UNIVERSAL HEALTH NETWORK
CLIENT PARTICIPATION AGREEMENT

THIS AGREEMENT, effective January 1,2006, is entered into by and between **Universal Health Network,** 639 Isbell Road #400, Reno NV 89509 ("PPO"), and City of Sparks, ("Client"), with principal offices at 431 Prater Way, Sparks, NV 89431

WHEREAS, PPO has created and maintains a network ("PPO Network") of health care providers ("Participating Providers"), by entering into agreements with them to provide health care services to individuals ("Beneficiaries") covered by Client's health services benefits program through an approved ERISA or insurance plan, in exchange for reimbursement at agreed-upon rates.

WHEREAS, Client provides benefits programs for its Beneficiaries, and

WHEREAS, on behalf of Client's Beneficiaries, Client seeks access to PPO's network of Participating Providers.

THEREFORE, in consideration of the foregoing and of the mutual covenants herein, intending to be legally bound hereby, the parties agree as follows:

I. DEFINITIONS

A "**Access Fees**" means the rates payable by Client to PPO for access to PPO Network, as set forth in Exhibit A, attached

B "**Alternative Rates**" means rates of reimbursement funded by Client for health care services rendered to Beneficiaries, as set forth in PPO's agreement with Participating Providers, whether in the form of a per diem, case or procedure rate, negotiated rate based on published charges, or fee schedule.

C "**Ancillary Provider(s)**" means non-physician/hospital provider(s) who are duly licensed to practice in the State of Nevada or appropriate state, and has entered into an agreement with PPO to provide medical-related Covered Services to Beneficiaries

D "**Beneficiary**" means any individual whose health care expenses are funded by Client

E "**Benefits Agreement**" means a written health insurance or indemnity plan under which Client provides health benefits to Beneficiaries, and which provides Beneficiaries with financial incentives to utilize Participating Providers for Covered Services

F "**Clean Claim**" means a claim that provides all necessary information for Beneficiary and the services rendered to allow Client or Client's TPA/Payor to discharge Client's claim liability within the time noted It shall also have the meaning generally understood in the industry and, by example but without limitation, does not include claims involving subrogation, coordination of benefits, pre-existing conditions, reinsurance claims, Medicare eligibility or COBRA issues

G "**Client**" means any employer, self-funded employer, insurance company, association, trust, third-party administrator, group, group of individuals, or entity with Beneficiaries that is contracted with PPO to utilize PPO services as supported within this Agreement

H. **"Covered Services"** means all medical services, which are covered by a Benefits Agreement applicable to a Beneficiary and to which Alternative Rates apply

I. **"Hospital"** means any hospital(s) which enters into agreement(s) with PPO and to which Alternative Rates apply.

J. **"Market"** means a geographic region defined by PPO for access and pricing purposes, defined in Exhibit A.

K. **"Medically Necessary Services"** or **"Medically Necessary"** means health services or supplies which are determined to be:

1. Appropriate and necessary for the symptoms, diagnosis or treatment of a medical condition;
2. provided for the diagnosis or direct care and treatment of a medical condition;
3. within standards of good medical practice within the national and local organized medical community;
4. not primarily for the convenience of a Beneficiary or a Participating Provider; and
5. the most appropriate supply or level of medical care which can safely be provided

L. **"Participating Physician"** means a Doctor of Medicine or a Doctor of Osteopathy, who is an active member of the Medical Staff of a Participating Hospital, is duly licensed to practice medicine in the State of Nevada or appropriate state, and has entered into an agreement with PPO to provide Covered Services to Beneficiaries.

M. **"Participating Provider(s)"** means Participating Physician(s), Hospital(s) and Ancillary Provider(s) who are licensed to practice in the State of Nevada or appropriate state, and have entered into an agreement with PPO to provide Covered Services to Beneficiaries

N **"Quality Review"** means the functions performed by the PPO's Quality Assurance Committee in order to evaluate the quality and appropriateness of Covered Services rendered to Beneficiaries

O. **Third Party Administrator (TPA)/Payor** as referenced in this Agreement, is a licensed entity contracted with Client to provide determinations of compensability and claims adjudication services of Client's Benefits Agreement

P **"Utilization Review"** means the function performed by PPO, or an individual or organization selected by Client, to review Covered Services rendered to a Beneficiary by a Participating Provider and to evaluate such Covered Services in order to determine whether they are Medically Necessary

Q **"UHR"** means UNIVERSAL HEALTH REVIEW, an operating division of PPO providing Utilization Review for PPO

R **"Working Day"** means Monday through Friday, excluding legal holidays

II. RELATIONSHIP BETWEEN PPO AND CLIENT

A Nothing in this Agreement shall be construed to interfere with a Beneficiary's freedom of choice to receive medical services from Participating Providers.

B. PPO's duties are limited to those specifically set forth herein. PPO does not determine eligibility or benefit availability for Beneficiaries under Client's Benefit Agreement. PPO does not exercise any control with respect to Client's Benefit Agreement policies, practices,

procedures, or assets including payment of claims. PPO has no responsibility for communicating with Beneficiaries about Client's Benefit Agreement coverage, including benefits and/or eligibility criteria or determinations.

C. Participating Providers solely are responsible for the professional advice and treatment rendered to Beneficiaries, and PPO disclaims any liability with respect to such matters

III. CLIENT'S SERVICES AND RESPONSIBILITIES

A Benefit Agreement Requirements
Client bears all responsibility for the education of its Beneficiaries as to the Beneficiaries' rights regarding their care and treatment, as defined by Client's Benefits Agreement. Benefits available under Client's Benefits Agreement must meet or exceed PPO's Alternative Rates. Client shall incorporate into its Benefits Agreement financial incentives for Beneficiaries to utilize Participating Providers for Covered Services, including but not limited to:

a. Reduction or elimination of individual deductibles;
b. reduction or elimination of family deductibles;
c reduction or elimination of co-insurance payments;
d promotion of Participating Providers as quality, cost-effective providers of medical services;
e. a minimum of twenty (20%) percent Benefits Agreement penalty for utilization of out-of-network providers.

B. Identification Cards and EOBs. Client shall permanently print or otherwise affix PPO's logo on all Beneficiary identification cards as of the effective date of the Client's agreement. Client is responsible for accuracy of ID cards and is liable for any damages assessed against PPO if ID cards are incorrect. Client or Client's TPA/Payor shall reference PPO on Explanation of Benefit notices sent to Participating Providers regarding claims paid at Alternative Rates pursuant to this Agreement. Client shall require Beneficiaries to present identification cards bearing PPO's logo at the time services are rendered.

