AMENDMENT TO
PHYSICIAN CONTRACT

United HealthCare Insurance Company acting on behalf of itself, United HealthCare of Texas, Inc., Evercare of Texas, LLC and its other corporate affiliates, is amending our contract with you. This Amendment amends the Physician Contract we entered into with you that is in effect on the day we send you this Amendment.

1. This Amendment is effective _____.

2. As of the effective date of this amendment, you will provide services to Medicare beneficiaries who are enrolled in Medicare benefit contracts that (A) are sponsored, issued or administered by us or another applicable participating entity and (B) replace, either partially or in its entirety, the original Medicare coverage (Medicare Part A and Medicare Part B) issued to beneficiaries by the Centers for Medicare and Medicaid Services. We will reimburse you for the services you provide to any of our Medicare customers that are covered by his or her benefit contract. The amount you receive will be based on the lesser of your billed charges or the contracted amount determined under the Physician Contract Representative Medicare Advantage Fee Schedule, a representative sample of which is attached to this amendment, and is subject to matters described in our agreement, including our reimbursement policies.

3. Section 3 of Appendix 2 (Definitions, Products and Services) to the Physician Contract is hereby amended by adding the following to the portion of Section 3 that sets forth the benefit contract types in which you participate:

   Medicare benefit contracts that (A) are sponsored, issued or administered by us or another applicable participating entity and (B) replace, either partially or in its entirety, the original Medicare coverage (Medicare Part A and Medicare Part B) issued to beneficiaries by the Centers for Medicare and Medicaid Services ("CMS"), other than Medicare Advantage Private Fee-For-Service Plans.

4. If Section 3 of Appendix 2 (Definitions, Products and Services) to the Physician Contract includes "Medicare benefit contracts" in the portion of Section 3 that sets forth the benefit contract types in which you do not participate, Section 3 to Appendix 2 to the Agreement is hereby further amended by deleting "Medicare benefit contracts" from the portion of the Appendix that sets forth the benefit contract types in which you do not participate.

5. If Section 3 of Appendix 2 (Definitions, Products and Services) to the Physician Contract includes "Benefit contracts sponsored, issued or administered by us or another applicable participating entity where the benefit contract is intended to replace, either partially or in its entirety, the traditional Medicare coverage (Medicare Part A and Medicare Part B) issued to beneficiaries by the Centers for Medicare and Medicaid Services" in the portion of Section 3 that sets forth the benefit contract types in which you do not participate, Section 3 to Appendix 2 to the Agreement is hereby further amended by deleting "Benefit contracts sponsored, issued or administered by us or another applicable participating entity where the benefit contract is intended to replace, either partially or in its entirety, the traditional Medicare coverage (Medicare Part A and Medicare Part B) issued to beneficiaries by the Centers for Medicare and Medicaid Services" from the portion of the Appendix that sets forth the benefit contract types in which you do not participate.

6. If Section 3 of Appendix 2 (Definitions, Products and Services) to the Physician Contract does not include "Medicare Advantage Private Fee-For-Service Plans" in the portion of Section 3 that sets forth the benefit contract types in which you do not participate, Section 3 to Appendix 2 to the Agreement is hereby further amended by adding "Medicare Advantage Private Fee-For-Service Plans" to the portion of the Appendix that sets forth the benefit contract types in which you do not participate.

7. The Physician Contract Representative Medicare Advantage Fee Schedule sample (Appendix 3) attached to this amendment is hereby added to the Physician Contract. This fee schedule sample does not replace any other fee schedule already included under our Agreement, or replace any other fee schedule sample that is already set forth in Appendix 3 of our Agreement. An expanded Medicare Advantage fee schedule can be obtained by contacting Network Management.

8. The Medicare Advantage Regulatory Appendix attached to this amendment is hereby added to the Physician Contract.

Except as amended by this Amendment, all provisions of the agreement shall remain in full force and effect.

