

SERFF Tracking Number: UHLC-125822831 State: Arkansas
 Filing Company: UnitedHealthcare of Arkansas, Inc. State Tracking Number: 40300
 Company Tracking Number:
 TOI: HOrg02G Group Health Organizations - Health Sub-TOI: HOrg02G.002B Any Size Group - POS
 Maintenance (HMO)
 Product Name: HMO
 Project Name/Number: UBH Provider Agreements - IND,GRP, FAC, REGAPP/

Filing at a Glance

Company: UnitedHealthcare of Arkansas, Inc.

Product Name: HMO

SERFF Tr Num: UHLC-125822831 State: ArkansasLH

TOI: HOrg02G Group Health Organizations -
Health Maintenance (HMO)

SERFF Status: Closed

State Tr Num: 40300

Sub-TOI: HOrg02G.002B Any Size Group -
POS

Co Tr Num:

State Status: Approved-Closed

Filing Type: Form

Co Status:

Reviewer(s): Rosalind Minor

Authors: Lori Anderson, Marianne
Kistner, Shelly Carothers, Cathy

Disposition Date: 09/19/2008

Dykhouse

Date Submitted: 09/18/2008

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: UBH Provider Agreements - IND,GRP, FAC, REGAPP

Status of Filing in Domicile: Authorized

Project Number:

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Overall Rate Impact:

Group Market Type: Employer

Filing Status Changed: 09/19/2008

State Status Changed: 09/19/2008

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

On behalf of United HealthCare of Arkansas, Inc. and their affiliates (collectively "United") and United Behavioral Health ("UBH"), enclosed for your review, please find the following new templates.

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- UBH Individual Provider Agreement_2008
- UBH Group Provider Agreement_2008
- UBH Facility Provider Agreement_2008
- UBH Arkansas Regulatory Attachment_2008, this attachment will be used with each of the above listed agreements.

These templates will be used by UBH, a UnitedHealth Group company, which provides mental health and substance abuse services and network to our members.

UBH recently completed a comprehensive review of their contracts and has made the above new and updated templates for which we request review.

Company and Contact

Filing Contact Information

Cathy Dykhouse, Regulatory Affairs Specialist Cathy_Dykhouse@uhc.com
 106 Farmer's Alley (269) 216-2105 [Phone]
 Kalamazoo, MI 49005-1100 (269) 216-2168[FAX]

Filing Company Information

UnitedHealthcare of Arkansas, Inc.	CoCode: 95446	State of Domicile: Arkansas
Plaza West Building	Group Code:	Company Type: HMO
415 North McKinley Street, Suite 300		
Little Rock, AK 72205	Group Name:	State ID Number:
(952) 992-7428 ext. [Phone]	FEIN Number: 63-1036819	

Filing Fees

Fee Required?	Yes
Fee Amount:	\$50.00
Retaliatory?	Yes
Fee Explanation:	\$50.00 per provider contract
Per Company:	No

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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
UnitedHealthcare of Arkansas, Inc.	\$200.00	09/18/2008	22590240

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	09/19/2008	09/19/2008

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Disposition

Disposition Date: 09/19/2008

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Form	UBH Individual Provider Agreement_2008	Approved-Closed	Yes
Form	UBH Group Provider Agreement_2008	Approved-Closed	Yes
Form	UBH Facility Provider Agreement_2008	Approved-Closed	Yes
Form	UBH Arkansas Regulatory Attachment_2008	Approved-Closed	Yes

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Form Schedule

Lead Form Number: IND2008

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	IND2008	Other	UBH Individual Provider Agreement_2008	Initial			UBH Individual Provider Agreement_2008.pdf
Approved-Closed	GRP2008	Other	UBH Group Provider Agreement_2008	Initial			UBH Group Provider Agreement_2008.pdf
Approved-Closed	FAC2008	Other	UBH Facility Provider Agreement_2008	Initial			UBH Facility Provider Agreement_2008.pdf
Approved-Closed	2008ARRegAttachment	Other	UBH Arkansas Regulatory Attachment_2008	Initial			UBH Arkansas Regulatory Attachment_2008.pdf

UNITED BEHAVIORAL HEALTH INDIVIDUAL PARTICIPATING PROVIDER AGREEMENT

THIS AGREEMENT, is between United Behavioral Health ("UBH") and the undersigned provider (hereinafter referred to as the "Provider"). This Agreement will become effective upon the date set forth in UBH's executed Acceptance Letter (the "Effective Date"). This Agreement sets forth the terms and conditions under which Provider shall participate in one or more networks developed by UBH and to Provider by UBH as a Participating Provider of Covered Services to Members.

ARTICLE 1 Definitions

Any capitalized term herein shall have the meaning as set forth in this Agreement. Any undefined term herein shall have the meaning as defined in the Provider Manual, the Protocols, or as may be defined by applicable state or federal laws or regulations, as applicable.

Affiliate: Each and every entity or business concern with which UBH, directly or indirectly, in whole or in part, either: (i) owns or controls; (ii) is owned or controlled by; or (iii) is under common ownership or control.

Benefit Plan: The specific plan of benefits for health care coverage, including MHSA Services, for a particular Member that is provided, sponsored or administered by UBH directly or through its Affiliate, or through a network rental arrangement UBH may have with a third-party, and contains the terms and conditions of a Member's coverage for MHSA Services, including applicable Member Expenses, exclusions and limitations, and all other provisions applicable to the coverage of such MHSA Services such as services rendered outside specified networks.

CMHC: A Community Mental Health Center.

CMHC Provider: An employee of a CMHC who provides mental health and/or substance abuse services, but is not a CMHC Supervising Provider.

CMHC Supervising Provider: A psychiatrist, psychologist, social worker, family or other therapist duly licensed and qualified in the state in which MHSA Services are provided to Members who practices as an employee of CMHC and has been approved as a CMHC Supervising Provider in writing by UBH.

Covered Services: MHSA Services that meet the terms and conditions for coverage pursuant to the Member's Benefit Plan, including such conditions as Medically Necessary and proper authorization, and in accordance with the Provider Manual, Protocols, and applicable laws and regulations.

Customary Charge: The fee for MHSA Services charged by Provider that does not exceed the fee Provider would ordinarily charge any other person regardless of whether the person is a Member.

Emergency Services: Unless otherwise defined by applicable state law, a serious health condition that arises suddenly and requires immediate care and treatment, generally received within twenty-four (24) hours of onset, to stabilize or avoid jeopardy to the life or health of a Member or, by actions of the Member, to the life or health of another. Emergency Services shall be available twenty-four (24) hours per day, seven (7) days per week.

Fee Maximums: The maximum amount Provider may receive as payment for provision of Covered Services to a Member, including Member Expenses, that are applicable to Provider and/or the Benefit Plan, as determined from time to time by UBH. UBH will provide the then-current Fee Maximums to Provider upon request.

Medicaid: A Medical Assistance Program providing health coverage benefits for low income persons pursuant to applicable state and federal laws and regulations.

Medically Necessary: Except as otherwise required by applicable state or federal law or regulations, for purposes of this Agreement, Medically Necessary means the term as it may be described in the Member's Benefit Plan for MHSA Services and which meets Payor's defined criteria for coverage as Covered Services. It may also, when applicable, have the meaning defined within the Protocols. Generally, however, Medically Necessary means treatment that is commonly recognized in the industry as consistent treatment that must be: (a) solely to treat the condition of the Member; (b) for the illness or injury of a diagnosis that is commonly recognized as a disease or injury; (c) reasonably expected to directly result in the restoration of health or function; (d) not experimental or investigational but is consistent with established and accepted national medical practice guidelines regarding type, frequency and duration of treatment; (e) without alternative treatment that is less intensive or invasive for the efficient treatment of the Member's condition; (f) not based on convenience for the Member; and (g) not otherwise excluded from the definition of Covered Services based upon the terms and conditions of the Member's Benefit Plan.

Medicare: Federally sponsored program providing health coverage benefits to individuals of qualifying age, disability, or disease.

Member: An individual who is eligible for, properly enrolled in, and covered under a Benefit Plan.

Member Expenses: Any amount of Customary Charges that are the Member's responsibility to pay Provider in accordance with the terms of the Member's Benefit Plan, including co-payments, co-insurance and deductible amounts.

Mental Health and Substance Abuse Services ("MHSA Services"): Health care services, treatment or supplies that are used to treat a mental health or substance abuse illness, condition or disease and which may be eligible for coverage under the Member's Benefit Plan.

Participating Provider: A health care professional, facility, CMHC Supervising Provider, psychiatrist, psychologist or other behavioral health professional or

organization, that is duly licensed or certified to provide MHSA Services within the state such MHSA Services are provided, and who has a written Individual Participating Provider Agreement in effect with UBH, directly or through another entity, to provide MHSA Services to Members.

Payment Policies: Guidelines adopted by UBH, from time to time, for calculating payment of claims under Benefit Plans.

Payor: The entity or person that has the financial responsibility for funding payment of Covered Services on behalf of a Member, and that is authorized to access MHSA Services in accordance with this Agreement.

Protocols: The programs, policies, protocols, processes, procedures, and requirements as such may change or be modified from time to time, and that are adopted by UBH or Payor, and which Provider agrees to follow as a condition of UBH accepting Provider as a Participating Provider, including, but not limited to, authorization procedures, credentialing and re-credentialing processes and plans, utilization management and care management processes, billing procedures, Payment Policies, providing or arranging for Emergency Services, quality improvement, peer review, on-site review, Member grievance and appeals processes, and any other policies, procedures, processes, activities or standards, wherever located as may apply to Provider's rights, obligations or responsibilities as a Provider of MHSA Services, whether in this Agreement, Provider Manual, or any other document as made accessible or available to Provider from time to time.

Provider Manual: A document or manual, however known or named, such as the Network Manual, containing the administrative policies, procedures and Protocols applicable to Benefit Plans provided, sponsored or administered by UBH or a Payor including, but not limited to, policies and procedures for credentialing, claims, quality improvement, and utilization management to which Provider is obligated.

ARTICLE 2 Duties of Provider

2.1 Provision of MHSA Services. Provider hereby acknowledges and agrees to cooperate and comply with all of the terms and conditions of the Provider Manual, Protocols, and this Agreement, and to dutifully perform as a Participating Provider for the provision of MHSA Services to Members within the UBH network(s) as designated by UBH or Payor. At the request of a Payor, Provider may not be authorized to provide MHSA Services for some or all of Payor's Members. Provider shall otherwise accept Members as new patients on the same basis as Provider is accepting non-Members as new patients without regard to race, religion, gender, color, national origin, age or physical or mental health status, or on any other basis deemed unlawful under federal, state or local law. At all times, Provider shall require any employed or subcontracted health care professionals and facilities to comply with the terms and conditions of this Agreement, all Protocols of UBH and Payor, the Provider Manual, as well as the requirements of all applicable laws and regulations.

2.2 Benefit Plan & Eligibility. MHSA Services provided by Provider to a Member pursuant to this Agreement are subject to all the terms and conditions of the Member's Benefit Plan including eligibility of the Member on the date MHSA Services are provided to the Member. Provider shall make reasonable effort to verify Member's eligibility at time of service by following appropriate procedures, including without limitation, and at a minimum, the terms and conditions of this Agreement, Protocols, the Provider Manual, and review of the Member's Benefit Plan identification card. Provider however recognizes that the Member eligibility information may be inaccurate at the time Provider obtains verification and that the Member, or the MHSA Services provided to the Member, may later be determined to be ineligible for coverage and, except as otherwise required by law, not eligible for payment under this Agreement. Under such circumstances, Provider may then, except as otherwise stated herein, directly bill the Member or other responsible party for such MHSA Services.

2.3 Provider Manual & Protocols. Provider shall be bound by, accept, strictly comply with, and cooperate with, the requirements set forth in the Provider Manual, credentialing plan, and all Protocols, as amended or modified from time to time by UBH and/or Payor, all of which are hereby incorporated herein by reference as if set forth fully herein, including without limitation quality improvement activities. Provider acknowledges and agrees that the Provider Manual and/or Protocols may contain service and contract requirements of certain Payors to which Provider shall strictly comply. Provider's failure to comply with the Provider Manual, Protocols and any other standards, procedures or policies may result in loss of, or reduction of payment or reimbursement to Provider, termination of this Agreement or the imposition of other corrective action by UBH.

2.4 Authorization Requirements. Subject to all applicable terms and conditions, including without limitation Section 2.2 above, and in accordance with the Provider Manual, Protocols, and requirements of the Member's Benefit Plan regarding authorization, Provider must request authorization for MHSA Services from UBH either telephonically or by another approved and accepted method recognized by UBH before providing any MHSA Services to a Member as a Covered Service. Authorizations shall subsequently be confirmed by UBH in writing. Except as otherwise permitted herein, only Emergency Services will be eligible for retroactive authorization at the sole discretion of UBH or as required by applicable law. Any authorization resulting from wrongful, fraudulent or negligent actions of Provider or a breach of this Agreement shall be null and void as of the time given.

2.5 Provider's Standard of Care. Nothing in this Agreement, the Provider Manual, the Benefit Plan, or the Protocols, including without limitation, UBH's utilization management and quality assurance and improvement standards and procedures, shall dictate MHSA Services provided by Provider or otherwise diminish Provider's obligation to freely communicate with and/or provide MHSA Services to Members in accordance with the applicable standard of care.

2.6 Continuity of Care; Referral to Other Health Professionals. Provider shall furnish Covered Services in a manner providing continuity of care and ready referral of

Members to other Participating Providers at times as may be appropriate and consistent with the standards of care in the community. If a Member requires additional services or evaluation, including Emergency Services, Provider agrees to refer Member to his/her primary care physician or another Participating Provider in accordance with the terms and conditions of Member's Benefit Plan. A Member requiring Emergency Services shall also be referred to the "9-1-1" emergency response system.