C Use of Name. PPO shall permit Client or Client's TPA/Payor to list PPO's name and logo, indicating Client's or Client's TPA/Payor's participation in the PPO Network, in Client's or Client's TPA/Payor's related written materials as well as on Client's or Client's TPA/Payor data base, however, no other use of PPO's name by Client or Client's TPA/Payor will be permitted without PPO's prior written approval

D. Eligibility and Coverage Determinations.

a. Client or Client's TPA/Payor solely shall be responsible for making all determinations regarding eligibility and benefits coverage in connection with this Agreement
b Client or Client's TPA/Payor shall verify a Beneficiary's eligibility within twenty-four (24) hours of an Participating Provider's request for verification.
c Client or Client's TPA/Payor shall be bound by authorizations for treatment, and/or certification of coverage of specified services, given to Participating Providers in writing or by telephone, provided that claims information is consistent with the information on which the authorization was based
d During ordinary business hours, Client or Client's TPA/Payor shall maintain a telephone number with sufficient lines to assure reasonable access for the confirmation that services are covered and a Beneficiary is eligible under a Benefits Agreement

E. Re-pricing. If PPO re-prices for Client or Client's TPA/Payor (refer to Exhibit A), Client agrees to have all Provider medical claims sent directly to PPO in a timely fashion for re-

pricing. If Client or Client's TPA/Payor is re-pricing, a ninety-five (95%) percent timeliness and accuracy rate is required, based on PPO's or accepted independent auditor's auditing tools. If the timeliness and accuracy rate falls below 95%, PPO will assume the re-pricing function at Client's expense.

F. Utilization Review. If PPO performs Utilization Review services for Client (refer to Exhibit A), Client agrees to:

a. Inform Beneficiary that Beneficiary is responsible for notifying UHR:
   i. Within 48 hours or less of any emergency admission
   ii Prior to an urgent admission occurring during working hours
   iii. At least six (6) working days prior to an elective admission that requires a second surgical opinion
   iv. Prior to the 37th week of gestation for a pregnancy admission, and again within forty-eight (48) hours of delivery
   v. For **all admissions** of Beneficiary and any covered dependents
   vi. Prior to all surgeries, diagnostic tests and treatment plans required by Client's benefit plan design to be pre-certified

b. If Client utilizes other managed care networks outside of PPO's service area, to periodically distribute a list of the other networks' Participating Providers to UHR.

c. Promptly forward to UHR all complaints and inquiries that may be received by Client or Client's TPA/Payor with respect to utilization management services and provide all information from Client's or Client's TPA/Payor's records, which may assist UHR in its response(s) to any complaints or inquiries

d. Acquire and pay for, if necessary, all records to be submitted to UHR when Client or Client's TPA/Payor requests a Medical Review for a determination of quality, appropriateness and/or medical necessity.

e Cooperate fully with UHR's personnel in the administration of contracted utilization management services

G. Payment Requirements for Participating Providers. Client or Client's TPA/Payor shall pay all non-disputed claims within thirty (30) calendar days following receipt of claims. (A disputed claim is a claim on which Client or Client's TPA/Payor needs to do extensive research to establish compliance with the Benefits Agreement). If full payment of the amount required to be paid by Client or Client's TPA/Payor is not paid within thirty (30) calendar days from the date that Client or Client's TPA/Payor receives Clean Claims, Client or Client's TPA/Payor may be required to pay Participating Provider the total of the claim, thereby losing the discount negotiated by PPO

H Disputed Claims. Client or Client's TPA/Payor shall notify Participating Providers within thirty (30) calendar receipt of a claim in dispute, and follow the Participating Provider's audit policy. Client or Client's TPA/Payor shall make payment to Participating Providers, at Alternative Rates, for all portions of the claim not in dispute. Client or Client's TPA/Payor shall cooperate with Participating Providers in resolving the dispute, and shall make available to PPO and to Participating Providers, at no charge, necessary documentation and personnel to facilitate resolution of the dispute. It is understood that if such disputes are not resolved within sixty (60) calendar days of notice to Participating Provider, Client or Client's TPA/Payor may forfeit the right to pay the disputed claim, or portion of the claim, at Alternative Rates.

I. Timeliness. Client or Client's TPA/Payor shall make Alternative Rate payments directly to Participating Providers for Covered Services rendered to Beneficiaries within thirty (30) calendar days of receipt of a Clean Claim.

J. Use of Alternative Rates.

a. Client or Client's TPA/Payor shall use the Alternative Rates exclusively for the purposes set forth herein. Use of the Alternative Rates in connection with claims for

services rendered to individuals who are not eligible Beneficiaries, is prohibited and shall be considered by PPO to be a material default in Client's obligations hereunder. In addition, Client or Client's TPA/Payor shall reimburse Participating Providers the difference between full charges and the inappropriately applied Alternative Rate(s).

b. In the Market for which Client purchases access to PPO Network, Client shall utilize PPO Network as its sole PPO network. In compensating Participating Providers for health care services rendered to Beneficiaries in connection with this Agreement, Client or Client's TPA/Payor shall use only Alternative Rates and may not use any other savings or cost-containment arrangement that otherwise might be available to Client or Client's TPA/Payor, for instance, Client shall not apply its own usual, and/or reasonable, and customary criteria.

c. Co-insurance ratios and deductibles shall be applied against Alternative Rates.

K Coordination of Benefits. Client or Client's TPA/Payor shall assist Participating Providers in coordinating benefits consistent with current industry standards. When Client is the secondary payor, Client's payment together with the primary payment and any co-insurance shall not exceed Alternative Rates.

L. Insured Services.

a. Client represents and warrants that it has sufficient money on hand to pay all claims that it reasonably anticipates will accrue over the three-month period immediately following execution of this Agreement and that at any point during the term of this Agreement, it shall have a reserve fund sufficient to pay all claims that it reasonably can anticipate will accrue during the three-month period which follows.

b. If Client's liability under this Agreement is covered by reinsurance, Client represents and warrants that the reinsurer periodically audits or certifies Client's ability to pay claims that are due and, in case of the Client's insolvency, will pay all claims due under this Agreement as if the reinsurer was the primary obligor.

M Administrative Services Only (ASO)

All obligations of Client set forth herein with respect to Beneficiaries shall be construed to apply to Client, Client's TPA'/Payors, or Reinsurers, and Client's respective Beneficiaries. It is understood that if TPA/Payor is rendering ASO, it is not liable for the payment of Client's obligations.

N Access Fees.

Client shall compensate PPO for services rendered by PPO, as defined in Exhibit A (Menu of Services), attached hereto. Administrative fees are subject to review and update by PPO on an annual basis. Payment is calculated for each month based on the number of employees as of the first day of each month, and is due to PPO by the tenth (10^{th}) day of the month following the service.

If Client pays PEPM Access Fees, payment shall be accompanied by a statement setting forth the number of employees entitled to access PPO Network during the prior month.

Interest of 1 5% per month shall apply to late Access Fee payments. In addition, Client shall pay all expenses incurred by PPO in connection with the collection of such fees, including any attorney's fees, whether or not suit is filed. If payment is not received within ninety (90) calendar days of service, PPO has the option to terminate Client.