The Physician Contract allows us to amend it without your signature. In this case, we have decided to make this Amendment effective only if you sign it, however, we still have the ability to amend the Physician Contract in the future without your signature.

United HealthCare Insurance Company on behalf of itself, United HealthCare of Texas, Inc., Evercare of Texas, LLC and its other corporate affiliates, as signed by its authorized representative:

Signature: _____

Print Name: _____

Title: _____

Date: _____

Physician Signature

Signature: _____

Print Name: _____

Title: _____

Street: _____

City: _____

State and Zip: _____

Date: _____

Appendix 3

Physician Contract
Representative Medicare Advantage Fee Schedule: DAL 7509/DAL 7510 (Rest of Texas)

The provisions of this appendix apply to services rendered by you to our Medicare customers covered by Medicare benefit contracts that (A) are sponsored, issued or administered by us or another applicable participating entity and (B) replace, either partially or in its entirety, the original Medicare coverage (Medicare Part A and Medicare Part B) issued to beneficiaries by CMS, other than Medicare Advantage Private Fee-For-Service Plans. The provisions of this appendix do not apply to services you render to Medicare beneficiaries pursuant to a commercial benefit contract.

We will use our best efforts to update the amounts for services listed in the attached fee schedule that are based on the CMS physician Medicare fee schedule on or before the later of (a) ninety (90) days after the effective date of any modification made by CMS to the CMS physician Medicare fee schedule; provided, however, in the event CMS makes a change to such modification after the effective date of such modification, we will use our best efforts to update the methodology and factors in accordance with such subsequent change within ninety (90) days after the date on which CMS places information regarding such subsequent change in the public domain, or (b) ninety (90) days after the date on which CMS initially place information regarding such modification in the public domain (e.g., CMS distributes program memoranda to providers).

Amounts listed in the attached sample fee schedule are gross amounts. Any co-payments, deductibles or coinsurance that our Medicare customer is responsible to pay under his or her benefit contract will be subtracted from the amount listed in the attached sample fee schedule in determining the amount to be paid by us or by a participating entity. The actual payment amount is also subject to matters described in our agreement, including our reimbursement policies.

MEDICARE ADVANTAGE REGULATORY REQUIREMENTS APPENDIX

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

SECTION 1
APPLICABILITY

This Appendix applies to the Covered Services Provider provides to Medicare Advantage Customers. In the event of a conflict between this Appendix and other appendices or any provision of the Agreement, the provisions of this Appendix shall control except: (1) with regard to Benefit Plans outside the scope of this Appendix; (2) as noted in Section 2 of this Appendix; or (3) as required by applicable law.

SECTION 2
DEFINITIONS

For purposes of this Appendix, the following terms shall have the meanings set forth below; provided, however, in the event any definition set forth in this Appendix is in conflict with any definition in the Agreement for the same or substantially similar term, the definition for such term in the Agreement shall control. All other capitalized terms not otherwise defined in this Appendix shall be as defined in the Agreement.

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

2.2 **CMS Contract:** A contract between the Centers for Medicare & Medicaid Services ("CMS") and a Medicare Advantage Organization for the provision of Medicare benefits pursuant to the Medicare Advantage Program under Title XVIII, Part C of the Social Security Act.

2.3 **Cost Sharing:** Those costs, if any, under a Benefit Plan that are the responsibility of the Customer, including deductibles, coinsurance, and copayments. Cost Sharing may also be referred to as patient expenses or other similar term under the Agreement.

2.4 **Covered Service:** A health care service or product for which a Customer is entitled to receive coverage from a Payer, pursuant to the terms of the Customer's Benefit Plan with that Payer. A Covered Service may also be referred to as a health service or other similar term under the Agreement.

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

2.6 **Dual Eligible Customer:** A Medicare Advantage Customer who is: (a) eligible for Medicaid; and (b) for whom the state is responsible for paying Medicare Part A and B Cost Sharing.