2.7 Member Access to Care. Provider shall ensure that Members have timely and reasonable access to MHSA Services and shall at all times be reasonably available to Members as is appropriate. If Provider is unavailable when Members call, instructions must be provided for the Member referring the Member to another Participating Provider or to his/her Benefit Plan. Provider shall arrange for an answering machine or service that shall provide the office hours and emergency information and be capable of receiving messages 24 hours a day.

2.8 Employees and Contractors of Provider. Provider will be responsible for and shall ensure that all of its employees and contractors are bound by, and meet the terms and conditions of, this Agreement, the Provider Manual and Protocols, at the time of providing Covered Services to Members. Failure of such employees or contractors to meet such terms and conditions, including without limitation, credentialing requirements, UBH may restrict them from providing Covered Services to Members.

All payments obligated by Payor shall be paid to Provider and Provider will be solely responsible for payments to its employees and contractors who may have provided MHSA Services. Provider agrees to defend, indemnify and hold UBH harmless for any claims, damages, actions, or judgments arising from any employee or contractor of Provider related to the provision of MHSA Services to Members.

ARTICLE 3 Payment Provisions

3.1 Payment for Covered Services. In accordance with the terms and conditions hereof, Payor shall pay Provider for Covered Services provided to a Member by Provider. Payment shall be the lesser of: (a) Provider's Customary Charge, less any applicable Member Expenses; or (b) the Fee Maximum for such MHSA Services, less any applicable Member Expenses.

Subject to the terms and conditions herein, the obligation for payment for Covered Services provided to a Member, less any applicable Member Expenses, is solely that of Payor. Additionally, UBH may arrange for claims processing services. When UBH is the Payor, UBH shall make obligated claim payments to Provider within 45 days (and shall use best efforts to encourage a third-party Payor to make payments within 45 days), or as otherwise required by law, of the date Payor receives all information necessary to process and pay a clean claim, except for claims for which there is coordination of benefits, Member Expense adjustments, disputes about coverage, systems failure or other such causes.

In the event a Member's Benefit Plan provides for a Member Expense whether stated as a flat fee or a percentage, the amount of the Member Expense shall be calculated in accordance with the Member's Benefit Plan or as determined by the Payor. The amount calculated pursuant to the preceding sentence shall be deducted from the amount Provider is to be paid for the Covered Services pursuant to this Agreement.

3.2 Submission of Claims. Provider shall submit claims for MHSA Services to UBH in a manner and format prescribed by UBH, whether in Protocols or otherwise, and which may be in an electronic format. All information necessary to process the claims must be received by UBH no more than 90 days from the date the MHSA Services are rendered. Provider agrees that claims received after this time period may be rejected for payment, at UBH's and/or Payor's sole discretion.

Unless otherwise directed by UBH, Provider shall submit claims using current CMS (HCFA) 1500 or UB04 forms, whichever is appropriate, with applicable coding including, but not limited to, ICD9, CPT, Revenue and HCPCS coding. Provider shall include in a claim the Member number, Customary Charges for the MHSA Services rendered to a Member during a single instance of service, Provider's Federal Tax I.D. number and/or other identifiers requested by UBH.

Payor shall have the right to make, and Provider shall have the right to request, corrective adjustments to a previous payment; provided however, that Payor shall have no obligation to pay additional amounts after 12 months from the date the initial claim was paid.

3.3 Payment in Full. Provider shall accept as payment in full for Covered Services rendered to Members such amounts as are paid by Payor pursuant to this Agreement and shall not bill Members for non-covered charges, other than Member Expenses, which result from Payor's reimbursement methodologies. In no event shall Provider bill a Member for the difference between Customary Charges and the amount Provider has agreed to accept as full reimbursement under this Agreement. Provider may collect Member Expenses from the Member. If Payor denies payment for services rendered by Provider on grounds that the services are not Medically Necessary, Provider shall not collect payment from the Member for the services unless the Member has knowledge of the determination of lack of Medical Necessity and has subsequently agreed in writing to be responsible for such charges and MHSA Services. Further, if any payment to Provider is denied, in part or full, due to Provider's failure to strictly comply with any term or condition in this Agreement, the Provider Manual, the Protocols, including without limitation, obtaining prior authorization, untimely filing of a claim, inaccurate or incorrect submission of or claim processing, or the insolvency of Payor pursuant to applicable law, it is agreed that Provider shall not, except for applicable Member Expenses, bill the Member or otherwise, directly or indirectly, seek or collect payment from the Member for any of the denied amounts. Any violation hereof by Provider shall be deemed a material breach. This provision shall apply regardless of whether any waiver or other document of any kind purporting to allow Provider to collect payment from the Member exists. These provisions shall survive the termination hereof and shall be construed to be for the benefit of the Member.

3.4 Coordination of Benefits. Provider shall be paid in accordance with Payor's coordination of benefits rules.

3.5 Financial Responsibility. In the event of a default (meaning a systematic failure by Payor to fund undisputed claim payments for Covered Services) by a Payor, except when due to the insolvency of Payor, UBH shall notify Provider in writing of such default following UBH's determination thereof. Any services which have been rendered by Provider prior to or after such notification, and which have not been paid for by Payor, shall be considered ineligible for reimbursement under this Agreement, and Provider may seek payment directly from the Payor and Member for such services.

3.6 Member Protection Provision. This provision supersedes and replaces the Financial Responsibility section (section 3.5 above) only in those cases where UBH, or its Affiliate, is the Payor, or when required by another specific Payor, or when required pursuant to applicable laws, statutes and regulations.

In no event, including, but not limited to, non-payment by Payor for MHSA Services rendered to Members by Provider, insolvency of Payor, or breach by UBH of any term or condition of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member or persons acting on behalf of the Member for MHSA Services eligible for reimbursement under this Agreement; provided, however, that Provider may collect from the Member, any Member Expenses or charges for services that are not covered as benefits under the Member's Benefit Plan.

The provisions of this Article shall apply to all Member protection provisions in this Agreement and shall: (a) apply to all MHSA Services rendered while this Agreement is in force; (b) survive the termination of this Agreement regardless of the cause of termination; (c) be construed to be for the benefit of the Members; and (d) except as otherwise stated in section 3.3, supersede any oral or written agreement, existing or subsequently entered into, between Provider and a Member or person acting on a Member's behalf, that requires the Member to pay for such MHSA Services.

3.7 Contracted Rate for Members. Provider agrees to continue to provide MHSA Services to Members who have exhausted his/her covered benefits under the Benefit Plan and agrees not to collect or charge more than the contracted rate for those MHSA Services. Provider may bill the Member directly for those MHSA Services for which there is no longer any coverage under the Benefit Plan, in accordance herewith.

ARTICLE 4

Laws, Regulations, and Licenses, and Liabilities of Parties

4.1 Laws, Regulations and Licenses. Provider shall maintain in good standing all federal, state and local licenses, certifications and permits -- without sanction, revocations, suspension, censure, probation or material restriction -- which are required to provide health care services according to the laws of the jurisdiction in which MHSA Services are provided, and shall comply with all applicable statutes and regulations.

Provider shall also require that all health care professionals employed by or under contract with Provider to render MHSA Services to Members, including covering Providers, comply with this provision.

4.2 Responsibility for Damages. Any and all damages, claims, liabilities or judgments, attorney fees, which may arise as a result of Provider's or its employee's or contractor's negligence or intentional wrongdoing shall be the sole responsibility of Provider.

4.3 Provider Liability Insurance. Provider shall procure and maintain, at Provider's sole expense, (a) medical malpractice or professional liability insurance in the amount of \$1,000,000 per occurrence and \$3,000,000 in aggregate if Provider is a Medical Doctor and \$1,000,000 per occurrence and in aggregate if Provider is not a Medical Doctor; and (b) comprehensive general and/or umbrella liability insurance in the amount of \$1,000,000 per occurrence and in aggregate. Provider shall also require that all health care professionals employed by or under contract with Provider to render MHSA Services to Members procure and maintain malpractice insurance, unless they are covered under Provider's insurance policies.

Provider's and other health care professionals' medical malpractice insurance shall be on either an "occurrence" or "claims made" basis provided that for a "claims made" policy, such policy must be written with an extended period reporting option under such terms and conditions as may be reasonably required by UBH. Prior to the Effective Date of this Agreement and at each policy renewal thereafter, Provider shall submit to UBH in writing evidence of insurance coverage.

ARTICLE 5 Notices

5.1 Notices. Provider shall notify UBH within ten (10) days of knowledge of any of the following:

- (a) changes in liability insurance carriers, termination of, renewal of or any other material changes in Provider's liability insurance, including reduction of limits, erosion of aggregate, changes in retention or non-payment of premium;
- (b) action which may result in or the actual suspension, sanction, revocation, condition, limitation, qualification or other material restriction on Provider's licenses, certifications or permits by any government under which Provider is authorized to provide health care services; and, of any suspension, revocation, condition, limitation, qualification or other material restriction of Provider's staff privileges at any licensed hospital, nursing home or other facility at which Provider has staff privileges during the term of this Agreement;
- (c) a change in Provider's name, address, ownership or Federal Tax I.D. number;
- (d) indictment, arrest or conviction for a felony or for any criminal charge related to the practice of Provider's profession;
- (e) claims or legal actions for professional negligence or bankruptcy;

- (f) provider's termination, for cause, from any other provider network offered by any plan, including, without limitation, any health care service plan, health maintenance organization, any health insurer, any preferred provider organization, any employer or any trust fund;
- (g) any occurrence or condition that might materially impair the ability of Provider to perform its duties under this Agreement; or
- (h) any condition or circumstance that may pose a direct threat to the safety of Provider, Providers' staff, or Members.

Unless otherwise specified in this Agreement, each and every notice and communication to the other party shall be in writing. All written notices or communication shall be deemed to have been given when delivered in person; or, on the date mailed, if delivered by first-class mail, proper postage prepaid and properly addressed to the appropriate party at the address set forth at the signature portion of this Agreement or to another address of which sending party has been notified, including without limitation, to UBH's Network Manager at the applicable address for notice as identified in the Provider Manual or Protocols. The parties shall, by written notice, provide and update each other with the most current address and names of all parties or designees that should receive certain notices or communication.

ARTICLE 6 Records

6.1 Confidentiality of Records. UBH and Provider shall maintain the confidentiality of all Member information and records in accordance with all applicable state and federal laws, statutes and regulations, including without limitation, the Health Insurance Portability and Accountability Act.

6.2 Maintenance of and UBH Access to Records. Provider shall maintain adequate medical, treatment, financial and administrative records related to MHSA Services provided by Provider under this Agreement for a period and in a manner consistent with the standards of the community and in accordance with the Provider Manual, Protocols and all applicable state and federal laws, statutes and regulations.

In order to perform its utilization management and quality improvement activities, UBH shall have access to such information and records, including claim records, within 14 days from the date the request is made, except that in the case of an audit by UBH, such access shall be given at the time of the audit. If requested by UBH, Provider shall provide copies of such records free of charge. During the term of this Agreement UBH shall have access to and the right to audit information and records to the extent permitted by the Provider Manual, or as otherwise required by state or federal laws, statutes or regulations or regulatory authority. Said rights shall continue following the termination hereof for the longer of three years or for such period as may be permitted by applicable state or federal law, regulatory authority, or Protocols.

It is Provider's responsibility to obtain any Member's consent in order to provide UBH with requested information and records or copies of records and to allow UBH to

release such information or records to Payors as necessary for the administration of the Benefit Plan or compliance with any state or federal laws, statutes and regulations applicable to the Payors.

Provider acknowledges that in receiving, storing, processing or otherwise dealing with information from UBH or Payor about Members, it is fully bound by the provisions of the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2; and Provider agrees that it will resist in judicial proceedings any effort to obtain access to information pertaining to patients otherwise than as expressly provided for in the federal confidentiality regulations, 42 CFR Part 2.

This section shall not be construed to grant UBH access to Provider's records that are created for purposes of assessing Provider's financial performance or for Provider's peer review activities, except to the extent the federal and/or state government and any of their authorized representatives have access to such records pursuant to Section 6.3.

6.3 Government and Accrediting Agency Access to Records. It is agreed that the federal, state and local government, or accrediting agencies including, but not limited to, the National Committee for Quality Assurance (the "NCQA"), and any of their authorized representatives, shall have access to, and UBH and Provider are authorized to release, in accordance with applicable statutes and regulations, all information and records or copies of such, within the possession of UBH or Provider, which are pertinent to and involve transactions related to this Agreement if such access is necessary to comply with accreditation standards, statutes or regulations applicable to UBH, Payor or Provider. Such access shall be available and provided during the term of this Agreement and for three years following the termination hereof, or such longer period as may be identified in the Provider Manual or Protocols or as required by applicable state or federal laws, statutes or regulations.

ARTICLE 7 Resolution of Disputes

7.1 Resolution of Disputes. It is agreed that prior to any other remedy available to the parties, UBH, Payor and/or Provider shall provide written notice of any disputes or claims arising out of their business relationship (the "Dispute") to the other party within thirty (30) days of the final decision date, action, omission or cause from which the Dispute arose, whichever is later (the "Dispute Date"). If the Dispute pertains to a matter which is generally administered by certain UBH procedures, such as a credentialing or quality improvement plan, the procedures set forth in that plan must be fully exhausted by Provider before Provider may invoke his or her rights as described herein. After receipt of the written notice of the Dispute, the parties agree to work together in good faith to resolve the Dispute. If the parties are unable to resolve the Dispute within thirty (30) days following receipt of the notice of the Dispute, and if either UBH, Provider or Payor desires to pursue formal resolution of the Dispute, then said party shall issue a notice of arbitration to the other parties. It is agreed that the parties

knowingly and voluntarily waive any right to a Dispute if arbitration is not initiated within one year after the Dispute Date.

Any arbitration proceeding under this Agreement shall be submitted to binding arbitration in accordance with the rules of the American Arbitration Association (“AAA”), and shall be conducted in a location agreed to by the parties or as selected by the AAA if the parties cannot agree on a location. The arbitrators may construe or interpret but shall not vary or ignore the terms of this Agreement, shall have no authority to award any punitive or exemplary damages, and shall be bound by controlling law. The parties acknowledge that because this Agreement affects interstate commerce the Federal Arbitration Act applies.

