INTRODUCTION

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

Guiding principles

We strive to operate in accordance with the following principles:

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

Next steps

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

UnitedHealthcare - Contract Support
Attention: Imaging Center
2300 W Plano Pkwy #C1E105
Plano, TX 75075-8427

(800) 382-5445

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

PRACTITIONER CONTRACT

UnitedHealthcare Insurance Company is entering into this agreement with you. It is doing so on behalf of itself, and its affiliates for certain products and services we offer our customers, all of which we describe in the attached Appendix 2.

This agreement applies to you and the services you provide in all of your practice arrangements and for all of your tax identification numbers, except that if your services are covered under an agreement between us and a medical group that you are part of, services that you provide through that medical group will be subject to that other agreement and not this agreement.

What you will do

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

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

Within one year of the effective date of this agreement, you must conduct business with us entirely on an electronic basis to the extent that we are able to conduct business electronically (described in the Administrative Guide), including but not limited to determining whether your patient is currently a customer, verifying the customer's benefit, and submitting your claim. We will communicate enhancements at www.UHCprovider.com as they become available and will make information available to you as to which products are supported by www.UHCprovider.com.

You must submit your claims within 90 days of the date of service. After we receive your claim, if we request additional information in order to process your claim, you must submit this additional information within 90 days of our request. If your claim or the additional information is not submitted within these timeframes, you will not be reimbursed for the services, and you may not charge our customer.

You will submit claims only for services performed by you or your staff. Pass through billing is not payable under this agreement and may not be billed to our customer. For laboratory services, you will only be reimbursed for the services that you are certified through the Clinical Laboratory Improvement Amendments (CLIA) to perform, and you must not bill our customers for laboratory services for which you are not certified.

You will submit claims that supply all applicable information. These claims are complete claims. Further information about complete claims is provided in our Administrative Guide.

If you disagree with our payment determination on a claim, you may submit an appeal as described in our Administrative Guide.

You will not charge our customers anything for the services you provide, if those services are covered services under their benefit contract, but the applicable co-pay, coinsurance or deductible amount. If the services you provide are denied or otherwise not paid due to your failure to notify us, to file a timely claim, to submit a complete claim, to respond to our request for information, or based on our reimbursement policies and methodologies, you may not charge our customer. If the services you provide are denied for reason of not being medically necessary, you may not charge our customer unless our customer has, with knowledge of our determination of a lack of medical necessity, agreed in writing to be

responsible for payment of those charges. If the services you provide are not covered under our customer's benefit contract, you may, of course, bill our customer directly. You will not require a customer to pay a "membership fee" or other fee in order to access you for covered services (except for co-payments, coinsurance and/or deductibles provided for under the customer's benefit contract) and will not discriminate against any customer based on the failure to pay such a fee.

You will cooperate with our reasonable requests to provide information that we need. We may need this information to perform our obligations under this agreement, under our programs and agreements with our customers, or as required by regulatory or accreditation agencies.

You will refer customers only to other network physicians and providers, except as permitted under our customer's benefit contract, or as otherwise authorized by us or the participating entity.

What we will do

We or the other applicable participating entity will promptly adjudicate and pay your complete claim for services covered by our customer's benefit contract. If you submit claims that are not complete,

- You may be asked for additional information so that your claim may be adjudicated; or
- Your claim may be denied and you will be notified of the denial and the reason for it; or
- We may in our discretion attempt to complete the claim and have it paid by us or the other applicable participating entity based on the information that you gave in addition to the information we have.

If governing law requires us to pay interest or another penalty for a failure to pay your complete claim for covered services within a certain time frame, we will follow those requirements. The interest or other penalty required by law will be the only additional obligation for not satisfying in a timely manner a payment obligation to you. In addition, if we completed a claim of yours that was not complete, there shall be no interest or other late payment obligation to you even if we subsequently adjust the payment amount based on additional information that you provide.