2.7 **Medicare Advantage Benefit Plans:** Benefit Plans sponsored, issued or administered by a Medicare Advantage Organization as part of the Medicare Advantage program or as part of the Medicare Advantage program together with the Prescription Drug program under Title XVIII, Part C and Part D, respectively, of the Social Security Act (as those program names may change from time to time).

2.8 **Medicare Advantage Customer or MA Customer:** A Customer eligible for and enrolled in a Medicare Advantage Benefit Plan in which Provider participates pursuant to the Agreement.

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

2.10 **Payer:** An entity obligated to a Customer to provide reimbursement for Covered Services under the Customer's Benefit Plan and authorized by United to access Provider's services under the Agreement. A Payer may also be referred to as a payor, participating entity or other similar term under the Agreement.

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

SECTION 3
PROVIDER REQUIREMENTS

3.1 **Data.** Provider shall cooperate with MA Organization in MA Organization's efforts to report to CMS all statistics and other information related to its business, as may be required or requested by CMS, including but not limited to risk adjustment data as defined in 42 CFR 422.310(a). Provider shall send to MA Organization all risk adjustment data and other Medicare Advantage program-related information as may be requested by MA Organization, within the timeframes specified and in a form that meets Medicare Advantage program requirements. By submitting data to MA Organization, Provider represents to MA Organization, and upon MA Organization's request Provider shall certify in writing, that the data is accurate, complete, and truthful, based on Provider's best knowledge, information and belief.

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

3.3 **Customer Protection.** Provider agrees that in no event, including but not limited to, non-payment by MA Organization or an intermediary, insolvency of MA Organization or an

intermediary, or breach by United of the Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any MA Customer or person (other than MA Organization or an intermediary) acting on behalf of the MA Customer for Covered Services provided pursuant to the Agreement or for any other fees that are the legal obligation of MA Organization under the CMS Contract. This provision does not prohibit Provider from collecting from MA Customers allowable Cost Sharing. This provision also does not prohibit Provider and an MA Customer from agreeing to the provision of services solely at the expense of the MA Customer, as long as Provider has clearly informed the MA Customer, in accordance with applicable law, that the MA Customer's Benefit Plan may not cover or continue to cover a specific service or services.

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

This provision shall be construed in favor of the MA Customer, shall survive the termination of the Agreement regardless of the reason for termination, including MA Organization's insolvency, and shall supersede any contrary agreement, oral or written, between Provider and an MA Customer or the representative of an MA Customer if the contrary agreement is inconsistent with this provision.

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

3.4 **Dual Eligible Customers.** Provider agrees that in no event, including but not limited to, non-payment by a state Medicaid agency or other applicable regulatory authority, other state source, or breach by United of the Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Dual Eligible Customer, person acting on behalf of the Dual Eligible Customer, or MA Organization (unless notified otherwise) for Medicare Part A and B Cost Sharing. Instead, Provider will either: (a) accept payment made by or on behalf of MA Organization as payment in full; or (b) bill the appropriate state source for such Cost Sharing amount. If Provider imposes an excess charge on a Dual Eligible Customer, Provider is subject to any lawful sanction that may be imposed under Medicare or Medicaid. This provision does not prohibit Provider and a Dual Eligible Customer from agreeing to the provision of services solely at the expense of the Dual Eligible Customer, as long as Provider has clearly informed the Dual Eligible Customer, in accordance with applicable law, that the Dual Eligible Customer's Benefit Plan may not cover or continue to cover a specific service or services.

3.5 **Eligibility.** Provider agrees to immediately notify MA Organization in the event Provider is or becomes excluded from participation in any federal or state health care program under Section 1128 or 1128A of the Social Security Act. Provider also shall not employ or contract for the provision of health care services, utilization review, medical social work or administrative services, with or without compensation, with any individual or entity that has been excluded from

participation in any federal or state health care program under Section 1128 or 1128A of the Social Security Act.