IV. PPO'S SERVICES AND RESPONSIBILITIES

A PPO shall enter into contracts with adequate numbers of Participating Providers to ensure conveniently located medical services for all Beneficiaries.

B PPO shall cooperate fully with the Client's and Client's TPA/Payor's personnel in the administration of the PPO program.

C PPO shall provide repricing services for Client as identified in Exhibit C, repricing all Participating Provider medical claims received and forwarding them in a timely fashion to the responsible party for adjudication and payment.

D PPO shall provide Utilization Review services for Client as identified in Exhibit C and as outlined in Exhibit B: Utilization Management Procedures.

E. PPO shall provide updates of Participating Provider information in PPO's electronic format on a monthly basis.

F. PPO shall provide data for Client directories and web pages. PPO hard copy directories are available per Exhibit A.

G PPO shall provide sufficient staff for customer service functions for Beneficiaries during standard Working Days.

H PPO shall provide a website, updated daily, for Beneficiary access to verify Participating Provider status under its domain sites www.uhnppo.com.

I. PPO shall provide education and orientation for Participating Providers.

J PPO shall assist Client with Beneficiary education during open enrollment.

V. MUTUAL RIGHTS AND OBLIGATIONS OF THE PARTIES

A Provision of Data. Both parties agree to provide all information reasonably necessary to implement, operate, and evaluate the services provided pursuant to this Agreement.

Client to provide copies of Benefit Agreement documents, and updates, within thirty (30) calendar days of any data changes

PPO to provide fee schedules in electronic and hard copy format and updates, if applicable, monthly provider updates, and monthly full data replacement loads.

B Compliance with State and Federal Laws. Both parties shall comply with all applicable state and federal statutes and regulations relating to this Agreement

C Confidentiality. The parties agree to hold all information provided by one party to the other exchanged in contemplation of, or in connection with duties under this Agreement, confidential for the term of this Agreement, and for three (3) years thereafter, and shall not disclose such information to any third party except as required to implement this Agreement, as required by law or regulation, or with the prior written permission of the other party

D Indemnification. Each party shall indemnify and hold the other party, including its officers, directors, employees, agents, successors and assignees, harmless from and against all claims, liability, loss, damages, and expenses, which may be alleged against or incurred by the other party and which are the result of breach of this Agreement or proximately caused by the negligent omission or commission of the indemnifying party in connection with any obligation set forth in this Agreement.

VI. MAINTENANCE OF RECORDS

A. During the term of this Agreement and for three (3) years after its termination, PPO shall maintain at its principal office all books and records concerning this Agreement. At all times during the term of this Agreement and for a period of six (6) months following the termination of this Agreement, Client or authorized representatives shall have the right to audit, at Client's expense, during regular working hours, and upon not less than forty-eight (48) hours notice to PPO, all such books and records to the extent necessary to permit Client to fulfill its contractual obligations to its Beneficiaries, subject to the right of PPO to protect its proprietary rights in its books and records and in any manuals, software systems, and/or programs which PPO may employ in its services.

B. Client agrees to reciprocal rights as stated above with regards to PPO having access to Client's or Client's TPA/Payor's books and records.

VII. DISPUTE RESOLUTION

If disputes relating to the terms of this Agreement, excluding Utilization Review, are not satisfactorily resolved, arbitration of the dispute shall be conducted in accordance with the guidelines of the American Arbitration Association in the State of Nevada. PPO and Client agree that the arbitration decisions shall be in writing, including, if either party requests, findings of fact and conclusions of law. The cost of arbitration shall be borne by the losing party or by such parties and in such proportions as the arbitrators may otherwise decide. The arbitration decision shall be binding on both parties in any subsequent litigation or other dispute.

VIII. TERM, AMENDMENT, AND TERMINATION

A. This Agreement shall become effective at 12:01 A.M. on effective date and shall remain in effect for one (1) year. At the end of this initial term, the Agreement shall be renewed automatically on each anniversary date of the execution of this Agreement for a period of one (1) year; provided, however, that either party may terminate this Agreement at any time, with or without cause, by giving the other party not less than ninety (90) calendar days prior written notice of such termination; provided further, that in the event of a material breach of this Agreement by either party, the other party may cancel this Agreement by giving written notice of cancellation to the breaching party. Cancellation for a material breach shall be effective immediately upon delivery of notice of cancellation, or at a later time if so specified. The non-breaching party may choose to set forth the actions necessary to cure the breach, but unless the breach is cured to the reasonable satisfaction of the non-breaching party within ten (10) calendar days after notification of the actions necessary to cure the breach, this contract will be terminated.

B. Any of the following occurrences shall constitute a "material breach" of this Agreement:
   a. The breaching party admits in writing that it is unable to pay its debts as they mature, makes any general assignment for the benefit of creditors, or seeks to avail itself of any law for the release of insolvent debtors;
   b. Insolvency, bankruptcy, dissolution, liquidation, or receivership proceedings are commenced by or with the consent of the breaching party, or are pending for more than thirty (30) calendar days against the breaching party;
   c. The breaching party breaches any material term or condition of this Agreement;
   d. The breaching party attempts to assign this Agreement in contravention of the provisions of Section IX of this Agreement.

C. Client shall be in default if Client fails to provide any data or information required to be provided, has not made any payment as required, or if Client or Client's TPA/Payor improperly uses Alternative Rate(s) as described in this Agreement.

D. If Client defaults in payment of Access Fees and is in arrears more than ninety (90) calendar days, PPO may terminate this Agreement for cause upon ten (10) calendar days written notice

E Upon termination, Client or Client's TPA/Payor immediately shall cease to use PPO's Alternative Rates and Client or Client's TPA/Payor shall not attempt to reprice any claim for services rendered by Participating Providers after the date of termination.

F Modifications of this Agreement. This Agreement may be modified at any time by mutual written consent of both parties.

IX. GENERAL PROVISIONS

A Assignment. Except as expressly provided otherwise in this Agreement, neither party shall, without the prior written consent of the other party, assign, delegate, or subcontract any of its rights or duties under this Agreement. Any assignment, delegation, or subcontract in contravention of this section shall be void and shall constitute a material breach of this Agreement.

B Attorneys' and Public Accountants' Fees. If either PPO or Client institutes any action, suit, or arbitration proceeding against the other which relates to any provision of this Agreement, the prevailing party in such proceeding shall recover costs and reasonable attorneys' and public accountants' fees incurred in connection with that proceeding. The amount to be recovered shall be determined by the trier of fact in such proceeding or in a separate action brought for that purpose

C Waiver of Breach; Governing Law; Entire Agreement No assent or waiver, express or implied, of any breach of any one or more of the provisions of this Agreement shall be deemed or taken to be a waiver of any other provision of this Agreement, or a waiver of any subsequent breach of the same provision. This Agreement shall be construed and enforced in accordance with the laws of the State of Nevada. This Agreement supersedes any and all other agreements, whether oral or written, between the parties with respect to the subject matter of this Agreement, and contains the entire agreement between the parties relating to that subject matter. This Agreement may not be modified except by an instrument in writing by the parties

D HIPAA Regulations. Attached is an Addendum covering HIPAA Protected Health Information under HIPAA Regulations, which is incorporated into this Agreement by reference.

