RESOLUTION

R2024-016

A Resolution Authorizing the County Administrator to Execute the UnitedHealthcare Ancillary Provider Participation Agreement.

Be it resolved by the County Board of the County of DeKalb, Illinois as follows:

WHEREAS, the DeKalb County Rehab & Nursing Center, in conjunction with Jordan Healthcare Group, has been working with local medical institutions to raise the census of the facility; and

WHEREAS, representatives of UnitedHealthcare have asked that the DCRNC become a provider under their network; and

WHEREAS, the Ancillary Provider Participation Agreement will allow the DCRNC to provide care for patients covered by UnitedHealthcare Insurance Company; and

WHEREAS, entering into this agreement provides opportunities to grow the census of the DCRNC; and

WHEREAS, Jordan Healthcare Group and the Human & Health Services Committee have reviewed the Ancillary Provider Participation Agreement ("Exhibit A") and believes that it is in the best interest of the DCRNC to enter into said agreement; and

NOW, THEREFORE, BE IT RESOLVED the DeKalb County Board hereby authorizes the County Administrator to execute the UnitedHealthcare Ancillary Provider Participation Agreement.

PASSED THIS 17TH DAY OF JANUARY, 2024 AT SYCAMORE, ILLINOIS

ATTEST:

Tasha Sims
DeKalb County Clerk

SIGNED:

Suzanne Willis, Chair
DeKalb County Board

Ancillary Provider Participation Agreement

This Agreement is entered into by and between UnitedHealthcare Insurance Company, contracting on behalf of itself, UnitedHealthcare of Illinois, Inc., and the other entities that are United's Affiliates (collectively referred to as "United") and Dekalb County Government dba Dekalb County Rehab & Nursing Center ("Facility").

This Agreement is effective on the later of the following dates (the "Effective Date"):

i) ________ or

ii) the first day of the first calendar month that begins at least 30 days after the date when this Agreement has been executed by all parties.

Through contracts with physicians and other providers of health care services, United maintains one or more networks of providers that are available to Customers. Facility is a provider of health care services.

United wishes to arrange to make Facility's services available to Customers. Facility wishes to provide those services, under the terms and conditions set forth in this Agreement.

The parties therefore enter into this Agreement.

Article I.
Definitions

The following terms when used in this Agreement have the meanings set forth below:

1.1 **Benefit Plan** means a certificate of coverage, summary plan description, or other document or agreement, whether delivered in paper or electronic format, under which a Payer is obligated to provide coverage of Covered Services for a Customer.

1.2 **Covered Service** is 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.

1.3 **Customary Charge** is the fee for health care services charged by Facility that does not exceed the fee Facility would ordinarily charge another person regardless of whether the person is a Customer.

1.4 **Customer** is a person eligible and enrolled to receive coverage from a Payer for Covered Services.

1.5 **Payment Policies** are the guidelines adopted by United for calculating payment of claims to facilities (including claims of Facility under this Agreement). The Payment Policies operate in conjunction with the specific reimbursement rates and terms set forth in the Payment Appendix or Payment Appendices to this Agreement. The Payment Policies may change from time to time as discussed in section 5.1 of this Agreement.

1.6 Payer is an entity obligated to a Customer to provide reimbursement for Covered Services under the Customer's Benefit Plan, and authorized by United to access Facility's services under this Agreement.

1.7 Protocols are the programs and administrative procedures adopted by United or a Payer to be followed by Facility in providing services and doing business with United and Payers under this Agreement. These Protocols may include, among other things, credentialing and recredentialing processes, utilization management and care management processes, quality improvement, peer review, Customer grievance, or concurrent review. The Protocols may change from time to time as discussed in section 4.4 of this Agreement.

1.8 United's Affiliates are those entities controlling, controlled by, or under common control with UnitedHealthcare Insurance Company.

Article II.
Representations and Warranties

2.1 Representations and warranties of Facility. Facility, by virtue of its execution and delivery of this Agreement, represents and warrants as follows:

i) Facility is a duly organized and validly existing legal entity in good standing under the laws of its jurisdiction of organization.

ii) Facility has all requisite corporate power and authority to conduct its business as presently conducted, and to execute, deliver and perform its obligations under this Agreement. The execution, delivery and performance of this Agreement by Facility have been duly and validly authorized by all action necessary under its organizational documents and applicable corporate law. This Agreement has been duly and validly executed and delivered by Facility and (assuming the due authorization, execution and delivery of this Agreement by United) constitutes a valid and binding obligation of Facility, enforceable against Facility in accordance with its terms, except as enforceability may be limited by the availability of equitable remedies or defenses and by applicable bankruptcy, insolvency, reorganization, moratorium or similar laws affecting the enforcement of creditors' rights generally.

iii) The execution, delivery and performance of this Agreement by Facility do not and will not violate or conflict with (a) the organizational documents of Facility, (b) any material agreement or instrument to which Facility is a party or by which Facility or any material part of its property is bound, or (c) applicable law.

iv) Facility has obtained and holds all registrations, permits, licenses, and other approvals and consents, and has made all filings, that it is required to obtain from or make with all governmental entities under applicable law in order to conduct its business as presently conducted and to enter into and perform its obligations under this Agreement.

v) Facility has been given an opportunity to review the Protocols and Payment Policies. See the Additional Manuals Appendix for additional information regarding the Protocols and Payment Policies applicable to Customers enrolled in certain Benefit Plans.

vi) Each submission of a claim by Facility pursuant to this Agreement constitutes the representation and warranty by it to United that (a) it has complied with the requirements of this Agreement with respect to the Covered Services involved and the submission of the claim, (b) the charge amount set forth on the claim is the Customary Charge and (c) the claim is a valid claim.

2.2 Representations and warranties of United. United, by virtue of its execution and delivery of this Agreement, represents and warrants as follows:

i) United is a duly organized and validly existing legal entity in good standing under the laws of its jurisdiction of organization.

ii) United has all requisite corporate power and authority to conduct its business as presently conducted, and to execute, deliver and perform its obligations under this Agreement. The execution, delivery and performance of this Agreement by United have been duly and validly authorized by all action necessary under its organizational documents and applicable corporate law. This Agreement has been duly and validly executed and delivered by United and (assuming the due authorization, execution and delivery of this Agreement by Facility) constitutes a valid and binding obligation of United, enforceable against United in accordance with its terms, except as enforceability may be limited by the availability of equitable remedies or defenses and by applicable bankruptcy, insolvency, reorganization, moratorium or similar laws affecting the enforcement of creditors' rights generally.

iii) The execution, delivery and performance of this Agreement by United do not and will not violate or conflict with (a) the organizational documents of United, (b) any material agreement or instrument to which United is a party or by which United or any material part of its property is bound, or (c) applicable law.

iv) United has obtained and holds all registrations, permits, licenses, and other approvals and consents, and has made all filings, that it is required to obtain from or make with all governmental entities under applicable law in order to conduct its business as presently conducted and to enter into and perform its obligations under this Agreement.

Article III.
Applicability of this Agreement

3.1 Facility's services.

i) This Agreement applies to Covered Services provided at Facility's service locations set forth in Appendix 1. If the service location is not listed in Appendix 1, this section 3.1 and this Agreement should nevertheless be understood as applying to the actual service locations that existed when this Agreement was executed, rather than to a billing address, post office box, or any other address set forth in Appendix 1.

In the event Facility begins providing services at other service locations, or under other Taxpayer Identification Number(s), those additional Taxpayer Identification Numbers, or locations will become subject to this Agreement only upon the written agreement of the parties. This subsection 3.1(i) applies to cases when Facility adds the location itself (such as through new construction or through conversion of a free-standing location to provider-based), and when Facility acquires, merges or comes under common ownership

with an existing provider that was not already under contract with United or one of United's Affiliates to participate in a network of health care providers).

ii) In the event Facility acquires or is acquired by, merges with, or otherwise becomes affiliated with another provider of health care services that is already under contract with United or one of United's Affiliates to participate in a network of health care providers, the payment rates for each of Facility's locations specified in this Agreement and the payment rates for the other provider will be (a) the rates set forth in the other agreement, or (b) the rates set forth in the applicable Payment Appendix to this Agreement, as decided by United with written notice to Facility.

iii) Facility will not transfer all or some of its assets to any other entity during the term of this Agreement, with the result that all or some of the Covered Services subject to this Agreement will be rendered by the other entity rather than by Facility, without the express written agreement of United. This subsection 3.1(iii) applies to arrangements under which another provider leases space from Facility after the Effective Date of this Agreement, so that Covered Services that were subject to this Agreement as of the Effective Date of this Agreement are rendered instead by another provider after the lease takes place.

3.2 Payers and Benefit Plans. United may allow Payers to access Facility's services under this Agreement for certain Benefit Plans, as described in Appendix 2. Appendix 2 may be modified by United upon 30 days written or electronic notice.

Section 8.3 of this Agreement will apply to Covered Services provided to Customers covered by Benefit Plans that are added to the list in Appendix 2 of Benefit Plans excluded from this Agreement as described above.

3.3 Patients who are not Customers. This Agreement does not apply to services rendered to patients who are not Customers at the time the services were rendered. Section 6.6 of this Agreement addresses circumstances in which claims for services rendered to those patients are inadvertently paid.

3.4 Health care. This Agreement and Customer Benefit Plans do not dictate the health care provided by Facility, or govern Facility's determination of what care to provide its patients, even if those patients are Customers. The decision regarding what care is to be provided remains with Facility and with Customers and their physicians, and not with United or any Payer.

3.5 Communication with Customers. Nothing in this Agreement is intended to limit Facility's right or ability to communicate fully with a Customer and the Customer's physician regarding the Customer's health condition and treatment options. Facility is free to discuss all treatment options without regard to whether or not a given option is a Covered Service. Facility is free to discuss with a Customer any financial incentives Facility may have under this Agreement, including describing at a general level the payment methodologies contained in this Agreement. Facility may also assist a Customer in estimating the cost of a given Covered Service.

Article IV.
Duties of Facility

4.1 Provide Covered Services. Facility will provide Covered Services to Customers. Facility must be in compliance with section 2.1(iv) of this Agreement and, to the extent Facility is subject to credentialing by United, Facility must be credentialed by United or its delegate prior to furnishing any Covered Services to Customers under this Agreement.