ARTICLE 8 Term and Termination

8.1 Term. This Agreement shall begin on the Effective Date and it shall remain in effect for one year, and shall automatically renew for successive 1-year terms until it is terminated in accordance with the provisions herein.

8.2 Termination. This Agreement may be terminated as follows:

- (a) by mutual agreement of UBH and Provider;
- (b) by either party upon 90 days prior written notice to the other party;
- (c) by either party, in the event of a material breach of this Agreement by the other party, upon 30 days prior written notice to the other party. The written notice shall specify the precise nature of the breach. In the event the breaching party cures the breach to the reasonable satisfaction of the non-breaching party, within 30 days after the non-breaching party's written notice, this Agreement shall not terminate;
- (d) by UBH immediately upon written notice to Provider, due to Provider's loss, suspension, restriction, probation, voluntary relinquishment, or any other adverse action taken against any of Provider's licenses or certification, or loss of insurance required under this Agreement;
- (e) by Provider upon 60 days prior written notice to UBH due to a unilateral amendment made to this Agreement pursuant to section 9.1;
- (f) by UBH in accordance with its credentialing plan;
- (g) by UBH immediately if UBH determines, in its sole discretion, that the health, safety or welfare of Members may be jeopardized by the continuation of this Agreement; or
- (h) by UBH in accordance with the Provider Manual or Protocols.

During periods of notice of termination, UBH reserves the right to transfer Members to another Participating Provider, and Provider agrees to cooperate and assist with such transfers.

If Provider is terminated through the UBH credentialing or recredentialing process, this Agreement shall be deemed terminated as of the date Provider has been terminated pursuant to a final action resulting from that process.

8.3 Information to Members. Provider acknowledges and agrees that UBH has the right to inform Members of Provider's termination and/or the notice of termination to Provider, and agrees to cooperate with UBH in matters concerning the termination/transition, and agrees to hold UBH harmless for exercising its rights hereunder. Provider also agrees to clearly inform Members of Provider's impending non-participation status upon the earlier of Member's next appointment or prior to the effective termination date.

8.4 Continuation of Services After Termination. At the option of UBH, Provider shall continue to provide MHSA Services authorized by UBH to Members who are receiving such services from Provider as of the effective date of termination of this Agreement, until Member can be satisfactorily transferred to another Participating Provider. Payor shall continue to pay Provider for such services at Provider's contracted rate.

ARTICLE 9 Miscellaneous

9.1 Amendment. UBH may amend this Agreement by sending notice of the amendment to Provider at least 30 days prior to its effective date. The Provider's signature is not required. It is agreed that this Agreement shall be automatically amended to comply with any and all applicable state or federal laws, regulations, statutes or the requirements of applicable regulatory authorities as of the effective date thereof, and which shall be deemed to be incorporated herein by reference as of its effective date. Likewise, if a Payor that is a governmental entity requires that certain provisions of this Agreement be removed, replaced, amended or that additional provisions be incorporated, such provisions shall be deemed to be removed, replaced, amended or additional provisions incorporated into this Agreement as of the effective date of such Payor requirement for all MHSA Services provided which are subject to such Payor requirements without the signature of Provider being required.

9.2 Assignment. UBH may assign all or any of its rights and responsibilities under this Agreement to any of its Affiliates. Provider may assign any of his or her rights and responsibilities under this Agreement to any person or entity only upon the prior written consent of UBH, which consent shall not be unreasonably withheld.

9.3 Administrative Responsibilities. UBH may delegate certain administrative responsibilities under this Agreement to another entity, including, but not limited to, its Affiliate or to Payor or its designee. In addition, certain Payor responsibilities may actually be performed by its designee.

9.4 Relationship Between UBH and Provider. The relationship between UBH and Provider is solely that of independent contractors and nothing in this Agreement or

otherwise shall be construed or deemed to create any other relationship, including one of employment, agency, joint venture or partnership.

9.5 Name, Symbol and Service Mark. During the term of this Agreement, Provider, UBH and Payor shall have the right to use each other's name solely to make public reference to Provider as a Participating Provider. Provider, UBH and Payor shall not otherwise use each other's name, symbol or service mark or that of their Affiliates without the prior written approval from the appropriate party.

9.6 Confidentiality. Neither party shall disclose to third parties any confidential or proprietary business information which it receives from the other party, including, but not limited to, financial statements, business plans, Protocols and programs; except that (a) Provider may disclose information to a Member relating to the Member's treatment plan and the payment methodology, but not specific rates; (b) UBH may disclose certain terms to Payors or designees that need the information to process claims or administer a Benefit Plan, and may file the form of this Agreement with any federal or state regulatory entity as may be required by applicable law; and (c) UBH shall be permitted to disclose, in its sole discretion, any other data or information that may be requested by applicable state and federal law, state regulations or governing agencies that pertain to this Agreement or that may relate to the enforcement of any right granted or term or condition of this Agreement.

9.7 Communication. UBH encourages Provider to discuss with Members treatment options and their associated risks and benefits, regardless of whether the treatment is covered under the Member's Benefit Plan. Nothing in this Agreement is intended to interfere with Provider's relationship with Members as patients of Provider, or with UBH's ability to administer its quality improvement, utilization management and credentialing programs.

9.8 Effects of New Statutes and Regulations and Changes of Conditions. The parties agree to re-negotiate this Agreement if either party would be materially adversely affected by continued performance as a result of a change in laws or regulations, a requirement that one party comply with an existing law or regulation contrary to the other party's prior reasonable understanding, or a change in UBH's arrangements with Payors. The party affected must promptly notify the other party of the change or required compliance and its desire to re-negotiate this Agreement. If a new agreement is not executed within 30 days of receipt of the re-negotiation notice, the party adversely affected shall have the right to terminate this Agreement upon 45 days prior written notice to the other party. Any such notice of termination must be given within 10 days following the expiration of the 30-day re-negotiation period.

9.9 Appendices. Additional and/or alternative provisions, if any, related to certain MHSA Services rendered by Provider to Members covered by certain Benefit Plans are set for in the Appendices.

9.10 Entire Agreement. On the Effective Date, this Agreement supersedes and replaces any existing Provider Agreements between the parties related to the provision

of MHSA Services, including any agreements between Provider and Affiliates of UBH for MHSA Services. This Agreement, together with any and all documents referenced herein, attachments, addenda, appendices, as may be amended or modified from time to time, whether contemporaneous or subsequently made pursuant to Section 9.1, are hereby incorporated herein by reference, and constitutes the entire agreement between the parties in regard to its subject matter (herein collectively referred to as this "Agreement").

9.11 Strict Compliance. The waiver of strict compliance or performance of any of the terms or conditions of this Agreement, the Provider Manual or the Protocols or of any breach thereof shall not be held or deemed to be a waiver of any subsequent failure to comply strictly with or perform the same or any other term or condition thereof or any breach thereof.

9.12 Severability. Should any provision of this Agreement violate the law or be held invalid or unenforceable as written by a court of competent jurisdiction, then said provision along with the remainder of this Agreement shall nonetheless be enforceable to the extent allowable under applicable law by first modifying said provision to the extent permitted so as to comply with applicable law; otherwise said provision shall be deemed void to the extent of such prohibition without invalidating the remainder of this Agreement.

9.13 Rules of Construction. In the event of any conflict between the terms of this Agreement and the terms of any other agreement or any other controlling document or any applicable state or federal laws, statutes and regulations relating to the subject matter hereof, the terms, except as otherwise expressly stated herein, shall first be read together to the extent possible; otherwise the terms that afford the greater protections to first UBH and second to the Benefit Plan shall prevail over the conflicting term, to the extent permitted by, in accordance with and subject to applicable law, statutes or regulations. The remainder of the Agreement shall otherwise remain without invalidating or deleting the remainder of the conflicting provision or the Agreement.

9.14 Governing Law. This Agreement shall be governed by and construed in accordance with applicable state and federal laws, statutes and regulations, including without limitation, ERISA.

9.15 Medicaid Members. If a Medicaid Appendix is attached to this Agreement Provider agrees to provide MHSA Services to Members enrolled in a Benefit Plan for Medicaid recipients and to comply with any additional requirements set forth in the Medicaid Appendix.

9.16 Medicare Members. If a Medicare Appendix is attached to this Agreement, Provider agrees to provide MHSA Services under this Agreement, to Members who are enrolled in a Benefit Plan for Medicare beneficiaries and to cooperate and comply with the provisions set forth in the attached Medicare Advantage Addendum. Provider also understands that UBH's agreements with Participating Providers are subject to review and approval by the Centers for Medicare and Medicaid Services ("CMS").

9.17 Survival. Upon any termination or expiration of this Agreement, the provisions herein which contemplates performance or observance subsequent to termination or expiration, including without limitation, sections 3.1, 3.2, 3.3, 3.6, 8.3, 8.4, 9.6 and Articles 6 and 7, shall survive and remain of full force and effect between the parties.

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

NAME OF PROVIDER

Attn: _____

Signature_____

Print Name_____

Title_____

Date_____

Federal Tax ID Number: _____

Medicare Number:_____

Medicaid Number:_____

UNITED BEHAVIORAL HEALTH GROUP PARTICIPATING PROVIDER AGREEMENT

THIS AGREEMENT, is between United Behavioral Health ("UBH") and the undersigned group provider (hereinafter referred to as the "Provider"). This Agreement will become effective upon the date set forth in UBH's executed Acceptance Letter (the "Effective Date"). This Agreement sets forth the terms and conditions under which Provider shall participate in one or more networks developed by UBH and to Provider by UBH as a Participating Provider of Covered Services to Members.

ARTICLE 1 Definitions

Any capitalized term herein shall have the meaning as set forth in this Agreement. Any undefined term herein shall have the meaning as defined in the Provider Manual, the Protocols, or as may be defined by applicable state or federal laws or regulations, as applicable.

Affiliate: Each and every entity or business concern with which UBH, directly or indirectly, in whole or in part, either: (i) owns or controls; (ii) is owned or controlled by; or (iii) is under common ownership or control.

Benefit Plan: The specific plan of benefits for health care coverage, including MHSA Services, for a particular Member that is provided, sponsored or administered by UBH directly or through its Affiliate, or through a network rental arrangement UBH may have with a third-party, and contains the terms and conditions of a Member's coverage for MHSA Services, including applicable Member Expenses, exclusions and limitations, and all other provisions applicable to the coverage of such MHSA Services such as services rendered outside specified networks.

CMHC: A Community Mental Health Center.

CMHC Provider: An employee of a CMHC who provides mental health and/or substance abuse services, but is not a CMHC Supervising Provider.

CMHC Supervising Provider: A psychiatrist, psychologist, social worker, family or other therapist duly licensed and qualified in the state in which MHSA Services are provided to Members who practices as an employee of CMHC and has been approved as a CMHC Supervising Provider in writing by UBH.

Covered Services: MHSA Services that meet the terms and conditions for coverage pursuant to the Member's Benefit Plan, including such conditions as Medically Necessary and proper authorization, and in accordance with the Provider Manual, Protocols, and applicable laws and regulations.

Customary Charge: The fee for MHSA Services charged by Provider that does not exceed the fee Provider would ordinarily charge any other person regardless of whether the person is a Member.

Emergency Services: Unless otherwise defined by applicable state law, a serious health condition that arises suddenly and requires immediate care and treatment, generally received within twenty-four (24) hours of onset, to stabilize or avoid jeopardy to the life or health of a Member or, by actions of the Member, to the life or health of another. Emergency Services shall be available twenty-four (24) hours per day, seven (7) days per week.

Fee Maximums: The maximum amount Provider may receive as payment for provision of Covered Services to a Member, including Member Expenses, that are applicable to Provider and/or the Benefit Plan, as determined from time to time by UBH. UBH will provide the then-current Fee Maximums to Provider upon request.

Group-based Provider: A health care professional, CMHC Supervising Provider, psychiatrist, psychologist, therapist or other behavioral health professional who is employed by or under contract or supervision to render MHSA Services to Members.

Group Participating Provider: An entity, organization, group, partnership or affiliation however categorized, consisting of health care professionals, facilities, CMHC Supervising Providers, psychiatrists, psychologists, therapists or other behavioral health professionals that is duly licensed or certified to provide MHSA Services within the state such that MHSA Services are provided, and who has a written Group Participating Provider Agreement in effect with UBH, directly or through another entity, to provide MHSA Services to Members.

Medicaid: A Medical Assistance Program providing health coverage benefits for low income persons pursuant to applicable state and federal laws and regulations.

Medically Necessary: Except as otherwise required by applicable state or federal law or regulations, for purposes of this Agreement, Medically Necessary means the term as it may be described in the Member's Benefit Plan for MHSA Services and which meets Payor's defined criteria for coverage as Covered Services. It may also, when applicable, have the meaning defined within the Protocols. Generally, however, Medically Necessary means treatment that is commonly recognized in the industry as consistent treatment that must be: (a) solely to treat the condition of the Member; (b) for the illness or injury of a diagnosis that is commonly recognized as a disease or injury; (c) reasonably expected to directly result in the restoration of health or function; (d) not experimental or investigational but is consistent with established and accepted national medical practice guidelines regarding type, frequency and duration of treatment; (e) without alternative treatment that is less intensive or invasive for the efficient treatment of the Member's condition; (f) not based on convenience for the Member; and (g) not otherwise excluded from the definition of Covered Services based upon the terms and conditions of the Member's Benefit Plan.

Medicare: Federally sponsored program providing health coverage benefits to individuals of qualifying age, disability, or disease.

Member: An individual who is eligible for, properly enrolled in, and covered under a Benefit Plan.

Member Expenses: Any amount of Customary Charges that are the Member's responsibility to pay Provider in accordance with the terms of the Member's Benefit Plan, including co-payments, co-insurance and deductible amounts.