The applicable participating entity will reimburse you for the services you deliver that our customer's benefit contract covers. The amount you receive will be based on the lesser of your billed charges or our fee schedule, which is described at Appendix 1 and is subject to the reimbursement (coding) policies and methodologies of us and the participating entities. Our reimbursement policies and methodologies are updated periodically and will be made available to you online or upon request. To request a copy of our reimbursement policies and methodologies, write to UnitedHealthcare - Contract Support, Attention: Imaging Center, 2300 W Plano Pkwy #C1E105, Plano, TX 75075-8427. Your reimbursement is also subject to our rules concerning retroactive eligibility, subrogation and coordination of benefits (as described in the Administrative Guide). We recognize CPT reporting guidelines as developed by the American Medical Association, as well as ICD diagnostic codes and hospital-based revenue codes. Following these guidelines does not imply a right to reimbursement for all services as coded or reported.

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

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

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

If either of us believes that a claim has not been paid correctly, either of us may seek correction of the payment within a 12-month period following the date the claim was paid, except that overpayments as a result of abusive or fraudulent billing practices may be pursued by us beyond the 12-month time frame mentioned above. In the event of an overpayment, we will correct these errors by adjusting future claim payment and/or by billing you for the amount of the overpayment.

How long our agreement lasts; how it gets amended; and how it can end

Assuming you are credentialed by us, and we execute this agreement, you will receive a copy from us with the effective date noted below the signature block. It continues until one of us terminates it.

We can amend this agreement or any of the appendices on 90 days written or electronic notice by sending you a copy of the amendment. Your signature is not required to make the amendment effective. However, if you do not wish to continue your participation with our network as changed by an amendment that is not required by law or regulation but that includes a material adverse change to this agreement, then you may terminate this agreement on 60 days written notice to us so long as you send this termination notice within 30 days of your receipt of the amendment.

In addition, either you or we can terminate this agreement, effective on an anniversary of the date this agreement begins, by providing at least 90 days prior written notice. Either you or we can terminate this agreement at any time if the other party has materially breached this agreement, by providing 60 days written notice, except that if the breach is cured before our agreement ends, the agreement will continue.

Either of us can immediately terminate this agreement if the other becomes insolvent or has bankruptcy proceedings initiated.

Finally, we can immediately terminate this agreement if any governmental agency or authority (including Medicare or Medicaid) sanctions you, if you no longer have your license to practice healthcare, if you no longer have hospital admitting privileges in any participating hospital, or in accordance with the terms of our Credentialing Plan.

We both agree that termination notices under this agreement must be sent by certified mail, return receipt requested, to UnitedHealthcare - Contract Support, Attention: Imaging Center, 2300 W Plano Pkwy #C1E105, Plano, TX 75075-8427, or to the post office address you provided us. We both will treat termination notices as “received” on the third business day after they are sent.

About data and confidentiality

We agree that your medical records do not belong to us. You agree the information contained in the claims you submit is ours. We both will protect the confidentiality of our customers’ information in accordance with applicable state and federal laws, rules, and regulations.

We are both prohibited from disclosing to third parties any fee schedule or rate information. There are three exceptions:

- You can disclose to our customer information relating to our payment methodology for a service the customer is considering (e.g., global fee, fee for service), but not specific rates (unless for purposes of benefit administration).
- We and the participating entities may use this information to administer our customers' benefit contracts and to pay your claims. We also may permit access to information by auditors and other consultants who need the information to perform their duties, subject to a confidentiality agreement.
- We both may produce this information in response to a court order, subpoena or regulatory requirement to do so, provided that we use reasonable efforts to seek to maintain confidential treatment for the information, or to a third party for an appropriate business purpose, provided that the disclosure is pursuant to a confidentiality agreement and the recipient of the disclosure is not a competitor of either of us.

What if we do not agree

The parties will work together in good faith to resolve any and all disputes between them ("Disputes") following the dispute procedures set out in our Administrative Guide. Disputes may include, but not be 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 you are acting as the assignee of one or more customer. In such cases, these procedures 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 you before you may invoke any right to arbitration under this section.

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 Dispute within 60 days after notice, either party may submit the Dispute to binding arbitration conducted by the American Arbitration Association ("AAA"). The arbitrators will use the AAA Healthcare Payor Provider Arbitration Rules, as amended. However, if a case involves 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. The arbitrator(s) will be selected from the AAA National Healthcare Roster or the AAA's National Roster of Arbitrators. Unless otherwise agreed in writing, arbitration must be initiated within one year after the date on which written notice of the Dispute was given, or any appeal process described in the Administrative Guide, whichever is later. If arbitration is not initiated in that time frame, the right to pursue the Dispute in any forum is waived.