4.2 Nondiscrimination. Facility will not discriminate against any patient, with regard to quality of service or accessibility of services, on the basis that the patient is a Customer.

4.3 Accessibility. At a minimum, Facility will be open during normal business hours, Monday through Friday.

4.4 Cooperation with Protocols. Facility will cooperate with and be bound by United's and Payers' Protocols. The Protocols include but are not limited to all of the following:

i) For non-emergency Covered Services, Facility will assist Customers to maximize their benefits by referring or directing Customers only to other providers that participate in United's network, except as authorized by United through United's process for approving out-of-network services for in-network benefits.

ii) As further described in the Protocols, Facility will provide notification and participate in utilization management programs regarding certain Covered Services, accept and return telephone calls from United staff, and respond to United requests for clinical information as required by United or Payer.

iii) Facility will make reasonable commercial efforts to assure that all Facility-based physician groups participate in United's network as long as this Agreement is in effect.

In the event that a Facility-based physician group is not a participating provider with United, Facility's Chief Financial Officer or equivalent senior level officer ("Facility Representative") will assist United in its efforts to negotiate an agreement with that group. Upon request by United, Facility Representative will:

a) meet with Facility-based physician group to encourage participation and require exchange of proposals. Facility Representative will provide United with meeting minutes within 15 days after the meeting. Meeting minutes will include a summary of the key discussion points and an outline of any actionable resolution options deemed by Facility Representative.

b) write letter(s) to Facility-based physician group encouraging the group to negotiate in good faith with United. The letter will also outline any contractual requirements in the agreement between Facility and Facility-based physician group that requires Facility-based physician group to negotiate in good faith with third party payers, or participate in third party payer networks, and any other provisions related to Facility-based physician group's participation with third party payers.

c) invoke any applicable penalties or other contractual terms in its agreement with Facility-based physician group related to its non-participating status with a third party payer.

d) allow independent legal counsel (mutually agreeable to all relevant parties) to review Facility's agreement with the Facility-based physician group to ensure Facility is fully invoking all the relevant terms and conditions of that agreement to require or

promote Facility-based physician group's participation status with United.

United will negotiate with Facility-based physician groups in good faith. United has no responsibility for the credentialing of any employed or sub-contracted Facility-based provider.

The Protocols will be made available to Facility online or upon request. Some or all Protocols also may be disseminated in the form of an administrative manual or guide or in other communications. Currently, the Protocols may be found at www.UHCprovider.com. United will notify Facility of any changes in the location of the Protocols.

United may change the Protocols from time to time. United will use reasonable commercial efforts to inform Facility at least 30 days in advance of any material changes to the Protocols. United may implement changes in the Protocols without Facility's consent if the change is applicable to all or substantially all facilities of the same type and in the same state as Facility (as used in this sentence, examples of a type of facility are an inpatient hospital, SNF, rehab hospital, or ambulatory surgery center). Otherwise, changes to the Protocols proposed by United to be applicable to Facility are subject to the terms of section 9.2 of this Agreement applicable to amendments.

4.5 **Employees and subcontractors.** Facility will assure that its employees, affiliates and any individuals or entities subcontracted by Facility to render services in connection with this Agreement adhere to the requirements of this Agreement. The use of employees, affiliates or subcontractors to render services in connection with this Agreement will not limit Facility's obligations and accountability under this Agreement with regard to these services. Facility affiliates are those entities that control, are controlled by or are under common control with Facility.

4.6 **Licensure.** Facility will maintain, without material restriction, such licensure, registration, and permits as are necessary to enable Facility to lawfully perform this Agreement.

4.7 **Liability insurance.** Facility will procure and maintain liability insurance. Except to the extent coverage is a state mandated placement, Facility's coverage must be placed with responsible, financially sound insurance carriers authorized or approved to write coverage in the state in which the Covered Services are provided. Facility's liability insurance must be, at a minimum, of the types and in the amounts set forth below. Facility's medical malpractice insurance must be either occurrence or claims made with an extended period reporting option. Prior to the Effective Date of this Agreement and within 10 days of each policy renewal thereafter, Facility will submit to United in writing evidence of insurance coverage.

TYPE OF INSURANCE	MINIMUM LIMITS
Medical malpractice and/or professional liability insurance	One Million Dollars ($1,000,000.00) per occurrence and Three Million Dollars ($3,000,000.00) aggregate
Commercial general and/or umbrella liability insurance	One Million Dollars ($1,000,000.00) per occurrence and aggregate

In lieu of purchasing the insurance coverage required in this section, Facility may, with the prior written approval of United, self-insure its medical malpractice and/or professional liability, as well as its commercial general liability. Facility will maintain a separate reserve for its self-

insurance. Prior to the Effective Date, Facility will provide a statement, verified by an independent auditor or actuary, that its reserve funding levels and process of funding appears adequate to meet the requirements of this section and fairly represents the financial condition of the fund. Facility will provide a similar statement during the term of this Agreement upon United's request, which will be made no more frequently than annually. Facility will assure that its self-insurance fund will comply with applicable laws and regulations.

4.8 Notice by Facility. Facility will give notice to United within 10 days after any event that causes Facility to be out of compliance with section 4.6 or 4.7 of this Agreement, or of any change in Facility's name, ownership, control, or Taxpayer Identification Number.

In addition, Facility will give written notice to United 45 days prior to the effective date of changes in existing remit address(es) and other demographic information.

4.9 Customer consent to release of medical record information. Facility will obtain any Customer consent required in order to authorize Facility to provide access to requested information or records as contemplated in section 4.10 of this Agreement, including copies of the Facility's medical records relating to the care provided to Customer.

4.10 Maintenance of and access to records. Facility will maintain medical, financial and administrative records related to Covered Services rendered by Facility under this Agreement, including claims records, for at least 6 years following the end of the calendar year during which the Covered Services are provided, unless a longer retention period is required by applicable law.

Facility will provide access to these records as follows:

i) to United or its designees, in connection with United's utilization management, quality assurance and improvement and for claims payment, health care operations and other administrative obligations, including reviewing Facility's compliance with the terms and provisions of this Agreement and appropriate billing practice. Facility will provide access during ordinary business hours within fourteen days after a request is made, except in cases of a United billing audit involving an allegation of fraud or abuse or the health and safety of a Customer (in which case, access must be given within 48 hours after the request) or of an expedited Customer appeal or grievance (in which case, access will be given so as to enable United to reasonably meet the timelines for determining the appeal or grievance). If records are requested to adjudicate a claim or to make a decision regarding a request for correction under 6.10, or regarding an appeal, Facility will provide copies of the requested records within fourteen days after the request is made; and

ii) to agencies of the government, in accordance with applicable law, to the extent that access is necessary to comply with regulatory requirements applicable to Facility, United, or Payers.

Facility will cooperate with United on a timely basis in connection with any such record request including, among other things, in the scheduling of and participation in an interview to review findings, within 30 days after United's request.

If such information and records are requested by United, Facility will provide copies of the records free of charge.

4.11 **Access to data.** Facility will collect and provide to United aggregate, de-identified quality data relating to care rendered at the Facility for United's use in responding to requests for such data from recognized employer coalitions (e.g., Leapfrog) or other recognized organizations that focus on quality of care. Facility will also provide such data to United that Facility provides to other third parties, such as other insurers, employer coalitions, government agencies, and accrediting bodies.

4.12 **Compliance with law.** Facility will comply with applicable regulatory requirements, including but not limited to those relating to confidentiality of Customer medical information.

4.13 **Electronic connectivity.** When made available by United, Facility will do business with United electronically. Facility will use www.UHCprovider.com to check eligibility status, claims status, and submit requests. Facility will use www.UHCprovider.com for additional functionalities (for instance, notification of admission) after United informs Facility that these functionalities have become available for the applicable Customer.

Article V.
Duties of United and Payers

5.1 **Payment of claims.** As described in further detail in Article VI of this Agreement, Payers will pay Facility for rendering Covered Services to Customers. United will make its Payment Policies available to Facility online or upon request. United may change its Payment Policies from time to time, and will make information available describing the change.

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United may amend this Agreement to add or modify contract rates for particular Benefit Plans ("Payment Terms Amendment"), upon 90 days prior written notice to Facility. Facility's signature is not required to make the Payment Terms Amendment effective. However, Facility may at that time elect not to participate in the impacted Benefit Plans, by sending written notice to United at the address set forth on the signature page of this Agreement, within 30 days after Facility's receipt of that Payment Terms Amendment.

5.2 **Liability insurance.** United will procure and maintain professional and general liability insurance, as United reasonably determines may be necessary to protect United and United's employees against claims, liabilities, damages or judgments that arise out of services provided by United or United's employees under this Agreement.

5.3 **Licensure.** United will maintain, without material restriction, such licensure, registration, and permits as are necessary to enable United to lawfully perform this Agreement.

5.4 **Notice by United.** United will give written notice to Facility within 10 days after any event that causes United to be out of compliance with section 5.2 or 5.3 of this Agreement, or of any change in United's name, ownership, control, or Taxpayer Identification Number. This section does not apply to changes of ownership or control that result in United being owned or controlled by an entity with which it was already affiliated prior to the change.

5.5 Compliance with law. United will comply with applicable regulatory requirements, including but not limited to those relating to confidentiality of Customer medical information and those relating to prompt payment of claims, to the extent those requirements are applicable.

5.6 Electronic connectivity. United will do business with Facility electronically by providing eligibility status, claims status, and accepting requests for claim adjustments, for those Benefit Plans supported by www.UHCprovider.com. United will communicate enhancements in www.UHCprovider.com functionality as they become available, as described in section 4.13 of this Agreement, and will make information available as to which Benefit Plans are supported by www.UHCprovider.com.

5.7 Employees and subcontractors. United will assure that its employees, affiliates and any individuals or entities subcontracted by United to render services in connection with this Agreement adhere to the requirements of this Agreement. The use of employees, affiliates or subcontractors to render services in connection with this Agreement will not limit United's obligations and accountability under this Agreement with regard to those services.

Article VI.
Submission, Processing, and Payment of Claims

6.1 Form and content of claims. Facility must submit claims for Covered Services as described in the Protocols, using current, correct and applicable coding.