Mental Health and Substance Abuse Services ("MHSA Services"): Health care services, treatment or supplies that are used to treat a mental health or substance abuse illness, condition or disease and which may be eligible for coverage under the Member's Benefit Plan.

Payment Policies: Guidelines adopted by UBH, from time to time, for calculating payment of claims under Benefit Plans.

Payor: The entity or person that has the financial responsibility for funding payment of Covered Services on behalf of a Member, and that is authorized to access MHSA Services in accordance with this Agreement.

Protocols: The programs, policies, protocols, processes, procedures, and requirements as such may change or be modified from time to time, and that are adopted by UBH or Payor, and which Provider agrees to follow as a condition of UBH accepting Provider as a Participating Provider, including, but not limited to, authorization procedures, credentialing and re-credentialing processes and plans, utilization management and care management processes, billing procedures, Payment Policies, providing or arranging for Emergency Services, quality improvement, peer review, on-site review, Member grievance and appeals processes, and any other policies, procedures, processes, activities or standards, wherever located as may apply to Provider's rights, obligations or responsibilities as a Provider of MHSA Services, whether in this Agreement, Provider Manual, or any other document as made accessible or available to Provider from time to time.

Provider Manual: A document or manual, however known or named, such as the Network Manual, containing the administrative policies, procedures and Protocols applicable to Benefit Plans provided, sponsored or administered by UBH or a Payor including, but not limited to, policies and procedures for credentialing, claims, quality improvement, and utilization management to which Provider is obligated.

ARTICLE 2 Duties of Provider

2.1 Provision of MHSA Services. Provider hereby acknowledges and agrees to cooperate and comply with all of the terms and conditions of the Provider Manual, Protocols, and this Agreement, and to dutifully perform as a Participating Provider for the provision of MHSA Services to Members within the UBH network(s) as designated by UBH or Payor. At the request of a Payor, Provider or Group-based Provider may not be authorized to provide MHSA Services for some or all of Payor's Members. Provider shall otherwise accept Members as new patients on the same basis as Provider is

accepting non-Members as new patients without regard to race, religion, gender, color, national origin, age or physical or mental health status, or on any other basis deemed unlawful under federal, state or local law. At all times, Provider shall require any employed or subcontracted health care professionals and facilities to comply with the terms and conditions of this Agreement, all Protocols of UBH and Payor, the Provider Manual, as well as the requirements of all applicable laws and regulations.

2.2 Benefit Plan & Eligibility. MHSA Services provided by Provider to a Member pursuant to this Agreement are subject to all the terms and conditions of the Member's Benefit Plan including eligibility of the Member on the date MHSA Services are provided to the Member. Provider shall make reasonable effort to verify Member's eligibility at time of service by following appropriate procedures, including without limitation, and at a minimum, the terms and conditions of this Agreement, Protocols, the Provider Manual, and review of the Member's Benefit Plan identification card. Provider however recognizes that the Member eligibility information may be inaccurate at the time Provider obtains verification and that the Member, or the MHSA Services provided to the Member, may later be determined to be ineligible for coverage and, except as otherwise required by law, not eligible for payment under this Agreement. Under such circumstances, Provider may then, except as otherwise stated herein, directly bill the Member or other responsible party for such MHSA Services.

2.3 Provider Manual & Protocols. Provider shall be bound by, accept, strictly comply with, and cooperate with, the requirements set forth in the Provider Manual, credentialing plan, and all Protocols, as amended or modified from time to time by UBH and/or Payor, all of which are hereby incorporated herein by reference as if set forth fully herein, including without limitation quality improvement activities. Provider acknowledges and agrees that the Provider Manual and/or Protocols may contain service and contract requirements of certain Payors to which Provider shall strictly comply. Provider's failure to comply with the Provider Manual, Protocols and any other standards, procedures or policies may result in loss of, or reduction of payment or reimbursement to Provider, termination of this Agreement or the imposition of other corrective action by UBH.

2.4 Authorization Requirements. Subject to all applicable terms and conditions, including without limitation Section 2.2 above, and in accordance with the Provider Manual, Protocols, and requirements of the Member's Benefit Plan regarding authorization, Provider must request authorization for MHSA Services from UBH either telephonically or by another approved and accepted method recognized by UBH before providing any MHSA Services to a Member as a Covered Service. Authorizations shall subsequently be confirmed by UBH in writing. Except as otherwise permitted herein, only Emergency Services will be eligible for retroactive authorization at the sole discretion of UBH or as required by applicable law. Any authorization resulting from wrongful, fraudulent or negligent actions of Provider or a breach of this Agreement shall be null and void as of the time given.

2.5 Provider's Standard of Care. Nothing in this Agreement, the Provider Manual, the Benefit Plan, or the Protocols, including without limitation, UBH's utilization

management and quality assurance and improvement standards and procedures, shall dictate MHSA Services provided by Provider or otherwise diminish Provider's obligation to freely communicate with and/or provide MHSA Services to Members in accordance with the applicable standard of care.

2.6 Continuity of Care; Referral to Other Health Professionals. Provider shall furnish Covered Services in a manner providing continuity of care and ready referral of Members to other Participating Providers at times as may be appropriate and consistent with the standards of care in the community. If a Member requires additional services or evaluation, including Emergency Services, Provider agrees to refer Member to his/her primary care physician or another Participating Provider in accordance with the terms and conditions of Member's Benefit Plan. A Member requiring Emergency Services shall also be referred to the "9-1-1" emergency response system.

2.7 Member Access to Care. Provider shall ensure that Members have timely and reasonable access to MHSA Services and shall at all times be reasonably available to Members as is appropriate. If Provider is unavailable when Members call, instructions must be provided for the Member referring the Member to another Participating Provider or to his/her Benefit Plan. Provider shall arrange for an answering machine or service that shall provide the office hours and emergency information and be capable of receiving messages 24 hours a day.

2.8 Employees and Contractors of Provider. Provider will be responsible for and shall ensure that all of its employees and contractors are bound by, and meet the terms and conditions of, this Agreement, the Provider Manual and Protocols, at the time of providing Covered Services to Members. Failure of such employees or contractors to meet such terms and conditions, including without limitation, credentialing requirements, UBH may restrict them from providing Covered Services to Members.

2.9 Credentialing. Provider shall provide UBH with the criteria utilized by Provider pursuant to its applicable or required criteria to select and credential employed or subcontracted health care professionals, including, but not limited to, Group-based Providers. UBH shall have the right to audit such criteria upon reasonable advance written notice to Provider.

2.10 Payment of Services. All payments obligated by Payor shall be paid to Provider and Provider will be solely responsible for payments to its employees, contractors and Group-based Providers who may have provided MHSA Services. Provider agrees to defend, indemnify and hold UBH harmless for any claims, damages, actions, or judgments arising from any employee or contractor of Provider related to the provision of MHSA Services to Members.

ARTICLE 3 Payment Provisions

3.1 Payment for Covered Services. In accordance with the terms and conditions hereof, Payor shall pay Provider for Covered Services provided to a Member by

Provider. Payment shall be the lesser of: (a) Provider's Customary Charge, less any applicable Member Expenses; or (b) the Fee Maximum for such MHSA Services, less any applicable Member Expenses, and in accordance with the Standard Payment Appendix(ces) attached hereto, if any.

Subject to the terms and conditions herein, the obligation for payment for Covered Services provided to a Member, less any applicable Member Expenses, is solely that of Payor. Additionally, UBH may arrange for claims processing services. When UBH is the Payor, UBH shall make obligated claim payments to Provider within 45 days (and shall use best efforts to encourage a third-party Payor to make payments within 45 days), or as otherwise required by law, of the date Payor receives all information necessary to process and pay a clean claim, except for claims for which there is coordination of benefits, Member Expense adjustments, disputes about coverage, systems failure or other such causes.

In the event a Member's Benefit Plan provides for a Member Expense whether stated as a flat fee or a percentage, the amount of the Member Expense shall be calculated in accordance with the Member's Benefit Plan or as determined by the Payor. The amount calculated pursuant to the preceding sentence shall be deducted from the amount Provider is to be paid for the Covered Services pursuant to this Agreement.

3.2 Submission of Claims. Provider shall submit claims for MHSA Services to UBH in a manner and format prescribed by UBH, whether in Protocols or otherwise, and which may be in an electronic format. All information necessary to process the claims must be received by UBH no more than 90 days from the date the MHSA Services are rendered. Provider agrees that claims received after this time period may be rejected for payment, at UBH's and/or Payor's sole discretion.

Unless otherwise directed by UBH, Provider shall submit claims using current CMS (HCFA) 1500 or UB04 forms, whichever is appropriate, with applicable coding including, but not limited to, ICD9, CPT, Revenue and HCPCS coding. Provider shall include in a claim the Member number, Customary Charges for the MHSA Services rendered to a Member during a single instance of service, Provider's Federal Tax I.D. number and/or other identifiers requested by UBH.

Payor shall have the right to make, and Provider shall have the right to request, corrective adjustments to a previous payment; provided however, that Payor shall have no obligation to pay additional amounts after 12 months from the date the initial claim was paid.

3.3 Payment in Full. Provider shall accept as payment in full for Covered Services rendered to Members such amounts as are paid by Payor pursuant to this Agreement and shall not bill Members for non-covered charges, other than Member Expenses, which result from Payor's reimbursement methodologies. In no event shall Provider bill a Member for the difference between Customary Charges and the amount Provider has agreed to accept as full reimbursement under this Agreement. Provider may collect Member Expenses from the Member. If Payor denies payment for services rendered by

Provider on grounds that the services are not Medically Necessary, Provider shall not collect payment from the Member for the services unless the Member has knowledge of the determination of lack of Medical Necessity and has subsequently agreed in writing to be responsible for such charges and MHSA Services. Further, if any payment to Provider is denied, in part or full, due to Provider's failure to strictly comply with any term or condition in this Agreement, the Provider Manual, the Protocols, including without limitation, obtaining prior authorization, untimely filing of a claim, inaccurate or incorrect submission of or claim processing, or the insolvency of Payor pursuant to applicable law, it is agreed that Provider shall not, except for applicable Member Expenses, bill the Member or otherwise, directly or indirectly, seek or collect payment from the Member for any of the denied amounts. Any violation hereof by Provider shall be deemed a material breach. This provision shall apply regardless of whether any waiver or other document of any kind purporting to allow Provider to collect payment from the Member exists. These provisions shall survive the termination hereof and shall be construed to be for the benefit of the Member.

3.4 Coordination of Benefits. Provider shall be paid in accordance with Payor's coordination of benefits rules.

3.5 Financial Responsibility. In the event of a default (meaning a systematic failure by Payor to fund undisputed claim payments for Covered Services) by a Payor, except when due to the insolvency of Payor, UBH shall notify Provider in writing of such default following UBH's determination thereof. Any services which have been rendered by Provider prior to or after such notification, and which have not been paid for by Payor, shall be considered ineligible for reimbursement under this Agreement, and Provider may seek payment directly from the Payor and Member for such services.

3.6 Member Protection Provision. This provision supersedes and replaces the Financial Responsibility section (section 3.5 above) only in those cases where UBH, or its Affiliate, is the Payor, or when required by another specific Payor, or when required pursuant to applicable laws, statutes and regulations.

In no event, including, but not limited to, non-payment by Payor for MHSA Services rendered to Members by Provider, insolvency of Payor, or breach by UBH of any term or condition of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member or persons acting on behalf of the Member for MHSA Services eligible for reimbursement under this Agreement; provided, however, that Provider may collect from the Member, any Member Expenses or charges for services that are not covered as benefits under the Member's Benefit Plan.

The provisions of this Article shall apply to all Member protection provisions in this Agreement and shall: (a) apply to all MHSA Services rendered while this Agreement is in force; (b) survive the termination of this Agreement regardless of the cause of termination; (c) be construed to be for the benefit of the Members; and (d) except as otherwise stated in section 3.3, supersede any oral or written agreement,

existing or subsequently entered into, between Provider and a Member or person acting on a Member's behalf, that requires the Member to pay for such MHSA Services.

3.7 Contracted Rate for Members. Provider agrees to continue to provide MHSA Services to Members who have exhausted his/her covered benefits under the Benefit Plan and agrees not to collect or charge more than the contracted rate for those MHSA Services. Provider may bill the Member directly for those MHSA Services for which there is no longer any coverage under the Benefit Plan, in accordance herewith.

ARTICLE 4

Laws, Regulations, and Licenses, and Liabilities of Parties

4.1 Laws, Regulations and Licenses. Provider shall maintain in good standing all federal, state and local licenses, certifications and permits -- without sanction, revocations, suspension, censure, probation or material restriction -- which are required to provide health care services according to the laws of the jurisdiction in which MHSA Services are provided, and shall comply with all applicable statutes and regulations. Provider shall also require that all health care professionals employed by or under contract with Provider to render MHSA Services to Members, including covering Providers, comply with this provision.

4.2 Responsibility for Damages. Any and all damages, claims, liabilities or judgments, attorney fees, which may arise as a result of Provider's or its employee's or contractor's negligence or intentional wrongdoing shall be the sole responsibility of Provider.

4.3 Provider Liability Insurance. Provider shall procure and maintain, at Provider's sole expense, (a) medical malpractice or professional liability insurance in the amount of \$1,000,000 per occurrence and \$3,000,000 in aggregate if Provider is a Medical Doctor and \$1,000,000 per occurrence and in aggregate if Provider is not a Medical Doctor; and (b) comprehensive general and/or umbrella liability insurance in the amount of \$1,000,000 per occurrence and in aggregate. Provider shall also require that all health care professionals employed by or under contract with Provider to render MHSA Services to Members procure and maintain malpractice insurance, unless they are covered under Provider's insurance policies.

Provider's and other health care professionals' medical malpractice insurance shall be on either an "occurrence" or "claims made" basis provided that for a "claims made" policy, such policy must be written with an extended period reporting option under such terms and conditions as may be reasonably required by UBH. Prior to the Effective Date of this Agreement and at each policy renewal thereafter, Provider shall submit to UBH in writing evidence of insurance coverage.

