UMC Audit and Finance Committee Meeting

Wednesday, January 21, 2026 2:00 pm

Delta Point Building - Emerald Conference Room - 1st Floor

Las Vegas, NV

AGENDA

University Medical Center of Southern Nevada
GOVERNING BOARD
AUDIT & FINANCE COMMITTEE
January 21, 2026 2:00 p.m.
901 Rancho Lane, Las Vegas, Nevada
Delta Point Building, Emerald Suite (1st Floor)

Notice is hereby given that a meeting of the UMC Governing Board Audit & Finance Committee has been called and will be held at the time and location indicated above, to consider the following matters:

This meeting has been properly noticed and posted online at University Medical Center of Southern Nevada's website http://www.umcsn.com and at Nevada Public Notice at https://notice.nv.gov/, and at 901 Rancho Lane. Las Vegas, NV (Principal Office)

- The main agenda is available on University Medical Center of Southern Nevada's website http://www.umcsn.com. For copies of agenda items and supporting back-up materials, please contact Stephanie Ceccarelli at (702) 765-7949. The Audit & Finance Committee may combine two or more agenda items for consideration.
- Items on the agenda may be taken out of order.
- The Audit & Finance Committee may remove an item from the agenda or delay discussion relating to an item at any time.

SECTION 1: OPENING CEREMONIES

CALL TO ORDER

1. Public Comment

   PUBLIC COMMENT. This is a period devoted to comments by the general public about items on ***this*** agenda. If you wish to speak to the Committee about items within its jurisdiction but not appearing on this agenda, you must wait until the "Comments by the General Public" period listed at the end of this agenda. Comments will be limited to three minutes. Please step up to the speaker's podium, clearly state your name and address, and please ***spell*** your last name for the record. If any member of the Committee wishes to extend the length of a presentation, this will be done by the Chair or the Committee by majority vote.

2. Approval of minutes of the regular meeting of the UMC Governing Board Audit and Finance Committee meeting of December 10, 2025. *(For possible action).*

3. Approval of Agenda. *(For possible action)*

SECTION 2: BUSINESS ITEMS

4. Receive the monthly and year-to-date financial reports for November and December FY26; and direct staff accordingly. *(For possible action)*

5. Receive an update from the Chief Financial Officer; and direct staff accordingly. *(For possible action)*

6. Review and recommend for ratification by the Governing Board, the Multispecialty Group Participation Agreement and Provider Incentive Program Amendment with P3 Health Partners-Nevada, LLC for Managed Care Services; or take action as deemed appropriate. *(For possible action)*

7. Review and recommend for ratification by the Governing Board the Ancillary Provider Participation Agreement and the Facility Participation Agreement with United Healthcare Insurance Company for Managed Care Services; or take action as deemed appropriate. (For possible action)

8. Review and recommend for ratification by the Governing Board, the Amendment Six to Participating Facility Agreement with SelectHealth, Inc. and SelectHealth Benefit Assurance, Inc. for Managed Care Services; or take action as deemed appropriate. *(For possible action)*

9. Review and recommend for ratification by the Governing Board Amendment One to the Memorandum of Understanding with SCAN Health Plan Nevada for Managed Care Services, or take action as deemed appropriate. (For possible action)

10. Review and recommend for ratification by the Governing Board Amendment Two and Amendment Three to the Hospital Participation Agreement with Prominence HealthFirst for Managed Care Services; or take action as deemed appropriate. (For possible action)

11. Review and recommend for ratification by the Governing Board the Eighth Amendment to Provider Services Agreement and Tenth Amendment to the Memorandum of Understanding with Intermountain IPA, LLC for Managed Care Services; or take action as deemed appropriate. (For possible action)

12. Review and recommend for ratification by the Governing Board, the Combined Services Agreement and Amendment with Molina Healthcare of Nevada, Inc. for Managed Care Services; or take action as deemed appropriate. (For possible action)

13. Review and recommend for approval by the Governing Board Amendment Two to the Provider Group Services Agreement with Optum Health Networks, Inc. for Managed Care Services; or take action as deemed appropriate. (For possible action)

14. Review and recommend for approval by the Governing Board the Blue Distinction Centers for Transplants Participation Agreement and Letter of Agreement with Anthem Blue Cross and Blue Shield Nevada for Managed Care Services; or take action as deemed appropriate. *(For possible action)*

15. Review and recommend for approval by the Governing Board the Institutional Provider Agreement with Evernorth Behavioral Health, Inc. for Managed Care Services; or take action as deemed appropriate. *(For possible action)*

16. Review and recommend for award by the Governing Board, the Bid No. 2025-11, UMC Quick Care Build Out 2100 W Charleston Project, PWP# CL-2026-111, to Monument Construction, the lowest responsive and responsible bidder, contingent upon submission of the required bonds and insurance; authorize the Chief Executive Officer to execute change orders within his delegation of authority; or take action as deemed appropriate. *(For possible action)*

17. Review and recommend for award by the Board of Hospital Trustees for University Medical Center of Southern Nevada, the Bid No. 2025-07, UMC 7 Story Tower &

Trauma Building Elevator Modernization Project, PWP# CL-2026-102, to Monument Construction, the lowest responsive and responsible bidder, contingent upon submission of the required bonds and insurance; authorize the Chief Executive Officer to execute change orders within his delegation of authority; or take action as deemed appropriate. *(For possible action)*

SECTION 3: EMERGING ISSUES

18. Identify emerging issues to be addressed by staff or by the Audit and Finance Committee at future meetings; and direct staff accordingly. (*For possible action)*

COMMENTS BY THE GENERAL PUBLIC

All comments by speakers should be relevant to the Committee's action and jurisdiction.

UMC ADMINISTRATION KEEPS THE OFFICIAL RECORD OF ALL PROCEEDINGS OF UMC GOVERNING BOARD AUDIT & FINANCE COMMITTEE. IN ORDER TO MAINTAIN A COMPLETE AND ACCURATE RECORD OF ALL PROCEEDINGS, ANY PHOTOGRAPH, MAP, CHART, OR ANY OTHER DOCUMENT USED IN ANY PRESENTATION TO THE BOARD SHOULD BE SUBMITTED TO UMC ADMINISTRATION. IF MATERIALS ARE TO BE DISTRIBUTED TO THE COMMITTEE, PLEASE PROVIDE SUFFICIENT COPIES FOR DISTRIBUTION TO UMC ADMINISTRATION.

THE COMMITTEE MEETING ROOM IS ACCESSIBLE TO INDIVIDUALS WITH DISABILITIES. WITH TWENTY-FOUR (24) HOUR ADVANCE REQUEST, A SIGN LANGUAGE INTERPRETER MAY BE MADE AVAILABLE (PHONE: 702-765-7949).

University Medical Center of Southern Nevada
Governing Board Audit and Finance Committee Meeting
December 10, 2025

Emerald Conference Room
Delta Point Building, 1st Floor
901 Rancho Lane
Las Vegas, Clark County, Nevada

The University Medical Center Governing Board Audit and Finance Committee met at the location and date above at the hour of 2:00 p.m. The meeting was called to order at the hour of 2:02 p.m. by Chair Robyn Caspersen and the following members were present, which constituted a quorum.

CALL TO ORDER

Board Members:

Present:
Robyn Caspersen
Harry Hagerty (via Teams)
Bill Noonan
Mary Lynn Palenik
Christian Haase (via Teams)

Absent:
None

Others Present:
Mason Van Houweling, Chief Operating Officer
Tony Marinello, Chief Operating Officer
Jennifer Wakem, Chief Financial Officer
Deb Fox, Chief Nursing Officer
Doug Metzger, Controller
Susan Pitz, General Counsel
Lia Allen, Assistant General Counsel - Contracts
Stephanie Ceccarelli, Board Secretary

SECTION 1. OPENING CEREMONIES

ITEM NO. 1 PUBLIC COMMENT

Committee Chair Caspersen asked if there were any public comments to be heard on any item on this agenda.

Speaker(s): None

ITEM NO. 2 Approval of minutes of the regular meeting of the UMC Governing Board Audit and Finance Committee meeting on November 12, 2025. *(For possible action)*

A motion was made by Member Noonan to approve the minutes as presented. Motion carried by a majority vote.

ITEM NO. 3 Approval of Agenda *(For possible action)*

A motion was made by Member Noonan to approve the agenda as presented. Motion carried by unanimous vote.

SECTION 2. BUSINESS ITEMS

ITEM NO. 4 Receive monthly and year-to-date financial report for October FY26; and direct staff accordingly. *(For possible action)*

DOCUMENTS SUBMITTED:
- October FY26 Financial Report

DISCUSSION:

Admissions were 2.5% below budget. Adjusted average daily census was 361 and ALOS was 5.69. Hospital CMI was 1.94 and Medicare was 1.93. There were 840 inpatient surgery cases and outpatient surgeries were above budget by 25 cases. There were 12 transplants and total ER visits were 335 patients above budget. ED to admission/observation was at 21.81%. Quick care volumes were 6.7% below budget and primary cares were below budget 9%. There were 361 telehealth visits. Ortho visits were up 731 cases and there were 118 deliveries. The Crisis Stabilization Center received 132 patients, and the outpatient infusion clinic saw 476 patients.

Member Noonan asked whether quick care locations were down in total or whether specific locations were showing a decrease. Ms. Wakem responded that Enterprise, Blue Diamond, and Sunset are the key drivers. Mr. Marinello added that there is competition in the area surrounding the Blue Diamond location. The conversation continued with the density of free-standing healthcare clinics in those areas.

Key stats trended were compared to the 12-month average. Observation cases increased. Length of stay was 5.59. Transplant cases were at a record low with 12 cases. Ortho had a record high with 3,400 visits.

Inpatient payor mix trends were consistent with prior months with the exception of Medicaid, which dropped 1.2%. Payor mix by type was presented as informational.

The October income statement showed net patient revenue $1.3 million above budget. Other revenue was down by $900K due to 340B revenue. Ms. Wakem reminded the committee of reimbursements from the county for losses from the Crisis Stabilization Center. As of October, the county has subsidized approximately $3 million in losses from CSC operations. Management is working on initiatives to minimize losses.

Total operating revenue was above budget $380K. Operating expenses were below budget $1.9 million. EBIDTA was $3.7 million on a budget of $1.6 million, exceeding budget.

Income statement year to date, net patient revenue is below budget $5.8 million and other revenue was down $2.4 million. Total operating revenue was below budget $8.2 million. Operating expenses were down $10.7 million.

EBIDTA was $7.7 million on a budget of $6.4 million, leaving $1.2 million above budget.

Salaries, wages, and benefits for October were reviewed. Although slightly over budget $130 K, overtime is down significantly. Contract labor is up slightly, but this is being monitored. SWB per FTE is up slightly.

Chair Caspersen asked what is contributing to the decrease in overtime and how this is impacting staff. Ms. Wakem commented on the efforts to manage overtime in a positive way. There was a continued discussion regarding the management of the overtime trend related to patient volumes.

All other expenses were below budget by $2.1 million, primarily due to supplies and 340B revenue.

Financial indicators were discussed in profitability, labor, liquidity, and cash collections. Net to gross was slightly 17.3% under budget, labor and liquidity were in the green. The point-of-sale collection goal was 92.9%.

Ms. Wakem provided an update on the FY26 organizational goals and noted progress. The goal related to denial reduction and documentation accuracy has been a challenge. Management will discuss this documentation with staff to maintain compliance. There was continued discussion regarding documentation compliance and efforts to improve the length of stay.

Next, the Committee discussed concerns related to cash flow. Approximately $50 million was received in supplemental payments. There was continued discussion regarding the reporting of investing activities of internally designated cash. The balance sheet was reviewed briefly.

FINAL ACTION TAKEN:
None

ITEM NO. 5 Receive an update report from the Chief Financial Officer; and direct staff accordingly. *(For possible action)*

DOCUMENTS SUBMITTED:
- None

DISCUSSION:

Ms. Wakem provided the following updates:

Medicare Cost Report:
The annual Medicare Cost Report was filed in November. The reporting came in higher than what was budgeted by $2.8 million, due to a grant award and organ acquisition cost.

BDO Single Audit Report:

Guidance has been received and the auditors will begin working on the single audit.

DSH Audit Report:

The audit for FY22 was finalized in October. There were no overpayments noted. There will be reporting of FY23 next year.

New Supplemental Payment Program:

The team is working to resolve and clarify matters related to this new program. The ACA Premium Subsidies are set to expire at the end of the year, and this is also being monitored.

Chair Caspersen:

The team thanked Chair Caspersen for her leadership, support, and guidance as chair of the Audit and Finance Committee. This will be her last Audit and Finance meeting.

FINAL ACTION TAKEN:
None taken

ITEM NO. 6 Review and recommend for approval by the Governing Board the Lease Agreement and Service Agreement with PNC Bank and FujiFilm Healthcare Americas Corporation; authorize the Chief Executive Officer to execute extensions and amendments; or take action as deemed appropriate. *(For possible action)*

DOCUMENTS SUBMITTED:
- Lease and Service Agreement
- PNC - Disclosure of Ownership
- FujiFilm Disclosure of Ownership

DISCUSSION:

This request seeks to establish a 48-month lease and service agreement for endoscopic scopes and video imaging equipment, as well as upgrade the existing equipment used in endoscopy.

FINAL ACTION TAKEN:
A motion was made by Member Noonan to approve the agreement and make a recommendation to the Governing Board to approve the agreement. Motion carried by unanimous vote.

ITEM NO. 7 Review and recommend for approval by the Governing Board the Master Purchasing Agreement with Vocera Communications, Inc.; authorize the Chief Executive Officer to execute extensions and amendments; or take action as deemed appropriate. *(For possible action)*

DOCUMENTS SUBMITTED:
- Master Purchase Agreement - Redacted
- Disclosure of Ownership

DISCUSSION:

This is a new 36-month purchasing agreement with Vocera to create a quieter and more healing environment for patient care. Wearable badges will enhance the safety of UMC's staff, simplify care coordination, and improve overall workflow efficiency by implementing a single, enterprise-wide communication and alert management platform. Additionally, this effort supports UMC's goal of achieving Magnet Status.

Through this agreement, UMC will receive the smart badges, 36-month subscription for the Vocera platform, implementation, warranty, and training. Implementation will begin after approval.

A discussion ensued regarding the capabilities of this technology and communication platform, as well as how it will be utilized hospital wide. Ms. Fox explained the security aspects of the system and how HIPAA is protected.

Chair Caspersen asked whether there would be an extension of services after 36 months and whether more equipment would be required. Ms. Allen responded that the subscription would be renewed after 36 months.

A lengthy discussion ensued about whether this equipment has transcription capabilities. Ms. Fox responded that records will still need to be documented, but this will enable seamless interfacing between nurses and physicians, improving staff responsiveness. The built-in security system will ensure staff safety.

The Committee would be interested in a demonstration of this equipment and how it works.

FINAL ACTION TAKEN:
A motion was made by Member Noonan to approve the agreement and to make a recommendation to the Governing Board to approve the agreement. Motion carried by unanimous vote.

ITEM NO. 8 Review and recommend for award by the Governing Board the RFQ No. 2025-06 Renal Dialysis Coordinator Services to Patient Pathways, LLC; approve the RFQ No. 2025-06 Service Agreement; authorize the Chief Executive Officer to execute the extension options and future amendments within his yearly delegation of authority; or take action as deemed appropriate. *(For possible action)*

DOCUMENTS SUBMITTED:
- Services Agreement

DISCUSSION:

In July 2025, a notice of interest was issued allowing companies to express interest in participating in a request for qualifications for Renal Dialysis Coordinator Services.

The agreement with the vendor specifies an approximate 48 to 72-hour turnaround time, allowing timely patient discharge from the hospital.

The vendor will coordinate the placement of patients needing kidney dialysis with local clinics and at the patient's location of choice. This is a 3-year agreement with a 30-day termination notice.

FINAL ACTION TAKEN:
A motion was made by Member Noonan to approve the agreement and to make a recommendation to the Governing Board to approve the agreement. Motion carried by unanimous vote.

ITEM NO. 9 Review and recommend for award by the Governing Board RFSOQ No. 2025-08 Professional Placement Services to multiple placement agencies; approve the RFSOQ No. 2025-08 Placement Services Agreements; authorize the Chief Executive Officer to exercise any extension options and execute any applicable candidate referral forms; or take action as deemed appropriate. *(For possible action)*

DOCUMENTS SUBMITTED:
- Various Vendor Professional Placement Services Agreements
- Disclosure of Ownership

DISCUSSION:

In October, a Request for Statements of Qualification was issued, inviting companies to express interest in professional placement services for professional and non-professional staff at UMC. Of the 25 respondents, 17 agencies were selected for their placement services.

This is a 3-year agreement with 2 one-year renewal options and termination upon 30 days' notice.

The Committee inquired about compensation for vendors based on performance and whether UMC has used any of the approved respondents. Ms. Allen responded that many of the respondents have been used previously at UMC, and that compensation is based on who fills the position. These matters are managed by Human Resources.

FINAL ACTION TAKEN:
A motion was made by Member Noonan to approve the agreements and to make a recommendation to the Governing Board to approve the agreements. Motion carried by unanimous vote.

ITEM NO. 10 Review and recommend for approval by the Governing Board the Third Amendment to License Agreement with Zynx Health Incorporated for clinical decision support solutions; or take action as deemed appropriate. *(For possible action)*

DOCUMENTS SUBMITTED:
- License Agreement – 3rd Amendment
- Disclosure of Ownership

DISCUSSION:

This amendment extends the license for software modules for the clinical decision support solutions for 5 years.

FINAL ACTION TAKEN:
A motion was made by Member Noonan to approve the amendment and to make a recommendation to the Governing Board to approve the amendment. Motion carried by unanimous vote.

SECTION 3: EMERGING ISSUES

ITEM NO. 11 Identify emerging issues to be addressed by staff or by the Audit and Finance Committee at future meetings; and direct staff accordingly. (*For possible action)*

None

At this time, Chair Caspersen asked if there were any public comment to be heard on any items not listed on the posted agenda.

COMMENTS BY THE GENERAL PUBLIC:

SPEAKERS(S): None

FINAL ACTION TAKEN:

At the hour of 3:02 p.m., the meeting was adjourned.

MINUTES APPROVED:
Minutes Prepared by: Stephanie Ceccarelli

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
GOVERNING BOARD AUDIT AND FINANCE COMMITTEE
AGENDA ITEM

Issue:	**Monthly Financial Reports for November FY26 and December FY26**	**Back-up:**
Petitioner:	Jennifer Wakem, Chief Financial Officer	

Recommendation:

That the Governing Board Audit and Finance Committee receive the monthly financial report for November FY26 and December FY26; and direct staff accordingly. ***(For possible action)***

FISCAL IMPACT:

None

BACKGROUND:

The Chief Financial Officer will present the financial report for November and December FY26 for the committee's review and direction.

Cleared for Agenda
January 21, 2026

Agenda Item #

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UMC
UNIVERSITY MEDICAL CENTER
November 2025
Financials
AFC Meeting
HOPE
UMC
1800

KEY INDICATORS – NOV

Current Month	Actual	Budget	Variance	% Var	Prior Year	Variance	% Var
APDs	18,402	18,016	387	2.15%	17,105	1,298	7.59%
Total Admissions	1,916	2,037	(121)	(5.95%)	1,855	61	3.29%
Observation Cases	729	808	(79)	(9.78%)	808	(79)	(9.78%)
ADC	383	369	14	3.83%	359	23	6.50%
ALOS (Admits)	5.29	5.43	(0.14)	(2.55%)	5.90	(0.61)	(10.34%)
ALOS (Obs)	1.27	1.20	0.07	5.91%	1.20	0.07	5.91%
Hospital CMI	1.81	1.84	(0.03)	(1.63%)	1.84	(0.04)	(1.63%)
Medicare CMI	2.00	2.01	(0.01)	(0.50%)	1.99	0.01	0.50%
IP Surgery Cases	803	820	(17)	(2.07%)	740	63	8.51%
OP Surgery Cases	621	669	(48)	(7.17%)	637	(16)	(2.51%)
Transplants	10	15	(5)	(33.33%)	15	(5)	(33.33%)
Total ER Visits	8,998	8,995	3	0.03%	8,907	91	1.02%
ED to Admission	14.21%	-	-	-	12.91%	1.30%	-
ED to Observation	7.60%	-	-	-	8.87%	(1.27%)	-
ED to Adm/Obs	21.82%	-	-	-	21.78%	0.04%	-
Quick Cares	15,424	17,682	(2,258)	(12.77%)	16,747	(1,323)	(7.90%)
Primary Care	5,866	6,759	(893)	(13.22%)	6,300	(434)	(6.89%)
UMC Telehealth - QC	361	548	(187)	(34.12%)	535	(174)	(32.52%)
OP Ortho Clinic	2,937	2,558	379	14.83%	2,134	803	37.63%
Deliveries	126	105	21	20.00%	110	16	14.55%
Crisis Stabilization Center	155	1,541	(1,386)	(89.94%)	-	155	100.00%
OP Infusion Clinic	430	320	110	34.38%	-	430	100.00%

SUMMARY INCOME STATEMENT – NOV

REVENUE	Actual	Budget	Variance	% Variance	
Total Gross Patient Revenue	$502,281,732	$468,351,065	$33,930,667	7.24%	
Net Patient Revenue	$82,197,403	$85,248,854	($3,051,451)	(3.58%)	
Other Revenue	$3,601,987	$4,275,505	($673,518)	(15.75%)	
Total Operating Revenue	**$85,799,390**	**$89,524,359**	**($3,724,969)**	**(4.16%)**	
Net Patient Revenue as a % of Gross	16.36%	18.20%	(1.84%)		
EXPENSE	**Actual**	**Budget**	**Variance**	**% Variance**	
Total Operating Expense	**$87,570,710**	**$92,701,824**	**($5,131,115)**	**(5.54%)**	
INCOME FROM OPS	**Actual**	**Budget**	**Variance**	**% Variance**	
Total Inc from Ops	**($1,771,320)**	**($3,177,465)**	**$1,406,145**	**44.25%**	
Add back: Depr & Amort.	$4,669,264	$4,903,195	($233,932)	(4.77%)	
Tot Inc from Ops plus Depr & Amort. (EBITDA)	**$2,897,944**	**$1,725,730**	**$1,172,214**	**67.93%**	
EBITDA Margin	**3.38%**	**1.93%**	**1.45%**	**-**	


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December 2025
Financials
AFC Meeting
HOPE
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1800

KEY INDICATORS – DEC

Current Month	Actual	Budget	Variance	% Var	Prior Year	Variance	% Var
APDs	19,727	19,679	48	0.24%	19,071	656	3.44%
Total Admissions	2,137	2,200	(63)	(2.87%)	2,142	(5)	(0.23%)
Observation Cases	706	742	(36)	(4.85%)	742	(36)	(4.85%)
ADC	389	386	3	0.77%	389	0	0.02%
ALOS (Admits)	5.39	5.44	(0.05)	(0.99%)	5.62	(0.23)	(4.09%)
ALOS (Obs)	1.16	1.03	0.13	12.51%	1.03	0.13	12.51%
Hospital CMI	1.74	1.87	(0.13)	(6.94%)	1.77	(0.04)	(1.69%)
Medicare CMI	1.74	2.01	(0.27)	(13.43%)	1.91	(0.18)	(8.90%)
IP Surgery Cases	800	847	(47)	(5.55%)	786	14	1.78%
OP Surgery Cases	688	692	(4)	(0.58%)	629	59	9.38%
Transplants	14	17	(3)	(17.65%)	17	(3)	(17.65%)
Total ER Visits	9,573	10,110	(537)	(5.31%)	10,010	(437)	(4.37%)
ED to Admission	16.24%	-	-	-	13.56%	2.69%	-
ED to Observation	6.56%	-	-	-	6.91%	(0.35%)	-
ED to Adm/Obs	22.80%	-	-	-	20.47%	2.33%	-
Quick Cares	18,021	22,038	(4,017)	(18.23%)	21,070	(3,049)	(14.47%)
Primary Care	6,213	7,266	(1,053)	(14.50%)	6,759	(546)	(8.08%)
UMC Telehealth - QC	434	554	(120)	(21.66%)	540	(106)	(19.63%)
OP Ortho Clinic	3,360	2,891	469	16.24%	2,458	902	36.70%
Deliveries	114	108	6	5.56%	106	8	7.55%
Crisis Stabilization Center	128	1,541	(1,413)	(91.69%)	-	128	100.00%
OP Infusion Clinic	438	320	118	36.88%	-	438	100.00%

TRENDING STATS

	Dec- 24	Jan- 25	Feb- 25	Mar- 25	Apr- 25	May- 25	Jun- 25	Jul- 25	Aug- 25	Sep- 25	Oct- 25	Nov- 25	Dec- 25	12-Mo Avg	Var
APDs	19,071	19,888	17,645	19,715	18,649	18,823	18,161	18,356	18,748	17,750	18,298	18,402	19,727	18,626	1,102
Total Admissions	2,142	2,164	2,019	2,117	2,036	2,079	1,992	2,024	1,983	1,888	1,990	1,916	2,137	2,029	108
Observation Cases	742	724	635	668	651	710	778	711	760	732	816	729	706	721	(15)
ADC	389	404	398	400	381	370	375	366	366	361	361	383	389	379	10
ALOS (Adm)	5.62	5.87	5.42	5.65	5.63	5.38	5.47	5.12	5.69	5.71	5.59	5.29	5.39	5.54	(0.15)
ALOS (Obs)	1.03	0.92	0.87	0.91	0.92	0.99	1.13	1.07	1.14	1.19	1.22	1.27	1.16	1.06	0.11
Hospital CMI	1.77	1.82	1.77	1.81	1.88	1.85	1.81	1.88	1.90	1.88	1.94	1.81	1.74	1.84	(0.10)
Medicare CMI	1.91	2.22	2.08	2.12	1.90	1.86	2.15	2.05	2.22	2.08	1.93	2.00	1.74	2.04	(0.30)
IP Surgery Cases	786	816	813	832	831	866	843	892	827	833	840	803	800	832	(32)
OP Surgery Cases	629	718	693	696	720	700	625	736	651	637	716	621	688	679	10
Transplants	17	13	20	15	17	17	20	14	15	17	12	10	14	16	(2)
Total ER Visits	10,010	9,564	8,625	9,685	9,585	9,663	9,098	9,353	9,694	9,418	9,502	8,998	9,573	9,433	140
ED to Admission	13.56%	14.38%	16.32%	14.98%	14.86%	14.67%	14.45%	14.88%	13.46%	13.46%	13.56%	14.21%	16.24%	14.40%	1.84%
ED to Observation	6.91%	7.08%	6.75%	6.21%	6.28%	6.79%	7.63%	6.94%	7.47%	7.33%	8.25%	7.60%	6.56%	7.10%	(0.54%)
ED to Adm/Obs	20.47%	21.46%	23.07%	21.19%	21.14%	21.46%	22.08%	21.82%	20.93%	20.79%	21.81%	21.82%	22.80%	21.50%	1.30%
Quick Care	21,610	21,066	17,943	18,862	17,245	16,278	14,173	13,988	15,862	15,783	16,284	15,785	18,021	17,073	948
Primary Care	6,759	8,108	7,198	7,705	8,055	7,289	6,729	7,199	6,679	7,073	7,437	5,866	6,213	7,175	(962)
UMC Telehealth - QC	540	620	476	444	417	357	371	371	346	342	361	361	434	417	17
OP Ortho Clinic	2,458	2,522	2,529	2,649	3,039	2,806	2,819	2,952	2,849	3,192	3,515	2,937	3,360	2,856	504
Deliveries	106	137	92	100	107	129	134	107	145	109	118	126	114	118	(4)
Crisis Stabilization Center	-	-	-	-	-	-	-	-	103	162	132	155	128	138	(10)
OP Infusion Clinic	-	-	241	289	298	297	257	395	503	398	476	430	438	299	139

Payor Mix Trend

IP- Payor Mix 12 Mo Dec- 25

Fin Class	Dec- 24	Jan- 25	Feb- 25	Mar- 25	Apr- 25	May- 25	Jun- 25	Jul- 25	Aug- 25	Sep- 25	Oct- 25	Nov- 25	Dec- 25	12-Mo Avg	Dec to Avg Var
Commercial	16.95%	16.52%	17.76%	17.75%	18.10%	17.40%	16.46%	17.27%	18.04%	16.75%	17.59%	18.76%	17.93%	17.45%	0.48%
Government	4.26%	3.95%	4.12%	3.29%	3.25%	4.34%	4.27%	4.25%	4.18%	4.18%	4.55%	4.36%	3.97%	4.08%	(0.11%)
Medicaid	41.55%	40.63%	42.60%	41.26%	41.89%	43.19%	41.18%	41.67%	42.36%	39.18%	40.20%	42.75%	42.50%	41.54%	0.96%
Medicare	32.35%	34.73%	30.62%	31.99%	31.76%	30.55%	32.35%	31.57%	29.44%	34.91%	32.77%	28.21%	31.76%	31.77%	(0.01%)
Self Pay	4.89%	4.17%	4.90%	5.71%	5.00%	4.52%	5.74%	5.24%	5.98%	4.98%	4.89%	5.92%	3.84%	5.16%	(1.32%)

Payor Mix by Type 12 Mo Avg Dec- 25

Fin Class	IP	ED	Surg IP	Surg OP
Commercial	17.45%	18.94%	21.61%	33.17%
Government	4.08%	5.59%	5.23%	5.38%
Medicaid	41.54%	48.02%	36.15%	33.05%
Medicare	31.77%	16.37%	32.22%	26.74%
Self Pay	5.16%	11.09%	4.79%	1.66%

Payor Mix Trend

QC- Payor Mix by Location 12-Mo Avg

QC	Aliante QC	Centennial QC	Nellis QC	Peccole QC	Spring Valley QC	Summerlin QC	Sunset QC	Enterprise QC	Blue Diamond QC
Commercial	53.96%	62.60%	31.67%	56.03%	49.20%	44.52%	56.58%	25.69%	67.85%
Government	3.49%	3.97%	1.27%	1.72%	1.45%	2.18%	2.65%	21.28%	1.88%
Medicaid	28.57%	13.88%	48.39%	14.75%	25.76%	25.93%	20.56%	40.58%	13.47%
Medicare	9.62%	15.44%	13.46%	23.11%	17.31%	22.29%	15.42%	7.71%	12.85%
Self Pay	4.36%	4.11%	5.21%	4.40%	6.28%	5.09%	4.79%	4.74%	3.96%

PC- Payor Mix by Location 12-Mo Avg

PC	Aliante PC	Centennial PC	Nellis PC	Peccole PC	Spring Valley PC	Summerlin PC	Sunset PC	Southern Highlands PC	PC Wellness	PC at Medical District
Commercial	54.75%	46.11%	30.80%	47.49%	39.69%	40.61%	45.18%	55.86%	47.68%	35.35%
Government	1.84%	1.89%	0.89%	0.87%	0.62%	0.50%	1.20%	0.95%	0.42%	1.04%
Medicaid	22.35%	14.55%	36.45%	17.94%	20.47%	17.10%	15.98%	13.26%	30.17%	38.39%
Medicare	19.48%	36.86%	29.39%	32.17%	38.07%	40.59%	36.27%	27.70%	21.52%	15.57%
Self Pay	1.58%	0.59%	2.46%	1.53%	1.15%	1.19%	1.38%	2.23%	0.21%	9.65%

SUMMARY INCOME STATEMENT – DEC

REVENUE	Actual	Budget	Variance	% Variance	
Total Gross Patient Revenue	$494,515,466	$494,816,307	($300,841)	(0.06%)	
Net Patient Revenue	$84,221,310	$90,238,509	($6,017,200)	(6.67%)	
Other Revenue	$3,430,509	$4,389,914	($959,406)	(21.85%)	
Total Operating Revenue	**$87,651,819**	**$94,628,424**	**($6,976,605)**	**(7.37%)**	
Net Patient Revenue as a % of Gross	17.03%	18.24%	(1.21%)		
EXPENSE	**Actual**	**Budget**	**Variance**	**% Variance**	
Total Operating Expense	**$90,799,691**	**$97,412,990**	**($6,613,300)**	**(6.79%)**	
INCOME FROM OPS	**Actual**	**Budget**	**Variance**	**% Variance**	
Total Inc from Ops	**($3,147,872)**	**($2,784,567)**	**($363,305)**	**(13.05%)**	
Add back: Depr & Amort.	$4,553,565	$4,903,355	($349,789)	(7.13%)	
Tot Inc from Ops plus Depr & Amort. (EBITDA)	**$1,405,693**	**$2,118,788**	**($713,095)**	**(33.66%)**	
EBITDA Margin	**1.60%**	**2.24%**	**(0.64%)**	**-**	

SUMMARY INCOME STATEMENT – YTD DEC

REVENUE	Actual	Budget	Variance	% Variance	
Total Gross Patient Revenue	$3,012,696,861	$2,877,718,516	$134,978,345	4.69%	
Net Patient Revenue	$505,861,691	$520,727,805	($14,866,114)	(2.85%)	
Other Revenue	$22,284,938	$26,308,276	($4,023,338)	(15.29%)	
Total Operating Revenue	**$528,146,629**	**$547,036,081**	**($18,889,452)**	**(3.45%)**	
Net Patient Revenue as a % of Gross	16.79%	18.10%	(1.30%)		
EXPENSE	**Actual**	**Budget**	**Variance**	**% Variance**	
Total Operating Expense	**$543,792,775**	**$566,267,822**	**($22,475,047)**	**(3.97%)**	
INCOME FROM OPS	**Actual**	**Budget**	**Variance**	**% Variance**	
Total Inc from Ops	**($15,646,146)**	**($19,231,740)**	**$3,585,595**	**18.64%**	
Add back: Depr & Amort.	$27,607,243	$29,493,827	($1,886,583)	(6.40%)	
Tot Inc from Ops plus Depr & Amort. (EBITDA)	**$11,961,097**	**$10,262,086**	**$1,699,011**	**16.56%**	
EBITDA Margin	**2.26%**	**1.88%**	**0.39%**	**-**	

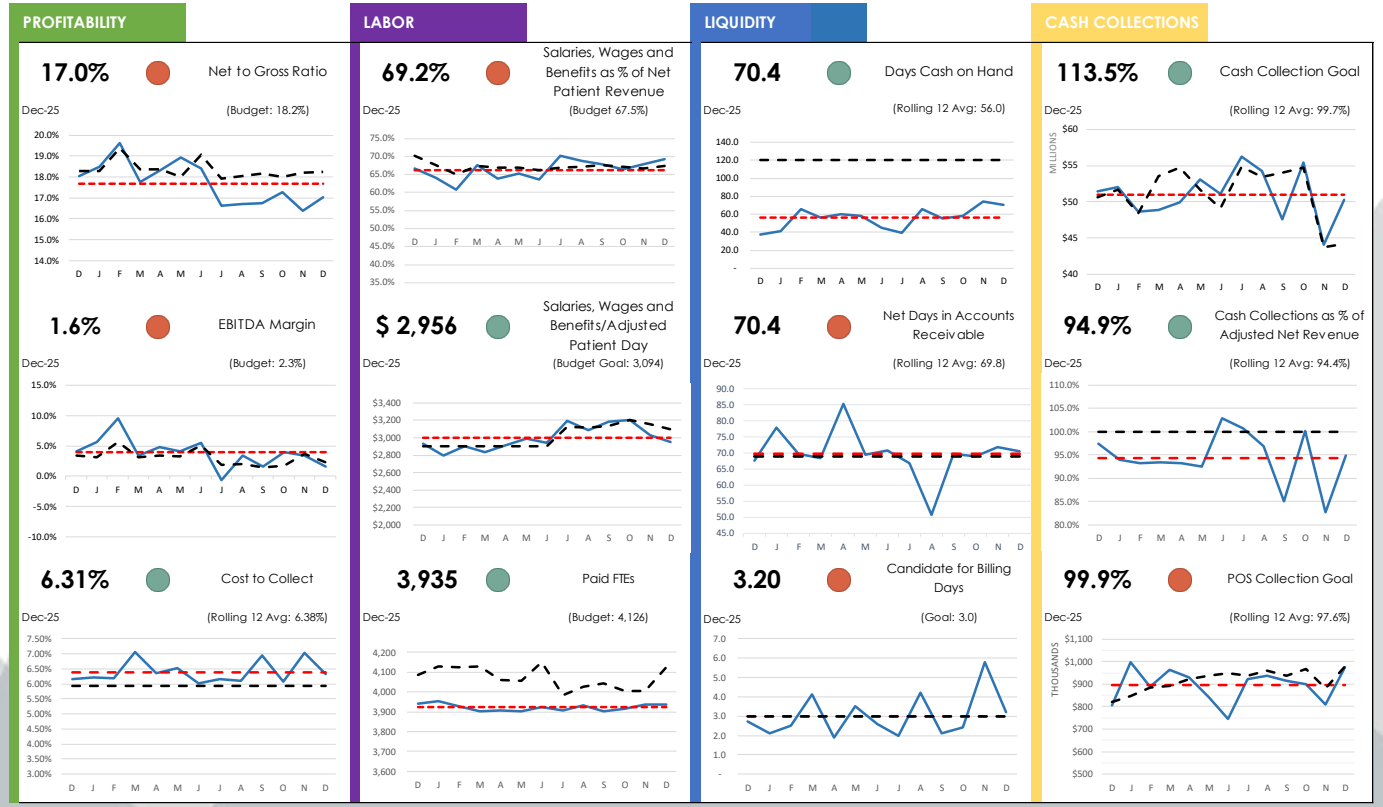
SALARY & BENEFIT EXPENSE – DEC

	Actual	Budget	Variance	% Variance	
Salaries	$38,833,888	$41,260,845	($2,426,958)	(5.88%)	
Benefits	$17,546,817	$17,921,211	($374,394)	(2.09%)	
Overtime	$702,070	$480,924	$221,145	45.98%	
Contract Labor	$1,231,371	$1,229,377	$1,994	0.16%	
TOTAL	$58,314,145	$60,892,357	($2,578,213)	(4.23%)	
Paid FTEs	3,935	4,126	(191)	(4.63%)	
Paid FTEs (Flex)	3,935	4,145	(210)	(5.06%)	
SWB per FTE	$14,819	$14,758	$61	0.41%	
SWB/APD	$2,956	$3,094	($138)	(4.47%)	
SWB % of Net	69.24%	67.48%	-	1.76%	
AEPOB	6.18	6.50	(0.32)	(4.86%)	

EXPENSES – DEC

	Actual	Budget	Variance	% Variance	
Professional Fees	$2,366,112	$3,097,050	($730,938)	(23.60%)	
Supplies	$16,218,368	$18,307,662	($2,089,294)	(11.41%)	
Purchased Services	$7,092,566	$7,552,336	($459,770)	(6.09%)	
Depreciation	$2,786,452	$3,040,067	($253,615)	(8.34%)	
Amortization	$1,767,113	$1,863,288	($96,174)	(5.16%)	
Repairs & Maintenance	$609,524	$996,742	($387,218)	(38.85%)	
Utilities	$465,419	$416,227	$49,192	11.82%	
Other Expenses	$1,077,216	$1,072,061	$5,155	0.48%	
Rental	$102,775	$175,200	($72,424)	(41.34%)	
Total Other Expenses	**$32,485,546**	**$36,520,633**	**($4,035,087)**	**(11.05%)**	

KEY FINANCIAL INDICATORS – DEC



ORGANIZATIONAL GOALS FINANCE/OPERATIONS DEC

	Jul	Aug	Sep	Oct	Nov	Dec	YTD	Target
Exceed fiscal year budgeted EBITDA	($514,892)	$3,018,149	$1,444,583	$3,709,620	$2,897,944	$1,405,693	$11,961,096	$10,262,086
Discharged to home ALOS with a target equal to or less than 4.01	3.82	4.18	4.08	4.18	3.82	3.89		4.01
Labor utilization with a target equal to or less than Adjusted EPOB of 6.26 or SWB per APD of $2,614 (excluding providers)								
SWB per APD of $2,614	$2,638	$2,589	$2,626	$2,638	$2,489	$2,414		$2,614
Adjusted EPOB of 6.26	6.23	6.12	6.22	6.23	6.01	5.79		6.26
Develop and execute a revenue capture initiative to improve NPSR by $7.5M, focused on denial reduction and documentation accuracy	1,296,874	846,818	(129,995)	430,512	204,169	152,782	2,801,160	(7,500,000)

FY26 CASH FLOW

	Dec 2025	Nov 2025	Oct 2025	YTD of FY2026
Operating Activities				
Cash received from patients and payors	84,034,476	131,448,742	103,864,641	602,058,133
Cash paid to vendors	(42,530,968)	(28,199,668)	(31,212,004)	(236,282,716)
Cash paid to employees	(54,780,033)	(61,872,364)	(66,735,668)	(296,338,407)
Other operating receipts/(disbursements)	2,661,200	2,977,923	3,144,909	17,463,553
Net cash provided by/(used in) operations	(10,615,325)	44,354,633	9,061,878	86,900,563
Investing Activities				
Purchase of property and equipment, net	(211,138)	(191,572)	(782,831)	(10,455,011)
Interest received	796,853	632,433	507,857	3,152,183
Addition/ (reduction) from/ (to) donor-restricted cash				
Addition/ (reduction) from/ (to) internally designated cash	261,619	1,534,731	(16,047,847)	(12,977,627)
Net cash provided by/(used in) investing activities	847,333	1,975,592	(16,322,820)	(20,280,455)
Financing Activities				
From/(to) Clark County	-	-	-	-
Unrestricted donations and other	-	-	-	-
Borrowing/(repayment) of debt	-	-	-	-
Interest paid	-	-	-	-
Other	609	-	1,632	2,241
Net cash provided by/(used in) financing activities	609	-	1,632	2,241
Increase/(decrease) in cash	(9,767,382)	46,330,225	(7,259,311)	66,622,348
Cash beginning of period	129,187,154	82,856,929	90,116,239	52,797,423
Cash end of period	119,419,772	129,187,154	82,856,928	119,419,772
Unrestricted cash	119,419,772	129,187,154	82,856,928	119,419,772
Cash restricted by donor	4,528,505	4,506,025	4,495,509	4,528,505
Internally designated cash	88,357,425	88,619,044	90,153,776	88,357,425

FY26 BALANCE SHEET HIGHLIGHTS

	Dec 2025	Nov 2025	Oct 2025
CASH			
Unrestricted	$ 119.4	$ 129.2	$ 82.9
Restricted by donor	4.5	4.5	4.5
Internally designated	88.3	88.6	90.2
	$ 212.2	$ 222.3	$ 177.6
NET WORKING CAPITAL	$ 186.5	$ 185.0	$ 186.5
NET PP&E	$ 306.9	$ 309.0	$ 307.5
LONG-TERM DEBT	$ -	$ -	$ -
NET PENSION LIABILITY	$ 676.7	$ 676.7	$ 676.7
NET POSITION	$ (211.0)	$ (208.3)	$ (206.8)

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
GOVERNING BOARD AUDIT AND FINANCE COMMITTEE
AGENDA ITEM

Issue: **CFO Update**	**Back-up:**
Petitioner: Jennifer Wakem, Chief Financial Officer	
Recommendation: **That the Audit and Finance Committee receive an update report from the Chief Financial Officer; and direct staff accordingly.** ***(For possible action)***	

FISCAL IMPACT:

None

BACKGROUND:

The Chief Financial Officer will provide an update on any financial matters of interest to the Board.

Cleared for Agenda
January 21, 2026

Agenda Item #

5

Agreements with $0 P&L impact and/or positive P&L impact (i.e. grants)										
Item #	Bid/RFP# or CBE	Vendor on GPO?	Contract Name	New Contract/ Amendment/Exercise Option/Change Order	Are Terms/Conditions the Same?	This Contract Term	Out Clause	Estimated Revenue	Requesting Department	Description/Comments
6	NRS 332.115(1)(f)	No	P3 - Provider Incentive Program Amendment	Amendment	No	1/1/25 - 12/31/25	180 w/out cause	Revenue based on volume	Managed Care	Through this Amendment, UMC is able to participate in certain incentive compensation for 2025 based on value-based care outcomes.
6	NRS 332.115(1)(f)	No	P3 - Multispecialty Group Participation Agreement	New Contract	n/a	9/1/25 - 8/31/27	180 w/out cause	Revenue based on volume	Managed Care	Since 2018, UMC has had an agreement with P3 Health Partners-Nevada, LLC ("P3") to provide its members healthcare access to the UMC Hospital and its associated Urgent Care facilities. This request is for ratification of a new Multispecialty Group Participation Agreement ("Agreement") with P3 for a two-year term.
7	NRS 332.115(1)(f)	No	United Healthcare - Ancillary Provider Participation Agreement	New Contract	n/a	11/1/25 - 10/31/28 (Commercial Products) 11/1/25 - 10/31/26 (Medicare Advantage Products)	180 w/out cause	Revenue based on volume	Managed Care	This request is for ratification of the Ancillary Provider Participation Agreement with UnitedHealthcare Insurance Company and its affiliates for healthcare services to UnitedHealthcare members at UMC locations. Ratification was necessary as the term was retroactively effective as of November 1, 2025, and immediate execution ensured it was loaded in UHC's internal systems.
7	NRS 332.115(1)(f)	No	United Healthcare - Facility Participation Agreement	New Contract	n/a	11/1/25 - 10/31/28 (Commercial Products) 11/1/25 - 10/31/26 (Medicare Advantage Products)	180 w/out cause	Revenue based on volume	Managed Care	This request is for ratification of the Facility Participation Agreement with UnitedHealthcare Insurance Company and its affiliates for healthcare services to UnitedHealthcare members at UMC locations. Ratification was necessary as the term was retroactively effective as of November 1, 2025, and immediate execution ensured it was loaded in UHC's internal systems.
8	NRS 332.115(1)(f)	No	Select Health	Amendment	No	Through 5/1/27	60 w/out cause	Revenue based on volume	Managed Care	This Amendment Six deletes and replaces the Compensation Schedule in the Agreement, which increases the reimbursement rates specified in the Compensation Schedule. All other terms in the Agreement are unchanged. Ratification of this amendment was necessary due to the retroactive nature of the change, as SelectHealth needed to load its systems as soon as possible to ensure the timely payment of claims.
9	NRS 332.115(1)(f)	No	SCAN	Amd to MOU	No	1/1/26 - 12/31/26	60 w/out cause	Revenue based on volume	Managed Care	This Amendment No. 1 to the MOU extends the term through December 31, 2026, and updates the compensation exhibit. Following the term, the MOU may be renewed for subsequent annual periods upon mutual written agreement.
10	NRS 332.115(1)(f)	No	Prominence Health - Amendment Two	Amendment	No	1/1/26 - 12/31/28	90 w/out cause	Revenue based on volume	Managed Care	Amendment Two updates and increases the facility, professional and Urgent Care reimbursement rates and extends the term of the Agreement through December 31, 2028.
10	NRS 332.115(1)(f)	No	Prominence Health - Amendment Three	Amendment	No	1/1/26 - 12/31/28	90 w/out cause	Revenue based on volume	Managed Care	Amendment Three adds the Nevada Medicaid Addendum to the Agreement, for UMC to provide covered services to beneficiaries enrolled in Prominence's Nevada Managed Medicaid and Children's Health Insurance Program (CHIP) products. It also adds additional facility and professional rates to the Agreement, effective January 1, 2026.
11	NRS 332.115(1)(f)	No	Intermountain - Provider Agrmt Eighth Amendment	Amendment	No	1/1/26 - 12/31/29 - Medicare 1/1/26 - 4/30/26 - Commercial	180 w/out cause	Revenue based on volume	Managed Care	Extends the term of Medicare Advantage Products to December 31, 2029, and Commercial Products to April 30, 2026. This Amendment will also increase the reimbursements.
11	NRS 332.115(1)(f)	No	Intermountain - MOU Tenth Amendment	Amendment	Yes	1/1/26 - 5/31/26	90 w/out cause	Revenue based on volume	Managed Care	Updates Exhibit C of the Agreement to include Anthem Blue Cross Blue Shield Medicare Advantage HMO, which will be effective January 1, 2026.
12	NRS 332.115(1)(f)	No	Molina Healthcare	New Contract	n/a	1/1/25 - 12/31/26	90 w/out cause	Revenue based on volume	Managed Care	This request is to enter into a Combined Services Agreement with Molina Healthcare of Nevada, Inc., which will supersede the previous Provider Services Agreement entered into in 2021 with Molina. Through this Agreement, UMC will realize increased reimbursement rates.
12	NRS 332.115(1)(f)	No	Molina Healthcare	Amendment	Yes	1/1/26-12/31/26	90 w/out cause	Revenue based on volume	Managed Care	Add a Value-Based Payment Program, which provides providers with the opportunity to earn incentives by improving the quality of care
13	NRS 332.115(1)(f)	No	Optum	Amendment	Yes	11/1/25-12/31/25	90 w/out cause	Revenue based on volume	Managed Care	This request is to approve the Second Amendment to the Agreement, which adds a Quality Incentive Program for those services provided to Optum members from Nov 1-Dec 31.
14	NRS 332.115(1)(f)	No	Anthem Blue Cross Blue Shield - Letter of Agreement	Amendment/Addnendum	Yes	1/1/26 - 12/31/26	30 w/out cause	Revenue based on volume	Managed Care	LOA to participate in the Behavioral Health Emergency Department Incentive Program (BHEDIP) with Community Care Health Plan of Nevada, Inc. encourages improvements in clinical quality indicators
14	NRS 332.115(1)(f)	No	Anthem Blue Cross Blue Shield - Participation Agreement	New Contract	No	2/1/26 - 1/31/29	60 w/out cause	Revenue based on volume	Managed Care	This request is to approve the Participation Agreement with Blue Cross and Blue Shield for Blue Distinction Centers for Transplants. Through this Agreement, UMC will be designated as a Blue Distinction Center in Anthem's directories and listings for its members, specifically for kidney and pancreas transplants. Anthem will also, at an increased rate, compensate UMC for the transplant services it provides to its members.
15	NRS 332.115(1)(f)	No	Evernorth Behavioral Health, Inc.	New Contract	No	Two years from date signed	60 w/out cause	Revenue based on volume	Managed Care	New agreement with Evernorth to provide health care services to its members at UMCs Crisis Stabilization Center

Agreements with a P&L Impact												
Item #	Bid/RFP# or CBE	Vendor on GPO?	Contract Name	New Contract / Amendment /Exercise Option/ Change Order	Are Terms/Conditions the Same?	This Contract Term	Out Clause	Contract Value	Capital / Maintenance and Support	Savings/Cost Increase	Requesting Department	Description/Comments
16	Formal Bid (No. 2025-11) Pursuant to NRS 338	No	Monument Construction	New Contract	N/A	6 Months	Termination, without cause, upon notice	$4,724,700	Capital Project 26-007	$1,775,300 below cost estimate	Plant Operations	Award Bid No. 2025-11 UMC Quick Care Build Out, for a build out of a planned UMC Quick Care location at 2100 W Charleston, to Monument Construction, the lowest responsive and responsible bidder.
17	Formal Bid (No. 2025-07) Pursuant to NRS 338	No	Monument Construction	New Contract	N/A	18 Months	Termination, without cause, upon notice	$5,649,883	Capital Project 25-043	$1,014,726 below cost estimate	Plant Operations	Award Bid No. 2025-07 UMC 7 Story Tower & Trauma Building Elevator Modernization, for significant refurbishment and enhancements to the elevators located at 7 Story Tower and Trauma Building of the Main Campus of UMC, to Monument Construction, the lowest responsive and responsible bidder.

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
GOVERNING BOARD AUDIT AND FINANCE COMMITTEE
AGENDA ITEM

Issue:	**Ratification of the Multispecialty Group Participation Agreement and Provider Incentive Program Amendment with P3 Health Partners-Nevada, LLC**	**Back-up:**
Petitioner:	Jennifer Wakem, Chief Financial Officer	**Clerk Ref. #**

Recommendation:

That the Governing Board Audit and Finance Committee review and recommend for ratification by the Governing Board, the Multispecialty Group Participation Agreement and Provider Incentive Program Amendment with P3 Health Partners-Nevada, LLC for Managed Care Services; or take action as deemed appropriate. ***(For possible action)***

FISCAL IMPACT:

Fund Number: 5430.011
Fund Name: UMC Operating Fund
Fund Number: 3000850000
Funded Pgm/Grant: N/A
Description: Managed Care Services
Bid/RFP/CBE: NRS 332.115(1)(f) – Insurance
Multispecialty Agreement Term:
9/1/2025 to 8/31/2027
Incentive Amendment Term:
1/1/2025 to 12/31/2025
Amount: Revenue based on volume
Out Clause: 180 days without cause

BACKGROUND:

Since 2018, UMC has had an agreement with P3 Health Partners-Nevada, LLC ("P3") to provide its members healthcare access to the UMC Hospital and its associated Urgent Care facilities. This request is for ratification of a new Multispecialty Group Participation Agreement ("Agreement") with P3 for a two-year term. The Agreement may be terminated without cause by either party, upon one hundred eighty days' notice.

The secondary request is for ratification of the P3 2025 Provider Incentive Program Amendment to the Provider Agreement ("Amendment"), entered into between UMC and P3. Through this Amendment, UMC is able to participate in certain incentive compensation for 2025 based on value-based care outcomes.

The Agreement and Amendment needed immediate execution to ensure that UMC received Medicare Advantage Incentives retroactively effective for the CY 2025, and to ensure the new Agreement rates were loaded into the P3 system prior to expiration of the then-current participation agreement on December 31, 2025.

Cleared for Agenda
January 21, 2026

Agenda Item #
6

UMC's Director of Managed Care has reviewed and recommends ratification of this Agreement and Amendment, which were also approved as to form by UMC's Office of General Counsel.

A Clark County business license is not required as UMC is the provider of hospital services to this insurance fund.

P3 2025 PROVIDER INCENTIVE PROGRAM AMENDMENT TO THE PROVIDER AGREEMENT

THIS P3 2025 PROVIDER INCENTIVE PROGRAM AMENDMENT (this "Amendment") is made and entered into effective January 1, 2025, regardless of the execution date hereof (the "Effective Date") by and between P3 Health Partners-Nevada, LLC ("Company"), and University Medical Center of Southern Nevada ("Group").

WHEREAS, the parties entered into that certain Provider Agreement effective August 28, 2018, as amended ("the Agreement"), which sets forth the terms and conditions under which Group may provide services to certain patients attributed to Company and for whom Group serves as their primary care provider; and

WHEREAS, the Agreement and the associated relationship between the parties may have involved certain incentive compensation, CDQIP, surplus, deficit, surplus distribution or shared savings models; and

WHEREAS, by executing this Amendment, the parties agree to amend the Agreement to better align incentive compensation under the Agreement with their mutually desired value-based care outcomes.

NOW THEREFORE, in consideration of the following, the parties agree to amend the Agreement as follows:

1. Any existing Clinical Documentation Quality & Integrity Program ("CDQIP"), whether incorporated into the Agreement or not, is hereby deleted and no longer in effect as of the Effective Date.

2. Any deficits or surpluses for the Performance Year, on the books of the Company, are hereby deleted in their entirety as of the Effective Date.

3. Any references to surplus or shared savings in the Agreement are hereby deleted.

4. The parties hereby agree to replace any and all CDQIP programs with the P3 2025 CDQIP, effective January 1, 2025, copy of which has been provided with this Amendment ("P3 2025 CDQIP").

5. The parties agree that the P3 2025 CDQIP shall remain in effect until such time as the Company provides notice to Group of an updated incentive program.

6. For the avoidance of doubt, the P3 2025 CDQIP shall be retroactively applied to the Effective Date; provided that, Group satisfies the electronic health record and data feed incentive on a mutually acceptable timeline during the Performance Year.

7. CDQIP payments will constitute administrative expenses for purposes of calculating any surplus or shared savings payments that Group may be eligible for related to the Performance Year that said payments were made. Such CDQIP payments shall be added in as an expense and accounted for in the shared savings calculation for said Performance Year.

8. Except as so amended herein, all other provisions of the Agreement shall remain in full force and effect. Any conflict between the Agreement and this Amendment shall be resolved in favor of this Amendment.

[SIGNATURE PAGE FOLLOWS. THIS AMENDMENT MAY BE EXECUTED IN COUNTERPARTS AND SENT VIA PDF]

IN WITNESS WHEREOF, the parties have executed this Amendment to be effective on the Effective Date.

P3 HEALTH PARTNERS- NEVADA, LLC

Signed by:
By: Nate Coiner
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Print
Name: Nate Coiner

Print
Title: VP Network

12/23/2025

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA

By: _____

Print
Name Mason VanHouweling

Print
Title: Chief Executive Officer

Federal
Tax ID: 886000436

P3 CLINICAL DOCUMENTATION QUALITY & INTEGRITY PROGRAM

[The information in this attachment is confidential and proprietary in nature.]

P3 MULTISPECIALTY GROUP PARTICIPATION AGREEMENT

COVER SHEET

Company	P3 Health Partners-Nevada, LLC
Participant/Group	University Medical Center of Southern Nevada
Schedules / Exhibits	☐ SCHEDULE 1- SERVICES AND COMPENSATION SCHEDULE ☐ EXHIBIT A- PARTICIPATION AND PARTICIPATING PROVIDER ORGANIZATIONAL STANDARDS ☐ EXHIBIT B- MEDICARE ADVANTAGE PROVIDER OBLIGATIONS ☐ EXHIBIT C- Intentionally Left Blank ☐ EXHIBIT D- OTHER FEDERAL LAWS ☐ SCHEDULE 2- INCENTIVE-BASED PAYMENT REQUIREMENTS ☐ EXHIBIT E- PARTICIPATION LISTING & NPI NUMBERS ☐ EXHIBIT F- PRODUCT PARTICIPATION LIST
Effective Date (to be completed by Company)	9/01/2025

P3 MULTISPECIALTY GROUP PARTICIPATION AGREEMENT

THIS P3 MULTISPECIALTY GROUP PARTICIPATION AGREEMENT (the "Agreement") is made and entered by and between P3 Health Partners-Nevada, LLC ("**Company**") and University Medical Center of Southern Nevada, a publicly owned and operated hospital created by virtue of Chapter 450 of the Nevada Revised Statutes, which employs primary care physician licensed to practice medicine in the State of Nevada (hereinafter "**Participant**" or "**Group**"), and, if a physician group practice, by and on behalf of each physician or provider of the physician group practice (collectively, "Participating Practitioners"). References to Participant throughout the Agreement shall also include each Participating Practitioner, as applicable. Company and Participant may be referred to individually as "Party" or, collectively, as "Parties."

PURPOSE

Company organizes and supports the deliberate organization of patient care activities and information sharing among Participating Providers of the Company to facilitate with the aim of achieving better care for individuals, improving health of populations and CMS and Health Plan metrics as applicable ("Care Management") in the State of Nevada.

In furtherance of such Care Management goals, Company has developed and will continue to develop innovative approaches to delivery and payment of medical services through the negotiation of contracts with certain Payors (as defined below). Specific terms and conditions of participation in Care Management Programs are set forth in the schedules and exhibits to this Agreement, including incentive programs, as applicable, as set forth on attached schedules and exhibits.

Participant wishes to participate in the Network of Participating Providers provided by Company to Payors with which Company contracts for the provision of covered health care services.

NOW, THEREFORE, for and in consideration of the mutual promises and covenants herein contained, and for the mutual reliance of the Parties, it is agreed by and between the Parties hereto as follows:

Section 1
Definitions

1.1 Affiliate: With respect to a Party, any entity that directly or indirectly controls, is controlled by or is under common control with such Party.

1.2 Benefit Plan: a certificate of coverage, summary plan description, or other document or agreement between a Member and a Payor, whether delivered in paper, electronic or other format, under which a Payor is obligated to provide Covered Services to a Member, subject to any procedures, conditions, limitations, exclusions and other rights and obligations governing the arrangement, including, but not limited to, the obligation of the Payor to pay or reimburse for all or a portion of the cost of such Covered Services.

1.3 Capitation: a payment system in which Company pays Group a specific amount in advance to provide Covered Services. Group is paid on a per Member per month ("PMPM") basis for all Members assigned to Group and its Participating Practitioners, and Group assumes all risk for delivering Covered Services. Capitation shall be described in more detail in the SCHEDULE I, SERVICES AND COMPENSATION SCHEDULE.

1.4 Care Management Program: includes Care Management Payor FFS Programs and Care Management Payor Risk Programs, and other alternative and incentive payment arrangements related to Covered Services.

1.5 Clean Claim: a request for payment for Covered Services on a CMS 1500 (or successor standard) form, or electronic equivalent of such form, submitted by Participant or Participant's designee to a Payor. Such claim should not contain defect, impropriety, lack of any required substantiating documentation, or particular circumstance

requiring special treatment that prevents timely payment and can be processed without need for obtaining additional information in accordance; whether submitted via electronic transactions using permitted standard code sets (e.g., CPT-4, CPT II, ICD-10, HCPCS, or their successors) as required by the applicable federal or State law or otherwise, all the data elements of the UB-04 or CMS-1500 (or successor standard) forms.

1.6 CMS: Centers for Medicare & Medicaid Services, an administrative agency of the United States Government, responsible for administering the federal Medicare and Medicaid programs.

1.7 Contracting Payor: any Payor that (i) has entered into an agreement with Company pursuant to which Company agrees to organize, arrange or provide Covered Services to Members; and (ii) Company has included the terms of such agreement, including but not limited to, applicable rate schedule(s) or other compensation methods, in a summary set forth on Schedule 1 and as such Payor and the corresponding Benefit Plans, each of which may be amended from time-to-time by Company or Health Plan in its sole and absolute discretion.

1.8 Copayment, Coinsurance, or Deductible (Cost Share): the portion of the cost of Covered Services the Member is obligated to pay directly to the Provider under Member's Evidence of Coverage and for which the Provider is responsible to collect directly from Member.

1.9 Covered Services: those Medically Necessary health care services and benefits a Member is eligible to receive under a Contracting Payor's Benefit Plan.

1.10 Covering Provider: a Participating Provider designated to provide Covered Services to Members when a Participating Provider is unavailable. Covering Provider should be part of the current approved Company.

1.11 Credentialing Standards: participation and membership eligibility standards included among Policies of Company (including, but not limited to, requirements concerning qualifications, licensure, professional liability insurance and maintenance of patient records) as further described in Section 2.11 below.

1.12 Emergency Medical Condition: a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the health of the Member, or in the case of a pregnant woman, the health of her unborn child; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

1.13 Emergency Services: Covered Services furnished by a qualified provider and necessary to evaluate or stabilize an Emergency Medical Condition.

1.14 Encounter Data: the data elements to be forwarded by Participant to Company for those Provider Services rendered to each Member by Participating Practitioner. The CMS 1500 is the required format for billing submission and shall include the following data elements: Member's full name and address, Member's identification number, Member's date of birth, Member's sex, Member's Contracting Payor affiliation, diagnostic code(s) and description (ICD-10/CPT Code), date of service, place of service, procedures, services or supplies furnished, Participating Practitioner's name, address and telephone number, and Participating Practitioner's charges.

1.15 Government Programs: Plans operated and/or administered by Company pursuant to a Government Sponsor.

1.16 Health Plan or Plan: the health benefits plan which a Payor makes available to Members, and which describes the costs, procedures, benefits, conditions, limitations, exclusions, and other obligations, binding the Members. Contracted Health Plan(s) will be communicated by Company to Participant and updated from time to time as applicable.

1.17 HIPAA: the Health Insurance Portability and Accountability Act of 1996, as amended by the Health Information Technology for Economic and Clinical Health Act of 2009, and any implementing regulations, as may be amended from time-to-time.

1.18 Laws: all applicable federal, State, and local laws, rules and regulations promulgated thereunder from time to time.

1.19 Medically Necessary or Medical Necessity: Covered Services that a health care provider, exercising prudent clinical judgment, would provide to a patient as set forth in the Member's Benefit Plan.

1.20 Medicare Advantage: Medicare health plan coverage offered by commercial Payors to provide Part A and Part B benefits to Members.

1.21 Member: an individual eligible and enrolled to receive coverage from a Payor for Covered Services.

1.22 Participating Physician: a duly licensed physician who is a Participating Provider or a physician acting on-call for a Participating Provider.

1.23 Participating Practitioner: any physician, hospital-based physician, mental health and/or substance abuse professional (which shall include psychiatrists, psychologists, social workers, psychiatric nurses, counselors, family or other therapists or other mental health/substance abuse professionals), or other individual or entity involved in the delivery of health care or ancillary services who or which has entered into and continues to have a current contract with Company to provide Covered Services to Members. To the extent that Participant is a group practice or is not an individual physician or other health care provider ("Group"), all individuals employed or contracted by Group must be credentialed pursuant to Policies and may not provide Covered Services to Members until such individuals have been fully credentialed and approved by Company or its designee.

1.24 Participating Provider: Participant, a Participating Practitioner, hospital, skilled nursing facility or other institutional or non-institutional health care provider or supplier of medical goods or services (including but not limited to home medical equipment, diagnostic services provider, and home health care provider) who is under contract with, or otherwise engaged by, Company to provide Covered Services to Members.

1.25 Payor: person or entity responsible for payment of Covered Services including, without limitation, a health plan, health maintenance organization, preferred provider organization, insurance company or carrier, employer, employer welfare benefit plan, multiple employer welfare arrangements, a state or federal governmental agency, including CMS, or other third-party payor.

1.26 Payor Contract: an agreement between a Payor and Company pursuant to which Company agrees to organize, arrange and/or provide Covered Services to Members, which Covered Services may include access to one or more of Company's provider network or vendor arrangements, except those excluded by a Benefit Plan.

1.27 PCP (Primary Care Provider): a Participating Physician or Advanced Practice provider approved by Company credentialing committee or through approved sub-delegation to provide Primary Care Provider services. PCPs may include, as determined by Company; internal medicine, pediatricians, family practitioners, general practitioners, and OB/GYNs.

1.28 Performance Metrics: evidence-based clinical performance metrics, quality benchmarks, practice guidelines and protocols and utilization control mechanisms defined by Company or Contracting Payors to implement value-based incentive programs.

1.29 Policies: any agreements, policies, rules, regulations, and/or procedures adopted by Contracting Payors and/or the Company relating to the administration and operations of Contracting Payors or the Company, including but not limited to, policies relating to Company programs, administration of participation agreements with

Participating Providers, Company participation requirements, care coordination requirements, medical review, referral policies, payment policies, risk-sharing arrangements and/or Payor Contracts. Such Policies shall be available via Company's internet web site; and/or a password-protected website portals for Participating Practitioners by letter, newsletter, electronic mail or other media and shall also include bulletins and other written material issued and distributed by Company or a Contracting Payor.

1.30 Provider Manual: the provider manual and any billing manuals, adopted by Company or any Health Plan which include, with limitation, requirements relating to utilization management, quality management, grievances and appeals, credentialing, claims payment and Product or Payor specific requirements, as may be amended from time to time by Company or Plan, including all Policies.

1.31 Provider Services: those professional medical services customarily performed by a Participating Practitioner in his or her designated area of practice.

1.32 Provider Agreement: an agreement entered into by Company directly with a Participating Provider or indirectly with an entity representing such Participating Provider, pursuant to which a Participating Provider agrees to provide certain Covered Services to Members and to abide by the compensation arrangements, prior authorization, utilization and care management policies and procedures established by Company.