6.2 Electronic filing of claims. Within six months after the Effective Date of this Agreement, Facility will use electronic submission for all of its claims under this Agreement that United is able to accept electronically.

6.3 Time to file claims. Unless a longer timeframe is required under applicable law, all information necessary to process a claim must be received by United no more than 90 days from the date of discharge or from the date outpatient Covered Services are rendered. If Payer is not the primary payer, and Facility is pursuing payment from the primary payer, the timely filing limit will begin on the date Facility receives the claim response from the primary payer.

In the event United requests additional information in order to process a claim, Facility will provide that additional information within 90 days of United's request, unless a longer timeframe is required under applicable law.

6.4 Payment of claims for Covered Services. Payer will pay claims for Covered Services as further described in the applicable Payment Appendix to this Agreement and in accordance with Payment Policies.

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Claims for Covered Services subject to coordination of benefits will be paid in accordance with the Customer's Benefit Plan and applicable state and federal law.

The obligation for payment under this Agreement is solely that of Payer, and not that of United unless United is the Payer.

6.5 Denial of claims for not following Protocols, for not filing timely, for Services not Covered under the Customer's Benefit Plan, or for lack of medical necessity.

i) **Non-compliance with Protocol.** Payment may be denied in whole or in part if Facility does not comply with a Protocol or does not file a timely claim as required under section 6.3 of this Agreement.

In the event payment is denied under this subsection 6.5(i) for Facility's failure to file a timely claim or to comply with a Protocol regarding notification or regarding lack of coverage approval on file, Facility may request reconsideration of the denial, and the denial under this subsection (i) will be reversed if Facility can show that, at the time the Protocols required notification or prior authorization, or at the time the claim was due:

- Facility did not know and was unable to reasonably determine that the patient was a Customer, and
- Facility took reasonable steps to learn that the patient was a Customer, and
- Facility promptly submitted a claim after learning the patient was a Customer.

A claim denied under this subsection (i) is also subject to denial for other reasons permitted under the Agreement; reversal of a denial under this subsection (i) does not preclude United from upholding a denial for one of these other reasons.

ii) **Non-Covered Services.** Services not covered under the applicable Benefit Plan are not subject to the rates or discounts of this Agreement. Facility may seek and collect payment from a Customer for such services (provided that Facility obtained the Customer's written consent).

iii) **Denials for lack of medical necessity through the prior authorization process.** If a service would otherwise be a Covered Service, but is not a Covered Service under the applicable Benefit Plan because it is determined through the prior authorization process to not meet the Benefit Plan's requirement of medical necessity, as defined in the Benefit Plan or applicable law (or not meet a similar concept in the Benefit Plan, such as not being consistent with nationally recognized scientific evidence as available, or not being consistent with prevailing medical standards and clinical guidelines), Facility may seek or collect payment from the Customer but only if, prior to receiving the service, the Customer had knowledge of the determination of non-coverage and specifically agreed in writing to be responsible for payment of those charges.

6.6 Retroactive correction of information regarding whether patient is a Customer. Prior to rendering services, Facility will ask the patient to present his or her Customer identification card. In addition, Facility may contact United to obtain the most current information available to United on the patient's status as a Customer.

However, such information provided by United is subject to change retroactively, under the following circumstances, (i) if United has not yet received information that an individual is no longer a Customer; (ii) if the individual's Benefit Plan is terminated retroactively for any reason including, but not limited to, non-payment of premium; (iii) as a result of the Customer's final decision regarding continuation of coverage pursuant to state and federal laws; or (iv) if eligibility information United receives is later proven to be false.

If Facility provides health care services to an individual, and it is determined that the individual was not a Customer at the time the health care services were provided, those services will not be eligible for payment under this Agreement and any claims payments made with regard to those

services may be recovered as overpayments under the process described in section 6.10 of this Agreement. Facility may then directly bill the individual, or other responsible party, for those services.

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6.7 Payment under this Agreement is payment in full. Payment as provided under section 6.4 of this Agreement, together with any co-payment, deductible or coinsurance for which the Customer is responsible under the Benefit Plan, is payment in full for a Covered Service. Facility will not seek to recover, and will not accept, any payment from Customer, United, Payer or anyone acting on their behalf, in excess of payment in full as provided in this section 6.7, regardless of whether that amount is less than Facility's billed charge or Customary Charge.

6.8 Customer hold harmless. Facility will not bill or collect payment from the Customer, or seek to impose a lien, for the difference between the amount paid under this Agreement and Facility's billed charge or Customary Charge, or for any amounts denied or not paid under this Agreement due to:

i) Facility's failure to comply with the Protocols,

ii) Facility's failure to file a timely claim,

iii) Payer's Payment Policies,

iv) inaccurate or incorrect claim processing,

v) insolvency or other failure by Payer to maintain its obligation to fund claims payments, if Payer is United, or is an entity required by applicable law to assure that its Customers not be billed in these circumstances, or

vi) a denial based on lack of medical necessity or based on consistency with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines, except as provided in section 6.5 of this Agreement.

This obligation to refrain from billing Customers applies even in those cases in which Facility believes that United or Payer has made an incorrect determination. In such cases, Facility may pursue remedies under this Agreement against United or Payer, as applicable, but must still hold the Customer harmless.

In the event of a default by a Payer other than those Payers covered by clause (v) of this section 6.8, Facility may seek payment directly from the Payer or from Customers covered by that Payer. However, Facility may do so only if it first inquires in writing to United as to whether the Payer has defaulted and, in the event that United confirms that Payer has defaulted (which confirmation will not be unreasonably withheld), Facility then gives United 15 days prior written notice of Facility's intent to seek payment from Payer or Customers. For purposes of this paragraph, a default is a systematic failure by a Payer to fund claims payments related to Customers covered through that Payer; a default does not occur in the case of a dispute as to whether certain claims should be paid or the amounts that should be paid for certain claims.

This section 6.8 and section 6.7 will survive the termination of this Agreement, with regard to Covered Services rendered prior to when the termination takes effect.

6.9 Consequences for failure to adhere to Customer protection requirements. If Facility collects payment from, brings a collection action against, or asserts a lien against a Customer for Covered Services rendered (other than for the applicable co-payment, deductible or coinsurance), contrary to section 6.7 or 6.8 of this Agreement, Facility will be in breach of this Agreement. This section 6.9 will apply regardless of whether Customer or anyone purporting to act on Customer's behalf has executed a waiver or other document of any kind purporting to allow Facility to collect such payment from Customer.

In the event of such a breach, Payer may deduct, from any amounts otherwise due Facility, the amount wrongfully collected from Customers, and may also deduct an amount equal to any costs or expenses incurred by the Customer, United or Payer in defending the Customer and otherwise enforcing sections 6.7 through 6.9 of this Agreement. Any amounts deducted by Payer in accordance with this provision will be used to reimburse the Customer and to satisfy any costs incurred. The remedy contained in this paragraph does not preclude United from invoking any other remedy for breach that may be available under this Agreement.

6.10 Correction of claims payments. If Facility does not seek correction of a given claim payment or denial by giving notice to United within 12 months after the claim was initially processed, it will have waived any right to subsequently seek such correction under this section 6.10, or through dispute resolution under Article VII of this Agreement or in any other forum.

Facility will repay overpayments within 30 days of written or electronic notice of the overpayment. Facility will promptly report any credit balance that it maintains with regard to any claim overpayment under this Agreement, and will return the overpayment to United within 30 days after posting it as a credit balance.

Recovery of overpayments may be accomplished by offsets against future payments.

Article VII.
Dispute Resolution

The parties will work together in good faith to resolve any and all disputes between them ("Disputes") including but not limited to the existence, validity, scope or termination of this Agreement or any term thereof, and all questions of arbitrability, with the exception of any question regarding the availability of class arbitration or consolidated arbitration, which is expressly waived below. Disputes also include any dispute in which Facility is acting as the assignee of one or more Customer. In such cases, Facility agrees that the provisions of this Article VII will apply, including without limitation the requirement for arbitration.

If the Dispute pertains to a matter which is generally administered by certain United procedures, such as a credentialing or quality improvement plan, the policies and procedures set forth in that plan must be fully exhausted by Facility before Facility may invoke any right to arbitration under this Article VII. For Disputes regarding payment of claims, a party must have timely initiated, and completed, the claim reconsideration and appeal process as set forth in the Administrative Guide in order to initiate the Dispute process.

If the parties are unable to resolve any such Dispute within 60 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 may do so only by submitting the Dispute to binding arbitration conducted by the American Arbitration Association ("AAA") in accordance with the AAA Healthcare Payor Provider Arbitration Rules, as they

may be amended from time to time (see http://www.adr.org), except that, in any case involving a Dispute in which a party seeks an award of $1,000,000 or greater or seeks termination of this Agreement, a panel of three arbitrators will be used; a single arbitrator cannot award $1,000,000 or more or order that this Agreement is terminated. The arbitrator(s) will be selected from the AAA National Healthcare Roster (as described in the AAA Healthcare Payor Provider Arbitration Rules) or the AAA's National Roster of Arbitrators (as described the AAA Commercial Arbitration Rules and Mediation Procedures). Unless otherwise agreed to in writing by the parties, if the party wishing to pursue the Dispute does not initiate the arbitration within one year after the date on which written notice of the Dispute was given, or, for Disputes subject to the procedures or processes described in the previous paragraph, within one year after the completion of the applicable procedure or process, it will have waived its right to pursue the Dispute in any forum.

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

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

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

The decision of the arbitrator(s) on the points in dispute will be binding. The parties acknowledge that because this Agreement affects interstate commerce the Federal Arbitration Act applies.

In the event any court determines that this arbitration procedure is not binding or otherwise allows litigation involving a Dispute to proceed, the parties hereby waive any and all right to trial by jury in, or with respect to, the litigation. The litigation would instead proceed with the judge as the finder of fact.

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

This Article VII will survive any termination of this Agreement.

Article VIII.
Term and Termination

8.1 **Term.** This Agreement will take effect on the Effective Date. This Agreement has an initial term of one year and will renew automatically for renewal terms of one year, until terminated pursuant to section 8.2 of this Agreement.