ARTICLE 5

Notices

5.1 Notices. Provider shall notify UBH within ten (10) days of knowledge of any of the following:

- (a) changes in liability insurance carriers, termination of, renewal of or any other material changes in Provider's liability insurance, including reduction of limits, erosion of aggregate, changes in retention or non-payment of premium;
- (b) action which may result in or the actual suspension, sanction, revocation, condition, limitation, qualification or other material restriction on Provider's licenses, certifications or permits by any government or applicable accrediting or regulatory agency under which Provider is accredited or regulated by or authorized to provide health care services, including without limitation, any action concerning Provider's credentialing criteria or the performance of its employees, contractors or its Group-based Providers; or any suspension, revocation, condition, limitation, qualification or other material restriction of Provider's staff privileges at any licensed hospital, nursing home or other facility at which Provider has staff privileges during the term of this Agreement;
- (c) a change in Provider's name, address, ownership or Federal Tax I.D. number;
- (d) indictment, arrest or conviction for a felony or for any criminal charge related to the practice of Provider's profession;
- (e) claims or legal actions for professional negligence or bankruptcy;
- (f) provider's termination, for cause, from any other provider network offered by any plan, including, without limitation, any health care service plan, health maintenance organization, any health insurer, any preferred provider organization, any employer or any trust fund;
- (g) any occurrence or condition that might materially impair the ability of Provider or Group-based Provider to perform its duties under this Agreement; or
- (h) any condition or circumstance that may pose a direct threat to the safety of Provider, Providers' staff, Group-based Provider or Members.

Unless otherwise specified in this Agreement, each and every notice and communication to the other party shall be in writing. All written notices or communication shall be deemed to have been given when delivered in person; or, on the date mailed, if delivered by first-class mail, proper postage prepaid and properly addressed to the appropriate party at the address set forth at the signature portion of this Agreement or to another address of which sending party has been notified, including without limitation, to UBH's Network Manager at the applicable address for notice as identified in the Provider Manual or Protocols. The parties shall, by written notice, provide and update each other with the most current address and names of all parties or designees that should receive certain notices or communication.

ARTICLE 6

Records

6.1 Confidentiality of Records. UBH and Provider shall maintain the confidentiality of all Member information and records in accordance with all applicable state and federal laws, statutes and regulations, including without limitation, the Health Insurance Portability and Accountability Act.

6.2 Maintenance of and UBH Access to Records. Provider shall maintain adequate medical, treatment, financial and administrative records related to MHSA Services provided by Provider under this Agreement for a period and in a manner consistent with the standards of the community and in accordance with the Provider Manual, Protocols and all applicable state and federal laws, statutes and regulations.

In order to perform its utilization management and quality improvement activities, UBH shall have access to such information and records, including claim records, within 14 days from the date the request is made, except that in the case of an audit by UBH, such access shall be given at the time of the audit. If requested by UBH, Provider shall provide copies of such records free of charge. During the term of this Agreement UBH shall have access to and the right to audit information and records to the extent permitted by the Provider Manual, or as otherwise required by state or federal laws, statutes or regulations or regulatory authority. Said rights shall continue following the termination hereof for the longer of three years or for such period as may be permitted by applicable state or federal law, regulatory authority, or Protocols.

It is Provider's responsibility to obtain any Member's consent in order to provide UBH with requested information and records or copies of records and to allow UBH to release such information or records to Payors as necessary for the administration of the Benefit Plan or compliance with any state or federal laws, statutes and regulations applicable to the Payors.

Provider acknowledges that in receiving, storing, processing or otherwise dealing with information from UBH or Payor about Members, it is fully bound by the provisions of the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2; and Provider agrees that it will resist in judicial proceedings any effort to obtain access to information pertaining to patients otherwise than as expressly provided for in the federal confidentiality regulations, 42 CFR Part 2.

This section shall not be construed to grant UBH access to Provider's records that are created for purposes of assessing Provider's financial performance or for Provider's peer review activities, except to the extent the federal and/or state government and any of their authorized representatives have access to such records pursuant to Section 6.3.

6.3 Government and Accrediting Agency Access to Records. It is agreed that the federal, state and local government, or accrediting agencies including, but not limited to, the National Committee for Quality Assurance (the "NCQA"), and any of their authorized representatives, shall have access to, and UBH and Provider are authorized to release, in accordance with applicable statutes and regulations, all information and records or copies of such, within the possession of UBH or Provider, which are pertinent to and involve transactions related to this Agreement if such access is necessary to comply with accreditation standards, statutes or regulations applicable to UBH, Payor or Provider. Such access shall be available and provided during the term of this Agreement and for three years following the termination hereof, or such longer period

as may be identified in the Provider Manual or Protocols or as required by applicable state or federal laws, statutes or regulations.

ARTICLE 7 Resolution of Disputes

7.1 Resolution of Disputes. It is agreed that prior to any other remedy available to the parties, UBH, Payor and/or Provider shall provide written notice of any disputes or claims arising out of their business relationship (the "Dispute") to the other party within thirty (30) days of the final decision date, action, omission or cause from which the Dispute arose, whichever is later (the "Dispute Date"). If the Dispute pertains to a matter which is generally administered by certain UBH procedures, such as a credentialing or quality improvement plan, the procedures set forth in that plan must be fully exhausted by Provider before Provider may invoke his or her rights as described herein. After receipt of the written notice of the Dispute, the parties agree to work together in good faith to resolve the Dispute. If the parties are unable to resolve the Dispute within thirty (30) days following receipt of the notice of the Dispute, and if either UBH, Provider or Payor desires to pursue formal resolution of the Dispute, then said party shall issue a notice of arbitration to the other parties. It is agreed that the parties knowingly and voluntarily waive any right to a Dispute if arbitration is not initiated within one year after the Dispute Date.

Any arbitration proceeding under this Agreement shall be submitted to binding arbitration in accordance with the rules of the American Arbitration Association ("AAA"), and shall be conducted in a location agreed to by the parties or as selected by the AAA if the parties cannot agree on a location. The arbitrators may construe or interpret but shall not vary or ignore the terms of this Agreement, shall have no authority to award any punitive or exemplary damages, and shall be bound by controlling law. The parties acknowledge that because this Agreement affects interstate commerce the Federal Arbitration Act applies.

ARTICLE 8 Term and Termination

8.1 Term. This Agreement shall begin on the Effective Date and it shall remain in effect for one year, and shall automatically renew for successive 1-year terms until it is terminated in accordance with the provisions herein.

8.2 Termination. This Agreement may be terminated as follows:

- (a) by mutual agreement of UBH and Provider;
- (b) by either party upon 90 days prior written notice to the other party;
- (c) by either party, in the event of a material breach of this Agreement by the other party, upon 30 days prior written notice to the other party. The written notice shall specify the precise nature of the breach. In the event the breaching party cures the breach to the reasonable satisfaction of the non-

- breaching party, within 30 days after the non-breaching party's written notice, this Agreement shall not terminate;
- (d) by UBH immediately upon written notice to Provider, due to Provider's loss, suspension, restriction, probation, voluntary relinquishment, or any other adverse action taken against any of Provider's or Group-based Providers licenses or certifications, or loss of insurance required under this Agreement, or failure to materially perform its credentialing and/or supervision of its employees, contractors or Group-based Providers;
 - (e) by Provider upon 60 days prior written notice to UBH due to a unilateral amendment made to this Agreement pursuant to section 9.1;
 - (f) by UBH in accordance with its credentialing plan;
 - (g) by UBH immediately if UBH determines, in its sole discretion, that the health, safety or welfare of Members may be jeopardized by the continuation of this Agreement; or
 - (h) by UBH in accordance with the Provider Manual or Protocols.

During periods of notice of termination, UBH reserves the right to transfer Members to another Participating Provider, and Provider agrees to cooperate and assist with such transfers.

If Provider is terminated through the UBH credentialing or recredentialing process, this Agreement shall be deemed terminated as of the date Provider has been terminated pursuant to a final action resulting from that process.

8.3 Information to Members. Provider acknowledges and agrees that UBH has the right to inform Members of Provider's termination and/or the notice of termination to Provider, and agrees to cooperate with UBH in matters concerning the termination/transition, and agrees to hold UBH harmless for exercising its rights hereunder. Provider also agrees to clearly inform Members of Provider's impending non-participation status upon the earlier of Member's next appointment or prior to the effective termination date.

8.4 Continuation of Services After Termination. At the option of UBH, Provider shall continue to provide MHSA Services authorized by UBH to Members who are receiving such services from Provider as of the effective date of termination of this Agreement, until Member can be satisfactorily transferred to another Participating Provider. Payor shall continue to pay Provider for such services at Provider's contracted rate.

8.5 Termination of Group-based Provider. A Group-based Provider's participation with UBH may be individually terminated under the same conditions Provider's participation may be terminated, as specified above. In addition, a Group-based Provider's participation with UBH may be terminated by UBH (a) immediately upon written notice to Provider due to Group-based Provider loss or suspension of licensure or certification; (b) failure to abide by established criteria as required by section 2.9; (c) loss of insurance as required under this Agreement; or (d) in accordance with UBH's credentialing process.

Furthermore, it is agreed that upon any such termination of a Group-based Provider pursuant to this section 8.5 that UBH shall deliver notice to Provider of such a termination, that Group-based Provider shall not provide MHSA Services to any Member as of the termination date of the Group-based Provider, unless otherwise agreed to by UBH in writing, and that this Agreement shall not be terminated, absent notice otherwise, upon the termination of any Group-based Provider.

ARTICLE 9 Miscellaneous

9.1 Amendment. UBH may amend this Agreement by sending notice of the amendment to Provider at least 30 days prior to its effective date. The Provider's signature is not required. It is agreed that this Agreement shall be automatically amended to comply with any and all applicable state or federal laws, regulations, statutes or the requirements of applicable regulatory authorities as of the effective date thereof, and which shall be deemed to be incorporated herein by reference as of its effective date. Likewise, if a Payor that is a governmental entity requires that certain provisions of this Agreement be removed, replaced, amended or that additional provisions be incorporated, such provisions shall be deemed to be removed, replaced, amended or additional provisions incorporated into this Agreement as of the effective date of such Payor requirement for all MHSA Services provided which are subject to such Payor requirements without the signature of Provider being required.

9.2 Assignment. UBH may assign all or any of its rights and responsibilities under this Agreement to any of its Affiliates. Provider may assign any of his or her rights and responsibilities under this Agreement to any person or entity only upon the prior written consent of UBH, which consent shall not be unreasonably withheld.

9.3 Administrative Responsibilities. UBH may delegate certain administrative responsibilities under this Agreement to another entity, including, but not limited to, its Affiliate or to Payor or its designee. In addition, certain Payor responsibilities may actually be performed by its designee.

9.4 Relationship Between UBH and Provider. The relationship between UBH and Provider is solely that of independent contractors and nothing in this Agreement or otherwise shall be construed or deemed to create any other relationship, including one of employment, agency, joint venture or partnership.

9.5 Name, Symbol and Service Mark. During the term of this Agreement, Provider, UBH and Payor shall have the right to use each other's name solely to make public reference to Provider as a Participating Provider. Provider, UBH and Payor shall not otherwise use each other's name, symbol or service mark or that of their Affiliates without the prior written approval from the appropriate party.

9.6 Confidentiality. Neither party shall disclose to third parties any confidential or proprietary business information which it receives from the other party, including, but not limited to, financial statements, business plans, Protocols and programs; except that (a)

Provider may disclose information to a Member relating to the Member's treatment plan and the payment methodology, but not specific rates; (b) UBH may disclose certain terms to Payors or designees that need the information to process claims or administer a Benefit Plan, and may file the form of this Agreement with any federal or state regulatory entity as may be required by applicable law; and (c) UBH shall be permitted to disclose, in its sole discretion, any other data or information that may be requested by applicable state and federal law, state regulations or governing agencies that pertain to this Agreement or that may relate to the enforcement of any right granted or term or condition of this Agreement.

9.7 Communication. UBH encourages Provider to discuss with Members treatment options and their associated risks and benefits, regardless of whether the treatment is covered under the Member's Benefit Plan. Nothing in this Agreement is intended to interfere with Provider's relationship with Members as patients of Provider, or with UBH's ability to administer its quality improvement, utilization management and credentialing programs.

9.8 Effects of New Statutes and Regulations and Changes of Conditions. The parties agree to re-negotiate this Agreement if either party would be materially adversely affected by continued performance as a result of a change in laws or regulations, a requirement that one party comply with an existing law or regulation contrary to the other party's prior reasonable understanding, or a change in UBH's arrangements with Payors. The party affected must promptly notify the other party of the change or required compliance and its desire to re-negotiate this Agreement. If a new agreement is not executed within 30 days of receipt of the re-negotiation notice, the party adversely affected shall have the right to terminate this Agreement upon 45 days prior written notice to the other party. Any such notice of termination must be given within 10 days following the expiration of the 30-day re-negotiation period.

9.9 Appendices. Additional and/or alternative provisions, if any, related to certain MHSA Services rendered by Provider to Members covered by certain Benefit Plans, rates, and fees are set for in the Appendices, Attachments and Addendum.

9.10 Entire Agreement. On the Effective Date, this Agreement supersedes and replaces any existing Provider Agreements between the parties related to the provision of MHSA Services, including any agreements between Provider and Affiliates of UBH for MHSA Services. This Agreement, together with any and all documents referenced herein, attachments, addenda, appendices, as may be amended or modified from time to time, whether contemporaneous or subsequently made pursuant to Section 9.1, are hereby incorporated herein by reference, and constitutes the entire agreement between the parties in regard to its subject matter (herein collectively referred to as this "Agreement").

9.11 Strict Compliance. The waiver of strict compliance or performance of any of the terms or conditions of this Agreement, the Provider Manual or the Protocols or of any breach thereof shall not be held or deemed to be a waiver of any subsequent failure to

comply strictly with or perform the same or any other term or condition thereof or any breach thereof.