1.32 Primary Care Provider ("PCP"): a Participating Group Provider whose area of practice and training is family practice, general medicine, internal medicine, geriatric medicine or pediatrics, or who is otherwise designated as a Primary Care Provider by Company, and who has agreed to provide primary care services and to coordinate and manage all Covered Services for Members who have selected or been assigned to such Participating Group Provider, if the applicable Plan provides for a Primary Care Provider.

1.33 Service Area: Clark County in the State of Nevada.

1.34 Specialist: a Participating Physician or Midlevel Provider who is professionally qualified to practice a designated specialty.

1.35 State: the state of Nevada.

1.36 Regulatory Requirements: all applicable Laws requirements of contracts and standards and requirements of any accrediting or certifying organizations.

1.37 Utilization Review or Utilization Management: the process to review and determine whether a proposed treatment, site of service and length of stay determination, if required, are consistent with generally recognized medical standards and procedures and applicable Company Policies, and includes evaluation of the Medical Necessity, appropriateness, and cost efficiency of the use of health care services under the provisions of the applicable Benefit Plan.

Section 2
Obligations and Representations of Participant

2.1 Provision of Services. Participant, through Participating Practitioners as applicable, shall provide to Members those Covered Services that are Provider Services within the Service Area. Participant shall abide by the terms and conditions of Payor Contracts that do not materially vary from the terms of this Agreement. Participant warrants that Participant is not subject to any contractual obligations that would restrict Participant from participating in any reimbursement or payment arrangement entered into by Company on behalf of Participant.

2.2 Non-Discrimination and Equitable Treatment of Members. Participant and Participating Practitioners agree: (a) not to differentiate or discriminate in the provision of Covered Services to Members because of race, color, creed, national origin, ancestry, religion, sex, marital status, sexual orientation, age (except as provided by Law),

health status, or physical or mental handicap; such as End Stage Renal Disease, Claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information or source of payment, and (b) to render Covered Services to Members in the same manner, in accordance with the same standards, and within the same time availability as offered to non-Benefit Plan patients consistent with existing medical/ethical/legal requirements for providing continuity of care to any patient. In addition, Participant and Participating Practitioners shall take into account a Member's literacy and culture when addressing Members and their concerns.

2.3 Hours and Accessibility of Care.

2.3.1 Generally. Participant and Participating Practitioners agree to abide by the terms of the attached Participant Access Standards Exhibit, which is incorporated here by reference.

2.3.2 Hours. Participating Practitioners shall devote such time as is necessary to the performance of Participant's obligations under this Agreement, including maintaining reasonable office hours in the Service Area. Participating Practitioners acting as a PCP will provide or arrange for the provision of services during normal business hours and provide or arrange for the provision of advice and assistance in emergency situations twenty-four (24) hour-per- day, seven (7) day-per-week, three-hundred-sixty-five (365) day per year basis, either personally or by covering arrangements with another Participating Practitioner who agrees to comply with the Policies, accepts compensation in accordance with this Agreement, agrees to comply with the terms of this Agreement, and is approved by Company. Each Participant shall maintain Participating Practitioner accessibility as requested by Company, either personally or by covering arrangements with another Participating Practitioner who agrees to comply with the Policies, accepts compensation in accordance with this Agreement, agrees to comply with the terms of this Agreement, and is approved by Company. If for any reason Participant reasonably believes it does not have the capability or capacity to meet the needs of Members, Participant shall notify Company immediately and in accordance with Section 7.5.

2.3.3 Participant Capacity. If Company determines at any time that Members' access to Participating Practitioners is unacceptable, Company and Participant may meet within thirty (30) calendar days to discuss..

2.3.4 Closed Panel. Participant and Participating Practitioners agree that a broad selection of physicians is important to Members and that Members expect physicians listed in Company's directories to be available to them. Participant and Participating Practitioners shall not close their panel to any Members. An exception to a closed panel may be made only with a written consent from Company. Company may, at its discretion, not assign new Members to Participant, effectively closing Participant and Participating Practitioners' panel, if either Participant or its Participating Practitioners do not maintain quality metrics or access standards.

2.4 Standards of Care. Participant shall exercise independent medical judgment in providing Covered Services to Members and Company shall not interfere with such independent medical judgment. All medical services performed by Participant hereunder shall be performed in a manner consistent with the proper practice of medicine, and such services shall be performed in accordance with the rules of ethics and conduct by the American Medical Association, the American Osteopathic Association and such other bodies, formal or informal, government or otherwise, from which Participants seek advice and guidance or by which they are subject to licensing and control.

2.5 Clinical Protocols and Care Management Activities. Participant hereby acknowledges that Company is continually engaged in developing processes for the identification, adoption, implementation and enforcement of evidence-based medical practice or clinical guidelines, disease management programs and other medical management and Utilization Review programs, and quality and cost improvement programs, activities and initiatives ("Network Care Management Initiatives"). Company will administer the Network Care Management Initiatives. Participant agrees to participate in initiatives, efforts and requirements related to the design, development, implementation and

operation of the Network Care Management Initiatives and abide by all of the terms and conditions of such Network Care Management Initiatives as set forth in the Policies. as Company may amend them from time to time. Company is continually engaged in the development of performance improvement processes for Participating Providers to assist with such compliance., and if necessary, Participant will participate in such processes. Participant understands and acknowledges that compliance with Network Care Management Initiatives will be monitored, and that the failure to comply could result in corrective action. Persistent non-compliance with the Company Care Management Initiatives will be considered in connection with re-credentialing of Participant to be a Participating Provider and may be a sufficient basis for termination of Participant's participation in Company and termination of this Agreement. Participant further agrees to abide by all final decisions of Company regarding quality improvement activities.

2.6 Utilization Review Program. Company utilizes systems of Utilization Review to promote adherence to accepted medical treatment standards and to encourage Participating Providers to minimize unnecessary medical costs consistent with sound medical judgment and in accordance with applicable law. Participant shall participate, as requested, and abide by the Utilization Review program guidelines of Company. (Participant shall provide Company Electronic Health or Electronic Medical Records ("EHR" or "EMR") access as applicable. In addition, Participant and Participating Provider agrees to grant access to Company during normal business hours, appropriate clinical records and information regarding Covered Services to Members. Access includes inspection of such records and information as required by Company or Contracting Payor to implement its Utilization Review program, perform administrative obligations and to verify Claims submitted by Participant. Access to records shall be provided in full compliance with all applicable Law.

2.7 Referrals. To the extent required by the terms of the applicable Benefit Plan, Participant shall refer or admit Members to Participating Practitioners for Covered Services and shall furnish such Participating Practitioners with complete information on treatment procedures and diagnostic tests performed in a culturally competent manner prior to such referral or admission. In addition, to the extent possible, Participant shall refer Members with out of network benefits, if any, to Participating Practitioners.

2.8 Meaningful Use and Electronic Prescribing. If applicable, except as otherwise set forth in the Policies, Participant shall use electronic medical records and electronic prescribing systems for Members in a manner compliant with Meaningful Use criteria and applicable Policies, to assist the Company with coordinating the electronic exchange of medical records and Claims information to facilitate Care Management of Members.

2.9 Medical Records; Confidentiality. Participant and Participating Practitioners shall prepare and maintain complete and accurate medical, financial and administrative records for each Member receiving Provider Services in compliance with Law. Participant shall maintain the confidentiality of information in such records and release such records only with the written consent of the Member or as otherwise authorized by law. As reasonably requested, and as permitted by applicable law, Participant shall permit Company, a Contracting Payor, and any external quality review organization mutually approved by the Company and Participant, to inspect and copy medical records maintained by Participant pertaining to Members. Participant shall furnish such information as may be required by Company and/or Contracting Payor to facilitate the information and record exchanges necessary for cost containment, quality assurance, peer review and audit programs or as otherwise required for the operation of Contracting Payor and/or Company. Participant shall make, if requested, one (1) copy of such records available at no cost. Additional copies requested are subject to usual and customary charges to Company, during normal business hours, as may be imposed on Company by a Contracting Payor, CMS< federal or State regulatory agency or accreditation organization.

2.10 Licensure and Certification. Participant agrees and shall require all Participating Practitioners to agree to procure and maintain for the term of this Agreement all license(s) and/or certification(s) as is required by applicable Law and Policies, including a board certification in their designated Specialty as applicable. Participant shall provide those Provider Services that Participant is licensed or certified to provide only through qualified personnel and shall assume responsibility for supervising and compensating such personnel and for requiring that such personnel adhere to the terms and conditions of this Agreement. Participant represents and warrants that all employees and others providing services hereunder on Participant's behalf are properly licensed or certified to provide such services. Participant shall furnish to Company such evidence of licensure or certification as Company may reasonably request. Participant shall notify Company immediately of any changes in licensure or certification status of Participant or any Participating Practitioner. If Participant or any Participating Practitioner violates any of the provisions of applicable Law or commits any act or engages in conduct for which any applicable Participant licenses or certifications are revoked or suspended, or otherwise is restricted by any state licensing or certification agency by which it is licensed or certified, Company may immediately terminate this Agreement.

2.11 Credentialing Standards. Participant shall comply with the Credentialing Standards established by Company. , and such additional standards and procedures as Company may, , reasonably deem appropriate
2.12
2.13 Clinical Privileges. Participant warrants that Participant, and its Participating Practitioners have and shall maintain clinical privileges at a Participating Provider facility(ies) within the Service Area.
2.14 Compliance with Federal, State and Local Rules and Regulations; Medicare Participation Standards. Participant and its Participating Practitioners agree to comply with all applicable Laws. Participant and its Participating Practitioners shall meet the standards for participation and all applicable requirements for providers of health care services under the Medicare and Medicaid Programs, including Medicare Advantage as set forth in the MA Exhibit, as applicable. Participant and its Participating Practitioners understand that CMS requires compliance with the provisions of this Section as a condition for participation in Medicare and Medicaid plans. Neither Participant nor its Participating Practitioners shall unlawfully discriminate against any of their employees or applicants for employment or against any Members on the basis of race, color, creed, national origin, ancestry, religion, sex, marital status, age (except as provided by Law), or physical or mental handicap. Participant and its Participating Practitioners shall ensure that the evaluation, and treatment of their employees and applicants for employment and of Members are free of such discrimination. In addition to any other requirement of this Agreement, Participant and its Participating Practitioners shall comply with Title VI of the Civil Rights act of 1964, as amended (42 U.S.C. Section 2000d et. seq.), Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. Section 794) and the regulations thereunder, Title IX of the Education Amendments of 1972, as amended (20 U.S.C. Section 1681 et. seq.), the Age Discrimination Act of 1975, as amended (42 U.S.C. Section 6101 et. seq.), Section 654, of the Omnibus Budget Reconciliation Act of 1981, as amended (41 U.S.C. Section 9849), the Americans with Disabilities Act (P.L. 101-365) and all implementing regulations, guidelines and standards as now or may be lawfully adopted under the statutes.

2.15 Notices and Reporting of Compliance Matters. If Participant reasonably believes a change to Participant may disrupt or threaten patient care, Participant agrees to promptly notify Company. To the extent neither prohibited by Law nor violative of applicable privilege, Participant and Participating Practitioners agree to provide prompt notice to Company, and shall provide all information reasonably requested by Company regarding (a) any litigation or administrative action brought against Participant and Participating Practitioners or any of its employees or affiliated providers that is related to the provision of health care services and could have a material impact on the Provider Services provided to Members; (b) reporting of self-referrals, loss of licensure or accreditation, and claims by governmental agencies or individual regarding fraud, abuse, self-referral, false claims, or kickbacks; and (c) any material change in services provided by Participant and Participating Practitioners or licensure status related to such services. Company and Participant agree to be mutually committed to promoting Member safety and quality. Therefore, Participant will report the occurrence of and waive all charges related to those conditions specified under Section 5001(c) of the Deficit Reduction Act, Section 2702 of the Affordable Care Act and any related or similar Law.

Participant agrees to use best efforts to provide Company with prior notice of, and in any event will provide notice as soon as reasonably practicable notice of, any actions taken by or against Participant and Participating Practitioners described in this Section.

2.16 Specific Representations Concerning Eligibility.

2.16.1 Excluded or Debarred Individuals. Participant further represents and warrants that: (a) there are no past or pending investigations, legal actions or matters subject to arbitration involving Participant or any of its Participating Practitioners or employees or to the best of its knowledge, contractors, governing body members (as defined in Chapter 21 of the Medicare Managed Care Manual), members, or any major shareholders (i.e., holders of five percent (5%) or more of outstanding shares) on matters relating to payments from government entities, both federal and State, for health care and or prescription drug services; (b) to the best of its knowledge, neither Participant nor any of its Participating Practitioners, employees, contractors, governing body members or any major shareholders have been criminally convicted or had a civil judgment entered against them for fraudulent activities, nor are they sanctioned under any Federal health care programs as defined in 42 U.S.C. § 1320a-7b(f) (the "Federal health care programs"); (c) to the best of its knowledge, neither Participant nor any of its Participating Practitioners, employees, contractors, governing body members or any major shareholders are on the "preclusion list" as such term is defined in 42 CFR § 422.2 or appear on the Office of Inspector General ("OIG") Excluded List or on the list of debarred contractors as published in the System for Award Management by the General Services Administration ("GSA") and Participant agrees that it will review the OIG's and GSA's exclusion lists prior to the hiring of any new employees, contractors, or governing body members and periodically thereafter. Participant agrees it is obligated to notify Company immediately of any change in circumstances that would require Participant to answer affirmatively to any of the statements in this Section. Any breach of this Section shall give Company the right to terminate this Agreement immediately for cause.

2.16.2 Quality Assurance. Participant also represents that Participant and Participating Practitioners have established an ongoing quality assurance/assessment program, which includes, but is not limited to, credentialing of employees and subcontractors. Participant shall supply to Company the relevant documentation, including, but not limited to, internal quality assurance/assessment protocols, State licenses and certifications, federal agency certifications and/or registrations upon request. Participant agrees not to use any person to perform any services for Contracting Payors if such person is physically located outside of one of the fifty United States or one of the United States Territories ("Offshore Entity") unless Participant requests Company to contact the applicable Contracting Payor. In that event, Contracting Payor, in its sole discretion and judgment, shall determine and inform Participant in writing whether the Offshore Entity may be utilized. Participant further agrees that Company has the right to audit any Offshore Entity prior to the provision of Covered Services under Benefit Plans.

2.17 Records. To the extent required by Law, Participant shall make available, upon written request from Company, the Secretary of U.S. Department of Health and Human Services ("HHS"), the Comptroller General of the United States, or any other duly authorized agent or representative, this Agreement and Participant's books, documents and records. Participant shall preserve and make available such books, documents and records for a period that is the longer of ten (10) years after the end of the term of this Agreement or the length of time required by state or federal law. If Participant is requested to disclose books, documents or records pursuant to this Section for any purpose, Participant shall notify Company of the nature and scope of such request, and Participant shall make available, upon written request of Company, all such books, documents or records. If Participant carries out any of the duties of the contract through a subcontract, with a value or cost of Ten Thousand Dollars ($10,000) or more over a twelve (12) month period, with a related organization, such subcontract shall contain a clause to the effect that until the expiration of ten (10) years after the furnishing of such Provider Services pursuant to such subcontract, the related organization shall make available, upon written request by the Secretary, or upon request by the Comptroller General, or any of their duly authorized representatives, the subcontract and books, documents and records of such organization that are necessary to verify the nature and extent of such costs.

2.18 Insurance.

2.18.1 Intentionally omitted.

2.18.2 Intentionally omitted.

2.18.3 Self-Insurance. Participant is owned and operated by Clark County pursuant to the provisions of Chapter 450 of the Nevada Revised Statues. Clark County is a political subdivision of the State of Nevada. As such, Clark County and Participant are protected by the limited waiver of sovereign immunity contained in Chapter 41 of the Nevada Revised Statutes. Participant is self-insured, as allowed by Chapter 41 of the Nevada Revised Statutes. Upon request, Participant will provide Company with a Certificate of Coverage prepared by its Risk Management Department certifying such self-coverage.

2.18.4 Certificate of Insurance. On or before the Effective Date, Participant shall provide Company with certificates of insurance or other written evidence of the insurance policies required by this Section in a form satisfactory to Company, on each annual renewal of such insurance policies during the Insurance Period, and as requested by Company on behalf of Participant. Participant shall provide Company with no less than thirty (30) calendar days' prior written notice of cancellation, or any material change in such professional malpractice liability insurance coverage.

2.18.5 Replacement Insurance. In the event Participant fails to procure, maintain or pay for any insurance policy required under this Section, Company shall have the right, but not the obligation, to procure, maintain or pay for such insurance policy. In such event, Participant shall reimburse Company for the cost thereof not more than ten (10) calendar days after Company's written request to Participant.

2.19 HIPAA. The Parties agree to comply with HIPAA. The Parties agree to enter into any further agreements as necessary to facilitate compliance with HIPAA. The Parties agree to be bound by the terms of the Business Associate Agreement set forth in the BAA Exhibit, as applicable.

2.20 Use of Name/Display of Logo.

2.20.1 Participant and Participating Practitioners consent, with prior approval, to the use of Participant and Participating Practitioners' names and other appropriate material consistent with the production of provider directories,

marketing literature, bids, proposals, license or State contract applications, and in other materials of Company in all formats, including, but not limited to, electronic media. Participant and Participating Practitioners may use Company's names, logos, trademarks or service marks in marketing materials or otherwise, upon receipt of Company's prior written consent, which shall not be unreasonably withheld.

2.20.2 Participant agrees and shall require Participating Practitioners to agree to: (i) allow Company to place Company signage and/or brochures, excluding any applications, in Participant's and Participating Practitioners' offices; (ii) mail an announcement of Participant's and Participating Practitioners' new affiliation with Company to their patients.

2.21 Participating Practitioners. If Participant is a Group, Participant shall provide to Company a complete list of Participating Practitioners, which shall include names, office addresses, office hours, telephone and facsimile numbers, and areas of practice or specialty ("Participating Practitioner List"). Notwithstanding any contrary interpretation of this Agreement or of any contracts between Participant and Participating Practitioners, Participant acknowledges and agrees that all provisions of this Agreement applicable to Participant shall apply with equal force to Participating Practitioners, unless clearly applicable only to Participant. Participant agrees all Participating Practitioners and any other subcontractor of Participant for services under this Agreement shall have a written agreement that requires any subcontractor to adhere to all applicable Laws.

2.22 Notification to Company. Participant agrees that Participant will notify Company in writing as soon as reasonably practicable, but no later than within fourteen (14) calendar days, of any of the following:

2.22.1 Malpractice Judgment. The final disposition of any professional malpractice lawsuit against Participant and the terms of such judgment or settlement, except as prohibited by law or agreement;

2.22.2 Licensure and Certification. Any granting of or any suspension, revocation, reduction, restriction, limitation, termination, denial or voluntary relinquishing (under threat of investigation or termination) of a Drug Enforcement Administration ("DEA") number, State controlled substance certificate, professional license, permit, certification, medical staff membership or clinical privilege (other than suspensions relating to medical record compliance), or exclusion from or investigation (excluding audits) resulting from participation in a Federal health care program occurring on or after the date of this Agreement;

2.22.3 Criminal Indictment, Arrest or Conviction. Any indictment, arrest or conviction for a felony or for any criminal charge related to Participant's services;

2.22.4 Other Relevant Judgment or Settlement. Any judgment or settlement involving Participant that might materially impair Participant's ability to perform the duties required by this Agreement;

2.22.5 Changes of Participant Information. Any change in Participant's business address, business telephone number, office hours, tax identification number, malpractice insurance carrier or coverage, State license number, or DEA registration number; or

2.22.6 Changes of Participating Practitioner Information. Any change in the information provided to Company in the Participating Practitioner List.

2.23 Taxes and Contribution. Participant shall be responsible for withholding and paying, as may be required by law, all federal, state, and local taxes and contributions with respect to, assessed against, or measured by such Participant's earnings hereunder, or salaries or other contributions or benefits paid or made available to any persons retained, employed or used by such Participant, and any and all other taxes and contributions applicable to its services for which such Participant may be responsible under any Laws, and such Participant shall make all returns and/or reports required in connection with any and all such Laws, taxes, contributions, and benefits.

2.24 Program Participation Requirements. To the extent Company is participating in such program(s) or initiative(s), Participant shall comply with the requirements set forth on the CMMI Exhibit, REACH Exhibit, MA Exhibit, and/or State Health Plan Requirements Exhibit, as applicable.

2.24.1 Intentionally Left Blank

2.25 Interference with Contractual Relations. Participant and Participating Practitioners shall not engage in activities that will cause Company to lose existing or potential Members, including but not limited to: (a) advising Company customers, including Contracting Payors and Participating Providers, or other entities currently under contract with Company to cancel, or not renew said contracts; (b) impeding or otherwise interfering with negotiations that Company is conducting for the provision of health benefits or Benefit Plans; or (c) using or disclosing to any third-party membership lists acquired during the term of this Agreement for the purpose of soliciting individuals who were or are Members or otherwise to compete with Company. Notwithstanding the foregoing, Company shall not prohibit, or otherwise restrict Participating Practitioners from advising or advocating on behalf of a Member who is his or her patient, for the following: (i) the Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered; (ii) any information the Member needs in order to decide among all relevant treatment options; (iii) the risks, benefits, and consequences of treatment or non-treatment; and (iv) the Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. This section shall continue to be in effect for a period of one (1) year after the expiration or termination of this Agreement.

Section 3
Obligations and Representations of Company

3.1 Establish and Maintain Provider Company. Company agrees to use good faith efforts to establish and maintain a Company of Participating Providers and to market such Company to various Payors.

3.1.1 Support and Infrastructure. Company agrees to use good faith efforts to establish and maintain appropriate Company programs, Policies and infrastructure necessary to perform its obligations under this Agreement, including the Credentialing Standards. As such, Company shall, if applicable, provide and/or arrange for the human, financial and technological resources as necessary to (i) develop and implement Company programs and Policies for the purposes of enabling Participating Providers to deliver high quality, efficiently delivered health care; (ii) enable financial risk-sharing among the Participating Providers; and (iii) successfully arrange for, solicit, negotiate, administer and evaluate performance under Payor Contracts, subject to the terms of this Agreement.

3.2 Steerage. Participation in the Company does not guarantee Members will access Participant's services.

3.3 Access to Company Care Management Information System. Company will provide Participant with access to Company's Care Management information system, as applicable, to facilitate Participant's participation in and compliance with Company Care Management Initiatives.

3.4 Performance Reports. Company will provide Participant with periodic reports concerning Participant's individual and aggregate compliance with Performance Metrics.

3.5 Notification to Participant.

3.5.1 Payor Contracts. Company shall provide Participant reasonable prior notification in writing or electronically (including through posting of such notification on Company's website) of the effective date of each Payor Contract that is entered into by Company, as applicable. Each Payor Contract shall be negotiated in accordance with the parameters set forth under the Policies, including those adopted by the Board based on the recommendation of the Company. Each new Payor Contract may constitute an amendment to

Schedule 1. Company shall notify Participant in writing or electronically in accordance with Section 3.8.2(i) below if any Payor Contract is terminated.

3.5.2 Other Notifications. Company agrees that it will notify Participant in writing or electronically within ten (10) calendar days of any of the following:

(i) Change in Payor Contract. Any material change, modification, limitation or termination of any Payor Contract that affects Participant's provision of, or reimbursement for, Provider Services or other compensation pursuant to this Agreement; and

(ii) Changes of Company Information. Any change in Company's business address, or material change in the nature or extent of its business or services.

3.6 Compliance with Laws. Company shall perform its obligations under this Agreement in compliance with all applicable Laws, rules and regulations. Company has and shall maintain in good standing all necessary permits and licenses required to operate its business and perform its obligations under this Agreement.

3.7 Limitation on Control. Company acknowledges that Participant is solely responsible for the professional decisions, judgments, treatments, diagnoses and services delivered to Members. Company shall neither have nor exercise any control or direction over Participant's professional medical judgment or the methods by which Participant performs professional medical services; provided, however, that Participant shall be subject to and shall at all times comply with the Company Policies.

3.8 Company's Insurance. Company at its sole cost and expense agrees to procure and maintain such policies of general and/or professional liability and other insurance (or maintain a self-insurance program) as shall be necessary to insure Company and its employees against any claim or claims for damages arising by reason of personal injuries or death occasioned directly or indirectly in connection with the performance of any service by Company under this Agreement and the administration of Benefit Plans.

3.9 Identification of Members. Wherever practicable, pursuant to standard practice or required by law, Company will require Contracting Payors to provide Members with an identification card, which indicates access to the Company.

3.10 Company Support Requirements. To the extent Company is participating in such program(s) or initiative(s), Company shall provide services in accordance with the CMMI Exhibit, REACH Exhibit, MA Exhibit, and/or State Health Plan Requirements Exhibit, as applicable.

3.11 Company shall not discriminate against any person on the basis of age, color, disability, gender, handicapping condition (including AIDS or AIDS related conditions), national origin, race, religion, sexual orientation, gender identity or expression or any other class protected by law or regulation.

Section 4 Payment and Billing

4.1 Rates; Compensation Methodologies. In accordance with the applicable Payor Contract, Company or Contracting Payor shall pay or arrange to pay Participant for Provider Services furnished by Participant to Members pursuant to the rate schedule(s) attached hereto as Schedule 1, which may be amended, revised, supplemented or replaced by Company upon mutual agreement between Company and Participant in writing. Payment shall be subject to the contract between the Company or Contracting Payor's, and Participant. , If there is any conflict between this Agreement and Policies resulting from code review and budget targets being exceeded, and the adjustment, payment or nonpayment of withholds on an individual or other basis and the timing thereof, risk-sharing arrangements with hospitals and/or Contracting Payors, and stop-loss insurance arrangements, this Agreement will control.

4.2 Care Management Payments. Payments made by a Payor under a Care Management Payor FFS Program or Care Management Payor Risk Program as participating provider incentives will be distributed to the applicable Participating Providers in accordance with methodologies approved by Company's board of directors, if necessary (the "Board"), including Payor contract-specific distribution methodologies set forth in Schedule 1.

Such methodologies may provide for Company's retention of a portion of such payments to cover overhead and administrative expenses.

4.3 Billing Procedure. Participant shall submit all Claims and/or Encounter Data, as applicable, for Provider Services rendered to Members on a CMS 1500 Claim form electronically or in such other format acceptable to Company or Contracting Payor and in accordance with Section 1.12~~1.11~~, and instructions provided by Company or Contracting Payor. Such Claims and/or Encounter Data shall be complete and accurate and conform to all standards and requirements set forth in applicable Laws, rules and regulations, and Contracting Payor and/or CMS instructions, as applicable. For Claims Participant submits electronically, Participant shall not submit a Claim to Company in paper form unless Company requests paper submissions or fails to pay or otherwise respond to electronic Claims submission in accordance with the time frames required under this Agreement or applicable Law. Claims and/or Encounter Data shall include identifying patient information and itemized records of services and charges in customary billing form and shall include all other information, including medical records, as required by Company, necessary to characterize the content and purpose of each encounter with a Member to a Contracting Payor. The services shall be described with sufficient particularity as to enable Company to determine whether or not the services are Provider Services. Participant further agrees that it and Participating Practitioners will timely submit Claims and clinical data by available electronic means within one hundred eighty (180) calendar days of the date of service or within the time specified by applicable Law. Participant agrees that Company, or the applicable Contracting Payor, will not be obligated to make payments for billings received more than one hundred eighty (180) calendar days (or such other period required by applicable Law) from (a) the date of service or (b) the date of receipt of the primary Payor's explanation of benefits when Company is the secondary Payor. Company may waive this requirement if Participant provides notice to Company, along with appropriate evidence, of other extraordinary circumstances outside the control of Participant that resulted in the delayed submission. Participant agrees, upon request of Company or a Contracting Payor, to provide written certification of the truthfulness, completeness and accuracy of Participant's Claims, Encounter Data, referrals, authorization requests, bill coding, tracers, adjustments and denials. There shall be no restrictions on Company's use of Encounter Data. Furthermore, upon written request, Company is obligated to return such Encounter Data to Participant or Participating Providers within a reasonable and routine time frame..

Acceptance of Payment. Except as otherwise provided herein, Participant shall accept payment made by Company or Contracting Payor in accordance with this Agreement as complete and full discharge of the liability of Company, the Contracting Payor and Members for the rendering of Provider Services. All final payment determinations for Provider Services, including but not limited to decisions concerning Medical Necessity, compliance with Policies, and submission of appropriate coding information, shall be made by Company and Contracting Payors, subject to their respective appeals processes, as applicable. In addition, unless Participant notifies Company of its payment disputes within one hundred and eighty days (180) calendar days, or such other period as required by applicable Law, of receipt of payment from Company, such payment will be considered full and final payment for the related Claims. Subject to applicable Law, Company: (i) upon written notification no less than thirty (30) days from an internal update to internal payment systems in response to additions, deletions, and changes to CMS may do so without obtaining any consent from Participant, Participating Practitioners, or any other .party. Company will provide, at the written request of Participant, a copy of the fee schedule in effect at the time of such request; (ii) 1 shall not be responsible for communicating such routine changes of this nature, and will update any applicable payment schedules on a prospective basis within ninety(90) calendar days from the date of publication and (iii) shall have no obligation to retroactively adjust Claims with dates of service prior to said change.

4.4 Overpayments and Adjustments

4.5.1 Discovered by Participant or Participating Provider: In the event Participant or Participating Provider discovers any overpayments made by Company or Health Plans or Payor, Participant or the applicable Participating Provider shall meet to discuss the means and method of said refund of h overpayments with the Company, Health Plan, or Payor within thirty (30) calendar days of discovery.

4.5.2 Discovered by Company: In the event Company, Health Plan, or Payor discovers an overpayment made to Participant or Participating Provider, Company or Payor Designee shall inform Participant or Participating Provider in writing and they shall have thirty (30) calendar days to meet and discuss the means and method of said overpayment.

4.5.3 Adjustments: Company, Health Plan, or Payor may make retroactive adjustments to payments for a period not to exceed twelve (12) months from the original date of payment or such period as may be required by applicable law. Provider may contest the amount of payment, denial, or nonpayment of a claim within thirty (30) calendar days of notification by Company, Health Plan or Payor. Company, Health Plan, or Payor will review Participant or Participating Provider requests, as well as Provider record, to determine whether claim was paid correctly. If it is determined a claim was incorrectly paid, resulting in an underpayment, Company, Health Plan, or Payor will agree to prompt payment within (90) calendar days, any additional amounts owed to Participating Provider. Failure of Participant and Participating Provider to object to claim determination within thirty (30) calendar days of payment, constitutes Participant or Participating Provider's acceptance of claim determination and no further action will take place. The above is subject to change based on changes to applicable Laws, regulation, or guidance that require the Company, Health Plan, or Payor to meet different regulatory requirements. Notwithstanding the foregoing, Company may but shall not be required to pay a claim for any amount due to the Provider that is less than or equal to one dollar ($1.00). Additionally, Provider may but shall not be required to remit an overpayment for any amount that may be to the Company that is less than or equal to one dollar ($1.00).

4.5.4 Third-Party Payors.

(i) Company, pursuant to Payor Contracts, may not be the primary Payor in various circumstances, including the following: (a) where Contracting Payor engages Company for Care Management, but maintains contracts with Participants providing for direct payment of Claims for Covered Services; (b) under the coordination of benefits provision of a Member's Benefit Plan with a Contracting Payor; (c) when a Contracting Payor may be secondary to Member's rights under the Workers' Compensation Law or the Medicare Program; or (d) due to an injury or illness caused by a third-party.

(ii) When Company or a Contracting Payor determines that it is not the primary Payor for some or all of the services provided and notifies Participant accordingly, or in the event Participant determines that Member has other coverage, Participant agrees to bill such other Payor. Payment for such services under this Agreement may be reduced by the amount of Participant's reimbursement from the other Payor or third-party as appropriate.

4.5.5 Eligibility Determinations. Company shall have the right to recover payments made to Participant if the payments are for services provided to an individual who is later determined to have been ineligible based upon information that is not available to Company at the time the service is rendered, or authorization is provided within three hundred sixty-five days from date of payment.

4.6 Encounter Data. If requested by Company, for Members for whom participate under this Agreement, Participant shall submit to Company electronically all Encounter Data, including medical records, necessary to characterize the content and purpose of Covered Services rendered by Participant to a Member. Encounter Data shall be in accordance with HEDIS guidelines. Additionally, Participant shall promptly provide Company with all corrections to the revisions of such Encounter Data. If such Encounter Data is not submitted within the timeframe provided herein, the Company, with 30 days prior written notice, may reduce or suspend incentive payments of Participant's until Participant is in compliance. Participant agrees, upon request of Company or a Contracting Payor, to provide written certification of the truthfulness, completeness and accuracy of Participant's Encounter Data.

4.7 No Billing of Members.

(i) In no event, including but not limited to nonpayment by Company, Participating Provider, or the applicable Contracting Payor, the insolvency of Company, Participating Provider, or a Contracting Payor, or breach of this Agreement, shall any Member be liable for any sums owed to Participant by Company, Participating Provider, or a Contracting Payor, and Participant shall not bill, charge, collect a deposit or other sum or seek compensation, remuneration or reimbursement from, or maintain any action or have any recourse against, or make any surcharge upon, a Member or person acting on a Member's behalf. Whenever a surcharge has occurred, Participant shall refund the surcharge to the Member within fifteen (15) calendar days of discovering, or being notified of, the surcharge. If Company or a Contracting Payor receives notice of any surcharge upon a Member, it shall be empowered to take appropriate action to remedy the situation.. Participant acknowledges and agrees that certain Members of Medicare Advantage Programs are held harmless from payment of fees that are the legal obligation of the Medicare Advantage Program. Said Members are also held harmless from payment for Covered Services provided by providers that do not participate with Company or a Medicare Advantage Program.

(ii) Notwithstanding the foregoing, this provision shall not prohibit Participant from billing or charging Members in the following circumstances: (a) applicable copayments, coinsurance and/or deductibles, if any, not collected at the time that Covered Services are rendered; and (b) for services that are not Covered Services only if: (i) the Member's Benefit Plan provides and/or Company confirms that the specific services are not covered; (ii) the Member was advised in writing prior to the services being rendered that the specific services may not be Covered Services; and (iii) the Member agreed in writing to pay for such services after being so advised. Participant acknowledges that Company's denial or adjustment of payment to Participant based on Company's performance of Utilization Management is not a denial of Covered Services under this Agreement or under the terms of a Benefit Plan, except if Company confirms otherwise under this Section. Participant may bill or charge individuals who were not Members at the time that services were rendered.

4.8 Group's Payment to Participating Group Providers. Group shall be financially responsible for payment to all Participating Group Providers who render Covered Services to Members. Group shall require all Participating Group Providers who render such services to look solely to Group for payment. In addition, Group shall be financially responsible for payment to any other physicians who render Covered Services to Members when Group has been compensated on a capitated basis, if any, for such services. Group shall pay on a timely basis all Participating Group Providers and other physicians who render Covered Services for which Group is financially responsible hereunder.

4.9 Survival of Obligations. The obligations set forth in this Section shall survive the termination of this Agreement regardless of the cause giving rise to such termination and shall be construed for the benefit of Members. These provisions shall supersede any oral or written agreement to the contrary now existing or hereafter entered into between Participant and any Member or any persons acting on behalf of either of them.

Section 5.0
Quality

Group acknowledges that the delivery of quality is a key factor in health care services. Company has identified certain incentive categories that assist it in measuring and supporting quality outcomes. Group also agrees that Company, and/or a Government Sponsor may withhold incentive compensation from time to time based upon certain quality metrics provided Company/Government Sponsor has provided notice to Group of such quality metrics. If applicable, Company will pay Group in accordance with Schedule 1 of this Agreement any adjustment to the withhold to be determined on an annual basis. In such an event, Company shall provide twelve (12) months advance written notice with respect to any change in the incentive categories and the measuring of quality outcomes.

Section 6.0
Compliance with Policies

6.1 Policies. Group and Participating Group Providers agree to cooperate with any Company quality activities (including quality measures and patient satisfaction) or review of Company or a Plan conducted by the National Committee for Quality Assurance (NCQA) or a federal or State agency with authority over Company and/or the Plan, as applicable. Group and Participating Group Providers agree to accept and comply with Company's Provider Manual including all Policies of which Group knows or reasonably should have known. Group and Participating Group Providers will utilize the electronic real time HIPAA compliant transactions, including but not limited to, eligibility, precertification and claim status inquiry transactions to the extent such electronic real time features are utilized by Company. Company may modify Policies upon mutual agreement by both parties in writing. Company will provide notice by letter, newsletter, electronic mail or other media, of Material Changes. Failure by Group to object in writing to any Material Change within forty-five (45) days following receipt thereof constitutes Group's acceptance of such Material Change. In the event that Group reasonably believes that a Material Change is likely to have a material adverse financial impact upon Group's practice, Group agrees to notify Company in writing, specifying the specific bases demonstrating a likely material adverse financial impact, and the Parties will negotiate in good faith an appropriate amendment, if any, to this Agreement. Notwithstanding the foregoing, , Company may modify the Policies to comply with applicable Law, with advanced notification as can be reasonably expected, but without the consent of Group., and the Policies shall be deemed to be automatically amended to conform with all Laws promulgated at any time having authority over this Agreement. Group and Participating Group Providers agree that noncompliance with any requirements of this Section 6.1 or any Policies will relieve Company or Government Sponsors and Members from any financial liability for the applicable portion of the Group Services. Group and Participating Group Provider are hereby delegated the responsibility for delivering the standardized notices, currently known as the Important Message from Medicare (IM) and the Detailed Notice of Discharge (DND), to Medicare Advantage Members in accordance with the procedures outlined in 42 C.F.R. Section 422.620 and as outlined in the Provider Manual. In the event that Group or Participating Group Provider does not deliver standardized notices in a timely manner, Group shall not bill Medicare Advantage Members (and for non-Capitated services Group shall not be paid by Company) for services provided after the time that services would no longer be Covered Services had the applicable notices been timely delivered.

6.2 Credentialing. Company shall maintain standards, policies and procedures for credentialing and recredentialing for health care professionals that provide Covered Services to Members under the Plans as set forth in the Provider Manual. Such credentialing shall be maintained in accordance with the requirements of State and federal Law and the standards of accreditation organizations. Group will comply with the credentialing and recredentialing requirements identified in the Provider Manual. This Agreement is contingent on Group and each Participating Provider successfully completing Company's credentialing process, as applicable. Group and Participating Group Providers agree to maintain updated CAQH profiles for each of its Participating Group Providers including but not limited to ensuring files are attested and up to date at time of credentialing and anytime thereafter. Group and Participating Group Providers agree upon request by Company or related entity to furnish credentialing information or documentation and furnish no later than 30 business days upon time of request.

6.3 Intentionally Left Blank

6.4 Utilization Management. Company utilizes systems of utilization review/quality improvement/peer review to promote adherence to accepted medical treatment standards and to encourage Participating Group Providers to minimize unnecessary medical costs consistent with sound medical judgment and in accordance with applicable law. To further this end, Participating Group Providers agree

(a) To participate, as requested, and to abide by Company's utilization review, patient management, quality improvement programs, and all other related programs (as modified from time to time) and decisions with respect to all Members.

(b) To comply with Company's pre-certification and utilization management requirements for all elective admissions and other Covered Services.

(c) To regularly interact and cooperate with Company's nurse care managers.

(d) To utilize in-network Participating Group Providers when appropriate.

(e) To abide by all Company's credentialing criteria and procedures, including site visits and medical chart reviews, and to submit to these processes biannually, annually, or otherwise, when applicable.

(f) To obtain advance authorization from Company prior to any non-Emergency Service admission, and in cases where a Member requires an Emergency Service hospital admission or post-stabilization Care Services, to notify Company, both in accordance with Company's Policies then in effect.

Except when a Member requires Emergency Services, Group and Participating Group Providers agree to comply with any applicable precertification and/or referral requirements under the Member's Plan prior to the provision of Provider Services. Group and Participating Group Providers agree to notify Company of all admissions of Members, and of all services for which Company requires notice, upon admission or prior to the provision of such services. For those Members who require services under a Specialty Program, Group and Participating Group Providers agree to work with Company in transferring the Member's care to a Specialty Program Provider.

6.5 Notices and Reporting of Compliance Matters. If Group reasonably believes a change to Group may disrupt or threaten patient care, Group agrees to notify Company. To the extent neither prohibited by Law nor violative of applicable privilege, Group and Participating Group Providers agree to provide notice to Company, and shall provide all information reasonably requested by Company regarding (a) any litigation or administrative action brought against Group and Participating Group Providers or any of its employees or affiliated providers which is related to the provision of health care services and could have a material impact on the Provider Services provided to Members; (b) reporting of self-referrals, loss of licensure or accreditation, and claims by governmental agencies or individual regarding fraud, abuse, self-referral, false claims, or kickbacks; and (c) any material change in services provided by Group and Participating Group Providers or licensure status related to such services. Group agrees to notify Company on a quarterly basis regarding any change in Group's demographic information or Participating Providers. Company and Group agree to be mutually committed to promoting Member safety and quality. Therefore, Group will report the occurrence of and waive all charges related to those conditions specified under Section 5001(c) of the Deficit Reduction Act, Section 2702 of the Affordable Care Act and any related or similar Law. Group agrees to use best efforts to provide Company with prior notice of, and in any event will provide notice as soon as reasonably practicable notice of, any actions taken by or against Group or Participating Group Providers described in this Section 6.4. Intentionally Left Blank

6.6 Proprietary Information. Each Party is prohibited from, and shall prohibit its Affiliates and Participating Group Providers from, disclosing to a third party the substance of this Agreement, or any information of a confidential nature, including but not limited to financial information, acquired from the other Party (or Affiliate or Participating Group Provider thereof) during the course of this Agreement, except to agents of such Party as necessary for such Party's performance under this Agreement, or as required by a Payor Contract or applicable Regulatory Requirements. Group and Participating Group Provider acknowledges and agrees that all information relating to Company's programs and Policies is proprietary information and neither shall disclose such information to any person or entity without Company's express written consent.

Notwithstanding the foregoing, Company acknowledges that Participant is a public county-owned hospital which is subject to the provisions of the Nevada Public Records Act, Nevada Revised Statutes Chapter 239, as may be amended from time to time, and as such its records are public documents available to copying and inspection by the public. If Participant receives a demand for the disclosure of any information related to this Agreement which Company has claimed to be confidential and proprietary, Participant will immediately notify Company of such

demand and Company shall immediately notify Participant of its intention to seek injunctive relief in a Nevada court for protective order. Company shall indemnify, defend and hold harmless Participant from any claims or actions, including all associated costs and attorney's fees, regarding or related to any demand for the disclosure of Company documents in Participant's custody and control in which Company claims to be confidential and proprietary.

6.7 Compliance with HIPAA.

6.6.1 HIPAA Obligations of Provider. Group acknowledges and agrees that with respect to the services provided by Participating Group Provider pursuant to this Agreement, Group and Participating Group Provider may be considered a Covered Entity, as defined by 45 C.F.R. Section 160.103 ("Covered Entity"). As a Covered Entity, Group and Participating Group Provider(s) agree to comply with all applicable provisions of the HIPAA and the HIPAA Rules and HITECH and the HITECH Standards. Group and Participating Group Provider further acknowledges and agrees that if Company receives protected health information, as defined in 45 C.F.R. Section 164.501, ("PHI") as a business associate, as defined in 45 C.F.R. Section 160.103, ("Business Associate"), Group and Participating Group Provider(s) may also be considered the subcontractor of a Business Associate. As the subcontractor of a Business Associate, Group and Participating Group Provider(s) agree to comply with the same privacy and security obligations that apply to Business Associates. With respect to Electronic Protected Health Information Group shall:

(a) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that Provider creates, receives, maintains, or transmits on behalf of Company, as required by the Security Standards;

(b) Ensure that any agent, including a subcontractor, to whom Group and Participating Group Provider(s) provides such information, agrees to implement reasonable and appropriate safeguards to protect PHI; and

(c) Report to Company any Security Incident of which it becomes aware.

6.6.2 Notwithstanding the foregoing, in Company's sole discretion and in accordance with its directions, Provider Group shall conduct, or pay the costs of conducting, an investigation of any incident required to be reported under this Section 6.6 shall provide, and/or pay the costs of providing, the required notices as set forth in this Section 6.6

6.7 HIPAA Obligations of Company. Company acknowledges and agrees that with respect to the services provided by Company pursuant to this Agreement, Company may be considered a business associate of both Group and Plans. With respect to PHI received by Company from Group or Plans, Company agrees to comply with all applicable provisions of HIPAA.

Section 7
Term and Termination

7.1 Eligibility to Participate in Company. Participant may be eligible to participate in the Company after satisfying the Credentialing Standards established by the Company.

7.2 Term. This Agreement shall be effective for an initial term of two (2) years from the Effective Date ("Initial Term"), and thereafter shall renew upon mutual written agreement for two (2) additional one (1) year terms (each, a "Renewal Term"), unless either Party provides one hundred eighty (180) calendar days advance written notice prior to the end of the Initial or any Renewal Term, or as otherwise in

accordance with this Agreement.

7.3 Termination without Cause. This Agreement may be terminated without cause by either party, when written notice given to other party at least one hundred eighty days (180) days.

7.4 Termination for Cause or Material Breach. This Agreement may be terminated at any time by either Party upon at least thirty (30) calendar days prior written notice of such termination to the other Party upon material default or substantial breach by such Party of one or more of its obligations hereunder, unless such material default or substantial breach is cured within thirty (30) calendar days of the notice of termination; provided, however, if such material default or substantial breach is incapable of being cured within such thirty (30) calendar day period, any termination pursuant to this Section 5.4 will be ineffective for the period reasonably necessary to cure such breach if the breaching Party has taken all steps reasonably capable of being performed within such thirty (30) calendar day period. Furthermore, Company may terminate the status of any Participating Practitioner for default or breach of said Participating Practitioner's obligations hereunder upon at least thirty (30) calendar days' written notice to said Participating Practitioner, unless such default or breach is cured within the notice period. Notwithstanding the foregoing, the effective date of such termination may be extended pursuant to Section 5.7 herein.

7.5 Termination by Company. Company may terminate this Agreement or, where applicable, the right of any Participating Practitioner to participate in Company, at Company's discretion, due to any of the following events:

7.5.1 Upon the expiration of thirty (30) calendar days after Company's receipt of Participant's notification indicating Participating Practitioner's voluntary retirement from the active practice of medicine;

7.5.2 Immediately upon the suspension or revocation of a Participating Practitioner's DEA certification or other right to prescribe and dispense controlled substances;

7.5.3 Immediately upon the suspension, withdrawal, expiration, revocation or non-renewal of any Federal, state or local license, certificate or other legal credential authorizing Participant and/or a Participating Practitioner's to practice his or her profession;

7.5.4 Immediately in the event of the exclusion, debarment or suspension of Participant and/or any Participating Practitioner from participation in any governmental sponsored program, including, but not limited to, the Medicare or the Medicaid program in any state;

7.5.5 Immediately in the event of any material breach or default by Participant of this Agreement, the terms and conditions of any Payor Contract or the Policies, following notice to Participant of such breach or default, if Participant does not cure such breach or default within thirty (30 calendar days of receipt of notice;

7.5.6 Immediately upon any false statement or material omission of a Participating Practitioner in the participation application and/or confidential information forms and all other requested information, as determined by Company in its sole discretion;

7.5.7 Immediately upon a determination by Company that Participant or Participating Practitioner's continued participation in provider network could result in harm to patients;

7.5.8 Immediately upon a Participating Practitioner's indictment, arrest or conviction of a felony or for any criminal charge related to or in any way impairing Provider's or Participating Practitioner's practice of medicine;

7.5.9 Immediately upon any adverse action with respect to a Participating Practitioner's hospital staff privileges, if applicable, occurrence on OIG or Preclusion listings;

7.5.10 Immediately upon the loss or material limitation of Participant's or Participating Practitioner's insurance under Section 2.18 of this Agreement;

7.5.11 Immediately upon the dissolution of Company;

7.5.12 Immediately upon a change of control or ownership of Participant to an entity not acceptable to Company; or

7.5.13 Immediately upon a final determination by the Board that Participant has failed to comply with requirements of Company as contemplated by the Policies.

7.6 Effect of Termination on Care Management Payments. Participant understands and agrees that upon termination of this Agreement (the "Termination Date"), Participant is no longer eligible to receive any Care Management Payments, including without limitation, shared savings, bonus payments or any PMPM payments pursuant to a Payor Agreement, with the limited exception that Participant shall receive only such PMPM payments owed to Participant through the end of the month in which the Termination Date occurred.

7.7 Obligations Following Termination. Except as otherwise provided in this Agreement, including any schedule and/or exhibit, the provisions of this Agreement shall be of no further force or effect following termination of this Agreement, provided that Company, Participant and Participating Practitioners will cooperate as provided in this Section 7.7. This Section 7.7 shall survive the termination of this Agreement, regardless of the cause of termination.

7.8 Continuity of Care. In the event of termination of this Agreement, Company and Participant shall use their best efforts to arrange for an orderly transition of patient care, consistent with standards of high-quality medical care, for Members who have been or are at the time under the care of Participant, to the care of another Participating Provider. If the event of such termination, Participant will identify in writing to Company all Members receiving treatment. Company will notify affected Members of the termination according to applicable Federal and State continuity of care Laws. Upon request of Company, Participant will continue to provide Covered Services to a Member receiving Covered Services from Participant on the effective termination date of this Agreement for the continuing care period required by applicable Law, unless Company makes provision for the assumption of such Covered Services by another Participant.

7.9 Upon Insolvency or Cessation of Operations. If this Agreement terminates as a result of insolvency or cessation of operations of Company, and as to Members of Contracting Payors that become insolvent or cease operations, then in addition to other obligations set forth in this Section, Participant and Participating Practitioners shall continue to provide Provider Services to all Members for the period for which premium has been paid and as required by applicable law.

7.10 Obligation to Cooperate. Upon notice of expiration or termination of this Agreement and/or an exhibit or schedule hereto, Participant and Participating Practitioners shall cooperate with Company and comply with Policies in the transfer of Members to other providers.

7.11 Obligation to Notify Members. Upon notice of termination of this Agreement and/or an exhibit or schedule hereto, Company shall provide reasonable advance notice of the impending termination to Members currently under the treatment of Participant and Participating Practitioners, or in the event of immediate termination, as soon as practicable after termination.

7.12 Obligations During Dispute Resolution Proceedings. In the event of any dispute between the Parties in which a Party has provided notice of termination under Section 5.4 and the dispute is required to be resolved or is submitted for resolution under Section 7 below, the termination of this Agreement shall be stayed, and the Parties shall continue to perform under the terms of this Agreement until the final resolution of the dispute.

Section 8
Liability of Parties

8.1 Indemnification.

8.1.2 Intentionally omitted.

8.1.2 Indemnification by Company. Company shall indemnify, defend and hold harmless Participant from and against any and all claims, causes of action, liabilities, losses, damages, penalties, assessments, judgments, awards or costs, including reasonable attorneys' fees and costs, arising out of, resulting from, or relating to: (i) Company's failure to comply with the terms of this Agreement or (ii) the negligent acts or omissions of Company or any employee or agent of Company in the performance of Company's obligations under this Agreement. The Parties recognize that, during the term of this Agreement and for a period thereafter, certain risk management issues, legal issues, claims or actions may arise that involve or could potentially involve the Parties and their respective employees and agents.

8.1.3 Cooperation. The Parties further recognize the importance of cooperating with each other in good faith when such issues, claims or actions arise, to the extent such cooperation does not violate any applicable Laws, cause the breach of any duties created by any policies of insurance or programs of self-insurance, or otherwise compromise the confidentiality of communications or information regarding the issues, claims or actions. As such, the Parties hereby agree to cooperate in good faith, using their best efforts, to address such risk management and claims handling issues in a manner that strongly encourages full cooperation between the Parties. The Parties further agree that if a controversy, dispute, claim, action or lawsuit (each, an "Action") arises with a third-party wherein both the Parties are included as defendants, each Party shall promptly disclose to the other Party in writing the existence and continuing status of the Action and any negotiations relating thereto. Each Party shall make every reasonable attempt to include the other Party in any settlement offer or negotiations. In the event the other Party is not included in the settlement, the settling Party shall immediately disclose to the other Party in writing the acceptance of any settlement and terms relating thereto.

8.1.4 This Section 8.1 shall survive the termination of this Agreement for any reason, including insolvency.

8.2 Limitation of Liability. Either Party's liability, if any, for damages to the other Party for any cause whatsoever arising out of or related to this Agreement, and regardless of the form of the action, shall be limited to the damaged Party's actual damages. Neither Party shall be liable for any indirect, incidental, punitive, exemplary, special or consequential damages of any kind whatsoever sustained as a result of a breach of this Agreement or any action, inaction, alleged tortious conduct, or delay by the other Party.

8.3 Disclaimer. Company makes no warranty or representation that compliance by Participant with this Agreement will be adequate or satisfactory for Participant's own purposes. Participant is solely responsible for all decisions made by Participant regarding compliance with applicable Laws and Payor Contracts, including without limitation all coding and billing decisions made by Participant.

Section 9
Miscellaneous

9.1 Entire Agreement. This Agreement is the entire understanding and agreement of the Parties regarding its subject matter, and supersedes any prior oral or written agreements, representations, understandings or discussions between the Parties. No other understanding between the Parties shall be binding on them unless set forth in writing, signed and attached to this Agreement.

9.2 Exhibits. The attached exhibits, together with all attachments to and other documents incorporated by reference in the exhibits, form an integral part of this Agreement and are incorporated into this Agreement wherever reference is made to them to the same extent as if they were set out in full at the point at which such reference is made.

9.3 Amendment. No changes, amendments or alterations to this Agreement shall be effective unless signed by both Parties, except as expressly provided herein. Notwithstanding the foregoing, Company may propose to amend this Agreement upon forty-five (45) calendar day prior written notice, by letter, newsletter, electronic mail or other media (an "Amendment"). Failure by Participant to object in writing to any such Amendment within such forty-five (45) day period constitutes Participant's acceptance of such Amendment. In the event that Participant reasonably believes that an Amendment is likely to have a material adverse impact upon Participant, Participant agrees to notify Company in writing, specifying the specific bases demonstrating a likely material adverse impact, and the Parties will negotiate in good faith an appropriate revised Amendment, if any, to this Agreement. Notwithstanding the foregoing, , Company may amend, with no less than 30 day notice, this Agreement to comply with applicable Law, or any order or directive of any applicable governmental agency, including but not limited to CMS, without the consent of Participant, and this Agreement shall be amended to conform with all Laws promulgated at any time by any state or federal regulatory agency or authority having supervisory authority over this Agreement. Unless such Law or governmental agency directs otherwise, the signature of Participant will not be required in order for the Amendment to take effect. Participant and Participating Practitioners agree that noncompliance with any requirements of this Section will relieve Company or Contracting Payors and Members from any financial liability for the applicable portion of the Provider Services.

9.4 Governing Law. This Agreement and the rights and obligations of the Parties hereunder shall be construed, interpreted, and enforced in accordance with, and governed by, the Laws of the State where the contract is executed and services are rendered.

9.5 Notice. All notices or communications required or permitted under this Agreement shall be given in writing and delivered personally or sent by United States registered or certified mail with postage prepaid and return receipt requested or by overnight delivery service (e.g., Federal Express, DHL). Notice shall be deemed given when sent, if sent as specified in this Section, or otherwise deemed given when received. In each case, notice shall be delivered or sent to:

If to Company:

P3 Health Partners-Nevada
Attn: Market President
2370 Corporate Circle, Suite 300
Henderson, NV 89074

Copy to:

P3 Health Partners
Attn: Chief Managed Care Officer
2370 Corporate Cir., Suite 300
Henderson, NV 89074

If to Participant:

University Medical Center of Southern Nevada
Attn: Legal Department and CC: Managed Care
1800 W. Charleston Blvd.
Las Vegas, NV 89102

or to such other address, and to the attention of such other person or officer as any Party may designate in a written notice that satisfies the requirements of this Section.

9.6 Partial Invalidity. In the event any provision of this Agreement is found to be legally invalid or unenforceable for any reason, the remaining provisions of this Agreement shall remain in full force and effect provided the fundamental rights and obligations remain reasonably unaffected.

9.7 Successors; Assignment. This Agreement relates solely to the provision of Provider Services by Participant and Participating Practitioners and does not apply to any other organization which succeeds to Participant assets, by

merger, acquisition or otherwise, or is an Affiliate of Participant unless such Affiliate or other organization is credentialed by Company. Neither Party may assign its rights or its duties and obligations under this Agreement without the prior written consent of the other Party, which consent may not be unreasonably withheld; provided, however, that Company may assign its rights or its duties and obligations in whole or in part to an Affiliate, successor in interest or other third-party designee.

9.8 Limitation on Control. Company shall neither have nor exercise any control or direction over Participant's professional medical judgment or the methods by which Participant performs professional medical services; provided, however, that Participant shall be subject to and shall at all times comply with the Policies.

9.9 Independent Contractors. Participant shall at all times be an independent contractor with respect to Company in the performance of Participant's obligations under this Agreement. Nothing in this Agreement shall be construed to create an employer/employee, joint venture, partnership, lease or landlord/tenant relationship between Company and Participant. Neither Participant nor any Participating Practitioner shall hold himself or herself out as an officer, agent or employee of Company, and shall not incur any contractual or financial obligation on behalf of Company without Company's prior written consent.

9.10 Member Grievance Dispute Resolution. Participant and Participating Practitioners agree to (a) cooperate with and participate in Company's applicable appeal, grievance and external review procedures (including, but not limited to, Medicaid appeals and expedited appeals procedures), (b) provide Company with the information necessary to resolve same, and (c) abide by decisions of the applicable appeals, grievance and review committees. Company will make available to Participant and Participating Practitioners information concerning the Member appeal, grievance and external review procedures at the time of entering into this Agreement.

9.11 Alternative Dispute Resolution. Company shall provide a mechanism whereby Participant may raise issues, concerns, controversies or claims regarding the obligations of the Parties under this Agreement. Any dispute that is not resolved through the reconciliation process or by informal meeting(s) of the Parties will be submitted in writing to the other Party within thirty (30) calendar days of any Party declaring in writing that the informal attempts at resolution have failed demanding good faith negotiation in a formal meeting between representatives of the Parties who have the requisite authority to resolve the dispute fully and finally. Participant shall exhaust this mechanism prior to instituting any arbitration or other permitted legal proceeding. The Parties agree that any dispute that may arise between the Parties shall not disrupt or interfere with the provision of services to Members. Discussions and negotiations held pursuant to this Section 7.11 shall be treated as inadmissible compromise and settlement negotiations for purposes of applicable rules of evidence.

9.12 Arbitration. The Parties shall in good faith attempt to resolve any controversy, dispute or disagreement arising out of or related to this Agreement, or breach thereof, by negotiation. If such controversy, dispute or disagreement is not resolved, then, at the request of either Party at any time, the controversy, dispute or disagreement shall be submitted to mediation under the American Arbitration Association ("AAA") Alternative Dispute Resolution Service Rules of Procedure for Mediation. If any dispute is not resolved by mediation within thirty (30) calendar days after selection of the mediator, the dispute shall, upon the request of either Party, be submitted to binding arbitration in accordance with the AAA Dispute Resolution Service Rules of Procedure for Arbitration. Mediation or arbitration, as the case may be, shall be held in Clark County, Nevada. Judgment on any award rendered by the arbitrator may be entered in any court having proper jurisdiction. The same person may serve both as the mediator and the arbitrator if the Parties so agree. This Section shall constitute the sole remedy of the Parties with respect to all claims or controversies concerning this Agreement or arising in any way out of the performance of this Agreement.

9.13 Joint Operating Committee. Once membership reaches 50 members or at Company's discretion a formal JOC cadence will be established. Company and Participant will each designate key management staff to serve on a Joint Operating Committee ("JOC"). The JOC will meet quarterly to discuss matters pertinent to the business relationship between the Parties and may meet more frequently as requested by either Party. Such discussions may include: (i) a request by either Party; (ii) a review of data on Participant's clinical performance under the Agreement;

(i) Participant's performance in cooperating with the Provider Manual1, (iv) any significant impact to the Company of unsatisfactory performance by Participant and (v) any significant impact to Participant of unsatisfactory performance by Company. The JOC may review any recommendations for process improvements that the Company or Participant would like implemented, but that are not required by CMS regulations, Law, or accreditation organizations.

9.14 Third-Party Beneficiaries. Except as otherwise provided in this Agreement to the contrary, this Agreement is entered into for the sole benefit of Company and Participant. Nothing contained herein or in the Parties' course of dealings shall be construed as conferring any third-party beneficiary status on any person or entity not a Party to this Agreement.

9.15 Suits or Other Actions. Each Party shall give prompt written notice to the other whenever he/she/it becomes aware of any written complaint from a Member or other person or becomes aware that a Member or other person has filed a claim or given written notice of intent to commence any suit or other action against either Party in connection with this Agreement or any professional services provided pursuant to this Agreement.

9.16 Confidential Information.

9.16.1 During the term of this Agreement, Participant may have access to and become acquainted with Trade Secrets and Confidential Information of Company. "Trade Secrets" includes information and data relating to Payor Contracts and accounts, clients (patients, patient groups, patient/beneficiary lists, as applicable), billing practices and procedures, business techniques and methods, strategic and marketing plans, operations and related data. "Confidential Information" includes Trade Secrets and any information related to the past, current or proposed operations, business or strategic plans, financial statements or reports, technology or services of Company or any Affiliate that Company discloses or otherwise makes available in any manner to Participant, or to which Participant may gain access pursuant to this Agreement, or which Participant knows or has reason to know is confidential information of Company or any Affiliate; whether such information is disclosed orally, visually or in writing, and whether or not bearing any legend or marking indicating that such information or data is confidential. By way of example, but not limitation, Confidential Information includes any and all know-how, processes, manuals, confidential reports, procedures and methods of Company, and any information, records and proceedings of Company committees and other bodies charged with the evaluation and improvement of the quality of care. Confidential Information also includes proprietary or confidential information of any third-party that may be in Company's or any Affiliate's possession.

(a) Confidential Information shall be and remain the sole property of Company, and shall, as applicable, be proprietary information protected under the Uniform Trade Secrets Act. Participant shall not use any Confidential Information for any purpose not expressly permitted by this Agreement or disclose any Confidential Information to any person or entity, without the prior written consent of Company. Participant shall protect the Confidential Information from unauthorized use, access, or disclosure in the same manner as Participant protects his, her, or its own confidential or proprietary information of a similar nature and with no less than reasonable care. All documents that Participant prepares, or Confidential Information that might be given to Participant pursuant to this Agreement, are the exclusive property of Company, and, without the prior written consent of Company, shall not be removed from Company's premises.

(b) Participant shall return to Company all Confidential Information and all copies thereof in Participant's possession or control and permanently erase all electronic copies of such Confidential Information, promptly upon the written request of Company, or the termination or expiration of this Agreement. Participant shall not copy, duplicate or reproduce any Confidential Information without the prior written consent of Company.

(c) Notwithstanding the above, nothing in this Agreement shall be interpreted to interfere with the Participant-patient relationship. Participant shall provide information regarding treatment

options in a culturally competent manner to patients, including those with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, and/or physical or mental disabilities.

(d) This Section shall survive the expiration or termination of this Agreement.

9.17 Force Majeure. If either Party shall be delayed or interrupted in the performance or completion of its obligations hereunder by any act, neglect or default of the other Party, or by an embargo, war, act of terror, riot, incendiary, fire, flood, earthquake, pandemic, epidemic or other calamity, act of God or of the public enemy, governmental act (including, but not restricted to, any government priority, preference, requisition, allocation, interference, restraint or seizure, or the necessity of complying with any governmental order, directive, ruling or request) then the time of completion specified herein shall be extended for a period equivalent to the time lost as a result thereof. This Section 7.19 shall not apply to either Party's obligations to pay any amounts owing to the other Party, nor to any strike or labor dispute involving such Party or the other Party.

9.18 Conflict. Participant acknowledges and agrees that the rates set forth by Company supersede any previously agreed upon rate in any Benefit Plan contract of Participant or any of its Participating Providers.

9.19 Headings. The headings in this Agreement are intended solely for convenience of reference and shall be given no effect in the construction or interpretation of this Agreement.

9.20 Counterparts; Signatures. This Agreement may be executed in one or more counterparts, each of which shall be deemed to be an original, but all of which together shall constitute one and the same instrument. Facsimile and electronic signatures shall be deemed to be original signatures for all purposes of this Agreement.

9.21 Waiver. The waiver by either Party of a breach or violation of any provision of this Agreement shall not operate as or be construed to be a waiver of any subsequent breach thereof. To be effective, all waivers must be in writing and signed by an authorized officer of the Party to be charged. Participant waives any claims or cause of action for fraud in the inducement or execution related hereto.

9.22 Severability. Any determination that any provision of this Agreement or any application thereof is invalid, illegal or unenforceable in any respect in any instance shall not affect the validity, legality and enforceability of such provision in any other instance, or the validity, legality or enforceability of any other provision of this Agreement. Neither Party shall assert or claim that this Agreement or any provision hereof is void or voidable if such Party performs under this Agreement without prompt and timely written objection.

9.23 Authorization. Each individual signing this Agreement warrants that such execution has been duly authorized by the Party for which he/she is signing. The execution and performance of this Agreement by each Party has been duly authorized by all necessary corporate or governance action, and this Agreement constitutes the valid and enforceable obligation of each Party in accordance with its terms.

[Remainder of page intentionally left blank. Signature page follows.]

IN WITNESS WHEREOF, the undersigned Parties have executed this Agreement by their duly authorized officers, intending to be legally bound hereby.

University Medical Center of Southern Nevada

By: _____

Printed Name: Mason VanHouweling

Title: Chief Executive Officer

Date: 12-27-25

P3 Health Partners-Nevada, LLC

By: Nate Coiner
4842F4F1019F4B7...

Printed Name: Nate Coiner

Title: VP Network

Date: 12/23/2025

REMITTANCE ADDRESS:

_____

_____

_____

Effective Date:
9/1/2025

MAIN TELEPHONE NUMBER: _____

CHIEF EXECUTIVE OFFICER: _____

BUSINESS OFFICE MANAGER: _____

FEDERAL TAX I.D. NUMBER: _____

NPI NUMBER: _____

SCHEDULE 1

SERVICES AND COMPENSATION SCHEDULE

[The information in this attachment is confidential and proprietary in nature.]

EXHIBIT A
PARTICIPATING GROUP PROVIDER ORGANIZATIONAL STANDARDS

[The information in this attachment is confidential and proprietary in nature.]

EXHIBIT B

MEDICARE ADVANTAGE PROVIDER OBLIGATIONS

[The information in this attachment is confidential and proprietary in nature.]

EXHIBIT C

Intentionally left blank

EXHIBIT D

OTHER FEDERAL LAWS

[The information in this attachment is confidential and proprietary in nature.]

SCHEDULE 2

INCENTIVE-BASED PAYMENT REQUIREMENTS

[The information in this attachment is confidential and proprietary in nature.]

EXHIBIT E

PARTICIPANT LISTING & NPI NUMBERS

[The information in this attachment is confidential and proprietary in nature.]

EXHIBIT F

PRODUCT PARTICIPATION LIST

[The information in this attachment is confidential and proprietary in nature.]

INSTRUCTIONS FOR COMPLETING THE
DISCLOSURE OF OWNERSHIP/PRINCIPALS FORM

Purpose of the Form

The purpose of the Disclosure of Ownership/Principals Form is to gather ownership information pertaining to the business entity for use by the University Medical Center of Southern Nevada Governing Board ("GB") in determining whether members of the GB should exclude themselves from voting on agenda items where they have, or may be perceived as having a conflict of interest, and to determine compliance with Nevada Revised Statute 281A.430, contracts in which a public officer or employee has interest is prohibited.