8.2 **Termination.** This Agreement may be terminated under any of the following circumstances:

i) by mutual written agreement of the parties;

ii) by either party, upon at least 90 days prior written notice, effective at the end of the initial term or effective at the end of any renewal term;

iii) by either party, upon 60 days prior written notice, in the event of a material breach of this Agreement by the other party; however, the termination will not take effect if the breach is cured within 60 days after notice of the termination; moreover, such termination may be deferred as further described in Article VII of this Agreement;

iv) by either party, upon 10 days prior written notice, in the event the other party loses licensure or other governmental authorization necessary to perform this Agreement, or fails to have insurance as required under section 4.7 or section 5.2 of this Agreement;

v) by United, upon 10 days prior written notice, in the event Facility loses accreditation; or

vi) by United, upon 90 days prior written notice, in the event:

a) Facility loses approval for participation under United's credentialing plan, or

b) Facility does not successfully complete the United's re-credentialing process as required by the credentialing plan; or

vii) by United, upon 90 days prior written notice, if none of Facility's services locations set forth on Appendix 1 has United membership enrolled in a Specialized MA Plan for Special Needs Individuals who are Institutionalized (as those terms are defined by 42 CFR 422.2).

8.3 **Ongoing Services to certain Customers after termination takes effect.** In the event a Customer is receiving any of the Covered Services listed below, as of the date the termination of this Agreement takes effect, Facility will continue to render those Covered Services to that Customer, and this Agreement will continue to apply to those Covered Services, after the termination takes effect, for the length of time indicated below:

Inpatient Covered Services	30 days or until discharge, whichever comes first
Pregnancy, Third Trimester – Low Risk	Through postpartum follow up visit
Pregnancy, First, Second or Third Trimester – Moderate Risk and High Risk	Through postpartum follow up visit
Non-Surgical Cancer Treatment	30 days or a complete cycle of radiation or chemotherapy, whichever is greater
End Stage Kidney Disease and Dialysis	30 days
Symptomatic AIDS undergoing active treatment	30 days
Circumstances where Payer is required by applicable law to provide transition coverage of services rendered by Facility	As applicable

after Facility leaves the provider network accessed by Payer.	

Article IX.
Miscellaneous Provisions

9.1 **Entire Agreement.** In order for this Agreement to be binding, a hard copy must be signed by both parties. This Agreement is the entire agreement between the parties with regard to its subject matter, and supersedes any prior written or unwritten agreements between the parties or their affiliates with regard to the same subject matter, except that this Agreement does not supersede a national agreement between the parties or their affiliates.

9.2 **Amendment.** This Agreement may only be amended in a writing signed by both parties, except that this Agreement may be unilaterally amended by United upon written notice to Facility in order to comply with applicable regulatory requirements. United will provide at least 30 days notice of any such regulatory amendment, unless a shorter notice is necessary in order to accomplish regulatory compliance.

9.3 **Nonwaiver.** The waiver by either party of any breach of any provision of this Agreement is not a waiver of any subsequent breach of the same or any other provision.

9.4 **Assignment.** This Agreement may not be assigned by either party without the written consent of the other party, except that this Agreement may be assigned by United to any of United's Affiliates.

Additionally, if United transfers to a third party all of its business described in a given line item in Appendix 2, section 1, or other line of business, United may assign this Agreement, only as it relates to that transferred business, to that third party. Such an assignment will not impact the relationship of the parties under this Agreement with regard to the remainder of United's business.

9.5 **Relationship of the parties.** The sole relationship between the parties to this Agreement is that of independent contractors. This Agreement does not create a joint venture, partnership, agency, employment or other relationship between the parties.

9.6 **No third-party beneficiaries.** United and Facility are the only entities with rights and remedies under this Agreement.

9.7 **Calendar days.** Unless this Agreement specifically provides otherwise, all references in this Agreement to a period of days refers to calendar days.

9.8 **Notice procedures.** Any notice required to be given under this Agreement must be in writing, except in cases in which this Agreement specifically permits electronic notice, or as otherwise permitted or required in the Protocols. Acceptable forms of written notice include facsimile, first class mail, certified mail, or overnight delivery by a national, recognized delivery service. All notices of termination of this Agreement by either party must be sent by certified mail, return receipt requested, addressed to the appropriate party at the address set forth on the signature portion of this Agreement. Each party will provide the other with proper addresses, facsimile numbers and electronic mail addresses.

9.9 Confidentiality. Neither party may disclose to a Customer, other health care providers, or other third parties any of the following information (except as required by an agency of the government):

i) any proprietary business information, not available to the general public, obtained by the party from the other party;

ii) the specific reimbursement amounts provided for under this Agreement, except for purposes of administration of benefits, including informing Customers, Benefit Plan sponsors and/or referring providers about the cost of a particular Covered Service or set of Covered Services; or

iii) any customer list of the other party regardless of how such customer list was generated.

This section 9.9 does not preclude the disclosure of information by United to a third party as part of the process by which the third party is considering whether to purchase services from United.

At least 48 hours before either party issues a press release, advertisement, or other media statement about the business relationship between the parties, that party will give the other party a copy of the material the party intends to issue.

Except as otherwise required by applicable law or stock exchange rule, Facility will not, and will not permit any of its representative affiliates, representatives or advisors to, issue or cause the publication of any press release or make any other public announcement, including, without limitation, any advertisement, with respect to this Agreement without the consent of United.

9.10 Governing law. This Agreement will be governed by and construed in accordance with the laws of the state in which Facility renders Covered Services, and any other applicable law.

9.11 Regulatory appendices. One or more regulatory appendix may be attached to this Agreement, setting forth additional provisions included in this Agreement in order to satisfy regulatory requirements under applicable law. These regulatory appendices, and any attachments to them, are expressly incorporated into this Agreement and are binding on the parties to this Agreement. In the event of any inconsistent or contrary language between a regulatory appendix and any other part of this Agreement, including but not limited to appendices, amendments and exhibits, the regulatory appendix will control, to the extent it is applicable.

9.12 Severability. Except as otherwise set forth in this Agreement, any provision of this Agreement that is unlawful, invalid or unenforceable in any situation in any jurisdiction will not affect the validity or enforceability of the remaining provisions of this Agreement or the lawfulness, validity or enforceability of the offending provision in any other situation or jurisdiction.

9.13 Survival. Notwithstanding the termination of this Agreement, this Agreement will continue to apply to Covered Services rendered while this Agreement was in effect. Additionally, section 9.9 of this Agreement, (except for the last paragraph) will survive the termination of this Agreement.

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

Dekalb County Government dba Dekalb County Rehab & Nursing Center, as signed by its authorized representative:	*Address to be used for giving notice to Facility under this Agreement:*
Signature:	Street: 2600 North Annie Glidden Road
Print Name: ________	City: Dekalb
Title: ________	State: IL Zip Code: 60115
Date: ________	Email: ________

UnitedHealthcare Insurance Company, on behalf of itself, UnitedHealthcare of Illinois, Inc., and other entities that are United's Affiliates, as signed by its authorized representative:

Signature:
Print Name: ________
Title: ________
Date: ________
Address to be used for giving notice to United under this Agreement: *Street:* 11020 Optum Circle Mail Route MN102-0400 *City:* Eden Prairie *State:* MN *Zip Code:* 55344
For office use only: Contract number: Month, day and year in which Agreement is first effective: ________

Appendix 1
Facility Location and Service Listings

Dekalb County Government dba Dekalb County Rehab & Nursing Center

IMPORTANT NOTES: Facility acknowledges its obligation under section 4.8 to promptly report any change in Facility's name or Taxpayer Identification Number. Failure to do so may result in denial of claims or incorrect payment.

The location where Covered Services will be rendered ("Service Location") MUST be listed in this Appendix.

FACILITY LOCATION - List BOTH the Service Location and the Billing Address for the Service Location	
Service Location	**Billing Address for the Service Location**
Facility Name	**Facility Name**
Dekalb County Rehab & Nursing Center	Dekalb County Rehab & Nursing Center
Street Address	**Street Address**
2600 North Annie Glidden Road	2600 North Annie Glidden Road
City	**City**
Dekalb	Dekalb
State and Zip Code	**State and Zip Code**
IL 60115	IL 60115
Phone Number	**Phone Number**
815-758-2477	815-758-2477
TIN	
366006548	
National Provider ID (NPI)	
1023011798	
ADDITIONAL FACILITY LOCATIONS - List BOTH the Service Location and the Billing Address for the Service Location	
Service Location	**Billing Address for the Service Location**
Facility Name	**Facility Name**
________	________
Street Address	**Street Address**
________	________
City	**City**
________	________
State and Zip Code	**State and Zip Code**
________	________
Phone Number	**Phone Number**
________	________
TIN	
________	
National Provider ID (NPI)	
________	

ADDITIONAL FACILITY LOCATIONS - List BOTH the Service Location and the Billing Address for the Service Location	
Service Location	**Billing Address for the Service Location**
Facility Name	**Facility Name**
_________	_________
Street Address	**Street Address**
_________	_________
City	**City**
_________	_________
State and Zip Code	**State and Zip Code**
_________	_________
Phone Number	**Phone Number**
_________	_________
TIN	
_________	
National Provider ID (NPI)	
_________	

Facility Name	**Facility Name**
_________	_________
Street Address	**Street Address**
_________	_________
City	**City**
_________	_________
State and Zip Code	**State and Zip Code**
_________	_________
Phone Number	**Phone Number**
_________	_________
TIN	
_________	
National Provider ID (NPI)	
_________	

Appendix 2
Benefit Plan Descriptions

Section 1. United may allow Payers to access Facility's services under this Agreement for the Benefit Plan types described in each line item below, unless otherwise specified in section 2 of this Appendix 2:

- Benefit Plans 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 Plans may or may not include an out-of-network benefit.

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

- Benefit Plans where Customers are not offered a network of participating providers from which they may receive Covered Services.

- Medicare Advantage Benefit Plans.

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Section 2. Notwithstanding the above section 1 of this Appendix 2, this Agreement will not apply to the Benefit Plan types described in the following line items:

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- Medicaid or CHIP Benefit Plans other than those separately addressed in this Appendix 2.

- Benefit Plans for Medicare Select.