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

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

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

3.9 **Records.**

(a) Maintenance; Privacy and Confidentiality; Customer Access. Provider shall maintain records and information related to the services provided under the Agreement, including but not limited to MA Customer medical records and other health and enrollment information, in an accurate and timely manner. Provider shall maintain such records for at least ten (10) years or such longer period as required by law. Provider shall safeguard MA Customer privacy and confidentiality, including but not limited to the privacy and confidentiality of any information that identifies a particular MA Customer, and shall comply with all federal and state laws regarding confidentiality and disclosure of medical records or other health and enrollment information. Provider shall ensure that MA Customers have timely access to medical records and information that pertain to them, in accordance with applicable law.

(b) Government Access to Records. Provider acknowledges and agrees that the Secretary of Health and Human Services, the Comptroller General, or their designees shall have the right to audit, evaluate and inspect any pertinent books, contracts, medical records, patient care documentation and other records and information belonging to Provider that involve transactions related to the CMS Contract. This right shall extend through ten (10) years from the later of the final date of the CMS Contract period in effect at the time the records were created or the date of completion of any audit, or longer in certain instances described in the applicable Medicare Advantage regulations. For the purpose of conducting the above activities, Provider shall make available its premises, physical facilities and equipment, records relating to MA Customers, and any additional relevant information CMS may require.

(c) MA Organization Access to Records. Provider shall grant MA Organization or its designees such audit, evaluation, and inspection rights identified in subsection 3.9(b) as are necessary for MA Organization to comply with its obligations under the CMS Contract. Whenever possible, MA Organization will give Provider reasonable notice of the need for such audit, evaluation or inspection, and will conduct such audit, evaluation or inspection at a reasonable time and place.

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 the manner requested by MA Organization, to meet any additional CMS requirements that may apply to the services.

3.12 **Offshoring.** Unless previously authorized by MA Organization in writing, all services provided pursuant to the Agreement that are subject to this Appendix must be performed within the United States, the District of Columbia, or the United States territories.

SECTION 4
OTHER

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

4.2 **Regulatory Amendment.** MA Organization may unilaterally amend this Appendix to comply with applicable laws and regulations and the requirements of applicable regulatory authorities, including but not limited to CMS. MA Organization shall provide written or electronic notice to Provider of such amendment and its effective date. Unless such laws, regulations or regulatory authority(ies) direct otherwise, the signature of Provider will not be required in order for the amendment to take effect.

UnitedHealthcare

Payment Appendix

Medicare Advantage Fee Information Document

Fee Schedule Specifications: as of 06/01/2015
Report Date: 06/01/2015

Fee Schedule ID: DAL 7509 - NonFacility

Linked Fee Schedule ID: DAL 7510 - Facility

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

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

Last Routine Maintenance Update: 04-01-2015

Fixed Fees: 84030 - $33.00 87804 - $14.00 S3620 - $38.00 V5242 - $2500.00 V5243 - $2500.00 V5244 - $2500.00 V5245 - $2500.00 V5246 - $2500.00 V5247 - $2500.00 V5248 - $5000.00 V5249 - $5000.00 V5250 - $5000.00 V5251 - $5000.00 V5252 - $5000.00 V5253 - $5000.00 V5254 - $2500.00 V5255 - $2500.00 V5256 - $2500.00 V5257 - $2500.00 V5258 - $5000.00 V5259 - $5000.00 V5260 - $5000.00 V5261 - $5000.00 V5262 - $2500.00 V5263 - $5000.00

Fee Amounts listed in the fee schedule are all-inclusive, including without limitation any applicable taxes. Unless specifically indicated otherwise, Fee Amounts represent global fees and may be subject to reductions based on appropriate Modifier (for example, professional and technical modifiers). As used in the previous sentence, "global fees" refers to services billed without a Modifier, for which the Fee Amount includes both the professional component and the technical component. Any co-payment, deductible or coinsurance that the customer is responsible to pay under the customer's benefit contract will be subtracted from the listed Fee Amount in determining the amount to be paid by the payer. The actual payment amount is also subject to matters described in this agreement, such as the Payment Policies. No payments will be made for any CMS additional compensation programs, including without limitation incentive or bonus payment programs. Please remember that this information is subject to the confidentiality provisions of this agreement.