General Instructions

Completion and submission of this Form is a condition of approval or renewal of a contract or lease and/or release of monetary funding between the disclosing entity and University Medical Center of Southern Nevada. Failure to submit the requested information may result in a refusal by the GB to enter into an agreement/contract and/or release monetary funding to such disclosing entity.

Detailed Instructions

All sections of the Disclosure of Ownership form must be completed. If not applicable, write in N/A.

Business Entity Type – Indicate if the entity is an Individual, Partnership, Limited Liability Company, Corporation, Trust, Non-profit Organization, or Other. When selecting 'Other', provide a description of the legal entity.

Non-Profit Organization (NPO) - Any non-profit corporation, group, association, or corporation duly filed and registered as required by state law.

Business Designation Group – Indicate if the entity is a Minority Owned Business Enterprise (MBE), Women-Owned Business Enterprise (WBE), Small Business Enterprise (SBE), Physically-Challenged Business Enterprise (PBE), Veteran Owned Business (VET), Disabled Veteran Owned Business (DVET), or Emerging Small Business (ESB) . This is needed in order to provide utilization statistics to the Legislative Council Bureau, and will be used only for such purpose.

- **Minority Owned Business Enterprise (MBE):** An independent and continuing business for profit which performs a commercially useful function and is at least 51% owned and controlled by one or more minority persons of Black American, Hispanic American, Asian-Pacific American or Native American ethnicity.
- **Women Owned Business Enterprise (WBE**): An independent and continuing business for profit which performs a commercially useful function and is at least 51% owned and controlled by one or more women.
- **Physically-Challenged Business Enterprise (PBE):** An independent and continuing business for profit which performs a commercially useful function and is at least 51% owned and controlled by one or more disabled individuals pursuant to the federal Americans with Disabilities Act.
- **Small Business Enterprise (SBE):** An independent and continuing business for profit which performs a commercially useful function, is not owned and controlled by individuals designated as minority, women, or physically-challenged, and where gross annual sales does not exceed $2,000,000.
- **Veteran Owned Business Enterprise (VET):** An independent and continuing Nevada business for profit which performs a commercially useful function and is at least 51 percent owned and controlled by one or more U.S. Veterans.
- **Disabled Veteran Owned Business Enterprise (DVET):** A Nevada business at least 51 percent owned/controlled by a disabled veteran.
- **Emerging Small Business (ESB):** Certified by the Nevada Governor's Office of Economic Development effective January, 2014. Approved into Nevada law during the 77th Legislative session as a result of AB294.

Business Name (include d.b.a., if applicable) – Enter the legal name of the business entity and enter the "Doing Business As" (d.b.a.) name, if applicable.

Corporate/Business Address, Business Telephone, Business Fax, and Email – Enter the street address, telephone and fax numbers, and email of the named business entity.

Nevada Local Business Address, Local Business Telephone, Local Business Fax, and Email – If business entity is out-of-state, but operates the business from a location in Nevada, enter the Nevada street address, telephone and fax numbers, point of contact and email of the local office. Please note that the local address must be an address from which the business is operating from that location. Please do not include a P.O. Box number, unless required by the U.S. Postal Service, or a business license hanging address.

***Number of Clark County Nevada Residents employed by this firm. (*Do not leave blank. If none or zero, put the number 0 in the space provided.)**

List of Owners/Officers – Include the full name, title and percentage of ownership of each person who has ownership or financial interest in the business entity. If the business is a publicly-traded corporation or non-profit organization, list all Corporate Officers and Directors only.

For All Contracts – **(Not required for publicly-traded corporations)**

1) Indicate if any individual members, partners, owners or principals involved in the business entity are a University Medical Center of Southern Nevada full-time employee(s), or appointed/elected official(s). If yes, the following paragraph applies.

   In accordance with NRS 281A.430.1, a public officer or employee shall not bid on or enter into a contract between a government agency and any private business in which he has a significant financial interest, except as provided for in subsections 2, 3, and 4.

2) Indicate if any individual members, partners, owners or principals involved in the business entity have a second degree of consanguinity or affinity relation to a University Medical Center of Southern Nevada full-time employee(s), or appointed/elected official(s) (reference form on Page 2 for definition). If **YES**, complete the Disclosure of Relationship Form.

A professional service is defined as a business entity that offers business/financial consulting, legal, physician, architect, engineer or other professional services.

Signature and Print Name – Requires signature of an authorized representative and the date signed.

Disclosure of Relationship Form – If any individual members, partners, owners or principals of the business entity is presently a University Medical Center of Southern Nevada employee, public officer or official, or has a second degree of consanguinity or affinity relationship to a University Medical Center of Southern Nevada employee, public officer or official, this section must be completed in its entirety.

DISCLOSURE OF OWNERSHIP/PRINCIPALS

Business Entity Type (Please select one)

☐ Sole Proprietorship	☐Partnership	X☐ Limited Liability Company	☐ Corporation	☐ Trust	☐ Non-Profit Organization	☐ Other

Business Designation Group (Please select all that apply)

☐ MBE	☐ WBE	☐ SBE	☐ PBE	☐ VET	☐DVET	☐ ESB
Minority Business Enterprise	Women-Owned Business Enterprise	Small Business Enterprise	Physically Challenged Business Enterprise	Veteran Owned Business	Disabled Veteran Owned Business	Emerging Small Business

Number of Clark County Nevada Residents Employed:

Corporate/Business Entity Name:	P3 Health Partners-Nevada, LLC	
(Include d.b.a., if applicable)		
Street Address:	2370 Corporate Circle, Suite 300	**Website: www.p3hp.org**
City, State and Zip Code:	Henderson, Nevada 89074	**POC Name: Kassi Belz** **Email: kbelz@p3hp.org**
Telephone No:	702-766-3719	**Fax No:**
Nevada Local Street Address: **(If different from above)**		**Website:**
City, State and Zip Code:		**Local Fax No:**
Local Telephone No:		**Local POC Name:** **Email:**

All entities, with the exception of publicly-traded and non-profit organizations**,** must list the names of individuals holding more than five percent (5%) ownership or financial interest in the business entity appearing before the Board.

Publicly-traded entities and non-profit organizations shall list all Corporate Officers and Directors in lieu of disclosing the names of individuals with ownership or financial interest. The disclosure requirement, as applied to land-use applications, extends to the applicant and the landowner(s).

Entities include all business associations organized under or governed by Title 7 of the Nevada Revised Statutes, including but not limited to private corporations, close corporations, foreign corporations, limited liability companies, partnerships, limited partnerships, and professional corporations.

Full Name	Title	% Owned (Not required for Publicly Traded Corporations/Non-profit organizations)
Aric Coffman, M.D.	Chief Executive Officer	Publicly traded
Leif Pedersen	Chief Financial Officer	Publicly traded
Amir Bacchus, M.D.	Chief Medical Officer	Publicly traded

This section is not required for publicly-traded corporations. Are you a publicly-traded corporation? ***X***☐ Yes ☐ No

1. Are any individual members, partners, owners or principals, involved in the business entity, a University Medical Center of Southern Nevada full-time employee(s), or appointed/elected official(s)?

   ☐ Yes ☐ No (If yes, please note that University Medical Center of Southern Nevada employee(s), or appointed/elected official(s) may not perform any work on professional service contracts, or other contracts, which are not subject to competitive bid.)

2. Do any individual members, partners, owners or principals have a spouse, registered domestic partner, child, parent, in-law or brother/sister, half-brother/half-sister, grandchild, grandparent, related to a University Medical Center of Southern Nevada full-time employee(s), or appointed/elected official(s)?

   ☐ Yes ☐ No (If yes, please complete the Disclosure of Relationship form on Page 2. If no, please print N/A on Page 2.)

I certify under penalty of perjury, that all of the information provided herein is current, complete, and accurate. I also understand that the University Medical Center of Southern Nevada Governing Board will not take action on land-use approvals, contract approvals, land sales, leases or exchanges without the completed disclosure form.

Signed by:
Todd Smith
Signature
2B7BE07D31C1427...

Todd M. Smith
Todd Smith
Print Name

Chief Legal Officer
Title

8/25/2025
Date

DISCLOSURE OF RELATIONSHIP

List any disclosures below: Not applicable
(Mark N/A, if not applicable.)

NAME OF BUSINESS OWNER/PRINCIPAL	NAME OF UMC* EMPLOYEE/OFFICIAL AND JOB TITLE	RELATIONSHIP TO UMC* EMPLOYEE/OFFICIAL	UMC* EMPLOYEE'S/OFFICIAL'S DEPARTMENT

* UMC employee means an employee of University Medical Center of Southern Nevada

"Consanguinity" is a relationship by blood. "Affinity" is a relationship by marriage.

"To the second degree of consanguinity" applies to the candidate's first and second degree of blood relatives as follows:

- Spouse – Registered Domestic Partners – Children – Parents – In-laws (first degree)
- Brothers/Sisters – Half-Brothers/Half-Sisters – Grandchildren – Grandparents – In-laws (second degree)

For UMC Use Only:

If any Disclosure of Relationship is noted above, please complete the following:

☐ Yes ☐ No Is the UMC employee(s) noted above involved in the contracting/selection process for this particular agenda item?

☐ Yes ☐ No Is the UMC employee(s) noted above involved in any way with the business in performance of the contract?

Notes/Comments:

_____
Signature

_____
Print Name
Authorized Department Representative

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
GOVERNING BOARD AUDIT AND FINANCE COMMITTEE
AGENDA ITEM

Issue:	**Ratification of the Ancillary Provider Participation Agreement and Facility Participation Agreement with United Healthcare Insurance Company**	**Back-up:**
Petitioner:	Jennifer Wakem, Chief Financial Officer	**Clerk Ref. #**

Recommendation:

That the Governing Board Audit and Finance Committee review and recommend for ratification by the Governing Board the Ancillary Provider Participation Agreement and the Facility Participation Agreement with UnitedHealthcare Insurance Company for Managed Care Services; or take action as deemed appropriate. ***(For possible action)***

FISCAL IMPACT:

Fund Number: 5430.011
Fund Name: UMC Operating Fund
Fund Number: 3000850000
Funded Pgm/Grant: N/A
Description: Managed Care Services
Bid/RFP/CBE: NRS 332.115(1)(f) – Insurance
Term:
November 1, 2025 – October 31, 2028 (Commercial Products);
November 1, 2025 – October 31, 2026 (Medicare Advantage Products)
Amount: Revenue based on volume
Out Clause: 180 days without cause, effective at the end of the initial or renewal term

BACKGROUND:

This request is for ratification of the Ancillary Provider Participation Agreement and the Facility Participation Agreement with UnitedHealthcare Insurance Company and its affiliates (the "Agreements") for healthcare services to UnitedHealthcare members at UMC locations.

Both Agreements are effective from November 1, 2025, through October 31, 2028, for commercial products. Medicare Advantage products covered under the Agreements will have an initial term of one year, ending on October 31, 2026. Ratification was necessary as the Agreements were retroactively effective as of November 1, 2025, and immediate execution ensured they were loaded in UHC's internal systems.

UMC's Director of Managed Care has reviewed and recommends ratification of the Agreements, which have also been approved as to form by UMC's Office of General Counsel.

Cleared for Agenda
January 21, 2026

Agenda Item #
7

A Clark County business license is not required as UMC is the provider of hospital services to this insurance fund.

Facility Participation Agreement

This Agreement is entered into by and between UnitedHealthcare Insurance Company, contracting on behalf of itself, PacifiCare of Nevada, Inc. and the other entities that are United's Affiliates (collectively referred to as "United") and University Medical Center Of Southern Nevada ("Facility").

This Agreement is effective on November 1, 2025 (the "Effective Date").

In the event this Agreement has not been executed timely in relation to the Effective Date, no interest or penalty otherwise required under applicable law will be due on any claim which was initially processed timely and accurately, but which requires reprocessing as a result of the untimely execution.

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

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

The parties therefore enter into this Agreement.

Article I
Definitions

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

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

1.2 **Covered Service** is a health care service or product for which a Customer is entitled to receive coverage from a Payer, pursuant to the terms of the Customer's Benefit Plan with that Payer.

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

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

1.5 **Facility Records** are Facility's medical, financial and administrative records related to Covered Services rendered by Facility under this Agreement, including claims records.

1.6 **Payment Policies** are the guidelines adopted by United for calculating payment of claims to providers of health care services. The Payment Policies operate in conjunction with the specific reimbursement rates and terms set forth in this Agreement. The Payment Policies may change from time to time as described in section 5.1 of this Agreement.

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

1.8 **Protocols** are the programs and administrative procedures adopted by United or a Payer to be followed by Facility in providing services and doing business with United and Payers under this Agreement. Protocols may include, among other things, credentialing and recredentialing processes, utilization management and care management processes, quality improvement, peer

review, Customer grievance, or concurrent review. Protocols may change from time to time as described in section 4.4 of this Agreement.

1.9 **Subcontractor** is an individual or entity contracted or otherwise engaged by a party to this Agreement.

1.10 **United Affiliates** are those entities controlling, controlled by, or under common control with UnitedHealthcare Insurance Company.

Article II
Representations and Warranties

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

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

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

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

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

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

vi) Each submission of a claim by Facility pursuant to this Agreement will be deemed to constitute the representation and warranty by Facility to United that (a) the representations and warranties of Facility set forth in this section 2.1 and elsewhere in this Agreement are true and correct as of the date the claim is submitted, (b) Facility has complied with the requirements of this Agreement with respect to the Covered Services involved and the submission of the claim, (c) the charge amount set forth on the claim is the Customary Charge and (d) the claim is a valid claim.

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

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

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

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

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

Article III
Applicability of this Agreement

3.1 Facility's services.

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

In the event Facility intends to begin providing services at other service locations or under other Taxpayer Identification Number(s), Facility will provide 60 days' advance notice to United. Those additional service locations or Taxpayer Identification Numbers will become subject to this Agreement only upon the written agreement of the parties. This subsection 3.1(i) applies to cases when Facility adds the location itself (such as through new construction or through conversion of a free-standing location to provider-based), and when Facility acquires, merges with or otherwise becomes affiliated with an existing provider that was not already under contract with United or a United Affiliate to participate in a network of health care providers.

ii) Facility will provide 60 days' advance notice to United in the event Facility intends to acquire or be acquired by, merge with, or otherwise become affiliated with another provider of health care services that is already under contract with United or a United Affiliate to participate in a network of health care providers. If one of these events occurs, this Agreement and the other agreement will each remain in effect and will continue to apply as they did prior to the acquisition, merger or affiliation, unless otherwise agreed to in writing by all parties to such agreements.

Similarly, Facility will provide 60 days' advance notice to United if Facility intends to buy assets of, or lease space from, a facility under contract directly with United or a United Affiliate to participate in a network of health care providers. If that occurs, and Facility provides services at that location, but does not assume the United contract held by the prior operator, Covered Services rendered at that location will be subject to the same rates and other key terms (including term and termination) as applied under the prior operator's contract.

iii) Facility will provide 60 days' advance notice to United in the event Facility intends to transfer all or some of its assets to another entity, with the result that all or some of the Covered Services subject to this Agreement will be rendered by the other entity rather than by Facility. In addition, Facility will request that United approve the assignment of this Agreement as it relates to those Covered Services, and if approved by United, Facility will ensure the other entity agrees to assume this Agreement. This subsection 3.1(iii) does not limit United's right under section 9.4 of this Agreement to elect whether to approve the assignment of this Agreement. This subsection 3.1(iii) applies to arrangements under which another provider intends to lease space from Facility, or intends to enter into a subcontract with Facility to perform services, after the Effective Date of this Agreement, so that Covered Services that were subject to this Agreement as of the Effective Date of this Agreement are rendered and billed instead by the other provider rather than by Facility after the lease or subcontract takes place.

3.2 Payers and Benefit Plans. United may allow Payers to access Facility's services under this Agreement for certain Benefit Plans, as described in Appendix 2. United may modify Appendix 2 without amendment to exclude Benefit Plans in Appendix 2 by providing 30 days prior written or electronic notice to Facility.

In addition to changes allowed above, United may make additional changes to Appendix 2 as described in section 3 of that appendix.

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

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

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

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

Article IV
Duties of Facility

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

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

4.3 **Accessibility**. Facility will be open 24 hours a day, seven days a week.

4.4 **Protocols**.

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

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

b) Facility will make reasonable commercial efforts to ensure that all Facility-based providers participate in United's network as long as this Agreement is in effect.

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

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

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

ii) **Availability of Protocols.** The Protocols will be made available to Facility online or upon request. Some or all Protocols also may be disseminated in the form of an administrative manual or guide or in other communications. Currently, the Protocols may be found at www.UHCprovider.com or as indicated in the Additional Manuals Appendix, if applicable. United will notify Facility of any changes in the location of the Protocols.

iii) **Changes to Protocols.** United may change the Protocols from time to time. United will use reasonable commercial efforts to inform Facility at least 30 days in advance of any material changes to the Protocols. United may implement changes in the Protocols without Facility's consent if the change is applicable to all or substantially all facilities of the same type offering similar services in United's network, and are located in the same state as Facility. Otherwise, changes to the Protocols proposed by United to be applicable to Facility are subject to the requirements regarding amendments in section 9.2 of this Agreement.

In the event that Facility believes that a change in the Protocols would result in increased costs for the Facility, Facility may, no later than 90 days after the effective date of the change, provide written notice to United of that belief. The notice must explain and quantify the projected financial impact to Facility of the change in the Protocols. In the event Facility sends such a notice, Facility and United will consult together about the issue. Both parties will work together in good faith to address and resolve the issues in a mutually satisfactory manner. If the issue is not resolved to Facility's satisfaction, Facility may initiate dispute resolution pursuant to Article VII of this Agreement. In the event the issue is arbitrated, the arbitration's scope will be limited to quantifying the financial impact to Facility of the change in the Protocols, and the arbitrator may award no more than the amount necessary to cover Facility's increased costs in light of that change. The change may be implemented while the dispute resolution process is proceeding, and the arbitrator cannot order that the changes not take place or be reversed. The arbitrator may also consider the impact of other changes made by United in its Protocols that have reduced Facility's costs and may balance any such reduction against the impact of the increased costs at issue.

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

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

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

TYPE OF INSURANCE	MINIMUM LIMITS
Medical malpractice and/or professional liability insurance	$5,000,000.00 per occurrence/claim and aggregate
Commercial general and/or umbrella liability insurance	$5,000,000.00 per occurrence/claim and aggregate

In lieu of purchasing the insurance coverage required in this section, Facility may self-insure any of the required insurance. Provider may elect to self-insure, in whole or in part, in the amounts and types of insurance required herein subject to the following requirements, Provider will maintain a separate reserve or trust for its self-insured programs which shall comply with all applicable laws and regulations and, if requested, provide to UnitedHealth Group a copy of the most recent evaluation of its self-insured funds prepared by an independent actuary to assure that funds are available at all times to pay claims in the amounts required above.

4.8 **Notice by Facility**. Facility will give notice to United within 10 days after any event that causes Facility to be out of compliance with section 4.6 or 4.7 of this Agreement. Facility will give notice to United at least 30 days prior to any change in Facility's name, ownership, control, NPI, or Taxpayer Identification Number.

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

4.10 **Maintenance of and access to records**.

i) **Maintenance.** Facility will maintain Facility Records for at least 10 years following the end of the calendar year during which the Covered Services are provided, unless a alternate retention period is required by applicable law.

ii) **Access to Agencies.** Facility will provide access to Facility Records to agencies of the government, in accordance with applicable law, to the extent access is necessary to comply with the requirements of such agencies as applicable to Facility, United or Payers.

iii) **Access to United.** Facility will provide United or its designees access to Facility Records for purposes of United's health care operations and other administrative obligations, including without limitation, utilization management, quality assurance and improvement, claims payment, and review or audit of Facility's compliance with the provisions of this Agreement and appropriate billing practices.

Facility will provide access to Facility Records by providing United electronic medical records ("EMR") access and electronic file transfer. When the requested Facility Records are not available through EMR access and electronic file transfer, Facility will submit those Facility Records through other means reasonably acceptable to United, such as facsimile, compact disc, or mail, that is suitable to the purpose for which United requested the Facility Records.

Facility Records provided by EMR access will be available to United on a 24 hour/7 day a week basis. Facility Records provided by electronic file transfer will be available to United within 24 hours of United's request for those Facility Records or a shorter time as may be required for urgent requests for Facility Records. Facility Records provided by other means will be available in the time frame specified in the request for the Facility Records; provided, however, Facility will have up to 30 days to provide the Facility Records for requests not related to urgent requests. Urgent requests are those requests for Facility Records to address allegations of fraud or abuse, matters related to the health and safety of a Customer, or related to an expedited appeal or grievance.

Facility may meet the requirements of this section 4.10 directly or through a subcontractor.

iv) **Audits.** Pursuant to paragraph (iii) above, United may request Facility Records from Facility for purposes of performing an audit of Facility's compliance with this Agreement, Facility's billing practices, or United's health care operations, including without limitation claims payments. In addition, United may perform audits at Facility's locations upon 14 days' prior notice. Facility will cooperate with United on a timely

basis in connection with any such audit including, among other things, in the scheduling of and participation in an interview to review audit findings, within 30 days after United's request.

v) When Facility has provided records through EMR access or file transfer, United will not request duplicative paper records from Facility.

vi) Upon invoice from Facility, United will pay for copies of Facility Records requested by United in cases where United requests the Facility Records more than once and the Facility Records are requested for some purpose other than claims processing, coverage determinations, other routine health benefits administration, or claim accuracy. Payment for paper copies will be made at a rate of $0.25 cents per page, not to exceed a total of $25.00 per record, plus postage. Payment for electronic copies on portable media will be made at a rate of $25.00, plus postage. Payment will be made at the rates set forth in this section unless a different rate is required under applicable law.

4.11 Access to data. Facility represents that in conducting its operations, it collects and reviews certain quality data relating to care rendered by Facility that is reported in a manner which has been validated by a third party as having a clear, evidence-based link to quality or safety (e.g., AHRQ standards) or which has been created by employer coalitions as proxies for quality (e.g., Leapfrog standards).

United recognizes that Facility has the sole discretion to select the metrics which it will track from time to time and that Facility's primary goal in so tracking is to advance the quality of patient care. If the information that Facility chooses to report on is available in the public domain in a format that includes all data elements required by United, United will obtain quality information directly from the source to which Facility reported. If the Facility does not report metrics in the public domain, on a quarterly basis, Facility will share these metrics with United as tracked against a database of all discharged, commercial patients (including patients who are not United customers). United may publish this data to entities to which United renders services or seeks to render services, and to Customers. Notwithstanding the foregoing, Facility agrees that it will participate in The Leapfrog Group's annual patient safety survey if Facility is among the hospitals Leapfrog seeks to survey.

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

4.13 Electronic connectivity. When made available by United, Facility will do business with United electronically, including EMR access and connectivity, and HL7 admission discharge and transfer (ADT). Facility will use the UnitedHealthcare LINK (LINK) service tool, found at www.UHCprovider.com, and/or other electronic connectivity as available, to check eligibility status, claims status, and submit requests for claims adjustment for products supported by United's online resources and other electronic connectivity. Facility will use LINK or other tools for additional functionalities (for example, notification of admission, prior authorization and any other available transaction or viewing) after United informs Facility that these functionalities have become available for the applicable Customer.

4.14 Implementation of quality improvement and patient safety programs. Facility will implement quality programs applicable to Facility that are recommended by nationally recognized third parties (such as The Leapfrog Group and CMS), as designated by United from time-to-time, such as The Leapfrog Group's programs related to Computer Physician Order Entry (CPOE), Evidence-based Hospital Referral (EHR), ICU Physician Staffing (IPS), and the 27

other patient safety practices arrived at by national consensus (National Quality Forum Safe Practices), as may be updated from time to time in the Protocols.

4.15 **Never events**. In the event a "never event" occurs in connection with Facility rendering services to a Customer, Facility will take the then current steps recommended by the Leapfrog Group. At present, these steps are set forth in the Leapfrog Group's "Position Statement on Never Events" (http://www.leapfroggroup.org) and are as follows:

i) Apologize to the patient and/or family affected by the never event.

ii) Report the event to United and to at least one of the following agencies: The Joint Commission, as part of its Sentinel Events policy; state reporting program for medical errors; or a Patient Safety Organization (e.g. Maryland Patient Safety Center).

iii) Perform a root cause analysis, consistent with instructions from the chosen reporting agency.

iv) Waive all costs directly related to the event. In order to waive such costs, Facility will not submit a claim for such costs to United or Payer (except as required by an applicable Payment Policy) and will not seek or accept payment for such costs from the Customer or anyone acting on behalf of the Customer.

v) Interview patients and/or families who are willing and able, to gather evidence for the root cause analysis.

vi) Inform the patient and/or his/her family of the action(s) that Facility will take to prevent future recurrences of similar events based on the findings from the root cause analysis.

vii) Have a protocol in place to provide support for caregivers involved in never events, and make that protocol known to all caregivers and affiliated clinicians.

viii) Perform an annual review to ensure compliance with each element of Leapfrog's Never Events Policy for each never event that occurred.

ix) Make a copy of this policy available to patients upon request.

For purposes of this section 4.15, a "never event" is an event included in the list of "serious reportable events" published by the National Quality Forum (NQF), as the list may be updated from time to time by the NQF and adopted by Leapfrog.

Article V
Duties of United and Payers

5.1 **Payment of claims**. As described in further detail in Article VI of this Agreement, Payers will pay Facility for rendering Covered Services to Customers. United will make its Payment Policies available to Facility online and upon request. United may change its Payment Policies from time to time. If United makes a change to a Payment Policy, United will provide Facility with written or electronic notice of the change, except when a change is generally consistent with the approach followed by CMS or other recognized industry authority or that merely incorporates updated information published by CMS or other recognized industry authority. If United changes a Payment Policy, and Facility believes that the change in the Payment Policy would inappropriately result in reduced reimbursement for Facility, Facility may provide written notice to United of that belief within 90 days after the effective date of that change; the notice must explain the basis for Facility's belief and quantify the projected financial impact to Facility of the change in the Payment Policy.

If Facility sends notice, Facility and United will consult together about the issue. Both parties will work together in good faith to address the issue and resolve in a mutually satisfactory manner. If the issue raised under the previous paragraph is not resolved to Facility's satisfaction, Facility may initiate dispute resolution pursuant to Article VII of this Agreement. In the event the issue is arbitrated, the arbitration's scope will be limited to determining whether the change would inappropriately result in reduced reimbursement for Facility and, if so, quantifying the financial impact to Facility of the change in the Payment Policy; the arbitrator may award no more than the amount necessary to cover Facility's reduced reimbursement for the then-current term of this Agreement. The arbitrator may also consider the impact of other changes made by United in its Payment Policies that have increased Facility's reimbursement, and may balance any such increases against the impact of the reimbursement reduction at issue. The change in Payment Policy may be implemented regardless of the pendency of any dispute resolution process under this paragraph, and the arbitrator cannot order that the change not take place or be reversed. This paragraph does not apply to a change that merely incorporates updated information published by CMS or other recognized industry authority into a Payment Policy that is already based on that authority.

In the event of a direct conflict between a Payment Policy and any of the payment appendices to this Agreement, the payment appendix will prevail.

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

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

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

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

5.6 **Electronic connectivity**. As described in section 4.13 of this Agreement, United will do business with Facility electronically. United will communicate enhancements in its electronic connectivity functionality as they become available.

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

Article VI
Submission, Processing, and Payment of Claims

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

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

6.3 **Time to file claims**. Unless a longer timeframe is required under applicable law, all information necessary to process a claim must be received by United no more than 120 days from the date Covered Services are rendered. If Payer is not the primary payer on a claim, and Facility is pursuing payment from the primary payer, the period in which Facility must submit the claim will begin on the date Facility receives the claim response from the primary payer.

6.4 **Payment of claims for Covered Services**. Payer will pay claims for Covered Services according to the amount specified in the applicable Payment Appendix(ices) to this Agreement and in accordance with Payment Policies.

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

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

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

A) This section 6.5(A) does not initially apply to the following Benefit Plans ("Excluded Benefit Plans"):

(1) Benefit Plans listed in the Additional Manuals Appendix to this Agreement, if such Appendix is included in this Agreement.

Excluded Benefit Plans are subject to section 6.5(B) below. If in the future United modifies the utilization management program applicable to the Excluded Benefit Plans, so as to make that program consistent with the utilization management program that applies to the other Benefit Plans subject to this Agreement, United may cause this entire section 6.5(A) to apply to those Excluded Benefit Plans by giving 90 days written notice to Facility.

i) **Non-compliance with Protocol**. Compliance with Protocols and timely claim filing are conditions precedent to payment under this Agreement. United will, deny payment in whole or in part if Facility does not comply with a Protocol or does not file a timely claim as required under the Agreement.

In the event payment is denied under this subsection 6.5(A)(i) for Facility's failure to comply with a Protocol regarding notification or regarding lack of coverage approval on file, Facility may request reconsideration of the denial, and the denial under this subsection 6.5(A)(i) will be reversed if Facility can show:

a) the denial was incorrect because Facility complied with the Protocol; or

b) Facility's services were medically necessary (as "medically necessary" is defined in subsection 6.5(A)(vii)); or

c) at the time the Protocols required notification or prior authorization, Facility did not know and was unable to reasonably determine that the patient was a Customer, Facility took reasonable steps to learn that the patient was a Customer, and Facility promptly submitted a claim after learning the patient was a Customer.

The grounds stated in clause (b) above are also a basis for reconsideration of a denial under subsection (iii), (iv) or (v) of this section 6.5(A).

The grounds stated in clause (c) above are also a basis for reconsideration of a denial for lack of timely claim filing under section 6.3 of this Agreement.

A claim denied under this subsection 6.5(A)(i) is also subject to denial for other reasons permitted under the Agreement; reversal of a denial under this subsection 6.5(A)(i) does not preclude United from upholding a denial for one of these other reasons.

ii) **Non-Covered Services**. Services not covered under the applicable Benefit Plan are not subject to the rates or discounts of this Agreement. Facility may seek and collect payment from a Customer for such services (provided that Facility obtained the Customer's written consent), except as provided below in subsections 6.5(A)(iv), (v) and (vi).

If an inpatient service is not a Covered Service because a discharge order has been written by a physician treating the Customer but the Customer has elected to remain an inpatient, Facility may seek and collect payment from the Customer for those non-Covered Services, but only if, (a) prior to receiving the service, the Customer had knowledge of the discharge order and the lack of coverage for additional inpatient service and specifically agreed in writing to be responsible for payment of those charges; or (b) Facility maintains a written record of the Customer's refusal to agree in writing to be responsible for those charges.

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

iv) **Clinical review of inpatient bed days**. If a determination is made after a Customer becomes an inpatient that services are not medically necessary (including cases in which some days are determined to be medically necessary and additional days in the same admission are determined to not be medically necessary), the claim with regard to services that are not medically necessary (including room, board, and other services for a given day) may be denied and Facility must not seek or collect payment from the Customer. Payment will be made in accordance with the applicable payment appendix for the part of the admission that is determined to be medically necessary, and Facility may collect from the Customer the applicable copayment, deductible or coinsurance for that part of the admission. A claim may also be denied in whole or in part under this subsection 6.5(A)(iv) in cases in which services cannot be determined to be medically necessary due to omission of information or failure to respond timely to United's request for information; Facility may request reconsideration of such a denial on grounds of medical necessity.

United will not reduce payment under this subsection 6.5(A)(iv) when the contract rate for the claim is not impacted by the length of stay, because the contract rate is determined

by an MS-DRG or similar methodology and is not subject to an inpatient outlier provision.

v) **Level of care determinations**. United may determine that the level of care provided for a given service was not medically necessary, because the service could appropriately have been rendered at a lower level of care (for instance, observation or ambulatory surgery rather than inpatient). If Facility submits a claim for the level of care deemed not medically necessary, United may deny the claim, and Facility will not seek or collect payment from the Customer. A claim may also be denied in whole or in part under this subsection 6.5(A)(v) in cases in which services cannot be determined to be medically necessary due to omission of information or failure to respond timely to United's request for information; Facility may request reconsideration of such a denial on grounds of medical necessity.

vi) **Delay in service**. If United determines that Facility did not execute a physician's written order (for instance, an admission order) in a timely manner and that, as a result, the Customer's inpatient stay was lengthened, United may deny the claims with regard to the bed day(s) at the end of the stay that would not have been needed were it not for the delay in service (including room, board and other services for the given day), and process the claim based on the contract rate that would apply without that day(s); Facility will not seek or collect payment from Customer in excess of the coinsurance, copayment or deductible associated with the claim as processed.

United will not reduce payment under this subsection 6.5(A)(vi) when the contract rate for a claim is not impacted by the length of stay, because the contract rate is determined by an MS-DRG or similar methodology and is not subject to an inpatient outlier provision.

vii) **Definition**. As used in subsection 6.5(A)(iii), "medical necessity" or "medically necessary" will be defined in accordance with the applicable Benefit Plan and applicable law or regulatory requirements.

As used in subsections 6.5(A)(i), (iv) and (v), "medical necessity" or "medically necessary" is defined as follows:

Medically Necessary - health care services provided for the purpose of preventing, evaluating, diagnosing or treating a sickness, injury, substance use disorder, condition, disease or its symptoms, that are all of the following as determined by United or its designee, within its sole discretion.

- In accordance with *Generally Accepted Standards of Medical Practice*.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the customer's sickness, injury, substance use disorder, disease or its symptoms.
- Not mainly for the Customer's convenience or that of the Customer's physician or other health care provider.
- Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Customer's sickness, injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally

recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on physician specialty society recommendations or professional standards of care may be considered. United reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within United's sole discretion.

B) This section 6.5(B) only applies to Excluded Benefit Plans.

Compliance with Protocols and timely claim filing are conditions precedent to payment under this Agreement. Payment will be denied in whole or in part if Facility does not comply with a Protocol or does not file a timely claim as required under this Agreement. Payment may also be denied for services provided that are determined by United to be medically unnecessary, and Facility may not bill the Customer for such services unless the Customer has, with knowledge of United's determination of a lack of medical necessity, agreed in writing to be responsible for payment of those charges.

In the event that payment of a claim is denied for lack of notification or for untimely filing, the denial will be reversed if Facility appeals within 12 months after the date of denial and can show all of the following:

i) that, at the time the Protocols required notification or at the time the claim was due, Facility did not know and was unable to reasonably determine that the patient was a Customer,
ii) that Facility took reasonable steps to learn that the patient was a Customer, and
iii) that Facility promptly provided notification, or filed the claim, after learning that the patient was a Customer.

This Agreement does not apply to services not covered under the applicable Benefit Plan. Facility may seek and collect payment from a Customer for such services, provided that the Facility first obtains the Customer's written consent.

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

However, such information provided by United is subject to change retroactively, under any of the following circumstances:

i) if United has not yet received information that an individual is no longer a Customer;

ii) if the individual's Benefit Plan is terminated retroactively for any reason including, but not limited to, non-payment of premium;

iii) as a result of the Customer's final decision regarding continuation of coverage pursuant to state and federal laws; or

iv) if eligibility information United receives is later proven to be false.

If Facility provides health care services to an individual, and it is determined that the individual was not a Customer at the time the health care services were provided, those services are not

payable under this Agreement and any payments made with regard to those services may be recovered as overpayments under the process described in section 6.10 of this Agreement. Facility may then directly bill the individual, or other responsible party, for those services.

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

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

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

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

iii) Payer's Payment Policies,

iv) inaccurate or incorrect claim processing,

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

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

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

Facility may seek payment directly from the Payer or from Customers upon 15 days prior notice to United, after Facility seeks and receives confirmation from United that the Payer is in default (other than a default covered by the above clause (v) of this section 6.8).For purposes of this paragraph, a default is a systematic failure by a Payer to fund claims payments related to Customers covered through that Payer. A default does not occur in the case of a dispute as to whether certain claims should be paid or the amounts that should be paid for certain claims.

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

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

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

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

Recovery of overpayments may be accomplished by offsets against future payments. United will provide written or electronic notice to Facility before using an offset as a means to recover an overpayment, and will not implement the offset if, within 45 days after the date of the notice, Facility refunds the overpayment or initiates an appeal.

Article VII
Dispute Resolution

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

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

If the parties are unable to resolve any such Dispute within 60 days following the date one party sent written notice of the Dispute to the other party, and if either party wishes to pursue the Dispute, it may do so only by submitting the Dispute to binding arbitration conducted by the American Arbitration Association ("AAA") in accordance with the AAA Healthcare Payor Provider Arbitration Rules, as they may be amended from time to time (see http://www.adr.org), except that, in any case involving a Dispute in which a party seeks an award of $1,000,000 or greater or seeks termination of this Agreement, a panel of three arbitrators will be used; a single arbitrator cannot award $1,000,000 or more or order that this Agreement is terminated. The arbitrator(s) will be selected from the AAA National Healthcare Roster (as described in the AAA Healthcare Payor Provider Arbitration Rules) or the AAA's National Roster of Arbitrators (as described the AAA Commercial Arbitration Rules and Mediation Procedures). Unless otherwise agreed to in writing by the parties, if the party wishing to pursue the Dispute does not initiate the arbitration within one year after the date on which written notice of the Dispute was given, or, for Disputes subject to the procedures or processes described in the previous paragraph, within one year after the completion of the applicable procedure or process, it will have waived its right to pursue the Dispute in any forum.

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

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

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

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

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

This Article VII will survive any termination of this Agreement.

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

Article VIII
Term and Termination

8.1 **Term**. This Agreement shall take effect on November 1, 2025. Commercial products will have an initial term of three years ending, on October 31, 2028, at 11:59 pm. Medicare Advantage products covered under this Agreement shall take effect on November 1, 2025, and have an initial term of one year, ending on October 31, 2026, at 11:59pm.

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

i) by mutual written agreement of the parties;

ii) by either party, upon at least 180 days' prior written notice, effective at the end of the initial term or effective at the end of any renewal term;

iii) by either party, upon 60 days' prior written notice, in the event of a material breach of this Agreement by the other party, which notice will include a specific description of the alleged breach; however, the termination will not take effect if the breach is cured within 60 days' after notice of the termination, or if the termination is deferred under Article VII of this Agreement;

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

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

vi) by United, immediately upon written notice, in the event:

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

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

8.3 Ongoing Services to certain Customers after termination takes effect.

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

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

ii) **Medicare Advantage Customers**. This section 8.3(ii) only applies if Facility participates in networks for Medicare Advantage Benefit Plans under this Agreement.

a) Ninety days prior to the effective date of the termination or expiration of this Agreement, United may remove Facility from any provider directory, online or in print, unless the parties agree otherwise.

b) To protect existing Medicare Advantage Customers who are patients of Facility from the disruption caused by the termination or expiration of this Agreement during the course of the Customer's Benefit Plan year, Facility will continue to provide Covered Services, and the terms of this Agreement will continue to apply, to Medicare Advantage Customers who have an existing relationship with Facility on the date the termination or expiration would be effective under the notice through the end of the calendar year. If the effective date of the termination or expiration would otherwise

occur during the month of December, Facility will continue to provide Covered Services, and the terms of this Agreement will continue to apply, to such Medicare Advantage Customers through the end of the following calendar year. However, payment to Facility for such continued care, as described in this paragraph, will be the greater of the contract rate in place at the time the termination or expiration of the Agreement would have been effective, or 101% of CMS.

Section 8.3(b) does not apply if United has terminated this Agreement due to:

1) an uncured material breach,

2) Facility losing licensure or other governmental authorization necessary to perform this Agreement, or

3) Facility failing to have insurance as required under section 4.7 of this Agreement.

Article IX
Miscellaneous Provisions

9.1 **Entire Agreement**. In order for this Agreement to be binding, it must be executed by all parties through written or electronic signature. This Agreement is the entire agreement between the parties with regard to its subject matter, and supersedes any prior written or unwritten agreements between the parties or their affiliates with regard to the same subject matter.

9.2 **Amendment**. In order for an amendment to this Agreement to be binding, it must be executed by all parties through written or electronic signature, except as otherwise provided in this section 9.2.

Additionally, United may amend this Agreement upon written notice to Facility in order to comply with applicable regulatory requirements but only if that amendment is imposed on a similar basis to all or substantially all of the facilities in United's network that would be similarly impacted by the regulation in question. United will provide at least 30 days' notice of any such regulatory amendment, unless a shorter notice period is necessary in order to comply with regulatory requirements.

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

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

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

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

9.6 **No third-party beneficiaries**. United and Facility are the only entities with rights and remedies under this Agreement. Any claims, collection actions or disputes may not be assigned, transferred or sold by either party without the written consent of the other party.

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

9.8 **Notice procedures**. Any notice required to be given under this Agreement must be in writing, except in cases in which this Agreement specifically permits electronic notice, or as otherwise permitted or required in the Protocols. Acceptable forms of written notice include, first class mail, certified mail, or overnight delivery by a national, recognized delivery service. All notices of termination of this Agreement by either party must be sent by certified mail, return receipt requested, addressed to the appropriate party at the address set forth on the signature portion of this Agreement. Each party will provide the other with proper addresses, electronic mail addresses. All notices will be deemed received upon receipt by the party to which notice is given or on the 5th business day following mailing, whichever occurs first.

9.9 **Confidentiality.** Neither party may disclose to a Customer, other health care provider, or other third party any of the following information (except as required by an agency of the government court order, other third party, or applicable laws or regulations):

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

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

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

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

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

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

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

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

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

9.14 **Fines; Penalties**. Facility will be responsible for any and all fines or penalties that may be assessed against United by any government agency that arise from Facility's failure to execute, deliver or perform its obligations under this Agreement.

9.15 **Counterpart Execution**. This Agreement may be executed in counterparts and sent via .pdf or facsimile each of which shall be deemed an original but all of which when taken together shall constitute but one and the same instrument.

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

University Medical Center Of Southern Nevada, as signed by its authorized representative: Signature: Mason Van Houweling	*Address to be used for giving notice to Facility under this Agreement:* Street: 1800 W CHARLESTON BLVD
Print Name: Mason Van Houweling	City: LAS VEGAS
Title: CEO	State: NV Zip Code: 89102
Date: 12/18/2025	E-mail:
UnitedHealthcare Insurance Company, on behalf of itself, PacifiCare of Nevada, Inc. and the other entities that are United Affiliates, as signed by its authorized representative: Signature: Jean McFarlane (12/17/2025 17:32:58 CST)	
Print Name: Jean McFarlane	
Title: Vice President, Network Contracting	
Date: 12/17/2025	

Address to be used for giving notice to United under this Agreement:
UnitedHealthcare

Attn: Network Market VP MN103

6022 Blue Circle Drive

Minnetonka, MN 55343

For office use only:

Contract Number: 83640051

Month, day and year in which Agreement is first effective:

Appendix 1
Facility Location and Service Listings
University Medical Center of Southern Nevada

[The information in this attachment is confidential and proprietary in nature.]

Appendix 2

Benefit Plan Descriptions

[The information in this attachment is confidential and proprietary in nature.]

Additional Manuals Appendix

[The information in this attachment is confidential and proprietary in nature.]

MEDICARE ADVANTAGE REGULATORY REQUIREMENTS APPENDIX

[The information in this attachment is confidential and proprietary in nature.]

Nevada Regulatory Requirements Appendix

[The information in this attachment is confidential and proprietary in nature.]

Per Diem

All Payer Appendix

[The information in this attachment is confidential and proprietary in nature.]

Payment Appendix Medicare Advantage

MS-DRG with APC

APPLICABILITY

[The information in this attachment is confidential and proprietary in nature.]

Ancillary Provider Participation Agreement

This Agreement is entered into by and between UnitedHealthcare Insurance Company, contracting on behalf of itself and the other entities that are United's Affiliates (collectively referred to as "United") and University Medical Center of Southern Nevada ("Ancillary Provider") for the purposes of making Ancillary Provider's services available to Members through one or more networks of providers maintained by United.

This Agreement is effective on November 1, 2025 (the "Effective Date").

Article I
Definitions

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

1.1 Benefit Plans.

- **Benefit Plan**: A certificate of coverage, summary plan description, or other document or agreement, whether delivered in paper or electronic format, under which a Payer is obligated to provide coverage of Covered Services for a Member.
- **Medicare Advantage Benefit Plans:** Benefit Plans sponsored, issued or administered by a Medicare Advantage organization as part of:

  i) the Medicare Advantage program under Title XVIII, Part C of the Social Security Act, or

  ii) the Medicare Advantage program together with the Prescription Drug program under Title XVIII, Part C and Part D, respectively, of the Social Security Act,

  as those program names may change from time to time.
- **Non-Governmental Benefit Plans:** Benefit Plans other than Medicare Advantage Benefit Plans or State Government Program Benefit Plans.
- **Participating Benefit Plans:** Those Medicare Advantage Benefit Plans, Non-Governmental Benefit Plans, and State Government Program Benefit Plans in which Ancillary Provider participates as described in the Network Participation Appendix.
- **State Government Program Benefit Plans:** Medicaid Benefit Plans, CHIP Benefit Plans, Medicaid Long Term Care Benefit Plans, Benefit Plans for the Uninsured, and Other Governmental Benefit Plan, as each may be described in the Network Participation Appendix.

1.2 Provider.

- **Customary Charge:** The fee for health care services charged by Ancillary Provider that does not exceed the fee Ancillary Provider would ordinarily charge another person regardless of whether the person is a Member.
- **Ancillary Provider Records:** Ancillary Provider's medical, financial and administrative records related to Covered Services rendered by Ancillary Provider under this Agreement, including claims records.

1.3 Payer and Member.

- **Alternate Payer:** An entity, other than a Payer, that has an agreement, directly or indirectly, with a Payer (as defined in this Agreement) that authorizes that entity to access Ancillary Provider's services under this Agreement. Alternate Payers may include, but are not limited to, insurance carriers, workers compensation insurance carriers, risk management entities, claims management entities, and third-party administrators. Any references to "Payer" in this Agreement include Alternate Payers, unless otherwise expressly provided for herein or in the applicable Supplement or other Protocol.

- **Covered Service:** A health care service or product for which a Member is entitled to receive coverage from a Payer, pursuant to the terms of the Member's Benefit Plan with that Payer.

- **Member:** A person eligible and enrolled to receive coverage from a Payer for Covered Services.

- **Payer:** An entity obligated to a Member to provide reimbursement for Covered Services under the Member's Benefit Plan, and authorized by United to access Ancillary Provider's services under this Agreement.

1.4 General.

- **Expansion:** Any of the following situations: (a) providing health care services or products at a service location that is not an Included Service Location, (b) providing health care services or products under a Taxpayer Identification Number that is not an Included TIN, (c) any acquisition of or affiliation with another ancillary provider or group of healthcare providers, regardless of the form or structure of such transaction, or (d) offering services as a New Provider Type.

- **Divestiture:** Any of the following situations: (a) any divestiture of an Included Service Location or entity with an Included TIN, or (b) Ancillary Provider's cessation of the provision of health care services or products at an Included Service Location or under an Included TIN (whether via dissolution or otherwise).

- **Included Service Location:** Those locations included on the Service Locations Appendix or added in accordance with the Ancillary Provider Service Location provisions of this Agreement.

- **Included TIN:** Those Taxpayer Identification Numbers included on the Service Locations Appendix or added in accordance with the Ancillary Provider Service Location provisions of this Agreement.

- **New Provider Type:** Any type of health care provider other than urgent care center.

- **Out of Scope Location**: Any location outside Clark.

- **Protocols:** The programs and administrative procedures established by United or a Payer to be followed by Ancillary Provider in providing services and doing business with United and Payers under this Agreement. Protocols may include credentialing and recredentialing processes, utilization management and care management processes, quality improvement, peer review, Member grievance, concurrent review, or administrative manuals or guides. The Protocols are available online at www.UHCprovider.com or a successor location. The Administrative Guide Supplements Appendix contains additional information regarding the Protocols applicable to Members enrolled in certain Benefit Plans.

- **Proposed Change**: Ancillary Provider's proposed change(s) to Included Service Locations and/or Included TINs in connection with an Expansion or Divestiture, including whether Ancillary Provider desires the impacted service location(s) or Taxpayer Identification Number(s) to be added to, deleted from, or changed on the Service Locations Appendix.

- **Reimbursement Policies:** The guidelines adopted by United for calculating payment of claims to providers of health care services. The Reimbursement Policies operate in conjunction with the specific reimbursement rates and terms set forth in this Agreement.

- **Subcontractor:** An individual or entity contracted or otherwise engaged by a party to this Agreement.

- **United's Affiliates:** Those entities controlling, controlled by, or under common control with UnitedHealthcare Insurance Company.

Article II
Scope of Agreement

2.1 Ancillary Provider Service Locations.

i) **Service Area.** This Agreement applies only to Covered Services provided at Included Service Locations under Included TINs. Included Service Locations and Included TINs as of the Effective Date are set forth in the Service Locations Appendix to this Agreement. This Agreement will not apply to Out of Scope Locations.

ii) **Changes to the Service Locations Appendix.** Ancillary Provider will provide United with written notice, in accordance with the notice provisions of this Agreement, at least 60 days prior to the proposed effective date of any Expansion or Divestiture. Ancillary Provider's notice will include, at a minimum: (a) the proposed effective date of any Expansion or Divestiture; (b) the impacted service locations and Taxpayer Identifications Numbers; and (c) the Proposed Change. United will notify Ancillary Provider within 60 days after receiving such notice if United agrees to the Proposed Change and, if applicable, the effective date of the Proposed Change.

iii) **Expansion.** Notwithstanding an Expansion, then, unless and until United agrees in writing otherwise:

a) This Agreement will remain in effect with respect to each Included Service Location and Included TIN prior to the Expansion.

b) This Agreement will not apply to health care services or products provided by an acquired ancillary provider or group of healthcare providers, by or at a New Provider Type, at any service location that is not an Included Service Location, or through any Taxpayer Identification Number that is not an Included TIN.

c) Any network participation agreement between United and any third party involved in the Expansion will remain in effect and will continue to apply as it did before the Expansion unless otherwise agreed to in writing by all parties to such agreements.

iv) **Divestiture**. Notwithstanding a Divestiture, unless and until United agrees in writing otherwise:

a) This Agreement will remain in effect with respect to each Included Service Location prior to the Divestiture. The Parties agree that the intent of this provision is to continue to apply Ancillary Provider's existing rates and agreement terms to each Included Service Location, irrespective of any Divestiture.

b) This Agreement will not apply to health care services or products provided at any service location that is not an Included Service Location.

c) Any network participation agreement between United and any third party involved in the Divestiture will remain in effect and continue to apply as it did before the Divestiture unless otherwise agreed to in writing by all parties to such agreement.

v) **Payment Rates.** Notwithstanding anything in this section, if an Expansion or Divestiture involves another provider of health care services subject to another network participation agreement with United, the payment rates under this Agreement and the other agreement will be, as decided by United, either this Agreement's payment rates and the other agreement payment rates.

2.2 Network Participation. United may allow Payers to access Ancillary Provider's services under this Agreement for certain Benefit Plan types, as described in the Network Participation Appendix.

i) United reserves the right at any time to designate Ancillary Provider as participating in (a) one or more Benefit Plan types and/or (b) certain specific Benefit Plans within a given Benefit Plan type. United will provide Ancillary Provider with 30 days' prior notice of the new Benefit Plan types and/or specific Benefit Plans within a given Benefit Plan type, along with the payment terms, regulatory requirements, and new Protocols (if any) applicable to the new Benefit Plans.

a) If the payment terms for such Benefit Plans are not different from the payment terms for Benefit Plans in which Ancillary Provider already is participating within the associated Benefit Plan type, then Ancillary Provider will accept such new Benefit Plans and payment terms and will comply with any related regulatory requirements.

b) If the payment terms for such Benefit Plans are different from the payment terms for Benefit Plans in which Ancillary Provider already is participating within the associated Benefit Plan type and Ancillary Provider does not object to the implementation of such new Benefit Plans and payment terms within the 30 days' notice period, Ancillary Provider will be deemed to have accepted the new Benefit Plans and new payment terms. In the event Ancillary Provider objects to the new Benefit Plans and new payment terms within the 30 days' notice period, the parties will confer in good faith to reach agreement. If such agreement cannot be reached, such new Benefit Plans, payment terms and any related regulatory requirements not previously applicable will not apply to this Agreement.

ii) United reserves the right at any time to exclude Ancillary Provider from participation:(a) in one or more Benefit Plan types and/or (b) in certain specific Benefit Plans within a given Benefit Plan type. United will provide Ancillary Provider with 30 days' prior notice of the excluded Benefit Plan types and/or specific Benefit Plans within a given Benefit Plan type. The section of this Agreement discussing ongoing services will apply to Covered Services

provided to Members covered by Benefit Plans from which Ancillary Provider is excluded from participating as described in this paragraph.

iii) United may have Capitation arrangements in place with one or more Capitated Organizations. If Ancillary Provider is the Capitated Organization, United will have a separate agreement with Ancillary Provider for the Capitation arrangement. The applicable Benefit Plan types under the Capitation arrangement will be set forth in that agreement. When United has a Capitation arrangement in place with Capitated Organizations, whether that is with Ancillary Provider or another entity, the provisions in the attached Capitation Arrangements and Financial Responsibility Appendix will apply. For purposes of this subsection, the terms "Capitation" and "Capitated Organization" are defined in the Capitation Arrangements and Financial Responsibility Appendix.

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

2.4 Communication with Members. Nothing in this Agreement is intended to limit Ancillary Provider's right or ability to communicate fully with a Member and the Member's physician regarding the Member's health condition and treatment options. Ancillary Provider is free to discuss all treatment options without regard to whether a given option is a Covered Service. Ancillary Provider is free to discuss with a Member Ancillary Provider's financial arrangements under this Agreement. Ancillary Provider may also assist a Member in estimating the cost of a given Covered Service.

2.5 Employees and Subcontractors. Each party will ensure that its employees, affiliates, and any Subcontractors engaged to render services in connection with this Agreement adhere to the requirements of this Agreement. A party's use of such employees, affiliates and Subcontractors will not limit its obligations and accountability under this Agreement.

2.6 Licensure. Each party will maintain, without material restriction, such licensure, registration, and permits as are necessary to enable that party to lawfully perform this Agreement.

2.7 Liability insurance.

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

ii) **Ancillary Provider Liability insurance.** Ancillary Provider will procure and maintain liability insurance. Except to the extent coverage is a state mandated placement, Ancillary Provider's coverage must be placed with insurance carriers that have an A.M. Best Rating of A-VII or better, and that are authorized or approved to write coverage in the state in which the Covered Services are provided. Ancillary Provider's liability insurance must be, at a minimum, of the types and in the amounts set forth below. Ancillary Provider's medical malpractice insurance must be either occurrence or claims made with an extended period reporting option of at least three years. Prior to the Effective Date of this Agreement and upon written request by United, Ancillary Provider will submit to United in writing evidence of insurance coverage.

- Medical malpractice and/or professional liability: $1,000,000 per occurrence/claim and $3,000,000 aggregate
- Commercial General/Umbrella: $1,000,000 per occurrence/claim and $2,000,000 aggregate
- Automobile: $5,000,000, combined single limit

In lieu of purchasing the insurance coverage required in this section, Ancillary Provider may self-insure any of the required insurance. Ancillary Provider may elect to self-insure, in whole or in part, in the amounts and types of insurance required herein subject to the following requirements: Provider will maintain a separate reserve or trust for its self-insured programs which shall comply with all applicable laws and regulations and, if requested, provide to UnitedHealth Group a copy of the most recent evaluation of its self-insured funds prepared by an independent actuary to assure that funds are available at all times to pay claims in the amounts required above..

2.8 **Notice of certain events.** Either party will give notice to the other party within 10 days after any event that causes the noticing party to be out of compliance with the licensure and insurance provisions of this Agreement. Ancillary Provider will give notice to United at least 30 days prior to any change in Ancillary Provider's name, ownership, control, National Provider Identifier (NPI), or Taxpayer Identification Number.

2.9 **Compliance with law.** Each party will comply with applicable statutes, regulations and other regulatory requirements, including but not limited to those relating to confidentiality of Member medical information. Additionally, United will comply with applicable prompt payment of claims requirements.

2.10 **Electronic connectivity.** When made available by United, Ancillary Provider will do business with United electronically. Ancillary Provider will use the UnitedHealthcare LINK (LINK) service tool (or its successor tool), found at www.UHCprovider.com (or its successor site), Point of Care Assist (or its successor tool) and/or other electronic connectivity as available, to check eligibility status, claims status, and submit requests for claims adjustment for products supported by United's online resources and other electronic connectivity. Ancillary Provider will use LINK or other tools for additional functionalities (for example, notification of admission, prior authorization and any other available transaction or viewing) after United Informs Ancillary Provider that these functionalities have become available for the applicable Member.

In addition to the accessibility of medical records requirements set forth elsewhere in this Agreement, upon United's request, Ancillary Provider will work with United to develop a plan to provide United with real-time data interoperability for Members' medical records in Ancillary Provider's EHR, in accordance with applicable Protocols.

2.11 **Protocols**.

i) **Compliance with Protocols.** Ancillary Provider will comply with all Protocols. Ancillary Provider acknowledges that it has had the opportunity to review the Protocols as of the Effective Date. United will ensure that Payer's Protocols are generally consistent with United's and are available to Ancillary Provider.

ii) **New or Revised Protocols**. From time to time, United may establish new or revised Protocols. United will provide Ancillary Provider with notice at least 30 days in advance of a

new or revised Protocol. United may implement a new or revised Protocol without Ancillary Provider's consent if the new or revised Protocol applies to substantially all participating providers of the same type offering similar services as Ancillary Provider located in Ancillary Provider's state.

iii) **Certain Protocols Concerning Referral to and Use of Participating Providers.**

a) **Non-Emergency Services.** For non-emergency Covered Services, Ancillary Provider will assist Members to maximize their benefits by referring or directing Members only to other providers that participate in United's network, except as otherwise authorized by United through United's process for approving out-of-network services at in-network benefit levels.

b) **PCP Notification.** If the Member's Benefit Plan requires the Member to receive certain Covered Services from or upon referral by a primary care physician, Medical Group Professionals must adhere to the following additional protocols:

1) Notify Member's primary care physician of referrals to other participating or non-participating providers.

2) Render Covered Services pursuant to the terms and limitations of the referral notification issued by or on behalf of the Member's primary care physician.

3) Notify the Member's primary care physician of all admissions.

c) **Cooperation With Requests for Clinical Information.** Medical Group will provide notification for certain Covered Services, accept and return telephone calls from United staff, and respond to United requests for clinical information, as required by United or Payer as described in the Protocols.

2.12 Nondiscrimination. Parties will not discriminate against any patient because of their status as a Member, regarding (i) quality of care or (ii) accessibility of services. Additionally, Parties will not discriminate against any Member based on the following: (i) race; (ii) ethnicity; (iii) national origin; (iv) religion; (v) sex or gender; (vi) age; (vii) mental or physical disability; (viii) mental health or medical condition; (ix) sexual orientation; (x) gender identity; (xi) medical history; (xii) genetic information; (xiii) type of health insurance; (xiv) claims experience; or (xv) type of payment. Ancillary Provider will maintain policies and procedures to demonstrate Ancillary Provider does not discriminate in the delivery of Covered Services.

2.13 Accessibility. At a minimum, Ancillary Provider will be open during normal business hours, Monday through Friday.

2.14 Maintenance of and access to records.

i) **Maintenance.** Ancillary Provider will maintain Ancillary Provider Records for at least 10 years following the end of the calendar year in which the Covered Services were provided unless an alternative retention period is required by applicable law.

ii) **Access to Agencies.** Ancillary Provider will provide access to Ancillary Provider Records to agencies of the government, in accordance with applicable law, to the extent access is necessary to comply with the requirements of such agencies as applicable to Ancillary Provider, United or Payers.

iii) **Access to United.** Ancillary Provider will provide United or its designees access to Ancillary Provider Records for purposes of United's health care operations and other administrative obligations, including without limitation, utilization management, quality assurance and improvement, claims payment, and review or audit of Ancillary Provider's compliance with the provisions of this Agreement and appropriate billing practices.

Ancillary Provider will provide access to Ancillary Provider Records by providing United electronic medical records ("EMR") access and electronic file transfer. When the requested Ancillary Provider Records are not available through EMR access and electronic file transfer, Ancillary Provider will submit those Ancillary Provider Records through other means reasonably acceptable to United, such as facsimile, compact disc, or mail, that is suitable to the purpose for which United requested the Ancillary Provider Records.

Ancillary Provider Records provided by EMR access will be available to United on a 24 hour/7 day a week basis. Ancillary Provider Records provided by electronic file transfer will be available to United within 24 hours of United's request for those Ancillary Provider Records or a shorter time as may be required for urgent requests for Ancillary Provider Records. Ancillary Provider Records provided by other means will be available in the time frame specified in the request for the Ancillary Provider Records; provided, however, Ancillary Provider will have up to 30 days to provide the Ancillary Provider Records for requests not related to urgent requests. Urgent requests are those requests for Ancillary Provider Records to address allegations of fraud or abuse, matters related to the health and safety of a Member or related to an expedited appeal or grievance.

Ancillary Provider may meet the requirements of this section directly or through a Subcontractor.

iv) **Audits.** Pursuant to paragraph (iii) above, United may request Ancillary Provider Records from Ancillary Provider for purposes of performing an audit of Ancillary Provider's compliance with this Agreement, Ancillary Provider billing practices, or United's health care operations, including without limitation claims payments. In addition, United may perform audits at Ancillary Provider's locations upon 14 days' prior notice. Ancillary Provider will cooperate with United on a timely basis in connection with any such audit including, among other things, in the scheduling of and participation in an interview to review audit findings, within 30 days after United's request.

v) **Duplicative requests.** When Ancillary Provider has provided records through EMR access or electronic file transfer, United will not request duplicative paper records from Ancillary Provider.

vi) **Cost of records.** Upon invoice from Facility, United will pay for copies of Facility Records requested by United in cases where United requests the Facility Records more than once and the Facility Records are requested for some purpose other than claims processing, coverage determinations, other routine health benefits administration, or claim accuracy. Payment for paper copies will be made at a rate of $0.25 cents per page, not to exceed a total of $25.00 per record, plus postage. Payment for electronic copies on portable media will be made at a rate of $25.00, plus postage. Payment will be made at the rates set forth in this section unless a different rate is required under applicable law.

2.15 Quality improvement and patient safety programs. Ancillary Provider will implement programs recommended by nationally recognized independent third parties related to quality

improvement and patient. Ancillary Provider may also implement its own quality improvement and patient safety programs. If Ancillary Provider implements its own programs, Ancillary Provider will provide a summary of those programs to United upon request.

Article III
Covered Services and Claims

3.1 Provide Covered Services. Ancillary Provider will provide Covered Services to Members. To extent Ancillary Provider is subject to credentialing by United, Ancillary Provider must be credentialed by United or its delegate prior to furnishing any Covered Services to Members under this Agreement.

3.2 Claims Submission.

i) **Form and content of claims.**
Each submission of a claim by Ancillary Provider pursuant to this Agreement is a representation and warranty by Ancillary Provider to United that Ancillary Provider has complied with the requirements of this Agreement with respect to the Covered Services involved and the submission of the claim, the charge amount set forth on the claim is the Customary Charge, and the claim is a valid claim. Ancillary Provider must submit claims for Covered Services as described in the Protocols, using current, correct and applicable coding.

ii) **Electronic filing of claims.** Ancillary Provider will submit claims electronically to the extent United can accept claims and attachments electronically.

iii) **Time to file claims.** Unless a longer timeframe is required under applicable law, Ancillary Provider will submit claims, inclusive of all information necessary to process a claim, within 120 days from the date of service for Covered Services. If Payer is the secondary payer for a claim and Ancillary Provider is pursuing payment from the primary payer, Ancillary Provider will submit claims within 120 days of the date Ancillary Provider receives the claim response from the primary payer. For purposes of this section, the date of service for an inpatient admission is the date of discharge.

3.3 Claims Payment; Reimbursement Policies.

i) **Claims Payment.** Payer will pay claims for Covered Services in accordance with the applicable Payment Appendix(ices) to this Agreement, Reimbursement Policies, and the applicable Benefit Plan. United does not prioritize fully insured claims over self-funded claims in its claims adjudication or payment process. Claims for Covered Services subject to coordination of benefits will be paid in accordance with the Member's Benefit Plan and applicable law.

ii) **Reimbursement Policies.** United will make its Reimbursement Policies available to Ancillary Provider online and upon request. Ancillary Provider acknowledges it has had the opportunity to review the Reimbursement Policies in effect as of the Effective Date.

iii) **New or Revised Reimbursement Policies.** From time to time, United may establish new or revised Reimbursement Policies. United will provide Ancillary Provider with notice at least 30 days in advance of the new or revised Reimbursement Policy.

iv) **Over and under payments.** If Ancillary Provider does not seek correction of a given claim payment or denial by giving notice to United within 12 months after the claim was initially

processed, it will have waived any right to subsequently seek such correction under this section, or through dispute resolution under Article IV of this Agreement or in any other forum.

In seeking correction of a given claim payment or denial under this section, Ancillary Provider must provide United with a written or electronic request. Such written or electronic request must contain all information and documentation that United reasonably needs to complete review of the request and render a decision thereon. Such information and documentation may include, without limitation, one or more of the following: (i) an explanation of Ancillary Provider's basis for seeking correction; (ii) member identification number; (iii) date of service; (iv) United's claim number; (v) CPT or billing code and claim level detail; (vi) date and content of United's payment or denial decision; (vii) date and outcomes of all reconsiderations and appeals (as applicable); and (viii) specific basis for Ancillary Provider's dispute of United's reconsideration or appeal decision(s). Ancillary Provider's failure to provide a timely written or electronic request consistent with the requirements of this section will constitute a waiver of Ancillary Provider's right to seek further review of the claim payment or denial under this, or through dispute resolution pursuant to the dispute resolution provisions of this Agreement or in any other forum.

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

Recovery of overpayments may be accomplished by offsets against future payments. United will provide written or electronic notice to Facility before using an offset as a means to recover an overpayment, and will not implement the offset if, within 45 days after the date of the notice, Facility refunds the overpayment or initiates an appeal.

v) **Correction of Member eligibility.** Except in the case of emergency services, Ancillary Provider will check Member's eligibility prior to rendering services. A Member's eligibility is subject to change retroactively if:

   a) United receives a change in eligibility from a Payer;

   b) Member's coverage under a Benefit Plan is terminated for any reason including, but not limited to, non-payment of premium;

   c) Member does not elect continuation of coverage pursuant to state and federal laws (e.g., COBRA continuation coverage); or

   d) United determines a Member was not eligible because false information was provided with respect to eligibility.

This Agreement does not apply to services rendered to patients who are not Members at the time the services were rendered. If Member was not eligible on the date of service, any payments made with regard to those services may be recovered as overpayments as described in this section. Ancillary Provider may directly bill the individual, or other responsible party, for those services. United will make reasonable commercial efforts to cause Payers to process eligibility changes within 120 days.