- Medicare and Medicaid Enrollees (MME) Benefit Plans.

- Medicare Advantage Private Fee-For-Service Benefit Plans and Medicare Advantage Medical Savings Account Benefit Plans.

- Benefit Plans for workers' compensation benefit programs.

- Other Governmental Benefit Plans.

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Note: Excluding certain Benefit Plans or programs from this Agreement does not preclude the parties or their affiliates from having or entering into a separate agreement providing for Facility's participation in a network for such Benefit Plans or programs.

Section 3. Definitions:

Note: United may adopt a different name for a particular Benefit Plan, and/or may modify information referenced in the definitions in this Appendix 2 regarding Customer identification cards. If that happens, section 1 or section 2 of this Appendix 2 will continue to apply to those Benefit Plans as it did previously, and United will provide Facility with the updated information. Additionally, United may revise the definitions in this Appendix 2 to reflect changes in the names or roles of United's business units, provided that doing so does not change Facility's participation status in Benefit Plans impacted by that change, and further provided that United provides Facility with the updated information.

MEDICARE:

- **Medicare Advantage Benefit Plans** means Benefit Plans 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 Plan** 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 Plan 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 Plans** means Benefit Plans 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.

________ ________

- **Children's Health Insurance Program ("CHIP") Benefit Plans** means Benefit Plans under the program authorized by Title XXI of the federal Social Security Act that is jointly financed by the federal and state governments and administered by the state.

________ ________

- **Other Governmental Benefit Plans** means Benefit Plans 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 Plans 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).

OTHER:

- **Individual Exchange Benefit Plans** means benefit plans administered pursuant to the federal Patient Protection and Affordable Care Act including benefit plans marketed through Individual Exchanges administered by either the federal government and/or a state government, and any off-Exchange version of such benefit plans (but not including benefit plans which are offered by employers or other group sponsors through an exchange mechanism, whether operated by the employer or group or by the federal or state government or other third party.)

Additional Manuals Appendix

For some of the Benefit Plans for which Facility may provide Covered Services under this Agreement, Facility is subject to additional requirements of one or more additional provider manuals ("Additional Manuals"). When this Agreement refers to Protocols or Payment 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 Care Provider Administrative Guide ("UnitedHealthcare Administrative Guide").

For Benefit Plans 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 Payment Policy. However, the Additional Manual does not control where it conflicts with applicable statutes or regulations.

The Additional Manuals will be made available to Facility on a designated website and upon request. The names of the Additional Manuals, the websites to view and download them, and the Benefit Plans to which they apply, are listed in Table 1 below. United may change the location of a website or the Customer identification card identifier used to identify Customers subject to a given Additional Manual; if United does so, United will inform Facility.

United may make changes to the Additional Manuals subject to this Appendix in accordance with the provisions of this Agreement relating to Protocol and Payment Policy changes.

Table 1

Type of Benefit Plan(s)	**Description of Applicable Additional Manual**	**Website**
No Additional Manuals Apply		
This row intentionally left blank	________	________
This row intentionally left blank	________	________

Free Standing Skilled Nursing Facility
Medicare Advantage Payment Appendix

DEKALB COUNTY GOVERNMENT DBA DEKALB COUNTY REHAB & NURSING CENTER

APPLICABILITY

Unless another appendix to the Agreement applies specifically to a particular Medicare Advantage Benefit Plan that covers a particular type of Customer, the provisions of this Appendix apply to Covered Services rendered to Customers enrolled in Medicare Advantage Benefit Plans, defined as follows:

Medicare Advantage Benefit Plans: Benefit Plans 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, but does not include Medicare Advantage Private Fee-For-Service plans, Medicare Advantage Institutional Special Needs Plans or Medicare Advantage Medical Savings Account plans.

Facility agrees to accept and admit any and all Customers directed to it by United or Payer, under the terms of the Agreement, and within the scope of Facility's license and health care capability. Failure to do so shall constitute a material breach of the Agreement and may subject the Facility to termination of the Agreement and from United's networks.

SECTION 1
Definitions

Unless otherwise defined in this Section 1, capitalized terms used in this Appendix have the meanings assigned to them in the Agreement, (or the meanings assigned in the Agreement to equivalent terms, such as "Benefit Contract" instead of "Benefit Plan", and "Health Services" instead of "Covered Services"). If any definition in this Appendix conflicts with another definition in the Agreement (including a definition of an equivalent term), the definition in this Appendix controls, with regard to Benefit Plans subject to this Appendix.

Admission: The admittance of a Customer to a licensed Skilled Nursing Facility for approved and covered Skilled Nursing Services upon the medically appropriate order of a Physician/Advanced Practice Clinician.

Average Wholesale Price (AWP): The average wholesale price for a pharmaceutical product which is provided to Payer by First Data Bank, Medical Economics or such other national drug data company as Payer may designate. The AWP of all applicable drugs shall be adjusted periodically by Payer based on the national drug data company reference source designated by Payer. The AWP pricing methodology is based on an average of the National Drug Code AWPs of all similar products by manufacturer, dosage, and package size included within a procedure billing code. At a future date and after written notice regarding the change in AWP pricing methodology is provided by Payer to Ancillary Provider ("Change in AWP Pricing Methodology"), Payer may implement a methodology based on the NDC pricing model methodology; i.e. the specific National Drug Code AWP for a specific product by manufacturer, dosage and package size. The parties agree that at the time of the Change in AWP Pricing Methodology, a Maximum Allowable Cost (MAC) program will be implemented.

CMS: The Centers for Medicare and Medicaid Services.

CMS Fee Schedule Amount: The fee amount specified in the Medicare fee schedule published by the Centers for Medicare and Medicaid Services for the CMS Carrier Locality in which services were provided, as of the date of service.

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.

Custodial Care: Domiciliary care, respite care, rest care, private duty nursing, or other non-health services such as assistance in activities of daily living.

Customary Charge: The fee for health care services charged by Facility that does not exceed the fee Facility would ordinarily charge another person regardless of whether the person is a Customer.

Customer Expenses: Copayments, deductibles, or coinsurance that are the financial responsibility of the Customer according to the Customer's Benefit Plan.

Eligible Charges: The Customary Charge for Covered Services.

Payment Method: A methodology for determining contract rates under this Appendix.

Per Diem: The Payment Method designated "Per Diem" for Admissions as set forth in Table 1 of this Appendix.

Per Unit: The Payment Method designated "Per Unit" for Covered Services as set forth in Table 3 of this Appendix, based on the CPT/HCPCS specific fee listed in Table 3 in this Appendix for each unit of a Covered Service provided to a Customer. The units reported for Covered Services for which the contract rate is a Per Unit must always equal the number of times a procedure or service is performed.

Per Visit: The Payment Method designated "Per Visit" for Covered Services as set forth in Table 2 of this Appendix and applicable to Covered Services rendered to a Customer in a one-calendar day period.

Physician/Advanced Practice Clinician: A Doctor of Medicine ("M.D."), a Doctor of Osteopathy ("D.O."), an Advanced Practice Nurse Practitioner ("NP") or another health care professional authorized under all applicable law and Facility bylaws to admit or refer Customers to Facility for Skilled Nursing Services and provide Covered Services to Customers.

Separately Reimbursable Covered Services: The Covered Services provided by Facility on an inpatient or outpatient basis set forth in Table 3 of this Appendix.

Skilled Nursing Facility: As defined in Section 1819(a) of the Social Security Act (the "Act"), the term "Skilled Nursing Facility" means an institution (or a distinct part of an institution) which (1) is primarily engaged in providing to residents (A) skilled nursing care and related services for residents who require medical or nursing care, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons, and is not primarily for the care and treatment of mental diseases; (2) has in effect a transfer agreement (meeting the requirements of section 1861(l)) of the Act with one or more hospitals having agreements in effect under section 1866 of the Act; and (3) meets the requirements for a skilled nursing facility described in subsections (b), (c), and (d) of Section 1819 of the Act, and any and all other certification requirements of the Centers for Medicare and Medicaid Services (CMS) and or applicable law, rule or

regulation.

Skilled Nursing Services: Services that meet all applicable CMS and/or MA Organization's coverage guidelines for Skilled Nursing Services, including all of the following criteria: (a) delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient; (b) ordered by a Physician/Advanced Practice Clinician; and (c) necessary for the treatment of the sickness or injury. Services relating to Custodial Care are not Skilled Nursing Services. A determination whether a service is a Skilled Nursing Service is based on both the skilled nature of the service and the need for Physician/Advanced Practice Clinician-directed medical management. Whether a service is a Skilled Nursing Service is not determined by the caregiver who performs the service.

SECTION 2
Payments for Covered Services

2.1 Payments Generally. Payments to Facility under this Appendix will be the lesser of (1) Facility's aggregate Eligible Charges, or (2) payment amounts ("Contract Rates") set forth in this Section and in accordance with all of the terms and conditions of the Agreement and this Appendix. All payments by United or Payer will be less any applicable Customer Expenses. Facility agrees to submit all claims for payment in accordance with all applicable coding and billing guidelines issued by CMS and United or Payer, including, without limitation, as specified in this Appendix.

2.2 Contract Rates for Skilled Nursing Services Admissions. For the provision of Covered Services to a Customer during an Admission, the Contract Rate is determined as described in this Section 2.2 including Table 1 and Section 2.4 including Table 3, subject to CMS Skilled Nursing Facility (SNF) Consolidated Billing bundling requirements and UnitedHealthcare Policies and Protocols. The Contract Rate for an Admission is the Contract Rate in effect on each day of the Admission. Facility must meet all CMS certification requirements applicable to a Covered Service to be eligible for reimbursement under this payment appendix.

Table 1: Skilled Nursing Services Category Table

SERVICE CATEGORY	SERVICE CATEGORY DEFINITION	PAYMENT METHOD	CONTRACT RATE
Skilled Nursing Services	Revenue Codes 0110, 0119, 0120, 0129, 0130, 0139	**Per Diem**	**$ 515.00**

2.2.1 High-Cost Medication Covered Services. Payer shall pay Facility for high-cost medication that exceed $100.00 per medication per day or three medications that combined exceed $240 per day and are Covered Services on a case-by case basis.