Payment Appendix
Medicare Advantage Fee Information Document

Section 1. Definition of Terms
Unless otherwise defined in this document, capitalized terms will have the meanings ascribed to them in the Agreement.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Fixed Fees: Fee Amounts that are set at amounts which do not change. The Fee Amounts listed are intended for pricing purposes only and are subject to other matters

described in this Agreement, such as the Payment Policies.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Type of Service: A general categorization of related CPT/HCPCS codes. Type of Service categories are intended to closely align with the CPT groupings in the Current Procedural Terminology code book (as published by the AMA) and the HCPCS groupings (as published by CMS).

The Office Lab Type of Service category represents those lab tests, as determined by United, in which the lab test result is necessary to make an informed treatment decision while the patient is in the office.

A partial or complete crosswalk mapping of CPT/HCPCS to Type of Service categories is available to you upon request.

Section 2. Alternate Fee Sources

In the event the Primary Fee Source contains no published Fee Basis amount, alternate (or "gap fill") Fee Sources may be used to supply the Fee Basis amount for

deriving the Fee Amount. For example, if a new CPT/HCPCS code has been created within the Type of Service category of codes described above, and CMS has not yet established an RBRVS value for that code, we use one of the Fee Sources that exist within the industry to fill that gap, such as but not limited to Ingenix Essential RBRVS. For that CPT/HCPCS code, we adopt the RBRVS value established by the gap-fill Fee Source, and determine the Fee Amount for that CPT/HCPCS code by applying to the gap-fill RBRVS the same Conversion Factor and Pricing Level that we apply to the CMS RBRVS for those CPT/HCPCS codes that have CMS RBRVS values. At such time in the future as CMS publishes its own RBRVS value for that CPT/HCPCS code, we would begin using the Primary Fee Source, CMS, to derive the Fee Amount for that code and no longer use the alternate Fee Source.

More information about all of our Fee Sources can be located at:

- Centers for Medicare and Medicaid Services (CMS) RBRVS and Fee Schedules: www.cms.hhs.gov
- Centers for Disease Control and Prevention (CDC) Private Sector Selling Price: www.cdc.gov/vaccines/programs/vfc/cdc-vac-price-list.htm
- Thomson Reuters Red Book: www.micromedex.com
- RJ Health Systems: www.reimbursementcodes.com
- Ingenix Essential RBRVS: www.ingenixonline.com
- American Society of Anesthesiologists: www.asahq.org

Section 3. Routine Updates

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

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

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

This fee schedule follows a "current year" construction methodology and will remain current with RVU, Conversion Factor, and flat rate fee (non-RVU based fees such as DME fees) changes as the basis for deriving Fee Amounts. Therefore, the annual publication of RVUs and Conversion Factors by CMS will affect this fee schedule. United will use reasonable commercial efforts to implement the updates in its systems on or before the later of (i) 90 days after the effective date of any modification made by the Fee Source or (ii) 90 days after the date on which the Fee Source initially places information regarding such modification in the public domain (for example, when CMS distributes program memoranda to providers). United will make the updates effective in its system on the effective date of the change by the Fee Source. However, claims already processed prior to the change being implemented by United will not be reprocessed unless otherwise required by law. Unless specifically stated otherwise, for those anesthesia services that are contracted on a time-based methodology, the Anesthesia Conversion Factor indicated within this document is fixed and will not change. Please refer to the Anesthesia Conversion Factor section above. In the event that CMS does not publish a complete set of Fee Basis amounts for a specific code (for example: Global, -TC, and -26 fees) and the code contains a status code of "C" (indicating the code is carrier priced), United will use reasonable commercial efforts to establish Fee Amounts for all modifiers associated with the code based on fee information available and published by the local fiscal intermediary and by fiscal intermediaries from other locations.