3.4 Denial of claims.

i) **Payment and Denial of Claims.** Coverage for the service under the Member's Benefit Plan (including Medical Necessity), timely claim filing, and Ancillary Provider's compliance with Protocols are conditions precedent to payment under this Agreement. Accordingly, at its discretion, United will deny payment in whole or in part for the following reasons:

a) **Failure to File Timely Claims.** Ancillary Provider fails to file a timely claim in accordance with this Agreement.

b) **Protocol Noncompliance.** Ancillary Provider fails to comply with a Protocol (including, without limitation, a Protocol regarding notification or prior authorization).

c) **Services Not Medically Necessary or Otherwise Not Covered Under the Member's Benefit Plan.** United determines prospectively, concurrently, or retrospectively that the service is not or was not Medically Necessary or that the Member's Benefit Plan otherwise excludes coverage for the service.

d) **Failure to Provide Information.** United cannot determine whether a service is Medically Necessary because Ancillary Provider omitted information or failed to respond timely to United's request for information ("Failure to Provide Information Denial").

e) **Other Permitted Reasons.** Any other reason permitted under this Agreement.

ii) **Limitations on Member Billing for Certain Denials.**

a) **Services not Covered under the Applicable Benefit Plan.** Services not covered under the applicable Benefit Plan are not subject to the rates or discounts of this Agreement. Ancillary Provider may seek and collect payment from a Member for such services, but only if Ancillary Provider obtained the Member's written consent. The preceding sentence does not apply to Prior Authorization Denials.

b) **Prior Authorization Denials.** If United determines through the prior authorization process that a service is not Medically Necessary ("Prior Authorization Denial"), Ancillary Provider may seek or collect payment from the Member only if, prior to receiving the service, the Member had knowledge of the determination of non-coverage and specifically agreed in writing to be responsible for payment of those charges.

c) **Failure to Provide Information Denials.** If United denies payment based on a Failure to Provide Information Denial, Ancillary Provider will not seek or collect payment from the Member for the services for which United denied payment.

d) **Other Member Billing Protections Not Affected.** This section supplements the other Member billing requirements and restrictions set forth in this Agreement.

iii) **Review of Certain Denials.**

a) **Protocol Noncompliance Denials (Notification or Prior Authorization).** This section does not apply to the following Benefit Plans: UnitedHealthcare Community Plan Medicaid, CHIP and Uninsured; UnitedHealthcare West; NHP; Oxford; River Valley; and MDIPA.

Ancillary Provider may appeal a denial for Ancillary Provider's failure to comply with a Protocol regarding notification or prior authorization. The denial will be reversed only if Ancillary Provider:

1) Submits the appeal within the applicable timeframes set forth in the regulatory appendix(ices) attached to this Agreement and in the applicable Administrative Guide Supplement(s); and

2) Shows one or more of the following:

A) The denial was incorrect because Ancillary Provider complied with the Protocol, or

B) At the time the Protocol required notification or prior authorization, Ancillary Provider did not know and was unable to reasonably determine that the patient was a Member, but Ancillary Provider took reasonable steps to learn that the patient was a Member and promptly submitted a claim after learning the patient was a Member.

A denial that is upheld on appeal is not be eligible for additional review by United. Reversal of a denial under this subsection does not preclude United from upholding the denial for another permitted reason under this Agreement.

b) **Failure to File Timely Claims.** Ancillary Provider may request reconsideration of a denial for Ancillary Provider's failure to file a timely claim in accordance with this Agreement. The denial will be reversed only if Ancillary Provider:

1) Submits the reconsideration request within the applicable timeframes set forth in the regulatory appendix (ices) attached to this Agreement and in the applicable Administrative Guide Supplement(s);

2) Shows one or more of the following:

A) The denial was incorrect because Ancillary Provider filed a timely claim, or

B) Ancillary Provider did not know and was unable to reasonably determine at the time by which a claim filing was required that the patient was a Member, but Ancillary Provider took reasonable steps to learn that the patient was a Member and promptly filed the claim after learning the patient was a Member.

Reversal of a denial under this subsection does not preclude United from upholding the denial for another permitted reason under this Agreement.

iv) **Medical Necessity.** For purposes of prior authorization, Medically Necessary or Medical Necessity will be defined in accordance with the applicable Benefit Plan and applicable law or regulatory requirements.

3.5 Payment in full. Payment provided pursuant to this Agreement, together with any Member cost-sharing under the Benefit Plan, is payment in full for a Covered Service. Nothing in this Agreement prevents Ancillary Provider from collecting any Member co-payment, deductible, or coinsurance at the time the Covered Service is provided. Ancillary Provider will use reasonable commercial efforts to determine or estimate the amount of Member liability before collection. Ancillary Provider will submit a claim for its services regardless of whether Ancillary Provider has collected from the Member as permitted under this section. If Ancillary Provider learns it has collected an amount in excess of the Member's liability, Ancillary Provider will promptly remit to Member the overpayment within 20 days from the date that Ancillary Provider first learned of the Member overpayment.

3.6 Member hold harmless; payer default.

i) **Member hold harmless**.

a) **Requirement to hold harmless.** Ancillary Provider will not bill or collect payment from the Member, or seek to impose a lien, for the difference between the amount paid under this Agreement and Ancillary Provider's Customary Charge, or for any amounts denied or not paid under this Agreement due to:

1) Ancillary Provider's failure to comply with the Protocols,

2) Ancillary Provider's failure to file a timely claim,

3) Application of Reimbursement Policies,

4) Inaccurate or incorrect claim processing,

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

6) A denial based on lack of medical necessity or based on consistency with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines, except as provided in the denial of claims provisions of this Agreement.

If Ancillary Provider believes one or more claim is paid incorrectly, Ancillary Provider may pursue remedies under this Agreement, but must still hold the Member harmless.

b) **Failure to hold harmless.** Failure to comply with the Member protection provisions of this section is a breach of this Agreement. Except as otherwise provided in this Agreement, this section applies regardless of whether the Member or anyone purporting to act on the Member's behalf has executed a waiver or other document of any kind purporting to allow Ancillary Provider to collect payment from the Member.

In the event of such a breach, Payer may deduct the amount wrongfully collected from Members from any amounts otherwise due Ancillary Provider. Payer may also deduct an amount equal to any costs or expenses incurred by the Member, United or Payer in defending the Member and otherwise enforcing this section. United will give Ancillary Provider 30 days' notice prior to any deduction under this section and will provide Ancillary Provider documentation to substantiate the deduction.

Any amounts deducted by Payer in accordance with this provision will be used to reimburse the Member and to satisfy any costs incurred. The remedy contained in this paragraph does not preclude United from invoking any other remedy for breach that may be available under this Agreement.

ii) **Payer default**.

a) **United's evaluation of Payers.** United will make reasonable commercial efforts to evaluate a Payer's financial ability to meet its claims payment obligations and to terminate or bring into compliance a Payer that has defaulted. A default is a systematic failure by a Payer to fund claims payments for Covered Services under Benefit Plans

sponsored by the Payer. A default is not a dispute as to whether certain claims should be paid or the payment amount for certain claims.

b) **Payer Default; non-application of agreement.** This Agreement does not apply to services rendered to Members covered by a Benefit Plan sponsored by a Payer in default, other than a default described immediately above. After confirming with United a Payer is in default, Ancillary Provider may seek payment directly from the Payer or from Members.

This section will survive the termination of this Agreement, regarding Covered Services rendered prior to when the termination takes effect.

Article IV
Dispute Resolution

4.1 Resolution of Disputes; Scope and Applicability. Every dispute or disagreement between the parties (each a "Dispute") is subject to the provisions of this Article IV, except Disputes concerning arbitrability or Disputes concerning the availability of class or consolidated arbitration, the right to which the parties expressly waive below. Examples of the types of disputes and disagreements that constitute Disputes include: those in any way relating to, arising out of or in connection with, or involving the performance, enforcement, breach, existence, validity, scope, interpretation, or termination of this Agreement or any term thereof or any right or obligation thereunder; and those in which Ancillary Provider is acting as the assignee of one or more Member(s).

4.2 Compliance with United Policies and Procedures. A party may not invoke the provisions of this Article IV unless and until it has timely and successfully complied with and exhausted all United policies and procedures applicable to the subject(s) of the Dispute. Examples of such United policies and procedures include: claim reconsideration and appeal processes; claims underpayments and denial correction processes (e.g., Claims Payment and Reimbursement Policies Section of this Agreement); grievance and complaints processes; processes governing medical/utilization management determinations, reviews, and appeals; medical and drug policies and guidelines; reconsideration rights under a provision of this Agreement (e.g., Denial of Claims Section of this Agreement); review and appeal processes mandated by law; and credentialing or quality improvement plans. United policies and procedures may be set forth in this Agreement, applicable administrative guide supplements, Reimbursement Policies, Protocols, medical and drug policies and guidelines, and Benefit Plans. United policies and procedures may change from time to time and may be issued and maintained in electronic and internet-based media or formats.

4.3 Informal Dispute Resolution; Notice Requirements. The parties will initially attempt to resolve a Dispute through the good-faith negotiation process described in this section. Disputes over the validity of a purported termination for uncured material breach will not be subject to this section and instead will be governed by and resolved through the arbitration process set forth below.

i) **Written Notice of Dispute.** The party invoking this section for a Dispute must send written notice of the Dispute to the other party. Such written notice must: (i) state that the noticing party is invoking this Agreement's dispute-resolution process; and (ii) explain the circumstances giving rise to and underlying the Dispute (including, to the extent applicable, the information and documentation required under the corrections of claim underpayments and denials provisions) and the basis for the noticing party's position regarding the Dispute.

ii) **Timely Provision of Written Notice of Dispute.** Any written notice of Dispute that is required to be provided under this section must be sent within the following time frames:

a) For a Dispute involving a matter that is subject to United policies or procedures, no later than the 60th day following the exhaustion of all such applicable United policies and procedures; and

b) For a Dispute involving matters not subject to United policies or procedures, no later than the 60th day following the noticing party's discovery of the action or omission that is the subject of the Dispute.

In the event one party fails to exhaust all applicable United policies and procedures for a Dispute, written notice of the Dispute by the other party is timely if sent no later than the 60th day following the final day by which exhaustion of all applicable United policies and procedures was required.

Nothing in this section shortens the period under applicable law or this Agreement during which United may pursue and complete recovery of an overpayment.

iii) **Negotiation Period.** A party that receives a valid written notice of a Dispute will promptly contact the noticing party to arrange for discussions (which may be virtual or telephonic) during which the parties will make reasonable commercial efforts to negotiate and resolve the Dispute. If the parties fail to resolve the Dispute by the 90th day following the other party's receipt of written notice (or by such other date to which the parties may mutually agree), either party may initiate formal dispute resolution pursuant to the next section of this Agreement.

4.4 **Arbitration.** The sole and exclusive means for settling any Dispute not successfully resolved is binding arbitration conducted by the American Arbitration Association ("AAA") in accordance with the AAA Commercial Arbitration Rules, as they may be amended from time to time (see http://www.adr.org).

i) **Timely Initiation of Arbitration.** Unless applicable law provides otherwise, a party submitting a Dispute to arbitration must initiate arbitration no later than 12 months following the date on which written notice of the Dispute was made pursuant to this Article. A party seeking resolution of a Dispute over the validity of a purported termination for uncured material breach must initiate arbitration no later than the 60th day following the initial termination notice, and unless the parties agree otherwise, the purported termination will be deferred the through the conclusion of the arbitration.

ii) **Arbitrator(s)/Panel Selection.** The arbitrator(s) will be selected from the AAA National Roster (as described in the AAA Commercial Arbitration Rules and Mediation Procedures). In an arbitration of a Dispute in which a party seeks an award of $1,000,000 or greater or termination of this Agreement, a panel of three arbitrators will be used.

iii) **Location.** Arbitration of a Dispute will be conducted in Clark County, Nevada.

iv) **Authority of Arbitrator(s); Burden of Proof.** The arbitrator(s) will be bound by controlling law and may construe or interpret—but must not vary or ignore—the terms of this Agreement. The arbitrator(s) will have no authority to award punitive, exemplary, indirect, or special damages, except in connection with a statutory claim that explicitly provides for that relief. In any arbitration of a Dispute involving disagreement over one or more claim

underpayments or denials, the arbitrator(s) must construe or interpret the applicable United policies and procedures, unless otherwise required by law. Any prejudgment interest awarded by the arbitrator(s) shall not exceed 3 percent per year. The burden of proof in any arbitration shall be on the party asserting the claims or defenses in the arbitration.

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

vi) **Class Actions, Joinder, Consolidation.** The parties expressly intend that any arbitration be conducted on an individual basis, so that no third parties may be consolidated or joined or allowed to proceed with class arbitration. The parties agree that any ruling by a court allowing class action proceedings or requiring consolidated litigation involving any third party(ies) would be contrary to their intent and would require immediate judicial review of such ruling.

vii) **Arbitration Decision.** The decision(s) and award(s) of the arbitrator(s) on the Dispute will be final and binding and will not be subject to further review in any forum (including judicial review).

viii) **FAA.** The parties acknowledge that because this Agreement affects interstate commerce the Federal Arbitration Act applies in addition to any applicable state or federal law.

ix) **Waiver of Jury Trial.** In the event a court determines that the arbitration procedure set forth in this section is not binding or otherwise allows litigation involving a Dispute to proceed, the parties hereby waive any right to trial by jury in, or with respect to, the litigation. The litigation would instead proceed with the judge as the finder of fact.

4.5 **Waiver.** Failure to timely comply with and exhaust the requirements and processes described in this Article will constitute a waiver of the party's right to review of the Dispute, through any judicial, administrative, or regulatory process, through United's internal processes, or in any other forum (including arbitration and litigation), except as otherwise required by law.

4.6 **Survival.** This Article will survive any termination of this Agreement.

Article V
Term and Termination

5.1 **Term.** This Agreement shall take effect on November 1, 2025. Commercial products will have an initial term of three years, ending on October 31, 2028, at 11:59 pm. Medicare Advantage products covered under this Agreement shall take effect on November 1, 2025, and have an initial term of one year, ending on October 31, 2026, at 11:59pm

i) The Term for Medicare Advantage Benefit Plans will end on October 31, 2026.

ii) The Term for Non-Governmental Benefit Plans will end on October 31, 2028.

5.2 Termination. This Agreement or a Participating Benefit Plan set forth on Network Participation Appendix may be terminated under any of the following circumstances:

i) By either party for Participating Benefit Plans that are:

a) Medicare Advantage Benefit Plans, upon at least 180 days' prior written notice;

b) Non-Governmental Benefit Plans, upon at least 180 days' prior written notice,

to the other party to be effective upon the expiration of the Term.

ii) by either party, upon 60 days' prior written notice, in the event of a material breach of this Agreement by the other party; the notice must include a specific description of the alleged material breach; however, the termination will not take effect if the breach is cured within 60 days after notice of the termination; moreover, termination may be deferred as further described in the dispute resolution provisions of this Agreement.

iii) by either party, upon 10 days' prior written notice, in the event the other party loses licensure or other governmental authorization necessary to perform this Agreement, or fails to have insurance as required by this Agreement.

iv) by United, upon 10 days' prior written notice, in the event Ancillary Provider loses accreditation.

v) by United, immediately upon written notice, if:

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

b) Ancillary Provider does not successfully complete United's re-credentialing process as required by the credentialing plan.

For the subparagraph on termination upon notice, each Participating Benefit Plan must be terminated separately in the timeframes listed. Termination of one Participating Benefit Plan will not result in termination of this Agreement or terminations of any other Participating Benefit Plan. This Agreement will automatically terminate on the date no Participating Benefit Plan remains in effect. United may update the Network Participation Appendix without amendment to accurately reflect the Participating Benefit Plans upon termination of any Participating Benefit Plan pursuant to this section.

5.3 Ongoing Services. This Section applies when a Member ceases to have network access to Ancillary Provider because of a termination of this Agreement or because of a change in relationship between United and Ancillary Provider, Payer and Ancillary Provider, Member and Ancillary Provider, or United and Member. If the Member is receiving any of the Covered Services listed below as of the effective date of the termination or change in relationship, then for the length of time reflected below Ancillary Provider will continue to render those Covered Services to that Member and this Agreement will continue to apply to those Covered Services.

- **Institutional Inpatient Covered Services:** The earlier of 90 days or discharge
- **Pregnancy:** The earlier of 90 days or through postpartum treatment

- **Terminally Ill per Social Security Act:** The earlier of 90 days or the completion of course of treatment

- **Serious and Complex Medical Conditions:** The earlier of 90 days or the completion of course of treatment for the condition

- **Any other conditions where a Payer is required to provide coverage for continued care by care provider after Member loses access to care provider due to a qualifying event under the federal Consolidated Appropriations Act, 2021 as may be subsequently amended, or applicable law or regulation:** As required by state regulatory appendix or applicable state or federal regulation or law

- **Ongoing Services to State Government Program Benefit Plan Members:** As required by the state regulatory appendix or United's contract with the state's Medicaid agency or state law

Article VI
Miscellaneous Provisions

6.1 **Entire Agreement.** In order for this Agreement to be binding, it must be executed by all parties through written or electronic signature. This Agreement is the entire agreement between the parties with regard to its subject matter, and supersedes any prior written or unwritten agreements between the parties or their affiliates with regard to the same subject matter.

6.2 **Amendment.** United may amend this Agreement or any of the appendices on 90 days' written or electronic notice by sending Ancillary Provider a copy of the amendment.

Additionally, United may amend this Agreement upon written notice to Ancillary Provider in order to comply with applicable regulatory requirements, but only if that amendment is imposed on a similar basis to all or substantially all of the medical groups in United's network that would be similarly impacted by the regulation in question. United will provide at least 30 days' notice of any such regulatory amendment unless a shorter notice period is necessary in order to comply with regulatory requirements.

Ancillary Provider's signature is not required to make the amendment effective. However, if the amendment is not required by law or regulation and would impose a material adverse impact on Ancillary Provider, then Ancillary Provider may terminate this Agreement on 60 days' written notice to United by sending a termination notice within 30 days after receipt of the amendment.

6.3 **Nonwaiver.** The waiver by either party of any breach of any provision of this Agreement will not operate as a waiver of any subsequent breach of the same or any other provision.

6.4 **Assignment.** This Agreement may not be assigned in whole or in part by either party without the written consent of the other party, except that this Agreement may be assigned by a party to an entity which is an affiliate of the party so long as the assignee is not a competitor of the other party.

Any partial assignment will not impact the relationship of the parties with respect to the remainder of this Agreement.

6.5 **Confidentiality.** Neither party may disclose, directly or indirectly, to a Member, other health care provider, or other third party any of the following information (except as required by an agency of the government, court order, other third party, or applicable laws or regulations):

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

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

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

For the avoidance of doubt, nothing in this Agreement will constitute a gag clause prohibited by the Consolidated Appropriations Act, 2021, as it may be amended from time to time. In addition, this section does not preclude the disclosure of information by United to a third party as part of a process by which the third party is evaluating administration of benefits or considering whether to purchase services from United.

During the term of this Agreement, United grants to Ancillary Provider a limited, non-sublicensable, non-transferable, and non-exclusive license to use within the United States the UNITEDHEALTHCARE name and logo (the "Licensed Marks") solely for the purposes of (i) using or displaying the Licensed Marks alongside names or logos of other insurance carriers with whom Ancillary Provider has a network participation agreement, or (ii) communicating verbally or in writing to Ancillary Provider's prospective or existing patients that Ancillary Provider has an agreement with United to provide health care services to Members. Ancillary Provider will comply with all requirements made available by United regarding the use of United's names, logos, trademarks, trade names, or other marks of United including those located in the Protocols. United may at any time withdraw its permission for Ancillary Provider to use any Licensed Marks, effective upon written notice to Ancillary Provider. All other uses of any names, logos, trademarks, trade names, or other marks of United require the advance written consent of United.

Ancillary Provider will not issue a press release or public disclosure related to this Agreement without the advanced written consent of United. Without limiting the generality of the foregoing, in the event either party issues a press release or other public disclosure about the business relationship between the parties, that party will ensure the content of such material does not (a) mischaracterize the nature of the relationship between the parties, (b) suggest any endorsement or promotion of the other party, or (c) disclose or describe information subject to the confidentiality obligations in this Agreement.

6.6 Notice procedures. Except as specified below, when notice is required under this Agreement, it will be provided in writing. Written notice may be delivered by any of the following methods: first class mail, certified mail; other methods as specified in a Protocol; or v) overnight delivery by a carrier service with proof of delivery. New or revised Reimbursement Policies and Protocols may be noticed online at www.uhcprovider.com or its successor, unless otherwise required by law. All notices of termination of all or part of this Agreement or Dispute by either party must be delivered by first class, certified mail; or overnight delivery and must be clearly marked as notice of termination or Dispute. A party may update its notice contact information by providing proper notice under this section. All notices will be deemed received upon receipt by the party to which notice is given or on the 5th business day following mailing, whichever occurs first.

As of the Effective Date of this Agreement, the notice contact information for each party is as follows:

UnitedHealthcare
Attn: Network Market VP MN103
6022 Blue Circle Drive
Minnetonka, MN 55343

Ancillary Provider: University Medical Center of Southern Nevada dba
UMC Quick Care
Attn: Legal Department
1800 W Charleston Blvd
Las Vegas, NV 89102

6.7 **No third-party beneficiaries.** United and Ancillary Provider are the only entities with rights and remedies under this Agreement. Any claims, collection actions or disputes may not be assigned, transferred, or sold by either party without the written consent of the other party.

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

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

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

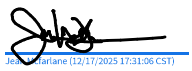
6.11 **Severability.** Except as otherwise set forth in this Agreement, any provision of this Agreement that is unlawful, invalid, or unenforceable in any situation in any jurisdiction will not affect the validity or enforceability of the remaining provisions of this Agreement or the lawfulness, validity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

6.12 **Survival.** In addition to any other provisions relating to survival, this Agreement will continue to apply to Covered Services rendered while this Agreement was in effect and in relation to confidentiality.

6.13 **Fines; Penalties.** United will be responsible for any fines or penalties that may be assessed against Ancillary Provider by any government agency that arise from the United's failure to execute, deliver or perform its obligations under this Agreement. Ancillary Provider will be responsible for any fines or penalties that may be assessed against United by any government agency that arise from Ancillary Provider's failure to execute, deliver or perform its obligations under this Agreement.

6.14 **Counterpart Execution**. This Agreement may be executed in counterparts and sent via .pdf or facsimile each of which shall be deemed an original but all of which when taken together shall constitute but one and the same instrument.

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

UnitedHealthcare Insurance Company, contracting on behalf of itself and the other entities that are United's Affiliates, as signed by its authorized representative:	**University Medical Center of Southern Nevada, as signed by its authorized representative:**
Signature: 	Signature: 
Name: Jean McFarlane	Name: Mason Van Houweling
Title: Vice President, Network Contracting	Title: Chief Executive Officer
Date: 12/17/2025	Date: 12/18/2025
For office use only: 52326304	

Service Location Appendix

(As of the Effective Date of this Agreement)

[The information in this attachment is confidential and proprietary in nature.]

Capitation Arrangements and Financial Responsibility Appendix

[The information in this attachment is confidential and proprietary in nature.]

Network Participation Appendix

Benefit Plan Description

[The information in this attachment is confidential and proprietary in nature.]

Administrative Guide Supplements Appendix

[The information in this attachment is confidential and proprietary in nature.]

Payment Appendix – Medicare Advantage

[The information in this attachment is confidential and proprietary in nature.]

MEDICARE ADVANTAGE REGULATORY REQUIREMENTS APPENDIX

[The information in this attachment is confidential and proprietary in nature.]

Nevada Regulatory Requirements Appendix

[The information in this attachment is confidential and proprietary in nature.]

DISCLOSURE OF OWNERSHIP/PRINCIPALS

Business Entity Type (Please select one)						
☐ Sole Proprietorship	☐Partnership	☐ Limited Liability Company	X☐ Corporation	☐ Trust	☐ Non-Profit Organization	☐ Other

Business Designation Group (Please select all that apply)						
☐ MBE	☐ WBE	☐ SBE	☐ PBE	☐ VET	☐DVET	☐ ESB
Minority Business Enterprise	Women-Owned Business Enterprise	Small Business Enterprise	Physically Challenged Business Enterprise	Veteran Owned Business	Disabled Veteran Owned Business	Emerging Small Business

Number of Clark County Nevada Residents Employed:

Corporate/Business Entity Name:	United HealthCare Services, Inc	
(Include d.b.a., if applicable)		
Street Address:	9900 Bren Road East	**Website:**
City, State and Zip Code:	Minnetonka, MN 55343	**POC Name:** **Email:**
Telephone No:		**Fax No:**
Nevada Local Street Address: **(If different from above)**	2716 N. Tenaya Way	**Website:**
City, State and Zip Code:	Las Vegas, NV 89128	**Local Fax No:**
Local Telephone No:		**Local POC Name:** **Email:**

All entities, with the exception of publicly-traded and non-profit organizations, must list the names of individuals holding more than five percent (5%) ownership or financial interest in the business entity appearing before the Board.

Publicly-traded entities and non-profit organizations shall list all Corporate Officers and Directors in lieu of disclosing the names of individuals with ownership or financial interest. The disclosure requirement, as applied to land-use applications, extends to the applicant and the landowner(s).

Entities include all business associations organized under or governed by Title 7 of the Nevada Revised Statutes, including but not limited to private corporations, close corporations, foreign corporations, limited liability companies, partnerships, limited partnerships, and professional corporations.

Full Name	Title	% Owned (Not required for Publicly Traded Corporations/Non-profit organizations)
UnitedHealth Group Incorporated	Delaware Corporation (publicly traded as UHN)	100%

This section is not required for publicly-traded corporations. Are you a publicly-traded corporation? ☐ Yes ☒ No

1. Are any individual members, partners, owners or principals, involved in the business entity, a University Medical Center of Southern Nevada full-time employee(s), or appointed/elected official(s)?

   ☐ Yes ☒ No (If yes, please note that University Medical Center of Southern Nevada employee(s), or appointed/elected official(s) may not perform any work on professional service contracts, or other contracts, which are not subject to competitive bid.)

2. Do any individual members, partners, owners or principals have a spouse, registered domestic partner, child, parent, in-law or brother/sister, half-brother/half-sister, grandchild, grandparent, related to a University Medical Center of Southern Nevada full-time employee(s), or appointed/elected official(s)?

   ☐ Yes ☒ No (If yes, please complete the Disclosure of Relationship form on Page 2. If no, please print N/A on Page 2.)

I certify under penalty of perjury, that all of the information provided herein is current, complete, and accurate. I also understand that the University Medical Center of Southern Nevada Governing Board will not take action on land-use approvals, contract approvals, land sales, leases or exchanges without the completed disclosure form.

Signature — Print Name: HEATHER LANG

Title: ASSISTANT SECRETARY — Date: 5/31/24

REVISED 7/25/2014

DISCLOSURE OF RELATIONSHIP

List any disclosures below:
(Mark N/A, if not applicable.)

NAME OF BUSINESS OWNER/PRINCIPAL	NAME OF UMC* EMPLOYEE/OFFICIAL AND JOB TITLE	RELATIONSHIP TO UMC* EMPLOYEE/OFFICIAL	UMC* EMPLOYEE'S/OFFICIAL'S DEPARTMENT

* UMC employee means an employee of University Medical Center of Southern Nevada

"Consanguinity" is a relationship by blood. "Affinity" is a relationship by marriage.

"To the second degree of consanguinity" applies to the candidate's first and second degree of blood relatives as follows:

- Spouse – Registered Domestic Partners – Children – Parents – In-laws (first degree)
- Brothers/Sisters – Half-Brothers/Half-Sisters – Grandchildren – Grandparents – In-laws (second degree)

For UMC Use Only:

If any Disclosure of Relationship is noted above, please complete the following:

☐ Yes ☐ No Is the UMC employee(s) noted above involved in the contracting/selection process for this particular agenda item?

☐ Yes ☐ No Is the UMC employee(s) noted above involved in any way with the business in performance of the contract?

Notes/Comments:

_____
Signature

_____
Print Name
Authorized Department Representative

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
GOVERNING BOARD AUDIT AND FINANCE COMMITTEE
AGENDA ITEM

Issue:	**Ratification of Amendment Six to the Participating Facility Agreement with SelectHealth, Inc. and SelectHealth Benefit Assurance, Inc.**	**Back-up:**
Petitioner:	Jennifer Wakem, Chief Financial Officer	**Clerk Ref. #**

Recommendation:

That the Governing Board Audit and Finance Committee review and recommend for ratification by the Governing Board, the Amendment Six to Participating Facility Agreement with SelectHealth, Inc. and SelectHealth Benefit Assurance, Inc. for Managed Care Services; or take action as deemed appropriate. ***(For possible action)***

FISCAL IMPACT:

Fund Number: 5430.011
Fund Name: UMC Operating Fund
Fund Center: 3000850000
Funded Pgm/Grant: N/A
Description: Managed Care Services
Bid/RFP/CBE: NRS 332.115(1)(f) – Insurance
Term: Through May 1, 2027
Amount: Revenue based on volume
Out Clause: 60 days w/o cause

BACKGROUND:

On May 27, 2020, the Governing Board approved the Participating Facility Agreement with SelectHealth, Inc. and SelectHealth Benefit Assurance, Inc. ("SelectHealth") for UMC to provide SelectHealth members covered services at the hospital and its associated Urgent Care facilities (the "Agreement"). Amendment One, effective October 8, 2020, added the Qualified Health Plan Addendum. Amendment Two, effective May 1, 2021, added SelectHealth Med (HMO/POS) Network to the existing Agreement. Amendment Three, effective May 1, 2023, updated the compensation schedule for Select Health Med (HMO/POS). Amendment Four, effective July 1, 2023, requested to update the revenue codes in the Compensation Schedule. Amendment Five, effective May 27, 2020, extended the term through May 1, 2027, and updated codes in the compensation schedule.

This Amendment Six deletes and replaces the Compensation Schedule in the Agreement, which increases the reimbursement rates specified in the Compensation Schedule. All other terms in the Agreement are unchanged. Ratification of this amendment was necessary due to the retroactive nature of the change, as SelectHealth needed to load its systems as soon as possible to ensure the timely payment of claims.

UMC's Director of Managed Care has reviewed and recommends ratification of this Amendment, which has also been approved as to form by UMC's Office of General Counsel.

A Clark County business license is not required as UMC is the provider of hospital services to this insurance fund.

Cleared for Agenda
January 21, 2026

Agenda Item #

8

AMENDMENT SIX TO THE PARTICIPATING FACILITY AGREEMENT

This Amendment Six to the Participating Facility Agreement ("Amendment Six") is made and entered into by and between SelectHealth, Inc. and SelectHealth Benefit Assurance Company, Inc. ("Select Health"), (collectively referred to as "Plan") and University Medical Center of Southern Nevada ("Hospital"). The effective date of Amendment Five is November 1, 2025 ("Effective Date").

WHEREAS, Plan and Hospital (each a "Party" and collectively, the "Parties") entered into a Participating Facility Agreement effective the 27th day of May, 2020, as amended by that certain amendment one to Participating Facility Agreement effective October 8, 2020 (the "Amendment One"), and by that amendment two to Participating Facility Agreement effective May 1, 2021 (the "Amendment Two"); and by that amendment three to Participating Facility Agreement effective May 1, 2023 (the "Amendment Three"), and by that amendment four to Participating Facility Agreement effective July 1, 2023 (the "Amendment Four"), and by that amendment five to Participating Facility Agreement effective May 1, 2025 (the "Amendment Five"), (collectively, the "Agreement"); and

WHEREAS, Section XII.3 of the Agreement allows Plan and Hospital to amend the Agreement by executing an amendment in writing; and

WHEREAS, the Parties desire to further update the revenue codes and compensation schedules in Exhibit A as attached hereto.

NOW THEREFORE, the Parties agree that the Agreement shall be amended as follows:

1. Exhibit A will be deleted in its entirety and replaced with Exhibit A attached and incorporated herein by reference.

Except as expressly stated herein, the Agreement remains in full force and effect.

IN WITNESS WHEREOF, the parties hereto have executed this Amendment Five to be effective as of the date indicated above.

SelectHealth, Inc. and **SelectHealth Benefit Assurance Company, Inc.**	**University Medical Center of Southern Nevada:**
By: Signed by: Todd Trettin 41C0D41ECABA447...	By: Mason Van Houweling
Print Name: Todd Trettin	Print Name: Mason Van Houweling
Title: VP & CFO	Title: Chief Executive Officer
Date: 12/16/2025	Date: 12-17-25

EXHIBIT A
Select Health Value Network
Select Health Med Network
Compensation Schedule

[The information in this attachment is confidential and proprietary in nature.]

INSTRUCTIONS FOR COMPLETING THE
DISCLOSURE OF OWNERSHIP/PRINCIPALS FORM

Purpose of the Form

The purpose of the Disclosure of Ownership/Principals Form is to gather ownership information pertaining to the business entity for use by the University Medical Center of Southern Nevada Governing Board ("GB") in determining whether members of the GB should exclude themselves from voting on agenda items where they have, or may be perceived as having a conflict of interest, and to determine compliance with Nevada Revised Statute 281A.430, contracts in which a public officer or employee has interest is prohibited.

General Instructions

Completion and submission of this Form is a condition of appr25oval or renewal of a contract or lease and/or release of monetary funding between the disclosing entity and University Medical Center of Southern Nevada. Failure to submit the requested information may result in a refusal by the GB to enter into an agreement/contract and/or release monetary funding to such disclosing entity.

Detailed Instructions

All sections of the Disclosure of Ownership form must be completed. If not applicable, write in N/A.

Business Entity Type – Indicate if the entity is an Individual, Partnership, Limited Liability Company, Corporation, Trust, Non-profit Organization, or Other. When selecting 'Other', provide a description of the legal entity.

Non-Profit Organization (NPO) - Any non-profit corporation, group, association, or corporation duly filed and registered as required by state law.

Business Designation Group – Indicate if the entity is a Minority Owned Business Enterprise (MBE), Women-Owned Business Enterprise (WBE), Small Business Enterprise (SBE), Physically-Challenged Business Enterprise (PBE), Veteran Owned Business (VET), Disabled Veteran Owned Business (DVET), or Emerging Small Business (ESB) . This is needed in order to provide utilization statistics to the Legislative Council Bureau, and will be used only for such purpose.

- **Minority Owned Business Enterprise (MBE):** An independent and continuing business for profit which performs a commercially useful function and is at least 51% owned and controlled by one or more minority persons of Black American, Hispanic American, Asian-Pacific American or Native American ethnicity.
- **Women Owned Business Enterprise (WBE**): An independent and continuing business for profit which performs a commercially useful function and is at least 51% owned and controlled by one or more women.
- **Physically-Challenged Business Enterprise (PBE):** An independent and continuing business for profit which performs a commercially useful function and is at least 51% owned and controlled by one or more disabled individuals pursuant to the federal Americans with Disabilities Act.
- **Small Business Enterprise (SBE):** An independent and continuing business for profit which performs a commercially useful function, is not owned and controlled by individuals designated as minority, women, or physically-challenged, and where gross annual sales does not exceed $2,000,000.
- **Veteran Owned Business Enterprise (VET):** An independent and continuing Nevada business for profit which performs a commercially useful function and is at least 51 percent owned and controlled by one or more U.S. Veterans.
- **Disabled Veteran Owned Business Enterprise (DVET):** A Nevada business at least 51 percent owned/controlled by a disabled veteran.
- **Emerging Small Business (ESB):** Certified by the Nevada Governor's Office of Economic Development effective January, 2014. Approved into Nevada law during the 77th Legislative session as a result of AB294.

Business Name (include d.b.a., if applicable) – Enter the legal name of the business entity and enter the "Doing Business As" (d.b.a.) name, if applicable.

Corporate/Business Address, Business Telephone, Business Fax, and Email – Enter the street address, telephone and fax numbers, and email of the named business entity.

Nevada Local Business Address, Local Business Telephone, Local Business Fax, and Email – If business entity is out-of-state, but operates the business from a location in Nevada, enter the Nevada street address, telephone and fax numbers, point of contact and email of the local office. Please note that the local address must be an address from which the business is operating from that location. Please do not include a P.O. Box number, unless required by the U.S. Postal Service, or a business license hanging address.

***Number of Clark County Nevada Residents employed by this firm. (*Do not leave blank. If none or zero, put the number 0 in the space provided.)**

List of Owners/Officers – Include the full name, title and percentage of ownership of each person who has ownership or financial interest in the business entity. If the business is a publicly-traded corporation or non-profit organization, list all Corporate Officers and Directors only.

For All Contracts – **(Not required for publicly-traded corporations)**

1) Indicate if any individual members, partners, owners or principals involved in the business entity are a University Medical Center of Southern Nevada full-time employee(s), or appointed/elected official(s). If yes, the following paragraph applies.

   In accordance with NRS 281A.430.1, a public officer or employee shall not bid on or enter into a contract between a government agency and any private business in which he has a significant financial interest, except as provided for in subsections 2, 3, and 4.

2) Indicate if any individual members, partners, owners or principals involved in the business entity have a second degree of consanguinity or affinity relation to a University Medical Center of Southern Nevada full-time employee(s), or appointed/elected official(s) (reference form on Page 2 for definition). If **YES**, complete the Disclosure of Relationship Form.

A professional service is defined as a business entity that offers business/financial consulting, legal, physician, architect, engineer or other professional services.

Signature and Print Name – Requires signature of an authorized representative and the date signed.

Disclosure of Relationship Form – If any individual members, partners, owners or principals of the business entity is presently a University Medical Center of Southern Nevada employee, public officer or official, or has a second degree of consanguinity or affinity relationship to a University Medical Center of Southern Nevada employee, public officer or official, this section must be completed in its entirety.

DISCLOSURE OF OWNERSHIP/PRINCIPALS

Business Entity Type (Please select one)						
☐ Sole Proprietorship	☐Partnership	☐ Limited Liability Company	☐ Corporation	☐ Trust	☒ Non-Profit Organization	☐ Other

Business Designation Group (Please select all that apply)						
☐ MBE	☐ WBE	☐ SBE	☐ PBE	☐ VET	☐DVET	☐ ESB
Minority Business Enterprise	Women-Owned Business Enterprise	Small Business Enterprise	Physically Challenged Business Enterprise	Veteran Owned Business	Disabled Veteran Owned Business	Emerging Small Business

Number of Clark County Nevada Residents Employed:

Corporate/Business Entity Name:	SelectHealth, Inc.	
(Include d.b.a., if applicable)		
Street Address:	5381 Green Street	**Website:** www.selethealth.org
City, State and Zip Code:	Murray, UT 84123	**POC Name:** Rachelle Lopez **Email:** Rachelle.lopez@selecthealth.org
Telephone No:	800-538-5038	**Fax No:** NA
Nevada Local Street Address: **(If different from above)**	6795 Agilysis Way, Ste 110	**Website:** www.selethealth.org
City, State and Zip Code:	Las Vegas, NV 89113	**Local Fax No:** NA
Local Telephone No:	800-538-5038	**Local POC Name:** Rachelle Lopez **Email:** Rachelle.lopez@selecthealth.org

All entities, with the exception of publicly-traded and non-profit organizations**,** must list the names of individuals holding more than five percent (5%) ownership or financial interest in the business entity appearing before the Board.

Publicly-traded entities and non-profit organizations shall list all Corporate Officers and Directors in lieu of disclosing the names of individuals with ownership or financial interest. The disclosure requirement, as applied to land-use applications, extends to the applicant and the landowner(s).

Entities include all business associations organized under or governed by Title 7 of the Nevada Revised Statutes, including but not limited to private corporations, close corporations, foreign corporations, limited liability companies, partnerships, limited partnerships, and professional corporations.

Full Name	Title	% Owned (Not required for Publicly Traded Corporations/Non-profit organizations)
Robert Hitchcock	President and CEO	
Bryan Nielsen	Secretary	
Todd Trettin	Treasurer, Chief Financial Officer	
Jon Griffith	Chief Operations Officer	
Heather O'Toole	Chief Medical Officer	
Robert Allen	Director/Trustee	
Michael Fordyce	Director/Trustee	
Elizabeth Owens	Director/Trustee	
Maria Summers	Director/Trustee	
Andrea Poole Wolcott	Director/Trustee	
Michael Anglin	Director/Trustee	
Deneece Glenn Huftalin	Director/Trustee	
Katherine Sanderson	Director/Trustee	
Cydni Rodgers Tetro	Director/Trustee	
Josh England	Director/Trustee	
David Sanford	Director/Trustee	
James Valin	Director/Trustee	
Kevin Potts	Director/Trustee	
Joseph Walker	Director/Trustee	

DISCLOSURE OF OWNERSHIP/PRINCIPALS

Meme Callnin	Director/Trustee	

This section is not required for publicly-traded corporations. Are you a publicly-traded corporation? ☐ Yes ☐ No

1. Are any individual members, partners, owners or principals, involved in the business entity, a University Medical Center of Southern Nevada full-time employee(s), or appointed/elected official(s)?

   ☐ Yes ☒ No (If yes, please note that University Medical Center of Southern Nevada employee(s), or appointed/elected official(s) may not perform any work on professional service contracts, or other contracts, which are not subject to competitive bid.)

2. Do any individual members, partners, owners or principals have a spouse, registered domestic partner, child, parent, in-law or brother/sister, half-brother/half-sister, grandchild, grandparent, related to a University Medical Center of Southern Nevada full-time employee(s), or appointed/elected official(s)?

   ☐ Yes ☒ No (If yes, please complete the Disclosure of Relationship form on Page 2. If no, please print N/A on Page 2.)

I certify under penalty of perjury, that all of the information provided herein is current, complete, and accurate. I also understand that the University Medical Center of Southern Nevada Governing Board will not take action on land-use approvals, contract approvals, land sales, leases or exchanges without the completed disclosure form.

Signed by: 42155712D85C748E...	Bryan Nielsen
Signature	Print Name
General Counsel	05/12/2025
Title	Date

DISCLOSURE OF RELATIONSHIP

List any disclosures below:
(Mark N/A, if not applicable.)

NAME OF BUSINESS OWNER/PRINCIPAL	NAME OF UMC* EMPLOYEE/OFFICIAL AND JOB TITLE	RELATIONSHIP TO UMC* EMPLOYEE/OFFICIAL	UMC* EMPLOYEE'S/OFFICIAL'S DEPARTMENT
N/A			

* UMC employee means an employee of University Medical Center of Southern Nevada

"Consanguinity" is a relationship by blood. "Affinity" is a relationship by marriage.

"To the second degree of consanguinity" applies to the candidate's first and second degree of blood relatives as follows:

- Spouse – Registered Domestic Partners – Children – Parents – In-laws (first degree)
- Brothers/Sisters – Half-Brothers/Half-Sisters – Grandchildren – Grandparents – In-laws (second degree)

For UMC Use Only:

If any Disclosure of Relationship is noted above, please complete the following:

☐ Yes ☐ No Is the UMC employee(s) noted above involved in the contracting/selection process for this particular agenda item?

☐ Yes ☐ No Is the UMC employee(s) noted above involved in any way with the business in performance of the contract?

Notes/Comments:

_____
Signature

_____
Print Name
Authorized Department Representative

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
GOVERNING BOARD AUDIT AND FINANCE COMMITTEE
AGENDA ITEM

Issue:	**Ratification of Amendment No. 1 to the Memorandum of Understanding with SCAN Health Plan Nevada, Inc.**	**Back-up:**
Petitioner:	Jennifer Wakem, Chief Financial Officer	**Clerk Ref. #**

Recommendation:

That the Governing Board Audit and Finance Committee review and recommend for ratification by the Governing Board Amendment One to the Memorandum of Understanding with SCAN Health Plan Nevada for Managed Care Services, or take action as deemed appropriate. ***(For possible action)***

FISCAL IMPACT:

Fund Number: 5430.011
Fund Name: UMC Operating Fund
Fund Number: 3000850000
Funded Pgm/Grant: N/A
Description: Managed Care Services
Bid/RFP/CBE: NRS 332.115(1)(f) – Insurance
Term: January 1, 2026, through December 31, 2026
Amount: Revenue based on volume
Out Clause: 60-days without cause

BACKGROUND:

On January 1, 2025, UMC entered into a Memorandum of Understanding ("MOU") with SCAN Health Plan Nevada, Inc. ("SCAN") enabling UMC to provide covered services to SCAN members.

This Amendment No. 1 ("Amendment") to the MOU extends the term through December 31, 2026, and updates the compensation exhibit. Following the term, the MOU may be renewed for subsequent annual periods upon mutual written agreement.

This is a request for ratification as the amendment needed to be executed immediately to ensure SCAN members remained in network with UMC after December 31, 2025, the MOU expiration date.

UMC's Director of Managed Care has reviewed and recommends ratification of this Amendment, which has also been approved as to form by UMC's Office of General Counsel.

A Clark County business license is not required as UMC is the provider of hospital services to this insurance fund.

Cleared for Agenda
January 21, 2026

Agenda Item #
9

AMENDMENT No. 1 TO THE AGREEMENT BETWEEN UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA AND SCAN HEALTH PLAN NEVADA, INC.

This AMENDMENT No. 1 ("Amendment") is entered into and made effective the first day of January, 2026, by and between SCAN Health Plan Nevada, Inc., a Nevada nonprofit corporation ("SCAN") and University Medical Center of Southern Nevada, a county owned and operated hospital created by virtue of Chapter 450 of the Nevada Revised Statutes doing business as University Medical Center (UMC) ("Provider").

RECITALS

WHEREAS, SCAN and Provider have entered into a Memorandum of Understanding and Term Sheet, dated January 1, 2025 (the "Agreement");

WHEREAS, SCAN and Provider have agreed on preliminary terms as set forth in the Agreement and are working in good faith to enter into a definitive agreement; and

WHEREAS, the parties desire to amend the Agreement, and the Agreement requires that all amendments be in writing.

NOW, THEREFORE, in consideration of the mutual covenants and promises herein contained, the parties hereto agree as follows:

AMENDMENT

1. Defined terms. The defined terms used in this Amendment, unless otherwise indicated herein, shall have the same meaning assigned to such terms in the Agreement.

2. Term. The term of the Agreement shall commence on January 1, 2026, and end on December 31, 2026, and may renew for subsequent one-year terms upon mutual written agreement, unless terminated by any of the parties upon 60 days' prior written notice.

3. Exhibit B, Compensation. Exhibit B of the Agreement shall be deleted in its entirety and replaced with a new Exhibit B as attached hereto and incorporated herein by this reference.

4. Except as amended hereby, the Agreement shall remain unchanged and in full force and effect. If any provision of the Agreement is inconsistent with the terms of this Amendment, the language in this Amendment shall control.

Signature page follows

IN WITNESS WHEREOF, the parties hereto have caused this Amendment to be executed by their duly authorized representatives as of the day and year first above written.

SCAN Health Plan Nevada, Inc.,
a Nevada nonprofit corporation

Signed Karen Schulte

Name Karen Schulte

Title President

Date 12/22/2025

University Medical Center of Southern Nevada,
a Nevada nonprofit corporation

Signed Mason VanHouweling

Name Mason VanHouweling

Title Chief Executive Officer

Date 12/17/2025

EXHIBIT B

COMPENSATION

[The information in this attachment is confidential and proprietary in nature.]

INSTRUCTIONS FOR COMPLETING THE
DISCLOSURE OF OWNERSHIP/PRINCIPALS FORM

Purpose of the Form

The purpose of the Disclosure of Ownership/Principals Form is to gather ownership information pertaining to the business entity for use by the University Medical Center of Southern Nevada Governing Board ("GB") in determining whether members of the GB should exclude themselves from voting on agenda items where they have, or may be perceived as having a conflict of interest, and to determine compliance with Nevada Revised Statute 281A.430, contracts in which a public officer or employee has interest is prohibited.

General Instructions

Completion and submission of this Form is a condition of approval or renewal of a contract or lease and/or release of monetary funding between the disclosing entity and University Medical Center of Southern Nevada. Failure to submit the requested information may result in a refusal by the GB to enter into an agreement/contract and/or release monetary funding to such disclosing entity.

Detailed Instructions

All sections of the Disclosure of Ownership form must be completed. If not applicable, write in N/A.

Business Entity Type – Indicate if the entity is an Individual, Partnership, Limited Liability Company, Corporation, Trust, Non-profit Organization, or Other. When selecting 'Other', provide a description of the legal entity.

Non-Profit Organization (NPO) - Any non-profit corporation, group, association, or corporation duly filed and registered as required by state law.

Business Designation Group – Indicate if the entity is a Minority Owned Business Enterprise (MBE), Women-Owned Business Enterprise (WBE), Small Business Enterprise (SBE), Physically-Challenged Business Enterprise (PBE), Veteran Owned Business (VET), Disabled Veteran Owned Business (DVET), or Emerging Small Business (ESB) . This is needed in order to provide utilization statistics to the Legislative Council Bureau, and will be used only for such purpose.

- **Minority Owned Business Enterprise (MBE):** An independent and continuing business for profit which performs a commercially useful function and is at least 51% owned and controlled by one or more minority persons of Black American, Hispanic American, Asian-Pacific American or Native American ethnicity.
- **Women Owned Business Enterprise (WBE**): An independent and continuing business for profit which performs a commercially useful function and is at least 51% owned and controlled by one or more women.
- **Physically-Challenged Business Enterprise (PBE):** An independent and continuing business for profit which performs a commercially useful function and is at least 51% owned and controlled by one or more disabled individuals pursuant to the federal Americans with Disabilities Act.
- **Small Business Enterprise (SBE):** An independent and continuing business for profit which performs a commercially useful function, is not owned and controlled by individuals designated as minority, women, or physically-challenged, and where gross annual sales does not exceed $2,000,000.
- **Veteran Owned Business Enterprise (VET):** An independent and continuing Nevada business for profit which performs a commercially useful function and is at least 51 percent owned and controlled by one or more U.S. Veterans.
- **Disabled Veteran Owned Business Enterprise (DVET):** A Nevada business at least 51 percent owned/controlled by a disabled veteran.
- **Emerging Small Business (ESB):** Certified by the Nevada Governor's Office of Economic Development effective January, 2014. Approved into Nevada law during the 77th Legislative session as a result of AB294.

Business Name (include d.b.a., if applicable) – Enter the legal name of the business entity and enter the "Doing Business As" (d.b.a.) name, if applicable.

Corporate/Business Address, Business Telephone, Business Fax, and Email – Enter the street address, telephone and fax numbers, and email of the named business entity.

Nevada Local Business Address, Local Business Telephone, Local Business Fax, and Email – If business entity is out-of-state, but operates the business from a location in Nevada, enter the Nevada street address, telephone and fax numbers, point of contact and email of the local office. Please note that the local address must be an address from which the business is operating from that location. Please do not include a P.O. Box number, unless required by the U.S. Postal Service, or a business license hanging address.

***Number of Clark County Nevada Residents employed by this firm. (*Do not leave blank. If none or zero, put the number 0 in the space provided.)**

List of Owners/Officers – Include the full name, title and percentage of ownership of each person who has ownership or financial interest in the business entity. If the business is a publicly-traded corporation or non-profit organization, list all Corporate Officers and Directors only.

For All Contracts – **(Not required for publicly-traded corporations)**

1) Indicate if any individual members, partners, owners or principals involved in the business entity are a University Medical Center of Southern Nevada full-time employee(s), or appointed/elected official(s). If yes, the following paragraph applies.

   In accordance with NRS 281A.430.1, a public officer or employee shall not bid on or enter into a contract between a government agency and any private business in which he has a significant financial interest, except as provided for in subsections 2, 3, and 4.

2) Indicate if any individual members, partners, owners or principals involved in the business entity have a second degree of consanguinity or affinity relation to a University Medical Center of Southern Nevada full-time employee(s), or appointed/elected official(s) (reference form on Page 2 for definition). If **YES**, complete the Disclosure of Relationship Form.

A professional service is defined as a business entity that offers business/financial consulting, legal, physician, architect, engineer or other professional services.

Signature and Print Name – Requires signature of an authorized representative and the date signed.

Disclosure of Relationship Form – If any individual members, partners, owners or principals of the business entity is presently a University Medical Center of Southern Nevada employee, public officer or official, or has a second degree of consanguinity or affinity relationship to a University Medical Center of Southern Nevada employee, public officer or official, this section must be completed in its entirety.

DISCLOSURE OF OWNERSHIP/PRINCIPALS

Business Entity Type (Please select one)						
☐ Sole Proprietorship	☐Partnership	☐ Limited Liability Company	☐ Corporation	☐ Trust	☒ Non-Profit Organization	☐ Other

Business Designation Group (Please select all that apply)						
☐ MBE	☐ WBE	☐ SBE	☐ PBE	☐ VET	☐DVET	☐ ESB
Minority Business Enterprise	Women-Owned Business Enterprise	Small Business Enterprise	Physically Challenged Business Enterprise	Veteran Owned Business	Disabled Veteran Owned Business	Emerging Small Business

Number of Clark County Nevada Residents Employed: approximately 20

Corporate/Business Entity Name:	SCAN Health Plan Nevada, Inc.	
(Include d.b.a., if applicable)		
Street Address:	3800 Kilroy Airport Way, Suite 100	**Website:www.scanhealthplan.com**
City, State and Zip Code:	Long Beach CA 90806	**POC Name:** Josh Martin **Email:** j.martin@scanhealthplan.com
Telephone No:	(800) 559-3500	**Fax No:**
Nevada Local Street Address: **(If different from above)**		**Website:**
City, State and Zip Code:		**Local Fax No:**
Local Telephone No:		**Local POC Name:** **Email:**

All entities, with the exception of publicly-traded and non-profit organizations**,** must list the names of individuals holding more than five percent (5%) ownership or financial interest in the business entity appearing before the Board.

Publicly-traded entities and non-profit organizations shall list all Corporate Officers and Directors in lieu of disclosing the names of individuals with ownership or financial interest. The disclosure requirement, as applied to land-use applications, extends to the applicant and the landowner(s).

Entities include all business associations organized under or governed by Title 7 of the Nevada Revised Statutes, including but not limited to private corporations, close corporations, foreign corporations, limited liability companies, partnerships, limited partnerships, and professional corporations.

Full Name	Title	% Owned (Not required for Publicly Traded Corporations/Non-profit organizations)
n/a		

This section is not required for publicly-traded corporations. Are you a publicly-traded corporation? ☐ Yes ☒ No

1. Are any individual members, partners, owners or principals, involved in the business entity, a University Medical Center of Southern Nevada full-time employee(s), or appointed/elected official(s)?

   ☐ Yes ☐ No ☒ UNKNOWN

(If yes, please note that University Medical Center of Southern Nevada employee(s), or appointed/elected official(s) may not perform any work on professional service contracts, or other contracts, which are not subject to competitive bid.)

2. Do any individual members, partners, owners or principals have a spouse, registered domestic partner, child, parent, in-law or brother/sister, half-brother/half-sister, grandchild, grandparent, related to a University Medical Center of Southern Nevada full-time employee(s), or appointed/elected official(s)?

   ☐ Yes ☐ No ☒ UNKNOWN

(If yes, please complete the Disclosure of Relationship form on Page 2. If no, please print N/A on Page 2.)

I certify under penalty of perjury, that all of the information provided herein is current, complete, and accurate. I also understand that the University Medical Center of Southern Nevada Governing Board will not take action on land-use approvals, contract approvals, land sales, leases or exchanges without the completed disclosure form.

Karen Schulte
Karen Schulte (Nov 22, 2024 14:17 PST)
Signature

Karen Schulte
Print Name

President
Title

11/22/2024
Date

REVISED 7/25/2014

DISCLOSURE OF RELATIONSHIP

List any disclosures below:
(Mark N/A, if not applicable.)

NAME OF BUSINESS OWNER/PRINCIPAL	NAME OF UMC* EMPLOYEE/OFFICIAL AND JOB TITLE	RELATIONSHIP TO UMC* EMPLOYEE/OFFICIAL	UMC* EMPLOYEE'S/OFFICIAL'S DEPARTMENT
N/A			

* UMC employee means an employee of University Medical Center of Southern Nevada

"Consanguinity" is a relationship by blood. "Affinity" is a relationship by marriage.

"To the second degree of consanguinity" applies to the candidate's first and second degree of blood relatives as follows:

- Spouse – Registered Domestic Partners – Children – Parents – In-laws (first degree)
- Brothers/Sisters – Half-Brothers/Half-Sisters – Grandchildren – Grandparents – In-laws (second degree)

For UMC Use Only:

If any Disclosure of Relationship is noted above, please complete the following:

☐ Yes ☐ No Is the UMC employee(s) noted above involved in the contracting/selection process for this particular agenda item?

☐ Yes ☐ No Is the UMC employee(s) noted above involved in any way with the business in performance of the contract?

Notes/Comments:

_____
Signature

_____
Print Name
Authorized Department Representative

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
GOVERNING BOARD AUDIT AND FINANCE COMMITTEE
AGENDA ITEM

Issue:	**Ratification of Amendment Two and Amendment Three to the Hospital Participation Agreement with Prominence HealthFirst**	**Back-up:**
Petitioner:	Jennifer Wakem, Chief Financial Officer	**Clerk Ref. #**

Recommendation:

That the Governing Board Audit and Finance Committee review and recommend for ratification by the Governing Board Amendment Two and Amendment Three to the Hospital Participation Agreement with Prominence HealthFirst for Managed Care Services; or take action as deemed appropriate. ***(For possible action)***

FISCAL IMPACT:

Fund Number: 5430.011
Fund Name: UMC Operating Fund
Fund Center: 3000850000
Funded Pgm/Grant: N/A
Description: Managed Care Services
Bid/RFP/CBE: NRS 332.115(1)(f) – Insurance
Term: January 1, 2026 – December 31, 2028
Amount: Revenue based on volume
Out Clause: 90 days w/o cause

BACKGROUND:

In January 2023, the Governing Board approved the Hospital Participation Agreement ("Agreement") between Prominence HealthFirst ("Prominence") and UMC to provide Prominence members access to UMC for medically necessary healthcare services. On March 26, 2025, the Agreement was amended to update the Professional and Urgent Care billing codes and to increase the payment rates.

Amendment Two updates and increases the facility, professional and Urgent Care reimbursement rates and extends the term of the Agreement through December 31, 2028.

Amendment Three adds the Nevada Medicaid Addendum to the Agreement, for UMC to provide covered services to beneficiaries enrolled in Prominence's Nevada Managed Medicaid and Children's Health Insurance Program (CHIP) products. It also adds additional facility and professional rates to the Agreement, effective January 1, 2026.

The Amendments had to be signed prior to January 1, 2026, to ensure continued services to Prominence members as the Agreement was due to terminate on December 31, 2025.

UMC's Director of Managed Care has reviewed and recommends ratification of the Amendments, which were approved as to form by UMC's Office of General Counsel.

A Clark County business license is not required as UMC is the provider of hospital services to this insurance fund.

Cleared for Agenda
January 21, 2026

Agenda Item #
10

AMENDMENT TWO
TO THE PROMINENCE HEALTHFIRST
HOSPITAL PARTICIPATION AGREEMENT

THIS AMENDMENT ("**Amendment**") is made to be effective on **January 1, 2026**, between **Prominence HealthFirst** ("**Prominence**") and **University Medical Center of Southern Nevada** ("**Hospital**") and hereby amends the Hospital Participation Agreement ("**Agreement**") effective January 1, 2023. Prominence and Hospital may be individually referred to herein as a "**Party**" and collectively as the "**Parties**."

RECITALS

Whereas, the Parties entered into the Agreement effective January 1, 2023; and

Whereas, Hospital issued a notice to Prominence dated September 12, 2025, terminating the Agreement effective December 1, 2025 (the "Termination Notice"); and

Whereas, the Parties now mutually desire to void the Termination Notice.

NOW, THEREFORE, in consideration of mutual covenants and agreements set forth herein, the Parties do hereby agree to amend the Agreement as follows:

AMENDMENT

1. The Termination Notice is hereby void. The Agreement shall continue in full force and effect through December 31, 2028.
2. Exhibit A Prominence Commercial Plan Hospital Fee Schedule titled UMC is deleted in its entirety and replaced with the attached Exhibit A Prominence Commercial Plan Hospital Fee Schedule titled UMC.
3. Exhibit B Prominence Commercial Physician/Provider Rates Fee Schedule titled UMC_Physicians is deleted in its entirety and replaced with Exhibit B Prominence Commercial Physician/Provider Rates Fee Schedule titled UMC_Physicians.
4. Section 6.6 of the Agreement shall be deleted in its entirety and replaced in its entirety with the following language:

   6.6 Hospital shall, provided the Customer's medical record is closed, submit all claim forms and required supporting documentation for services rendered to the Customer within ninety (90) days of the date of service or the date of discharge, or as otherwise required by applicable law. Failure by Hospital to submit claims within the timeframe specified by Prominence shall constitute a waiver of payment for such claims, unless Hospital demonstrates good cause for the delay as determined by Prominence in its sole discretion. Prominence agrees to review and respond in good faith to any claims submitted by Hospital in accordance with this Agreement.

All other terms and conditions of the Agreement remain in full force effect.

[Signatures appear on the following page.]

IN WITNESS WHEREOF, the Parties have caused this Amendment to be executed by its duly authorized representatives.

Prominence HealthFirst

Signed: Kamal Jemmoua

Print Name: Kamal Jemmoua

Title: Chief Executive Officer

Date: 12/17/2025

University Medical Center of Southern Nevada

Signed: Mason Van Houweling

Print Name: Mason Van Houweling

Title: Chief Executive Officer

Date: 12-18-25

Tax ID Number: **86-6000436**

EXHIBIT A
Prominence Commercial Plan
Payment Rules

[The information in this attachment is confidential and proprietary in nature.]

EXHIBIT B

Prominence Commercial Plan

Physician/Provider Rates

[The information in this attachment is confidential and proprietary in nature.]

AMENDMENT THREE
TO THE PROMINENCE HEALTHFIRST
HOSPITAL PARTICIPATION AGREEMENT

THIS AMENDMENT ("**Amendment**") is made to be effective on **January 1, 2026**, between **Prominence HealthFirst** ("**Prominence**") and **University Medical Center of Southern Nevada** ("**Hospital**") and hereby amends the Hospital Participation Agreement ("**Agreement**") effective January 1, 2023. Prominence and Hospital may be individually referred to herein as a "**Party**" and collectively as the "**Parties**."

NOW, THEREFORE, in consideration of mutual covenants and agreements set forth herein, the Parties do hereby agree to amend the Agreement as follows:

1. Nevada Medicaid Addendum is hereby added to the Agreement effective January 1, 2026. Subject to the Health Plan's product addition provisions set forth in the Hospital Participation Agreement, Medical Center shall provide covered services to beneficiaries enrolled in Health Plan's Nevada Managed Medicaid and Children's Health Insurance Program ("CHIP") Product. This Product is established under Health Plan's Medicaid contract with CareSource Nevada Co. or its affiliates (the "CareSource Nevada Medicaid Plan").
2. Nevada Compensation Schedule Hospital/Facility Exhibit A- Hospital/Facility Rates is hereby added to the Agreement effective January 1, 2026.
3. Nevada Medicaid Compensation Schedule Individual Participating Physician or Participating Physician Group Exhibit A- Physician or Physician Group Rates is hereby added to the Agreement effective January 1, 2026.

All other terms and conditions of the Agreement remain in full force effect.

IN WITNESS WHEREOF, the Parties have caused this Amendment to be executed by its duly authorized representatives.

Prominence HealthFirst

Signed: Kamal Jemmoua

Print Name: Kamal Jemmoua

Title: Chief Executive Officer

Date: 12/18/2025

University Medical Center of Southern Nevada

Signed: Mason Van Houweling

Print Name: Mason Van Houweling

Title: Chief Executive Officer

Date: 12/18/2025

Tax ID Number: **86-6000436**

NEVADA MEDICAID ADDENDUM

This Nevada Medicaid Addendum applies to Covered Services rendered by Hospital/Facility ("Hospital") to Members enrolled in any Nevada managed Medicaid and Children's Health Insurance Program ("**CHIP**") Health Benefit Plan administered by CareSource Nevada Co. or its affiliates ("**CareSource's Nevada Medicaid Plan**"). This Addendum will become effective as of the effective date of any Medicaid and CHIP contract between CareSource and the Nevada Department of Health and Human Services, Division of Health Care Financing and Policy (the "**Nevada Medicaid Contract**") to the extent CareSource is awarded a Nevada Medicaid Contract. Capitalized terms shall have the meanings defined in this Addendum, the Agreement, or the Nevada Medicaid Contract. In the event of a conflict between the terms of the Agreement and the terms of this Addendum, the terms of this Addendum shall control. To the extent required, this Addendum shall act as an amendment to the Agreement's list of network products to which the Agreement applies to include CareSource's Nevada Medicaid Plan.

ARTICLE I - GENERAL TERMS

1.1 **Governing Law and Venue.** For any dispute arising out of or related to the Agreement with respect to Health Benefit Plans covered by this Addendum, the validity, enforceability, and interpretation of the Agreement shall be governed by the laws of Nevada; and Clark County, Nevada shall be the sole, proper venue of any arbitration, proceeding, or special proceeding between the Parties.

1.2 **Term and Termination.** In addition to the Parties' termination rights as set forth in the Agreement, this Addendum will immediately terminate if the State terminates CareSource's Nevada Medicaid Contract or if CareSource otherwise discontinues offering CareSource Nevada Medicaid Plans.

ARTICLE II - PAYMENT RATES

2.1 **Payment Rates.** For Covered Services rendered by Hospital to Members enrolled in CareSource's Nevada Medicaid Plan, CareSource will reimburse Hospital at the rates set forth in the attached compensation schedule(s).

ARTICLE III - REGULATORY LANGUAGE

3.1 **Member Held Harmless.** In addition to the Member hold harmless provisions contained in the Agreement, Hospital agrees as follows:

3.1.1 In no event, including but not limited to nonpayment by CareSource, insolvency of CareSource, or breach of this Agreement, shall Hospital bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Member or a Member's representative for Health Services provided pursuant to this Agreement.

3.1.2 This Agreement does not prohibit Hospital from collecting coinsurance, deductibles, or copayments, as specifically provided under the Nevada Medicaid Contract, or fees for uncovered services delivered on a fee-for-service basis to Members to the extent permitted under this Agreement and applicable Law.

3.1.3 This Agreement does not prohibit Hospital and a Member from agreeing to continue Health Services solely at the expense of the Member, as long as Hospital has clearly informed the Member that CareSource may not cover or continue to cover a specific Health Service and discloses the costs of the Health Services.

3.1.4 Except as provided herein, this Agreement does not prohibit Hospital from pursuing any available legal remedy.

This paragraph 3.1 shall be construed in favor of the Member; shall survive the termination of the Agreement regardless of the reason for the termination, including, without limitation, the insolvency of CareSource or any applicable intermediary; and shall supersede any oral or written contrary agreement between Hospital and a Member or the representative of the Member.

3.2 **Continuity of Care.** In the event of CareSource's insolvency, the insolvency of any applicable intermediary, or any other cessation of operations, Hospital must continue to deliver Covered Services

to a Member without billing the Member for any amount other than coinsurance, deductibles, or copayments, as specifically provided in the Nevada Medicaid Contract, until the earlier of:

3.2.1 The date of the cancellation of the Member's coverage under the Health Benefit Plan, including, without limitation, any extension of coverage provided pursuant to the terms of the Health Benefit Plan or applicable Law; or

3.2.2 The date on which this Agreement otherwise would have terminated if CareSource had remained in operation, including, without limitation, any extension of coverage provided pursuant to the terms of the Health Benefit Plan or applicable Law.

This paragraph 3.2 shall be construed in favor of the Member; shall survive the termination of the Agreement regardless of the reason for the termination, including, without limitation, the insolvency of CareSource or any applicable intermediary; and shall supersede any oral or written contrary agreement between Hospital and a Member or the representative of the Member.

