows:

1. by mutual agreement of Plan and Medical Group.
2. by either party upon 90 days prior written notice to the other party.
3. by either party, in the event of a breach of this Agreement by the other party, upon 30 days prior written notice to the other party.
4. by Plan immediately upon written notice to Medical Group, due to Medical Group's loss of insurance required under this Agreement.
5. by Medical Group upon 30 days prior written notice to Plan due to an amendment made to this Agreement pursuant to section 10.1.

Plan shall have the right to notify Members of the termination of this Agreement.

9.3 **Termination of Medical Group Physician.** A Medical Group Physician's participation with Plan may be individually terminated under the same conditions Medical Group's participation may be terminated, as specified above. In addition, a Medical Group Physician's participation with Plan may be terminated by Plan (1) immediately upon written notice to the Medical Group Physician due to his or her loss or suspension of licensure or certification, or loss of insurance as required under this Agreement; and (2) in accordance with Plan's credentialing process.

Medical Group shall receive notice of termination by Plan of any Medical Group Physician.

In the event of the termination of a Medical Group Physician, that Medical Group Physician shall not provide Health Services to Members after the effective date of termination, unless otherwise agreed to by Plan in writing.

The termination of any Medical Group Physician shall not constitute termination of the entire Agreement.

9.4 **Termination Procedures.** For purposes of this section, Medical Group Physician and Medical Group shall be referred to as "treating physician" or "physician." In the event that any language in this section conflicts with other provisions of this Agreement, the language in this section shall prevail.

1. The termination of a Medical Group Physician or Medical Group, except for reason of medical competence or professional behavior, does not release Plan or Payor from the obligation to reimburse the treating physician who is treating a Member of special circumstance. "Special circumstance" means a condition such as a disability, acute condition, life threatening illness, or pregnancy of more than 24 weeks, in which the treating physician reasonably believes that transferring the Member's care to another physician could cause harm to the Member. If the treating physician believes that a special circumstance exists, the treating physician may request permission to provide continuing treatment to the Member. Procedures for resolving disputes regarding the necessity for continuing treatment by the treating physician shall be resolved using the appeal procedure for medical

necessity determinations as described in the provider manual. Reimbursement to the treating physician for Health Services of special circumstance shall be made at the negotiated rates as set forth in this Agreement. The treating physician agrees not to seek payment from the Member for any amounts which would have been covered as Health Services if the treating physician were still a Participating Provider. The Plan or Payor shall not be obligated to reimburse the treating physician for ongoing treatment of a Member that is provided:

a) 90 days or more after the effective date of the treating physician's termination; or

b) beyond nine months in the case of a Member who at the time of the treating physician's termination has been diagnosed with a terminal illness; or

c) beyond the delivery and immediate postpartum care, including the follow-up checkup within the first six weeks of delivery, in the case of a Member who is past the 24th week of pregnancy at the time of the treating physician's termination.

2. To aid in the continuity of treatment, the treating physician shall transfer the Member's medical records to the Member's new physician. Plan shall provide reasonable notice to Members regarding the impending termination of his or her treating physician. Reasonable notice is defined as 30 days prior to termination or as soon thereafter as reasonably possible.

3. No retaliatory action shall occur, including termination or refusal to renew a contract, against a physician, because the physician has, on behalf of a Member, reasonably filed a complaint against Plan or has appealed a decision of the Plan.

4. Plan will provide the physician with a written explanation of the reason for termination. The physician may request and is entitled to a review of the proposed termination prior to the effective date of the termination and within 60 days of such request except: (a) in cases in which there is imminent harm to patient health, or (b) an action by a state medical board, licensing board or other governmental agency that effectively impairs the physician's ability to practice medicine, or (c) in cases of fraud or malfeasance. The decision of the advisory panel must be considered but is not binding on Plan. Plan shall provide the affected physician, upon request, a copy of the recommendation of the advisory review panel and Plan's determination.

5. Plan and physician will remain liable for any obligations or liabilities arising from conduct prior to termination. Physician shall notify any Member seeking his/her professional services after the date of termination that physician is no longer a Participating Provider. If physician provides services to a Member after the date of termination and fails to provide notice as described in this section, physician agrees that payment for such services shall be made at the rates set forth in this Agreement. This Section survives the termination of this Agreement.

SECTION 10
Miscellaneous

10.1 Amendment. Plan may amend this Agreement to comply with the requirements of state and federal regulatory authorities, and shall give written notice to Medical Group of such amendment and its effective date. Unless such regulatory authorities direct otherwise, the signature of Medical Group will not be required. All other amendments require mutual written consent by both parties.

10.2 Assignment. Plan may assign all or any of its rights and responsibilities under this Agreement to any entity controlling, controlled by or under common control with Plan. Medical Group may assign any of its rights and responsibilities under this Agreement to any person or entity only upon the prior written consent of Plan, which consent shall not be unreasonably withheld.

10.3 Administrative Responsibilities. Plan may delegate certain administrative responsibilities under this Agreement to another entity, including, but not limited to, Payor or its designee. In addition, certain Payor responsibilities may actually be performed by its designee.

10.4 Relationship Among the Parties. The relationship among the parties is solely that of independent contractors and nothing in this Agreement or otherwise shall be construed or deemed to create any other relationship, including one of employment, agency or joint venture.

10.5 Name, Symbol and Service Mark. During the term of this Agreement, Medical Group, Plan and Payor shall have the right to use each other's name solely to make public reference to Medical Group as a Participating Provider. Medical Group, Plan and Payor shall not otherwise use each other's name, symbol or service mark without prior written approval.