Any arbitration proceeding under this Agreement will be conducted in Marion County, Indiana. 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 be contrary to the terms of this Agreement and require immediate judicial review. Notwithstanding anything in this Agreement to the contrary, this paragraph may not be severed from this provision 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 provision. While the arbitration remains pending, the termination for breach will not take effect.

This provision will survive any termination of this Agreement.

What is our relationship to one another

You are an independent contractor. This means we do not have an employer-employee, principal-agent, partnership, joint venture, or similar arrangement. It also means that you make independent health care treatment decisions. We do not. We do not reserve any right to control those treatment decisions. It further means that each of us is responsible for the costs, damages, claims, and liabilities that result from our own acts.

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

We may assign this agreement to any entity that is an affiliate of UnitedHealthcare Insurance Company at the time of the assignment.

This is it

This contract, the appendices and the items referenced in the attached Appendix 1, constitute our entire understanding. It replaces any other agreements or understandings with regard to the same subject matter - - oral or written - - that you have with us or any of our affiliates.

Federal law and the applicable law of the jurisdiction where you provide health care services govern our agreement. Such laws and the rules and regulations promulgated under them, when they are applicable, control and supersede our agreement. The Regulatory Appendix referenced in Appendix 1, and any attachment to it, is expressly incorporated to govern our agreement and is binding on both of us. In the event of any inconsistent or contrary language between the Regulatory Appendix (when it applies) and any other part of our agreement, including but not limited to appendices, amendments and exhibits, the Regulatory Appendix will control.

Conclusion

If you agree with these terms, please execute both copies of the agreement below and return them to us. With your signature, you confirm you understand the contract, including the dispute resolution procedures described in the section of this agreement entitled "What if we do not agree", the appendices and the items referenced in the attached Appendix 1.

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

AGREED BY:

Practitioner:

Marlise K Fletter
NP

Address to be used for giving notice under the agreement:

Signature:		Street:	10620 CORPORATE DR STE A
Print Name and Title:	Test Provider	City:	FORT WAYNE
DBA (if applicable):		State:	IN
Date:	July 17, 2020	Zip Code:	46845
Email:	provider@email.com	TIN:	351968205
National Provider Identification (NPI) Number:	1467418079		

UnitedHealthcare Insurance Company, on behalf of itself and its affiliates, as signed by its authorized representative:

Signature: _____

Print Name: _____

Title: _____

Date: _____

For office use only: PH 123

Deal Number: 89501691

Month, day and year in which agreement is first effective: August 28, 2020

Appendix 1

We include as part of our agreement the following additional materials that bind you and us:

Appendix 2	**Definitions, Products and Services** This appendix sets forth definitions for our "customer" and "participating entities" as well as lists the type of benefit contracts offered to our customers.
Payment Appendices	**Fee Information Document includes:** Fee Specifications Document, Fee Schedule Sample, and Additional Information About Your Fee Schedule. Further information about the fee schedule (such as additional fee samples) can be requested by writing to UnitedHealthcare - Contract Support, Attention: Imaging Center, 2300 W Plano Pkwy #C1E105, Plano, TX 75075-8427 or through our website at www.UHCprovider.com.
Appendix 3	**Locations.** This document provides information about your office, billing, and mailing locations. Please remember that, as described on page 2, this agreement applies to all of your locations even if you do not list all of your current locations or if you add a location in the future.
State Regulatory Requirements Appendix	In some instances, states add requirements to our agreement that are set forth in this appendix.
Medicare Regulatory Requirements Appendix	(This appendix applies only if you are in our Medicare network) Your participation in our network for customers with Medicare benefit contracts is subject to additional Medicare requirements set forth in this appendix.
Medicaid and/or CHIP Regulatory Requirements Appendix(ices)	(These appendix(ices) apply only if you are in our Medicaid and/or CHIP network.) Your participation in our network for customers with Medicaid or CHIP benefit contracts is subject to additional requirements set forth in this appendix(ices).
Administrative Guide	Our Administrative Guide governs the mechanics of our relationship. Our Administrative Guide may be viewed by going to www.UHCprovider.com, and it will also be made available to you upon request. We may make changes to the Administrative Guide or other administrative protocols upon 30 days electronic or written notice to you. Additionally, for some of the benefit contracts for which you may provide covered services under this agreement, you are subject to additional requirements of one or more additional provider manuals ("Additional Manuals"). When this agreement refers to protocols or reimbursement policies it is also referring to the Additional Manuals. An Additional Manual may be a separate document or it may be a supplement to the UnitedHealthcare Care Provider Administrative Guide ("UnitedHealthcare Administrative Guide"). For benefit contracts subject to an Additional Manual, the Additional Manual controls if it conflicts with any of the following: (1) a provision of this agreement or of the UnitedHealthcare Administrative Guide; or (2) a United protocol or reimbursement policy. However, the Additional Manual does not control where it conflicts with