E, Notices. Any and all notices or other communications required or permitted by this Agreement shall be in writing and shall be delivered personally or by United States Mail, First Class, postage prepaid, certified or registered, return receipt requested, and addressed to the contacts listed below. Such notices shall be effective upon delivery, or on the date indicated on the receipt. Either party may change its address or domain name by giving written notice of the change to the other party in this manner

PPO
Universal Health Network
Attn: Mary Hoover, VP
639 Isbell Road, Suite 400
Reno, Nevada 89509
Telephone: 1-800-776-6959, x210

Client
City of Sparks
Attn: Randy Waterman, Benefits and Risk Mngmt
431 Prater Way
Sparks, NV 89431
Telephone: 1-775-353-2346

IN WITNESS WHEREOF, duly authorized representatives of the parties executed this Agreement below

UNIVERSAL HEALTH NETWORK

Signature

By: Mary Hoover

Title: Vice President

Date:

Federal Tax ID: 23-2745115

CITY OF SPARKS

By: Geno Martini

Title: Its Mayor

Date: 11/14/05

ATTEST:

By: Deborine Dolan

Its City Clerk

APPROVED AS TO FORM

By: Chester H Adams

Its City Attorney

UHN Business Associate Addendum
To
Client Participation Agreement

Addendum (the "Addendum") to the Client Participation Agreement (the "Agreement") entered into the First day of January, 2006, by and between Universal Health Network (Business Associate) and City of Sparks (Covered Entity).

WHEREAS, Covered Entity will make available and/or transfer to Business Associate certain Protected Health Information, in conjunction with goods or services to be provided by Business Associate to Covered Entity, that is confidential and subject to privacy protections afforded by federal law; and,

WHEREAS, Business Associate will have access to and/or receive from Covered Entity certain Protected Health Information that shall be used or disclosed only in accordance with this Addendum, and applicable federal privacy regulations.

NOW, THEREFORE, for good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, Covered Entity and Business Associate agree as follows:

I. Definitions

Terms used, but not otherwise defined, in this Addendum shall have the same meaning as those terms in 45 CFR 160.103 and 164.501.

(a) Business Associate. "Business Associate" shall mean Universal Health Network

(b) Covered Entity "Covered Entity" shall mean the participating client as defined in the Agreement

(c) Individual "Individual" shall have the same meaning as the term "individual" in 45 CFR 164.501 and shall include a person who qualifies as a personal representative in accordance with 45 CFR 164.502(g).

(d) Privacy Rule "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR part 160 and part 164, subparts A and E

(e) Protected Health Information. "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 CFR 164 501, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

(f) Required By Law. "Required By Law" shall have the same meaning as the term "required by law" in 45 CFR 164 501.

(g) Secretary "Secretary" shall mean the Secretary of the Department of Health and Human Services or his designee

II. Obligations and Activities of Business Associate

(a) Business Associate agrees to not use or further disclose Protected Health Information other than as permitted or required by the Agreement or as Required By Law

(b) Business Associate agrees to use appropriate safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this Addendum.

(c) Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this Addendum

(d) Business Associate agrees to report to Covered Entity any use or disclosure of the Protected Health Information not provided for by this Addendum of which it becomes aware.

(e) Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by Business Associate on behalf of Covered Entity agrees to the same restrictions and conditions that apply through this Addendum to Business Associate with respect to such information.

(f) Business Associate agrees to provide access, at the request of Covered Entity, and in the time and manner designated by Covered Entity, to Protected Health Information in a Designated Record Set, to Covered Entity or, as directed by Covered Entity, to an Individual in order to meet the requirements under 45 CFR 164 524.

(g) Business Associate agrees to make any amendment(s) to Protected Health Information in a Designated Record Set that the Covered Entity directs or agrees to pursuant to 45 CFR 164 526 at the request of Covered Entity or an Individual, and in the time and manner designated by Covered Entity.

(h) Business Associate agrees to make internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Entity available to the Covered Entity, or at the request of the Covered Entity to the Secretary, in a time and manner designated by the Covered Entity or the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule.

(i) Business Associate agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR 164 528.

(j) Business Associate agrees to provide to Covered Entity or an Individual, in time and manner designated by Covered Entity, information collected in accordance with Section II (i) of this Addendum, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR 164 528

III Permitted Uses and Disclosures by Business Associate

(a) Except as otherwise limited in this Addendum, Business Associate may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Agreement, provided that such use or disclosure would not violate the Privacy Rule if done by Covered Entity or the minimum necessary policies and procedures of the Covered Entity

(b) Except as otherwise limited in this Addendum, Business Associate may use Protected Health Information for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.

(c) Except as otherwise limited in this Addendum, Business Associate may disclose Protected Health Information for the proper management and administration of the Business Associate, provided that disclosures are required by law, or Business Associate obtains reasonable assurances from the

person to whom the information is disclosed that it will remain confidential and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

(d) Except as otherwise limited in this Addendum, Business Associate may use Protected Health Information to provide Data Aggregation Services to Covered Entity as permitted by 42 CFR 164 504(e)(2)(i)(B).

(e) Business Associate may use Protected Health Information to report violations of law to appropriate Federal and State authorities, consistent with 42 CFR 164.502(j)(i)

(f) For purposes of administration and management of the Agreement, Business Associate may disclose Protected Health Information to other Business Associates contracted with Covered Entity including but not limited to brokers and payors of record and any pharmacy/vision/dental plans in connection with the administration of the Benefits Agreement.

IV Obligations of Covered Entity

(a) Covered Entity shall notify Business Associate of any limitation(s) in its Notice of Privacy Practices of Covered Entity in accordance with 45 CFR 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of Protected Health Information.

(b) Covered Entity shall notify Business Associate with any changes in, or revocation of, permission by Individual to use or disclose Protected Health Information, to the extent that such changes may affect Business Associate's use or disclosure of Protected Health Information.

(c) Covered Entity shall notify Business Associate of any restriction to the use or disclosure of Protected Health Information that Covered Entity has agreed to in accordance with 45 CFR 164 522, to the extent that such restriction may affect Business Associate's use or disclosure of Protected Health Information.