High Cost Medication Covered Services must be approved in advance of the Customer's Admission to Facility. Any high-cost medications that are Covered Services that occur after the Customer's Admission to Facility shall require prior approval of United before the Customer is discharged from the facility. High cost medications shall be paid at the Average Wholesale Price (AWP) of the drug, minus twenty percent (20%), less any applicable Customer Expenses.

The following must be included on the claim:

- Revenue code 636
- Name of medication and NDC#
- HCPCS code
- Dosage

2.2.2 TPN Covered Services. Payer shall pay Facility for TPN Covered Services on a case-by case basis. TPN Covered Services must be approved in advance of the Customer's Admission to Facility. Any TPN that are Covered Services, that occur after the Customer's Admission to Facility, shall require prior approval of United before the Customer is discharged from the facility. TPN shall be reimbursed at the current CMS fee schedule.

The following must be included on the claim:

- Revenue code 270
- HCPCS code

2.3 Contract Rates for Outpatient Covered Services. The Contract Rate for the provision of the Covered Services set forth in Table 2 of this Appendix rendered by Facility to a Customer on an outpatient basis (not during an Admission), will be as set forth in Table 2 of this Appendix. Facility is required to identify each date of service when submitting claims for Outpatient Covered Services spanning multiple dates of service.

If more than one type of Service Category is provided to a Customer on an outpatient basis during one calendar day, United or Payer will pay facility for each Service Category.

Table 2: Outpatient Covered Services Category Table

SERVICE CATEGORY	SERVICE CATEGORY DEFINITION	PAYMENT METHOD	CONTRACT RATE
Physical Therapy	Revenue Codes 0420, 0421, 0422, 0423, 0424, 0429	**Per Visit**	**$ 65.00**
Occupational Therapy	Revenue Codes 0430, 0431, 0432, 0433, 0434, 0439	**Per Visit**	**$ 65.00**
Speech Therapy	Revenue Codes 0440, 0441, 0442, 0443, 0444, 0449	**Per Visit**	**$ 65.00**

2.4 Contract Rates for Separately Reimbursable Covered Services. The Contract Rate for the provision of the Covered Services set forth in Table 3 of this Appendix rendered by Facility to a Customer on an inpatient or outpatient basis, will be as set forth in Table 3 of this Appendix. If more than one type of Separately Reimbursable Service Category listed on Table 3 below is provided to a Customer during one calendar day, the applicable contract rate for each Separately Reimbursable Service Category will be considered in calculating the aggregate contract rate.

Table 3: Separately Reimbursable Covered Services Category Table

SERVICE CATEGORY	SERVICE CATEGORY DEFINITION	PAYMENT METHOD	CONTRACT RATE
Annual Vaccination-Influenza	Revenue Code 0636 and CPT Codes 90630-90698, 90756, HCPCS Codes Q2034-Q2039	**Per Unit**	**100% of the CMS Fee Schedule**
Annual Vaccination Administration-Influenza	Revenue Code 0771 and HCPCS Code G0008	**Per Unit**	**100% of the CMS Fee Schedule**
Annual Vaccination-Pneumococcal	Revenue Code 0636 and CPT Codes 90670, 90677 or 90732	**Per Unit**	**100% of the CMS Fee Schedule**

Annual Vaccine Administration- Pneumococcal	Revenue Code 0771 and HCPCS Code G0009	Per Unit	100% of the CMS Fee Schedule

SECTION 3
Miscellaneous Provisions

3.1 Inclusive Rates. The contract rates established by this Appendix for the service categories listed in Tables 1, 2, and 3 are all-inclusive and represent the entire payment for the provision to the Customer of all Covered Services that are in the applicable service category, including but not limited to those Covered Services that are generally and customarily provided as a part of the service in the applicable service category. No additional payments will be made for any services or items covered (or not covered) under the Customer's Benefit Plan and billed for separately by Facility.

3.2 Payment Code Updates. United will update any codes required to be submitted by Facility, such as revenue codes, ICD-10-CM codes or successor version, HCPCS codes and/or CPT codes from time to time according to changes in the industry, including among other things (a) the latest edition of the Current Procedural Terminology (CPT) manual which is revised by the American Medical Association, (b) the latest edition of the HCPCS manual which is revised by the Centers for Medicare and Medicaid Services (CMS), (c) the latest edition of the ICD-10-CM manual, or successor version, which is issued by the U.S. Department of Health and Human Services, and (d) the latest revenue code guidelines from the National Uniform Billing Committee. Unless specified elsewhere in this Appendix, the contract rate for a new, replacement, or modified code(s) will be at the existing contract rate for the appropriate code(s) it replaced or modified. United will not generally notify Facility of these code updates.

SECTION 4
Termination

4.1 Term and Termination. In addition to as set forth in the termination provisions in the Agreement, United may terminate this Appendix and Facility's rights and obligations to provide Covered Services for Customers enrolled in Benefit Plans covered by this Appendix on no less than ninety (90) days' prior written notice to the Facility for any reason.

SECTION 5
Amendment of Appendix

5.1 Amendment of this Appendix. United may amend this Appendix, including the Payment Methods and Contract Rates upon ninety (90) days' written notice to Facility. Facility may notify United within thirty (30) days from receipt of such notice of Facility's objection to any amendment, in which case the parties agree to negotiate in good faith to address any objections raised by Facility. In the event Facility timely objects and its objections cannot be resolved by the parties acting reasonably and in good faith, then either party may terminate this Appendix upon sixty (60) days' written notice to the other party.

Free Standing Skilled Nursing Facility
Commercial Payment Appendix

DEKALB COUNTY GOVERNMENT DBA DEKALB COUNTY REHAB & NURSING CENTER

APPLICABILITY

Unless another appendix to the Agreement applies specifically to a particular Covered Service as it covers a particular type of Customer, the provisions of this Appendix apply to Covered Services rendered to Customers covered by Benefit Plans sponsored, issued or administered by all Payers.

Facility agrees to accept and admit any and all Customers directed to it by United or Payer, under the terms of the Agreement, and within the scope of Facility's license and health care capability. Failure to do so shall constitute a material breach of the Agreement and may subject the Facility to termination of the Agreement and from United's networks.

SECTION 1
Definitions

Unless otherwise defined in this Section 1, capitalized terms used in this Appendix have the meanings assigned to them in the Agreement (or the meanings assigned in the Agreement to equivalent terms, such as "Benefit Contract" instead of "Benefit Plan", and "Health Services" instead of "Covered Services"). If any definition in this Appendix conflicts with another definition in the Agreement (including a definition of an equivalent term), the definition in this Appendix controls, with regard to Benefit Plans subject to this Appendix.

Admission: The admittance of a Customer to a licensed Skilled Nursing Facility for approved and covered Skilled Nursing Services upon the medically appropriate order of a Physician/Advanced Practice Clinician.

Average Wholesale Price (AWP): The average wholesale price for a pharmaceutical product which is provided to Payer by First Data Bank, Medical Economics or such other national drug data company as Payer may designate. The AWP of all applicable drugs shall be adjusted periodically by Payer based on the national drug data company reference source designated by Payer. The AWP pricing methodology is based on an average of the National Drug Code AWPs of all similar products by manufacturer, dosage, and package size included within a procedure billing code. At a future date and after written notice regarding the change in AWP pricing methodology is provided by Payer to Ancillary Provider ("Change in AWP Pricing Methodology"), Payer may implement a methodology based on the NDC pricing model methodology; i.e. the specific National Drug Code AWP for a specific product by manufacturer, dosage and package size. The parties agree that at the time of the Change in AWP Pricing Methodology, a Maximum Allowable Cost (MAC) program will be implemented.

CMS: The Centers for Medicare and Medicaid Services.

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.

Custodial Care: Domiciliary care, respite care, rest care, private duty nursing, or other non-health services such as assistance in activities of daily living.

Customary Charge: The fee for health care services charged by Facility that does not exceed the fee Facility would ordinarily charge another person regardless of whether the person is a Customer.

Customer Expenses: Copayments, deductibles, or coinsurance that are the financial responsibility of the Customer according to the Customer's Benefit Plan.

Eligible Charges: The Customary Charge for Covered Services.

Payment Method: A methodology for determining contract rates under this Appendix.

Per Diem: The Payment Method designated "Per Diem" for Admissions as set forth in Table 1 of this Appendix.

Per Visit: The Payment Method designated "Per Visit" for Covered Services as set forth in Section 2.3 and Table 2 of this Appendix and applicable to Covered Services rendered to a Customer in a one-calendar day period.

Physician/Advanced Practice Clinician: A Doctor of Medicine ("M.D."), a Doctor of Osteopathy ("D.O."), an Advanced Practice Nurse Practitioner ("NP") or another health care professional authorized under all applicable law and Facility bylaws to admit or refer Customers to Facility for Skilled Nursing Services and provide Covered Services to Customers.

Skilled Nursing Facility: As defined in Section 1819(a) of the Social Security Act (the "Act"), the term "Skilled Nursing Facility" means an institution (or a distinct part of an institution) which (1) is primarily engaged in providing to residents (A) skilled nursing care and related services for residents who require medical or nursing care, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons, and is not primarily for the care and treatment of mental diseases; (2) has in effect a transfer agreement (meeting the requirements of section 1861(l)) of the Act with one or more hospitals having agreements in effect under section 1866 of the Act; and (3) meets the requirements for a skilled nursing facility described in subsections (b), (c), and (d) of Section 1819 of the Act, and any and all other certification requirements of the Centers for Medicare and Medicaid Services (CMS) and or applicable law, rule or regulation.

Skilled Nursing Services: Services that meet all applicable CMS and/or MA Organization's coverage guidelines for Skilled Nursing Services, including all of the following criteria: (a) delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient; (b) ordered by a Physician/Advanced Practice Clinician; and (c) necessary for the treatment of the sickness or injury. Services relating to Custodial Care are not Skilled Nursing Services. A determination whether a service is a Skilled Nursing Service is based on both the skilled nature of the service and the need for Physician/Advanced Practice Clinician-directed medical management. Whether a service is a Skilled Nursing Service is not determined by the caregiver who performs the service.