<table>
<tr><td></td><td>applicable statutes or regulations.

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

We may make changes to the Additional Manuals subject to this provision in accordance with the provisions of this agreement relating to protocol and reimbursement policy changes.

Table 1.
<table>
<tr><th>Benefit Contract</th><th>Description of Applicable Additional Manual</th><th>Website</th></tr>
<tr><td colspan="3">No Additional Manuals Apply</td></tr>
</table>
</td></tr>
<tr><td>Credentialing Plan</td><td>To review our credentialing plan, visit www.UHCprovider.com.
This plan requires you to carry malpractice insurance in amounts with carriers and on terms and conditions that are customary for practitioners like you in your community. To request access to, or a copy of, our credentialing plan, write to UnitedHealthcare - Contract Support, Attention: Imaging Center, 2300 W Plano Pkwy #C1E105, Plano, TX 75075-8427.</td></tr>
</table>

Appendix 2
Definitions, Products and Services

Section 1. Customer. Individuals who are enrolled in benefit contracts insured or administered by us or any participating entity are included in our use of the phrase "customer" in this agreement.

Section 2. Participating entities. The following entities have access to our agreement:

- UnitedHealthcare Insurance Company and its affiliates;
- Groups receiving administrative services from UnitedHealthcare Insurance Company or its affiliates or that have arranged for network access through an entity that has contracted with UnitedHealthcare Insurance Company or one of its affiliates.

Section 3. Products and services.

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

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

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

- Benefit contracts where customers are not offered a network of participating providers from which they may receive covered services.
- Medicare Advantage Benefit Contracts.
- Medicare and Medicaid Enrollees (MME) Benefit Contracts.
- Benefit contracts for Medicare Select.
- Benefit contracts for workers' compensation programs.
- Medicare Advantage Private Fee-For-Service benefit contracts and Medicare Advantage Medical Savings Account benefit contracts.
- Other Governmental Benefit Contracts.

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

Section 4. Definitions:

Note: We may adopt a different name for a particular benefit contract, and/or may modify information referenced in the definitions in this Appendix 2 regarding customer identification cards. If that happens, section 3a or section 3b of this Appendix 2 will continue to apply to those benefit contracts as it did previously, and we will provide you with the updated information. Additionally, we may revise the

definitions in this Appendix 2 to reflect changes in the names or roles of our business units, provided that doing so does not change your participation status in benefit contracts impacted by that change, and further provided that we provide you with the updated information.

MEDICARE:

- **Medicare Advantage Benefit Contracts** means benefit contracts sponsored, issued or administered by a Medicare Advantage organization as part of:
  i) the Medicare Advantage program under Title XVIII, Part C of the Social Security Act, or
  ii) the Medicare Advantage program together with the Prescription Drug program under Title XVIII, Part C and Part D, respectively, of the Social Security Act,
  as those program names may change from time to time.

- **Medicare and Medicaid Enrollees (MME) Benefit Contracts** means the CMS sponsored Financial Alignment Demonstration Plan providing integrated care benefits for individuals eligible for both the state Medicaid program and the Medicare program (Parts A, B, C and D). At such time as this benefit contract is no longer a demonstration project and is fully implemented in the state, this definition will be interpreted to refer to the fully implemented plan.

MEDICAID, CHIP AND OTHER STATE PROGRAMS:

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

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

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

Payment Appendix - All Payer

All Payer Fee Information Document: IN 18904

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

Appendix 3 - LOCATIONS

Please remember that, as described on page 2, this agreement applies to all of your locations even if you do not list all of your current locations or if you add a location in the future.