V Permissible Requests by Covered Entity

Covered Entity shall not request Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if done by Covered Entity

VI Term and Termination

(a) Term. The Term of this Addendum shall be effective as of the date of the Agreement, and shall terminate when all of the Protected Health Information provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is not feasible to return or destroy Protected Health Information, protections are extended to such information, in accordance with the termination provisions in this Section

(b) Termination for Cause. Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall either: (1) Provide an opportunity for Business Associate to cure the breach or end the violation and terminate this Addendum, and the Agreement if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity; or, (2) Immediately terminate this Addendum, and the Agreement if Business Associate has breached a material term of this Addendum and cure is not possible; or, (3) If neither termination nor cure are feasible, Covered Entity shall report the violation to the Secretary

(c) Effect of Termination.

(1) Except as provided in paragraph (2) of this section, upon termination of this Addendum, for any reason, Business Associate shall return or destroy all Protected Health Information received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate Business Associate shall retain no copies of the Protected Health Information

(2) In the event that Business Associate determines that returning or destroying the Protected Health Information is not feasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction not feasible. Upon mutual agreement of the Parties that return or destruction of Protected Health Information is not feasible, Business Associate shall extend the protections of this Addendum to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction not feasible, for so long as Business Associate maintains such Protected Health Information

VII Miscellaneous

(a) Regulatory References A reference in this Addendum to a section in the Privacy Rule means the section as in effect or as amended, and for which compliance is required

(b) Amendment The Parties agree to take such action as is necessary to amend this Addendum from time to time as is necessary for Covered Entity to comply with the requirements of the Privacy Rule and the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191

(c) Survival The respective rights and obligations of Business Associate under Section VI (c) of this Addendum shall survive the termination of this Addendum

(d) Interpretation Any ambiguity in this Addendum shall be resolved in favor of a meaning that permits Covered Entity to comply with the Privacy Rule

(e) All Other Terms Of Agreement Except as modified by the terms of this Addendum, all other terms of the Agreement shall remain in full force and effect

(f) Conflict In the event of a conflict between the terms of this Addendum and the Agreement, the provisions of this Addendum shall be deemed controlling

Initials of.

Business Associate: _____

Covered Entity: _____

City of Sparks PPO Network/Utilization Management

PRICING

PPO Access & Utilization Management	2006	2007	2008	Comments
Start Up Fee	N/C	N/C	N/C	No Charge
Network Access	$ 0.10	$ 0.50	$ 0.50	Per Employee Per Month (PEPM)
COE's	included	included	included	**Included in Network Access
Claim Re-pricing (if applicable)	N/A	N/A	N/A	Per Employee Per Month (PEPM)
Utilization Management *(Lgr. Case fee below)	$1.90	$2.00	$2.00	Per Employee Per Month (PEPM)
Total Cost Per Employee/Month	***$2.00***	***$2.50***	***$2.50***	*Per Employee Per Month (PEPM)*
*Large Claims Case Management (per hour)	$110.00	$110.00	$115.00	Per hour in 1/4 hour increments
Disease Management Fee	N/A	N/A	N/A	
Provider Directory Fee (per directory)	$1.65	*	*	* UHN directory cost plus 10% (Current estimate is a continued $1 65 per directory for years 2007 and 2008.)
Reports	included	included	included	Standard quarterly reports as presented in the RFP.
Other (Identify)	$0.00	$0.00	$0.00	
Total bundled PPO Access & Utilization Management	**$1.90**	**$2.00**	**$2.00**	**PEPM + hourly Catastrophic Case Management + printed provider directories**
Hygeia Wrap Around Network (Not included)	N/A	N/A	N/A	Requires separate contract

Q: Are the prices quoted above predicated upon a certain volume of enrollment? If so, please elaborate
No, UHN has offered our best prices for this client.
Q: Will these prices be reduced with increased enrollment? Please elaborate.
UHN has already offered our best prices for this client.

** Centers of Excellence (COE) included with PPO access Re-pricing for COE's is done by UHN at no charge

Payment is calculated for each month based on the number of employees as of the first day of each month, and is due to PPO by the tenth (10^{th}) day of the month following the service. A penalty may be applied if payments are not received by the due date.

EXHIBIT B
UNIVERSAL HEALTH REVIEW
UTILIZATION MANAGEMENT PROCEDURES

I. INTRODUCTION.

A. *Universal Health Review ("Review Organization") shall establish and maintain review procedures and screening criteria based on nationally recognized standards and guidelines, and professional expertise, in order to help ensure the appropriate delivery of medically necessary medical services. The utilization management process has two primary objectives:*

1. *To assure that Covered Services provided to Covered Members are Medically Necessary, and*
2. *To assure that Covered Services are provided in a cost-efficient way while meeting professional standards for quality of care*

B. *Payor/TPA shall accept approval decisions made by Review Organization regarding the Medical Necessity of Covered Services when such approval decisions are communicated in writing to Hospital, Participating Physician, Member and/or Payor, subject to Member coverage and benefit plan parameters. Adverse determinations by Review Organization of Medical Necessity shall be subject to the appeal procedures stated in Part VB of this Exhibit.*

Adverse determinations of benefits, eligibility and compensability shall be appealed to the Payor/TPA. Payor shall ensure the appeals process is set forth in the applicable summary plan document.

II DEFINITIONS.

The following definitions are in addition to any definitions defined within a Provider's Agreement:

A *"Certification Letter" means a document that includes Review Organization's determination regarding Medical Necessity and length of stay pursuant to this Agreement. It does not imply or confer benefits, eligibility or compensability.*

B *"Concurrent Review" or "Retroactive Review" is the evaluation of medical services during or after such services are being or have been rendered, to confirm medical necessity and length of stay.*

C. *"Covered Member" or "Member" is an individual who meets a health plan's eligibility requirements and for whom premium payments are paid in order to receive Covered Benefits as defined in the applicable benefit plan document.*

D *"Covered Service" means health services an insurer, government agency, health plan or employer offers under the terms of a contract, as specified in the applicable health plan.*

E. *"Day of Service" means a measure of time during which a Covered Member receives Covered Services and which occurs when a Covered Member occupies an inpatient bed as of 12:00 midnight, or when a Covered Member who is admitted and discharged within the same day occupies an inpatient bed, but not otherwise counting the day of discharge.*

F. *"Medical Director" means a validly licensed physician who is employed by or who has a signed agreement with Review Organization to assist with the process of Utilization Management.*

G. *"Medically Necessary Services", "Medically Necessary", "Medical Necessity" all mean medical services or supplies which are determined by Review Organization to be:*

1. *appropriate and necessary for the symptoms, diagnosis or treatment of a medical condition*
2. *within national standards of good medical practice and the organized medical community,*
3. *not primarily for the convenience of an insured member or a Participating Physician/Provider,*
4. *the most appropriate supply or level of medical care which can safely be provided, and*
5. *as further defined in the Member's benefit agreement*

**Services, supplies and accommodations will not automatically be considered Medically Necessary because they were prescribed by a physician. Review Organization may consult with their medical director, physician advisors, medical consultants, peer review or other appropriate sources for their recommendations.*