10.6 Confidentiality. No party shall disclose to third parties any confidential or proprietary business information which it receives from the other party, including, but not limited to, financial statements, business plans, protocols and programs; except that (1) Medical Group may disclose information to a Member relating to the Member's treatment plan and the payment methodology, but not specific rates, and (2) Plan may disclose certain terms to Payors or designees that need the information to process claims or administer a Benefit Contract, and may file the form of this Agreement with any federal or state regulatory entity as may be required by applicable law.

10.7 Communication. Plan encourages Medical Group to discuss with Members treatment options and their associated risks and benefits, regardless of whether the treatment is covered under the Member's Benefit Contract. Nothing in this Agreement is intended to interfere with Medical Group's relationship with Members as patients of

Medical Group, or with Plan's ability to administer its quality improvement, utilization management and credentialing programs.

10.8 Appendices. Additional and/or alternative provisions, if any, related to certain Health Services rendered by Medical Group to Members covered by certain Benefit Contracts are set forth in the Appendices.

10.9 Entire Agreement. This Agreement constitutes the entire agreement between the parties in regard to its subject matter.

10.10 Governing Law. This Agreement shall be governed by and construed in accordance with applicable state law and ERISA.

10.11 Medicare Members. If a Medicare Appendix is attached to this Agreement, Medical Group agrees to provide Health Services to Members who are enrolled in a Benefit Contract for Medicare beneficiaries. Medical Group also understands that Plan's agreements with Participating Providers are subject to review and approval by the Health Care Financing Administration ("HCFA"). Medical Group is in compliance with any applicable HCFA regulations including those related to private contracts.

10.12 Posting of Complaint Procedure. As required by Texas law, Medical Group shall post a notice in Medical Group's office notifying Members of the process for resolving complaints with Plan. The notice must include the Texas Department of Insurance's toll-free number for filing complaints.

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

The Effective Date of this Agreement is _____

United HealthCare of Texas, Inc.
4835 LBJ Freeway, Suite 1100
Dallas, TX 75244

Signature _____
Robert H. Jacomin, M.D.

Title COO

Date _____

North Texas Ear, Nose & Throat Associates
4333 Josey Lane, Suite 100
Carrollton, TX 75010

Signature _____

Name _____

Date _____

TIN # Various

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

The Effective Date of this Agreement is 6-1-2000.

United HealthCare of Texas, Inc.
4835 LBJ Freeway, Suite 1100
Dallas, TX 75244

Signature _____
Robert H. Jacqmin, M.D

Title COO

Date 6-2-00

North Texas Ear, Nose & Throat Associates
4333 Josey Lane, Suite 100
Carrollton TX 75010

Signature _____

Name John M. Moore, M.D

Date 12-13-99

TIN # Various

All Payor Appendix
Fee Maximum

APPLICABILITY

Unless another Appendix to this Agreement applies specifically to certain Members, the provisions of this Appendix apply to Health Services rendered by Medical Group to Members covered by Benefit Contracts sponsored, issued or administered by all Payors.

SECTION 1
Definitions

Fee Maximums: The maximum fees for Health Services rendered by Participating Providers. Samples of the most recent Fee Maximums are available to Medical Group upon request.

SECTION 2
Payment

Payor shall pay Medical Group for Health Services rendered to a Member the lesser of (1) eighty percent (80%) of Medical Group's Customary Charge, less any applicable Member Expenses, or (2) the Fee Maximum for such Health Services, less any applicable Member Expenses. For the purposes of this Agreement Fee Maximum shall be defined as follows:

- HMO and Choice products - approximately 130% of 1997 Medicare RBRVS
- POS, EPO and PPO products - approximately 145% of 1997 Medicare RBRVS
- All products – 100% AWP for drugs/supplies; AWP values will be updated on a quarterly basis by Plan/Payor
- Clinical laboratory services will be reimbursed at national laboratory rates

Exhibit 1
Networks of Participating Providers

Medical Group shall participate in the networks of Participating Providers established by Plan for the Benefit Contract types identified below:

- Benefit Contracts where Members are offered a network of Participating Providers and must select a Primary Care Physician. The Primary Care Physician coordinates the Member's care and approves the rendering of Health Services to Members by other providers. An option for this Benefit Contract allows the Member to receive Health Services from a Participating or non-Participating Provider, without the approval of the Primary Care Physician.

- Benefit Contracts where Members are offered a network of Participating Providers but are not required to select a Primary Care Physician. The Member may receive Health Services from a Participating Provider of his or her choice. An option for this Benefit Contract allows the Member to receive Health Services from non-Participating Providers.

- Benefit Contracts where Members are not offered a network of Participating Providers from which they may receive Health Services.

Medical Group shall **NOT** participate in the networks of Participating Providers established by Plan for the Benefit Contract types identified below:

- Benefit Contracts for workers' compensation benefit programs.

Plan may establish one or more limited, custom networks of Participating Providers for any of the commercial Benefit Contract types described above. These networks are established upon a Payor's or client's request, and may or may not be subsets of the commercial networks of Participating Providers described above. Provider shall participate in these custom networks in Plan's sole discretion.

CONFIDENTIAL

Texas Medical & Surgical Associates
8440 Walnut Hill Lane, Suite 400 • Dallas, Texas 75231 • (214) 345-1400

Date: 2-15-05 Time: 11:15

Please deliver the following 17 pages (including this cover page) to:

Name: Michele Torne

Firm: _____ Telephone # _____

Address: _____ Fax # 817-423-2161

From: Kim Weaver

If you do not receive all pages properly, please call (214) 345-5755

Our Fax number is (214) 345-1452

Message:

UHC Contract