SUMMARY DISCLOSURE FORM

(1) Compensation terms

(a) Manner of payment:

[ ] Fee for service

[ ] Capitation

[ ] Risk

[ ] Other [...............] See [...............]

(b) Fee schedule available at [...............]

(c) Fee calculation schedule available at [...............]

(d) Identity of internal processing edits available at [...............]

(e) Information in (c) and (d) is not required if information in (b) is provided.

(2) List of products or networks covered by this contract

[ ]

[ ]

[ ]

[ ]

[ ]

(3) Term of this contract [...............]

(4) Contracting entity or payer responsible for processing payment available at [...............]

(5) Internal mechanism for resolving disputes regarding contract terms available at [...............]

(6) Addenda to contract

Title

Subject

(a)

(b)

(c)

(d)

(7) Telephone number to access a readily available mechanism, such as a specific web site address, to allow a participating provider to receive the information in (1) through (6) from the payer.

IMPORTANT INFORMATION--PLEASE READ CAREFULLY

The information provided in this Summary Disclosure Form is a guide to the attached Health Care Contract as defined in section 3963.01(I) of the Ohio Revised Code. The terms and conditions of the attached Health Care Contract constitute the contract rights of the parties.

Reading this Summary Disclosure Form is not a substitute for reading the entire Health Care Contract. When you sign the Health Care Contract, you will be bound by its terms and conditions. These terms and conditions may be amended over time pursuant to section 3963.04 of the Ohio Revised Code. You are encouraged to read any proposed amendments that are sent to you after execution of the Health Care Contract.

Nothing in this Summary Disclosure Form creates any additional rights or causes of action in favor of either party.