H *"Norms" means quantifiable observed performances derived from aggregated data related to health care services provided to a statistically significant number of persons and published in a reputable journal.*

I. *"Participating Provider" means a hospital and/or other health facility, physician and/or other health professional who has entered into an agreement with Payer or Managed Care Organization to provide Covered Services at reduced rates to Covered Members.*

J. *"Physician Advisor" means a validly licensed physician who is employed by or agrees formally or informally to assist Review Organization with the process of Utilization Management as defined in this Exhibit.*

K *"Plan Document" is a formal written document which describes the plan of benefits and the provisions under which such benefits will be paid to Covered Members, including any amendments.*

L *"Preauthorization" is the evaluation of medical services to confirm medical necessity, appropriate length of stay, and cost-efficiency as appropriate. Preauthorization requirements are defined in the benefit plan document applicable to each Covered Member's medical insurance.*

M *"Review Organization" means a professional organization whose licensed employees are competent to conduct initial review, data analysis and other functions involved in confirming the medical necessity, appropriateness and cost-effectiveness of healthcare services. Review Organization, in this case Universal Health Review, does not determine benefits, eligibility or compensability of Covered Members' claims.*

N *"Screening Criteria" means those written and developed guidelines adopted by Review Organization to assist with determining Medical Necessity, appropriateness and length of stay for (proposed) medical services.*

O. *"TPA" means a third party administrator or an organization outside of the insuring organization which handles administrative duties which include, in part, the adjudication and payment of claims. TPA and/or payer shall ensure that the applicable benefit plan document establishes reasonable procedures governing the filing of benefit claims,*

notification of benefit determinations, and appeal of adverse benefit determinations. Such governing plan procedures shall include preauthorization requirements, definition of an individual who has been authorized to act on behalf of a claimant, time frames for pre-service and post-service claim reviews and adverse determination appeals

P *"Utilization Management" means that function performed by an individual or organization ("Review Organization") selected to review Covered Services (to be) rendered to a Covered Member in order to determine whether services are Medically Necessary, cost efficient, and meet professional standards for quality care.*

Q. *"Working Day" means Monday through Friday, excluding legal holidays.*

III. *RESPONSIBILITIES OF THE REVIEW ORGANIZATION, PHYSICIAN AND HOSPITAL*

A. *Responsibilities of the Review Organization*

1. *Review Organization shall develop, adopt, update, and maintain screening criteria.*
   a. *Screening criteria shall be developed or adopted for the purpose of making an initial determination of whether an inpatient admission, continued inpatient stay, or an outpatient procedure, test, treatment, or Covered Service is Medically Necessary, appropriate, and cost-efficient.*
      (1) *Screening criteria enable a review nurse to select those cases for review by the Medical Director and/or physician advisors which appear to be outside adopted or developed professional Screen Criteria or Norms.*
   b *Screening Criteria shall be based on cumulative information of health care services provided to a statistically significant number of persons, with clinical interpretations and analyses. Professional expertise, current professional literature published in reputable journals and community standards will be taken into consideration.*
   c *Initial review may include a request for a second medical opinion, particularly relevant to surgical procedures, for non-emergency admissions and outpatient services*
2. *Review Organization shall utilize professionally qualified review nurse personnel to perform the duties of preauthorization, concurrent or retroactive review and catastrophic case management. The review nurse shall have the authority to use screening criteria for preauthorization approval, and assign or extend an approved length of stay for a Member's inpatient stay and/or outpatient procedure, test or treatment.*
3 *Review Organization may issue an adverse determination for a proposed admission, continued inpatient stay, level of care, or outpatient Covered Service, but such adverse determination may be made only after review by the Medical Director and/or physician advisor either formally or informally, of available information contained in the Member's medical record and/or after a reasonable attempt at consulting either verbally or in writing with the Member's physician/representative. Such adverse determinations shall be subject to reconsideration and appeal as provided in this Exhibit.*
4. *Review Organization shall respond to a request for preauthorization of medical necessity for a non-urgent care claim within two days but in no case longer than six Working Days unless delay is due to failure of the Member/provider to submit the information necessary to determine Medical Necessity*
   a. *Required information shall be communicated to the Member/provider within two days of receipt of the non-urgent preservice claim, either verbally or if requested, in writing.*
   b. *Member or provider shall be afforded at least 45 days within which to*

provide the specified information before an adverse determination letter is issued. Member or their representative shall be notified of this time frame along with Review Organizations request for information.

5. *Review Organization shall respond to a request for preauthorization of medical necessity for an urgent care pre-service claim within 24 hours but in no case longer than 48 hours (whether adverse or not) after receipt of the claim unless Member/provider fails to provide information necessary to determine Medical Necessity.*
   a. *Required information shall be communicated to the Member/provider within 24 hours either verbally or if requested, in writing*
   b. *Member/provider shall be afforded 48 hours in which to provide the specified information before an Adverse determination is issued. Member or their representative shall be notified of this time frame along with Review Organization's request for information.*
   c. *Notification of an adverse determination relative to an urgent care claim may initially be communicated orally but will be followed by written confirmation within 3 days after oral notification.*
6. *Review Organization shall respond to a request for concurrent authorization or extension of an urgent care claim within 24 hours provided that such claim is made at least 24 hours before the expiration of the authorized length of stay, number of treatments or period of time*

7. *Review Organization shall communicate approved lengths of stay for authorized hospital admissions. Concurrent reviews, if appropriate, shall be conducted on a designated review date. Hospital, physician or Member shall be responsible for notification to Review Organization of continued stay past the approved length of stay. If contacted appropriately, Review Organization shall determine Medical Necessity for continued inpatient/outpatient care and if necessary, a continued stay review date will be set. This process shall continue until Member is discharged or Medical Director determines that based upon available information documented in Member's medical records, continued inpatient stay, level of care or outpatient Covered Service is not Medically Necessary.*
8. *Review Organization shall respond to a request for authorization of a retroactive/post-service claim within 15 days unless delay is due to failure of the Member/provider to submit the information necessary to determine Medical Necessity.*
   a. *Required information shall be communicated to the Member/provider/TPA within five Working Days either verbally or in writing.*
   b. *Member/provider shall be afforded 45 days within which to provide the specified information before an adverse determination letter is issued. Member shall be notified of this time frame along with the request for information.*
   c. *Costs incurred in obtaining medical records (if any) shall be borne by the person(s) or entity requesting the reconsideration.*
9. *Review Organization shall issue a written adverse determination within the time frames given in the preceding paragraphs*
   a. *The notification shall set forth, in a manner calculated to be understood by the Member/provider the clinical judgment or specific reason(s) for the adverse determination and/or a description of any additional material or information necessary for the Member/provider to perfect the claim, and why such information is necessary.*
   b. *The notification shall confirm that Review Organization's determination is only applicable to the medical necessity of a specific service; the Member/provider must appeal to the TPA/payer for adverse determinations of eligibility, benefits and compensability.*
   c. *Review Organization shall provide an initial completeness review only of*

our determinations of Medical Necessity. Requests for formal peer review, appeals regarding eligibility, benefits and compensability, and information and decisions regarding mediation or dispute resolution all fall within the purview of the Plan insurer or Plan fiduciary. Universal Health Review is not a Plan fiduciary or insurer.