3.3 **Notice of Insolvency.** CareSource shall provide written notice to Hospital as soon as practicable if a court determines CareSource or any applicable intermediary to be insolvent or any other cessation of operations of CareSource or any applicable intermediary.

3.4 **Access to Records.** Hospital shall make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of Members, and to comply with the applicable state and federal laws related to the confidentiality of medical and health records and the Member's right to see, obtain copies of or amend their medical and health records.

3.5 **Non-Assignment**. Neither Hospital nor PPO may assign or delegate the rights and responsibilities under this Medicaid Addendum without the prior written consent of the other party.

3.6 **Notice of Change**. PPO shall provide notice to Hospital of any material changes to the provisions of this Medicaid Addendum or any documents incorporated by reference into it. Such notice shall be provided within 30 days of such material change. A material change is one that results in or could reasonably result in the completion of, fulfillment of or execution of this Medicaid Addendum.

3.7 **Quality Assurance Programs**. Hospital shall cooperate with all CareSource quality assurance programs.

3.8 **Access to Medical Records**. Hospital shall allow CareSource access to the medical records of CareSource Members. Hospital shall comply with HIPAA, including, but not limited to, its requirements concerning access to medical records for purposes of quality reviews conducted by the Secretary of the United States, Department of Health and Human Services (the Secretary), the State, or agents thereof. Medical Records must be available to health care practitioners at each encounter.

3.9 **CareSource Nevada Medicaid Plan Policies and Procedures**. Hospital shall comply with all CareSource Nevada Medicaid Plan's policies and procedures, including, but not limited to, those applicable to claim submission and authorizations. Such policies and procedures shall be available on CareSource Nevada Medicaid Plan's website.

NEVADA COMPENSATION SCHEDULE
HOSPITAL/FACILITY
EXHIBIT A – HOSPITAL/FACILITY RATES

[The information in this attachment is confidential and proprietary in nature.]

NEVADA MEDICAID COMPENSATION SCHEDULE
INDIVIDUAL PARTICIPATING PHYSICIAN OR PARTICIPATING PHYSICIAN GROUP
EXHIBIT A – PHYSICIAN OR PHYSICIAN GROUP RATES

[The information in this attachment is confidential and proprietary in nature.]

INSTRUCTIONS FOR COMPLETING THE
DISCLOSURE OF OWNERSHIP/PRINCIPALS FORM

Purpose of the Form

The purpose of the Disclosure of Ownership/Principals Form is to gather ownership information pertaining to the business entity for use by the University Medical Center of Southern Nevada Governing Board ("GB") in determining whether members of the GB should exclude themselves from voting on agenda items where they have, or may be perceived as having a conflict of interest, and to determine compliance with Nevada Revised Statute 281A.430, contracts in which a public officer or employee has interest is prohibited.

General Instructions

Completion and submission of this Form is a condition of approval or renewal of a contract or lease and/or release of monetary funding between the disclosing entity and University Medical Center of Southern Nevada. Failure to submit the requested information may result in a refusal by the GB to enter into an agreement/contract and/or release monetary funding to such disclosing entity.

Detailed Instructions

All sections of the Disclosure of Ownership form must be completed. If not applicable, write in N/A.

Business Entity Type – Indicate if the entity is an Individual, Partnership, Limited Liability Company, Corporation, Trust, Non-profit Organization, or Other. When selecting 'Other', provide a description of the legal entity.

Non-Profit Organization (NPO) - Any non-profit corporation, group, association, or corporation duly filed and registered as required by state law.

Business Designation Group – Indicate if the entity is a Minority Owned Business Enterprise (MBE), Women-Owned Business Enterprise (WBE), Small Business Enterprise (SBE), Physically-Challenged Business Enterprise (PBE), Veteran Owned Business (VET), Disabled Veteran Owned Business (DVET), or Emerging Small Business (ESB) . This is needed in order to provide utilization statistics to the Legislative Council Bureau, and will be used only for such purpose.

- **Minority Owned Business Enterprise (MBE):** An independent and continuing business for profit which performs a commercially useful function and is at least 51% owned and controlled by one or more minority persons of Black American, Hispanic American, Asian-Pacific American or Native American ethnicity.
- **Women Owned Business Enterprise (WBE**): An independent and continuing business for profit which performs a commercially useful function and is at least 51% owned and controlled by one or more women.
- **Physically-Challenged Business Enterprise (PBE):** An independent and continuing business for profit which performs a commercially useful function and is at least 51% owned and controlled by one or more disabled individuals pursuant to the federal Americans with Disabilities Act.
- **Small Business Enterprise (SBE):** An independent and continuing business for profit which performs a commercially useful function, is not owned and controlled by individuals designated as minority, women, or physically-challenged, and where gross annual sales does not exceed $2,000,000.
- **Veteran Owned Business Enterprise (VET):** An independent and continuing Nevada business for profit which performs a commercially useful function and is at least 51 percent owned and controlled by one or more U.S. Veterans.
- **Disabled Veteran Owned Business Enterprise (DVET):** A Nevada business at least 51 percent owned/controlled by a disabled veteran.
- **Emerging Small Business (ESB):** Certified by the Nevada Governor's Office of Economic Development effective January, 2014. Approved into Nevada law during the 77th Legislative session as a result of AB294.

Business Name (include d.b.a., if applicable) – Enter the legal name of the business entity and enter the "Doing Business As" (d.b.a.) name, if applicable.

Corporate/Business Address, Business Telephone, Business Fax, and Email – Enter the street address, telephone and fax numbers, and email of the named business entity.

Nevada Local Business Address, Local Business Telephone, Local Business Fax, and Email – If business entity is out-of-state, but operates the business from a location in Nevada, enter the Nevada street address, telephone and fax numbers, point of contact and email of the local office. Please note that the local address must be an address from which the business is operating from that location. Please do not include a P.O. Box number, unless required by the U.S. Postal Service, or a business license hanging address.

***Number of Clark County Nevada Residents employed by this firm. (*Do not leave blank. If none or zero, put the number 0 in the space provided.)**

List of Owners/Officers – Include the full name, title and percentage of ownership of each person who has ownership or financial interest in the business entity. If the business is a publicly-traded corporation or non-profit organization, list all Corporate Officers and Directors only.

For All Contracts – **(Not required for publicly-traded corporations)**

1) Indicate if any individual members, partners, owners or principals involved in the business entity are a University Medical Center of Southern Nevada full-time employee(s), or appointed/elected official(s). If yes, the following paragraph applies.

   In accordance with NRS 281A.430.1, a public officer or employee shall not bid on or enter into a contract between a government agency and any private business in which he has a significant financial interest, except as provided for in subsections 2, 3, and 4.

2) Indicate if any individual members, partners, owners or principals involved in the business entity have a second degree of consanguinity or affinity relation to a University Medical Center of Southern Nevada full-time employee(s), or appointed/elected official(s) (reference form on Page 2 for definition). If **YES**, complete the Disclosure of Relationship Form.

A professional service is defined as a business entity that offers business/financial consulting, legal, physician, architect, engineer or other professional services.

Signature and Print Name – Requires signature of an authorized representative and the date signed.

Disclosure of Relationship Form – If any individual members, partners, owners or principals of the business entity is presently a University Medical Center of Southern Nevada employee, public officer or official, or has a second degree of consanguinity or affinity relationship to a University Medical Center of Southern Nevada employee, public officer or official, this section must be completed in its entirety.

DISCLOSURE OF OWNERSHIP/PRINCIPALS

Business Entity Type (Please select one)						
☐ Sole Proprietorship	☐Partnership	☐ Limited Liability Company	☒ Corporation	☐ Trust	☐ Non-Profit Organization	☐ Other

Business Designation Group (Please select all that apply) N/A						
☐ MBE	☐ WBE	☐ SBE	☐ PBE	☐ VET	☐DVET	☐ ESB
Minority Business Enterprise	Women-Owned Business Enterprise	Small Business Enterprise	Physically Challenged Business Enterprise	Veteran Owned Business	Disabled Veteran Owned Business	Emerging Small Business

Number of Clark County Nevada Residents Employed: 18

Corporate/Business Entity Name:	Prominence HealthFirst	
(Include d.b.a., if applicable)	Prominence Health Plan	
Street Address:	8311 W. Sunset Road Suite 105	**Website:** prominencehealthplan.com
City, State and Zip Code:	Las Vegas, NV 89113	**POC Name:** Philip Ramirez **Email:** philip.ramirez@uhsinc.com
Telephone No:	775-770-9348	**Fax No:** N/A
Nevada Local Street Address: **(If different from above)**	N/A	**Website:**
City, State and Zip Code:		**Local Fax No:**
Local Telephone No:		**Local POC Name:** **Email:**

All entities, with the exception of publicly-traded and non-profit organizations**,** must list the names of individuals holding more than five percent (5%) ownership or financial interest in the business entity appearing before the Board.

Publicly-traded entities and non-profit organizations shall list all Corporate Officers and Directors in lieu of disclosing the names of individuals with ownership or financial interest. The disclosure requirement, as applied to land-use applications, extends to the applicant and the landowner(s).

Entities include all business associations organized under or governed by Title 7 of the Nevada Revised Statutes, including but not limited to private corporations, close corporations, foreign corporations, limited liability companies, partnerships, limited partnerships, and professional corporations.

Full Name	Title	% Owned (Not required for Publicly Traded Corporations/Non-profit organizations)
Prominence Holdings, LLC	Entity	100%

This section is not required for publicly-traded corporations. Are you a publicly-traded corporation? ☐ Yes ☐ No

1. Are any individual members, partners, owners or principals, involved in the business entity, a University Medical Center of Southern Nevada full-time employee(s), or appointed/elected official(s)?

   ☐ Yes ☒ No (If yes, please note that University Medical Center of Southern Nevada employee(s), or appointed/elected official(s) may not perform any work on professional service contracts, or other contracts, which are not subject to competitive bid.)

2. Do any individual members, partners, owners or principals have a spouse, registered domestic partner, child, parent, in-law or brother/sister, half-brother/half-sister, grandchild, grandparent, related to a University Medical Center of Southern Nevada full-time employee(s), or appointed/elected official(s)?

   ☐ Yes ☒ No (If yes, please complete the Disclosure of Relationship form on Page 2. If no, please print N/A on Page 2.)

I certify under penalty of perjury, that all of the information provided herein is current, complete, and accurate. I also understand that the University Medical Center of Southern Nevada Governing Board will not take action on land-use approvals, contract approvals, land sales, leases or exchanges without the completed disclosure form.

Signature

Philip Ramirez
Print Name

Chief Compliance Officer
Title

1/5/2023
Date

REVISED 7/25/2014

DISCLOSURE OF RELATIONSHIP

List any disclosures below:
(Mark N/A, if not applicable.)

NAME OF BUSINESS OWNER/PRINCIPAL	NAME OF UMC* EMPLOYEE/OFFICIAL AND JOB TITLE	RELATIONSHIP TO UMC* EMPLOYEE/OFFICIAL	UMC* EMPLOYEE'S/OFFICIAL'S DEPARTMENT
N/A	N/A	N/A	N/A

* UMC employee means an employee of University Medical Center of Southern Nevada

"Consanguinity" is a relationship by blood. "Affinity" is a relationship by marriage.

"To the second degree of consanguinity" applies to the candidate's first and second degree of blood relatives as follows:

- Spouse – Registered Domestic Partners – Children – Parents – In-laws (first degree)
- Brothers/Sisters – Half-Brothers/Half-Sisters – Grandchildren – Grandparents – In-laws (second degree)

For UMC Use Only:

If any Disclosure of Relationship is noted above, please complete the following:

☐ Yes ☐ No Is the UMC employee(s) noted above involved in the contracting/selection process for this particular agenda item?

☐ Yes ☐ No Is the UMC employee(s) noted above involved in any way with the business in performance of the contract?

Notes/Comments:

_____
Signature

_____
Print Name
Authorized Department Representative

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
GOVERNING BOARD AUDIT AND FINANCE COMMITTEE
AGENDA ITEM

Issue:	**Ratification of the Eighth Amendment to Provider Services Agreement and Tenth Amendment to the Memorandum of Understanding with Intermountain IPA, LLC**	**Back-up:**
Petitioner:	Jennifer Wakem, Chief Financial Officer	**Clerk Ref. #**

Recommendation:

That the Governing Board Audit and Finance Committee review and recommend for ratification by the Governing Board the Eighth Amendment to Provider Services Agreement and Tenth Amendment to the Memorandum of Understanding with Intermountain IPA, LLC for Managed Care Services; or take action as deemed appropriate. ***(For possible action)***

FISCAL IMPACT:

Fund Number: 5430.011
Fund Name: UMC Operating Fund
Fund Center: 3000850000
Funded Pgm/Grant: N/A
Description: Managed Care Services
Bid/RFP/CBE: NRS 332.115(1)(f) – Insurance
Eighth Amendment Term:
1/1/2026 to 12/31/2029 – Medicare Advantage Products
1/1/2026 to 4/30/2026 – Commercial Products
MOU Tenth Amendment Term:
1/1/2026 to 5/31/2026
Amount: Revenue based on volume

BACKGROUND:

On December 16, 2020, the Governing Board approved the Provider Service Agreement ("Agreement") with HCP IPA Nevada, LLC ("HCP") to provide its members with continued healthcare access to UMC, its associated Urgent Care facilities, and to adjust the Urgent Care reimbursement. It has subsequently been amended to update compensation fee schedules and adjust the term dates.

This request is for ratification of Amendment Number Eight to the Agreement, which extends the term of the Medicare Advantage Products to December 31, 2029, and the term for Commercial Products until April 30, 2026. This Amendment will also increase various reimbursement rates for services under the compensation attachments. Ratification was necessary, as the Agreement was due to terminate on December 31, 2025, leaving members out of network.

Cleared for Agenda
January 21, 2026

Agenda Item #
11

On June 19, 2012, the Board of Hospital Trustees approved a Memorandum of Understanding ("MOU") with Intermountain for the treatment of Intermountain Medicare Advantage members. The MOU was subsequently amended over the term to update compensation fee schedules and adjust the term dates.

This request is for ratification of the Tenth Amendment to the MOU, which updates Exhibit C of the Agreement to include Anthem Blue Cross Blue Shield Medicare Advantage HMO, effective January 1, 2026. Ratification was necessary as the parties needed further time for negotiations.

UMC's Director of Managed Care has reviewed and recommends ratification of the Amendments, which were reviewed and approved as to form by UMC's Office of General Counsel.

A Clark County business license is not required, as UMC is the provider of hospital services to the Intermountain insurance fund.

TENTH AMENDMENT TO
The Memorandum of Understanding Between
Intermountain IPA, LLC
University Medical Center of Southern Nevada

THIS TENTH AMENDMENT ("Amendment"), dated and effective January 1, 2026, is entered into by and between University Medical Center of Southern Nevada, (hereinafter referred to as "Hospital") and Intermountain IPA, LLC ((f/k/a DaVita Medical IPA Nevada, LLC dba JSA P5 Nevada, LLC and HealthCare Partners of Nevada, and HCP IPA Nevada, LLC)hereinafter referred to as "Company").

WHEREAS, the Parties have previously executed a Memorandum of Understanding (the "MOU") effective June 1, 2012;amended on June 1, 2015 to extend the term period and adjust the contract rates; amended on July 13, 2017 to do a Name Change and adjust the Per Diem Exclusions section; amended on June 1, 2018 to extend the term period and adjust the contract rates; amended on June 1, 2020 to do a Name Change, adjust contract rates, and modify Exhibit C; amended on February 1, 2021 to delete Exhibit C and replace with Exhibit C Plans; amended on January 1, 2022 to delete Exhibit C and replace with Exhibit C Plans; amended on June 1, 2023 to update HCP IPA Nevada, LLC's name and extend the term period and adjust the contract rates; and amended on January 1, 2025 to delete Exhibit C and replace with Exhibit C Plans; and

WHEREAS, the Parties desire to further amend the MOU to modify Exhibit C.

NOW THEREFORE, in consideration of the mutual covenants and agreements contained herein and in the MOU, the parties agree to amend the MOU as follows:

1. Delete Exhibit C Plans dated January 1, 2025, in its entirety and replace with Exhibit C as follows:

Exhibit C Plans

a. Alignment Health Plan of Nevada Medicare Advantage HMO
b. Alignment Health Plan of North Carolina Medicare Advantage HMO
c. Anthem Blue Cross Blue Shield Medicare Advantage HMO*
d. Humana Medicare Advantage HMO
e. SCAN Health Plan Nevada Medicare Advantage HMO
f. SelectHealth Medicare Advantage HMO
g. United Healthcare Medicare Advantage HMO
h. United Healthcare Medicare Advantage PPO

*Effective date is January 1, 2026.

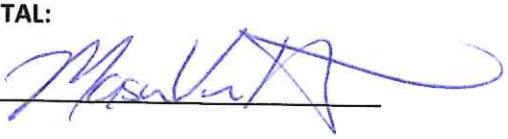
2. This Amendment supersedes any terms of the Agreement (including previous amendments) in conflict with the terms herein. All other terms of the Agreement remain in full force and effect. All capitalized terms used in this Amendment and not otherwise defined shall have the meanings set forth in the Agreement. A Party's signature below denotes agreement to these terms by its authorized representative.

The Parties ratify and affirm the MOU and agree that it is in full force and effect as amended herein. In case of conflict between the terms of the MOU and the terms of this Amendment, the terms of this Amendment will control.

[The balance of this page is intentionally left blank]

IN WITNESS WHEREOF, the Parties have the authority necessary to bind the entities identified herein and have executed this Amendment to be effective as of the Effective Date.

HOSPITAL:

By: 

Name: Mason VanHouweling

Title: Chief Executive Officer

Date: 12-17-25

COMPANY

By: Devaraj A. Ramsamy

Digitally signed by Devaraj A. Ramsamy
Date: 2025.12.12 14:42:12 -08'00'

Name: Dev Ramsamy

Title: Regional VP Finance, Desert Region

Date: 12/12/2025

AMENDMENT NUMBER EIGHT

This Amendment Number Eight ("Amendment"), dated and effective January 01, 2026 (the "Effective Date"), amends the Provider Service Agreement by and between Intermountain IPA, LLC, a Nevada limited liability company ("Company") and University Medical Center of Southern Nevada, ("Provider") originally dated January 01, 2021, as amended.

WHEREAS, the parties have previously executed a Provider Service Agreement effective January 1, 2021, a First Amendment effective January 1, 2022, a Second Amendment effective February 1, 2023, a Third Amendment effective February 1, 2023, a Fourth Amendment effective September 1, 2023, a Fifth Amendment effective December 1, 2023 , a Sixth Amendment effective July 1, 2024, a Seventh Amendment effective January 1, 2025 (collectively, the "Agreement"); and

Whereas, Company and Provider now desire to amend the Agreement.

NOW, THEREFORE, the parties agree the Agreement is hereby amended as follows:

1. **Section 4.1 Term of Agreement** – Medicare Advantage products shall be extended for an additional 36 months commencing on January 1, 2026 ending December 31, 2029, at 11:59pm, unless terminated sooner in accordance with the provisions of this Agreement. Commercial Products shall be extended for an additional 4 months commencing on January 1, 2026 ending April 30, 2026, unless terminated sooner in accordance with the provisions of this Agreement.

2. **Attachment A-1 Capitated Compensation – II a. Capitation for Primary Care Services Medicare Advantage HMO Capitation** shall be deleted in its entirety and restated as follows:

   Medicare Advantage HMO Capitation – Capitation for Members enrolled in a capitated Medicare Advantage HMO plan shall be equal to [redacted] PMPM for each Medicare Advantage HMO Member assigned to Provider under a capitated agreement.

3. **Attachment A-2 Fee for Service Compensation II Carve-Outs – Sections F, H, I, J, K and L** shall be deleted in its entirety and restated as follows:

   f. Payments for Urgent Care Services. For urgent care services rendered to Members, Company shall reimburse Provider as defined herein:

[The information in this attachment is confidential and proprietary in nature.]

IN WITNESS WHEREOF, the parties hereto have executed and delivered this Amendment to be effective as of the Effective Date.

University Medical Center of Southern Nevada

By

Mason VanHouweling

Name

CEO

Title

12/23/25

Date

Intermountain IPA, LLC

Devaraj A. Ramsamy

Digitally signed by Devaraj A. Ramsamy
Date: 2025.12.29 06:28:01 -08'00'

By

Devaraj A. Ramsamy

Name

Region VP Finance - Desert Region

Title

12/29/2025

Date

INSTRUCTIONS FOR COMPLETING THE DISCLOSURE OF OWNERSHIP/PRINCIPALS FORM

Purpose of the Form

The purpose of the Disclosure of Ownership/Principals Form is to gather ownership information pertaining to the business entity for use by the Board of County Commissioners ("BCC") in determining whether members of the BCC should exclude themselves from voting on agenda items where they have, or may be perceived as having a conflict of interest, and to determine compliance with Nevada Revised Statute 281A.430, contracts in which a public officer or employee has interest is prohibited.

General Instructions

Completion and submission of this Form is a condition of approval or renewal of a contract or lease and/or release of monetary funding between the disclosing entity and the appropriate Clark County government entity. Failure to submit the requested information may result in a refusal by the BCC to enter into an agreement/contract and/or release monetary funding to such disclosing entity.

Detailed Instructions

All sections of the Disclosure of Ownership form must be completed.

Type of Business – Indicate if the entity is an Individual, Partnership, Limited Liability Corporation, Corporation, Trust, Non-profit, or Other. When selecting 'Other', provide a description of the legal entity.

Business Designation Group – Indicate if the entity is a Minority Owned Business Enterprise (MBE), Women Owned Business Enterprise (WBE), Small Business Enterprise (SBE), Physically-Challenged Business Enterprise (PBE), Large Business Enterprise (LBE) or Nevada Business Enterprise (NBE).

Minority Owned Business Enterprise (MBE):
An independent and continuing business for profit which performs a commercially useful function and is at least 51% owned and controlled by one or more minority persons of Black American, Hispanic American, Asian-Pacific American or Native American ethnicity.
Women Owned Business Enterprise (WBE):
An independent and continuing business for profit which performs a commercially useful function and is at least 51% owned and controlled by one or more women.
Physically-Challenged Business Enterprise (PBE):
An independent and continuing business for profit which performs a commercially useful function and is at least 51% owned and controlled by one or more disabled individuals pursuant to the federal Americans with Disabilities Act.
Small Business Enterprise (SBE):
An independent and continuing business for profit which performs a commercially useful function, is not owned and controlled by individuals designated as minority, women, or physically-challenged, and where gross annual sales does not exceed $2,000,000.
Nevada Business Enterprise (NBE):
Any business headquartered in the State of Nevada and is owned or controlled by individuals that are not designated as socially or economically disadvantaged.
Large Business Enterprise (LBE):
An independent and continuing business for profit which performs a commercially useful function and is not located in Nevada.

Business Name (include d.b.a., if applicable) – Enter the legal name of the business entity and enter the "Doing Business As" (d.b.a.) name, if applicable.

Business Address, Business Telephone, Business Fax, and Email – Enter the street address, telephone and fax numbers, and email of the named business entity.

Local Business Address, Local Business Telephone, Local Business Fax, and Email – If business entity is out-of-state, but has a local office in Nevada, enter the Nevada street address, telephone and fax numbers, and email of the local office.

List of Owners – Include the full name, title and percentage of ownership of each person who has ownership or financial interest in the business entity. If the business is a publicly-traded corporation, list all Corporate Officers and members of the Board of Directors only.

For All Contracts –

1) Indicate if any individual members, partners, owners or principals involved in the business entity are a Clark County full-time employee(s), or appointed/elected official(s). If yes, the following paragraph applies.

   In accordance with NRS 281A.430.1, a public officer or employee shall not bid on or enter into a contract between a government agency and any private business in which he has a significant financial interest, except as provided for in subsections 2, 3, and 4.

2) Indicate if any individual members, partners, owners or principals involved in the business entity have a second degree of consanguinity or affinity relation to a Clark County full-time employee(s), or appointed/elected official(s) (reference form on Page 3 for definition). If **YES**, complete the Disclosure of Relationship Form.

Clark County is comprised of the following government entities: Clark County, University Medical Center of Southern Nevada, Department of Aviation (McCarran Airport), and Clark County Water Reclamation District.

A professional service is defined as a business entity that offers business/financial consulting, legal, physician, architect, engineer or other professional services.

Signature and Print Name – Requires signature of an authorized representative and the date signed.

Disclosure of Relationship Form – If any individual members, partners, owners or principals of the business entity is presently a Clark County employee, public officer or official, or has a second degree of consanguinity or affinity relationship to a Clark County employee, public officer or official, this section must be completed in its entirety. Include the name of business owner/principal, name of Clark County employee(s), public officer or official, relationship to Clark County employee(s), public officer or official, and the Clark County department where the Clark County employee, public officer or official, is employed.

DISCLOSURE OF OWNERSHIP/PRINCIPALS

Type of Business					
☐ Individual	☐ Partnership	☒ Limited Liability Corporation	☐ Corporation	☐ Trust	☐ Other

Business Designation Group (For informational purposes only)					
☐ MBE	☐ WBE	☐ SBE	☐ PBE	☐ LBE	☐ NBE
Minority Business Enterprise	Women-Owned Business Enterprise	Small Business Enterprise	Physically Challenged Business Enterprise	Large Business Enterprise	Nevada Business Enterprise

Business Name:	Intermountain IPA, LLC	
(Include d.b.a., if applicable)		
Business Address:	6355 S. Buffalo Drive, Third Floor	Las Vegas, NV 89113
Business Telephone:	702-318-2400	**Email:** https://intermountainnv.org/contact-us/
Business Fax:		
Local Business Address	6355 S. Buffalo Drive, Third Floor	Las Vegas, NV 89113
Local Business Telephone:	702-318-2400	**Email:** https://intermountainnv.org/contact-us/
Local Business Fax:		

All non-publicly traded corporate business entities must list the names of individuals holding more than five percent (5%) ownership or financial interest in the business entity appearing before the Board.

"Business entities" include all business associations organized under or governed by Title 7 of the Nevada Revised Statutes, including but not limited to private corporations, close corporations, foreign corporations, limited liability companies, partnerships, limited partnerships, and professional corporations.

Corporate entities shall list all Corporate Officers and Board of Directors in lieu of disclosing the names of individuals with ownership or financial interest. The disclosure requirement, as applied to land-use transactions, extends to the applicant and the landowner(s).

Full Name	Title	% Owned (Not required for Publicly Traded Corporations)
Paul Krakovitz,MD	President, Secretary	None (officer only)
Justin Bollenback	Vice President, Chief Financial Officer	None (officer only)
Cara Camiolo, MD	Chief Medical Officer	None (officer only)

1. Are any individual members, partners, owners or principals, involved in the business entity, a Clark County, University Medical Center, Department of Aviation, or Clark County Water Reclamation District full-time employee(s), or appointed/elected official(s)?

   ☐ Yes ☒ No (If yes, please note that County employee(s), or appointed/elected official(s) may not perform any work on professional service contracts, or other contracts, which are not subject to competitive bid.)

2. Do any individual members, partners, owners or principals have a spouse, registered domestic partner, children, parent, in-laws or brothers/sisters, half-brothers/half-sister, grandchildren, grandparents, in-laws related to a Clark County, University Medical Center, Department of Aviation, or Clark County Water Reclamation District full-time employee(s), or appointed/elected official(s)?

   ☐ Yes ☒ No (If yes, please disclose on the attached Disclosure of Relationship form.)

I certify under penalty of perjury, that all of the information provided herein is current, complete, and accurate. I also understand that the Board will not take action on land-use approvals, contract approvals, land sales, leases or exchanges without the completed disclosure form.

Signature

John D. Lach
Print Name

VP, Contracting + MSO
Title

4/4/23
Date

DISCLOSURE OF RELATIONSHIP

List any disclosures below:

NAME OF BUSINESS OWNER/PRINCIPAL	NAME OF COUNTY* EMPLOYEE(S)	RELATIONSHIP TO COUNTY* EMPLOYEE	COUNTY DEPARTMENT

* County employee means Clark County, University Medical Center, Department of Aviation, or Clark County Water Reclamation District.

"Consanguinity" is a relationship by blood. "Affinity" is a relationship by marriage.

"To the second degree of consanguinity" applies to the candidate's first and second degree of blood relatives as follows:

- Spouse – Registered Domestic Partners – Children – Parents – In-laws (first degree)
- Brothers/Sisters – Half-Brothers/Half-Sisters – Grandchildren – Grandparents – In-laws (second degree)

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
GOVERNING BOARD AUDIT AND FINANCE COMMITTEE
AGENDA ITEM

Issue:	**Ratification of the Combined Services Agreement and Amendment with Molina Healthcare of Nevada, Inc.**	**Back-up:**
Petitioner:	Jennifer Wakem, Chief Financial Officer	**Clerk Ref. #**

Recommendation:

That the Governing Board Audit and Finance Committee review and recommend for ratification by the Governing Board, the Combined Services Agreement and Amendment with Molina Healthcare of Nevada, Inc. for Managed Care Services; or take action as deemed appropriate. ***(For possible action)***

FISCAL IMPACT:

Fund Number: 5430.011
Fund Name: UMC Operating Fund
Fund Number: 3000850000
Funded Pgm/Grant: N/A
Description: Managed Care Services
Bid/RFP/CBE: NRS 332.115(1)(f) – Insurance
Term: January 1, 2025 – December 31, 2026
Amount: Revenue based on volume
Out Clause: 90 days without cause

BACKGROUND:

This request is to enter into a Combined Services Agreement with Molina Healthcare of Nevada, Inc. ("Molina") which will supersede the previous Provider Services Agreement entered into in 2021 with Molina. Through this Agreement, UMC will realize increased reimbursement rates. The term of this Agreement is through December 31, 2026, with the option for three subsequent yearly renewals. The Amendment to the agreement introduces a Value-Based Payment Program, which offers providers the opportunity to earn incentives by enhancing the quality of care.

Ratification of the Agreement and Amendment was necessary as the parties' final negotiations were reached after the previous target date.

UMC's Director of Managed Care has reviewed and recommends ratification of the Agreement and Amendment, which were also approved as to form by UMC's Office of General Counsel.

A Clark County business license is not required as UMC is the provider of hospital services to this insurance fund.

Cleared for Agenda
January 21, 2026

Agenda Item #
12

MOLINA HEALTHCARE OF NEVADA, INC.
COMBINED SERVICES AGREEMENT

SIGNATURE PAGE

In consideration of the promises and representations stated herein, the Parties agree as set forth in this Agreement. The Authorized Representative acknowledges, warrants, and represents that the Authorized Representative has the authority and authorization to act on behalf of its Party. The Authorized Representative further acknowledges and represents that he/she received and reviewed this Agreement in its entirety.

The Authorized Representative of Provider acknowledges the Provider Manual was available for review prior to entering into this Agreement and agrees that Provider will comply with the provisions set forth under the Provider Manual section and other applicable provisions related to the Provider Manual in the Agreement.

The Authorized Representative for each Party executes this Agreement with the intent to bind the Parties in accordance with this Agreement.

Provider Signature and Information.

University Medical Center of Southern Nevada ("Provider") – Matching the applicable tax form (i.e. W-9, Line 1):	
Authorized Representative's Signature: Mason Van Houweling	Authorized Representative's Name – Printed: Mason Van Houweling
Authorized Representative's Title: CEO	Authorized Representative's Signature Date: 12/12/2025
Telephone Number: (702) 383-2000	Fax Number – Official Correspondence:
Mailing Address – Official Correspondence: 1800 W. Charleston Blvd., Las Vegas, Nevada, 89102	Payment Address – If different than Mailing Address:
IRS 1099 Address – If different than Mailing Address:	Email Address – Official Correspondence:
Tax ID Number – As listed on applicable tax form:	NPI – That corresponds to the Tax ID Number: 88-60000436

Health Plan Signature and Information.

Molina Healthcare of Nevada, Inc., a Nevada Corporation ("Health Plan")	
Authorized Representative's Signature: Sara Cooper	Authorized Representative's Name – Printed: Sara Cooper
Authorized Representative's Title: VP, Network Management	Authorized Representative's Countersignature Date: 12/15/25
Mailing Address – Official Correspondence: 8329 W Sunset Rd #100 Las Vegas, NV 89113	Email Address – Official Correspondence:
Effective Date of the Agreement ("Effective Date"): 1/1/25	

COMBINED SERVICES AGREEMENT

Provider and Health Plan enter into this Agreement as of January 1, 2025 (the "Effective Date"). The Provider and Health Plan each are referred to as a "Party" and collectively as the "Parties."

RECITALS

A. WHEREAS, Health Plan is a corporation licensed and approved by required governmental agencies to operate a health care service plan, including without limitation, to issue benefit agreements covering the provision of health care and related services and supplies in accordance with the law;

B. WHEREAS, Provider is a licensed Clark County owned and operated acute care hospital established pursuant to Chapter 450 of the Nevada Revised Statutes and accredited by Det Norske Veritas (DNV) and, certified for participation under Medicare and Medicaid, Title XVIII and XIX of the Social Security Act that desires to provide hospital services to Participants under the terms of this Agreement;

C. WHEREAS, the Parties intend by entering into this Agreement they will make health care and related services and supplies available to eligible recipients enrolled in various Products (referenced in Attachment A) covered under this Agreement; and

D. WHEREAS, Parties previously entered into a Provider Services Agreement effective from January 1, 2022, through December 31, 2024.

NOW, THEREFORE, in consideration of the promises and representations stated, the Parties agree as follows:

ARTICLE ONE – DEFINITIONS

1.1 Capitalized words or phrases in this Agreement have the meaning set forth below unless Health Plan is required to follow a different definition pursuant to a Law or a Government Program Requirement.

a. **Advance Directive** means a Member's written instruction, recognized under Law, relating to the provision of health care when the Member is not competent to make a health care decision as determined under Law.

b. **Affiliate** means an entity owned or controlled by Health Plan or Molina Healthcare, Inc.

c. **Agreement** means this Combined Services Agreement between Provider and Health Plan and all attachments, exhibits, addenda, amendments, and incorporated documents or materials.

d. **Appeals and Grievance Programs** mean the policies and procedures established by Health Plan to timely identify, process, and resolve Member and Provider appeals, grievances, complaints, disputes, or inquiries.

e. **Centers for Medicare and Medicaid Services** ("CMS") means the agency responsible for Medicare and certain parts of Medicaid, CHIP, Medicare-Medicaid Program, and the Health Insurance Marketplace.

f. **Claim** means a bill for Covered Services provided by Provider.

g. **Clean Claim** means a Claim for Covered Services submitted on an appropriate industry standard form, which has no defect, impropriety, lack of required substantiating documentation necessary to adjudicate the Claim, or particular circumstance requiring special treatment that prevents timely adjudication of the Claim.

h. **Covered Services** mean those health care and related services and supplies, including Emergency Services, provided to a Member that are Medically Necessary and are benefits of the Member's Product.

i. **Cultural Competency Plan** means a plan that ensures Members receive Covered Services in a manner that takes into account, but is not limited to, developmental disabilities, physical disabilities, differential abilities, cultural and ethnic backgrounds, and limited English proficiency.

j. **Date of Service** means the date on which Provider provides Covered Services or, for inpatient services, the date the Member is discharged.

k. **Downstream Entity** means any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the Medicare Advantage, Medicaid, CHIP, or MMP Products below the level of the arrangement between Health Plan (or applicant) and Provider. These written arrangements continue down to the level of the ultimate provider for health and administrative services.

l. **Emergency Services** mean Medically Necessary health care services that are provided to a Member by a provider of health care after the sudden onset of a medical condition that manifests itself by symptoms of such sufficient severity that a prudent person would believe that the absence of immediate medical attention could result in: (i) serious jeopardy to the health of an insured; (ii) serious jeopardy to the health of an unborn child; (iii) serious impairment of a bodily function; or (iv) serious dysfunction of any bodily organ or part.

m. **Encounter Data** means the information that is captured in a Clean Claim and the additional information required

for compliance with Laws and Government Program Requirements.

n. **Government Contract** means the contract between Health Plan and a governmental agency for a Product.

o. **Government Program Requirements** mean the requirements of governmental agencies for a Product, which includes, but are not limited to, the requirements set forth in the Government Contract.

p. **Health Insurance Marketplace** means those health insurance products/programs required by Title I of the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), referred to collectively as the Affordable Care Act, including all implementing statutes and regulations.

q. **Health Plan** means Molina Healthcare of Nevada, Inc., a Nevada Corporation.

r. **Law** means, without limitation, federal, state/commonwealth, tribal, or local statutes, codes, orders, ordinances, and regulations applicable to this Agreement.

s. **Medicaid** means the joint federal-state or federal-commonwealth program provided for under Title XIX of the Social Security Act, as amended.

t. **Medically Necessary or Medical Necessity** means health care services or products that a prudent physician would provide to a patient to prevent, diagnose or treat an illness, injury or disease, or any symptoms thereof, that are necessary and: (i) provided in accordance with generally accepted standards of medical practice; (ii) clinically appropriate with regard to type, frequency, extent, location and duration; (iii) not primarily provided for the convenience of the patient, physician or other provider of health care; (iv) required to improve a specific health condition of an insured or to preserve the existing state of health of the insured; and (v) the most clinically appropriate level of health care that may be safely provided to the insured.

u. **Medicare Advantage** ("MA") means a program in which private health plans provide health care and related services and supplies through a Government Contract with CMS, which is authorized under Title XVIII of the Social Security Act, as amended (otherwise known as "Medicare"). Medicare Advantage also includes Medicare Advantage Special Needs Plans ("MA-SNP").

v. **Medicare-Medicaid Program** ("MMP") means a program in which private health plans provide health care and related services and supplies to beneficiaries eligible for both Medicaid and Medicare through a Government Contract with CMS and the state/commonwealth.

w. **Member** means a person enrolled in a Product and who is eligible to receive Covered Services.

x. **Molina Fee Schedule** means the Health Plan's fee schedule, inclusive of all reimbursement rates Health Plan is required to reimburse Provider within this Agreement.

y. **Molina Marketplace** means the products offered and sold by Health Plan under the requirements of the Health Insurance Marketplace.

z. **Overpayment** means a payment Provider receives, which after applicable reconciliation, Provider is not entitled to receive or retain pursuant to Laws, Government Program Requirements, or this Agreement.

aa. **Participating Provider** means an individual or entity that is contracted with Health Plan to provide health care and related services and supplies to Members and, as applicable, is credentialed by Health Plan or Health Plan's designee.

bb. **Products** mean the health insurance programs, identified on Attachment A, Products, in which Provider agrees to participate and which will include any successors to the health insurance programs.

cc. **Provider** means the entity or person identified on the Signature Page of this Agreement and includes the entities as listed on Attachment H, Provider Identification Sheet, and, as applicable, the persons performing Covered Services on behalf of the entity or person identified on the Signature Page of this Agreement. Provider will ensure all persons and entities performing Covered Services comply with the applicable terms of the Agreement. Each person or entity will be considered an "Individual Provider."

dd. **Provider Manual** means Health Plan's provider manuals, policies, procedures, documents, educational materials, and, as applicable, Supplemental Materials, setting forth Health Plan's requirements and rules that Provider is required to follow.

ee. **Quality Improvement Program** ("QI Program") means the policies and procedures, interventions, and systems, developed by Health Plan for monitoring, assessing, and improving the accessibility, quality, and continuity of care provided to Members.

ff. **Responsible Entity** means an entity, including, but not limited to, a capitated independent practice association or any entities that are capitated by Health Plan, which are financially responsible for certain Covered Services.

gg. **State Children's Health Insurance Program** ("SCHIP" or "CHIP") means the program established pursuant to Title XXI of the Social Security Act, as amended.

hh. **Subcontractor** means an individual or organization, including Downstream Entity, with which Provider contracts for the provision of Covered Services or administrative functions related to the performance of this Agreement. For the avoidance of doubt, a Subcontractor does not include Individual Providers.

ii. **Utilization Review and Management Program** ("UM Program") means the policies, procedures, and systems developed by Health Plan for evaluating and monitoring the Medical Necessity, appropriateness, efficacy, or efficiency of core health care benefits and services, procedures or settings and ambulatory review, prospective review, concurrent review, second opinions, care management, discharge planning, or retrospective reviews, including, but not limited to, under-utilization and over-utilization.

ARTICLE TWO – PROVIDER OBLIGATIONS

2.1 **Provider Standards.**

a. **Standard of Care.** Provider agrees to provide Covered Services within the scope of Provider's business. Provider will ensure all services and interactions with Members are at a level of care and competence that equals or exceeds generally accepted and professionally recognized standards of practice, rules, and standards of professional conduct, and Laws and Government Program Requirements.

b. **Facilities, Equipment, and Personnel.** Provider's facilities, equipment, personnel, technology (hardware and software), and administrative services will be at a level and quality necessary to perform Provider's duties under this Agreement and to comply with Laws and Government Program Requirements. Provider will further ensure that its personnel comply with the applicable terms of this Agreement.

c. **Prior Authorization.** For a Covered Service that requires a prior authorization, Provider is required to obtain prior authorization from Health Plan for such Covered Service. Provider will not have to obtain prior authorizations before providing Emergency Services.

d. **Use of Participating Providers.** Except in the case of Emergency Services or when Provider obtains prior authorization, Provider will only utilize Participating Providers to provide Covered Services. Provider will notify Health Plan so that Health Plan can determine the appropriate provider to perform the services if a Participating Provider is not available.

e. **Prescriptions.** When prescribing medications that a Member gets through a pharmacy, Provider will follow Health Plan's Drug Formulary/Prescription Drug List, and prior authorization and prescription policies. Provider acknowledges the authority of pharmacies to substitute generics or low-cost alternative prescriptions for the prescribed medications.

f. **Provider-Member Communication.** Health Plan encourages open Provider-Member communication regarding Medical Necessity, appropriate treatment, and care. Provider is free to communicate all treatment options to Members regardless of limitations on Covered Services.

g. **Member Eligibility Verification.** Provider will verify a Member's eligibility before providing a Covered Service unless the situation involves the provision of an Emergency Service and will confirm eligibility in a manner that is consistent with Law and Government Program Requirements on redeterminations of eligibility.

h. **Availability and Hours of Service.** Provider will ensure Emergency Services and Covered Services related to inpatient hospitalizations are available twenty-four (24) hours a day, seven (7) days a week. Provider will make necessary and appropriate arrangements to ensure the availability of non-emergent Covered Services during Provider's normal business hours unless otherwise required by Laws and Government Program Requirements.

i. **Hospital Admission.** Provider will immediately notify Health Plan of a Member hospital admission, including any inpatient admission, and when a Member is seen in the emergency department.

j. **Privileges.** Provider agrees to use its best efforts to arrange privileges or other appropriate access for Participating Providers, including hospitalist providers, who are qualified medical or osteopathic physicians and Health Plan's case management staff, provided the individuals meet the credentialing requirements and privileges standards established by Provider.

k. **Access.** Provider agrees to use its best efforts to arrange privileges or other appropriate access to Provider's inpatient/outpatient facilities for Participating Providers, including hospitalist providers, who are qualified medical or osteopathic physicians and Health Plan's case management staff, provided the individuals meet the credentialing requirements and privileges standards established by Provider.

l. **Medical and Allied Health Care Professionals.**

i. Provider will ensure that medical and allied health care professionals provide health care and related services in accordance with applicable Laws. Provider will ensure that medical and allied health care professionals providing health care services within its facilities are, as applicable, licensed, certified, credentialed, re-credentialed, and privileged within the scope of the individual's specialty. Additionally, Provider will require notice from a medical or allied health care professional when, as applicable: (i) a required license is limited, suspended, or revoked or a disciplinary proceeding is commenced against the individual by a governmental or accrediting agency; (ii) there is a lapse in required insurance coverage; or (iii) the individual is excluded/precluded or terminated from participation in a state/commonwealth or federal health care program.

ii. If Provider identifies a deficiency in the delivery of health care services by a medical or allied health care professional, Provider will take appropriate corrective action. Corrective action may include the termination, suspension, reduction, or modification of privileges. Provider will notify Health Plan within five (5) business days should any disciplinary or other action of any kind be implemented against a medical or allied health care professional that results in the termination, suspension, reduction, or modification of privileges if permitted by Law.

2.2 **Rights of Members.** Provider will observe, protect, and promote the rights of Members.

2.3 **Use of Name.** Neither Provider nor Health Plan will use the other's name, including, but not limited to, trademarks, service marks, domain names, or logos ("Marks") without the prior written approval of the other Party. This Agreement does not grant either Party a license or sublicense to the other Party's Marks.

2.4 **Non-Discrimination.** Provider will not differentiate or discriminate against individuals based on their status as protected veterans or because of race, color, religion, national origin, ancestry, age, sex, marital status, sexual orientation, physical, sensory or mental handicap, disability, socioeconomic status, or participation in publicly financed programs of health care services or any other basis prohibited by Law. Provider will provide Covered Services in the same location, in the same manner, in accordance with the same standards, and within the same time or availability, regardless of payer.

2.5 **Recordkeeping.**

a. **Maintaining Records.** Provider will maintain complete and correct books and records relating to services provided under this Agreement for tax, accounting, and operation purposes. Provider will maintain medical and billing records ("Records") for each Member to whom Provider provides health care and related services and supplies. The Member's Records will contain all information required by Laws, generally accepted and prevailing professional practices, applicable Government Program Requirements, and Health Plan's policies and procedures. Provider will retain such Records for as long as required by Laws and Government Program Requirements. This section will survive any termination.

b. **Confidentiality of Member Record.** Provider will comply with all Laws, including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health ("HITECH") Act, Health Plan's policies and procedures, and Government Program Requirements regarding privacy and confidentiality. Provider will not disclose or use a Member's name, address, social security number, identity, other personal information, treatment modality, or Record without obtaining appropriate authorization. This section does not affect or limit Provider's obligation to make available the Record, Encounter Data, and information concerning a Member's care to Health Plan, a governmental agency, or another provider of health care. This section will survive any termination.

c. **Delivery of Member Information.** Provider will promptly deliver to Health Plan, upon request or as may be required by Laws, Health Plan's policies and procedures, Government Program Requirements, or third-party payers, any information, statistical data, Encounter Data, or Record pertaining to a Member to the extent permitted by Law. Provider is responsible for the costs associated with producing the above items. Provider will further give direct access to the items as requested by Health Plan or as required by a governmental agency. This section will survive any termination.

d. **Member Access to Member Record.** Provider will give each Member access to the Member's Record and other applicable information in accordance with Laws, Government Program Requirements, and Health Plan's policies and procedures. This section will survive any termination.

2.6 **Program Participation.**

a. **Participation in Appeals and Grievance Programs.** Provider will participate in and comply with Health Plan's Appeals and Grievance Programs. Provider's failure to exhaust Health Plan's Appeals and Grievance Program will bar Provider from obtaining other remedies available under this Agreement.

b. **Participation in Quality Improvement Program.** Provider will participate in and comply with Health Plan's QI Program. Provider will cooperate in conducting peer reviews and audits of care and services provided by Provider.

c. **Participation in Utilization Review and Management Program.** Provider will participate in and comply with Health Plan's UM Program. Provider will cooperate with Health Plan in audits to identify, confirm, and assess utilization levels of Covered Services.

d. **Participation in Credentialing.** Provider will participate in and comply with Health Plan's credentialing and re-credentialing program. Provider must be credentialed by Health Plan or Health Plan's designee before providing Covered Services and must remain credentialed throughout the term of the Agreement to continue to provide Covered Services. Provider will promptly notify Health Plan of any change in the information submitted or relied upon by Provider to achieve or maintain its credentialed status.

e. **Health Education/Training.** Provider will participate in and comply with Health Plan's provider education and training program, which includes the Cultural Competency Plan and such standards, policies, and procedures as may be necessary for Health Plan to comply with Laws and Government Program Requirements.

2.7 **Provider Manual.** Provider will comply with the Provider Manual which is incorporated by reference into this Agreement as may be unilaterally updated by Health Plan. Provider acknowledges the Provider Manual is available to Provider at Health Plan's website. A physical copy of the Provider Manual is available upon request.

2.8 **Supplemental Materials.** Health Plan may issue bulletins or other written materials in order to supplement the Provider Manual or to give additional instruction, guidance, or information ("Supplemental Materials"). Health Plan may issue Supplemental Materials in an electronic format, which includes, but is not limited to, posting on Health Plan's web-portal; physical copies are available upon request. Supplemental Materials become binding upon Provider as of the effective date indicated on the Supplemental Materials or, if applicable, the effective date will be determined in accordance with this Agreement.

2.9 **Health Plan's Electronic Processes and Initiatives.** Provider will participate in and comply with Health Plan's electronic processes and initiatives, including, but not limited to, electronic submission of prior authorization, access to electronic medical records, electronic claims filing, electronic data interchange ("EDI"), electronic remittance advice, electronic fund transfers, and registration and use of Health Plan's web-portal.

2.10 **Information Reporting and Changes.** Provider will deliver to Health Plan a complete and accurate list of its business/practice/facility locations and, as applicable, a list of each person and entity performing Covered Services, together with the specific information required for administration of this Agreement. The information includes, but is not limited to, the information required by Health Plan to produce provider directories and any subsequent changes to that information. Provider will use best efforts deliver any changes as to who are the persons and entities covered under this Agreement within thirty (30) days. Each person or entity will only be part of this Agreement after Provider has received written approval from Health Plan, which includes, but is not limited to, confirmation that credentialing is complete, if required. Notwithstanding the above, if a Law or Government Program Requirement requires the delivery of information described in this section in another manner or different timeframe, Provider will notify Health Plan in accordance with the Law or Government Program Requirement. Health Plan also reserves the right to request such information at any time.

2.11 **Standing.**

a. **Requirements.** Provider represents it has the appropriate approvals, including, but not limited to, applicable licenses, certifications, registrations, and permits to provide Covered Services in accordance with Laws and Government Program Requirements. Provider will deliver evidence of any approvals to Health Plan upon request. Provider will maintain such approvals in good standing, free of disciplinary action, and in unrestricted status. Provider will promptly notify Health Plan of changes in its status, including, but not limited to, disciplinary action taken or proposed by any agency responsible for oversight of Provider.

b. **Unrestricted Status.** Provider represents to its best knowledge, information, and belief, neither it, nor any of its employees, temporary employees, volunteers, consultants, members of its board of directors, officers, or contractors or any persons or entities with an ownership or control interest in Provider as defined and set forth in

42 CFR 455.101 and 455.104 (collectively, "Personnel") have been excluded from participation in the Medicare Program, any state, commonwealth, or the District of Columbia's Medicaid Program, or any other federal health care program (collectively "Federal Health Care Program"). Provider agrees that it must check the Department of Health and Human Services Office of Inspector General List of Excluded Individuals and Entities, the System for Award Management, any other list maintained by a state, commonwealth, or federal government, and every state, commonwealth, and the District of Columbia's Medicaid exclusion lists (including criminal background and registry checks) to determine whether Provider or any of its Personnel have been excluded from participation in any Federal Health Care Program. These databases must be checked for any new Personnel and thereafter not less than monthly. Provider will notify Health Plan immediately in writing if Provider determines that Provider or any of its Personnel are suspended or excluded from any Federal Health Care Program. Provider agrees that it is subject to 2 CFR Part 376 and will require its Personnel to agree that they are subject to 2 CFR Part 376. If a governmental agency imposes a penalty, sanction, or other monetary adjustment or withhold due to Provider's non-compliance with this provision or any payments were made to Provider while under non-compliance with this provision, Health Plan will issue a letter requesting payment of the amount imposed.

c. **Legal Actions.** Provider will give prompt written notice to Health Plan of: (i) a legal claim asserted by a Member and information about its resolution; (ii) a criminal investigation or charge, information, or indictment filed and information about its resolution; and (iii) a legal claim that may jeopardize financial soundness and information about its resolution. This section will survive any termination.

d. **Insurance. Provider is owned and operated by Clark County pursuant to the provisions of Chapter 450 of the Nevada Revised Statutes. Clark County is a political subdivision of the State of Nevada. As such, Clark County and Provider are protected by the limited waiver of sovereign immunity contained in Chapter 41 of the Nevada Revised Statutes. Provider is self-insured as allowed by Chapter 41 of the Nevada Revised Statutes. Upon request, Provider will provide Health Plan with a Certificate of Coverage prepared by its Risk Management Department certifying such self-coverage.**

2.12 **Non-Solicitation of Members.** Provider will not solicit or encourage Members to select another health plan. Nothing in this provision is intended to limit the information available to Members related to Medical Necessity, appropriate treatment, or alternative care.

2.13 **Laws and Government Program Requirements.**

a. **Compliance with Laws and Government Program Requirements.** Provider will comply with the Laws that are applicable to this Agreement. Provider acknowledges Health Plan has entered into Government Contracts and Provider agrees it will comply with the applicable Government Program Requirements for each Product. Upon written request from Provider, Health Plan will give Provider a copy of each Government Contract under which Provider is participating, redacted to remove financial and other private and trade secret information.

b. **Fraud and Abuse Reporting.** Provider will comply with Laws and Government Program Requirements relating to fraud, waste, and abuse. Provider will establish and maintain policies and procedures for identifying and investigating fraud, waste, and abuse. In the event Provider discovers an occurrence of fraud, waste, or abuse, Provider will promptly notify Health Plan. Provider will participate in and comply with investigations conducted by Health Plan or by a governmental agency. This section will survive any termination.

c. **Advance Directive.** Provider will comply with Laws and Government Program Requirements related to Advance Directives.

d. **Ownership Disclosure Information.** If applicable, Provider must disclose to Health Plan or, if applicable, Health Plan's designee, the name and address of each person, entity, or business with an ownership or control interest in the disclosing entity before the Effective Date and throughout the term of this Agreement. Provider or disclosing entity must also disclose to Health Plan or, if applicable, Health Plan's designee whether any person, entity, or business with an ownership or control interest in the disclosing entity are related to another as spouse, parent, child, or sibling before the Effective Date and throughout the term of this Agreement. Furthermore, there must be disclosure of the name of any other disclosing entity in which a person with an ownership or controlling interest in the Provider or disclosing entity also has an ownership or control interest.

2.14 **Reciprocity Agreements.** Provider will cooperate with Affiliates and agrees to ensure reciprocity of health care and related services and supplies to Affiliates' enrollees. For Affiliates' enrollees, Provider will be compensated for Clean Claims that are determined to be payable at the rate set forth in this Agreement unless otherwise required by a Law or Government Program Requirement. Provider will follow the hold harmless provisions of this Agreement for Affiliates' enrollees.

2.15 **Abuse, Neglect, and Exploitation.** Provider will comply with the Laws and Government Program Requirements relating to the reporting of abuse, neglect, and exploitation.

2.16 **Transfer of Members.** Provider will not unilaterally assign or transfer Members to another Participating Provider or non-Participating Provider without the prior written approval of Health Plan.

2.17 **Condition Change.** Provider will promptly notify Health Plan's Care Management Team upon becoming aware of a significant change in a Member's health or functional status or death.

ARTICLE THREE – HEALTH PLAN'S OBLIGATIONS

3.1 **Health Plan Compliance.** Health Plan will comply with all Laws and Government Program Requirements that are applicable to this Agreement.

3.2 **Member Eligibility Determination.** Health Plan will maintain data on Member eligibility and enrollment. Health Plan will promptly verify Member eligibility at the request of Provider.

3.3 **Prior Authorization Review.** Health Plan will respond with a determination on a prior authorization request in accordance with the time frames required by Laws and Government Program Requirements after receiving all necessary information from Provider.

3.4 **Medical Necessity Determination.** Health Plan's determination regarding Medical Necessity, including, but not limited to, determinations of level of care and length of stay, will govern.

3.5 **Member Services.** Health Plan will provide services to Members, including, but not limited to, assisting Members in selecting a primary care physician, processing Member complaints and grievances, informing Members of Health Plan's policies and procedures, providing Members with membership cards, providing Members with information about Health Plan, and providing Members with access to Health Plan's Provider Directory.

3.6 **Provider Services.** Health Plan will make available a Provider Services Department that, among other Health Plan duties, is available to assist Provider with questions about this Agreement.

3.7 **Corrective Action.** Health Plan and governmental agencies routinely monitor the level, manner, and quality of Covered Services provided as well as Provider's compliance with this Agreement. If a deficiency is identified, Health Plan or an agency, in its sole discretion, may choose to issue a corrective action plan to address the deficiency. Provider is required to accept and implement such corrective action plan. Provider is not entitled to a corrective action plan prior to any termination.

3.8 **Reassignment of Members.** Health Plan reserves the right to reassign, limit, or deny the assignment or selection of Members to Provider if Health Plan determines that Provider poses a threat to Members' health and safety or during a termination notice period in accordance with Laws and Government Program Requirements. Provider will ensure copies of the Member's medical records are delivered to the new provider within ten (10) business days of receipt of the Health Plan's or the Member's request to transfer the records. Subject to the foregoing, if Provider requests reassignment of a Member, Health Plan will consider reassignment in accordance with Laws and Government Program Requirements or, if there are no applicable Laws or Government Program Requirements, upon good cause shown by Provider.

3.9 **Quality Bonus Payment Program.** Health Plan may offer Provider the opportunity to participate in Health Plan's Quality Bonus Payment Program ("QBPP"). The QBPP will promote quality of care if offered. Provider must register with Health Plan's web portal and remain in compliance with this Agreement to be eligible for any QBPP. Payments under the QBPP will be based on the terms of the QBPP as set forth in the Provider Manual, in a Supplemental Material, or in an amendment to this Agreement. QBPP payments are not guaranteed payments and are paid separately from the compensation due pursuant to the terms of this Agreement.

ARTICLE FOUR – CLAIMS PAYMENT

4.1 **Claims.** Provider will promptly submit to Health Plan Claims for Covered Services in a standard form that is acceptable to Health Plan. Provider is not eligible for payment on Claims submitted after one hundred and eighty (180) days from the Date of Service, unless Health Plan is required to follow a different timeframe pursuant to a Law or Government Program Requirement. When Health Plan is the secondary payer, Provider is not eligible for payment

for Claims submitted after three hundred and sixty-five (365) days from the Date of Service, unless Health Plan is required to follow a different timeframe pursuant to a Law or Government Program Requirement. Provider will include all medical records pertaining to the Claim if requested by Health Plan and as may be required by Health Plan's policies and procedures.

4.2 **Compensation.** Health Plan will pay Provider for Clean Claims for Covered Services, that are determined to be payable, in accordance with Laws, Government Program Requirements, and this Agreement. Health Plan will make payment within sixty (60) days, unless otherwise required by Laws or Government Program Requirements. Provider agrees to accept such payments, Member cost-sharing, coordination of benefits, and amounts due from third-parties as payment in full for Covered Services. Provider's failure to comply with the terms of this Agreement may result in non-payment to Provider.

4.3 **Member Cost-Sharing.** Provider is responsible for the collection of co-payments, co-insurances, and deductibles, if any, from Members. Provider agrees to bill Members and collect such cost-sharing amounts from Members.

4.4 **Member Hold Harmless.** Provider agrees in no event, including, but not limited to, non-payment, insolvency, or breach of this Agreement by Health Plan, will Provider bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against a Member or person acting on a Member's behalf for Covered Services provided pursuant to this Agreement. This does not prohibit Provider from collecting co-payments, co-insurances, or deductibles as specifically provided in the Member's evidence of coverage or fees for non-Covered Services in accordance with Laws and Government Program Requirements. For the purposes of this section non-Covered Services do not include services that have been determined to be not Medically Necessary by Health Plan. This section will survive any termination, regardless of the reason for the termination, including insolvency of Health Plan.

4.5 **Coordination of Benefits.** Health Plan is a secondary payer where another entity is the primary payer. Provider will inquire of each Member to learn if the Member has health insurance or health benefits other than from Health Plan or is entitled to payment from: (i) another insurer or plan of any type; or (ii) a third party under any other form of compensation, including, but not limited to, personal injury settlements. Provider will file and make reasonable efforts to collect such potential entitlements and Provider will promptly notify Health Plan of such potential entitlement. Provider will be compensated in an amount equal to the allowable Clean Claim less the amount due from other health insurances or health benefits, insurers or plans, or third-parties, not to exceed the amount specified in the Compensation Schedule of this Agreement.

4.6 **Offset** In the event of an Overpayment, Health Plan will issue an Overpayment letter requesting repayment of the funds.. Recovery of overpayments may be accomplished by offsets against future payments. Molina will provide written or electronic notice to Provider before using an offset as a means to recover an overpayment, and will not implement the offset if, within 45 days after the date of the notice, Provider refunds the overpayment or initiates an appeal. As applicable to the Product, Provider will comply with the Laws and Government Program Requirements regarding the identification and return of Overpayments. Provider will notify Health Plan and applicable governmental agencies of any Overpayments identified by Provider. Notwithstanding any other provision of this Agreement, the recoupment rights for an Overpayment may be exercised to the time period permitted by Law. Such rights will not be subject to any requirement of prior or other approval from a court or other governmental agency that may now or hereafter have jurisdiction over Health Plan or Provider unless otherwise required for compliance with a Law or Government Program Requirement. This section will survive any termination.

4.7 **Claim Review.** Claims will be reviewed and paid in accordance with Health Plan's policies and procedures which are based on Health Plan's experience and industry standard billing and payment rules, including, but not limited to, the Uniform Billing ("UB") manual and editor, Current Procedural Terminology ("CPT") and Healthcare Common Procedure Coding System ("HCPCS"), federal and state/commonwealth billing and payment rules, National Correct Coding Initiatives ("NCCI") Edits, and Federal Drug Administration ("FDA") definitions and determinations of designated implantable devices and implantable orthopedic devices. Furthermore, Provider acknowledges Health Plan's right to conduct Medical Necessity reviews and apply clinical practice standards to determine appropriate payment. Payment may exclude certain items not billed in accordance with Health Plan's policies and procedures or that do not meet Medical Necessity criteria. This section will survive any termination.

4.8 **Claim Auditing.** Provider acknowledges Health Plan's right to conduct post-payment billing audits. Provider will cooperate with Health Plan's audits of claims and payments upon written notice during regular business hours provide requested claims information, all supporting medical records, Provider's charging policies, and other related data. Health Plan will use established industry claims adjudication, and clinical practices, federal and state/commonwealth guidelines,

and Health Plan's policies and data to determine the appropriateness of the billing, coding, and payment. This section will survive any termination.

4.9 **Financially Responsible Entity Payments.** If Provider provides Covered Services that are the responsibility of a Responsible Entity, Provider will look solely to the Responsible Entity for payment for the Covered Services.

4.10 **Timely Submission of Encounter Data.** Provider understands Health Plan may have certain contractual reporting obligations that require timely submission of Encounter Data. If a Clean Claim does not contain the necessary Encounter Data, Provider will submit Encounter Data to Health Plan. This section will survive any termination.

ARTICLE FIVE – TERM AND TERMINATION

5.1 **Term.** This Agreement will commence on the Effective Date, and shall remain in effect until December 31, 2026. Thereafter, the term may renew for three (3) successive one (1) year increments upon mutual written agreement, unless terminated by either Party in accordance with this Agreement.

5.2 **Termination without Cause.** This Agreement, an individual Product, or an Individual Provider under this Agreement, may be terminated without cause at any time by either Party by giving at least ninety (90) days prior written notice to the other Party.

5.3 **Termination with Cause.** In the event of a breach of a material provision of this Agreement, the Party claiming the breach will give the other Party written notice of termination setting forth the facts underlying its claim that the other Party breached this Agreement. The Party receiving the notice of termination will have thirty (30) days from the date of receipt of such notice to remedy or cure the claimed breach to the satisfaction of the other Party. During this thirty (30) day period, the Parties agree to meet as reasonably necessary and to confer to resolve the claimed breach. If the Party receiving the notice of termination has not remedied or cured the breach within such thirty (30) day period, the Party who delivered the notice of termination has the right to immediately terminate this Agreement, or an individual Product or an Individual Provider under this Agreement, upon expiration of the thirty (30) day period. Notwithstanding the forgoing, either Party may immediately terminate this Agreement, an individual Product, or an Individual Provider under this Agreement, without providing the other Party the opportunity to cure a material breach should the terminating Party reasonably believe the material breach of this Agreement to be non-curable.

5.4 **Immediate Termination.** Notwithstanding any other provision of this Agreement, this Agreement, an individual Product, or an Individual Provider under this Agreement, may immediately be terminated upon written notice to the other Party in the event any of the following occurs:

a. Provider's license or any other approval needed to provide Covered Services is limited, suspended, or revoked, a disciplinary proceeding is commenced against Provider by a governmental or accrediting agency, or an indictment is issued against Provider;

b. Provider fails to maintain adequate levels of insurance;

c. Provider has not or is unable to comply with Health Plan's credentialing requirements, including, but not limited to, having or maintaining credentialing status;

d. Either Party becomes insolvent or files a petition to declare bankruptcy or for reorganization under the bankruptcy laws of the United States, or a trustee in bankruptcy or receiver for Provider or Health Plan is appointed by appropriate authority;

e. If Provider is capitated or participating in another risk-sharing compensation methodology and Health Plan determines Provider is financially incapable of bearing capitation or other applicable risk-sharing compensation methodology;

f. Health Plan reasonably determines that Provider's facility, equipment, or Personnel are insufficient to provide Covered Services;

g. Either Party is excluded/precluded from participation in a state, commonwealth, or federal health care program;

h. Provider is terminated as a provider by a state, commonwealth, or federal health care program;

i. Provider engages in fraud, waste, or abuse or permits fraud, waste, or abuse by another in connection with the Party's obligations under this Agreement;

j. Health Plan reasonably determines that Covered Services are not being properly provided or arranged for by Provider and such failure poses a threat to Members' health and safety;

k. Provider violates any Law;

l. Provider fails to satisfy the terms of a corrective action plan; or

m. Termination is required by a governmental agency.

5.5 **Notice to Members.** In the event of any termination, Health Plan will give reasonable notice to Members who are currently receiving care and the Parties will ensure the continuity of care in accordance with and to the extent required by Laws and Government Program Requirements.

5.6 **Transfer Upon Termination.** In the event of any termination, Health Plan may transfer Members to another provider.

ARTICLE SIX – GENERAL PROVISIONS

6.1 **Indemnification.** Each Party will indemnify and hold harmless the other Party and its officers, directors, shareholders, employees, agents, and representatives from any and all liabilities, losses, damages, claims, and expenses of any kind, including costs and attorneys' fees, which result from a breach of the duties and obligations of the indemnifying Party or its officers, directors, shareholders, employees, agents, and representatives under this Agreement. Each Party agrees to give the other Party prompt written notice of any claim made against the other Party. This section will survive the termination of this Agreement. The Party seeking indemnification under this Section must notify the other Party in writing within thirty (30) days of being served with any Claim or within thirty (30) days of being notified of any Claim to which the Party seeking indemnification contends such indemnification applies. Failure to notify the other Party shall not be deemed a waiver of the right to seek indemnification, unless the actions of the other Party have been prejudiced by the failure to provide notice within the required time period

The Party from whom indemnification is sought shall provide the defense with respect to Claims to which this Section applies and in doing so shall have the right to control the defense, including but not limited to, selection of counsel and settlement with respect to such Claims; provided, however, no settlement of a claim that involves a remedy other than the payment of money by the indemnifying Party shall be entered into without the prior written consent of the indemnified Party. The Party seeking indemnification will make all relevant records available to the indemnifying Party and reasonably cooperate in defending against any Claim. Either Party may assume responsibility for the direction of its own defense at any time, including the right to settle or compromise any claim, action, suit, or proceeding against it without the consent of the other Party, provided that settling without the consent of the Party from whom indemnification is sought shall be deemed a waiver of the right to indemnification This Section shall survive the termination of this Agreement.

a. Indemnification by Provider. To the extent expressly authorized by Nevada law, Provider agrees to indemnify and hold Health Plan harmless from and against any and all liability, losses, damages, claims or cause of actions, and expenses connected therewith (including reasonable attorney's fees and court costs), caused or asserted to have been caused, directly or indirectly, by or as a result of (a) Provider's failure to perform its obligations under the terms of this Agreement, or (b) the negligent and/or intentional actions of officers, employees, servants, agents, representatives, or any person directly engaged or retained by Provider to discharge its obligations under this agreement. However, Provider explicitly retains all defenses to such indemnification that may exist under Nevada law.

b. Indemnification by Health Plan. Health Plan agrees to indemnify Provider from all liability, loss, damage, claim or expense of any kind, whatsoever, including costs and attorneys' fees which result from negligent or reckless acts or omissions by Health Plan, its agents or employees, director or officers regarding the duties and obligations of Health Plan under this Agreement. However, Health Plan explicitly retains all defenses to such indemnification that may exist under Nevada law.