b. Quarterly Updates in Response to Changes Published by Primary Fee Sources

United updates its fee schedule in response to changes published by Primary Fee Sources as a result of additions, deletions, and changes to CPT codes by the AMA or HCPCS codes by CMS and any subsequent changes to CMS' annual update. United updates its fee schedules for new CPT/HCPCS codes using the applicable Conversion Factor and Pricing Level of the original construction methodology along with the then-current RVU of the published CPT/HCPCS code. The effective date of the updates described in this subsection b. will be no later than the first day of the next calendar quarter after final publication by the Fee Source, except that if that quarter begins less than 60 days after final publication, the effective date will be no later than the first day of the calendar quarter following the next calendar quarter. For example, if final publication by the Fee Source is on April 10, the fee update under this subsection b. will be effective no later than July 1, and if final publication by the Fee Source is on June 10, the fee update under this subsection b. will be effective no later than October 1. In the event that CMS does not publish a complete set of Fee Basis amounts for a specific code (for example: Global, -TC, and -26 fees) and the code contains a status code of "C" (indicating the code is carrier priced), United will use reasonable commercial efforts to establish Fee Amounts for all modifiers associated with the code based on fee information available and published by the local fiscal intermediary and by fiscal intermediaries from other locations.

c. Price Changes for Immunizations and Injectables

United routinely updates the Fee Amounts in response to price changes for immunizations and injectables published by the Fee Sources. In addition, United's Executive Drug Pricing Forum (EDPF) meets on a quarterly basis to review and evaluate the drug prices that will be used in each quarterly update. The EDPF may address topics

including pricing for emerging drugs, anticipated manufacturer price changes, and special circumstances (for example, H1N1 vaccine). Based on supporting information provided by the drug manufacturer or the Fee Source, United's EDPF may elect to establish a Fee Amount or override a Fee Amount, as published by the Fee Source, in favor of a Fee Amount that is more appropriate and reasonable for a particular vaccine or drug. These Fee Amount updates will be effective as described below.

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

d. Other Updates

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

For More Information

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

decision while the patient is in the office.

A partial or complete crosswalk mapping of CPT/HCPCS to Type of Service categories is available to you upon request.

Section 2. Alternate Fee Sources

In the event the Primary Fee Source contains no published Fee Basis amount, alternate (or "gap fill") Fee Sources may be used to supply the Fee Basis amount for deriving the Fee Amount. For example, if a new CPT/HCPCS code has been created within the Type of Service category of codes described above, and CMS has not yet established an RBRVS value for that code, we use one of the Fee Sources that exist within the industry to fill that gap, such as but not limited to Ingenix Essential RBRVS. For that CPT/HCPCS code, we adopt the RBRVS value established by the gap-fill Fee Source, and determine the Fee Amount for that CPT/HCPCS code by applying to the gap-fill RBRVS the same Conversion Factor and Pricing Level that we apply to the CMS RBRVS for those CPT/HCPCS codes that have CMS RBRVS values. At such time in the future as CMS publishes its own RBRVS value for that CPT/HCPCS code, we would begin using the Primary Fee Source, CMS, to derive the Fee Amount for that code and no longer use the alternate Fee Source.

More information about all of our Fee Sources can be located at:

- Centers for Medicare and Medicaid Services (CMS) RBRVS and Fee Schedules: www.cms.hhs.gov
- Centers for Disease Control and Prevention (CDC) Private Sector Selling Price: www.cdc.gov/vaccines/programs/vfc/cdc-vac-price-list
- Thomson Reuters Red Book: www.micromedex.com
- RJ Health Systems: www.reimbursementcodes.com
- Ingenix Essential RBRVS: www.ingenixonline.com
- American Society of Anesthesiologists: www.asahq.org

Section 3. Routine Maintenance

Except as further described within this document, United will use reasonable commercial efforts to update the amounts listed in this fee schedule as published by the Fee Source on or before the later of (a) ninety (90) days after the effective date of any modification made by the Fee Source or (b) ninety (90) days after the date on which the Fee Source initially places information regarding such modification in the public domain (for example, when CMS distributes program memoranda to providers). Claims already processed prior to the change being implemented by United will not be reprocessed unless otherwise required by law.