9.12 Severability. Should any provision of this Agreement violate the law or be held invalid or unenforceable as written by a court of competent jurisdiction, then said provision along with the remainder of this Agreement shall nonetheless be enforceable to the extent allowable under applicable law by first modifying said provision to the extent permitted so as to comply with applicable law; otherwise said provision shall be deemed void to the extent of such prohibition without invalidating the remainder of this Agreement.

9.13 Rules of Construction. In the event of any conflict between the terms of this Agreement and the terms of any other agreement or any other controlling document or any applicable state or federal laws, statutes and regulations relating to the subject matter hereof, the terms, except as otherwise expressly stated herein, shall first be read together to the extent possible; otherwise the terms that afford the greater protections to first UBH and second to the Benefit Plan shall prevail over the conflicting term, to the extent permitted by and in accordance with and subject to applicable law, statutes or regulations. The remainder of the Agreement shall otherwise remain without invalidating or deleting the remainder of the conflicting provision or the Agreement.

9.14 Governing Law. This Agreement shall be governed by and construed in accordance with applicable state and federal laws, statutes and regulations, including without limitation, ERISA.

9.15 Medicaid Members. If a Medicaid Appendix is attached to this Agreement Provider agrees to provide MHSA Services to Members enrolled in a Benefit Plan for Medicaid recipients and to comply with any additional requirements set forth in the Medicaid Appendix.

9.16 Medicare Members. If a Medicare Appendix is attached to this Agreement, Provider agrees to provide MHSA Services under this Agreement, to Members who are enrolled in a Benefit Plan for Medicare beneficiaries and to cooperate and comply with the provisions set forth in the attached Medicare Advantage Addendum. Provider also understands that UBH's agreements with Participating Providers are subject to review and approval by the Centers for Medicare and Medicaid Services ("CMS").

9.17 Survival. Upon any termination or expiration of this Agreement, the provisions herein which contemplates performance or observance subsequent to termination or expiration, including without limitation, sections 2.9, 2.10, 3.1, 3.2, 3.3, 3.6, 8.3, 8.4, 9.6 and Articles 6 and 7, shall survive and remain of full force and effect between the parties.

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

NAME OF PROVIDER

Attn: _____

Signature_____

Print Name_____

Title_____

Date_____

Federal Tax ID Number: _____

Medicare Number:_____

Medicaid Number:_____

UNITED BEHAVIORAL HEALTH FACILITY PARTICIPATING PROVIDER AGREEMENT

THIS AGREEMENT is between United Behavioral Health ("UBH") and the undersigned facility provider (hereinafter referred to as the "Provider"). This Agreement will become effective upon the date set forth in UBH's executed Acceptance Letter (the "Effective Date"). This Agreement sets forth the terms and conditions under which Provider shall participate in one or more networks developed by UBH and to Provider by UBH as a Participating Provider of Covered Services to Members.

ARTICLE 1 Definitions

Any capitalized term herein shall have the meaning as set forth in this Agreement. Any undefined term herein shall have the meaning as defined in the Provider Manual, the Protocols, or as may be defined by applicable state or federal laws or regulations, as applicable.

Affiliate: Each and every entity or business concern with which UBH, directly or indirectly, in whole or in part, either: (i) owns or controls; (ii) is owned or controlled by; or (iii) is under common ownership or control.

Benefit Plan: The specific plan of benefits for health care coverage, including MHSA Services, for a particular Member that is provided, sponsored or administered by UBH directly or through its Affiliate, or through a network rental arrangement UBH may have with a third-party, and contains the terms and conditions of a Member's coverage for MHSA Services, including applicable Member Expenses, exclusions and limitations, and all other provisions applicable to the coverage of such MHSA Services such as services rendered outside specified networks.

CMHC: A Community Mental Health Center.

CMHC Provider: An employee of a CMHC who provides mental health and/or substance abuse services, but is not a CMHC Supervising Provider.

CMHC Supervising Provider: A psychiatrist, psychologist, social worker, family or other therapist duly licensed and qualified in the state in which MHSA Services are provided to Members who practices as an employee of CMHC and has been approved as a CMHC Supervising Provider in writing by UBH.

Covered Services: MHSA Services that meet the terms and conditions for coverage pursuant to the Member's Benefit Plan, including such conditions as Medically Necessary and proper authorization, and in accordance with the Provider Manual, Protocols, and applicable laws and regulations.

Customary Charge: The fee for MHSA Services charged by Provider that does not exceed the fee Provider would ordinarily charge any other person regardless of whether the person is a Member.

Emergency Services: Unless otherwise defined by applicable state law, a serious health condition that arises suddenly and requires immediate care and treatment, generally received within twenty-four (24) hours of onset, to stabilize or avoid jeopardy to the life or health of a Member or, by actions of the Member, to the life or health of another. Emergency Services shall be available twenty-four (24) hours per day, seven (7) days per week.

Facility-based Provider: A health care professional, who is employed by or under contract or supervision to render MHSA Services to Members. Facility-based Providers include, but are not limited to, emergency room physicians, pathologists, radiologists, anesthesiologists, certified registered nurse anesthetists ("CRNAs"), and internists.

Facility Participating Provider: A health care professional, facility, CMHC Supervising Provider, or other organization that has a written Facility Participating Provider Agreement in effect with UBH, directly or through another entity, to provide MHSA Service to Members.

Medicaid: A Medical Assistance Program providing health coverage benefits for low income persons pursuant to applicable state and federal laws and regulations.

Medically Necessary: Except as otherwise required by applicable state or federal law or regulations, for purposes of this Agreement, Medically Necessary means the term as it may be described in the Member's Benefit Plan for MHSA Services and which meets Payor's defined criteria for coverage as Covered Services. It may also, when applicable, have the meaning defined within the Protocols. Generally, however, Medically Necessary means treatment that is commonly recognized in the industry as consistent treatment that must be: (a) solely to treat the condition of the Member; (b) for the illness or injury of a diagnosis that is commonly recognized as a disease or injury; (c) reasonably expected to directly result in the restoration of health or function; (d) not experimental or investigational but is consistent with established and accepted national medical practice guidelines regarding type, frequency and duration of treatment; (e) without alternative treatment that is less intensive or invasive for the efficient treatment of the Member's condition; (f) not based on convenience for the Member; and (g) not otherwise excluded from the definition of Covered Services based upon the terms and conditions of the Member's Benefit Plan.

Medicare: Federally sponsored program providing health coverage benefits to individuals of qualifying age, disability, or disease.

Member: An individual who is eligible for, properly enrolled in, and covered under a Benefit Plan.

Member Expenses: Any amount of Customary Charges that are the Member's responsibility to pay Provider in accordance with the terms of the Member's Benefit Plan, including co-payments, co-insurance and deductible amounts.

Mental Health and Substance Abuse Services ("MHSA Services"): Health care services, treatment or supplies that are used to treat a mental health or substance

abuse illness, condition or disease and which may be eligible for coverage under the Member's Benefit Plan.

Payment Policies: Guidelines adopted by UBH, from time to time, for calculating payment of claims under Benefit Plans.

Payor: The entity or person that has the financial responsibility for funding payment of Covered Services on behalf of a Member, and that is authorized to access MHSA Services in accordance with this Agreement.

Protocols: The programs, policies, protocols, processes, procedures, and requirements as such may change or be modified from time to time, and that are adopted by UBH or Payor, and which Provider agrees to follow as a condition of UBH accepting Provider as a Participating Provider, including, but not limited to, authorization procedures, credentialing and re-credentialing processes and plans, utilization management and care management processes, billing procedures, Payment Policies, providing or arranging for Emergency Services, quality improvement, peer review, on-site review, Member grievance and appeals processes, and any other policies, procedures, processes, activities or standards, wherever located as may apply to Provider's rights, obligations or responsibilities as a Provider of MHSA Services, whether in this Agreement, Provider Manual, or any other document as made accessible or available to Provider from time to time.

Provider Manual: A document or manual, however known or named, such as the Network Manual, containing the administrative policies, procedures and Protocols applicable to Benefit Plans provided, sponsored or administered by UBH or a Payor including, but not limited to, policies and procedures for credentialing, claims, quality improvement, and utilization management to which Provider is obligated.

ARTICLE 2 Duties of Provider

2.1 Provision of MHSA Services. Provider hereby acknowledges and agrees to cooperate and comply with all of the terms and conditions of the Provider Manual, Protocols, and this Agreement, and to dutifully perform as a Participating Provider for the provision of MHSA Services to Members within the UBH network(s) as designated by UBH or Payor. At the request of a Payor, Provider or Facility-based Provider may not be authorized to provide MHSA Services for some or all of Payor's Members. Provider shall otherwise accept Members as new patients on the same basis as Provider is accepting non-Members as new patients without regard to race, religion, gender, color, national origin, age or physical or mental health status, or on any other basis deemed unlawful under federal, state or local law. At all times, Provider shall require any employed or subcontracted health care professionals and facilities to comply with the terms and conditions of this Agreement, all Protocols of UBH and Payor, the Provider Manual, as well as the requirements of all applicable laws and regulations.

2.2 Benefit Plan & Eligibility. MHSA Services provided by Provider to a Member pursuant to this Agreement are subject to all the terms and conditions of the Member's Benefit Plan including eligibility of the Member on the date MHSA Services are provided to the Member. Provider shall make reasonable effort to verify Member's eligibility at time of service by following appropriate procedures, including without limitation, and at a minimum, the terms and conditions of this Agreement, Protocols, the Provider Manual, and review of the Member's Benefit Plan identification card. Provider however recognizes that the Member eligibility information may be inaccurate at the time Provider obtains verification and that the Member, or the MHSA Services provided to the Member, may later be determined to be ineligible for coverage and, except as otherwise required by law, not eligible for payment under this Agreement. Under such circumstances, Provider may then, except as otherwise stated herein, directly bill the Member or other responsible party for such MHSA Services.

2.3 Provider Manual & Protocols. Provider shall be bound by, accept, strictly comply with, and cooperate with, the requirements set forth in the Provider Manual, credentialing plan, and all Protocols, as amended or modified from time to time by UBH and/or Payor, all of which are hereby incorporated herein by reference as if set forth fully herein, including without limitation quality improvement activities. Provider acknowledges and agrees that the Provider Manual and/or Protocols may contain service and contract requirements of certain Payors to which Provider shall strictly comply. Provider's failure to comply with the Provider Manual, Protocols and any other standards, procedures or policies may result in loss of, or reduction of payment or reimbursement to Provider, termination of this Agreement or the imposition of other corrective action by UBH.

2.4 Authorization Requirements. Subject to all applicable terms and conditions, including without limitation Section 2.2 above, and in accordance with the Provider Manual, Protocols, and requirements of the Member's Benefit Plan regarding authorization, Provider must request authorization for MHSA Services from UBH either telephonically or by another approved and accepted method recognized by UBH before providing any MHSA Services to a Member as a Covered Service. Authorizations shall subsequently be confirmed by UBH in writing. Except as otherwise permitted herein, only Emergency Services will be eligible for retroactive authorization at the sole discretion of UBH or as required by applicable law. Any authorization resulting from wrongful, fraudulent or negligent actions of Provider or a breach of this Agreement shall be null and void as of the time given. The terms of this section shall prevail over any inconsistent term or condition in the Member's Benefit Plan or other document related to obtaining prior authorization.

2.5 Provider's Standard of Care. Nothing in this Agreement, the Provider Manual, the Benefit Plan, or the Protocols, including without limitation, UBH's utilization management and quality assurance and improvement standards and procedures, shall dictate MHSA Services provided by Provider or otherwise diminish Provider's obligation to freely communicate with and/or provide MHSA Services to Members in accordance with the applicable standard of care.

2.6 Continuity of Care; Referral to Other Health Professionals. Provider shall furnish Covered Services in a manner providing continuity of care and ready referral of Members to other Participating Providers at times as may be appropriate and consistent with the standards of care in the community. If a Member requires additional services or evaluation, including Emergency Services, Provider agrees to refer Member to his/her primary care physician or another Participating Provider in accordance with the terms and conditions of Member's Benefit Plan. A Member requiring Emergency Services shall also be referred to the "9-1-1" emergency response system.

2.7 Member Access to Care. Provider shall ensure that Members have timely and reasonable access to MHSA Services and shall at all times be reasonably available to Members as is appropriate. If Provider is unavailable when Members call, instructions must be provided for the Member referring the Member to another Participating Provider or to his/her Benefit Plan. Provider shall arrange for an answering machine or service that shall provide the office hours and emergency information and be capable of receiving messages 24 hours a day.

2.8 Employees and Contractors of Provider. Provider will be responsible for and shall ensure that all of its employees and contractors are bound by, and meet the terms and conditions of, this Agreement, the Provider Manual and Protocols, at the time of providing Covered Services to Members. Failure of such employees or contractors to meet such terms and conditions, including without limitation, credentialing requirements, UBH may restrict them from providing Covered Services to Members.

2.9 Credentialing. Provider shall provide UBH with the criteria utilized by Provider to select and credential employed or subcontracted health care professionals and facilities including, but not limited to, Facility-based Providers. UBH shall have the right to audit such criteria upon reasonable advance written notice to Provider.

2.10 Payment of Services. All payments obligated by Payor shall be paid to Provider and Provider will be solely responsible for payments to its employees, contractors and Facility-based Providers who may have provided MHSA Services. Provider agrees to defend, indemnify and hold UBH harmless for any claims, damages, actions, or judgments arising from any employee or contractor of Provider related to the provision of MHSA Services to Members.

2.11 Arrangements for Post-Discharge Follow-up Care. Prior to discharging a Member, Provider shall coordinate post-discharge follow-up care with UBH and assure that the Member has a follow-up plan including a scheduled appointment with the appropriate providers as deemed necessary.