10. *Review Organization shall provide a twenty-four (24) hour toll-free phone number for Member or Member's qualified representative/provider to call and notify Review Organization of an emergency admission. Review Organization will not provide twenty-four hour on-call review services.*
11. *Notification to Review Organization should be completed by Member or Member's qualified representative in compliance with Member's benefit plan document requirements.*
12. *All determinations and appeal decisions regarding benefits, applicable penalties, eligibility and compensability of claims will be rendered by the TPA/Payer.*
13. *In making any determination regarding whether an inpatient admission or a continued inpatient stay is Medically Necessary, Review Organization shall consider all available relevant information and document its actions and the rationale for its determinations.*

B. *Responsibilities of the Participating Physician*

1. *To avoid possible retrospective denial or penalties for unauthorized non-emergency admissions and/or other medical services provided to Members, the physician shall submit information in accordance with Member's benefit plan requirements to Review Organization at least three working days prior to the scheduled service.*
2. *At least the following information shall be provided by the physician to Review Organization at the time of the request for preauthorization review:*
   a. *Patient name and identification number*
   b. *Patient's date of birth and gender*
   c. *Insured's name, employer, insured SS#, current mailing address and telephone number*
   d. *Diagnosis/reason for admission*
   e. *(Scheduled) date of admission*
   f. *Treatment plan and estimated length of stay*
   g. *Proposed surgery and date of surgery, as applicable*
   h. *Name, address and complete telephone number of admitting facility or provider of service*
   i. *Name, address, telephone and fax numbers of admitting physician*
   j. *Additional information to help determine Medical Necessity or as requested by Review Organization*

C. *Responsibilities of Hospital*

1. *If hospital has not received notification of a pre-admission determination at the time of a scheduled admission, it shall contact the admitting physician and/or Review Organization to request the determination. Non-compliance with the Member's pre-admission authorization requirements may result in retrospective denial of payment or payment penalties, as determined by the payer.*
   a. *Information required for pre-admission or emergency admission review shall be the same as provided in III.B.2 of this Exhibit*
2. *Hospital shall notify Review Organization at the time any Member is admitted. If a Member is admitted on a day other than a Working Day, Hospital shall notify Review Organization of the admission within* ***forty-eight (48) hours*** *of admission or as required in Member's benefit plan document.*

a. *Review Organization shall accept as notification a faxed copy of Hospital's admission sheet*

IV. *OUT OF NETWORK/REFERRAL CARE*

A *Referrals to Other Hospitals or non-Preferred Providers*

1 *Referrals for Covered Services to a non-contracted provider or facility may require pre-review and approval by TPA/payer or Review Organization if Member is to receive maximum benefit coverage.*

a. *Pre-review for referral care may be requested by Member, Member's qualified representative, physician or hospital, and shall be performed according to this Exhibit.*

b *Review Organization shall evaluate all available documentation and determine whether the proposed services are Medically Necessary, appropriate, and whether they could be safely and adequately accommodated by a contracted provider.*

B *Continued Non-preferred Provider Care*

1 *Review Organization shall consider all relevant documentation regarding Medical Necessity of non-contracted provider care, including emergency admissions and continued stay, in compliance with benefit plan requirements.*

2 *Review Organization shall determine the Medical Necessity and cost-efficiency of continued non-contracted provider care and determine whether and when Member's care could be accommodated by a contracted provider, determinations are subject to appeal.*

a. *Applicable penalties are adjudicated by the TPA/Payer.*

V. *OTHER PROCEDURES AND INFORMATION*

A *Adverse Decision and Appeal Procedures*

1 *If a contracted physician exceeds the thresholds for over-utilization as compared to norms, contracted physician may be placed on probation or other applicable sanctions may be applied as determined by the credentialing committee or Review Organization.*

a *Reviewers may include Medical Director, physician advisor(s), medical consultants, peer review or other appropriate sources for recommendations, at network's discretion*

b *If Participating Provider's performance fails to satisfy network within ninety (90) days of being sanctioned or placed on probation, Participating Provider's network agreement may be terminated*

B. *An appeal for completeness of Review Organization's determination that services [to be] provided are/were not Medically Necessary, appropriate or cost-efficient shall be initially reviewed by the Medical Director, physician advisor, and/or a panel of independent physicians or medical consultants at Review Organization's discretion. All further appeals, requests for formal peer review, decisions of benefits, eligibility and compensability shall be addressed to the TPA/payer.*

a. *Member, Provider and Payer shall be notified of Review Organization's decision in writing, as appropriate.*

C *Information Regarding Pre-certification*

1 *TPA/Payer shall supply each Member with an identification card listing the name*

and phone number of Review Organization, timeliness of compliance with, and specific pre-certification requirements

VI. *CONFIDENTIALITY*

A. *During Review Organization's Utilization Management process, patient-specific information shall be kept confidential in accordance with Federal and State regulations, and be used solely for the purpose of Utilization Management and quality assurance.*

B. *Elective enrollment with an insurance product shall automatically confer the right to release of information for purposes of Utilization management unless this is revoked by Member in writing. Hospital and physician or ancillary provider may reserve the right to discuss with Member the release of information to Review Organization.*

1. *If Member or Member's representative will not authorize the release of information to Review Organization, the policy of Review Organization or that of the Health Benefit Plan must be followed regarding that refusal.*
2. *Review Organization cannot determine Medical Necessity without adequate objective information, which must be submitted for review. If Review Organization has made a reasonable attempt to obtain such data and failed, case may be pended or denied, subject to a written request for reconsideration when accompanied by all pertinent medical records.*
    a. *Costs incurred in obtaining the medical records (if any) shall be borne by the person(s) or entity requesting the review*

UNIVERSAL HEALTH NETWORK/UNIVERSAL HEALTH REVIEW
NEVADA PREFERRED PROFESSIONALS

NEW	☒	Reno:	(800) 776-6959 or (775) 356-1159/Fax# (775) 356-5746
CHANGE	☐	Las Vegas:	(702) 360-9044/Fax# (702) 228-4269
TERM	☐	Louisiana:	(504) 620-7004/Fax# (504) 620-7001

Completed by Client Representative: Randy Waterman, Risk & Benefits Manager (Name, Title) Date: 11/09/05

PAYOR: CDS Group Health
Address : PO Box 50190
City, State, Zip, County: Sparks, NV 89435 (Washoe)

*Please **attach a contact list** with toll free #'s when applicable, fax #'s and e-mail addresses specifically for marketing/new group rep., claims, eligibility and benefits*