6.1 **Relationship of the Parties.** Nothing contained in this Agreement is intended to create, nor will it be construed to create, any relationship between the Parties other than that of independent parties contracting with each other solely for effectuating this Agreement. This Agreement is not intended to create a relationship of agency, representation, joint venture, or employment between the Parties. Nothing herein contained will prevent the Parties from entering into similar arrangements with other parties. Each Party will maintain separate and independent management and will be responsible for its own operations. Nothing contained in this Agreement is intended to create, nor will it be construed to create, any right in any third party to enforce this Agreement.

6.2 **Governing Law.** The laws of the State of Nevada and Clark County will govern this Agreement to the extent such laws are not preempted by federal laws.

6.3 **Entire Agreement.** This Agreement, including attachments, addenda, amendments, Provider Manual, Supplemental Materials, and incorporated documents or materials, contains the entire agreement between the Parties relating to the rights granted and obligations imposed by this Agreement. Any prior agreements, promises, negotiations, or

representations, either oral or written, between the Parties and relating to the subject matter of this Agreement, are of no force or effect.

6.4 **Severability.** If a term, provision, covenant, or condition of this Agreement is held by a court of competent jurisdiction or any governmental agency with oversight authority for this Agreement to be invalid, void, or unenforceable, the remaining provisions will remain in full force and effect and will in no way be affected, impaired, or invalidated because of such decision.

6.5 **Headings and Construction.** The headings in this Agreement are for reference purposes only and are not considered a part of this Agreement in construing or interpreting its provisions. It is the Parties' desire that if a provision of this Agreement is determined to be ambiguous, then the rule of construction that such provision is construed against its drafter will not apply to the interpretation of the ambiguous provision. The following rules of construction apply to this Agreement: (i) the word "day" means calendar day unless otherwise specified; (ii) the term "business day" means Monday through Friday, except federal holidays; (iii) all words used in this Agreement will be construed to be of such gender or number as circumstances require; (iv) references to specific statutes, regulations, rules or forms, such as CMS-1500, include subsequent amendments or successors to them; and (v) references to any government department or agency include any successor departments or agencies.

6.6 **Non-exclusivity.** This Agreement will not be construed to be an exclusive Agreement between the Parties. Nor will it be deemed to be an Agreement requiring Health Plan to refer Members to Provider.

6.7 **Amendments.**

a. **Regulatory Amendments.** Health Plan may immediately amend this Agreement to maintain consistency or compliance with applicable policy, directive, Law, or Government Program Requirement at any time and without Provider's consent. Such regulatory amendment will be binding upon Provider.

b. **Non-Regulatory Amendments.** Notwithstanding the Regulatory Amendments section, Health Plan may otherwise amend this Agreement upon forty-five (45) days prior written notice to Provider. If Provider does not deliver a written disapproval to such amendment within the forty-five (45) day period, the amendment will be deemed accepted by and binding upon Provider. If Health Plan receives a written disapproval within the forty-five

(45) day period, the Parties agree to meet and confer in good faith to determine if a revised amendment can be accepted by and binding upon the Parties.

6.8 **Delegation or Subcontract.** Provider will submit to Health Plan a list identifying Provider's Subcontractors with a description of the services each Subcontractor provides. Provider will promptly submit updates to the list to Health Plan. Provider will ensure each Subcontractor complies with the applicable terms of this Agreement. Provider's contract with a Subcontractor will be in writing and will bind the Subcontractor to the applicable terms required for compliance with this Agreement. Health Plan has the right to request Provider limit the use of a Subcontractor that does not meet the applicable terms of the Agreement and Provider will take reasonable action to comply with the request.

6.9 **Assignment.** Except as expressly provided otherwise in this Agreement, neither Pary shall, without the prior written consent of the other Party assign, delegate, subcontract or transfer, in whole or in part, any of its rights, duties, or obligations under this Agreement without the prior written consent of other Party. Notwithstanding the foregoing, either Party shall give written notice to other Party if entity is succeeded.

6.10 **Arbitration.**

a. **Arbitration Requirements.** Any dispute, claim, or controversy arising out of or relating to this Agreement or the breach, termination, enforcement, interpretation, or validity thereof, including the determination of the scope or applicability of this agreement to arbitrate (hereafter "Dispute"), shall be determined by arbitration, subject to the terms of this section. The arbitration shall take place in, Clark County Nevada before one (1) arbitrator. The arbitrator will be an attorney with at least fifteen (15) years of experience, including at least five (5) years of experience in health care. In the event an arbitrator is not available with the listed requirements; an arbitrator must be a licensed attorney with five (5) years' experience. The arbitration shall be administered by JAMS pursuant to its Comprehensive Arbitration Rules and Procedures. Judgment on the award may be entered in any court having jurisdiction. This section shall not preclude the Parties from seeking provisional remedies in aid of arbitration from a court of appropriate jurisdiction. Matters that primarily involve Provider's professional competence or conduct (i.e., malpractice, professional negligence, or wrongful death) are not eligible for arbitration.

b. **Meet and Confer.** Prior to the initiation of arbitration, the Parties shall attempt to resolve any Dispute arising out of or relating to this Agreement via a good faith "Meet and Confer." To initiate a Meet and Confer, a Party shall deliver to the other Party a written notice of the Dispute that includes a demand to Meet and Confer. The notice shall include: (i) a statement of the Party's position and a summary of arguments supporting that position; and (ii) the name and contact information of the executive who will participate in the Meet and Confer. The Meet and Confer shall be held within forty-five (45) days of the delivery of the notice, at a mutually acceptable time and place, between appropriate representatives of the Parties, including a person authorized to settle the Dispute (the "First Meeting"). The Parties may agree to further discussions after the First Meeting. At no time prior to the First Meeting shall either Party initiate an arbitration or litigation related to this Agreement, except to pursue a provisional remedy that is authorized by law or by JAMS Rules or by agreement of the Parties. This limitation is inapplicable to a Party if the other party refuses to comply with the requirements of this subsection.

c. **Rules for Arbitration.** The arbitrator will have no authority to give a remedy or award damages that would not be available to such prevailing Party in a court of law, nor will the arbitrator have the authority to award punitive, exemplary, or treble damages. The arbitrator will deliver a written reasoned decision within thirty (30) days of the close of arbitration, unless an alternate agreement is made during the arbitration. The Parties adopt and agree to implement the JAMS Optional Arbitration Appeal Procedure that is in place at the time of the arbitration with respect to any final award in an arbitration arising out of or related to this Agreement.

The Parties agree to accept any decision by the arbitrator, which is grounded in applicable law, as a final determination of the matter in dispute. The award may be vacated, modified or corrected pursuant to the Federal Arbitration Act, 9 USC §§ 9-11. Grounds for vacating an award include: (i) where the award was procured by corruption, fraud, or undue means; (ii) where the arbitrators were guilty of misconduct or exceeded their powers; (iii) evident material miscalculation; (iv) evident material mistake in the description of any person, thing, or property referred to in the award; and (v) imperfections in a matter of form not affecting the merits.

Each Party shall bear its own costs and expenses of arbitration, including its own attorneys' fees, and shall bear an equal share of the arbitrator and administrative fees of arbitration.

Arbitration must be initiated within one (1) year of the earlier of the date the Dispute arose, was discovered, or should have been discovered with reasonable diligence; otherwise the Dispute will be deemed waived and the complaining Party shall be barred from initiating arbitration or other proceedings. The Parties expressly agree that the deadline to file arbitration shall not be subject to waiver, tolling, alteration, or modification of any kind or for any reason other than fraud.

6.11 **Notice.**

a. **Delivery.** All notices required or permitted by this Agreement, except for Supplemental Materials, will be in writing and delivered by one of the following: (i) in person; (ii) by U.S. Postal Service ("USPS") registered, certified, or express mail with postage prepaid; (iii) by overnight courier that guarantees next day delivery; (iv) Notice is deemed given: (i) on the date of personal delivery; (ii) on the second day after the postmark date for USPS registered, certified, or express mail with postage prepaid; (iii) or on the date of delivery shown by overnight courier.

b. **Addresses.** The mailing address, email address, and facsimile number set forth under the Signature Page will be the Party's information for delivery of notice. Each Party may change its information through written notice in compliance with this section without amending this Agreement. Notice will be sent to the attention of the Authorized Representative.

6.12 **Waiver.** A failure or delay of a Party to exercise or enforce any provision of this Agreement will not be deemed a waiver of any right of that Party. Any waiver must be specific, in writing, and executed by the Parties.

6.13 **Execution in Counterparts and Duplicates.** This Agreement may be executed in counterparts, each of which will be deemed an original, but all of which together will constitute one and the same instrument. The Parties agree facsimile signatures, pdf signatures, photocopied signatures, electronic signatures, or signatures scanned and sent via email will have the same effect as original signatures.

6.14 **Force Majeure.** Neither Party will be liable or deemed to be in default for any delay or failure to perform any duty under this Agreement resulting directly or indirectly, from acts of God, civil or military authority, acts of a public enemy, war, accident, fire, explosion, earthquake, flood, strikes by either Party's employees, or any other similar cause beyond the reasonable control of such Party if it is determined that: (i) the Party used the efforts a reasonable person would during the force majeure event to perform its duties under this Agreement; and (ii) the Party's inability to perform its duties during the force majeure event is not due to its failure to take measures to protect itself against the force majeure event.

6.15 **Confidentiality.** Any information disclosed by either Party in fulfillment of its duties under this Agreement, including, but not limited to, health care information, compensation rates, and the terms of the Agreement, will be kept confidential. Information provided to Provider, including, but not limited to, Member lists, QI Programs, certification/credentialing criteria, compensation rates, and any other administrative protocols or procedures of Health Plan, is the proprietary property of Health Plan and will be kept confidential. Provider will not disclose or release information to a third party without the written consent of Health Plan. However, each Party may share information with its subsidiaries and affiliates and its respective Personnel and designees as necessary to fulfill the terms of this Agreement. Nothing in the Agreement will preclude either Party from disclosing information as required for compliance with a Law or Government Program Requirement or as required to comply with a governmental authority request provided that the information is only disclosed in a manner and to the extent required for compliance and in accordance with applicable Law. Provider will either return confidential information or destroy confidential information and provide confirmation of the destruction to Health Plan upon request if the Agreement terminates. This section will survive any termination. Notwithstanding the foregoing, Health Plan acknowledges that Provider is a public county-owned hospital which is subject to the provisions of the Nevada Public Records Act, Nevada Revised Statutes Chapter 239, as may be amended from time to time, and as such records are public documents available for copying and inspection by the public. If Provider receives a demand for the disclosure of any information related to the Agreement which Health Plan has claimed to be confidential and proprietary, Provider will immediately notify Health Plan of such demand and Health Plan shall immediately notify Provider of its intention to seek injunctive relief in a Nevada court for protective order. Health Plan shall indemnify, defend and hold harmless Provider from any claims or actions, including all associated costs and attorney's fees, regarding or related to any demand for the disclosure of Health Plan's documents in Provider's custody and control in which Health Plan claims to be confidential and proprietary.

6.16 **Adjustments.** If a governmental agency imposes a penalty, sanction, or other monetary adjustment or withhold due to Provider's non-compliance with this Agreement, Health Plan will be able to collect the amount imposed on or withheld from Health Plan. Health Plan will issue a letter requesting payment of the amount imposed or withheld. This section will survive any termination.

6.17 **Expenses.** Unless otherwise specifically stated in the Agreement, all costs and expenses incurred in connection with this Agreement will be paid by the Party incurring the cost or expense.

6.18 **Offshore Resources.** Neither Provider nor its Subcontractors will perform any work related to the administration of the Agreement outside the United States of America without the prior written consent of Health Plan.

ATTACHMENT A
Products

[The information in this attachment is confidential and proprietary in nature.]

ATTACHMENT B

Compensation Schedule

[The information in this attachment is confidential and proprietary in nature.]

ATTACHMENT B-1

Chard Description Master Limit Protection

[The information in this attachment is confidential and proprietary in nature.]

ATTACHMENT C

State of Nevada Required Provisions

State Laws

[The information in this attachment is confidential and proprietary in nature.]

ATTACHMENT D

Medicaid and CHIP

Laws and Government Program Requirements

[The information in this attachment is confidential and proprietary in nature.]

ATTACHMENT E

Medicare Advantage

Laws and Government Program Requirements

[The information in this attachment is confidential and proprietary in nature.]

ATTACHMENT F

Medicare-Medicaid Program

Laws and Government Program Requirements

[The information in this attachment is confidential and proprietary in nature.]

ATTACHMENT G

Molina Marketplace

Laws and Government Program Requirements

[The information in this attachment is confidential and proprietary in nature.]

ATTACHMENT H

Provider Identification Sheet

Laws and Government Program Requirements

[The information in this attachment is confidential and proprietary in nature.]

MOLINA HEALTHCARE OF NEVADA INC.

VALUE-BASED PAYMENT PROGRAMS AMENDMENT

University Medical Center of Southern Nevada ("Provider") and Molina Healthcare of Nevada, Inc. ("Health Plan") enter into this Value-Based Payment Programs Amendment ("Amendment") on the Effective Date specified below. The Provider and Health Plan are referred to as a "Party" or collectively referred as the "Parties."

RECITALS

A. Whereas, the Parties entered into a Combined Services Agreement, effective January 1, 2025, as amended ("Agreement");

B. Whereas, the Parties desire to amend Attachment A of the Agreement so that Provider may participate in Health Plan's Value-Based Payment Programs as listed in 'Medicaid and CHIP', Section 1.1, which gives Provider the opportunity to earn incentives through improving the overall quality care provided and outcomes.

Now, therefore, the Parties agree to amend the Agreement as stated herein.

1.1 **Value-Based Payment Programs.**

Attachment A – Primary Care Provider Pay-For-Quality, is added to the Agreement.

1.2 **Effective Date.** This Amendment becomes effective on January 1, 2026.

1.3 **Value-Based Payment Programs Allocation**. To meet any government reporting requirements, Health Plan will allocate the incentive payments computed under the Value-Based Payment Programs to the calendar year quarters/MLR reporting periods they relate to, based on reasonable accounting principles.

1.4 **Value-Based Payment Programs Changes.** This Amendment may be changed on notice from Health Plan for changes in Law, regulations, regulatory guidance, or Government Program Requirements.

1.5 **Full Force and Effect**. The terms of the Agreement apply to this Amendment, except as otherwise defined herein. All prior agreements and amendments solely between the Parties establishing a quality incentive or providing for a care coordination payment are deemed terminated and no longer in effect as of the Effective Date.

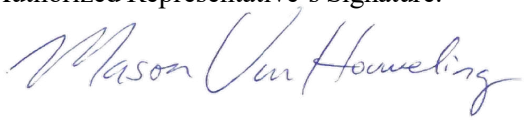
1.6 **Counterparts.** This Amendment may be executed in one or more counterparts, each of which together will be deemed an original, but all of which together will constitute the same instrument.

Signature Authorization Page Follows

In consideration of the promises and representations stated, the Parties agree as set forth in this Amendment. The Authorized Representative acknowledges, warrants, and represents that the Authorized Representative has the authority and authorization to act on behalf of their Party. The Authorized Representative further acknowledges and represents that they received and reviewed this Amendment in its entirety.

The Authorized Representative for each Party executes this Amendment with the intent to bind the Parties in accordance with this Amendment.

Provider Signature and Information.

Provider's Legal Name ("Provider") – as listed on applicable tax form (i.e., W-9): University Medical Center of Southern Nevada	
Authorized Representative's Signature: 	Authorized Representative's Name – Printed: Mason Van Houweling
Authorized Representative's Title: Chief Executive Officer	Authorized Representative's Signature Date: 12/22/25
Tax ID Number – As listed on corresponding tax form:	
Value-Based Payment Programs Notice – Email Address:	

Health Plan Signature and Information.

Molina Healthcare of Nevada Inc. ("Health Plan")	
Authorized Representative's Signature: Sara Cooper	Authorized Representative's Name – Printed: Sara Cooper
Authorized Representative's Title: VP, Network Management	Authorized Representative's Countersignature Date: 12/23/25

ATTACHMENT A

Medicaid Primary Care Provider Pay-For-Quality

This attachment describes Health Plan's Primary Care Provider Pay-For-Quality ("PCP P4Q") and its requirements. This PCP P4Q Program is applicable to the Medicaid Product only and is being implemented in accordance with the provision titled "Quality Bonus Payment Program," "Quality Improvement Program" or equivalent section thereof in your Agreement.

ARTICLE ONE

1.1 **PCP P4Q Program Overview.**

a. The objective of this PCP P4Q is to reward Eligible Providers for their efforts in providing high-quality care to PCP P4Q Program Members to support optimal care coordination, treatment planning, improved quality outcomes and referrals to specialists or other resources. It is also designed to assist in identifying Members who could potentially benefit from case management or other programs. Our PCP P4Q Program Members benefit from this PCP P4Q Program by receiving more regular and proactive assessments to ensure proper preventive care and care management.

b. The Quality Measures are consistent with the Performance Period NCQA, HEDIS® and Medicaid and other national quality performance standards, technical specifications, and requirements.

ARTICLE TWO

2.1 **Definitions.**

a. **Administrative Data** means healthcare data captured in industry standard, structured formats such as claims data, inclusive of Current Procedural Terminology ("CPT") II, Healthcare Common Procedure Coding System ("HCPCS"), Uniform Bill Revenue Codes ("UBREV") and Social Determinant of Health ("SDOH") Z codes, Encounter Data, or relevant clinical documents shared in Clinical Document Architecture ("CDA"), Continuity of Care Document ("CCD"), or Consolidated Clinical Data Architecture ("CCDA") format, as applicable.

b. **Applicable Member** means a PCP P4Q Program Member that meets the inclusion criteria for one or more Quality Measure during the Performance Period.

c. **Bonus** means a bonus payment an Eligible Provider may be eligible to receive if the PCP P4Q Program requirements are met. A bonus will be paid for each Quality Measure that the Eligible Provider qualifies for and completes during the Performance Period.

d. **Eligible Provider** means the assigned or attributed primary care provider ("PCP"), or specialist serving as a PCP, for a PCP P4Q Program Member, who has an active Agreement with Health Plan. PCP's who are in practice together using the same tax identification number with an active Agreement with Health Plan are considered a PCP group and Eligible Providers.

e. **Encounter Data** means the information that is captured in a Clean Claim and the additional information needed for compliance with Laws and Government Program Requirements.

f. **Government Contracts** means those contracts between Health Plan and State and federal agencies for the arrangement of health care services.

g. **Government Programs** mean various government sponsored health products in which Health Plan participates.

h. **Government Program Requirements** mean the requirements of governmental authorities for a Government Program, which include, but are not limited to, the requirements set forth in the Government Contracts.

i. **PCP P4Q & SDS Program Member** means a Medicaid Member enrolled with the Health Plan, who is attributed by Health Plan to an Eligible Provider, either by assignment or selection, during the Performance Period.

j. **Performance Period** means the period of time when a Provider is evaluated against this program, typically a twelve (12) calendar month length of time. The specific Performance Period for the PCP P4Q Program is indicated in Section 7.1.a.
k. **State** means the state/commonwealth of Nevada.
l. **Supplemental Data** means electronic supplemental files such as lab flat files, claims flat files, etc., as agreed to by Health Plan, that Eligible Provider may also timely submit in addition to Administrative Data.

ARTICLE THREE

3.1 **General Guidelines to be an Eligible Provider.** In addition to the definition of Eligible Provider, the Eligible Provider must meet the following requirements to be considered an Eligible Provider:

a. PCP must be the assigned Eligible Provider for the PCP P4Q Program Members during the Performance Period.
b. Eligible Provider and Health Plan will meet at least quarterly to review performance and collaborate on actions to improve documentation, and close quality gaps.

ARTICLE FOUR

4.1 **Health Plan Responsibilities.**

a. PCP P4Q Program Member assignment to or removal from Eligible Provider's attribution in this PCP P4Q Program is done at the sole discretion of the Health Plan.
b. Each month, Health Plan will supply the Eligible Provider with a list of its PCP P4Q Program Members and the Applicable Members for each Quality Measure. Additionally, Health Plan will supply the Eligible Provider with a monthly quality scorecard report.
c. The Quality Measures described in Table 1 in this attachment will be used for evaluating Eligible Provider's quality performance during the Performance Period. Eligible Provider's performance on the identified benchmarks or targets, as demonstrated and verified by Administrative Data, Supplemental Data and such other reporting as may be specified in this attachment, shall result in payment of the Bonus amounts specified for successful completion of the metric(s) for each Quality Measure in this attachment.
e. Future Laws or Government Program requirements may require changes to the PCP P4Q Program. Health Plan agrees to provide notice of the change to Eligible Provider in accordance with the Value-Based Payment Programs Notices section below as soon as practicable.

ARTICLE FIVE

5.1 **Eligible Provider Responsibilities and Payment.**

a. Eligible Providers may be eligible to earn a Bonus for each Quality Measure if:
i. Eligible Provider achieves the NCQA Medicaid HMO percentile or Health Plan supplied benchmark for the Quality Measure, as specified in Table 1 and
ii. all other PCP P4Q Program requirements are met.

b. Eligible Provider will be paid for each Applicable Member who has completed the Quality Measure for the highest percentile achieved for all Applicable Members and will not be paid for all percentiles. A Bonus is only paid for Applicable Members who have completed the Quality Measure during the Performance Period.
c. Each Quality Measure is evaluated independently.
d. Eligible Provider must submit Administrative Data and Supplemental Data no later than one (1) month following the completion of the Performance Period, in order to be included in the Performance Period PCP P4Q Program and its calculations. Health Plan may, at its sole discretion, decide to include or exclude Administrative Data and/or Supplemental Data in this PCP P4Q Program and its calculations.
e. Health Plan may request additional documentation such as medical records if unable to verify information for Applicable Members using timely submitted Administrative Data and/or Supplemental Data.

f. Each Quality Measure and Supplemental Data activity is evaluated independently.

g. **Data Sharing.**

i. Eligible Provider shall deliver all relevant clinical documents electronically in a format stated in the Provider Manual or otherwise agreed to by Health Plan. This includes but is not limited to: Direct Remote EMR access, Supplemental Data, medical records, or other data sharing methods for clinical quality information, as agreed to by Health Plan.

ii. Eligible Provider will participate in Health Plan's program to communicate clinical information using the format stated in the Provider Manual or otherwise agreed to by Health Plan.

iii. Eligible Provider's mechanism for exchanging health information will comply with the Health Insurance Portability and Accountability Act ("HIPAA") and will be approved by the Office of the National Coordination of Health Information Technology ("ONC").

h. The Parties recognize that Bonuses in Table 1, may be subject to adjustments due to retroactive changes in PCP P4Q Program Members' enrollment with Health Plan and assignment to Eligible Provider.

i. Earned Bonuses are paid to the Eligible Provider that is on record as the assigned provider for the PCP P4Q Program Member as of the completion of the Performance Period.

j. Earned Bonus payments will be made based on the current Tax ID information on file for the Eligible Provider.

k. Health Plan will use reasonable efforts to distribute the final earned Bonus to Eligible Providers within seven (7) months following the completion of the Performance Period.

l. Eligible Provider shall only earn a Bonus for the provision of appropriate and Medically Necessary Covered Services.

ARTICLE SIX

6.1 **Additional Conditions.** Additional conditions for Eligible Provider to receive a Bonus under this PCP P4Q Program are:

a. Health Plan will have sole discretion in determining whether the PCP P4Q Program requirements are satisfied, and any earned Bonus will be made solely at Health Plan's discretion. There is no right to appeal any decision made in connection with this PCP P4Q Program. Health Plan reserves the right to modify the PCP P4Q Program to comply with regulatory and Government Program Requirements and if the PCP P4Q Program is revised, Health Plan will send a notice to Eligible Provider by email or other means of notice permitted under the Agreement and in accordance with the Value-Based Payment Programs Notices section herein.

b. Eligible Provider's Agreement or amendment incorporating this PCP P4Q Program with Health Plan must be signed and countersigned by both Parties, have a prospective effective date for the Performance Period, and remain active as of the completion of the Performance Period and at the time any earned Bonus is distributed.

c. Any Bonus earned through this PCP P4Q Program will be in addition to the compensation arrangement set forth in Eligible Provider's Agreement. In the event Health Plan determines that Eligible Provider has received an Overpayment, Health Plan may offset any Bonus that may have otherwise been paid to Eligible Provider against the Overpayment, pursuant to the Offset provision or equivalent section(s) thereof, in the Agreement.

d. **Value-Based Payment Programs Notices**. Except as otherwise required by Law, Health Plan will notify Eligible Provider of any updates to this PCP P4Q Program via a notice consistent with this section and in accordance with the Agreement. Notwithstanding the foregoing, the Parties may elect to provide any required or permitted notice by email, personal delivery, registered mail, certified mail, express mail, overnight or next-day delivery by an express delivery service carrier (e.g., FedEx, UPS, etc.). Notice by email is deemed given on the date of transmission of the email. Notice by registered mail, certified mail, express mail, or an express delivery service carrier is deemed given on the date of delivery.

e. **No Inducement to Reduce or Limit Medically Necessary Services**. No incentives or payment of any kind will be made directly or indirectly to Eligible Provider as an inducement to reduce or limit Medically Necessary health care services or supplies furnished to a PCP P4Q Program Member.

f. **No Further Incentive Compensation**. Except as provided in this PCP P4Q Program, Eligible Provider may not seek additional reimbursement from a federal or State government-sponsored health program for the quality incentives covered in this attachment. No compensation is available under this PCP P4Q for services that are not Medically Necessary or appropriate for a PCP P4Q Program Member.

g. **Records**. In addition to any audit or inspection rights contained elsewhere in the Agreement, Health Plan upon prior notice, may request, and Provider shall timely make available, any Administrative Data, Supplemental Data, Encounter Data, books, contracts, computer or other electronic systems, including medical records and documentation, or such other information as may be necessary to comply with applicable Law or to respond to a request from a Government Agency to substantiate the validity of any incentive payment under this attachment.

ARTICLE SEVEN

7.1 **Term.**

a. The PCP P4Q Program will commence on January 1, 2026, and continue through December 31, 2026, ("PCP P4Q Program Initial Performance Period").

b. At the expiration of the PCP P4Q Program Initial Performance Period, the PCP P4Q Program may renew upon mutual written agreement for successive one year Performance Periods unless terminated by either Party in accordance with the provisions in this attachment. If required by Health Plan, to participate in the PCP P4Q Program for a subsequent Performance Period, the Parties must execute a new amendment providing updated quality metrics and related financial awards prior to the commencement of each subsequent Performance Period.

7.2. **Termination.**

a. This PCP P4Q Program may be terminated without cause by either Party if the terminating Party gives the other Party written notice of its intent to terminate at least ninety (90) days before the expiration of the PCP P4Q Program Initial Performance Period or a subsequent Performance Period, which will be effective at the end of the PCP P4Q Program Initial Performance Period or the subsequent Performance Period, as applicable.

b. This PCP P4Q Program can be terminated pursuant to the terms stated herein without terminating the underlying Agreement. This PCP P4Q Program will terminate concurrently with the underlying Agreement should the Agreement terminate for any reason specified therein.

7.3 **Effect of Termination.** Except as otherwise required by Law, no PCP P4Q Program Bonus will be due or owing when the PCP P4Q Program is terminated during the Performance Period.

7.4 **Entire Attachment.** This PCP P4Q Program attachment, including exhibits, appendices, addenda, amendments, Supplemental Materials, and incorporated documents or materials, contains the entire agreement between the Parties relating to the rights granted and obligations imposed by this PCP P4Q Program. Any prior incentive agreements, promises, negotiations, or representations, either oral or written, between the Parties and relating to the subject matter of this PCP P4Q Program, are of no force or effect.

Tables 1 Quality Measures, Benchmarks, and Bonuses

Table 1 set forth the Quality Measures and corresponding Bonuses that may be awarded for achieving the specified benchmarks or meeting the Year-over-Year (YoY) improvement thresholds during the Performance Period.

An Eligible Provider shall be eligible to receive a Bonus for each Quality Measure completed for Applicable Member who completed the Quality Measure in Table 1 by either (i) achieving the specified benchmark or (ii) demonstrating Year-over-Year improvement.

For purposes of determining Year-over-Year improvement, performance shall be calculated based on the Eligible Provider's results from the prior Performance Period compared to the corresponding results in the current Performance Period.

If an Eligible Provider meets both the specified Performance Target and the Year-over-Year improvement threshold for a given Quality Measure, the Bonus corresponding to the higher applicable benchmark or improvement tier shall apply.

The Bonuses for Quality, as described in Table 1, represent per-member-per-year (PMPY) amounts that an Eligible Provider may be awarded upon achieving and completing the specified benchmark(s) or demonstrating the required Year-over-Year improvement for the Eligible Provider's Applicable Members. Only one Bonus will be awarded per completed Quality Measure, which shall correspond to the highest benchmark or improvement tier achieved and completed by the Eligible Provider.

[REMAINDER OF PAGE INTENTIONALLY LEFT BLANK]

Table 1: Quality Measures, Benchmarks, and Bonuses

[The information in this attachment is confidential and proprietary in nature.]

INSTRUCTIONS FOR COMPLETING THE
DISCLOSURE OF OWNERSHIP/PRINCIPALS FORM

Purpose of the Form

The purpose of the Disclosure of Ownership/Principals Form is to gather ownership information pertaining to the business entity for use by the University Medical Center of Southern Nevada Governing Board ("GB") in determining whether members of the GB should exclude themselves from voting on agenda items where they have, or may be perceived as having a conflict of interest, and to determine compliance with Nevada Revised Statute 281A.430, contracts in which a public officer or employee has interest is prohibited.

General Instructions

Completion and submission of this Form is a condition of approval or renewal of a contract or lease and/or release of monetary funding between the disclosing entity and University Medical Center of Southern Nevada. Failure to submit the requested information may result in a refusal by the GB to enter into an agreement/contract and/or release monetary funding to such disclosing entity.

Detailed Instructions

All sections of the Disclosure of Ownership form must be completed. If not applicable, write in N/A.

Business Entity Type – Indicate if the entity is an Individual, Partnership, Limited Liability Company, Corporation, Trust, Non-profit Organization, or Other. When selecting 'Other', provide a description of the legal entity.

Non-Profit Organization (NPO) - Any non-profit corporation, group, association, or corporation duly filed and registered as required by state law.

Business Designation Group – Indicate if the entity is a Minority Owned Business Enterprise (MBE), Women-Owned Business Enterprise (WBE), Small Business Enterprise (SBE), Physically-Challenged Business Enterprise (PBE), Veteran Owned Business (VET), Disabled Veteran Owned Business (DVET), or Emerging Small Business (ESB) . This is needed in order to provide utilization statistics to the Legislative Council Bureau, and will be used only for such purpose.

- **Minority Owned Business Enterprise (MBE):** An independent and continuing business for profit which performs a commercially useful function and is at least 51% owned and controlled by one or more minority persons of Black American, Hispanic American, Asian-Pacific American or Native American ethnicity.
- **Women Owned Business Enterprise (WBE**): An independent and continuing business for profit which performs a commercially useful function and is at least 51% owned and controlled by one or more women.
- **Physically-Challenged Business Enterprise (PBE):** An independent and continuing business for profit which performs a commercially useful function and is at least 51% owned and controlled by one or more disabled individuals pursuant to the federal Americans with Disabilities Act.
- **Small Business Enterprise (SBE):** An independent and continuing business for profit which performs a commercially useful function, is not owned and controlled by individuals designated as minority, women, or physically-challenged, and where gross annual sales does not exceed $2,000,000.
- **Veteran Owned Business Enterprise (VET):** An independent and continuing Nevada business for profit which performs a commercially useful function and is at least 51 percent owned and controlled by one or more U.S. Veterans.
- **Disabled Veteran Owned Business Enterprise (DVET):** A Nevada business at least 51 percent owned/controlled by a disabled veteran.
- **Emerging Small Business (ESB):** Certified by the Nevada Governor's Office of Economic Development effective January, 2014. Approved into Nevada law during the 77th Legislative session as a result of AB294.

Business Name (include d.b.a., if applicable) – Enter the legal name of the business entity and enter the "Doing Business As" (d.b.a.) name, if applicable.

Corporate/Business Address, Business Telephone, Business Fax, and Email – Enter the street address, telephone and fax numbers, and email of the named business entity.

Nevada Local Business Address, Local Business Telephone, Local Business Fax, and Email – If business entity is out-of-state, but operates the business from a location in Nevada, enter the Nevada street address, telephone and fax numbers, point of contact and email of the local office. Please note that the local address must be an address from which the business is operating from that location. Please do not include a P.O. Box number, unless required by the U.S. Postal Service, or a business license hanging address.

***Number of Clark County Nevada Residents employed by this firm. (*Do not leave blank. If none or zero, put the number 0 in the space provided.)**

List of Owners/Officers – Include the full name, title and percentage of ownership of each person who has ownership or financial interest in the business entity. If the business is a publicly-traded corporation or non-profit organization, list all Corporate Officers and Directors only.

For All Contracts – **(Not required for publicly-traded corporations)**

1) Indicate if any individual members, partners, owners or principals involved in the business entity are a University Medical Center of Southern Nevada full-time employee(s), or appointed/elected official(s). If yes, the following paragraph applies.

   In accordance with NRS 281A.430.1, a public officer or employee shall not bid on or enter into a contract between a government agency and any private business in which he has a significant financial interest, except as provided for in subsections 2, 3, and 4.

2) Indicate if any individual members, partners, owners or principals involved in the business entity have a second degree of consanguinity or affinity relation to a University Medical Center of Southern Nevada full-time employee(s), or appointed/elected official(s) (reference form on Page 2 for definition). If **YES**, complete the Disclosure of Relationship Form.

A professional service is defined as a business entity that offers business/financial consulting, legal, physician, architect, engineer or other professional services.

Signature and Print Name – Requires signature of an authorized representative and the date signed.

Disclosure of Relationship Form – If any individual members, partners, owners or principals of the business entity is presently a University Medical Center of Southern Nevada employee, public officer or official, or has a second degree of consanguinity or affinity relationship to a University Medical Center of Southern Nevada employee, public officer or official, this section must be completed in its entirety.

DISCLOSURE OF OWNERSHIP/PRINCIPALS

Business Entity Type (Please select one)						
☐ Sole Proprietorship	☐Partnership	☐ Limited Liability Company	☒ Corporation	☐ Trust	☐ Non-Profit Organization	☐ Other

Business Designation Group (Please select all that apply)						
☐ MBE	☐ WBE	☐ SBE	☐ PBE	☐ VET	☐DVET	☐ ESB
Minority Business Enterprise	Women-Owned Business Enterprise	Small Business Enterprise	Physically Challenged Business Enterprise	Veteran Owned Business	Disabled Veteran Owned Business	Emerging Small Business

Number of Clark County Nevada Residents Employed: 84

Corporate/Business Entity Name:	Molina Healthcare of Nevada, Inc.	
(Include d.b.a., if applicable)	n/a	
Street Address:	8329 W Sunset Road Suite 100	**Website: www.molinahealthcare.com**
City, State and Zip Code:	Las Vegas, NV 89117	**POC Name: Sara Irizarry** **Email: sara.irizarry@molinahealthcare.com**
Telephone No:	725-246-2099	**Fax No:**
Nevada Local Street Address: **(If different from above)**		**Website:**
City, State and Zip Code:		**Local Fax No:**
Local Telephone No:		**Local POC Name:** **Email:**

All entities, with the exception of publicly-traded and non-profit organizations**,** must list the names of individuals holding more than five percent (5%) ownership or financial interest in the business entity appearing before the Board.

Publicly-traded entities and non-profit organizations shall list all Corporate Officers and Directors in lieu of disclosing the names of individuals with ownership or financial interest. The disclosure requirement, as applied to land-use applications, extends to the applicant and the landowner(s).

Entities include all business associations organized under or governed by Title 7 of the Nevada Revised Statutes, including but not limited to private corporations, close corporations, foreign corporations, limited liability companies, partnerships, limited partnerships, and professional corporations.

Full Name	Title	% Owned (Not required for Publicly Traded Corporations/Non-profit organizations)
Molina Healthcare, Inc., a Delaware corporation (NYSE:MOH)	Sole shareholder	100%
(No individuals hold any stock of Molina Healthcare of Nevada, Inc.)		

This section is not required for publicly-traded corporations. Are you a publicly-traded corporation? ☐ Yes ☒ No MHNV is not a publicly-traded corporation, but it is wholly owned by Molina Healthcare, Inc., a publicly-traded corporation. Therefore, we do not believe the section below logically applies.

1. Are any individual members, partners, owners or principals, involved in the business entity, a University Medical Center of Southern Nevada full-time employee(s), or appointed/elected official(s)?

   ☐ Yes X No (If yes, please note that University Medical Center of Southern Nevada employee(s), or appointed/elected official(s) may not perform any work on professional service contracts, or other contracts, which are not subject to competitive bid.)

2. Do any individual members, partners, owners or principals have a spouse, registered domestic partner, child, parent, in-law or brother/sister, half-brother/half-sister, grandchild, grandparent, related to a University Medical Center of Southern Nevada full-time employee(s), or appointed/elected official(s)?

   ☐ Yes X No (If yes, please complete the Disclosure of Relationship form on Page 2. If no, please print N/A on Page 2.)

I certify under penalty of perjury, that all of the information provided herein is current, complete, and accurate. I also understand that the University Medical Center of Southern Nevada Governing Board will not take action on land-use approvals, contract approvals, land sales, leases or exchanges without the completed disclosure form.

DISCLOSURE OF OWNERSHIP/PRINCIPALS

Sara Irizarry	*Sara Irizarry*
Signature	Print Name
VP, Network Management	*3/20/23*
Title	Date

DISCLOSURE OF RELATIONSHIP

List any disclosures below:
(Mark N/A, if not applicable.)

NAME OF BUSINESS OWNER/PRINCIPAL	NAME OF UMC* EMPLOYEE/OFFICIAL AND JOB TITLE	RELATIONSHIP TO UMC* EMPLOYEE/OFFICIAL	UMC* EMPLOYEE'S/OFFICIAL'S DEPARTMENT

* UMC employee means an employee of University Medical Center of Southern Nevada

"Consanguinity" is a relationship by blood. "Affinity" is a relationship by marriage.

"To the second degree of consanguinity" applies to the candidate's first and second degree of blood relatives as follows:

- Spouse – Registered Domestic Partners – Children – Parents – In-laws (first degree)
- Brothers/Sisters – Half-Brothers/Half-Sisters – Grandchildren – Grandparents – In-laws (second degree)

For UMC Use Only:

If any Disclosure of Relationship is noted above, please complete the following:

☐ Yes ☐ No Is the UMC employee(s) noted above involved in the contracting/selection process for this particular agenda item?

☐ Yes ☐ No Is the UMC employee(s) noted above involved in any way with the business in performance of the contract?

Notes/Comments:

_____
Signature

_____
Print Name
Authorized Department Representative

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
GOVERNING BOARD AUDIT AND FINANCE COMMITTEE
AGENDA ITEM

Issue:	**Amendment Two to Provider Group Services Agreement with Optum Health Networks, Inc. f/k/a/ Life Print Health, Inc.**	**Back-up:**
Petitioner:	Jennifer Wakem, Chief Financial Officer	**Clerk Ref. #**

Recommendation:

That the Governing Board Audit and Finance Committee review and recommend for approval by the Governing Board Amendment Two to the Provider Group Services Agreement with Optum Health Networks, Inc. for Managed Care Services; or take action as deemed appropriate. ***(For possible action)***

FISCAL IMPACT:

Fund Number: 5430.111 Fund Name: UMC Operating Fund
Fund Center: 3000850000 Funded Pgm/Grant: N/A
Description: Managed Care Services
Bid/RFP/CBE: NRS 332.115(1)(f) – Insurance
Term for incentive payments: 11/1/2025 – 12/31/2025; Agreement term is through 7/31/27
Amount: Revenue based on volume
Out Clause: 90 days w/o cause

BACKGROUND:

On November 1, 2022, UMC entered into a Provider Group Services Agreement for Specialty Care Services ("Agreement") with Optum Health Networks ("Optum"), for UMC to provide services to Optum members. Amendment One to the Agreement, effective August 1, 2025, extended the term for a two-year period and increased Medicare Payment rates.

This request is to approve the Second Amendment to the Agreement, which adds a Quality Incentive Program for those services provided to Optum members from Nov 1-Dec 31.

UMC's Director of Managed Care has reviewed and recommends approval of this Amendment, which has also been approved as to form by UMC's Office of General Counsel.

A Clark County business license is not required as UMC is the provider of hospital services to this insurance fund.

Cleared for Agenda
January 21, 2026

Agenda Item #
13

Amendment Two to the Provider Group Services Agreement

This Amendment ("Amendment Two") is to the **Provider Group Services Agreement**, effective as of **November 1, 2022** (the "Agreement"), between **Optum Health Networks, Inc. fka Lifeprint Health, Inc.** (collectively, "Optum") and **University Medical Center of Southern Nevada** (the "Provider").

This Amendment Two is effective on **November 1, 2025** (the "Amendment Two Effective

Date"). The parties agree to modify the Agreement as follows:

The capitalized terms used in this Amendment Two, but not otherwise defined, will have the meanings ascribed to them in the Agreement.

1. Section 9 is added to Exhibit H – Quality Incentive Program as follows:

9. New Member Form

Description of Program: Provider Group will be eligible to receive an incentive for the completion of a OptumCare Physician Member specific form, made available to the Provider Group via the Optum Pro Portal. The New Member Form is designed to identify new OptumCare Physician Members with emerging and/or chronic conditions, provide preventative care services education, and promote wellness for improved OptumCare Physician Member outcomes. OptumCare understands the completion of the New Member Form requires additional time and effort. Provider Group will be eligible to receive a payment for each completed New Member Form submitted. This incentive is applicable to dates of service November 1 – December 31, 2025, only.

Measurement and Reporting: To qualify for the incentive: (1) New Member Form must be reviewed and completed by the Provider and submitted within 60 days of OptumCare Physician Member visit.

Incentive Calculation: [redacted]

Incentive Payment: Each New Member Form payment is conditioned on the Provider completing and submitting the form to OptumCare within 60 days of OptumCare Physician Member's visit with dates of service between November 1 – December 31, 2025.

All other provisions of the Agreement will remain in full force and effect. In the event of a conflict between the terms of the Agreement and this Amendment Two, the Amendment Two will control.

Optum Health Networks, Inc. fka Lifeprint Health, Inc. on behalf of itself, and its other affiliates, as signed by its authorized representative	**University Medical Center of Southern Nevada**, as signed by its authorized representative
Signature: _____	**Signature:** _____
Print Name: _____	**Print Name and Title:** Mason Van Houweling, Chief Executive Officer
Title: _____	**Date:** _____
Date: _____	**TIN:** **886000436**

Agreement Number: 01593337.0

INSTRUCTIONS FOR COMPLETING THE
DISCLOSURE OF OWNERSHIP/PRINCIPALS FORM

Purpose of the Form

The purpose of the Disclosure of Ownership/Principals Form is to gather ownership information pertaining to the business entity for use by the University Medical Center of Southern Nevada Governing Board ("GB") in determining whether members of the GB should exclude themselves from voting on agenda items where they have, or may be perceived as having a conflict of interest, and to determine compliance with Nevada Revised Statute 281A.430, contracts in which a public officer or employee has interest is prohibited.

General Instructions

Completion and submission of this Form is a condition of approval or renewal of a contract or lease and/or release of monetary funding between the disclosing entity and University Medical Center of Southern Nevada. Failure to submit the requested information may result in a refusal by the GB to enter into an agreement/contract and/or release monetary funding to such disclosing entity.

Detailed Instructions

All sections of the Disclosure of Ownership form must be completed. If not applicable, write in N/A.

Business Entity Type – Indicate if the entity is an Individual, Partnership, Limited Liability Company, Corporation, Trust, Non-profit Organization, or Other. When selecting 'Other', provide a description of the legal entity.

Non-Profit Organization (NPO) - Any non-profit corporation, group, association, or corporation duly filed and registered as required by state law.

Business Designation Group – Indicate if the entity is a Minority Owned Business Enterprise (MBE), Women-Owned Business Enterprise (WBE), Small Business Enterprise (SBE), Physically-Challenged Business Enterprise (PBE), Veteran Owned Business (VET), Disabled Veteran Owned Business (DVET), or Emerging Small Business (ESB) . This is needed in order to provide utilization statistics to the Legislative Council Bureau, and will be used only for such purpose.

- **Minority Owned Business Enterprise (MBE):** An independent and continuing business for profit which performs a commercially useful function and is at least 51% owned and controlled by one or more minority persons of Black American, Hispanic American, Asian-Pacific American or Native American ethnicity.
- **Women Owned Business Enterprise (WBE**): An independent and continuing business for profit which performs a commercially useful function and is at least 51% owned and controlled by one or more women.
- **Physically-Challenged Business Enterprise (PBE):** An independent and continuing business for profit which performs a commercially useful function and is at least 51% owned and controlled by one or more disabled individuals pursuant to the federal Americans with Disabilities Act.
- **Small Business Enterprise (SBE):** An independent and continuing business for profit which performs a commercially useful function, is not owned and controlled by individuals designated as minority, women, or physically-challenged, and where gross annual sales does not exceed $2,000,000.
- **Veteran Owned Business Enterprise (VET):** An independent and continuing Nevada business for profit which performs a commercially useful function and is at least 51 percent owned and controlled by one or more U.S. Veterans.
- **Disabled Veteran Owned Business Enterprise (DVET):** A Nevada business at least 51 percent owned/controlled by a disabled veteran.
- **Emerging Small Business (ESB):** Certified by the Nevada Governor's Office of Economic Development effective January, 2014. Approved into Nevada law during the 77th Legislative session as a result of AB294.

Business Name (include d.b.a., if applicable) – Enter the legal name of the business entity and enter the "Doing Business As" (d.b.a.) name, if applicable.

Corporate/Business Address, Business Telephone, Business Fax, and Email – Enter the street address, telephone and fax numbers, and email of the named business entity.

Nevada Local Business Address, Local Business Telephone, Local Business Fax, and Email – If business entity is out-of-state, but operates the business from a location in Nevada, enter the Nevada street address, telephone and fax numbers, point of contact and email of the local office. Please note that the local address must be an address from which the business is operating from that location. Please do not include a P.O. Box number, unless required by the U.S. Postal Service, or a business license hanging address.

***Number of Clark County Nevada Residents employed by this firm. (*Do not leave blank. If none or zero, put the number 0 in the space provided.)**

List of Owners/Officers – Include the full name, title and percentage of ownership of each person who has ownership or financial interest in the business entity. If the business is a publicly-traded corporation or non-profit organization, list all Corporate Officers and Directors only.

For All Contracts – **(Not required for publicly-traded corporations)**

1) Indicate if any individual members, partners, owners or principals involved in the business entity are a University Medical Center of Southern Nevada full-time employee(s), or appointed/elected official(s). If yes, the following paragraph applies.

   In accordance with NRS 281A.430.1, a public officer or employee shall not bid on or enter into a contract between a government agency and any private business in which he has a significant financial interest, except as provided for in subsections 2, 3, and 4.

2) Indicate if any individual members, partners, owners or principals involved in the business entity have a second degree of consanguinity or affinity relation to a University Medical Center of Southern Nevada full-time employee(s), or appointed/elected official(s) (reference form on Page 2 for definition). If **YES**, complete the Disclosure of Relationship Form.

A professional service is defined as a business entity that offers business/financial consulting, legal, physician, architect, engineer or other professional services.

Signature and Print Name – Requires signature of an authorized representative and the date signed.

Disclosure of Relationship Form – If any individual members, partners, owners or principals of the business entity is presently a University Medical Center of Southern Nevada employee, public officer or official, or has a second degree of consanguinity or affinity relationship to a University Medical Center of Southern Nevada employee, public officer or official, this section must be completed in its entirety.

DISCLOSURE OF OWNERSHIP/PRINCIPALS

Business Entity Type (Please select one)						
☐ Sole Proprietorship	☐Partnership	☐ Limited Liability Company	☒ Corporation	☐ Trust	☐ Non-Profit Organization	☐ Other

Business Designation Group (Please select all that apply)						
☐ MBE	☐ WBE	☐ SBE	☐ PBE	☐ VET	☐DVET	☐ ESB
Minority Business Enterprise	Women-Owned Business Enterprise	Small Business Enterprise	Physically Challenged Business Enterprise	Veteran Owned Business	Disabled Veteran Owned Business	Emerging Small Business

Number of Clark County Nevada Residents Employed: 2,154

Corporate/Business Entity Name:	Optum Health Networks, Inc. (f/k/a LifePrint Health, Inc.)	
(Include d.b.a., if applicable)	OptumCare	
Street Address:	2716 N. Tenaya Way	**Website:** www.optum.com
City, State and Zip Code:	Las Vegas, NV 89128	**POC Name:** Simone Cook, VP, Network and Contracting **Email:** simone.cook1@optum.com
Telephone No:	(702) 242-7713	**Fax No:** (855)-275-4390
Nevada Local Street Address: **(If different from above)**		**Website:**
City, State and Zip Code:		**Local Fax No:**
Local Telephone No:		**Local POC Name:** **Email:**

All entities, with the exception of publicly-traded and non-profit organizations**,** must list the names of individuals holding more than five percent (5%) ownership or financial interest in the business entity appearing before the Board.

Publicly-traded entities and non-profit organizations shall list all Corporate Officers and Directors in lieu of disclosing the names of individuals with ownership or financial interest. The disclosure requirement, as applied to land-use applications, extends to the applicant and the landowner(s).

Entities include all business associations organized under or governed by Title 7 of the Nevada Revised Statutes, including but not limited to private corporations, close corporations, foreign corporations, limited liability companies, partnerships, limited partnerships, and professional corporations.

Full Name	Title	% Owned (Not required for Publicly Traded Corporations/Non-profit organizations)
Collaborative Care Holdings, LLC		100%
OptumHealth Holdings, LLC		100%
Optum, Inc.		100%
United Healthcare Services, Inc.		100%
UnitedHealth Group Incorporated		Publicly Traded

This section is not required for publicly-traded corporations. Are you a publicly-traded corporation? ☒ Yes ☐ No

1. Are any individual members, partners, owners or principals, involved in the business entity, a University Medical Center of Southern Nevada full-time employee(s), or appointed/elected official(s)?

   ☐ Yes ☒ No (If yes, please note that University Medical Center of Southern Nevada employee(s), or appointed/elected official(s) may not perform any work on professional service contracts, or other contracts, which are not subject to competitive bid.)

2. Do any individual members, partners, owners or principals have a spouse, registered domestic partner, child, parent, in-law or brother/sister, half-brother/half-sister, grandchild, grandparent, related to a University Medical Center of Southern Nevada full-time employee(s), or appointed/elected official(s)?

   ☐ Yes ☒ No (If yes, please complete the Disclosure of Relationship form on Page 2. If no, please print N/A on Page 2.)

I certify under penalty of perjury, that all of the information provided herein is current, complete, and accurate. I also understand that the University Medical Center of Southern Nevada Governing Board will not take action on land-use approvals, contract approvals, land sales, leases or exchanges without the completed disclosure form.

JC Rhodes

Signature

John C. Rhodes, MD

Print Name

President & CEO

Title

April 23, 2025

Date

REVISED 7/25/2014

DISCLOSURE OF RELATIONSHIP

List any disclosures below:
(Mark N/A, if not applicable.)

NAME OF BUSINESS OWNER/PRINCIPAL	NAME OF UMC* EMPLOYEE/OFFICIAL AND JOB TITLE	RELATIONSHIP TO UMC* EMPLOYEE/OFFICIAL	UMC* EMPLOYEE'S/OFFICIAL'S DEPARTMENT
N/A			

* UMC employee means an employee of University Medical Center of Southern Nevada

"Consanguinity" is a relationship by blood. "Affinity" is a relationship by marriage.

"To the second degree of consanguinity" applies to the candidate's first and second degree of blood relatives as follows:

- Spouse – Registered Domestic Partners – Children – Parents – In-laws (first degree)
- Brothers/Sisters – Half-Brothers/Half-Sisters – Grandchildren – Grandparents – In-laws (second degree)

For UMC Use Only:

If any Disclosure of Relationship is noted above, please complete the following:

☐ Yes ☐ No Is the UMC employee(s) noted above involved in the contracting/selection process for this particular agenda item?

☐ Yes ☐ No Is the UMC employee(s) noted above involved in any way with the business in performance of the contract?

Notes/Comments:

_____
Signature

_____
Print Name
Authorized Department Representative

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
GOVERNING BOARD AUDIT AND FINANCE COMMITTEE
AGENDA ITEM

Issue:	**Blue Distinction Centers for Transplants Participation Agreement and Letter of Agreement with Anthem Blue Cross and Blue Shield Nevada**	**Back-up:**
Petitioner:	Jennifer Wakem, Chief Financial Officer	**Clerk Ref. #**

Recommendation:

That the Governing Board Audit and Finance Committee review and recommend for approval by the Governing Board the Blue Distinction Centers for Transplants Participation Agreement and Letter of Agreement with Anthem Blue Cross and Blue Shield Nevada for Managed Care Services; or take action as deemed appropriate. ***(For possible action)***

FISCAL IMPACT:

Fund Number: 5430.011
Fund Name: UMC Operating Fund
Fund Center: 3000850000
Funded Pgm/Grant: N/A
Description: Managed Care Services
Bid/RFP/CBE: NRS 332.115(1)(f) – Insurance
Participation Agreement Term:
February 1, 2026 – January 31, 2029
Letter of Agreement Term:
January 1, 2026 - December 31, 2026; continues annually thereafter on a calendar year basis
Amount: Revenue based on volume
Out Clause: Participation Agreement: 60-day prior written notice; LOA: 30-day prior written notice

BACKGROUND:

This request is to approve the Participation Agreement with Blue Cross and Blue Shield for Blue Distinction Centers for Transplants. Through this Agreement, UMC will be designated as a Blue Distinction Center in Anthem's directories and listings for its members, specifically for kidney and pancreas transplants. Anthem will also, at an increased rate, compensate UMC for the transplant services it provides to its members. This Agreement will remain in effect for a period of three (3) years unless terminated without cause by any party upon sixty (60) days' prior written notice.

A secondary request is for UMC to enter into a Letter of Agreement with Anthem to participate in the Behavioral Health Emergency Department Incentive Program (BHEDIP) with Community Care Health Plan of Nevada, Inc. Participation in the program is expected to encourage improvements in clinical quality

Cleared for Agenda
January 21, 2026

Agenda Item #
14

indicators, as well as member outcomes and focus. The term of this LOA continues annually unless terminated by either party.

UMC's Director of Managed Care has reviewed and recommends approval of these Agreements, which have also been approved as to form by UMC's Office of General Counsel.

A Clark County business license is not required as UMC is the provider of hospital services to this insurance fund.

Nevada | Anthem Blue Cross and Blue Shield Healthcare Solutions | Medicaid Managed Care

11/19/2025

UNIVERSITY MEDICAL CTR OF SOUTHERN NEVADA
1800 W CHARLESTON BLVD
LAS VEGAS, NV 89102

Subject: Intent to participate in the Behavioral Health Emergency Department Incentive Program (BHEDIP)

Dear UNIVERSITY MEDICAL CTR OF SOUTHERN NEVADA:

This Letter of Agreement (LOA) sets forth the understanding and agreement of UNIVERSITY MEDICAL CTR OF SOUTHERN NEVADA (facility) to participate in the Behavioral Health Emergency Department Incentive Program (BHEDIP) with Community Care Health Plan of Nevada, Inc. as of January 1, 2026. This LOA and any exhibits, attachments, program descriptions and amendments hereto constitute the entire LOA and understanding between the parties with respect to the subject matter hereof. Community Care Health Plan of Nevada, Inc. has furnished the Facility with a written BHEDIP Program Description. By signing this LOA, the Facility acknowledges that they have reviewed and accepted the terms and conditions set forth in this LOA and in the aforementioned program description.

This LOA shall continue in full force and effect until such time as it is terminated with 30 days prior written notice by either Community Care Health Plan of Nevada, Inc. or the Facility. The BHEDIP Program Description may be modified from time to time by Community Care Health Plan of Nevada, Inc. at its sole discretion without the need for a formal amendment. Community Care Health Plan of Nevada, Inc. may terminate the program upon written notice to the Facility as more fully described in the BHEDIP Program Description. The program operates on a calendar year basis, and the Facility understands and agrees their eligibility to participate in one year of the program does not guarantee eligibility to participate in any subsequent years. The Facility's eligibility to participate in the program requires that they meet the qualifications set forth in the BHEDIP Program Description, maintain in good standing as outlined in the Participating Provider/Facility Agreement with Community Care Health Plan of Nevada, Inc., and not be in material breach of any of the terms and conditions required under such agreement or the BHEDIP Program Description. The execution of

this LOA by both parties does not guarantee the Facility's eligibility to participate in the program but acts as the Facility's agreement to participate if they otherwise meet the qualifications of the program.

By signing this LOA, the Facility certifies that their performance under the program will be and remain in full compliance with all applicable federal and state laws, as well as rules and regulations regarding the provision of services to Community Care Health Plan of Nevada, Inc. members. The Facility further certifies that in arranging services for Community Care Health Plan of Nevada, Inc. members or in arranging for the provision of such services to members, except where required for the benefit for a member, they will not limit, delay, restrict or withhold the provision of medically necessary covered services.

Neither will the Facility discriminate in accepting or retaining any member as a patient or in providing or arranging for the provision of medically necessary covered services to a member on the basis of a member's health needs or status. The Facility acknowledges and agrees that any effort to limit the delivery or availability of medically necessary covered services or to discriminate on the basis of health status will be grounds for immediate termination of the Facility's eligibility for participation in the program and shall further constitute a material breach of the Facility's Participating Provider/Facility Agreement with Community Care Health Plan of Nevada, Inc.

For good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged by the Facility, the Facility is executing this LOA for the purpose of enabling themselves to participate in the program.

Sincerely,

Ashley DeLanis
RVP Provider Solutions
Community Care Health Plan of Nevada, Inc.

Community Care Health Plan of Nevada, Inc.

By: _____
Ashley DeLanis [Name]
RVP, Provider Solutions [Title]
_____[Date]

Agreed to and accepted by:

University Medical Center of Southern Nevada

By: _____
Mason Van Houweling [Printed name]
Chief Executive Officer [Title]
UNIVERSITY MEDICAL CTR OF SOUTHERN NEVADA [Facility name]
886000436 [TIN]
1800 W. Charleston Blvd. [Address]
Las Vegas, Nevada, 89102
(702)383-3982 [Phone]
January 1, 2026 [Date]

Is the above address the remit address? ☒ Yes ☐ No
If not, please provide the remit name and address below:
_____ [Facility name to appear on check]
_____ [Address]
_____

2026 Behavioral Health Emergency Department

Incentive Program (BHEDIP) Description

[The information in this attachment is confidential and proprietary in nature.]

BLUE CROSS AND BLUE SHIELD
BLUE DISTINCTION® CENTERS FOR TRANSPLANTS
PARTICIPATION AGREEMENT

THIS AGREEMENT (together with all attachments, as amended from time to time, the "Agreement") by and between **UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA** ("Hospital"), **ANTHEM BLUE CROSS AND BLUE SHIELD NEVADA**. ("Local Plan"), an Independent Licensee of BCBSA ("Local Plan"), and **BLUE CROSS AND BLUE SHIELD ASSOCIATION ("BCBSA")**, an association of independent Blue Cross and/or Blue Shield Plans ("Blue Plans"), and an Illinois not-for-profit corporation ("BCBSA"), is effective as of February 1, 2026 (the "Effective Date" of this Agreement).

WHEREAS, Hospital is designated as a participant in the Blue Distinction Centers for Transplants ("BDCT") program, for the Transplant Type(s) and Subdesignation(s) identified in Attachment A ("Designation[s]"), pursuant to the terms set forth in this Agreement.

NOW THEREFORE, in consideration of the mutual covenants and promises herein contained, the parties agree as follows:

ARTICLE I: DEFINITIONS

1.1 "BDCT" means Blue Distinction Centers for Transplants, which is a national program administered by BCBSA for Referring Plans' provision of certain Transplant Services benefits to Members.

1.2 "BDCT Selection Criteria" means the selection criteria developed by the BCBSA, which Hospital must meet to be considered eligible for designation in the BDCT program and to provide designated Transplant Services to Members under this Agreement.

1.3 "BDCT Procedures Manual" means the manual containing various procedural requirements for BDCT Referral, claims submission and payment, and other administrative functions under the BDCT program, as revised from time to time, which is incorporated herein by reference and is made available to Hospital from BCBSA and/or the Local Plan.

1.4 "BDCT Referral" means the Referring Plan's written approval for Hospital to provide the proposed Transplant Services under the BDCT program at the applicable Global Rate, which is given before the Member's transplant or retransplant (except as provided in this Agreement for Emergency Services), as described further in Article III.

1.5 "Bone Marrow/Stem Cell" Transplant or "BMSC" Transplant means any transplant of stem cells harvested from bone marrow, peripheral blood, or placental/umbilical cord blood for the treatment of human disease.

1.6 "Case Management" means a program implemented and administered by a Referring Plan to coordinate Transplant Services and claims administration for its Members.

1.7 "Clean Claim," unless otherwise defined by applicable state or federal law, means a claim completed in compliance with UB-04, the CMS-1500, their successors, or another provider billing form that the Referring Plan determines provides sufficient documentation to enable timely processing and satisfies billing requirements including, but not limited to, claims bundling (as set forth in the BDCT Procedures Manual).

1.8 "Emergency Services" means those Transplant Services furnished or required to evaluate and treat an "Emergency Medical Condition," as defined under applicable Federal or State law.

1.9 "Established Charges" means the schedule of regular charges of Hospital, Participating Physicians, and Participating Providers for Transplant Services. In no event shall Established Charges for a Member with a BDCT Referral be higher than those for the same services when provided to a patient or Member without a BDCT Referral; excluding (a) rates applicable to a health care provider's (or its affiliates') own employees or their dependents; and (b) governmental payer rates for Medicare or Medicaid patients.

1.10 "Excluded Services" means those services identified in Attachment B (incorporated by reference herein), which may be provided in connection with a transplant or retransplant and are not included in the payment rates set forth in Attachment A (incorporated by reference herein).

1.11 "Global Rate" means the payment for Transplant Services rendered during the Global Period, calculated as set forth in Attachment A. The Global Rate is subject to any copayment, coinsurance, or deductible charges set forth in the Member Benefit Contract.

1.12 "Global Period" means the number of days set forth in Attachment A during which the Global Rate is available for Transplant Services (and retransplants, as applicable).

1.13 "Member" means an individual who, at all times throughout the admission to Hospital for Transplant Services: (i) is an eligible subscriber or eligible dependent who is enrolled in a Member Benefit Contract issued by a Referring Plan, and (ii) is eligible to receive Transplant Services under the applicable Member Benefit Contract.

1.14 "Member Benefit Contract" means the document evidencing covered healthcare benefits, which is issued to each Member by a Referring Plan.

1.15 "Non-Covered Services" means those health care services that are not Transplant Services and that are not benefits under the Member Benefit Contract; and, therefore, are the Member's own financial responsibility.

1.16 "**Outlier Rate"** means payment for inpatient Transplant Services rendered for inpatient days after the end of the Global Period, calculated as set forth in Attachment A.

1.17 "Participating Physician" means a physician who provides Transplant Services to a Member.

1.18 "Participating Provider" means a health care provider, other than a Participating Physician, that provides Transplant Services to a Member (such as a skilled nursing facility, home health care agency, or other ancillary provider).

1.19 "Referring Plan" means a Blue Plan that participates in the BDCT program and therefore may refer its Members to Hospital for a transplant under this Agreement.

1.20 "Surcharge" means an additional amount that is charged to, paid by, or collected from a Member for any Transplant Service, other than any copayment, coinsurance or deductible authorized by the Member Benefit Contract.

1.21 "Transplant Services" means those services and products described in Attachment B for a transplant and/or retransplant procedure that are to be provided by Hospital, Participating Physicians, or other Participating Providers under the terms of this Agreement.

ARTICLE II: DESIGNATION AND CLINICAL REQUIREMENTS

2.1 BDCT Designation(s), Contingent on Accurate Information and Ongoing Compliance with BDCT Selection Criteria. Each of Hospital's BDCT Designation(s) is set forth in Attachment A (incorporated by reference herein), and is contingent on Hospital's ongoing compliance during the Term of this Agreement with all BDCT Selection Criteria under the BDCT program (as updated from time to time and for each BDCT evaluation cycle at www.bcbs.com), together with all Local Blue Plan Criteria (if any; see Attachment C, incorporated by reference herein). Hospital's participation in the BDCT program is voluntary. This Agreement does not alter, amend, or replace any other agreement that may exist between any parties to this Agreement. Hospital represents and warrants that the information it supplied to BCBSA and Local Plan in response to the then most recent BDCT evaluation cycle (including Hospital's then most recent Provider Survey response, incorporated by reference herein) remains true and correct, as of the Effective Date of this Agreement. Hospital represents and warrants that it is and will remain in compliance with all BDCT Selection Criteria, and Hospital will provide BCBSA and the Local Plan with written notice within thirty (30) days if Hospital fails to so comply, at any time during the Term of this Agreement.

2.2 Participating Physician and Participating Provider Compliance with Agreement. Hospital will require each Participating Physician and each Participating Provider in writing to comply with the terms of this Agreement (which writing may be in the form of a contract, medical staff policies and procedures, or other documentation sufficient to bind Participating Physician or Participating Provider to comply).

2.3 Participation in BlueCard Network. Under the BDCT Selection Criteria, Hospital is required to be a participating provider in the Local Plan's BlueCard PPO Network. Additionally, Hospital will require all physicians and surgeons who manage and perform transplant procedures for the Transplant Type(s) shown in Attachment A to be

participating providers in the Local Plan's BlueCard PPO Network. Hospital must provide notice to BCBSA within thirty (30) days after each change (arrival or departure) from Hospital's staff, with regard to any such physicians and surgeons in Hospital's transplant program.

2.4 Project Liaison. Hospital will designate one (or more) individual(s) to act as liaison(s) for the BDCT program.

2.5 BDCT Procedures Manual. All parties will abide by the BDCT Procedures Manual, which describes administrative processes under the BDCT program.