SECTION 2
Payments for Covered Services

2.1 Payments Generally. Payments to Facility under this Appendix will be the lesser of (1) Facility's aggregate Eligible Charges, or (2) payment amounts ("Contract Rates") set forth in this Section and in accordance with all of the terms and conditions of the Agreement and this Appendix. All payments by United or Payer will be less any applicable Customer Expenses. Facility agrees to submit all claims for payment in accordance with all applicable coding and billing guidelines issued by CMS and United or Payer, including, without limitation, as specified in this Appendix.

2.2 Contract Rates for Skilled Nursing Services Admissions. For the provision of Covered Services to a Customer during an Admission, the Contract Rate is determined as described in this Section 2.2 including Table 1, subject to CMS Skilled Nursing Facility (SNF) Consolidated Billing bundling requirements and UnitedHealthcare Policies and Protocols. The Contract Rate for an Admission is the Contract Rate in effect on

each day of the Admission.

Table 1: Skilled Nursing Services Category Table

SERVICE CATEGORY	SERVICE CATEGORY DEFINITION	PAYMENT METHOD	CONTRACT RATE
Skilled Nursing Services	Revenue Codes 0110, 0119, 0120, 0129, 0130, 0139	**Per Diem**	**$ 515.00**

2.2.1 High-Cost Medication Covered Services. Payer shall pay Facility for high-cost medication that exceed $100.00 per medication per day or three medications that combined exceed $240 per day and are Covered Services on a case-by case basis.

High Cost Medication Covered Services must be approved in advance of the Customer's Admission to Facility. Any high-cost medications that are Covered Services that occur after the Customer's Admission to Facility shall require prior approval of United before the Customer is discharged from the facility. High cost medications shall be paid at the Average Wholesale Price (AWP) of the drug, minus twenty percent (20%), less any applicable Customer Expenses.

The following must be included on the claim:

- Revenue code 636
- Name of medication and NDC#
- HCPCS code
- Dosage

2.2.2 TPN Covered Services. Payer shall pay Facility for TPN Covered Services on a case-by case basis. TPN Covered Services must be approved in advance of the Customer's Admission to Facility. Any TPN that are Covered Services, that occur after the Customer's Admission to Facility, shall require prior approval of United before the Customer is discharged from the facility. TPN shall be reimbursed at the current CMS fee schedule.

The following must be included on the claim:

- Revenue code 270
- HCPCS code

2.3 Contract Rates for Outpatient Covered Services. The Contract Rate for the provision of the Covered Services set forth in Table 2 of this Appendix rendered by Facility to a Customer on an outpatient basis (not during an Admission), will be as set forth in Table 2 of this Appendix. Facility is required to identify each date of service when submitting claims for Outpatient Covered Services spanning multiple dates of service.

If more than one type of Service Category is provided to a Customer on an outpatient basis during one calendar day, United or Payer will pay facility for each Service Category.

Table 2: Outpatient Covered Services Category Table

SERVICE CATEGORY	SERVICE CATEGORY DEFINITION	PAYMENT METHOD	CONTRACT RATE
Physical Therapy	Revenue Codes 0420, 0421, 0422, 0423, 0424, 0429	**Per Visit**	**$ 65.00**

Occupational Therapy	Revenue Codes 0430, 0431, 0432, 0433, 0434, 0439	Per Visit	$ 65.00
Speech Therapy	Revenue Codes 0440, 0441, 0442, 0443, 0444, 0449	**Per Visit**	**$ 65.00**

SECTION 3
Miscellaneous Provisions

3.1 Inclusive Rates. The contract rates established by this Appendix for the service categories listed in Tables 1 and 2 are all-inclusive and represent the entire payment for the provision to the Customer of all Covered Services that are in the applicable service category, including but not limited to those Covered Services that are generally and customarily provided as a part of the service in the applicable service category. No additional payments will be made for any services or items covered (or not covered) under the Customer's Benefit Plan and billed for separately by Facility.

3.2 Payment Code Updates. United will update any codes required to be submitted by Facility, such as revenue codes, ICD-10-CM codes or successor version, HCPCS codes and/or CPT codes from time to time according to changes in the industry, including among other things (a) the latest edition of the Current Procedural Terminology (CPT) manual which is revised by the American Medical Association, (b) the latest edition of the HCPCS manual which is revised by the Centers for Medicare and Medicaid Services (CMS), (c) the latest edition of the ICD-10-CM manual, or successor version, which is issued by the U.S. Department of Health and Human Services, and (d) the latest revenue code guidelines from the National Uniform Billing Committee. Unless specified elsewhere in this Appendix, the contract rate for a new, replacement, or modified code(s) will be at the existing contract rate for the appropriate code(s) it replaced or modified. United will not generally notify Facility of these code updates.

SECTION 4
Termination

4.1 Term and Termination. In addition to as set forth in the termination provisions in the Agreement, United may terminate this Appendix and Facility's rights and obligations to provide Covered Services for Customers enrolled in Benefit Plans covered by this Appendix on no less than ninety (90) days' prior written notice to the Facility for any reason.

SECTION 5
Amendment of Appendix

5.1 Amendment of this Appendix. United may amend this Appendix, including the Payment Methods and Contract Rates upon ninety (90) days' written notice to Facility. Facility may notify United within thirty (30) days from receipt of such notice of Facility's objection to any amendment, in which case the parties agree to negotiate in good faith to address any objections raised by Facility. In the event Facility timely objects and its objections cannot be resolved by the parties acting reasonably and in good faith, then either party may terminate this Appendix upon sixty (60) days' written notice to the other party.

MEDICARE ADVANTAGE REGULATORY REQUIREMENTS APPENDIX

SKILLED NURSING FACILITY

THIS MEDICARE ADVANTAGE REGULATORY REQUIREMENTS APPENDIX ("Appendix") supplements and is made part of the network participation agreement ("Agreement") between UnitedHealthcare Insurance Company and/or one or more of its affiliates ("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 Custodial Care: Domiciliary care, respite care, rest care, private duty nursing or other non-health services, such as assistance in activities of daily living.

2.6 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.

2.7 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.

2.8 I-SNP Customer: A Medicare Advantage Customer who is enrolled in an I-SNP or IE-SNP Medicare Advantage Benefit Plan that (A) is a specialized Medicare Advantage plan for special needs individuals (as that term is defined in the Code of Federal Regulations provision currently codified at 42

CFR § 422.2) and (B) exclusively enrolls special needs individuals who are institutionalized (as that term is defined the Code of Federal Regulations provision currently codified at in 42 CFR § 422.2). Those Benefit Plans will include a reference to “Nursing Home” or “Nursing Care” on the face of the valid identification card of any Customer eligible for and enrolled in those Benefit Plans. A different identification card identifier may be adopted in the future. In the event that occurs, United will provide information to Provider regarding the new I-SNP Customer identification cards.

2.9 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).

2.10 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.

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

2.12 Nurse Practitioner: A registered nurse who has graduated from a program which prepares registered nurses for advanced or extended practice and who is certified as a nurse practitioner by the American Nursing Association.

2.13 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.

2.14 Physician Assistant: A health care professional licensed to practice medicine with physician supervision. Physician assistants are trained in intensive education programs accredited by the Commission on Accreditation of Allied Health Education Programs.

2.15 Primary Care Physician: A Doctor of Medicine or a Doctor of Osteopathy or another health care professional as authorized under state law, Skilled Nursing Facility bylaws and the applicable Benefit Plan to admit or refer patients to a Skilled Nursing Facility for Covered Services who: (a) has been selected by or assigned to an I-SNP Customer to provide and/or coordinate the I-SNP Customer’s Covered Services; (b) whose practice predominantly includes internal medicine, family or general practice; and (c) who participates in United’s network.

2.16 Primary Care Team: A team comprised of a care manager, a Primary Care Physician, and a Nurse Practitioner or Physician assistant.

2.17 Skilled Nursing Facility: A Medicare-certified nursing facility that: (a) provides Skilled Nursing Services; and (b) is licensed and operated as required by applicable law.

2.18 Skilled Nursing Services: Services that meet applicable CMS or MA Organization’s applicable coverage guidelines, including all of the following criteria: (a) delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient; (b) ordered by a Physician; and (c) necessary for the treatment of the sickness or injury. Services relating to Custodial Care are not Skilled Nursing Services. A determination whether a service is a Skilled Nursing Service is based on both the skilled nature of the service and the need for Physician-directed medical management. Whether a service is a Skilled Nursing Service is not determined by the caregiver who performs the service.

SECTION 3

PROVIDER REQUIREMENTS

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

3.2 Policies. Provider shall comply with MA Organization's policies and procedures.

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. 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. In the event of MA Organization's or an intermediary's insolvency or other cessation of operations or termination of MA Organization's contract with CMS, Provider shall continue to provide Covered Services to an MA Customer through the later of the period for which premium has been paid to MA Organization on behalf of the MA Customer, or, in the case of an MA Customer who is hospitalized as of such period or date, the MA Customer's discharge.

This provision shall be construed in favor of the MA Customer, shall survive the termination of the 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.

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.

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

those services or items after the date or during the time period specified by the applicable regulatory authorities.

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

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

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

3.9 Records.

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

(b) Retention. Provider shall maintain records and information related to the services provided under the 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 other records, at least ten (10) years from the final date of the CMS Contract period in effect at the time the records were created, or such longer period as required by law.

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

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

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

SECTION 4
ADDITIONAL REQUIREMENTS RELATED TO
I-SNP CUSTOMERS

4.1 Applicability. The provisions in this Section 4 apply to Providers that are Skilled Nursing Facilities and have I-SNP Customers.

4.2 Access to I-SNP Customers. Provider shall provide the Primary Care Team access to I-SNP Customers in accordance with the institutional special needs plan ("SNP") model of care.

4.3 Services. The Primary Care Team shall provide care coordination and care management services and oversee acute episodic care in accordance with the institutional SNP model of care. Provider shall

provide skilled and non-skilled Covered Services, as specified in the Agreement, including any payment appendix attached to the Agreement that is applicable to I-SNP Customers.

4.4 Training Plan and Protocols for SNP Model of Care. Provider shall comply with MA Organization's training plan for the institutional SNP model of care. MA Organization will provide Provider with the training plan, including protocols for serving I-SNP Customers in accordance with the SNP model of care.

4.5 Credentialing of the Primary Care Team. United will properly credential members of the Primary Care Team and will provide evidence to Provider upon request.