Stop Loss Amount: $148,500 (Per Individual)
Re-Insurance Co. Name: Allianz Life Insurance Co. Phone # : 800-328-5600, ext 45068 Contact: Deb Swanson

BROKER/AGENT/CONTACT: Roger Olsen
Address: PO Box 10950
City, State, Zip, County: Reno, NV 89510-0950 (Washoe)
Company Name: ABD Insurance & Financial Services
Telephone: 775-686-2468
Fax: 775-337-1123
E-mail: rro@abdi.com

GROUP NAME: City of Sparks Medical & Dental Plan
Policy # : N/A
# of Lives/ City Located : 759 Sparks, NV

Effective Date: 01/01/06 **Renewal Date:** 01/01/07
Address: 431 Prater Way
City, State, Zip, County: Sparks, NV 89431 (Washoe)
Contact: Randy Waterman
Term Date : N/A
Telephone: 775-353-2346
Fax: 775-353-2499
E-mail: rwaterman@cityofsparks.us

ACCESS NETWORK	REPRICING	UTILIZATION MANAGEMENT
Yes/No - Is Group Self-funded	Yes/No - UHN reprices, If NO, identify agent repricing	Yes/No - Prior Authorization by UHR if NO, list company name/toll free #
Yes/No - Universal Health Network	CDS GROUP HEALTH (Company)	(Company)
Yes/No - Nevada Preferred Professionals	800-455-4236 (Toll free telephone #)	(Toll free telephone #)
Yes/No - PPO	Yes/No - Qtrly claims savings report If YES, list address and contact	**********
Yes/No - Centers of Excellence	**Submit the following:**	*Please submit this group's benefit plan*
Yes/No - EPO (UHN Only)	- Address to submit repriced claims	**********
Yes/No - W/C (UHN Only)	N/A (Address)	Yes/No - Second Surgical Opinion by UHR
Yes/No - Does this group have access to any non-UHN networks, if YES, please attach Network name, contact name, toll free number, and hospital listing		☐ Use UHR list
*SEE "SPECIAL INSTRUCTIONS & INFORMATION" (BELOW)		☐ Use Plan List (PIs attach)

NATIONAL CARE NETWORK VIA CDS GROUP HEALTH (TPA) PPO Deductibles: Family: $200 Individual: $100 Primary visit copay:	City, State and Zip Code Contact/Title Toll free telephone # Fax #	**CCM Services provided by:** Company Name: UHN Contact Name: Toll free telephone #: Ext #: Fax #:

Special Instructions and information: (May attach additional information if desired)

1. "Wrap Network" is provided by National Care Network via the plan's TPA (CDS Group Health).
2. The plan also has a global travel assistance program via Sun Life Financial, referred to as Assist America. This plan is available to all active employees and their dependents. It is NOT available to retirees and their dependents. A brochure (with contact info is attached)
3. The plan has direct contracts (via the Nevada Health Care Coalition/Nevada Health Partners) with a number of medical providers. A list of those contracts is attached.

Please complete the following PreAuthorization Requirements for this Client group

******* Please submit this group's Benefit Plan Design *******

Yes X No ____ Is Universal (UHR) providing Utilization Management Services for this group?

* CAN THESE ALSO BE SENT TO CDS GROUP HEALTH ?

IF YES, where are the potential catastrophic case notifications sent?

Company Name: City of Sparks Phone #: 775-353-2346
Contact Person: Randy Waterman Fax #: 775-353-2499

IF NO, Please list:
UM Company Name: ____ Toll-free Phone #: ____
Contact Person: ____ Fax #: ____

IF Universal (UHR) provides Utilization Management Services for this group, please complete the following:

Yes X No ____ 1=Do all inpatient admissions, except for emergencies, require preauthorization?

800-455-4236 3=List the toll-free phone number to verify this group's benefits.

Yes X No ____ 10=Does UHR preauthorize behavioral health admits?

Fill in $$ amount: N/A 30=If outpatient surgery preauthorization is required for procedures exceeding a certain $ amount.

Yes ____ No X 40=Do all outpatient surgical procedures require preauthorization?

Yes ____ No X 50=Do only outpatient surgical procedures, which require general anesthesia, require preauthorization?

Yes ____ No X 60=Do all outpatient surgical procedures, not performed in a physician's office, require preauthorization?

Fill in $$ amount: N/A 70=If outpatient diagnostic testing, exceeding a certain $ amount per test, requires preauthorization.

Yes ____ No X 80=Do MRI / MRA / PET scans require preauthorization? Please circle the applicable service(s).

Yes ____ No X 90=Do CT scans require preauthorization?

Yes ____ No X 110=Do outpatient cardiac caths require preauthorization?

Attach List 120=Identify other services not included in this questionnaire which require preauthorization: ____

Yes ____ No X 130=Do PT/OT/ST outpatient service(s) require preauthorization? Please circle the applicable service(s).

Fill in $$ amount: N/A 150=If PT services, exceeding a certain $ amount, require preauthorization.

Fill in number of 'base' visits: N/A 160=If PT visits, in excess of a certain # of visits, require preauthoriztion.

Yes ____ No X 190=Do all chiropractic treatments require preauthorization?

Fill in $$ amount: N/A 200=If chiropractic services, exceeding a certain $ amount, require preauthorization.

Fill in number of 'base' visits: N/A 210=If chiropractic visits, exceeding a certain # of visits, require preauthorization.

Yes ____ No X 220=Do partial hospitalizations, less than 24 hrs per day, for mental/nervous services require preauthorization?

Yes ____ No X 230=Do mental/nervous services require preauthorization by EmployeeAssistancePerson?

Fill in number of 'base' visits: N/A 240=If outpatient mental health visits, exceeding a certain # of visits, require preauthorization.

Yes ____ No X 250=Do partial hospitalizations, less than 24 hours per day, for substance abuse services require preauthorization?

Yes ____ No X 260=Do substance abuse services require preauthorization by EmployeeAssistancePerson?

Fill in number of 'base' visits: N/A 270=If outpatient substance abuse visits, exceeding a certain # of visits, require preauthorization.

Yes ____ No X 280=Do home health services require preauthorization?

Yes _____ No X 290=Do home IV/Infusion services require preauthorization, if not being followed under case management?

Yes _____ No X 300=Does home obstetrical (OB) monitoring require preauthorization?

Fill in $$ amount: N/A 310=If durible medical equipment (DME) require preauthorization, when cost exceeds a certain $ amount.

Yes _____ No X 340=If payor is secondary, another insurance company is primary insurer, do services still require preauthorization?

Yes _____ No X 350=Is Second Surgical Opinion mandatory by UHR?

Attach List IF YES, Do you use a Client/Payor-specific Second Surgical Opinion list?

Yes _____ No X 360=Is UHR to provide high risk pregnancy screening for an additional fee?