ARTICLE 3 Payment Provisions

3.1 Payment for Covered Services. In accordance with the terms and conditions hereof, Payor shall pay Provider for Covered Services provided to a Member by Provider. Payment shall be the lesser of: (a) Provider's Customary Charge, less any

applicable Member Expenses; or (b) the fee pursuant to the Standard Payment Appendix(ces) attached hereto, if any.

Subject to the terms and conditions herein, the obligation for payment for Covered Services provided to a Member, less any applicable Member Expenses, is solely that of Payor. Additionally, UBH may arrange for claims processing services. When UBH is the Payor, UBH shall make obligated claim payments to Provider within 45 days (and shall use best efforts to encourage a third-party Payor to make payments within 45 days), or as otherwise required by law, of the date Payor receives all information necessary to process and pay a clean claim, except for claims for which there is coordination of benefits, Member Expense adjustments, disputes about coverage, systems failure or other such causes.

In the event a Member's Benefit Plan provides for a Member Expense whether stated as a flat fee or a percentage, the amount of the Member Expense shall be calculated in accordance with the Member's Benefit Plan or as determined by the Payor. The amount calculated pursuant to the preceding sentence shall be deducted from the amount Provider is to be paid for the Covered Services pursuant to this Agreement.

3.2 Submission of Claims. Provider shall submit claims for MHSA Services to UBH in a manner and format prescribed by UBH, whether in Protocols or otherwise, and which may be in an electronic format. All information necessary to process the claims must be received by UBH no more than 90 days from the date of discharge and 90 days from the date all outpatient MHSA Services are rendered. Provider agrees that claims received after this time period may be rejected for payment, at UBH's and/or Payor's sole discretion.

Unless otherwise directed by UBH, Provider shall submit claims using current CMS (HCFA) 1500 or UB04 forms, whichever is appropriate, with applicable coding including, but not limited to, ICD9, CPT, Revenue and HCPCS coding. Provider shall include in a claim the Member number, Customary Charges for the MHSA Services rendered to a Member during a single instance of service, Provider's Federal Tax I.D. number and/or other identifiers requested by UBH.

Payor shall have the right to make, and Provider shall have the right to request, corrective adjustments to a previous payment; provided however, that Payor shall have no obligation to pay additional amounts after 12 months from the date the initial claim was paid.

3.3 Payment in Full. Provider shall accept as payment in full for Covered Services rendered to Members such amounts as are paid by Payor pursuant to this Agreement and shall not bill Members for non-covered charges, other than Member Expenses, which result from Payor's reimbursement methodologies. In no event shall Provider bill a Member for the difference between Customary Charges and the amount Provider has agreed to accept as full reimbursement under this Agreement. Provider may collect Member Expenses from the Member. If Payor denies payment for services rendered by Provider on grounds that the services are not Medically Necessary, Provider shall not

collect payment from the Member for the services unless the Member has knowledge of the determination of lack of Medical Necessity and has subsequently agreed in writing to be responsible for such charges and MHSA Services. Further, if any payment to Provider is denied, in part or full, due to Provider's failure to strictly comply with any term or condition in this Agreement, the Provider Manual, the Protocols, including without limitation, obtaining prior authorization, untimely filing of a claim, inaccurate or incorrect submission of or claim processing, or the insolvency of Payor pursuant to applicable law, it is agreed that Provider shall not, except for applicable Member Expenses, bill the Member or otherwise, directly or indirectly, seek or collect payment from the Member for any of the denied amounts. Any violation hereof by Provider shall be deemed a material breach. This provision shall apply regardless of whether any waiver or other document of any kind purporting to allow Provider to collect payment from the Member exists. These provisions shall survive the termination hereof and shall be construed to be for the benefit of the Member.

Provider acknowledges that the amounts paid to Provider under this Agreement includes payment for services provided by Provider to Members who are enrolled as Medicare beneficiaries.

3.4 Coordination of Benefits. Provider shall be paid in accordance with Payor's coordination of benefits rules.

3.5 Financial Responsibility. In the event of a default (meaning a systematic failure by Payor to fund undisputed claim payments for Covered Services) by a Payor, except when due to the insolvency of Payor, UBH shall notify Provider in writing of such default following UBH's determination thereof. Any services which have been rendered by Provider prior to or after such notification, and which have not been paid for by Payor, shall be considered ineligible for reimbursement under this Agreement, and Provider may seek payment directly from the Payor and Member for such services.

3.6 Member Protection Provision. This provision supersedes and replaces the Financial Responsibility section (section 3.5 above) only in those cases where UBH, or its Affiliate, is the Payor, or when required by another specific Payor, or when required pursuant to applicable laws, statutes and regulations.

In no event, including, but not limited to, non-payment by Payor for MHSA Services rendered to Members by Provider, insolvency of Payor, or breach by UBH of any term or condition of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member or persons acting on behalf of the Member for MHSA Services eligible for reimbursement under this Agreement; provided, however, that Provider may collect from the Member, any Member Expenses or charges for services that are not covered as benefits under the Member's Benefit Plan.

The provisions of this Article shall apply to all Member protection provisions in this Agreement and shall: (a) apply to all MHSA Services rendered while this Agreement is in force; (b) survive the termination of this Agreement regardless of the

cause of termination; (c) be construed to be for the benefit of the Members; and (d) except as otherwise stated in section 3.3, supersede any oral or written agreement, existing or subsequently entered into, between Provider and a Member or person acting on a Member's behalf, that requires the Member to pay for such MHSA Services.

3.7 Contracted Rate for Members. Provider agrees to continue to provide MHSA Services to Members who have exhausted his/her covered benefits under the Benefit Plan and agrees not to collect or charge more than the contracted rate for those MHSA Services. Provider may bill the Member directly for those MHSA Services for which there is no longer any coverage under the Benefit Plan, in accordance herewith.

ARTICLE 4

Laws, Regulations, and Licenses, and Liabilities of Parties

4.1 Laws, Regulations and Licenses. Provider shall maintain in good standing all federal, state and local licenses, certifications and permits -- without sanction, revocations, suspension, censure, probation or material restriction -- which are required to provide health care services according to the laws of the jurisdiction in which MHSA Services are provided, and shall comply with all applicable statutes and regulations. Provider shall also require that all health care professionals employed by or under contract with Provider to render MHSA Services to Members, including covering Providers, comply with this provision.

4.2 Responsibility for Damages. Any and all damages, claims, liabilities or judgments, attorney fees, which may arise as a result of Provider's or its employee's or contractor's negligence or intentional wrongdoing shall be the sole responsibility of Provider.

4.3 Provider Liability Insurance. Provider offering acute care services shall procure and maintain, at Provider's sole expense, (a) medical malpractice insurance in the amounts of \$5,000,000 per occurrence and in aggregate, and (b) comprehensive general and/or umbrella liability insurance in the amount of \$5,000,000 per occurrence and in aggregate. Whereas Provider offering non-acute care services shall procure and maintain, at Provider's sole expense, (c) medical malpractice insurance in the amounts of \$1,000,000 per occurrence and \$3,000,000 in aggregate, and (d) comprehensive general and/or umbrella liability insurance in the amount of \$1,000,000 per occurrence and \$3,000,000 in aggregate. Provider shall also require that all health care professionals employed by or under contract with Provider to render MHSA Services to Members procure and maintain, unless they are covered under Provider's insurance policies, a comprehensive general and/or umbrella liability insurance in the amount of \$1,000,000 per occurrence and in aggregate and medical malpractice or professional liability insurance and comprehensive coverage in the amount of \$1,000,000 per occurrence and \$3,000,000 in aggregate if a Medical Doctor, and \$1,000,000 per occurrence and in aggregate if not a Medical Doctor.

Provider's and other health care professionals' medical malpractice insurance shall be on either an "occurrence" or "claims made" basis provided that for a "claims

made” policy, such policy must be written with an extended period reporting option under such terms and conditions as may be reasonably required by UBH. Prior to the Effective Date of this Agreement and at each policy renewal thereafter, Provider shall submit to UBH in writing evidence of insurance coverage.

4.4 Self-Insurance Option. In lieu of compliance with section 4.3 above, Provider may with the prior written approval of UBH, self-insure for medical malpractice liability, as well as comprehensive general liability. Provider shall maintain a separate reserve for its self-insurance. Upon reasonable request by UBH, Provider shall provide a statement, verified by an independent auditor or actuary, that the reserve maintained by Provider for its self-insurance is sufficient and adequate. In addition to maintaining its self-insurance, Provider shall assure that all health care professionals employed by or under contract with Provider to render MHSA Services to Members procure and maintain adequate medical malpractice insurance unless they are covered by Provider’s self-insurance. Failure to maintain adequate self-insurance shall trigger the requirement to obtain and maintain Insurance under section 4.3.

ARTICLE 5 Notices

5.1 Notices. Provider shall notify UBH within ten (10) days of knowledge of any of the following:

- (a) changes in liability insurance carriers, termination of, renewal of or any other material changes in Provider's liability insurance, including reduction of limits, erosion of aggregate, changes in retention or non-payment of premium, or any material adverse change in Provider’s financial status which affects its self-insurance;
- (b) action which may result in or the actual suspension, sanction, revocation, condition, limitation, qualification or other material restriction on Provider's or any of Facility-based Provider’s licenses, certifications or permits by any government or accrediting or regulatory agency under which Provider or Facility-based Provider is accredited or regulated by or authorized to provide health care services;
- (c) a change in Provider's name, address, ownership or Federal Tax I.D. number;
- (d) indictment, arrest or conviction for a felony or for any criminal charge related to the practice of Provider's profession;
- (e) claims or legal actions for professional negligence or bankruptcy;
- (f) provider's termination, for cause, from any other provider network offered by any plan, including, without limitation, any health care service plan, health maintenance organization, any health insurer, any preferred provider organization, any employer or any trust fund;
- (g) any occurrence or condition that might materially impair the ability of Provider or Facility-based Provider to perform its duties under this Agreement;
- (h) any condition or circumstance that may pose a direct threat to the safety of Provider, Providers' staff, Facility-based Provider or Members; or

- (i) action taken by Provider to suspend, revoke or allow the voluntary relinquishment of the medical staff membership or clinical privileges of any Facility-based Provider or Facility Participating Provider, unless the action will last 30 days or less.

Unless otherwise specified in this Agreement, each and every notice and communication to the other party shall be in writing. All written notices or communication shall be deemed to have been given when delivered in person; or, on the date mailed, if delivered by first-class mail, proper postage prepaid and properly addressed to the appropriate party at the address set forth at the signature portion of this Agreement or to another address of which sending party has been notified, including without limitation, to UBH's Network Manager at the applicable address for notice as identified in the Provider Manual or Protocols. The parties shall, by written notice, provide and update each other with the most current address and names of all parties or designees that should receive certain notices or communication.

ARTICLE 6

Records

6.1 Confidentiality of Records. UBH and Provider shall maintain the confidentiality of all Member information and records in accordance with all applicable state and federal laws, statutes and regulations, including without limitation, the Health Insurance Portability and Accountability Act.

6.2 Maintenance of and UBH Access to Records. Provider shall maintain adequate medical, treatment, financial and administrative records related to MHSA Services provided by Provider under this Agreement for a period and in a manner consistent with the standards of the community and in accordance with the Provider Manual, Protocols and all applicable state and federal laws, statutes and regulations.

In order to perform its utilization management and quality improvement activities, UBH shall have access to such information and records, including claim records, within 14 days from the date the request is made, except that in the case of an audit by UBH, such access shall be given at the time of the audit. If requested by UBH, Provider shall provide copies of such records free of charge. During the term of this Agreement UBH shall have access to and the right to audit information and records to the extent permitted by the Provider Manual, or as otherwise required by state or federal laws, statutes or regulations or regulatory authority. Said rights shall continue following the termination hereof for the longer of three years or for such period as may be permitted by applicable state or federal law, regulatory authority, or Protocols.

It is Provider's responsibility to obtain any Member's consent in order to provide UBH with requested information and records or copies of records and to allow UBH to release such information or records to Payors as necessary for the administration of the Benefit Plan or compliance with any state or federal laws, statutes and regulations applicable to the Payors.

Provider acknowledges that in receiving, storing, processing or otherwise dealing with information from UBH or Payor about Members, it is fully bound by the provisions of the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2; and Provider agrees that it will resist in judicial proceedings any effort to obtain access to information pertaining to patients otherwise than as expressly provided for in the federal confidentiality regulations, 42 CFR Part 2.

This section shall not be construed to grant UBH access to Provider's records that are created for purposes of assessing Provider's financial performance or for Provider's peer review activities, except to the extent the federal and/or state government and any of their authorized representatives have access to such records pursuant to Section 6.3.

6.3 Government and Accrediting Agency Access to Records. It is agreed that the federal, state and local government, or accrediting agencies including, but not limited to, the National Committee for Quality Assurance (the "NCQA"), and any of their authorized representatives, shall have access to, and UBH and Provider are authorized to release, in accordance with applicable statutes and regulations, all information and records or copies of such, within the possession of UBH or Provider, which are pertinent to and involve transactions related to this Agreement if such access is necessary to comply with accreditation standards, statutes or regulations applicable to UBH, Payor or Provider. Such access shall be available and provided during the term of this Agreement and for three years following the termination hereof, or such longer period as may be identified in the Provider Manual or Protocols or as required by applicable state or federal laws, statutes or regulations.

ARTICLE 7 Resolution of Disputes

7.1 Resolution of Disputes. It is agreed that prior to any other remedy available to the parties, UBH, Payor and/or Provider shall provide written notice of any disputes or claims arising out of their business relationship (the "Dispute") to the other party within thirty (30) days of the final decision date, action, omission or cause from which the Dispute arose, whichever is later (the "Dispute Date"). If the Dispute pertains to a matter which is generally administered by certain UBH procedures, such as a credentialing or quality improvement plan, the procedures set forth in that plan must be fully exhausted by Provider before Provider may invoke his or her rights as described herein. After receipt of the written notice of the Dispute, the parties agree to work together in good faith to resolve the Dispute. If the parties are unable to resolve the Dispute within thirty (30) days following receipt of the notice of the Dispute, and if either UBH, Provider or Payor desires to pursue formal resolution of the Dispute, then said party shall issue a notice of arbitration to the other parties. It is agreed that the parties knowingly and voluntarily waive any right to a Dispute if arbitration is not initiated within one year after the Dispute Date.