Provider: Marlise K Fletter NP

Primary Service Location Address:	Address: 10620 CORPORATE DR STE A		
	City: FORT WAYNE	State: IN	Zip: 46845
	Tel #: (260) 423-2567	Fax #: (260) 420-2415	
Billing Address:	Address: 10620 CORPORATE DR STE A		
	City: FORT WAYNE	State: IN	Zip: 46845
	Tel #: (260) 423-2567	Fax #: (260) 420-2415	

Additional Service Location Address:	Address: 10620 CORPORATE DR STE A		
	City: FORT WAYNE	State: IN	Zip: 46845
	Tel #: (260) 423-2567	Fax #: (260) 420-2415	
Billing Address:	Address: 10620 CORPORATE DR STE A		
	City: FORT WAYNE	State: IN	Zip: 46845
	Tel #: (260) 423-2567	Fax #: (260) 420-2415	

Mailing Address:	Address:		
	City:	State:	Zip:
	Tel #:	Fax #:	

Indiana Regulatory Requirements Appendix

This Indiana 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's Affiliates (collectively referred to as "United") and the health care professional or entity named in the Agreement ("Provider").

This Appendix applies to all products or benefit plans sponsored, issued or administered by or accessed through United to the extent such products are regulated under Indiana 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.

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

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

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

I. Provisions applicable to Benefit Plans regulated under Indiana insurance and/or Health Maintenance Organization (HMO) law:

1. Liability Insurance. Provider locations in the state of Indiana shall be considered adequately insured for purposes of this Agreement, with respect to Covered Services provided to Customers who reside in Indiana, if Provider has procured liability insurance through an admitted insurance company, has paid the appropriate surcharge to the State of Indiana and is in compliance with the provisions of the Indiana Medical Malpractice Act. Evidence of payment of the surcharge must be submitted to United prior to this Agreement becoming effective.

2. Amendments to this Agreement. To the extent this Agreement allows United to amend the Agreement unilaterally, United may amend this Agreement by sending a copy of the amendment to Provider at least 45 days prior to its effective date. If Provider chooses not to approve the amendment, Provider may terminate this Agreement by notifying United in writing within 15 days after receiving the amendment. Such termination will take effect 90 days after United receives the written notice from Provider. Provider will not be required to comply with the amendment if Provider chooses to terminate the Agreement, and United may not penalize Provider for choosing to terminate the Agreement. Except in the case of an emergency, Provider is required to disclose that this Agreement is terminating to Customers before rendering Covered Services.

This provision does not apply to amendments required to comply with any state or federal regulatory authorities.

3. Disclosure. In accordance with Ind. Code Ann. § 27-8-11-4.5 and 27-13-15-1, nothing in the Agreement should be construed to prohibit Provider from disclosing (1) the terms of the Agreement as it relates to any financial or other incentives to Provider to limit medical services by Provider; or (2) any treatment options available to a Customer, including those not covered by a Customer's benefit plan. United shall not penalize Provider financially or in any other manner for making a disclosure permitted in this section I.3.

4. Prompt pay. United or Payer, as applicable, shall pay or deny claims in accordance with claims payment provisions contained in Indiana Code §§ 27-13-36.2 and 27-8-5.7, as applicable.

5. Copies of medical records. Provider shall comply with Indiana Administrative Code Title 760 §1-71 with regard to fees for copies of medical records.

6. Claims adjustments. United or Payer may not, more than two years after the date on which an overpayment on a claim was made: (1) request that Provider repay the overpayment; or (2) adjust a subsequent claim filed by Provider as a method of obtaining reimbursement of the overpayment from Provider. United or Payer may not be required to correct a payment error to a Provider more than two years after the date on which a payment on the claim was made. This provision does not apply in cases of fraud, with respect to the claim on which an overpayment or underpayment was made.

Adjusted subsequent claims for overpayments are required to have an identification of the claim on which the overpayment was made; and if ascertainable, the party financially responsible for the overpaid amount, and the amount that is being reimbursed to United or Payer through the adjusted subsequent claims.