United routinely updates its fee schedule in an effort to stay current with coding practices widely used in the health care industry; in response to price changes for immunizations and injectable medications; and to remain in compliance with the intent of the contractual agreement. Routine maintenance occurs when United mechanically incorporates revised information created by a third party that is the Fee Source. United will not generally attempt to communicate routine maintenance of this nature and will use reasonable commercial efforts to implement updates as further described below. Providers may expect the following types of fee updates to this fee schedule:

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

The annual publication of RVUs and Conversion Factors by CMS may affect this fee schedule. This fee schedule follows a "current year" construction methodology; therefore, it is intended to remain current with RVU, Conversion Factor, and flat rate fee (non-RVU based fees such as DME fees) changes as the basis for deriving Fee Amounts. As such, the annual update changes published by CMS will similarly be reflected in this fee schedule for dates of service on and after the effective date published by CMS. Unless specifically stated otherwise, for those anesthesia services that are contracted on a time-based methodology, the Anesthesia Conversion Factor indicated within this document is fixed and will not change. Please refer to the Anesthesia Conversion Factor section above.

b. Price Changes for Immunizations and Injectable Medications

United routinely updates its fee schedule in response to price changes for immunizations and injectable medications published by the Fee Sources. The effective date of fee updates under this subsection b will be no later than the first day of the next calendar quarter after final publication by the Fee Source, except that if that quarter begins less than 60 days after final publication, the effective date will be no later than the first day of the next calendar quarter. For example, if final publication by the fee source is on April 10, the fee update under this subsection b will be effective no later than July 1, and if final publication by the Fee Source is on June 10, the fee update under this subsection b will be effective no later than October 1. For purposes of this paragraph, the date of a claim is the date of service.

United's Executive Drug Pricing Forum (EDPF) meets on a quarterly basis to review and evaluate the drug prices that will be used in each quarterly update. Topics that the EDPF may address:

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

Fee Schedule ID: DAL 7509 - NonFacility

Linked Fee Schedule ID: DAL 7510 - Facility

- Emerging drugs pricing
- Anticipated or pending manufacturer price changes
- Special circumstance pricing (for example, H1N1 vaccine)

Based on supporting information provided by the drug manufacturer or the Fee Source, United's EDPF may elect to establish a Fee Amount or override a Fee Amount, as published by the Fee Source, in favor of a Fee Amount that is more appropriate and reasonable for a particular vaccine or drug.

c. CPT/HCPCS Code Updates

United routinely updates its fee schedule in response to additions, deletions, and changes to CPT codes by the AMA; HCPCS codes by CMS; CMS changes to its annual update; 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. United updates our fee schedules for new CPT/HCPCS codes using the applicable Conversion Factor and Pricing Level of the original construction methodology along with the then-current RVU of the published CPT/HCPCS code. The effective date of fee updates under this subsection c will be no later than the first day of the next calendar quarter after final publication by the Fee Source, except that if that quarter begins less than 60 days after final publication, the effective date will be no later than the first day of the calendar quarter following the next calendar quarter. For example, if final publication by the Fee Source is on April 10, the fee update under this subsection c will be effective no later than July 1, and if final publication by the Fee Source is on June 10, the fee update under this subsection c will be effective no later than October 1. For purposes of this paragraph, the date of a claim is the date of service.

d. Carrier Priced Codes

In the event that CMS does not publish a complete set of Fee Basis amounts for a specific code (for example: Global, -TC, and -26 fees) and the code contains a status code of "C" (indicating the code is carrier priced), United will use reasonable commercial efforts to establish Fee Amounts for all modifiers associated with the code based on fee information available and published by the local fiscal intermediary and by fiscal intermediaries from other locations.

For More Information

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