4.6 Transition of Care. In the event Provider's participation with MA Organization terminates during the course of an I-SNP Customer's care, Provider and MA Organization shall cooperate in transitioning the I-SNP Customer to another provider.

4.7 Term. If United or Provider terminates the Agreement in accordance with the Agreement's termination section that allows a party to terminate without cause and that termination is effective before December 31st, the Agreement shall stay in effect with respect to I-SNP Customers until the December 31st that next follows the effective date of termination.

SECTION 5
OTHER

5.1 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 promptly process and pay or deny them no later than sixty (60) days after Provider receives request for payment for those services from subcontracted providers.

5.2 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.

Illinois Regulatory Requirements Appendix

This Illinois Regulatory Requirements Appendix (the "Appendix") is made part of the Agreement entered into between **UnitedHealthcare Insurance Company,** contracting on behalf of itself, the entities named in the Agreement, and the other entities that are United 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 are regulated under Illinois laws; provided, however, that the requirements in this Appendix will not apply to the extent they are preempted by the Medicare Modernization Act or other applicable law.

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."

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.

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.

Article I.
Provisions applicable to Benefit Plans regulated under Illinois Insurance and HMO law

1.1 Notice of nonrenewal or termination. United must give Provider advance notice of nonrenewal or termination of this Agreement in the form and for the length of time as provided in the Agreement, but in no case less than 60 days' prior to the date of nonrenewal or termination. The notice shall include a name and address to which Provider may direct comments and concerns regarding the nonrenewal or termination and the telephone number maintained by the Department for consumer complaints. Immediate written notice may be provided without 60 days' notice if Provider's license has been disciplined by a State licensing board or when United reasonably believes direct imminent physical harm to Customers under Provider's care may occur. Provider must give United advance notice of nonrenewal or termination of this Agreement in the form and for the length of time as provided in the Agreement, but in no case less than 60 days' notice for termination with cause, and at least 90 days' notice for termination without cause. Primary care providers must notify active affected patients of nonrenewal or termination of Provider from United, except in the case of incapacitation.

1.2 Transition of services. This provision applies if Provider is a physician or hospital. In accordance with the Network Adequacy and Transparency Act:

a) If this Agreement is terminated for reasons other than those involving imminent harm to a patient or a final disciplinary action by a State licensing board and Provider remains within United's service area, United shall permit the Customer to continue an ongoing course of treatment with Provider during a transitional period for the following duration:
   i) 90 days from the date of the notice to the Customer of Provider's disaffiliation from United if the Customer has an ongoing course of treatment; or
   ii) if the Customer has entered the third trimester of pregnancy at the time of Provider's disaffiliation, a period that includes the provision of postpartum care directly related to the delivery.

b) Notwithstanding the provisions of paragraph (a) of this section 1.2, such care shall be authorized by United during the transitional period in accordance with the following:
   i) Provider receives continued reimbursement from United at the rates and terms and conditions applicable under this Agreement prior to the start of the transitional period;
   ii) Provider adheres to United's quality assurance requirements, including provision to United of necessary medical information related to such care; and
   iii) Provider otherwise adheres to United's policies and procedures, including, but not limited to, procedures regarding referrals and obtaining preauthorizations for treatment.

c) The provisions of this section 1.2 governing health care provided during the transition period do not apply if the Customer has successfully transitioned to another provider participating in United, if the Customer has already met or exceeded the benefit limitations of the plan, or if the care provided is not medically necessary.

1.3. Appeals, external review and complaints. United, Payer or Provider shall comply with applicable provisions of Illinois laws and regulations as they relate to appeal and external review of United's coverage decisions and complaints related to administrative issues, including but not limited to those set forth in 215 ILCS 134/45, 215 ILCS 134/50, and the Health Carrier External Review Act at 215 ILCS 180/1 et seq.

1.4. Communication. United shall not prohibit Provider from discussing any specific or all treatment options with Customers irrespective of United's position on those treatment options or from advocating on behalf of Customers within the utilization review, grievance, or appeals processes established by United in accordance with any rights or remedies available under applicable State or federal law.

1.5. Prompt payment. United or Payer shall ensure that all claims and indemnities concerning health care services other than for any periodic payment shall be paid within 30 days after receipt of due written proof of such loss. Provider shall be notified of any known failure to provide sufficient documentation for a due proof of loss within 30 days after receipt of the claim for health care services. Failure to pay within such period shall entitle Provider to interest at the rate of 9% per year from the 30th day after receipt of such proof of loss to the date of late payment, provided that interest amounting to less than one dollar need not be paid. Any required interest payments shall be made within 30 days after the payment.

1.6. Provider Directory. Provider shall notify United electronically or in writing of any changes to Provider's information as listed in United's provider directory.

1.7. Utilization Review. United, Payer or Provider shall comply with applicable provisions of Illinois laws and regulations as they relate to utilization review of health care services, including but not limited to those set forth in 215 ILCS 134/85 (Utilization review program registration). In the event United delegates to Provider any or all utilization review activities under this Agreement, Provider shall obtain and maintain appropriate licenses under Illinois law.

Article II.
Provisions applicable to Benefit Plans regulated under
Illinois HMO law only

2.1. Customer protection provision. Provider agrees that in no event, including but not limited to nonpayment by Payer of amounts due Provider under this Agreement, insolvency of Payer or any breach of this Agreement by United, shall Provider or its assignees or subcontractors have a right to or seek any type of payment from, bill, charge, collect a deposit from, or have any recourse against, the Customer, persons acting on the Customer's behalf (other than Payer), the employer or group contract holder for services provided pursuant to this Agreement; except for the payment of applicable co-payments or deductibles for Covered Services or fees for services not covered by Payer. The requirements of this clause shall survive any termination of this Agreement for services rendered prior to such termination, regardless of the cause of such termination. Customers, the persons acting on the Customer's behalf (other than Payer), and the employer or group contract holder shall be third party beneficiaries of this clause. This clause supersedes any oral or written agreement now existing or hereafter entered into between Provider and the Customer, persons acting on the Customer's behalf (other than Payer) and the employer or group contract holder.

2.2. Provider professional liability insurance. Provider shall maintain professional liability insurance and shall notify United at least 15 days prior to the cancellation of Provider’s professional liability insurance.

2.3. Quality Assessment and Improvement Act. United, Provider and any subcontractors Provider may use, agree to comply with the quality assessment program mandated by the Illinois HMO Act (215 ILCS 125/2-8(b)). In the event United delegates any or all quality assessment or quality improvement activities to Provider or an agent of Provider, Provider agrees that it, and its agent, if applicable, shall comply with United’s quality assessment program.

2.4. Emergency Services Act. With respect to emergency Covered Services rendered to Customers, United and Provider shall comply with applicable provisions of 215 ILCS 5/370o, 215 ILCS 134/65, 215 ILCS 134/70 and 50 Ill. Adm. Code 4520.110.

2.5. Patients’ Rights Act. United and Provider shall comply with applicable provisions of the Illinois Managed Care Reform and Patient Rights Act at 215 ILCS 134/1 et seq.

2.6. Confidentiality of Customer information. A Customer’s medical information must be kept confidential pursuant to 215 ILCS 5/1001 et seq.

2.7. Examination of quality of care records. Provider shall provide access to a Customer’s medical records in order for United to comply with regulatory examinations.

2.8. No termination for advocacy. This Agreement shall not be terminated by United to retaliate against or punish Provider in the event that Provider: (a) advocates in good faith on behalf of a Customer; (b) files a complaint against United; or (c) appeals a decision of United.

2.9. Capitated MCOs. This section 2.9 applies only if Provider is a Managed Care Organization (MCO) which means a partnership, association, corporation or other legal entity, including but not limited to individual practice associations (IPAs) and Physician Hospital Organizations (PHOs), which delivers or arranges for the delivery of health care services through providers it has contracted with or otherwise made arrangements with to furnish such health care services, and if Provider is paid by Payer on a capitation basis.

a) Provider will submit to United, copies of its quarterly financial statements, which shall include Provider's balance sheet and statements of income and cash flow within 45 days after the end of each fiscal period. In addition, Provider will submit, within 90 days after the end of Provider's fiscal year, copies of its audited annual financial statements prepared in accordance with generally accepted accounting principles if available. The Illinois Department of Insurance (Department), at its discretion, may require United to submit for inspection by the Department such statements as United has received from Provider. Such information shall be deemed confidential by the Department.

b) Provider agrees to fully cooperate with, and disclose all relevant information requested by, United's actuaries for the preparation of their opinion in accordance with the Actuarial Standards Board Actuarial Standards of Practice No. 16.

c) United acknowledges that, in the event of Provider's insolvency, Payer is secondarily liable as the ultimate risk bearer for unpaid health care services rendered to its enrollees.

Article III.
Provisions applicable to Benefit Plans regulated under Illinois Insurance law only

3.1. Licensure. Provider shall be licensed by the State of Illinois, and will notify United immediately upon a change in licensure or certification status.

3.2. Admitting privileges. If Provider is a physician, Provider must have admitting privileges in at least one hospital with which United has a written provider contract. United shall be notified immediately of any changes in privileges at any hospital or admitting facility. Reasonable exceptions may be made for a physician who, because of the type of clinical specialty, or location or type of practice, does not customarily have admitting privileges.

3.3. Provider professional liability coverage. Provider shall have and maintain professional liability coverage and shall notify United within 10 days after Provider's receipt of notice of any reduction or cancellation of the required coverage.

3.4. Non-discrimination. Provider will provide health care services without discrimination against any Customer on the basis of participation in the preferred provider program, source of payment, age, sex, ethnicity, religion, sexual preference, health status or disability.

3.5. Access to Customer benefit information, Protocols and Payment Policies. Provider may access a Customer's benefit information, including copayment information and information regarding changes in benefits by calling the telephone number on the back of the Customer's identification card. United's Protocols and Payment Policies are available to Provider online or upon request.

3.6. Assignment. The rights and responsibilities under the Agreement can be sold, leased, assigned, assumed or otherwise delegated in accordance with the terms of the Agreement. The assignee must

comply with all the terms and conditions of the Agreement being assigned, including all appendices, policies and fee schedules.