ARTICLE III: BDCT REFERRAL REQUIREMENTS

3.1 BDCT Referral. two separate steps may be required for each Member (referred to collectively as "BDCT Referral"): an initial BDCT Referral for Hospital to initiate donor search and preparation services (optional, at the Referring Plan's request); and a final BDCT Referral for Hospital to admit the Member for the Transplant Services (required, issued by the Referring Plan). Except as provided in this Agreement for Emergency Services, Hospital will admit Members for Transplant Services only after Hospital's receipt of the final BDCT Referral from the Member's Referring Plan. Referring Plan will provide BCBSA with a quarterly utilization report identifying the number of Members referred to Hospital for Transplant Services under this Agreement.

3.2 Emergency Services. If BDCT Referral cannot be obtained before Emergency Services are provided to a Member, then Hospital will notify the Referring Plan as soon as possible, but not later than one (1) business day after admission, to coordinate the admission with the Referring Plan and to obtain BDCT Referral for that Member's Transplant Services.

ARTICLE IV: PAYMENT

4.1 Payment Rate. For Transplant Services provided to its Members, Referring Plan will pay Hospital, and Hospital agrees to accept without Surcharges, the applicable amounts set forth in Attachment A (entitled, "Designation(s) and Payment Rates"); subject to the benefit maximums, copayment, coinsurance, and deductible provisions of the corresponding Member Benefit Contract. Hospital is responsible for provision of and compensation for all Transplant Services, including (but not limited to) compensation of each Participating Physician and each Participating Provider. All amounts due under this Agreement will be billed by Hospital as set forth in this Article IV. Hospital will prohibit each Participating Physician and each Participating Provider from billing a Referring Plan, Local Plan, or BCBSA separately for any Transplant Services and Hospital will explicitly include this prohibition in the written documentation required by Section 2.2.

4.2 Payment In Full. Hospital will not seek compensation for Transplant Services from any person or entity other than the Referring Plan and in no event (including but not limited to a Referring Plan's non-payment, insolvency, or breach of this Agreement) will Hospital bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse for Transplant Services against any Member or persons other than the Member's own Referring Plan; and, as part of its compliance obligations in Section 2.2, above, Hospital also will require that each Participating Physician and each Participating Provider will not do so. This provision shall not prohibit collection of any applicable copayments, coinsurance, or deductibles billed in accordance with the terms of the applicable Member Benefit Contract. BCBSA and Blue Plans other than the Referring Plan shall have no financial responsibility for Transplant Services.

4.3 Member Responsibility for Non-Covered Services. Occasionally, a Member might request services of Hospital that are: (i) for items other than Transplant Services and/or (ii) not covered by the Member Benefit Contract. Hospital will provide Referring Plan's Case Management coordinator with prompt written notice of all such services; and, if Referring Plan confirms in writing that such services are Non-Covered Services under the Member Benefit Contract, then payment for such Non-Covered Services are the Member's financial responsibility; provided, that Hospital has advised the Member of his/her payment responsibility in writing and has obtained the Member's written consent to proceed before rendering any such Non-Covered Services. BCBSA and Blue Plans other than the Referring Plan shall have no financial responsibility for any Non-Covered Services.

4.4 Claim Submission and Payment Timing

(a) Unless otherwise required by state law, Referring Plan will pay Hospital or will notify Hospital if additional claims information is required, no later than sixty (60) days after Referring Plan's receipt from Hospital of the complete set of Clean Claims (bundled with the charges of all Participating Physicians and all Participating Providers); all, as set forth in

Attachment A and the BDCT Procedures Manual. As a condition of payment, Hospital will certify in writing that it has bundled all Established Charges. If Hospital receives notice requesting additional claims information, then Hospital will be paid no later than sixty (60) days after Referring Plan receives the complete additional information as requested.

(b) If timely payment is not made under this Agreement, Referring Plan will pay Hospital interest at the rate established by applicable law, on the full amount due and unpaid, subject to Member benefit maximums, coinsurance, deductibles, and copayments. Interest will not start to accrue until sixty (60) days after the Referring Plan has received the complete set of Clean Claims; or, if additional information is requested, sixty (60) days after the Referring Plan has received the completed additional information. If applicable law does not provide for interest on late payments, then the applicable interest rate shall be one percent (1%) per month on the amount due and unpaid.

4.5 Coordination of Benefits. When a Member is eligible for benefits for Transplant Services under more than one health benefits plan or program, the Referring Plan will coordinate benefits with such other plan or program in accordance with federal and state laws and the Member Benefit Contract. Hospital shall cooperate with Referring Plan by obtaining information from Members regarding other coverage they have and providing such information to the Member's Referring Plan.

4.6 Inspection and Audit by Referring or Local Plan. Hospital agrees to permit Referring Plan or Local Plan, upon reasonable advance notice and during normal business hours, to inspect, audit, and duplicate any records maintained by Hospital relating to a Member's Transplant Services that are related to Referring Plan's payment activities or health care operations. Hospital may charge a customary rate for medical record requests per record, provided that such rate complies with applicable law.

ARTICLE V: INSURANCE AND INDEMNIFICATION

5.1 Hospital's Obligations. Hospital is owned and operated by Clark County pursuant to the provisions of Chapter 450 of the Nevada Revised Statutes. Clark County is a political subdivision of the State of Nevada. As such, Clark County and Hospital are protected by the limited waiver of sovereign immunity contained in Chapter 41 of the Nevada Revised Statutes. Hospital is self-insured as allowed by Chapter 41 of the Nevada Revised Statutes. Upon request, Hospital will provide BCBSA with a Certificate of Coverage prepared by its Risk Management Department certifying such self-coverage.

5.2 BCBSA's Obligations. BCBSA, solely in relation to its duties and obligations under this Agreement, agrees to indemnify and hold Hospital harmless from any and all liability, loss and damage, claims or expense of any kind, including costs and attorneys' fees, that result from the negligent or willful acts or omissions of BCBSA, its agents or employees. Such indemnification and hold harmless shall not apply to the extent that any matters result from the negligent or willful acts or omissions of Hospital, Participating Physicians, Participating Providers, Local Plan, or Referring Plans, or their respective agents or employees. The parties acknowledge and agree that Hospital is responsible for making decisions regarding the treatment and care of individual Members, each Member's Referring Plan is responsible for making benefit coverage determinations and payments for that Member under this Agreement, and BCBSA makes no treatment decisions, benefit coverage determinations, or payments under this Agreement.

BCBSA shall secure and maintain at its expense throughout the Term of this Agreement an adequate policy or policies of commercial general liability and cyber insurance to insure BCBSA, its agents and employees in connection with BCBSA's administrative obligations under this Agreement.

ARTICLE VI: EXCHANGE OF PROTECTED HEALTH INFORMATION

6.1 Relationships under HIPAA. The parties acknowledge and agree that Hospital and Referring Plan are covered entities pursuant to 45 C.F.R. Parts 160 – 164 (the "HIPAA Rules") and that Local Plan and BCBSA are each a business associate of Referring Plan, as those terms are defined in the HIPAA Rules.

6.2 Cooperation for Case Management and Discharge Planning

(a) **Cooperation.** Hospital will cooperate with Referring Plan and will provide Referring Plan with all information relating to a Member that is reasonably necessary for case management (including BDCT Referral, discharge planning, and coordination of patient care before, during, and after the Member's BDCT Referral for Transplant Services) and for Referring Plan's payment activities and health care operations.

(b) **Discharge Plan.** For each Member receiving Transplant Services, Hospital shall provide Referring Plan with a written discharge plan (which may be in electronic form) for the Member's treatment and follow-up care, no later than two (2) business days before discharging the Member, so that Referring Plan can coordinate post-discharge care in accordance with the Member Benefit Contract and avoid having the Member and/or Referring Plan incur any out of network or other increased costs.

ARTICLE VII: TERM AND TERMINATION

7.1 Term; and Termination, Generally. This Agreement and Hospital's Designation(s) as a Blue Distinction Center for Transplants will begin on the Effective Date of this Agreement and will remain in effect for three (3) years (the "Term"); provided, that Hospital continues to meet the then current BDCT Selection Criteria. Additional Designation(s) for which Hospital becomes eligible following future BDCT program evaluation cycles may be added via written amendment(s) to this Agreement that will be effective as of the effective date of the corresponding amendment. This Agreement may be terminated without cause by any party upon sixty (60) days' prior written notice to the other parties. Additionally, this Agreement may be terminated for cause by any party upon thirty (30) days' prior written notice specifying the nature of another party's material breach of this Agreement; provided, that such breach is not cured to the non-breaching party's reasonable satisfaction within that 30-day period.

7.2 Additional Termination Rights. In addition to general termination rights under Section 7.1, each party has the right to terminate this Agreement immediately by notice to the other parties if any of the following events occur:

(a) Suspension or revocation of Hospital's license(s);

(b) Suspension, revocation, or loss of any of the following, unless fully reversed within 30 days of its initial occurrence: (i) Hospital's Medicare participation status, (ii) Hospital's fully accredited status with at least one national organization identified in the BDCT Selection Criteria, or (iii) Hospital's UNOS membership status (if Hospital has a related BDCT Designation);

(c) Hospital's failure to continue to satisfy the BDCT Selection Criteria, as revised for each evaluation cycle;

(d) Hospital's failure to maintain insurance policies, in accordance with this Agreement; or

(e) Financial instability, as evidenced if any party (which, for Hospital, includes Hospital's parent and/or system) becomes insolvent, files (or has filed against it) a petition in bankruptcy (or any similar petition under any insolvency law of any jurisdiction), proposes any dissolution, liquidation, composition, financial reorganization or recapitalization with creditors, or if a receiver, trustee, custodian or similar agent is appointed or takes possession of any property or business of such party.

7.3 Closure, Suspension, or Termination of Hospital's Own Transplant Programs. Hospital shall provide all parties with written notice:

(a) at least sixty (60) days before Hospital closes any of Hospital's own transplant program(s) for any Transplant Type(s) for which Hospital has received a BDCT Designation under Attachment A, and this Agreement will terminate immediately upon such closure with respect to such Transplant Type(s); and

(b) immediately after any of Hospital's own transplant programs are otherwise suspended or terminated, and this Agreement will terminate immediately thereafter.

7.4 Termination of Blue Distinction Centers for Transplants Program. Hospital's Designation(s) shall terminate immediately upon BCBSA's termination of the BDCT program. Hospital's Designation for an individual Transplant Type shall terminate immediately if BCBSA sunsets all designations for that Transplant Type under the BDCT program. BCBSA shall provide sixty (60) days' prior notice of such BDCT program changes to all parties.

7.5 Continuation of Care upon Termination of this Agreement, a Designation, or a Global Rate for Combination Transplants. Hospital will continue to provide (and Referring Plan will continue to be responsible for) Transplant Services to all Members who received initial or final BDCT Referral for a transplant (or retransplant) before the effective date of termination (or expiration) of: (i) this Agreement; (ii) Hospital's Designation for any Transplant Type; or (iii) any Global Rate for a combination transplant. All such Transplant Services will be upon the same terms set forth in this Agreement immediately before such termination (or expiration). Such Termination (or expiration) shall not relieve Hospital or Referring Plan from Hospital's ongoing continuation of care obligations to provide Transplant Services and

Referring Plan's obligation to pay Hospital for Transplant Services, for all Members who received BDCT Referrals from Referring Plan before the effective date of such termination (or expiration). Within thirty (30) days after the effective date of such termination (or expiration), Hospital will provide a written list with the names of all such Members to the respective Referring Plan(s), for their convenient reference; and Hospital will cooperate with the Members' corresponding Referring Plan(s) to revise the list to include any Members who received timely initial or final BDCT Referrals but were inadvertently omitted from Hospital's initial list.

ARTICLE VIII: MISCELLANEOUS

8.1 Advertising and Promotion. Each party retains ownership and control of its name, symbols, trademarks, and service marks presently existing or later established. Except as otherwise provided, no party shall use either of the other parties' names, symbols, trademarks or service marks in any manner, including without limitation for advertising promotion, without the prior written consent of such other party, and shall cease any consented to usage immediately upon written notice or upon termination of this Agreement, whichever is sooner.

This Agreement does not convey to Hospital any right to use the **BLUE CROSS and/or BLUE SHIELD** names, trademarks, service marks, or design logos (collectively, together with all derivatives thereof, the **"BC/BS Marks"**), except to the limited extent provided in the attached "Facility Guidelines for Designation Usage" in Attachment D (incorporated by reference). Hospital will comply with the terms set forth in Attachment D whenever Hospital references its Designation under the BDCT program. Except as set forth in Attachment D with respect to the BCBS Marks, Hospital will not use in a logo any cross or shield design (or design that gives the commercial impression of a cross or shield) that contains the color blue (or that gives the commercial impression of the color blue), or any other name, mark, or design logo that is confusingly similar to the BC/BS Marks. Hospital represents and warrants that it and all its corporate affiliates (including its parent, siblings, subsidiaries, and other affiliated corporate entities) (collectively, "Hospital's Affiliates") are not using any cross or shield design (or design that gives the commercial impression of a cross or shield) that contains the color blue (or that gives the commercial impression of the color blue), or any other name, mark, or design logo that is confusingly similar to the BC/BS Marks. Hospital shall not be deemed in violation of the previous two sentences regarding any individual name, mark, or design to the extent that Hospital and Hospital's Affiliates are in compliance with a written letter from or settlement with BCBSA legal counsel with respect to such name, mark, or design, or are actively engaged in good faith negotiations with BCBSA legal counsel to resolve any such issues expeditiously. To the extent that any issues surrounding any such name, mark, or design logo have not been resolved and accepted in writing by BCBSA legal counsel as of the Effective Date, then, notwithstanding anything to the contrary herein and without limiting BCBSA's rights hereunder, Hospital shall not advertise, market, announce, or otherwise make reference to its Designation under the BDCT program (including but not limited to those usages referenced in Attachment D), unless and until all such issues have been resolved and accepted in writing by BCBSA legal counsel.

8.2 Data Use. The parties agree that BCBSA may share Hospital's individual Provider Survey responses ("Raw Data") and results ("Scores") with Blue Plans and, pursuant to a confidentiality agreement, Blue Plans' current and prospective accounts, for purposes of evaluation, case management, quality improvement, and Blue Plans' design of customized products and networks. BCBSA may combine Hospital's Raw Data and Scores together with other hospitals' data to create aggregate information for public dissemination, provided that such aggregate information will not identify Hospital by name and will not contain any Protected Health Information (as defined in the HIPAA Rules). Hospital's Raw Data and Scores will not be publicly disseminated beyond the extent permitted above without Hospital's prior written consent, unless required by law (e.g., subpoena). Notwithstanding the foregoing, a Blue Plan may disclose information as reasonably necessary to comply with Division BB, Title II of the Consolidated Appropriations Act, 2021.

8.3 Survival. Articles IV, V, VI, VII, and VIII will survive the Term and termination or expiration of this Agreement.

8.4 General. This Agreement contains the entire agreement between the parties with respect to Hospital's participation in the BDCT program, and, when fully executed, will supersede any prior oral or written agreements relating thereto. Captions used in this Agreement are for reference only and have no substantive meaning. Any modification of this Agreement must be made in writing and signed by all parties. No provision of this Agreement may be waived except in a writing signed by the party against which the waiver is to be effective. Unenforceability of any provision will not affect the enforceability of any other provision. No party shall assign its rights or obligations under this Agreement without prior written consent of the other parties. This Agreement is not intended and will not be deemed to create any relationship between the parties other than that of independent contractors, none of which shall be construed to be the agent, employer, employee, or representative of any other party. No persons, except for Referring Plans, are third party beneficiaries under this Agreement. All notices under this Agreement will be sent in writing to the parties at the addresses shown on the signature page and will be deemed given upon the date of receipt (if delivered by a national courier) or four (4) business days after sending by registered or certified US Mail. This Agreement may be executed in one or more

counterparts, each of which will be a separate document but all of which together will constitute one and the same instrument; electronic signatures are acceptable and are as effective as original hand executed hard copies.

8.5 **Non-Discrimination**: Neither party shall discriminate against any person on the basis of age, color, disability, gender, handicapping condition (including AIDS or AIDS related conditions), national origin, race, religion, sexual orientation, gender identity or expression or any other class protected by law or regulation.

8.6 **Public Records**: Local Plan and BCBSA acknowledge that Hospital is a public county-owned hospital which is subject to the provisions of the Nevada Public Records Act, Nevada Revised Statutes Chapter 239, as may be amended from time to time, and as such its records are public documents available for copying and inspection by the public. If Hospital receives a demand for the disclosure of any information related to the Agreement which a Local Plan or BCBSA has claimed to be confidential and proprietary, Hospital will immediately notify the Local Plan or BCBSA of such demand and Local Plan and BCBSA shall immediately notify Hospital of its intention to seek injunctive relief in a Nevada court for protective order. Local Plan and BCBSA shall indemnify, defend and hold harmless Hospital from any claims or actions, including all associated costs and attorney's fees, regarding or related to any demand for the disclosure of Local Plan or BCBSA documents in Hospital's custody and control in which Local Plan or BCBSA claims to be confidential and proprietary.

The rest of this page has been left blank intentionally.

IN WITNESS WHEREOF, the parties, through their duly authorized representatives, have executed this Agreement.

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA

By its duly authorized representative:

Signature: _____
Print Name: _____
Print Title: _____
Address: _____
_____
Date: _____

ANTHEM BLUE CROSS AND BLUE SHIELD OF NEVADA

By its duly authorized representative:

Signature: _____
Print Name: _____
Print Title: _____
Address: _____
_____
Date: _____

BLUE CROSS AND BLUE SHIELD ASSOCIATION

Signature: _____
Print Name: _____
Print Title: Senior Director, Network Portfolio
Address: 200 East Randolph Street, Suite 1800
Chicago, Illinois 60601-6400
Date: _____

ATTACHMENT A:

DESIGNATION(S) AND PAYMENT RATES

[The information in this attachment is confidential and proprietary in nature.]

ATTACHMENT B: TRANSPLANT SERVICES AND EXCLUDED SERVICES

[The information in this attachment is confidential and proprietary in nature.]

ATTACHMENT C

LOCAL BLUE PLAN CRITERIA
BLUE DISTINCTION® CENTERS FOR TRANSPLANTS
ANTHEM BLUE CROSS AND BLUE SHIELD (NEVADA)

[The information in this attachment is confidential and proprietary in nature.]

ATTACHMENT D

PROVIDER GUIDELINES FOR
BLUE DISTINCTION CENTER DESIGNATION USAGE
Rev. 5/9/2024

[The information in this attachment is confidential and proprietary in nature.]

INSTRUCTIONS FOR COMPLETING THE
DISCLOSURE OF OWNERSHIP/PRINCIPALS FORM

Purpose of the Form

The purpose of the Disclosure of Ownership/Principals Form is to gather ownership information pertaining to the business entity for use by the University Medical Center of Southern Nevada Governing Board ("GB") in determining whether members of the GB should exclude themselves from voting on agenda items where they have, or may be perceived as having a conflict of interest, and to determine compliance with Nevada Revised Statute 281A.430, contracts in which a public officer or employee has interest is prohibited.

General Instructions

Completion and submission of this Form is a condition of approval or renewal of a contract or lease and/or release of monetary funding between the disclosing entity and University Medical Center of Southern Nevada. Failure to submit the requested information may result in a refusal by the GB to enter into an agreement/contract and/or release monetary funding to such disclosing entity.

Detailed Instructions

All sections of the Disclosure of Ownership form must be completed. If not applicable, write in N/A.

Business Entity Type – Indicate if the entity is an Individual, Partnership, Limited Liability Company, Corporation, Trust, Non-profit Organization, or Other. When selecting 'Other', provide a description of the legal entity.

Non-Profit Organization (NPO) - Any non-profit corporation, group, association, or corporation duly filed and registered as required by state law.

Business Designation Group – Indicate if the entity is a Minority Owned Business Enterprise (MBE), Women-Owned Business Enterprise (WBE), Small Business Enterprise (SBE), Physically-Challenged Business Enterprise (PBE), Veteran Owned Business (VET), Disabled Veteran Owned Business (DVET), or Emerging Small Business (ESB) . This is needed in order to provide utilization statistics to the Legislative Council Bureau, and will be used only for such purpose.

- **Minority Owned Business Enterprise (MBE):** An independent and continuing business for profit which performs a commercially useful function and is at least 51% owned and controlled by one or more minority persons of Black American, Hispanic American, Asian-Pacific American or Native American ethnicity.
- **Women Owned Business Enterprise (WBE**): An independent and continuing business for profit which performs a commercially useful function and is at least 51% owned and controlled by one or more women.
- **Physically-Challenged Business Enterprise (PBE):** An independent and continuing business for profit which performs a commercially useful function and is at least 51% owned and controlled by one or more disabled individuals pursuant to the federal Americans with Disabilities Act.
- **Small Business Enterprise (SBE):** An independent and continuing business for profit which performs a commercially useful function, is not owned and controlled by individuals designated as minority, women, or physically-challenged, and where gross annual sales does not exceed $2,000,000.
- **Veteran Owned Business Enterprise (VET):** An independent and continuing Nevada business for profit which performs a commercially useful function and is at least 51 percent owned and controlled by one or more U.S. Veterans.
- **Disabled Veteran Owned Business Enterprise (DVET):** A Nevada business at least 51 percent owned/controlled by a disabled veteran.
- **Emerging Small Business (ESB):** Certified by the Nevada Governor's Office of Economic Development effective January, 2014. Approved into Nevada law during the 77th Legislative session as a result of AB294.

Business Name (include d.b.a., if applicable) – Enter the legal name of the business entity and enter the "Doing Business As" (d.b.a.) name, if applicable.

Corporate/Business Address, Business Telephone, Business Fax, and Email – Enter the street address, telephone and fax numbers, and email of the named business entity.

Nevada Local Business Address, Local Business Telephone, Local Business Fax, and Email – If business entity is out-of-state, but operates the business from a location in Nevada, enter the Nevada street address, telephone and fax numbers, point of contact and email of the local office. Please note that the local address must be an address from which the business is operating from that location. Please do not include a P.O. Box number, unless required by the U.S. Postal Service, or a business license hanging address.

***Number of Clark County Nevada Residents employed by this firm. (*Do not leave blank. If none or zero, put the number 0 in the space provided.)**

List of Owners/Officers – Include the full name, title and percentage of ownership of each person who has ownership or financial interest in the business entity. If the business is a publicly-traded corporation or non-profit organization, list all Corporate Officers and Directors only.

For All Contracts – **(Not required for publicly-traded corporations)**

1) Indicate if any individual members, partners, owners or principals involved in the business entity are a University Medical Center of Southern Nevada full-time employee(s), or appointed/elected official(s). If yes, the following paragraph applies.

   In accordance with NRS 281A.430.1, a public officer or employee shall not bid on or enter into a contract between a government agency and any private business in which he has a significant financial interest, except as provided for in subsections 2, 3, and 4.

2) Indicate if any individual members, partners, owners or principals involved in the business entity have a second degree of consanguinity or affinity relation to a University Medical Center of Southern Nevada full-time employee(s), or appointed/elected official(s) (reference form on Page 2 for definition). If **YES**, complete the Disclosure of Relationship Form.

A professional service is defined as a business entity that offers business/financial consulting, legal, physician, architect, engineer or other professional services.

Signature and Print Name – Requires signature of an authorized representative and the date signed.

Disclosure of Relationship Form – If any individual members, partners, owners or principals of the business entity is presently a University Medical Center of Southern Nevada employee, public officer or official, or has a second degree of consanguinity or affinity relationship to a University Medical Center of Southern Nevada employee, public officer or official, this section must be completed in its entirety.

DISCLOSURE OF OWNERSHIP/PRINCIPALS

Business Entity Type (Please select one)						
☐ Sole Proprietorship	☐Partnership	☐ Limited Liability Company	X Corporation	☐ Trust	☐ Non-Profit Organization	☐ Other

Business Designation Group (Please select all that apply)						
☐ MBE	☐ WBE	☐ SBE	☐ PBE	☐ VET	☐DVET	☐ ESB
Minority Business Enterprise	Women-Owned Business Enterprise	Small Business Enterprise	Physically Challenged Business Enterprise	Veteran Owned Business	Disabled Veteran Owned Business	Emerging Small Business

Number of Clark County Nevada Residents Employed:

Corporate/Business Entity Name:	Rocky Mountain Hospital and Medical Service, Inc.	
(Include d.b.a., if applicable)	d/b/a Anthem Blue Cross and Blue Shield and HMO Colorado, Inc., d/b/a HMO Nevada and Community Care Health Plan of Nevada, Inc.	
Street Address:	9133 W. Russell Rd.	**Website: www.anthem.com**
City, State and Zip Code:	Las Vegas, NV 89148	**POC Name: Ashley DeLanis** **Email: ashley.delanis@anthem.com**
Telephone No:	702-271-0648	**Fax No: N/A**
Nevada Local Street Address: **(If different from above)**	Same a above	**Website: Same as above**
City, State and Zip Code:	Same as above	**Local Fax No: N/A**
Local Telephone No:	Same as above	**Local POC Name: Same as above** **Email: Same as above**

All entities, with the exception of publicly-traded and non-profit organizations**,** must list the names of individuals holding more than five percent (5%) ownership or financial interest in the business entity appearing before the Board.

Publicly-traded entities and non-profit organizations shall list all Corporate Officers and Directors in lieu of disclosing the names of individuals with ownership or financial interest. The disclosure requirement, as applied to land-use applications, extends to the applicant and the landowner(s).

Entities include all business associations organized under or governed by Title 7 of the Nevada Revised Statutes, including but not limited to private corporations, close corporations, foreign corporations, limited liability companies, partnerships, limited partnerships, and professional corporations.

Full Name	Title	% Owned (Not required for Publicly Traded Corporations/Non-profit organizations)

This section is not required for publicly-traded corporations. Are you a publicly-traded corporation? X Yes ☐ No

1. Are any individual members, partners, owners or principals, involved in the business entity, a University Medical Center of Southern Nevada full-time employee(s), or appointed/elected official(s)?

   ☐ Yes X No (If yes, please note that University Medical Center of Southern Nevada employee(s), or appointed/elected official(s) may not perform any work on professional service contracts, or other contracts, which are not subject to competitive bid.)

2. Do any individual members, partners, owners or principals have a spouse, registered domestic partner, child, parent, in-law or brother/sister, half-brother/half-sister, grandchild, grandparent, related to a University Medical Center of Southern Nevada full-time employee(s), or appointed/elected official(s)?

   ☐ Yes X No (If yes, please complete the Disclosure of Relationship form on Page 2. If no, please print N/A on Page 2.)

I certify under penalty of perjury, that all of the information provided herein is current, complete, and accurate. I also understand that the University Medical Center of Southern Nevada Governing Board will not take action on land-use approvals, contract approvals, land sales, leases or exchanges without the completed disclosure form.

Signature	Ashley DeLanis Print Name
RVP, PSO Title	9/9/2025 Date

REVISED 7/25/2014

DISCLOSURE OF RELATIONSHIP

List any disclosures below:
(Mark N/A, if not applicable.)

NAME OF BUSINESS OWNER/PRINCIPAL	NAME OF UMC* EMPLOYEE/OFFICIAL AND JOB TITLE	RELATIONSHIP TO UMC* EMPLOYEE/OFFICIAL	UMC* EMPLOYEE'S/OFFICIAL'S DEPARTMENT
N/A			

* UMC employee means an employee of University Medical Center of Southern Nevada

"Consanguinity" is a relationship by blood. "Affinity" is a relationship by marriage.

"To the second degree of consanguinity" applies to the candidate's first and second degree of blood relatives as follows:

- Spouse – Registered Domestic Partners – Children – Parents – In-laws (first degree)
- Brothers/Sisters – Half-Brothers/Half-Sisters – Grandchildren – Grandparents – In-laws (second degree)

For UMC Use Only:

If any Disclosure of Relationship is noted above, please complete the following:

☐ Yes ☐ No Is the UMC employee(s) noted above involved in the contracting/selection process for this particular agenda item?

☐ Yes ☐ No Is the UMC employee(s) noted above involved in any way with the business in performance of the contract?

Notes/Comments:

_____
Signature

_____
Print Name
Authorized Department Representative

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
GOVERNING BOARD AUDIT AND FINANCE COMMITTEE
AGENDA ITEM

Issue:	**Institutional Provider Agreement with Evernorth Behavioral Health, Inc.**	**Back-up:**
Petitioner:	Jennifer Wakem, Chief Financial Officer	**Clerk Ref. #**

Recommendation:

That the Governing Board Audit and Finance Committee review and recommend for approval by the Governing Board the Institutional Provider Agreement with Evernorth Behavioral Health, Inc. for Managed Care Services; or take action as deemed appropriate. ***(For possible action)***

FISCAL IMPACT:

Fund Number: 5430.011
Fund Name: UMC Operating Fund
Fund Number: 3000850000
Funded Pgm/Grant: N/A
Description: Managed Care Services
Bid/RFP/CBE: NRS 332.115(1)(f) – Insurance
Term: 2 years from the date last signed; may renew for two (2) annual terms
Amount: Revenue based on volume
Out Clause: 60 days without cause

BACKGROUND:

In 2020, Cigna Behavioral changed its name to Evernorth Behavioral Health ("Evernorth") In the past 18 months, Evernorth has expanded its Behavioral Care Group from virtual services in six markets and a network of 1,000 providers to more than 5,000 providers across all 50 states. Evernorth now plans to grow the medical group to more than 15,000 providers this year. This request is to enter into the Institutional Provider Agreement with Evernorth to provide health care services to its members at UMCs Crisis Stabilization Center. The term of the agreement is for two years and may be renewed for two one-year terms.

UMC's Director of Managed Care has reviewed and recommends approval of this agreement, which has also been approved as to form by UMC's Office of General Counsel.

A Clark County business license is not required as UMC is the provider of hospital services to this insurance fund.

Cleared for Agenda
January 21, 2026

Agenda Item #
15

INSTITUTIONAL PROVIDER AGREEMENT

This Institutional Provider Agreement ("Agreement") is between Evernorth Behavioral Health, Inc. and its affiliates ("Evernorth Behavioral Health, Inc.") and University Medical Center of Southern Nevada, a publicly owned and operated hospital created by virtue of Chapter 450 of the Nevada Revised Statutes ("Provider") and is effective upon the date last signed by the parties below (the "Effective Date").

RECITALS

A. Evernorth Behavioral Health, Inc. arranges for or administers the provision of health care services;

B. Evernorth Behavioral Health, Inc. contracts directly or indirectly with physicians, hospitals and other behavioral health care practitioners and entities to provide or arrange for, at predetermined rates, the delivery of such health care services;

C. Provider is a licensed hospital or program that desires to provide services to Participants under the terms of this Agreement.

NOW, THEREFORE, the parties agree as follows:

SECTION 1. DEFINITIONS

1.1 Administrative Guidelines
means the rules, policies, and procedures adopted by Evernorth Behavioral Health, Inc. or a Payor to be followed by Provider in providing services and doing business with Evernorth Behavioral Health, Inc. and Payors under this Agreement. This term expressly includes Evernorth Behavioral Health, Inc.'s Medical Management program.

1.2 Benefit Plan
means a certificate of coverage, summary plan description or other document or agreement which specifies the health care services to be provided or reimbursed for the benefit of a Participant.

1.3 Billed Charges
means the fees billed by Provider under Provider's standard charge master which fees shall not discriminate based upon the identity of the party financially responsible for the service.

1.4 Evernorth Behavioral Health, Inc. Affiliate
means any subsidiary or affiliate of Evernorth Behavioral Health, Inc.

1.5 Coinsurance
means a payment that is the financial responsibility of the Participant under a Benefit Plan for Covered Services that is calculated as a percentage of the contracted reimbursement rate for such services or, if reimbursement is on a basis other than a fee-for-service amount, as a percentage of an Evernorth Behavioral Health, Inc. determined fee schedule or as an Evernorth Behavioral Health, Inc. determined percentage of actual charges.

1.6 Copayment
means a payment that is the financial responsibility of the Participant under a Benefit Plan for Covered Services that is calculated as a fixed dollar amount.

1.7 Covered Services
means those health care services for which a Participant is entitled to receive coverage under the terms and conditions of the Participant's Benefit Plan.

1.8 Deductible
means a payment for Covered Services calculated as a fixed dollar amount that is the financial responsibility of the Participant under a Benefit Plan prior to qualifying for reimbursement for subsequent health care costs under the terms of a Benefit Plan.

1.9 Medically Necessary/Medical Necessity
means services and supplies that satisfy the Medical Necessity requirements under the applicable Benefit Plan. No service is a Covered Service unless it is Medically Necessary.

1.10 Participant
means any individual, or eligible dependent of such individual, whether referred to as "Insured," "Subscriber," "Member," "Participant," "Enrollee," "Dependent" or similar designation, who is eligible and enrolled to receive Covered Services, or who is a continuing care patient as defined by applicable federal law.

1.11 Participating Provider
means a hospital, program, physician or group of physicians or any other health care practitioner or entity that has a direct or indirect contractual arrangement with Evernorth Behavioral Health, Inc. to provide Covered Services with regard to the Benefit Plan covering the Participant.

1.12 Payor
means the person or entity obligated to a Participant to provide reimbursement for Covered Services under the Participant's Benefit Plan, and which Evernorth Behavioral Health, Inc. has agreed may access services under this Agreement.

1.13 Quality Management
means the program described in the Administrative Guidelines relating to the quality of Covered Services provided to Participants.

1.14 Utilization Management
means a process to review and determine whether certain health care services provided or to be provided are Medically Necessary and in accordance with the Administrative Guidelines.

SECTION 2. DUTIES OF PROVIDER

2.1 Provider Services
Provider shall provide Covered Services to Participants upon the terms and conditions set forth in this Agreement and the Administrative Guidelines. All services provided by Provider within the scope of Provider's practice or license must be provided on a participating basis. Regardless of Provider's physical location, all aspects of Provider's practice are participating under the terms of this Agreement unless Covered Services are provided under the terms of another applicable Evernorth Behavioral Health, Inc. participation agreement.

2.2 Standards
Provider shall provide Covered Services in accordance with (i) the same standard of care, skill and diligence customarily used by similar providers in the community in which such services are rendered, (ii) the requirements of applicable law, (iii) the standards of applicable accreditation organizations, and (iv) the provisions of Evernorth Behavioral Health, Inc.'s Quality Management program. Provider agrees to render Covered Services to all Participants in the same manner, in accordance with the same standards and with the same time availability as offered to other patients. Provider shall not differentiate or discriminate in the treatment of any Participant because of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, gender identity, age, health status, veteran's status, handicap or source of payment.

2.3 Credentialing
Evernorth Behavioral Health, Inc. will be responsible for credentialing and recredentialing Provider. Providers shall cooperate with Evernorth Behavioral Health, Inc.'s credentialing and recredentialing process and shall furnish all records necessary for such process. Provider shall warrant in their application

for participation that the information contained in their application is true and correct. Provider shall notify Evernorth Behavioral Health, Inc. in writing within thirty (30) days of any material change in the information contained in Provider's application for participation with Evernorth Behavioral Health, Inc. Provider must satisfy Evernorth Behavioral Health, Inc.'s credentialing requirements, and Evernorth Behavioral Health, Inc. shall have the right to exclude any provider who or which, in Evernorth Behavioral Health, Inc.'s judgment, does not meet Evernorth Behavioral Health, Inc.'s credentialing criteria.

Provider shall ensure that all health care providers who perform any of the services for which Provider is responsible under this Agreement are credentialed and recredentialed in accordance with the accreditation credentialing standards and maintain all necessary licenses or certifications required by state or federal law, if applicable. Provider shall comply with Evernorth Behavioral, Inc.'s requests for information to ensure that all Participating Providers meet Payor's credentialing standards during the term of this Agreement. Provider shall immediately restrict, suspend or terminate any such health care provider from providing services to Participants under this Agreement if such provider ceases to meet the licensing/certification requirements or other professional standards described in this Agreement.

Provider agrees to arrange staff privileges or other appropriate access for Participating Providers who apply for such staff privileges or access provided they are qualified physicians and meet the reasonable standards of practice established by the hospital medical staff and the bylaws, rules and regulations of hospital. Hospital rosters of Participating Providers with staff privileges shall be provided to Evernorth Behavioral Health, Inc. upon request at no charge to Evernorth Behavioral Health, Inc.

2.4 Insurance

Throughout the term of this Agreement, Provider shall maintain at Provider's expense general and professional liability coverage as provided by Chapter 41 of the Nevada Revised Statutes. Provider shall give Evernorth Behavioral Helah a certificate of insurance evidencing such coverage upon request. Provider shall give Evernorth Behavioral Health immediate written notice of cancellation, material modification or termination of such insurance.

2.5 Administrative Guidelines

Provider shall comply with the Administrative Guidelines. Some or all Administrative Guidelines may be communicated in the form of a provider reference manual, in other written materials distributed by Evernorth Behavioral Health, Inc. to Provider and/or at a website identified by Evernorth Behavioral Health, Inc. Administrative Guidelines may change from time to time. Evernorth

Behavioral Health, Inc. will give Provider advance notice of material changes to Administrative Guidelines. In the event that Provider reasonably believes that a Payment Policy is likely to have a material financial impact, Provider will notify Evernorth Behavioral Health, Inc., and the Parties will meet and negotiate in good faith an appropriate amendment if any, to this Agreement.

2.6 Quality Management

Provider shall comply with the requirements of and participate in Quality Management as specified in the Administrative Guidelines.

2.7 Utilization Management

Provider shall comply with the requirements of and participate in Utilization Management as specified in this Agreement and the Administrative Guidelines. Payment may be denied for failure to comply with such Utilization Management requirements and Provider shall not bill the Participant for any such denied payment. Evernorth Behavioral Health, Inc.'s Utilization Management requirements include, but are not limited to, the following: a) precertification must be secured from Evernorth Behavioral Health, Inc. or its designee for those services and procedures for which it is required as specified in the Administrative Guidelines; b) Provider must provide Evernorth Behavioral Health, Inc. or Evernorth Behavioral Health, Inc.'s designee with all of the information requested by Evernorth Behavioral Health, Inc. or its designee to make its Utilization Management determinations within a 24 hour timeframe specified by Evernorth Behavioral Health, Inc. or its designee in such request Inc. or its designee in such request; and

c) Provider will refer Participants to and/or use Participating Providers for the provision of Covered Services except in the case of an emergency or as otherwise required by law.

If Provider inappropriately refers a Participant to a non-Participating Provider in a non-emergency situation without the Participant's express written consent, and thereby causes the Participant to become responsible for the charges of the non-Participating Provider, or to incur more charges than if such care had been received from a Participating Provider, Evernorth Behavioral Health, Inc. or an Evernorth Behavioral Health, Inc. Affiliate may, in its sole discretion, satisfy the obligation to the non-Participating Provider for such services.

2.8 Records

Provider shall maintain medical records and documents relating to Participants as may be required by applicable law and for the period of time required by law. Medical records of Participants and any other records containing individually identifiable information relating to Participants will be regarded as confidential, and Provider and Evernorth Behavioral Health, Inc. shall comply with applicable federal and state law regarding such records. Provider will obtain Participants' consent to or authorization for the disclosure of private and medical record information for any disclosures required under this Agreement if required by law.

Upon request, Provider will provide Evernorth Behavioral Health, Inc. with a copy of Participants' medical records and other records maintained by Provider relating to Participants. These records shall be provided to Evernorth Behavioral Health, Inc. at no charge unless Evernorth Behavioral Health, Inc. requests a copy of a particular record that it has previously requested and received. If copying costs are payable, Provider shall submit an invoice to Evernorth Behavioral Health, Inc. and payment for such records will be made at a rate of $.25 cents per page, not to exceed a total of $50 per record. Records will be provided within the timeframes requested by Evernorth Behavioral Health, Inc, and will also be made available during normal business hours for inspection by Evernorth Behavioral Health, Inc., Evernorth Behavioral Health, Inc.'s designee, accreditation organizations, or to any governmental agency that requires access to these records. This provision survives the termination of this Agreement.

2.9 Cooperation with Evernorth Behavioral Health, Inc. and Evernorth Behavioral Health, Inc. Affiliates

Provider shall cooperate with Evernorth Behavioral Health, Inc. or its designee in the implementation of Evernorth Behavioral Health, Inc.'s Participant appeal procedure. Provider shall also cooperate with Evernorth Behavioral Health, Inc. and Evernorth Behavioral Health, Inc. Affiliates in establishing and implementing such policies and programs as may be reasonably requested by Evernorth Behavioral Health, Inc. or an Evernorth Behavioral Health, Inc. Affiliate for purposes of Evernorth Behavioral Health, Inc.'s or an Evernorth Behavioral Health, Inc. Affiliate's business operations or required by Payor to comply with applicable law or accreditation requirements.

2.10 Laboratory Services

Provider shall not market or promote itself as a Participating Provider for laboratory services or otherwise issue any communications that state or imply that it is a Participating Provider for laboratory services, except as otherwise agreed in writing by Evernorth Behavioral Health, Inc.

2.11 Provider Locations

This Agreement shall specifically exclude those services rendered at Provider locations other than those facilities agreed upon and utilized as of the Effective Date unless otherwise agreed in writing by Evernorth Behavioral Health, Inc.

2.12 Attending Providers

Prior to the Effective Date and on or before each anniversary of this Agreement, facility will provide Evernorth Behavioral Health, Inc. with a list of all providers and provider groups who render services to patients, including but not limited to, those who provide services to facility patients in the specialty areas of psychiatry, anesthesiology, radiology, pathology and emergency. Such list shall include the name of the group with which the provider is associated (if applicable) and the tax identification number utilized for payment of such physician's services. Facility shall notify Evernorth Behavioral Health, Inc. of any changes to the information on such list. With respect to those providers who are not employed by or compensated by facility, facility will require such providers to obtain contracts with Evernorth Behavioral Health, Inc.

SECTION 3. DUTIES OF EVERNORTH BEHAVIORAL HEALTH, INC.

3.1 Payors, Benefit Plan Types, Notice of Changes to Benefit Plan Types Evernorth Behavioral Health, Inc. may allow Payors to access Provider's services under this Agreement for the Benefit Plan types as described in Exhibit C. Evernorth Behavioral Health, Inc. will give thirty (30) days advance notice to Provider if Evernorth Behavioral Health, Inc. removes a Benefit Plan type described in Exhibit C for Provider's services that Payors will no longer access under this Agreement.

3.2 Benefit Information

Evernorth Behavioral Health, Inc. will give Provider access to benefit information concerning the type, scope and duration of benefits to which a Participant is entitled as specified in the Administrative Guidelines.

3.3 Participant and Participating Provider Identification

Evernorth Behavioral Health, Inc. will establish a system of Participant identification and will identify Participating Providers to those Payors and Participants who are offered a network of Participating Providers. However, Evernorth Behavioral Health, Inc. makes no representations or guarantees concerning the number of Participants that will be referred to Provider as a result of this Agreement and reserves the right to direct Participants to selected Participating Providers and/or influence a Participant's choice of Participating Provider.

SECTION 4. COMPENSATION

4.1 Payments

Payments for Covered Services will be the lesser of the billed charge or the applicable fee under Exhibit A, and minus any applicable Copayments, Coinsurance and/or Deductibles. The rates in this Agreement will be payment in full for all services furnished to Participants under this Agreement. Provider shall look solely to Payor for payment for Covered Services except for Copayments, Coinsurance and/or Deductibles. Provider shall submit claims for Covered Services at the location identified by Evernorth Behavioral Health, Inc. and in the manner and format specified in this Agreement. Claims for Covered Services must be submitted within one hundred eighty (180) days of the date of service or, if Payor is the secondary payor, within one hundred eighty (180) days of the date of the explanation of payment from the primary payor. Claims received after one hundred eighty (180) day period may be , and Provider shall not bill Evernorth Behavioral Health, Inc., the Payor or the Participant for those denied services. Amounts due and owing under this Agreement with respect to complete claims for Covered Services will be payable within the timeframes required by applicable law.

4.2 Underpayments

If Provider believes Provider has been underpaid for a Covered Service, Provider must submit a written request for an appeal or adjustment with Evernorth Behavioral Health, Inc. or its designee within three hundred sixty-five (365) days from the date of Payor's payment or explanation of payment. The request must be submitted in accordance with Evernorth Behavioral Health, Inc.'s dispute resolution process. Requests for appeals or adjustments submitted after this date may be denied for payment and Provider will not be permitted to bill Evernorth Behavioral Health, Inc., Payor or the Participant for those services for which payment was denied.

4.3 Copayments, Coinsurance and Deductibles

Provider may charge a Participant applicable Copayments, Coinsurance and/or Deductibles in accordance with the terms of the Participant’s Benefit Plan and the process set out in the Administrative Guidelines.

4.4 Limitations on Billing Participants

Provider agrees that in no event, including but not limited to nonpayment by Payor, Payor’s insolvency or breach of this Agreement shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from or have any recourse against Participants or persons other

than the applicable Payor for Covered Services or for any amounts denied or not paid under this Agreement due to Provider's failure to comply with the requirements of Evernorth Behavioral Health, Inc.'s or its designee's Utilization Management program or other Administrative Guidelines or failure to file a timely claim or appeal. This provision does not prohibit collection of any applicable Copayments, Coinsurance and/or Deductibles. This provision survives termination of this Agreement, is intended to be for the benefit of Participants and supersedes any oral or written agreement to the contrary now existing or hereafter entered into between Provider and a Participant or persons acting on the Participant's behalf. Modifications to this section will become effective no earlier than the date permitted by applicable law.

4.5 Billing Patients Who Cease to Be Participants

Provider may bill a patient directly for any services provided following the date that patient ceases to be a Participant and Payor has no obligation to pay for services for such patients.

4.6 Participant Incentives Prohibited

Provider shall not directly or indirectly establish, arrange, encourage, participate in or offer any Participant Incentive.

(A) Participant Incentive means any arrangement by Provider:

(1) to reduce or satisfy a Participant's cost-sharing obligations (including, but not limited to Copayments, Deductible and/or Coinsurance);

(2) to pay on behalf of or reimburse a Participant for any portion of the Participant's costs for coverage under a policy or plan insured or administered by Evernorth Behavioral Health, Inc. or an Evernorth Behavioral Health, Inc. Affiliate;

(3) that provides a Participant with any form of material financial incentive (other than the reimbursement terms under this Agreement), to receive Covered Services from the Provider or its affiliates.

(B) In the event of non-compliance with this provision:

(1) Evernorth Behavioral Health, Inc. may terminate this Agreement, such non-compliance being a "material breach" of this Agreement;

(2) Provider shall not be entitled to reimbursement under this Agreement with respect to Covered Services provided to a Participant in connection with a Participant Incentive, and;

(3) Evernorth Behavioral Health, Inc. may take such other action appropriate to enforce this provision.

4.7 Non-Medically Necessary and/or Non-Covered Services

Provider shall not charge a Participant for a service that is not Medically Necessary and/or not a Covered Service unless, in advance of providing the service, Provider has notified the Participant of the cost per day of the service, that the particular service will not be covered and the Participant acknowledges in writing that they will be responsible for payment for such service.

4.8 Overpayments

Provider shall, after researching and within three hundred sixty-five (365) days after receiving notice from Evernorth Behavioral Health, Inc., refund Evernorth Behavioral Health, Inc. any excess payment made by a Payor to Provider if Provider is for any reason overpaid for health care services or supplies.

4.9 Audits

Upon reasonable notice and during regular business hours, Evernorth Behavioral Health, Inc. or its designee will have the right to review and make copies of all records maintained by Provider with respect to all payments received by Provider from all sources for Covered Services provided to Participants. Evernorth Behavioral Health, Inc. or its designee will have the right to conduct audits of such records and may audit its own records to determine if amounts have been properly paid under this Agreement. Provider shall have forty-five (45) days to notify Evernorth Behavioral Health, Inc. that it disputes the audit findings. Any amounts determined to be due and owing as a result of such audits and not disputed within forty-five (45) days by Provider shall be promptly paid. This provision survives the termination of this Agreement.

4.10 Coordination of Benefits

Certain claims for Covered Services are claims for which another payor may be primarily responsible under coordination of benefit (COB) rules. Provider may pursue those claims in accordance with the process set out in the Administrative Guidelines.

4.10.1 Evernorth Behavioral Health, Inc.as Secondary Payor (non-Medicare)

Evernorth Behavioral Health, Inc.'s payment, when added to the amount payable from other sources under the applicable COB rules, will be no greater than the payment for Covered Services under the Evernorth Behavioral Health, Inc. provider agreement and is subject to the terms and conditions of the Participant's health benefit plan and applicable state and federal law.

4.10.2 Evernorth Behavioral Health, Inc.'s payment, when added to the amount payable from other sources under the applicable COB rules, will be no greater than the payment for Covered Services under the Evernorth Behavioral Health, Inc. provider agreement and is subject to the terms and conditions of the Participant's health benefit plan and applicable state and federal law. Medicare as Primary Payor

When the Evernorth Behavioral Health, Inc. plan is the secondary payor to Medicare, Provider and Evernorth Behavioral Health, Inc. are required to follow Medicare billing rules. Payment will be made in accordance with all applicable Medicare requirements, including but not limited to Medicare COB rules. The Medicare COB rules require Evernorth Behavioral Health, Inc.'s financial responsibility as the secondary payor to be limited to the Participant's financial liability (i.e. the applicable Medicare copayment, coinsurance, and/or deductible) after application of the Medicare-approved amount. The Medicare payment plus the Participant liability (applicable Medicare copayment, coinsurance, and/or deductible) amounts constitute payment in full, and Provider is prohibited from collecting any monies in excess of this amount.

4.11 Applicability of the Rates

The rates in this Agreement apply to all services provided to Participants in the Benefit Plan types covered by this Agreement, including services covered under a Participant's in or out-of-network benefits and whether the Payor or Participant is financially responsible for payment

SECTION 5. TERM AND TERMINATION

5.1 Term of This Agreement

This Agreement begins on the Effective Date and continues for two (2) years, unless earlier terminated as set forth below. Upon written approval by both parties, this Agreement may renew for two (2) subsequent one (1) year terms.

5.2 How This Agreement Can Be Terminated

Either Provider or Evernorth Behavioral Health, Inc. can terminate this Agreement at any time by providing at least sixty (60) days advance written notice.

Either Provider or Evernorth Behavioral Health, Inc. can terminate this Agreement immediately if the other becomes insolvent or is in material breach of this Agreement or the Administrative Guidelines. Evernorth Behavioral Health, Inc. can terminate this Agreement immediately (or upon such longer notice required by applicable law, if any) if Provider no longer maintains the

licenses required to perform its duties under this Agreement, Provider is disciplined by any licensing, regulatory, accreditation organization or any other professional organization with jurisdiction over Provider, or if Provider no longer satisfies Evernorth Behavioral Health, Inc.'s credentialing requirements. While investigating alleged occurrences of any of the foregoing events listed in this paragraph, Evernorth Behavioral Health, Inc. may suspend referrals and/or reassign Participants from Provider. Evernorth Behavioral Health, Inc. shall notify Provider in writing if referrals are suspended or reassigned for this reason.

Upon termination of this Agreement for any reason, the rights of each party terminate, except as provided in this Agreement. Termination will not release Provider or Evernorth Behavioral Health, Inc. from obligations under this Agreement prior to the effective date of termination.

Upon notice of termination of this Agreement or of a Participating Provider's participation with a particular Benefit Plan type, Provider will cooperate with Evernorth Behavioral Health, Inc. and provide Evernorth Behavioral Health, Inc. with a listing of Participants affected by the termination seven (7) business days prior to the date of the notice of termination.

5.3 Services upon Termination

Upon termination of this Agreement, Provider shall continue to provide Covered Services for those patients being treated for a chronic condition requiring continuity of care for whom an alternative means of receiving necessary care was not arranged at the time of such termination Provider shall continue to provide Covered Services to such Participants so long as the Participant retains eligibility under a Benefit Plan until the completion of such services, the Participant has been safely transferred to another Participating Provider or the date required by applicable law. Provider shall be compensated for Covered Services provided to any such Participant in accordance with the terms of the Agreement. Provider shall accept payment from Payor in accordance with the terms of this Participant's Benefit Plan as payment in full for Covered Services. Provider has no obligation under this Agreement to provide services to individuals who cease to be Participants.

SECTION 6. GENERAL PROVISIONS

6.1 Confidentiality

The parties acknowledge that, as a result of this Agreement, each may have access to certain trade secrets or other confidential and proprietary information of the other. Each party shall hold such trade secrets or other confidential and proprietary information, including the terms of this Agreement, in confidence and shall not use or disclose such information, either by publication or otherwise, to any person without the prior written consent of the other party except as may be required by lawand except as may be required to fulfill the rights and obligations set forth in this Agreement. This provision shall not be construed to prohibit Evernorth Behavioral Health, Inc. from disclosing

information to Evernorth Behavioral Health, Inc's affiliates or the agents or subcontractors of Evernorth Behavioral Health, Inc. or its Affiliates or from disclosing the terms and conditions of this Agreement, including reimbursement rates, to existing or potential Payors, Participants or other customers of Evernorth Behavioral Health, Inc. or its Affiliates or their representatives. This provision survives the termination of this Agreement. Nothing in this provision shall be construed to prohibit communications necessary or appropriate for the delivery of health care services, communications regarding coverage and coverage appeal rights or any other communications expressly protected under applicable law

Notwithstanding the foregoing, Evernorth Behavioral Health, Inc. acknowledges that Provider is a public county-owned hospital which is subject to the provisions of the Nevada Public Records Act, Nevada Revised Statutes Chapter 239, as may be amended from time to time, and as such records are public documents available for copying and inspection by the public. If Provider receives a demand for the disclosure of any information related to the Agreement which Evernorth Behavioral Health, Inc. has claimed to be confidential and proprietary, Provider will immediately notify Evernorth Behavioral Health, Inc. of such demand and Evernorth Behavioral Health, Inc. shall immediately notify Provider of its intention to seek injunctive relief in a Nevada court for protective order. Evernorth Behavioral Health, Inc. shall indemnify, defend and hold harmless Provider from any claims or actions, including all associated costs and attorney's fees, regarding or related to any demand for the disclosure of Evernorth Behavioral Health, Inc.'s documents in Provider's custody and control in which Evernorth Behavioral Health, Inc. claims to be confidential and proprietary.

6.2 Independent Parties

Provider and Evernorth Behavioral Health, Inc. are independent contractors. Evernorth Behavioral Health, Inc. and Provider do not have an employer-employee, principal-agent, partnership or similar relationship. Nothing in this Agreement, including Provider's participation in care collaboration, population management, pay for performance, Quality Management, Utilization Management and other similar programs, nor any coverage determination made by Evernorth Behavioral Health, Inc. or a Payor, is intended to interfere with or affect Provider's independent judgment in providing health care services to its patients. Nothing in the Agreement is intended to create any right for Evernorth Behavioral Health, Inc. or any other party to intervene in or influence Provider's medical decision-making regarding any Participant.

6.3 Indemnification

Each party agrees to indemnify, defend and hold harmless the other, its agents and employees from and against any and all liability or expense, including defense costs and legal fees, incurred in connection with third party claims for damages of any nature, including but not limited to bodily injury, death, personal injury, property damage, or other damages arising from the performance of or failure to perform, its obligations under this Agreement, unless it is determined that the liability was the direct consequence of negligence or willful misconduct on the part of the other party, its agents or employees. This provision shall survive the termination of this Agreement Provider explicitly retains all defenses to such indemnification that may exist under Nevada law, and any indemnification by Provider under this paragraph shall be subject to and limited by the provisions of Chapter 41 of the Nevada Revised Statutes, as applicable.

6.4 Internal Dispute Resolution

Disputes that might arise between the parties regarding the performance or interpretation of the Agreement must first be resolved through the applicable internal dispute resolution process outlined in the Administrative Guidelines. In the event the dispute is not resolved through that process, either party can request in writing that the parties attempt in good faith to resolve the dispute promptly by negotiation between designated representatives of the parties who have authority to settle the dispute. If the matter is not resolved within sixty (60) days of such a request, either party may initiate arbitration by providing written notice to the other. With respect to a payment or termination dispute (excluding termination with notice), Provider must submit a request for arbitration within twelve (12) months of the date of the letter communicating the final decision under Evernorth Behavioral Health, Inc.'s internal dispute resolution process unless applicable law specifically requires a longer time period to request

arbitration. If arbitration is not requested within that twelve (12) month period, Evernorth Behavioral Health, Inc.'s final decision under its internal dispute resolution process will be binding on Provider and Provider shall not bill Evernorth Behavioral Health, Inc., Payor or the Participant for any payment denied because of the failure to timely submit a request for arbitration.

6.5 Arbitration

If the dispute is not resolved through Evernorth Behavioral Health, Inc.'s internal dispute resolution process, the controversy shall be resolved through binding arbitration in Nevada. The arbitration shall be conducted in sixty (60) days in accordance with the Rules of the American Arbitration Association then in effect, and which to the extent of the subject matter of the arbitration, shall be binding not only on all parties to the agreement, but on any other entity controlled by, in control of or under common control with the party to the extent that such affiliate joins in the arbitration, and judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction thereof. Each party shall assume its own costs, but the compensation and expenses of the arbitrator and any administrative fees or costs shall be borne equally by the parties. The decision of the arbitrator shall be final, conclusive and binding, and no action at law or in equity may be instituted by either party other than to enforce the award of the arbitrator. The parties intend this alternative dispute resolution procedure to be a private undertaking and agree that an arbitration conducted under this provision shall not be consolidated with an arbitration involving other parties, and that the arbitrator shall be without power to conduct an arbitration on a class basis.

6.6 Material Adverse Change Amendments

In the event that the state or federal law requires that the terms of this Agreement must be changed, then, upon notice from Evernorth Behavioral Health, this Agreement shall be deemed to be automatically amended to conform to the requirements of such state or federal law, and the partes shall continue to perform under this Agreement as modified

6.7 All Other Amendments – Except as provided above, amendments to this Agreement shall be agreed to in advance in writing by Evernorth Behavioral Health, Inc. and Provider.

6.8 Assignment and Delegation

Neither Evernorth Behavioral Health, Inc. nor Provider may assign any rights or delegate any obligations under this Agreement without the written consent of the other party; provided, however, that any reference to Evernorth Behavioral Health, Inc. includes any successor in interest and Evernorth Behavioral Health, Inc. may assign its duties, rights and interests under this Agreement in whole or in part to an Evernorth Behavioral Health, Inc. Affiliate or may delegate any and all of its duties to a third party in the ordinary course of business.

6.9 Sale of Business/Change in Management

If, during the term of this Agreement, Provider desires (i) to sell, transfer or convey its business or any substantial portion of its business assets to another entity or Provider is the subject of a sale, transfer or conveyance of its business by another entity or (ii) Provider enters into a management contract with another entity, Provider shall so advise Evernorth Behavioral Health, Inc. in writing at least one hundred twenty (120) days prior to the transaction effective date in order to obtain Evernorth Behavioral Health, Inc.'s written consent as to which Evernorth Behavioral Health, Inc. participating provider agreement applies, if any, to services rendered by you or the surviving entity, on a post-transaction basis. Failure to provide advance notification and obtain Evernorth Behavioral Health, Inc.'s written consent will result in Evernorth Behavioral Health, Inc. determining which, if any, Evernorth Behavioral Health, Inc. participating provider agreement applies to services rendered on a post-transaction basis. Dependent upon when Evernorth Behavioral Health, Inc. learns of the transaction, this may result in a retroactive adjustment to reimbursement and an overpayment recovery process. Provider warrants and covenants that this Agreement will be part of the transfer, will be assumed by the new entity and that the new entity will honor and be fully bound by the terms and conditions of this Agreement unless the new entity already has an agreement with Evernorth Behavioral Health, Inc. or an Evernorth Behavioral Health, Inc. Affiliate, in which case Evernorth Behavioral Health, Inc., in its sole discretion, will determine which Agreement will prevail. Notwithstanding the above, if Evernorth Behavioral Health, Inc., in its sole discretion, is of the opinion that the Agreement cannot be satisfactorily performed by the assuming entity or does not want to do business with that entity for whatever reason, Evernorth Behavioral Health, Inc. may terminate this Agreement by giving

Provider sixty (60) days written notice, notwithstanding any other provision in the Agreement.

This Agreement shall not, without Evernorth Behavioral Health, Inc.'s written consent, be applicable to any hospital, physician or physician group or ancillary provider that is acquired (directly or indirectly) by or enters into a management, co-management, professional services, leasing, joint venture or similar agreement or arrangement with Provider or Provider affiliate. Provider shall notify Evernorth Behavioral Health, Inc. one hundred twenty (120) days in advance of any such acquisition or arrangement.

6.10 Use of Name

Provider agrees that Evernorth Behavioral Health, Inc. may include descriptive information about Provider in literature distributed to existing or potential Participants, Participating Providers and Payors. That information will include, but not be limited to, Provider's name, telephone number, address and specialties. Provider may identify itself as a Participating Provider with respect to those Benefit Plan types in which Provider participates with Evernorth Behavioral Health, Inc. Provider's use of Evernorth Behavioral Health, Inc.'s name or an Evernorth Behavioral Health, Inc. Affiliate's name, or any other use of Provider's name by Evernorth Behavioral Health, Inc. will be upon prior written approval or as the parties may agree.

6.11 Notices

Any notice required under this Agreement must be in writing and sent by United States mail, postage prepaid, to Evernorth Behavioral Health, Inc. and Provider at the addresses below. Evernorth Behavioral Health, Inc. may also notify Provider by sending an electronic notice with automatic receipt verification to Provider's email address below. Either party can change the address for notices by giving written notice of the change to the other party in the manner just described.

Evernorth Behavioral Health, Inc. notice address:
Evernorth Behavioral Health, Inc.
Attention: Network Operations
6625 West 78th Street, Suite 100
Bloomington, MN 55439

Provider notice address and email:
University Medical Center of Southern Nevada
1800 W. Charleston Blvd.
Las Vegas, NV 89102
Attn: Legal Department - Contracts
Cc: Kimberly.Carroll@umcsn.com

6.12 Governing Law/Regulatory Addenda

Applicable federal law and Nevada law govern this Agreement. One or more regulatory addenda may be attached or included in the Administrative Guidelines to the Agreement setting out provisions that are required by law with respect to Covered Services rendered to certain Participants (i.e. Participants under an insured plan). These provisions are incorporated into this Agreement to the extent required by law and as specified in such Addenda. Provider understands that this Agreement may be subject to filing requirements in certain jurisdictions. To the extent that a state agency requires an update or modification to this Agreement or a regulatory addenda to this Agreement, both parties consent to immediate modification to comply with the applicable agency.

6.13 Waiver of Breach/Severability

If any party waives a breach of any provision of this Agreement, it will not operate as a waiver of any subsequent breach. If any portion of this Agreement is unenforceable for any reason, it will not affect the enforceability of any remaining portions.

6.14 Budget Act

Evernorth Behavioral Health, Inc. agrees that to the extent required by NRS 354.626, the financial obligation of Provider under this Agreement between the parties shall not exceed those monies appropriated and approved by Provider for the then current fiscal year under the Local Government Budget Act. Provider agrees that this section shall not apply if subject to a statutory exception or otherwise inapplicable, nor be utilized as a subterfuge or in a discriminatory or improper fashion as it relates to this Agreement.

6.15 Fiscal Fund Out Clause.

Evernorth Behavioral Health, Inc. agrees that to the extent required by NRS 354.626 that this Agreement shall terminate and the Provider's obligations under it shall be extinguished at the end of any of Provider's fiscal years in which Provider's governing body fails to appropriate monies for the ensuring fiscal year sufficient for the payment of all amounts which could then become due under this Agreement. Provider agrees that this section shall not apply if subject to a statutory exception or otherwise inapplicable, nor be utilized as a subterfuge or in a discriminatory or improper fashion as it relates to this Agreement. In the event this section is invoked, this Agreement will expire on the 30th day of June of the fiscal year. Termination under this section shall not relieve Provider of its obligations incurred through the 30th day of June of the fiscal year for which monies were appropriated.

6.16 Force Majeure.

In the event that performance by either Evernorth Behavioral Health, Inc. or Provider of any covenant, duty or obligation imposed under this Agreement becomes impossible or impracticable because of the occurrence of an event of force majeure, including, without limitation, acts of war, insurrection, civil strife

and commotion, labor unrest, sentinel event, or acts of God, then performance of such covenant, duty or obligation by such party shall be excused during the continuance of such event of force majeure; provided, however, that such performance by such party shall be accomplished as soon as reasonably practicable after such event of force majeure has ceased.

6.17 Entire Agreement/Copy of Original Agreement

This Agreement, including any exhibits to it or documents incorporated by reference, such as the Administrative Guidelines, contains all of the terms and conditions agreed upon by the parties and supersedes all other agreements between the parties, either oral or in writing, regarding the subject matter. A copy of this fully executed Agreement is an acceptable substitute for the original fully executed Agreement.

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed by their duly authorized representatives below.

AGREED AND ACCEPTED BY:

Provider: University Medical Center of Southern Nevada

Provider Address: 1800 W. Charleston Blvd.
Las Vegas, NV 89102

Contract Email Address: Kimberly.Carroll@umcsn.com

Authorized Signature: _____

Printed Name: Mason Van Houweling

Title: CEO

Date Signed:

Address: Evernorth Behavioral Health, Inc.
Attention: Network Operations
6625 West 78th Street, Suite 100
Bloomington, MN 55439

Evernorth Behavioral Health, Inc.

Authorized Signature:

Printed Name: **Eva Borden**

Title: **President Behavioral Health**

Effective Date:

EXHIBIT A

Compensation

[The information in this attachment is confidential and proprietary in nature.]

EXHIBIT B

Intentionally Left Blank

EXHIBIT C

PLANS by Type of Business

Evernorth Behavioral Health, Inc. Benefit Plan types, which may include*:

1. Health Maintenance Organizations
2. Preferred Provider Organizations
3. Third-Party Administrators
4. Employee Assistance Programs
5. SureFit
6. Individual & Family Plans
7. Local Plus
8. Self-Insured Employers
9. Strategic Alliances
10. Customer-Specific Network(s) of Participating Providers
11. Medicare
12. Disability Management Programs
13. Workers Compensation

*There may be certain states or regions in which certain Benefit Plan types listed on this Exhibit C are not offered. To the extent this is applicable, Evernorth Behavioral Health, Inc. shall only allow Payors to access Provider's services under this Agreement for the Benefit Plan types which are offered in such state or region

EXHIBIT D

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INSTRUCTIONS FOR COMPLETING THE
DISCLOSURE OF OWNERSHIP/PRINCIPALS FORM

Purpose of the Form

The purpose of the Disclosure of Ownership/Principals Form is to gather ownership information pertaining to the business entity for use by the University Medical Center of Southern Nevada Governing Board ("GB") in determining whether members of the GB should exclude themselves from voting on agenda items where they have, or may be perceived as having a conflict of interest, and to determine compliance with Nevada Revised Statute 281A.430, contracts in which a public officer or employee has interest is prohibited.

General Instructions

Completion and submission of this Form is a condition of approval or renewal of a contract or lease and/or release of monetary funding between the disclosing entity and University Medical Center of Southern Nevada. Failure to submit the requested information may result in a refusal by the GB to enter into an agreement/contract and/or release monetary funding to such disclosing entity.

Detailed Instructions

All sections of the Disclosure of Ownership form must be completed. If not applicable, write in N/A.