7. No most-favored-nation. Nothing is this agreement shall: (1) prohibit, or grant United the option to prohibit, Provider from contracting with another insurer or HMO to accept a lower payment for health care services than to the payment specified in this Agreement; (2) require, or grant United the option to require, Provider to accept a lower payment from United if Provider agrees with another insurer or HMO to accept a lower payment for health care services; (3) require, or grant United an option of, termination or renegotiation of this Agreement if Provider agrees with another insurer or HMO to accept lower payment for health care services; or (4) require Provider to disclose Provider's reimbursement rates with other insurers or HMOs.

8. All Products Provision. As a condition of entering into a contract for the provision of health care services other than health care services to Customers of a health maintenance organization, Provider may not be required to provide health care services to Customers of a health maintenance organization. However, as a condition of entering into a contract for the provision of health care services other than health care services to Customers of a health maintenance organization, Provider may be required to provide health care services to Customers of a health maintenance organization in an emergency or upon referral. If Provider is required to provide health care services to Customers of a health maintenance organization in cases of emergency or referral, Provider shall be reimbursed for those services at rates established under this Agreement, but Provider shall not be required to comply with the terms and conditions of the health maintenance organization.

9. Prior Authorization. United and Provider will comply with all applicable provisions of IC 27-1-37.5 according to the timeframes specified therein, including, but not limited to the following: (a) Provider must submit and United must accept a request for prior authorization through a secure electronic transmission; and (b) Provider must notify United of any change in Provider's electronic or U.S. mail address, not more than seven days after the change is made.

II. Provisions applicable to Benefit Plans regulated under Indiana HMO law only:

1. Customer protection provision. In the event United or Payer fails to pay for Covered Services as specified by this Agreement, the Customer is not liable to Provider for any sums owed by the United or Payer. Provider may not collect or attempt to collect from a Customer any sums that are owed by United or Payer. Neither Provider nor its trustee, agent, representative, or assignee may bring or maintain any legal action against a Customer to collect sums owed by United or Payer. If Provider brings or maintains a legal action against a Customer for an amount owed to the Provider by United or Payer, Provider is liable to Customer for costs and attorney's fees incurred by the Customer in defending the legal action. Provided, however that Provider shall not be liable to the Customer for such costs and attorney's fees if Provider can demonstrate a reasonable basis for believing at the time the legal action was brought and while the legal action was maintained that United or Payer did not owe the sums Provider sought to collect from the Customer.

2. Continuation of Covered Services after termination.

(a) In the event the Agreement is terminated by United, a Customer who is hospitalized for a medical or surgical condition on the date of termination will have continuation of coverage for inpatient Covered Services. This continuation of coverage is not required after one of the following occurs: (i) the discharge of the Customer from the hospital; (ii) 60 days pass after the Agreement is terminated by United; (iii) the hospitalized Customer obtains from another carrier coverage that includes the coverage provided by United; (iv) a contract holder terminates the Customer's Benefit Plan, or United or Payer terminates the Customer's Benefit Plan as described in Ind. Code Ann. § 27-13-7-13(4) and (5); or (v) a Customer terminates his or her coverage. United or Payer may provide benefits that exceed the continuation of coverage required by this section 2(a), either in the types or time period of health care services covered, or both. This section 2(a) does not apply in the event United is placed in receivership.

(b) In the event the Agreement is terminated for United's receivership, and a Customer is receiving health care services from Provider, Provider is obligated to continue the provision of Covered Services to that Customer (i) for the duration of the contract period for which premiums have been paid, or (ii) if the Customer is hospitalized on the date of receivership for the longer of: (1) the period ending when the Customer is discharged from hospitalization; or (2) the duration of the contract period for which premiums have been paid.

3. Termination of this Agreement. Provider will give advance notice to United, in the form and for the length of time as provided in the Agreement, but in no case less than 60 days, before terminating this Agreement. In the event Provider, or the group of providers of which Provider is a part, provides 30% or more of the health care services received by Customers of United, then Provider must give advance notice to United, in the form and for the length of time as provided in the Agreement, but in no case less than 120 days before terminating the Agreement.

4. No penalty for representation or prohibition for disclosure. United may not take action against Provider solely on the basis that Provider represents a Customer in a grievance filed under Ind. Code Ann. § 27-13-10-11.

5. Confidentiality of Customer medical information. Provider shall comply with all applicable laws and regulations regarding the confidentiality of a Customer's medical information, including but not limited to those set forth in Ind. Code Ann. § 27-13-31-1.