Business Entity Type – Indicate if the entity is an Individual, Partnership, Limited Liability Company, Corporation, Trust, Non-profit Organization, or Other. When selecting 'Other', provide a description of the legal entity.

Non-Profit Organization (NPO) - Any non-profit corporation, group, association, or corporation duly filed and registered as required by state law.

Business Designation Group – Indicate if the entity is a Minority Owned Business Enterprise (MBE), Women-Owned Business Enterprise (WBE), Small Business Enterprise (SBE), Physically-Challenged Business Enterprise (PBE), Veteran Owned Business (VET), Disabled Veteran Owned Business (DVET), or Emerging Small Business (ESB) . This is needed in order to provide utilization statistics to the Legislative Council Bureau, and will be used only for such purpose.

- **Minority Owned Business Enterprise (MBE):** An independent and continuing business for profit which performs a commercially useful function and is at least 51% owned and controlled by one or more minority persons of Black American, Hispanic American, Asian-Pacific American or Native American ethnicity.
- **Women Owned Business Enterprise (WBE**): An independent and continuing business for profit which performs a commercially useful function and is at least 51% owned and controlled by one or more women.
- **Physically-Challenged Business Enterprise (PBE):** An independent and continuing business for profit which performs a commercially useful function and is at least 51% owned and controlled by one or more disabled individuals pursuant to the federal Americans with Disabilities Act.
- **Small Business Enterprise (SBE):** An independent and continuing business for profit which performs a commercially useful function, is not owned and controlled by individuals designated as minority, women, or physically-challenged, and where gross annual sales does not exceed $2,000,000.
- **Veteran Owned Business Enterprise (VET):** An independent and continuing Nevada business for profit which performs a commercially useful function and is at least 51 percent owned and controlled by one or more U.S. Veterans.
- **Disabled Veteran Owned Business Enterprise (DVET):** A Nevada business at least 51 percent owned/controlled by a disabled veteran.
- **Emerging Small Business (ESB):** Certified by the Nevada Governor's Office of Economic Development effective January, 2014. Approved into Nevada law during the 77th Legislative session as a result of AB294.

Business Name (include d.b.a., if applicable) – Enter the legal name of the business entity and enter the "Doing Business As" (d.b.a.) name, if applicable.

Corporate/Business Address, Business Telephone, Business Fax, and Email – Enter the street address, telephone and fax numbers, and email of the named business entity.

Nevada Local Business Address, Local Business Telephone, Local Business Fax, and Email – If business entity is out-of-state, but operates the business from a location in Nevada, enter the Nevada street address, telephone and fax numbers, point of contact and email of the local office. Please note that the local address must be an address from which the business is operating from that location. Please do not include a P.O. Box number, unless required by the U.S. Postal Service, or a business license hanging address.

Number of Clark County Nevada Residents employed by this firm. **(Do not leave blank. If none or zero, put the number 0 in the space provided.)**

List of Owners/Officers – Include the full name, title and percentage of ownership of each person who has ownership or financial interest in the business entity. If the business is a publicly-traded corporation or non-profit organization, list all Corporate Officers and Directors only.

For All Contracts – **(Not required for publicly-traded corporations)**

1) Indicate if any individual members, partners, owners or principals involved in the business entity are a University Medical Center of Southern Nevada full-time employee(s), or appointed/elected official(s). If yes, the following paragraph applies.

   In accordance with NRS 281A.430.1, a public officer or employee shall not bid on or enter into a contract between a government agency and any private business in which he has a significant financial interest, except as provided for in subsections 2, 3, and 4.

2) Indicate if any individual members, partners, owners or principals involved in the business entity have a second degree of consanguinity or affinity relation to a University Medical Center of Southern Nevada full-time employee(s), or appointed/elected official(s) (reference form on Page 2 for definition). If **YES**, complete the Disclosure of Relationship Form.

A professional service is defined as a business entity that offers business/financial consulting, legal, physician, architect, engineer or other professional services.

Signature and Print Name – Requires signature of an authorized representative and the date signed.

Disclosure of Relationship Form – If any individual members, partners, owners or principals of the business entity is presently a University Medical Center of Southern Nevada employee, public officer or official, or has a second degree of consanguinity or affinity relationship to a University Medical Center of Southern Nevada employee, public officer or official, this section must be completed in its entirety.

DISCLOSURE OF OWNERSHIP/PRINCIPALS

Business Entity Type (Please select one)						
☐ Sole Proprietorship	☐Partnership	☐ Limited Liability Company	☒ Corporation	☐ Trust	☐ Non-Profit Organization	☐ Other

Business Designation Group (Please select all that apply)						
☐ MBE	☐ WBE	☐ SBE	☐ PBE	☐ VET	☐DVET	☐ ESB
Minority Business Enterprise	Women-Owned Business Enterprise	Small Business Enterprise	Physically Challenged Business Enterprise	Veteran Owned Business	Disabled Veteran Owned Business	Emerging Small Business

Number of Clark County Nevada Residents Employed:

Corporate/Business Entity Name:	Evernorth Behavioral Health, Inc..	
(Include d.b.a., if applicable)		
Street Address:	701 S Carson St, Ste200	**Website:** www.cigna.com
City, State and Zip Code:	Carson City, NV, 89701	**POC Name:** Eva Borden **Email eva.borden@cignahealthcare.com**
Telephone No:	860.560.6787	**Fax No:** 860.560.6787
Nevada Local Street Address: **(If different from above)**	n/a	**Website:** same as above
City, State and Zip Code:	n/a	**Local Fax No:** same as above
Local Telephone No:	n/a	**Local POC Name:** same as above **Email:** same as above

All entities, with the exception of publicly-traded and non-profit organizations, must list the names of individuals holding more than five percent (5%) ownership or financial interest in the business entity appearing before the Board.

Publicly-traded entities and non-profit organizations shall list all Corporate Officers and Directors in lieu of disclosing the names of individuals with ownership or financial interest. The disclosure requirement, as applied to land-use applications, extends to the applicant and the landowner(s).

Entities include all business associations organized under or governed by Title 7 of the Nevada Revised Statutes, including but not limited to private corporations, close corporations, foreign corporations, limited liability companies, partnerships, limited partnerships, and professional corporations.

Full Name	Title	% Owned (Not required for Publicly Traded Corporations/Non-profit organizations)

This section is not required for publicly-traded corporations. Are you a publicly-traded corporation? ☒ Yes ☐ No

1. Are any individual members, partners, owners or principals, involved in the business entity, a University Medical Center of Southern Nevada full-time employee(s), or appointed/elected official(s)?

   ☐ Yes ☐ No (If yes, please note that University Medical Center of Southern Nevada employee(s), or appointed/elected official(s) may not perform any work on professional service contracts, or other contracts, which are not subject to competitive bid.)

2. Do any individual members, partners, owners or principals have a spouse, registered domestic partner, child, parent, in-law or brother/sister, half-brother/half-sister, grandchild, grandparent, related to a University Medical Center of Southern Nevada full-time employee(s), or appointed/elected official(s)?

   ☐ Yes ☐ No (If yes, please complete the Disclosure of Relationship form on Page 2. If no, please print N/A on Page 2.)

I certify under penalty of perjury, that all of the information provided herein is current, complete, and accurate. I also understand that the University Medical Center of Southern Nevada Governing Board will not take action on land-use approvals, contract approvals, land sales, leases or exchanges without the completed disclosure form.

Eva Borden
Signature

Eva Borden
Print Name

President Behavioral Health
Title

01/12/2026
Date

DISCLOSURE OF RELATIONSHIP

List any disclosures below:
(Mark N/A, if not applicable.)

NAME OF BUSINESS OWNER/PRINCIPAL	NAME OF UMC* EMPLOYEE/OFFICIAL AND JOB TITLE	RELATIONSHIP TO UMC* EMPLOYEE/OFFICIAL	UMC* EMPLOYEE'S/OFFICIAL'S DEPARTMENT

* UMC employee means an employee of University Medical Center of Southern Nevada

"Consanguinity" is a relationship by blood. "Affinity" is a relationship by marriage.

"To the second degree of consanguinity" applies to the candidate's first and second degree of blood relatives as follows:

- Spouse – Registered Domestic Partners – Children – Parents – In-laws (first degree)
- Brothers/Sisters – Half-Brothers/Half-Sisters – Grandchildren – Grandparents – In-laws (second degree)

For UMC Use Only:

If any Disclosure of Relationship is noted above, please complete the following:

☐ Yes ☐ No Is the UMC employee(s) noted above involved in the contracting/selection process for this particular agenda item?

☐ Yes ☐ No Is the UMC employee(s) noted above involved in any way with the business in performance of the contract?

Notes/Comments:

_____
Signature

_____
Print Name
Authorized Department Representative

DISCLOSURE OF RELATIONSHIP

Cigna Directors and Officers

Name	Title
David M. Cordani	Chairman and Chief Executive Officer, The Cigna Group
William J. DeLaney	Director, The Cigna Group
Eric J. Foss	Director, The Cigna Group
Elder Granger, M.D.	Director, The Cigna Group
Neesha Hathi	Director, The Cigna Group
George Kurian	Director, The Cigna Group
Kathleen M. Mazzarella	Director, The Cigna Group
Mark B. McClellan, M.D., Ph.D.	Director, The Cigna Group
Philip O. Ozuah, M.D., Ph.D.	Director, The Cigna Group
Kimberly A. Ross	Director, The Cigna Group
Eric C. Wiseman	Director, The Cigna Group
Donna F. Zarcone	Director, The Cigna Group
Ann Dennison	EVP, Chief Financial Officer, The Cigna Group
Brian C. Evanko	President, Chief Operating Officer, The Cigna Group
Nicole S. Jones	EVP, Chief Administrative Officer and General Counsel, The Cigna Group
Bryan Holgerson	President, Cigna Healthcare

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
GOVERNING BOARD AUDIT AND FINANCE COMMITTEE
AGENDA ITEM

Issue:	**Award of Bid No. 2025-11, UMC Quick Care Build Out 2100 W Charleston Project, PWP# CL-2026-111, to Monument Construction.**	**Back-up:**
Petitioner:	Jennifer Wakem, Chief Financial Officer	**Clerk Ref. #**

Recommendation:
That the Governing Board Audit and Finance Committee review and recommend for award by the Governing Board, the Bid No. 2025-11, UMC Quick Care Build Out 2100 W Charleston Project, PWP# CL-2026-111, to Monument Construction, the lowest responsive and responsible bidder, contingent upon submission of the required bonds and insurance; authorize the Chief Executive Officer to execute change orders within his delegation of authority; or take action as deemed appropriate. ***(For possible action)***

FISCAL IMPACT:

Fund Number: 5420.000 Fund Name: UMC Operating Fund
Fund Center: 3000999901 Funded Pgm/Grant: N/A
Description: Award of Bid 2025-11 UMC Quick Care Build Out 2100 W Charleston
Bid/RFP/CBE: Formal bid pursuant to NRS 338.1385.
Term: No more than 180 days from the date provided in a Notice to Proceed from UMC to Vendor, subject to any alteration in days allowed for in subsequently executed change orders, if applicable.
Amount: $4,724,700.00
Out Clause: UMC has the right to immediately terminate for convenience upon notice.

BACKGROUND:

On November 10, 2025, Bid No. 2025-11 was published in the Las Vegas Review-Journal and posted on the Nevada Government eMarketplace (NGEM) Portal, soliciting bid proposals for improvements to a building located at 2100 W Charleston Blvd., Las Vegas, NV 89102. The building is an approximately 14,239 square foot space that UMC intends to operate as a UMC Quick Care clinic location. The scope of this construction project includes, but is not limited to, the demolition and addition of walls and finishes, and upgrades to the HVAC rooftop units. The scope further includes mechanical, electrical, and plumbing alterations.

Cleared for Agenda
January 21, 2026

Agenda Item #
16

UMC received the following bids:

Bids Received	Total Base Bid Amounts
Monument Construction	$ 4,711,700.00
SHF International LLC	$ 4,756,305.00
Starke Contractors (Starke Enterprise LLC)	$ 5,013,284.64
The Korte Company	$ 5,329,442.00
JMB Construction, Inc.	$ 5,569,810.00
DM Stanek Corporation	$ 5,838,576.15
Builders United	$ 5,947,770.00
Roche Constructors, Inc.	$ 6,166,700.00

All of the above bids were received and unsealed on December 10, 2025. The apparent lowest base bid of $4,711,700.00 was received from Monument Construction, a Nevada corporation, which correctly submitted all required documentation within the relevant deadlines.

Following the bid unsealing, UMC determined that one of Monument Construction's bid attachments contained an error due to UMC having previously issued addenda that modified a line item on the respective form. Accordingly, Monument Construction was allowed to correct the issue, which resulted in an increased base bid total of $4,724,700. Therefore, after the correction, Monument Construction remained the lowest responsive and responsible bidder.

The term of the agreement is no more than 180 days from the date provided in a Notice to Proceed, subject to any alteration in days allowed for in subsequently executed change orders, if applicable, plus a 12-month workmanship warranty. UMC may terminate the Agreement for convenience prior to, or during, the performance of the work.

UMC's Director of Facilities Maintenance has reviewed the bid documents and recommends this award. The recommendation of award to Monument Construction is in accordance with NRS 338.1385(5), which requires a public body or its authorized representative to award a contract to the lowest responsive and responsible bidder.

The bid documents and notice of award have been approved as to form by UMC's Office of General Counsel.

Monument Construction currently holds a Clark County Business License.

January 28, 2026

Monument Construction
ATTN: Jon Wayne Nielsen, President
7787 Eastgate Road, #110
Henderson, NV 89011

RE: NOTICE OF AWARD
UMC BID NUMBER 2025-11, UMC Quick Care Build Out 2100 W Charleston Project (PWP NO. CL-2026-111)

Dear Mr. Nielsen,

Thank you for submitting all of the required documentation for the above-referenced Bid. All documentation appears to be in order, and this project is hereby awarded to Monument Construction in the amount of the base bid of $4,724,700. This Notice of Award letter authorizes you to immediately execute the required contracts with your equipment and material supplier(s) and required subcontractor(s). No substitution of listed subcontractor(s) is permitted unless first submitted to University Medical Center of Southern Nevada ("UMC") in writing and in accordance with the contract documents. A copy of the contract document is enclosed for your records. In accordance with the contract documents, if you have not already done so, please provide the following within ten (10) business days of the date of this award: Certificate of Insurance for Builders Risk/Course of Construction; Labor and Material Payment Bond; Performance Bond and Guaranty Bond.

This is not the Notice to Proceed. UMC's Plant Operations Department will administer this contract and will contact you in the near future to schedule the project kickoff meeting. They will also coordinate with our Public Safety Office/Officers and Contracts Management teams to ensure you have all of the resources and support needed to complete this project. Further, they will ensure project activities do not unduly disrupt services to our patients, their loved ones, staff and the public.

Thank you for your continued interest in doing business with UMC.

Sincerely,

Mason Van Houweling
Chief Executive Officer

Enclosure(s): Contract Documents (Bid Document and Contractor's Bid Form)

Cc: Monty Bowen, Plant Operations
William Rawlinson, Plant Operations
Tamera Hone, Plant Operations

BID ATTACHMENT 1

BID NUMBER BID NO. 2025-11

BID TITLE UMC QUICK CARE BUILD OUT 2100 W CHARLESTON

Bidder Statement of Authority to Submit Bid

Bidder hereby offers and agrees to furnish the material(s) and service(s) in compliance with all terms, conditions, specifications, and amendments in the Invitation to Bid and any written exceptions in the offer. We understand that the items in this Invitation to Bid, including, but not limited to, all required certificates are fully incorporated herein as a material and necessary part of the contract.

The undersigned hereby states, under penalty of perjury, that all information provided is true, accurate, and complete, and states that he/she has the authority to submit this bid.

I certify, under penalty of perjury, that I have the legal authorization to bind the firm hereunder:

JWN龍	Monument Construction
SIGNATURE OF AUTHORIZED REPRESENTATIVE	LEGAL NAME OF FIRM
Jon Wayne Nielsen	7787 Eastgate Rd #110
NAME AND TITLE OF AUTHORIZED REPRESENTATIVE	ADDRESS OF FIRM
702-530-2303	Henderson, NV 89011
PHONE NUMBER OF AUTHORIZED REPRESENTATIVE	CITY, STATE ZIP
jwn@buildmonuments.com	12/5/2025
EMAIL ADDRESS	DATE

BUSINESS LICENSE / CONTRACTORS LICENSE INFORMATION:

CURRENT STATE : Nevada	**LICENSE NO.** NV20101633041	**ISSUE DATE:** 2010	**EXPIRATION DATE:** 8/31/2026
CURRENT COUNTY: Clark	**LICENSE NO.** 2024331409	**ISSUE DATE:** 2010	**EXPIRATION DATE:** 4/30/2026
CURRENT CITY: Henderson	**LICENSE NO.** 2024331409	**ISSUE DATE:** 2010	**EXPIRATION DATE:** 4/30/2026

BID ATTACHMENT 2

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA

BID FORM

BID NO. 2025-11
UMC Quick Care Build Out 2100 W Charleston
PWP NUMBER: CL- 2026-111

Monument Construction

(NAME)

7787 Eastgate Rd #110, Henderson, NV 89011

(ADDRESS)

I, THE UNDERSIGNED BIDDER:

1. Agree, if awarded this Contract, I will complete all work for which a Contract may be awarded and to furnish any and all labor, equipment, materials, transportation, and other facilities required for the services as set forth in the Bidding and Contract Documents.

2. Have examined the Contract Documents and the site(s) for the proposed work and satisfied themselves as to the character, quality of work to be performed, materials to be furnished and as to the requirements of the specifications.

3. Have completed all information in the blanks provided and have submitted the following within this Bid:

   a) **BID ATTACHMENT 5**: Have listed the name of each Subcontractor which will be paid an amount exceeding five percent (5%) of the Total Base Bid amount.

   b) **BID ATTACHMENT 3**: Attached a bid security in the form of, at my option, a Cashier's Check, Certified Check, Money Order, or Bid Bond in favor of the OWNER in the amount of five percent (5%) of the Total Base Bid amount.

   c) If claiming the preference eligibility, I have submitted a valid Certificate of Eligibility with this Bid.

4. I acknowledge that if I am one of the three apparent low bidders at the bid opening, and if I have listed Subcontractor(s) pursuant to NRS 338.141, I must submit **BID ATTACHMENT 4** within two (2) hours after completion of the bid opening pursuant to the Instructions to Bidders, forms must be submitted via email to fred.parandi@umcsn.com and I understand that OWNER shall not be responsible for lists received after the two-hour time limit, regardless of the reason. I understand that submission after the two-hour time limit is not allowed and will be returned to me and the bid will be deemed non-responsive. I acknowledge that for all projects, I will list:

   a) My firm's name on the list If my firm will perform any work which is more than 1 percent (1%) of the BIDDER's total bid and which is not being performed by a subcontractor. The BIDDER shall also include on the list:

      1) A description of the labor or portion of the work that the BIDDER will perform: or

      2) A statement that the BIDDER will perform all work other than that being performed by a subcontractor listed.

   b) The name of each first-tier subcontractor who will provide labor or a portion of the work on the public work to the BIDDER for which the first-tier subcontractor will be paid an amount exceeding $250,000.

   c) If I will employ a first tier subcontractor who will provide labor or a portion of the work on the public work to the BIDDER for which the first tier subcontractor will not be paid an amount exceeding $250,000, the name of each first tier subcontractor who will provide labor or a portion of the work on the public work to the BIDDER for which the first tier subcontractor will be paid 1 percent (1%) of the BIDDER's total bid or $50,000, whichever is greater.

5. I acknowledge that if I am one of the three apparent low BIDDER(s)at bid opening, and if I have submitted a valid Certificate of Eligibility as described in 3 (c) above, I must submit **BID ATTACHMENT 6**, Affidavit Pertaining to Preference Eligibility, within two-hours after completion of the bid opening pursuant to the General Conditions. The forms must be submitted via email to fred.parandi@umcsn.com. OWNER shall not be responsible for lists received after the two-hour time limit, regardless of the reason. I understand that submission of the Certificate after the two-hour time limit is not allowed and it will be returned to me, and the bid will be deemed non-responsive.

6. I acknowledge that if I am one of the three apparent low BIDDER(s) for the base bid at the bid opening, I must submit the **BID ATTACHMENT 7, Schedule of Values**, by 5:00 PM on the next business day.

7. I acknowledge that if notified that I am the low BIDDER, I must submit **BID ATTACHMENT 8, Prime Contractor Acknowledgment of UMC Procedures & Practices and the Representations and Certifications** form by 5:00 PM of the next business day.

8. I acknowledge that if notified that I am the low BIDDER, I must submit **EXHIBIT E** by 5:00 PM of the next business day.

9. I acknowledge that if I am one of the three apparent low BIDDER(s) for the base bid at the bid opening, I must submit the **BID ATTACHMENT 10** "**Disclosure of Ownership/Principals"** form within 24-hours of request.

10. I acknowledge that my bid is based on the current State of Nevada prevailing wages, if applicable.

11. I acknowledge that I have not breached a public work contract for which the cost exceeds $25,000,000, within the preceding year, for failing to comply with NRS 338.147 and the requirements of a contract in which I have submitted within 2 hours of the bid opening an Affidavit pertaining to preference eligibility.

12. I will provide the following submittals within ten (10) business days from receipt of Notice of Intent to Award:

    a) Performance Bond, Labor and Material Payment Bond and a Guaranty Bond, for 100% of the Contract amount as required.

    b) Certificates of insurance for Commercial General Liability in the amount of $1,000,000, Automobile Liability in the amount of $1,000,000, Pollution Liability, which includes Asbestos Liability or include an additional Asbestos Liability endorsement in the amount of $1,000,000 including Asbestos Abatement Liability (proof of subcontractor certificate of insurance must be provided) and Workers' Compensation insurance issued by an insurer qualified to underwrite Workers' Compensation insurance in the State of Nevada, as required by law.

13. I acknowledge that if I do not provide the above submittals on or before the **tenth** business day after Notice of Intent to Award or do not keep the bonds or insurance policies in effect or allow them to lapse during the performance of the Contract; I will pay over to the OWNER the amount of **$200.00** per day as liquidated damages.

14. I confirm this bid is genuine and is not a sham or collusive, or made in the interest of, or on behalf of any person not herein named, nor that the Bidder in any manner sought to secure for themselves an advantage over any bidders.

15. I further propose and agree that if my bid is accepted, I will commence to perform the work called for by the contract documents on the date specified in the Notice to Proceed and I will complete all work within the calendar days **specified in the General Conditions.**

16. I further propose and agree that I will accept as full compensation for the work to be performed the price written in the Bid Schedule below.

17. I have carefully checked the figures below and the OWNER will not be responsible for any error or omissions in the preparation or submission of this Bid.

18. I agree no verbal agreement or conversation with an officer, agent or employee of the OWNER, either before or after the execution of the contract, shall affect or modify any of the terms or obligations of this Bid.

19. I am responsible to ascertain the number of addenda issued, and I hereby acknowledge receipt of the following addenda:

Addendum No.	1	dated,	11.18.2025	Addendum No.		dated,	
Addendum No.	2	dated,	12.03.2025	Addendum No.		dated,	
Addendum No.		dated,		Addendum No.		dated,	
Addendum No.		dated,		Addendum No.		dated,	

20. I agree to perform all work described in the drawings, specifications, and other documents for the amounts quoted below:

ITEM NUMBER	ITEM DESCRIPTION	LUMP SUM
1.	GENERAL REQUIREMENTS/OVERHEAD AND PROFIT INCLUDING SUPERVISION; MOBILIZATION, INCLUDING BONDS, INSURANCES	$ 126,054.50
2.	PERMITS AND FEES	$ 38,000.00
3.	3rd PARTY TESTING/QAA	$ 8,000.00
4.	WOOD, PLASTICS, AND COMPOSITES	$ 730,204.83
5.	THERMAL AND MOISTURE PROTECTION	$ 72,864.09
6.	FINISHES	$ 500,890.56
7.	SPECIALTIES	$ 140,527.63
8.	MILLWORK	$ 330,597.89
9.	EQUIPMENT	$ 289,433.71
10.	PLUMBING	$ 264,450.00
11.	HVAC	$ 400,000.00
12.	ELECTRICAL	$ 406,011.19
13.	COMMUNICATIONS	$ 172,676.42
14.	FIRE SUPPRESSION	$ 104,517.47
15.	ROOFING	$ 60,000.00
16.	LEAD WALLS	$ 75,000.00
17.	ELECTRONIC CARD READERS (HONEYWELL)	$ 99,136.00
18.	ELECTRONIC SECURITY CAMERAS	$ 80,000.00
19.	FIRE ALARM	$ 106,335.71
20.	ALLOWANCE FOR OWNER SUPPLIED ITEMS INSTALLED	$ 5,000.00
21.	CONSTRUCTION CONTINGENCY	$ 715,000.00
22.		
	TOTAL BID AMOUNT	$ 4,724,700.00

Quantities stated are to be used to evaluate proposals and will not alleviate the BIDDER from completing all work as required in the Contract Documents and Plans. Each BIDDER is held responsible for the examination and/or to have acquainted themselves with any conditions at the job site which would affect their work before submitting a bid. Failure to meet these criteria shall not relieve the BIDDER of the responsibility of completing the Bid without extra cost to the project OWNER. **Estimates of quantities of the various items of work and materials, as set forth in the Proposal Form, are approximates only and given solely to be used as a uniform basis for the comparison.**

ADDITIVE ALTERNATES

The OWNER may exercise the following items subject to the availability of funds. The additive alternate price quoted shall remain firm throughout the Contract term, as detailed in Instruction to Bidders.

Alternative	ITEM DESCRIPTION	TOTAL
1.		$
2.		$
3.		$
4.		$

Alternative	ITEM DESCRIPTION	TOTAL
5.		$
6.		$
7.		$
	ADD ALTERNATES AMOUNT	$
	GRAND TOTAL BID AMOUNT	$ 4,724,700.00

21. BUSINESS ENTERPRISE INFORMATION:

The BIDDER submitting this Bid is a ☐ MBE ☐ WBE ☐ PBE ☐ SBE ☐ VET ☐ DVET ☐ ESB as defined in the Instructions to Bidders.

22. BUSINESS ETHNICITY INFORMATION:

The BIDDER submitting the Bid Ethnicity is ☒ Caucasian (CX) ☐ African American (AA) ☐ Hispanic American (HA) ☐ Asian Pacific American (AX) ☐ Native American (NA)) ☐ Pacific Islander (PI)

☐ Other as defined in the Instructions to Bidders.

23. BIDDERS' PREFERENCE Is the Bidder claiming Bidders' Preference?

☒ Yes If yes, the Bidder acknowledges that he/she is required to follow the requirements set forth in the Affidavit (**Bid Attachment 6**).

☐ No **I do not have a Certificate of Eligibility to receive preference in bidding**.

24. Monument Construction
LEGAL NAME OF FIRM AS IT WOULD APPEAR IN CONTRACT

7787 Eastgate Rd #110
ADDRESS OF FIRM

Henderson, NV 89011
CITY, STATE, ZIP CODE

(702) 530-2303
TELEPHONE NUMBER

702.947.2606
FAX NUMBER

NEVADA STATE CONTRACTORS' BOARD LICENSE INFORMATION:

I certify that the license(s) listed below will be the license(s) used to perform the majority of the work on this project.

LICENSE NUMBER: A-0080649, B-0075502

LICENSE CLASS: A, B

LICENSE LIMIT: Unlimited

ONE TIME LICENSE LIMIT INCREASE $_____ IF YES, DATE REQUESTED _____

DUN & BRADSTREET NUMBER 01960820

CLARK COUNTY BUSINESS LICENSE NO. 2024331409

STATE OF NEVADA BUSINESS LICENSE NO. NV20101633041

Jon Wayne Nielsen	jwn@buildmonuments.com
AUTHORIZED REPRESENTATIVE (PRINT OR TYPE)	E-MAIL ADDRESS
JWN龍	12/10/2025
SIGNATURE OF AUTHORIZED REPRESENTATIVE	TODAY'S DATE

INSTRUCTIONS FOR COMPLETING THE
DISCLOSURE OF OWNERSHIP/PRINCIPALS FORM

Purpose of the Form

The purpose of the Disclosure of Ownership/Principals Form is to gather ownership information pertaining to the business entity for use by the University Medical Center of Southern Nevada Governing Board ("GB") in determining whether members of the GB should exclude themselves from voting on agenda items where they have, or may be perceived as having a conflict of interest, and to determine compliance with Nevada Revised Statute 281A.430, contracts in which a public officer or employee has interest is prohibited.

General Instructions

Completion and submission of this Form is a condition of approval or renewal of a contract or lease and/or release of monetary funding between the disclosing entity and University Medical Center of Southern Nevada. Failure to submit the requested information may result in a refusal by the GB to enter into an agreement/contract and/or release monetary funding to such disclosing entity.

Detailed Instructions

All sections of the Disclosure of Ownership form must be completed. If not applicable, write in N/A.

Business Entity Type – Indicate if the entity is an Individual, Partnership, Limited Liability Company, Corporation, Trust, Non-profit Organization, or Other. When selecting 'Other', provide a description of the legal entity.

Non-Profit Organization (NPO) - Any non-profit corporation, group, association, or corporation duly filed and registered as required by state law.

Business Designation Group – Indicate if the entity is a Minority Owned Business Enterprise (MBE), Women-Owned Business Enterprise (WBE), Small Business Enterprise (SBE), Physically-Challenged Business Enterprise (PBE), Veteran Owned Business (VET), Disabled Veteran Owned Business (DVET), or Emerging Small Business (ESB) . This is needed in order to provide utilization statistics to the Legislative Council Bureau, and will be used only for such purpose.

- **Minority Owned Business Enterprise (MBE):** An independent and continuing business for profit which performs a commercially useful function and is at least 51% owned and controlled by one or more minority persons of Black American, Hispanic American, Asian-Pacific American or Native American ethnicity.
- **Women Owned Business Enterprise (WBE**): An independent and continuing business for profit which performs a commercially useful function and is at least 51% owned and controlled by one or more women.
- **Physically-Challenged Business Enterprise (PBE):** An independent and continuing business for profit which performs a commercially useful function and is at least 51% owned and controlled by one or more disabled individuals pursuant to the federal Americans with Disabilities Act.
- **Small Business Enterprise (SBE):** An independent and continuing business for profit which performs a commercially useful function, is not owned and controlled by individuals designated as minority, women, or physically-challenged, and where gross annual sales does not exceed $2,000,000.
- **Veteran Owned Business Enterprise (VET):** An independent and continuing Nevada business for profit which performs a commercially useful function and is at least 51 percent owned and controlled by one or more U.S. Veterans.
- **Disabled Veteran Owned Business Enterprise (DVET):** A Nevada business at least 51 percent owned/controlled by a disabled veteran.
- **Emerging Small Business (ESB):** Certified by the Nevada Governor's Office of Economic Development effective January, 2014. Approved into Nevada law during the 77th Legislative session as a result of AB294.

Business Name (include d.b.a., if applicable) – Enter the legal name of the business entity and enter the "Doing Business As" (d.b.a.) name, if applicable.

Corporate/Business Address, Business Telephone, Business Fax, and Email – Enter the street address, telephone and fax numbers, and email of the named business entity.

Nevada Local Business Address, Local Business Telephone, Local Business Fax, and Email – If business entity is out-of-state, but operates the business from a location in Nevada, enter the Nevada street address, telephone and fax numbers, point of contact and email of the local office. Please note that the local address must be an address from which the business is operating from that location. Please do not include a P.O. Box number, unless required by the U.S. Postal Service, or a business license hanging address.

***Number of Clark County Nevada Residents employed by this firm. (*Do not leave blank. If none or zero, put the number 0 in the space provided.)**

List of Owners/Officers – Include the full name, title and percentage of ownership of each person who has ownership or financial interest in the business entity. If the business is a publicly-traded corporation or non-profit organization, list all Corporate Officers and Directors only.

For All Contracts – **(Not required for publicly-traded corporations)**

1) Indicate if any individual members, partners, owners or principals involved in the business entity are a University Medical Center of Southern Nevada full-time employee(s), or appointed/elected official(s). If yes, the following paragraph applies.

   In accordance with NRS 281A.430.1, a public officer or employee shall not bid on or enter into a contract between a government agency and any private business in which he has a significant financial interest, except as provided for in subsections 2, 3, and 4.

2) Indicate if any individual members, partners, owners or principals involved in the business entity have a second degree of consanguinity or affinity relation to a University Medical Center of Southern Nevada full-time employee(s), or appointed/elected official(s) (reference form on Page 2 for definition). If **YES**, complete the Disclosure of Relationship Form.

A professional service is defined as a business entity that offers business/financial consulting, legal, physician, architect, engineer or other professional services.

Signature and Print Name – Requires signature of an authorized representative and the date signed.

Disclosure of Relationship Form – If any individual members, partners, owners or principals of the business entity is presently a University Medical Center of Southern Nevada employee, public officer or official, or has a second degree of consanguinity or affinity relationship to a University Medical Center of Southern Nevada employee, public officer or official, this section must be completed in its entirety.

BID ATTACHMENT 10
DISCLOSURE OF OWNERSHIP/PRINCIPALS

Business Entity Type (Please select one)

☐ Sole Proprietorship	☐Partnership	☐ Limited Liability Company	☒ Corporation	☐ Trust	☐ Non-Profit Organization	☐ Other

Business Designation Group (Please select all that apply)

☐ MBE	☐ WBE	☐ SBE	☐ PBE	☐ VET	☐DVET	☐ ESB
Minority Business Enterprise	Women-Owned Business Enterprise	Small Business Enterprise	Physically Challenged Business Enterprise	Veteran Owned Business	Disabled Veteran Owned Business	Emerging Small Business

Number of Clark County Nevada Residents Employed: 100

Corporate/Business Entity Name:	Monument Construction	
(Include d.b.a., if applicable)		
Street Address:	7787 Eastgate Rd #110	**Website:** https://buildmonuments.com/
City, State and Zip Code:	Henderson, NV 89011	**POC Name:** Jon wayne Nielsen **Email:** Jwn@buildmonuments.com
Telephone No:	(702) 530-2303	**Fax No:** 702.947.2606
Nevada Local Street Address: **(If different from above)**		**Website:**
City, State and Zip Code:		**Local Fax No:**
Local Telephone No:		**Local POC Name:** **Email:**

All entities, with the exception of publicly-traded and non-profit organizations**,** must list the names of individuals holding more than five percent (5%) ownership or financial interest in the business entity appearing before the Board.

Publicly-traded entities and non-profit organizations shall list all Corporate Officers and Directors in lieu of disclosing the names of individuals with ownership or financial interest. The disclosure requirement, as applied to land-use applications, extends to the applicant and the landowner(s).

Entities include all business associations organized under or governed by Title 7 of the Nevada Revised Statutes, including but not limited to private corporations, close corporations, foreign corporations, limited liability companies, partnerships, limited partnerships, and professional corporations.

Full Name	Title	% Owned (Not required for Publicly Traded Corporations/Non-profit organizations)
Jon Wayne Nielsen	President	100%

This section is not required for publicly-traded corporations. Are you a publicly-traded corporation? ☐ Yes ☒ No

1. Are any individual members, partners, owners or principals, involved in the business entity, a University Medical Center of Southern Nevada full-time employee(s), or appointed/elected official(s)?

   ☐ Yes ☒ No (If yes, please note that University Medical Center of Southern Nevada employee(s), or appointed/elected official(s) may not perform any work on professional service contracts, or other contracts, which are not subject to competitive bid.)

2. Do any individual members, partners, owners or principals have a spouse, registered domestic partner, child, parent, in-law or brother/sister, half-brother/half-sister, grandchild, grandparent, related to a University Medical Center of Southern Nevada full-time employee(s), or appointed/elected official(s)?

   ☐ Yes ☒ No (If yes, please complete the Disclosure of Relationship form on Page 2. If no, please print N/A on Page 2.)

I certify under penalty of perjury, that all of the information provided herein is current, complete, and accurate. I also understand that the University Medical Center of Southern Nevada Governing Board will not take action on land-use approvals, contract approvals, land sales, leases or exchanges without the completed disclosure form.

JWN龍 — Signature

Jon Wayne Nielsen — Print Name

President — Title

11.18.25 — Date

REVISED 7/25/2014

BID ATTACHMENT 10 (page 2)
DISCLOSURE OF RELATIONSHIP

List any disclosures below:
(Mark N/A, if not applicable.)

NAME OF BUSINESS OWNER/PRINCIPAL	NAME OF UMC* EMPLOYEE/OFFICIAL AND JOB TITLE	RELATIONSHIP TO UMC* EMPLOYEE/OFFICIAL	UMC* EMPLOYEE'S/OFFICIAL'S DEPARTMENT
N/A			

* UMC employee means an employee of University Medical Center of Southern Nevada

"Consanguinity" is a relationship by blood. "Affinity" is a relationship by marriage.

"To the second degree of consanguinity" applies to the candidate's first and second degree of blood relatives as follows:

- Spouse – Registered Domestic Partners – Children – Parents – In-laws (first degree)
- Brothers/Sisters – Half-Brothers/Half-Sisters – Grandchildren – Grandparents – In-laws (second degree)

For UMC Use Only:

If any Disclosure of Relationship is noted above, please complete the following:

☐ Yes ☐ No Is the UMC employee(s) noted above involved in the contracting/selection process for this particular agenda item?

☐ Yes ☐ No Is the UMC employee(s) noted above involved in any way with the business in performance of the contract?

Notes/Comments:

_____
Signature

_____
Print Name
Authorized Department Representative

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
GOVERNING BOARD AUDIT AND FINANCE COMMITTEE
AGENDA ITEM

Issue:	**Award of Bid No. 2025-07, UMC 7 Story Tower & Trauma Building Elevator Modernization Project, PWP# CL-2026-102, to Monument Construction**	**Back-up:**
Petitioner:	Jennifer Wakem, Chief Financial Officer	**Clerk Ref. #**

Recommendation:
That the Governing Board Audit and Finance Committee review and recommend for award by the Board of Hospital Trustees for University Medical Center of Southern Nevada, the Bid No. 2025-07, UMC 7 Story Tower & Trauma Building Elevator Modernization Project, PWP# CL-2026-102, to Monument Construction, the lowest responsive and responsible bidder, contingent upon submission of the required bonds and insurance; authorize the Chief Executive Officer to execute change orders within his delegation of authority; or take action as deemed appropriate. ***(For possible action)***

FISCAL IMPACT:

Fund Number: 5420.000 Fund Name: UMC Operating Fund
Fund Center: 3000999901 Funded Pgm/Grant: N/A
Description: Award of Bid 2025-07 UMC 7 Story Tower & Trauma Building Elevator Modernization
Bid/RFP/CBE: Formal bid pursuant to NRS 338.1385.
Term: No more than 540 days from the date provided in a Notice to Proceed, subject to any alteration in days allowed for in subsequently executed change orders, if applicable.
Amount: $5,649,883.00
Out Clause: UMC has the right to immediately terminate for convenience upon notice

BACKGROUND:

On October 27, 2025, Bid No. 2025-07 was published in the Las Vegas Review-Journal and posted on the Nevada Government eMarketplace (NGEM) Portal, soliciting bid proposals for the completion of an elevator modernization project to take place within the 7 Story Tower and Trauma Building of the main campus of UMC. As a part of the scope, the existing traction elevators are to be completely replaced and/or refurbished to meet current safety standards, improve efficiency, and enhance user experience.

Cleared for Agenda
January 21, 2026

Agenda Item #
17

UMC received bids as follows:

Bids Received	Total Base Bid Amounts
Monument Construction	$ 5,072,200.00
Builders United, LLC	$ 5,731,395.28
Taylor International Corp.	$ 6,128,219.00
SHF International LLC	$ 6,212,059.00
Cobblestone Construction (Benchmark Contracting Inc.)	$ 6,912,146.25

All of the above bids were received on or before November 19, 2025 and were unsealed on November 19, 2025. The apparent lowest base bid of $5,072,200.00 was received from Monument Construction, a Nevada corporation, which correctly submitted all required documentation within the relevant deadlines.

Following the bid unsealing, UMC sought additional information from both Monument and Monument's elevator subcontractor, to assess their's qualifications to undertake the work specified in the bid. Based on the information provided, UMC determined that Monument's elevator subcontractor did not possess the requisite qualifications. Therefore, UMC formally requested a substitution in accordance with NRS 338.141(5)(a).

Thereafter, Monument provided revised bid documents, substituting its elevator subcontractor. This change resulted in a change to Monument's base bid amount.

Below are the revised base bid totals:

Bids Received	Total Base Bid Amounts
Monument Construction	$ 5,590,795.00
Builders United, LLC	$ 5,731,395.28
Taylor International Corp.	$ 6,128,219.00
SHF International LLC	$ 6,212,059.00
Cobblestone Construction (Benchmark Contracting Inc.)	$ 6,912,146.25

Accordingly, after the subcontractor substitution, Monument Construction remained the lowest responsive and responsible bidder.

In addition to the base bid amount, which covers the scope, UMC chose several additives, Additive Alternatives 1 through 3, to ensure that the elevators are serviced during the project. Such additives increase the total necessary expenditure and required authorization by $59,088.00, to a grand total of $5,649,883.00.

The term of the agreement is no more than 540 days from the date provided in a Notice to Proceed, subject to any alteration in days allowed for in subsequently executed change orders, if applicable, plus a 12-month workmanship warranty. UMC may terminate the Agreement for convenience prior to, or during, the performance of the work.

UMC's Director of Facilities Maintenance has reviewed the bid documents and recommends this award. The recommendation of award to Monument Construction is in accordance with NRS 338.1385(5), which requires a public body or its authorized representative to award a contract to the lowest responsive and responsible bidder.

The bid documents and notice of award have been approved as to form by UMC's Office of General Counsel.

Monument Construction currently holds a Clark County Business License.

January 28, 2026

Monument Construction
ATTN: Jon Wayne Nielsen, President
7787 Eastgate Road, #110
Henderson, NV 89011

RE: NOTICE OF AWARD
UMC BID NUMBER 2025-07, UMC 7 Story Tower & Trauma Building Elevator Modernization Project (PWP NO. CL-2026-102)

Dear Mr. Nielsen,

Thank you for submitting all of the required documentation for the above-referenced Bid. All documentation appears to be in order, and this project is hereby awarded to Monument Construction in the amount of the base bid of $5,590,795 plus $59,088 for selected additives, for a total of $5,649,883. This Notice of Award letter authorizes you to immediately execute the required contracts with your equipment and material supplier(s) and required subcontractor(s). No substitution of listed subcontractor(s) is permitted unless first submitted to University Medical Center of Southern Nevada ("UMC") in writing and in accordance with the contract documents. A copy of the contract document is enclosed for your records. In accordance with the contract documents, if you have not already done so, please provide the following within ten (10) business days of the date of this award: Certificate of Insurance for Builders Risk/Course of Construction; Labor and Material Payment Bond; Performance Bond and Guaranty Bond.

This is not the Notice to Proceed. UMC's Plant Operations Department will administer this contract and will contact you in the near future to schedule the project kickoff meeting. They will also coordinate with our Public Safety Office/Officers and Contracts Management teams to ensure you have all of the resources and support needed to complete this project. Further, they will ensure project activities do not unduly disrupt services to our patients, their loved ones, staff and the public.

Thank you for your continued interest in doing business with UMC.

Sincerely,

Mason Van Houweling
Chief Executive Officer

Enclosure(s): Contract Documents (Bid Document and Contractor's Bid Form)

Cc: Monty Bowen, Plant Operations
William Rawlinson, Plant Operations

BID ATTACHMENT 1

BID NUMBER 2025-07

BID TITLE UMC 7 Story Tower & Trauma Building Elevator Modernization

Bidder Statement of Authority to Submit Bid

Bidder hereby offers and agrees to furnish the material(s) and service(s) in compliance with all terms, conditions, specifications, and amendments in the Invitation to Bid and any written exceptions in the offer. We understand that the items in this Invitation to Bid, including, but not limited to, all required certificates are fully incorporated herein as a material and necessary part of the contract.

The undersigned hereby states, under penalty of perjury, that all information provided is true, accurate, and complete, and states that he/she has the authority to submit this bid.

I certify, under penalty of perjury, that I have the legal authorization to bind the firm hereunder:

JWN龍	Monument Construction
SIGNATURE OF AUTHORIZED REPRESENTATIVE	LEGAL NAME OF FIRM
Jon Wayne Nielsen - President	7787 Eastgate Rd #110
NAME AND TITLE OF AUTHORIZED REPRESENTATIVE	ADDRESS OF FIRM
702.530.2303	Henderson, NV, 89011
PHONE NUMBER OF AUTHORIZED REPRESENTATIVE	CITY, STATE ZIP
Jwn@buildmonuments.com	11.17.2025
EMAIL ADDRESS	DATE

BUSINESS LICENSE / CONTRACTORS LICENSE INFORMATION:

CURRENT STATE : NV	**LICENSE NO.** 20101633041	**ISSUE DATE:** 08.18.2025	**EXPIRATION DATE:** 08/31/2026
CURRENT COUNTY: Clark	**LICENSE NO.** 2024331409	**ISSUE DATE:** 02.01.2012	**EXPIRATION DATE:** 04.30.2026
CURRENT CITY: Henderson	**LICENSE NO.** 2024331409	**ISSUE DATE:** 02.01.2012	**EXPIRATION DATE:** 04.30.2026

BID ATTACHMENT 2

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA

BID FORM

BID NO. 2025-07
UMC 7 Story Tower & Trauma Building Elevator Modernization
PWP NUMBER: CL- 2026-102

Monument Construction
(NAME)

7787 Eastgate Rd #110, Henderson, NV 89011
(ADDRESS)

I, THE UNDERSIGNED BIDDER:

1. Agree, if awarded this Contract, I will complete all work for which a Contract may be awarded and to furnish any and all labor, equipment, materials, transportation, and other facilities required for the services as set forth in the Bidding and Contract Documents.

2. Have examined the Contract Documents and the site(s) for the proposed work and satisfied themselves as to the character, quality of work to be performed, materials to be furnished and as to the requirements of the specifications.

3. Have completed all information in the blanks provided and have submitted the following within this Bid:

   a) **BID ATTACHMENT 5**: Have listed the name of each Subcontractor which will be paid an amount exceeding five percent (5%) of the Total Base Bid amount.

   b) **BID ATTACHMENT 3**: Attached a bid security in the form of, at my option, a Cashier's Check, Certified Check, Money Order, or Bid Bond in favor of the OWNER in the amount of five percent (5%) of the Total Base Bid amount.

   c) If claiming the preference eligibility, I have submitted a valid Certificate of Eligibility with this Bid.

4. I acknowledge that if I am one of the three apparent low bidders at the bid opening, and if I have listed Subcontractor(s) pursuant to NRS 338.141, I must submit **BID ATTACHMENT 4** within two (2) hours after completion of the bid opening pursuant to the Instructions to Bidders, forms must be submitted via email to fred.parandi@umcsn.com and I understand that OWNER shall not be responsible for lists received after the two-hour time limit, regardless of the reason. I understand that submission after the two-hour time limit is not allowed and will be returned to me and the bid will be deemed non-responsive. I acknowledge that for all projects, I will list:

   a) My firm's name on the list If my firm will perform any work which is more than 1 percent (1%) of the BIDDER's total bid and which is not being performed by a subcontractor. The BIDDER shall also include on the list:

      1) A description of the labor or portion of the work that the BIDDER will perform: or

      2) A statement that the BIDDER will perform all work other than that being performed by a subcontractor listed.

   b) The name of each first tier subcontractor who will provide labor or a portion of the work on the public work to the BIDDER for which the first tier subcontractor will be paid an amount exceeding $250,000.

   c) If I will employ a first tier subcontractor who will provide labor or a portion of the work on the public work to the BIDDER for which the first tier subcontractor will not be paid an amount exceeding $250,000, the name of each first tier subcontractor who will provide labor or a portion of the work on the public work to the BIDDER for which the first tier subcontractor will be paid 1 percent (1%) of the BIDDER's total bid or $50,000, whichever is greater.

5. I acknowledge that if I am one of the three apparent low BIDDER(s)at bid opening, and if I have submitted a valid Certificate of Eligibility as described in 3 (c) above, I must submit **BID ATTACHMENT 6**, Affidavit Pertaining to Preference Eligibility, within two-hours after completion of the bid opening pursuant to the General Conditions. The forms must be submitted via email to fred.parandi@umcsn.com. OWNER shall not be responsible for lists received after the two-hour time limit, regardless of the reason. I understand that submission of the Certificate after the two-hour time limit is not allowed and it will be returned to me and the bid will be deemed non-responsive.

6. I acknowledge that if I am one of the three apparent low BIDDER(s) for the base bid at the bid opening, I must submit the **BID ATTACHMENT 7, Schedule of Values**, by 5:00 PM on the next business day.

7. I acknowledge that if notified that I am the low BIDDER, I must submit **BID ATTACHMENT 8, Prime Contractor Acknowledgment of UMC Procedures & Practices and the Representations and Certifications** form by 5:00 PM of the next business day.

8. I acknowledge that if notified that I am the low BIDDER, I must submit **EXHIBIT E** by 5:00 PM of the next business day.

9. I acknowledge that if I am one of the three apparent low BIDDER(s) for the base bid at the bid opening, I must submit the **BID ATTACHMENT 10** "**Disclosure of Ownership/Principals"** form within 24-hours of request.

10. I acknowledge that my bid is based on the current State of Nevada prevailing wages, if applicable.

11. I acknowledge that I have not breached a public work contract for which the cost exceeds $25,000,000, within the preceding year, for failing to comply with NRS 338.147 and the requirements of a contract in which I have submitted within 2 hours of the bid opening an Affidavit pertaining to preference eligibility.

12. I will provide the following submittals within ten (10) business days from receipt of Notice of Intent to Award:

    a) Performance Bond, Labor and Material Payment Bond and a Guaranty Bond, for 100% of the Contract amount as required.

    b) Certificates of insurance for Commercial General Liability in the amount of $1,000,000, Automobile Liability in the amount of $1,000,000, Pollution Liability, which includes Asbestos Liability or include an additional Asbestos Liability endorsement in the amount of $1,000,000 including Asbestos Abatement Liability (proof of subcontractor certificate of insurance must be provided) and Workers' Compensation insurance issued by an insurer qualified to underwrite Workers' Compensation insurance in the State of Nevada, as required by law. **Note: The requirement is that general contractors have pollution liability and asbestos abatement liability coverage in the aforementioned amounts. UMC is not requiring subcontractors to have pollution and asbestos liability. However, the general contractor may require this of a subcontractor, at the general contractor's discretion, in order to protect the general contractor.**

13. I acknowledge that if I do not provide the above submittals on or before the **tenth** business day after Notice of Intent to Award or do not keep the bonds or insurance policies in effect or allow them to lapse during the performance of the Contract; I will pay over to the OWNER the amount of **$200.00** per day as liquidated damages.

14. I confirm this bid is genuine and is not a sham or collusive, or made in the interest of, or on behalf of any person not herein named, nor that the Bidder in any manner sought to secure for themselves an advantage over any bidders.

15. I further propose and agree that if my bid is accepted, I will commence to perform the work called for by the contract documents on the date specified in the Notice to Proceed and I will complete all work within the calendar days **specified in the General Conditions.**

16. I further propose and agree that I will accept as full compensation for the work to be performed the price written in the Bid Schedule below.

17. I have carefully checked the figures below and the OWNER will not be responsible for any error or omissions in the preparation or submission of this Bid.

18. I agree no verbal agreement or conversation with an officer, agent or employee of the OWNER, either before or after the execution of the contract, shall affect or modify any of the terms or obligations of this Bid.

19. I am responsible to ascertain the number of addenda issued, and I hereby acknowledge receipt of the following addenda:

Addendum No.	1	dated,	11.05.2025	Addendum No.		dated,	
Addendum No.	2	dated,	11.14.2025	Addendum No.		dated,	
Addendum No.	3	dated,	11.17.2025	Addendum No.		dated,	
Addendum No.		dated,		Addendum No.		dated,	

20. I agree to perform all work described in the drawings, specifications, and other documents for the amounts quoted below:

ITEM NUMBER	ITEM DESCRIPTION	LUMP SUM
1.	MODERNIZE PASSENGER ELEVATOR T1 INCLUDING *PERMIT FEES	$ 468,060.00
2.	MODERNIZE PASSENGER ELEVATOR T2 INCLUDING *PERMIT FEES	$ 468,060.00
3.	MODERNIZE PASSENGER ELEVATOR P2 INCLUDING *PERMIT FEES	$ 468,060.00
4.	MODERNIZE PASSENGER ELEVATOR P3 INCLUDING *PERMIT FEES	$ 468,060.00
5.	MODERNIZE SERVICE ELEVATOR S4 INCLUDING *PERMIT FEES	$ 468,060.00
6.	MODERNIZE SERVICE ELEVATOR S5 INCLUDING *PERMIT FEES	$ 468,060.00
7.	MODERNIZE SERVICE ELEVATOR S5A INCLUDING *PERMIT FEES	$ 468,060.00
8.	CODE REQUIRED IMPROVEMENTS/ REVISIONS TO ELEVATOR EQUIPMENT ROOM PENTHOUSE OF 7 STORY TOWER	$1,271,574.00
9.	OWNER CONTINGENCY	$ 800,000.00
10.	HONEYWELL FIRE ALARM AND HVAC CONTROLS	$ 242,801.00
	TOTAL BID AMOUNT	$ 5,590,795.00

Quantities stated are to be used to evaluate proposals and will not alleviate the BIDDER from completing all work as required in the Contract Documents and Plans. Each BIDDER is held responsible for the examination and/ or to have acquainted themselves with any conditions at the job site which would affect their work before submitting a bid. Failure to meet these criteria shall not relieve the BIDDER of the responsibility of completing the Bid without extra cost to the project OWNER. **Estimates of quantities of the various items of work and materials, as set forth in the Proposal Form, are approximates only and given solely to be used as a uniform basis for the comparison.**

ADDITIVE ALTERNATES

The OWNER may exercise the following items subject to the availability of funds. The additive alternate price quoted shall remain firm throughout the Contract term, as detailed in Instruction to Bidders.

Alternative	ITEM DESCRIPTION	TOTAL
1.	INTERIM MAINTENANCE/PREVENTATIVE MAINTENANCE DURING PERIOD FROM NOTICE TO PROCEED UNTIL REFURBISHMENT HAS BEEN COMPLETED FOR T1 AND T2	$ 18,588.00
2.	INTERIM MAINTENANCE/PREVENTATIVE MAINTENANCE DURING PERIOD FROM NOTICE TO PROCEED UNTIL REFURBISHMENT HAS BEEN COMPLETED FOR P2 AND P3	$ 16,200.00
3.	INTERIM MAINTENANCE/PREVENTATIVE MAINTENANCE DURING PERIOD FROM NOTICE TO PROCEED UNTIL REFURBISHMENT HAS BEEN COMPLETED FOR S4, S5 AND S5A	$ 24,300.00
4.	Initial 5-Year Maintenance Cost	$212,856.00
5.	Year 6 Maintenance Cost	$ 44,274.00
6.	Year 7 Maintenance Cost	$ 46,487.00
7.		$
	ADD ALTERNATES AMOUNT	$ 362,705.00
	GRAND TOTAL BID AMOUNT	$ 5,953,500.00

21. BUSINESS ENTERPRISE INFORMATION:

The BIDDER submitting this Bid is a ☐ MBE ☐ WBE ☐ PBE ☐ SBE ☐ VET ☐ DVET ☐ ESB as defined in the Instructions to Bidders.

22. BUSINESS ETHNICITY INFORMATION:

The BIDDER submitting the Bid Ethnicity is ☒ Caucasian (CX) ☐ African American (AA) ☐ Hispanic American (HA) ☐ Asian Pacific American (AX) ☐ Native American (NA)) ☐ Pacific Islander (PI)

☐ Other as defined in the Instructions to Bidders.

23. BIDDERS' PREFERENCE Is the Bidder claiming Bidders' Preference?

☒ Yes If yes, the Bidder acknowledges that he/she is required to follow the requirements set forth in the Affidavit (**Bid Attachment 6**).

☐ No **I do not have a Certificate of Eligibility to receive preference in bidding**.

24. Monument Construction
LEGAL NAME OF FIRM AS IT WOULD APPEAR IN CONTRACT

7787 Eastgate Rd #110
ADDRESS OF FIRM

Henderson, NV 89011
CITY, STATE, ZIP CODE

(702) 530-2303
TELEPHONE NUMBER

702.947.2606
FAX NUMBER

NEVADA STATE CONTRACTORS' BOARD LICENSE INFORMATION:

I certify that the license(s) listed below will be the license(s) used to perform the majority of the work on this project.

LICENSE NUMBER: A-0080649, B-0075502

LICENSE CLASS: A, B

LICENSE LIMIT: Unlimited

ONE TIME LICENSE LIMIT INCREASE $_____ IF YES, DATE REQUESTED _____

DUN & BRADSTREET NUMBER 01960820

CLARK COUNTY BUSINESS LICENSE NO. 2024331409

STATE OF NEVADA BUSINESS LICENSE NO. NV20101633041

Jon Wayne Nielsen
AUTHORIZED REPRESENTATIVE (PRINT OR TYPE)

Jwn@buildmonuments.com
E-MAIL ADDRESS

JWN龍
SIGNATURE OF AUTHORIZED REPRESENTATIVE

11.19.2025
TODAY'S DATE

INSTRUCTIONS FOR COMPLETING THE
DISCLOSURE OF OWNERSHIP/PRINCIPALS FORM

Purpose of the Form

The purpose of the Disclosure of Ownership/Principals Form is to gather ownership information pertaining to the business entity for use by the University Medical Center of Southern Nevada Governing Board ("GB") in determining whether members of the GB should exclude themselves from voting on agenda items where they have, or may be perceived as having a conflict of interest, and to determine compliance with Nevada Revised Statute 281A.430, contracts in which a public officer or employee has interest is prohibited.

General Instructions

Completion and submission of this Form is a condition of approval or renewal of a contract or lease and/or release of monetary funding between the disclosing entity and University Medical Center of Southern Nevada. Failure to submit the requested information may result in a refusal by the GB to enter into an agreement/contract and/or release monetary funding to such disclosing entity.

Detailed Instructions

All sections of the Disclosure of Ownership form must be completed. If not applicable, write in N/A.

Business Entity Type – Indicate if the entity is an Individual, Partnership, Limited Liability Company, Corporation, Trust, Non-profit Organization, or Other. When selecting 'Other', provide a description of the legal entity.

Non-Profit Organization (NPO) - Any non-profit corporation, group, association, or corporation duly filed and registered as required by state law.

Business Designation Group – Indicate if the entity is a Minority Owned Business Enterprise (MBE), Women-Owned Business Enterprise (WBE), Small Business Enterprise (SBE), Physically-Challenged Business Enterprise (PBE), Veteran Owned Business (VET), Disabled Veteran Owned Business (DVET), or Emerging Small Business (ESB) . This is needed in order to provide utilization statistics to the Legislative Council Bureau, and will be used only for such purpose.

- **Minority Owned Business Enterprise (MBE):** An independent and continuing business for profit which performs a commercially useful function and is at least 51% owned and controlled by one or more minority persons of Black American, Hispanic American, Asian-Pacific American or Native American ethnicity.
- **Women Owned Business Enterprise (WBE**): An independent and continuing business for profit which performs a commercially useful function and is at least 51% owned and controlled by one or more women.
- **Physically-Challenged Business Enterprise (PBE):** An independent and continuing business for profit which performs a commercially useful function and is at least 51% owned and controlled by one or more disabled individuals pursuant to the federal Americans with Disabilities Act.
- **Small Business Enterprise (SBE):** An independent and continuing business for profit which performs a commercially useful function, is not owned and controlled by individuals designated as minority, women, or physically-challenged, and where gross annual sales does not exceed $2,000,000.
- **Veteran Owned Business Enterprise (VET):** An independent and continuing Nevada business for profit which performs a commercially useful function and is at least 51 percent owned and controlled by one or more U.S. Veterans.
- **Disabled Veteran Owned Business Enterprise (DVET):** A Nevada business at least 51 percent owned/controlled by a disabled veteran.
- **Emerging Small Business (ESB):** Certified by the Nevada Governor's Office of Economic Development effective January, 2014. Approved into Nevada law during the 77th Legislative session as a result of AB294.

Business Name (include d.b.a., if applicable) – Enter the legal name of the business entity and enter the "Doing Business As" (d.b.a.) name, if applicable.

Corporate/Business Address, Business Telephone, Business Fax, and Email – Enter the street address, telephone and fax numbers, and email of the named business entity.

Nevada Local Business Address, Local Business Telephone, Local Business Fax, and Email – If business entity is out-of-state, but operates the business from a location in Nevada, enter the Nevada street address, telephone and fax numbers, point of contact and email of the local office. Please note that the local address must be an address from which the business is operating from that location. Please do not include a P.O. Box number, unless required by the U.S. Postal Service, or a business license hanging address.

***Number of Clark County Nevada Residents employed by this firm. (*Do not leave blank. If none or zero, put the number 0 in the space provided.)**

List of Owners/Officers – Include the full name, title and percentage of ownership of each person who has ownership or financial interest in the business entity. If the business is a publicly-traded corporation or non-profit organization, list all Corporate Officers and Directors only.

For All Contracts – **(Not required for publicly-traded corporations)**

1) Indicate if any individual members, partners, owners or principals involved in the business entity are a University Medical Center of Southern Nevada full-time employee(s), or appointed/elected official(s). If yes, the following paragraph applies.

   In accordance with NRS 281A.430.1, a public officer or employee shall not bid on or enter into a contract between a government agency and any private business in which he has a significant financial interest, except as provided for in subsections 2, 3, and 4.

2) Indicate if any individual members, partners, owners or principals involved in the business entity have a second degree of consanguinity or affinity relation to a University Medical Center of Southern Nevada full-time employee(s), or appointed/elected official(s) (reference form on Page 2 for definition). If **YES**, complete the Disclosure of Relationship Form.

A professional service is defined as a business entity that offers business/financial consulting, legal, physician, architect, engineer or other professional services.

Signature and Print Name – Requires signature of an authorized representative and the date signed.

Disclosure of Relationship Form – If any individual members, partners, owners or principals of the business entity is presently a University Medical Center of Southern Nevada employee, public officer or official, or has a second degree of consanguinity or affinity relationship to a University Medical Center of Southern Nevada employee, public officer or official, this section must be completed in its entirety.

BID ATTACHMENT 10
DISCLOSURE OF OWNERSHIP/PRINCIPALS

Business Entity Type (Please select one)

☐ Sole Proprietorship	☐Partnership	☐ Limited Liability Company	☒ Corporation	☐ Trust	☐ Non-Profit Organization	☐ Other

Business Designation Group (Please select all that apply)

☐ MBE	☐ WBE	☐ SBE	☐ PBE	☐ VET	☐DVET	☐ ESB
Minority Business Enterprise	Women-Owned Business Enterprise	Small Business Enterprise	Physically Challenged Business Enterprise	Veteran Owned Business	Disabled Veteran Owned Business	Emerging Small Business

Number of Clark County Nevada Residents Employed: 100

Corporate/Business Entity Name:	Monument Construction	
(Include d.b.a., if applicable)		
Street Address:	7787 Eastgate Rd #110	**Website:** https://buildmonuments.com/
City, State and Zip Code:	Henderson, NV 89011	**POC Name:** Jon wayne Nielsen **Email:** Jwn@buildmonuments.com
Telephone No:	(702) 530-2303	**Fax No:** 702.947.2606
Nevada Local Street Address: **(If different from above)**		**Website:**
City, State and Zip Code:		**Local Fax No:**
Local Telephone No:		**Local POC Name:** **Email:**

All entities, with the exception of publicly-traded and non-profit organizations**,** must list the names of individuals holding more than five percent (5%) ownership or financial interest in the business entity appearing before the Board.

Publicly-traded entities and non-profit organizations shall list all Corporate Officers and Directors in lieu of disclosing the names of individuals with ownership or financial interest. The disclosure requirement, as applied to land-use applications, extends to the applicant and the landowner(s).

Entities include all business associations organized under or governed by Title 7 of the Nevada Revised Statutes, including but not limited to private corporations, close corporations, foreign corporations, limited liability companies, partnerships, limited partnerships, and professional corporations.

Full Name	Title	% Owned (Not required for Publicly Traded Corporations/Non-profit organizations)
Jon Wayne Nielsen	President	100%

This section is not required for publicly-traded corporations. Are you a publicly-traded corporation? ☐ Yes ☒ No

1. Are any individual members, partners, owners or principals, involved in the business entity, a University Medical Center of Southern Nevada full-time employee(s), or appointed/elected official(s)?

   ☐ Yes ☒ No (If yes, please note that University Medical Center of Southern Nevada employee(s), or appointed/elected official(s) may not perform any work on professional service contracts, or other contracts, which are not subject to competitive bid.)

2. Do any individual members, partners, owners or principals have a spouse, registered domestic partner, child, parent, in-law or brother/sister, half-brother/half-sister, grandchild, grandparent, related to a University Medical Center of Southern Nevada full-time employee(s), or appointed/elected official(s)?

   ☐ Yes ☒ No (If yes, please complete the Disclosure of Relationship form on Page 2. If no, please print N/A on Page 2.)

I certify under penalty of perjury, that all of the information provided herein is current, complete, and accurate. I also understand that the University Medical Center of Southern Nevada Governing Board will not take action on land-use approvals, contract approvals, land sales, leases or exchanges without the completed disclosure form.

JWN龍 — Signature

Jon Wayne Nielsen — Print Name

President — Title

11.18.25 — Date

REVISED 7/25/2014

BID ATTACHMENT 10 (page 2)
DISCLOSURE OF RELATIONSHIP

List any disclosures below:
(Mark N/A, if not applicable.)

NAME OF BUSINESS OWNER/PRINCIPAL	NAME OF UMC* EMPLOYEE/OFFICIAL AND JOB TITLE	RELATIONSHIP TO UMC* EMPLOYEE/OFFICIAL	UMC* EMPLOYEE'S/OFFICIAL'S DEPARTMENT
N/A			

* UMC employee means an employee of University Medical Center of Southern Nevada

"Consanguinity" is a relationship by blood. "Affinity" is a relationship by marriage.

"To the second degree of consanguinity" applies to the candidate's first and second degree of blood relatives as follows:

- Spouse – Registered Domestic Partners – Children – Parents – In-laws (first degree)
- Brothers/Sisters – Half-Brothers/Half-Sisters – Grandchildren – Grandparents – In-laws (second degree)

For UMC Use Only:

If any Disclosure of Relationship is noted above, please complete the following:

☐ Yes ☐ No Is the UMC employee(s) noted above involved in the contracting/selection process for this particular agenda item?

☐ Yes ☐ No Is the UMC employee(s) noted above involved in any way with the business in performance of the contract?

Notes/Comments:

_____
Signature

_____
Print Name
Authorized Department Representative

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
GOVERNING BOARD AUDIT AND FINANCE COMMITTEE
AGENDA ITEM

Issue: **Emerging Issues**	**Back-up:**
Petitioner: Jennifer Wakem, Chief Financial Officer	

Recommendation:

That the Audit and Finance Committee identify emerging issues to be addressed by staff or by the Audit and Finance Committee at future meetings; and direct staff accordingly. ***(For possible action)***

FISCAL IMPACT:

None

BACKGROUND:

None

Cleared for Agenda
January 21, 2026

Agenda Item #
18