Any arbitration proceeding under this Agreement shall be submitted to binding arbitration in accordance with the rules of the American Arbitration Association ("AAA"),

and shall be conducted in a location agreed to by the parties or as selected by the AAA if the parties cannot agree on a location. The arbitrators may construe or interpret but shall not vary or ignore the terms of this Agreement, shall have no authority to award any punitive or exemplary damages, and shall be bound by controlling law. The parties acknowledge that because this Agreement affects interstate commerce the Federal Arbitration Act applies.

ARTICLE 8 Term and Termination

8.1 Term. This Agreement shall begin on the Effective Date and it shall remain in effect for one year, and shall automatically renew for successive 1-year terms until it is terminated in accordance with the provisions herein.

8.2 Termination. This Agreement may be terminated as follows:

- (a) by mutual agreement of UBH and Provider;
- (b) by Provider at the end of any term, as defined in Section 8.1, upon 120 days prior written notice to UBH;
- (c) by UBH upon 120 days prior written notice to Provider;
- (d) by either party, in the event of a material breach of this Agreement by the other party, upon 30 days prior written notice to the other party. The written notice shall specify the precise nature of the breach. In the event the breaching party cures the breach to the reasonable satisfaction of the non-breaching party, within 30 days after the non-breaching party's written notice, this Agreement shall not terminate;
- (e) by UBH immediately upon written notice to Provider, due to Provider's loss, suspension, restriction, probation, voluntary relinquishment, or any other adverse action taken against any of Provider's licenses or certifications, or loss of insurance or failure to maintain financial reserves sufficient to provide the level of self-insurance required under this Agreement;
- (f) by Provider upon 60 days prior written notice to UBH due to a unilateral amendment made to this Agreement pursuant to section 9.1;
- (g) by UBH in accordance with its credentialing plan;
- (h) by UBH immediately if UBH determines, in its sole discretion, that the health, safety or welfare of Members may be jeopardized by the continuation of this Agreement; or
- (i) by UBH in accordance with the Provider Manual or Protocols.

During periods of notice of termination, UBH reserves the right to transfer Members to another Participating Provider, and Provider agrees to cooperate and assist with such transfers.

If Provider is terminated through the UBH credentialing or recredentialing process, this Agreement shall be deemed terminated as of the date Provider has been terminated pursuant to a final action resulting from that process.

8.3 Information to Members. Provider acknowledges and agrees that UBH has the right to inform Members of Provider's termination and/or the notice of termination to Provider, and agrees to cooperate with UBH in matters concerning the termination/transition, and agrees to hold UBH harmless for exercising its rights hereunder. Provider also agrees to clearly inform Members of Provider's impending non-participation status upon the earlier of Member's next appointment or prior to the effective termination date.

8.4 Continuation of Services After Termination. At the option of UBH, Provider shall continue to provide MHSA Services authorized by UBH to Members who are receiving such services from Provider as of the effective date of termination of this Agreement, until Member can be satisfactorily transferred to another Participating Provider. Payor shall continue to pay Provider for such services at Provider's contracted rate.

ARTICLE 9 Miscellaneous

9.1 Amendment. UBH may amend this Agreement by sending notice of the amendment to Provider at least 30 days prior to its effective date. The Provider's signature is not required. It is agreed that this Agreement shall be automatically amended to comply with any and all applicable state or federal laws, regulations, statutes or the requirements of applicable regulatory authorities as of the effective date thereof, and which shall be deemed to be incorporated herein by reference as of its effective date. Likewise, if a Payor that is a governmental entity requires that certain provisions of this Agreement be removed, replaced, amended or that additional provisions be incorporated, such provisions shall be deemed to be removed, replaced, amended or additional provisions incorporated into this Agreement as of the effective date of such Payor requirement for all MHSA Services provided which are subject to such Payor requirements without the signature of Provider being required. Renegotiation of the rates in this Agreement, shall be upon the mutual consent of the parties.

9.2 Assignment. UBH may assign all or any of its rights and responsibilities under this Agreement to any of its Affiliates. Provider may assign any of his or her rights and responsibilities under this Agreement to any person or entity only upon the prior written consent of UBH, which consent shall not be unreasonably withheld.

9.3 Administrative Responsibilities. UBH may delegate certain administrative responsibilities under this Agreement to another entity, including, but not limited to, its Affiliate or to Payor or its designee. In addition, certain Payor responsibilities may actually be performed by its designee.

9.4 Relationship Between UBH and Provider. The relationship between UBH and Provider is solely that of independent contractors and nothing in this Agreement or otherwise shall be construed or deemed to create any other relationship, including one of employment, agency, joint venture or partnership.

9.5 Name, Symbol and Service Mark. During the term of this Agreement, Provider, UBH and Payor shall have the right to use each other's name solely to make public reference to Provider as a Participating Provider. Provider, UBH and Payor shall not otherwise use each other's name, symbol or service mark or that of their Affiliates without the prior written approval from the appropriate party.

9.6 Confidentiality. Neither party shall disclose to third parties any confidential or proprietary business information which it receives from the other party, including, but not limited to, financial statements, business plans, Protocols and programs; except that (a) Provider may disclose information to a Member relating to the Member's treatment plan and the payment methodology, but not specific rates; (b) UBH may disclose certain terms to Payors or designees that need the information to process claims or administer a Benefit Plan, and may file the form of this Agreement with any federal or state regulatory entity as may be required by applicable law; and (c) UBH shall be permitted to disclose, in its sole discretion, any other data or information that may be requested by applicable state and federal law, state regulations or governing agencies that pertain to this Agreement or that may relate to the enforcement of any right granted or term or condition of this Agreement.

9.7 Communication. UBH encourages Provider to discuss with Members treatment options and their associated risks and benefits, regardless of whether the treatment is covered under the Member's Benefit Plan. Nothing in this Agreement is intended to interfere with Provider's relationship with Members as patients of Provider, or with UBH's ability to administer its quality improvement, utilization management and credentialing programs.

9.8 Effects of New Statutes and Regulations and Changes of Conditions. The parties agree to re-negotiate this Agreement if either party would be materially adversely affected by continued performance as a result of a change in laws or regulations, a requirement that one party comply with an existing law or regulation contrary to the other party's prior reasonable understanding, or a change in UBH's arrangements with Payors. The party affected must promptly notify the other party of the change or required compliance and its desire to re-negotiate this Agreement. If a new agreement is not executed within 30 days of receipt of the re-negotiation notice, the party adversely affected shall have the right to terminate this Agreement upon 45 days prior written notice to the other party. Any such notice of termination must be given within 10 days following the expiration of the 30-day re-negotiation period.

9.9 Appendices. Additional and/or alternative provisions, if any, related to certain MHSA Services rendered by Provider to Members covered by certain Benefit Plans, rates, and fees are set for in the Appendices, Attachments and Addendum.

9.10 Entire Agreement. On the Effective Date, this Agreement supersedes and replaces any existing Provider Agreements between the parties related to the provision of MHSA Services, including any agreements between Provider and Affiliates of UBH for MHSA Services. This Agreement, together with any and all documents referenced herein, attachments, addenda, appendices, as may be amended or modified from time

to time, whether contemporaneous or subsequently made pursuant to Section 9.1, are hereby incorporated herein by reference, and constitutes the entire agreement between the parties in regard to its subject matter (herein collectively referred to as this "Agreement").

9.11 Strict Compliance. The waiver of strict compliance or performance of any of the terms or conditions of this Agreement, the Provider Manual or the Protocols or of any breach thereof shall not be held or deemed to be a waiver of any subsequent failure to comply strictly with or perform the same or any other term or condition thereof or any breach thereof.

9.12 Severability. Should any provision of this Agreement violate the law or be held invalid or unenforceable as written by a court of competent jurisdiction, then said provision along with the remainder of this Agreement shall nonetheless be enforceable to the extent allowable under applicable law by first modifying said provision to the extent permitted so as to comply with applicable law; otherwise said provision shall be deemed void to the extent of such prohibition without invalidating the remainder of this Agreement.

9.13 Rules of Construction. In the event of any conflict between the terms of this Agreement and the terms of any other agreement or any other controlling document or any applicable state or federal laws, statutes and regulations relating to the subject matter hereof, the terms, except as otherwise expressly stated herein, shall first be read together to the extent possible; otherwise the terms that afford the greater protections to first UBH and second to the Benefit Plan shall prevail over the conflicting term, to the extent permitted by and in accordance with and subject to applicable law, statutes or regulations. The remainder of the Agreement shall otherwise remain without invalidating or deleting the remainder of the conflicting provision or the Agreement.

9.14 Governing Law. This Agreement shall be governed by and construed in accordance with applicable state and federal laws, statutes and regulations, including without limitation, ERISA.

9.15 Medicaid Members. If a Medicaid Appendix is attached to this Agreement Provider agrees to provide MHSA Services to Members enrolled in a Benefit Plan for Medicaid recipients and to comply with any additional requirements set forth in the Medicaid Appendix.

9.16 Medicare Members. If a Medicare Appendix is attached to this Agreement, Provider agrees to provide MHSA Services under this Agreement, to Members who are enrolled in a Benefit Plan for Medicare beneficiaries and to cooperate and comply with the provisions set forth in the attached Medicare Advantage Addendum. Provider also understands that UBH's agreements with Participating Providers are subject to review and approval by the Centers for Medicare and Medicaid Services ("CMS").

9.17 Survival. Upon any termination or expiration of this Agreement, the provisions herein which contemplates performance or observance subsequent to termination or

expiration, including without limitation, sections 2.9, 2.10, 2.11, 3.1, 3.2, 3.3, 3.6, 8.3, 8.4, 9.6 and Articles 6 and 7, shall survive and remain of full force and effect between the parties.

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

Upon the acceptance and execution hereof by both parties hereto, the Effective Date of this Agreement is: _____
(to be completed by UBH only)

UNITED BEHAVIORAL HEALTH
425 Market Street, 12th Floor
San Francisco, CA 94105-2426
Attn: Contract Administration

NAME OF PROVIDER

Attn: _____

Signature _____

Signature _____

Michelle Brennan Cooke, PhD

Print Name _____

Vice President, CNS

Title _____

Date _____

Date _____

Federal Tax ID Number: _____

Medicare Number: _____

Medicaid Number: _____

STANDARD PAYMENT APPENDIX

Unless otherwise provided by additional Appendices, the provisions of this Appendix apply to MHSA Services provided by Provider to Members covered by Benefit Plans sponsored or issued by any Payor for which UBH has agreed to provide access to one of its networks of Facility Participating Providers.

SECTION 1 Definitions

1.1 Eligible Expenses: The Customary Charges for MHSA Services subject to Fee Maximums. Payment of all or a portion of the Eligible Expenses, pursuant to the terms of this Appendix, shall be considered payment in full for all MHSA Services provided to the Member, including but not limited to, nursing care, diagnostic and therapeutic services, supplies, medications, and room and board charges, provided during the admission, unless otherwise provided for in this Agreement. Such payment {does}{does not} **CHOOSE ONE** include physician fees.

1.2 Per Diem Payment: The payment made to Provider for each day of an admission of a Member. Such payment shall be considered payment in full for all MHSA Services provided to the Member during each day of the admission, including but not limited to, nursing care, diagnostic and therapeutic services, supplies, medications and room and board charges. Such payment {does}{does not} **CHOOSE ONE** include physician fees.

SECTION 2 Payment for Inpatient MHSA Services

2.1 MHSA Services Provided During an Inpatient Admission. For MHSA Services authorized by UBH and provided to a Member during {an inpatient admission, Provider shall be paid by Payor the lesser of (a) Provider's Customary Charge, less any applicable Member Expenses; or (b) the percentage of Eligible Expenses, less any applicable Member Expenses} <<**RETAIN FOR INPATIENT ELIGIBLE EXPENSE PAYMENT**>> {each day of an inpatient admission, Provider shall be paid by Payor the lesser of (a) Provider's Customary Charge, less any applicable Member Expenses; or (b) the Per Diem Payment(s)} <<**RETAIN FOR INPATIENT PER DIEM PAYMENT**>> set forth below, less any applicable Member Expenses.

MHSA Health Services with Mental Health Diagnosis			
Age Category	Per Diem	Billing Code	(UBH use only) Room types
Adult (18 years or more)			
Adolescent (13 to 17 years)			
Child (12 years or less)			

<<**CLEAN-UP AS NECESSARY**>>

MHSA Health Services with Substance Abuse Diagnosis			
Age Category	Per Diem	Billing Code	(UBH use only) Room types
Adult (18 years or more)			
Adolescent (13 to 17 years)			
Child (12 years or less)			

<<**CLEAN-UP AS NECESSARY**>>

SECTION 3<<DELETE IF NO INPATIENT MHSA SERVICES>>

**Payment for Mental Health
Partial Hospitalizations/Day Treatment Programs**

3.1 <<CHANGE SECTION # AS APPROPRIATE>>Partial Hospitalizations/Day Treatment Programs for MHSA Services with a Mental Health Diagnosis. For MHSA Services with a mental health diagnosis that are authorized by UBH and provided to a Member during {an admission for a partial hospitalization/day treatment program, Provider shall be paid by Payor the lesser of (a) Provider's Customary Charge, less any applicable Member Expenses; or (b) the percentage of Eligible Expenses, less any applicable Member Expenses} **<<RETAIN FOR MH PART HOSP/DAY TX ELIGIBLE EXPENSE PAYMENT>>** {each day of an admission for a partial hospitalization/day treatment program, Provider shall be paid by Payor the lesser of (a) Provider's Customary Charge, less any applicable Member Expenses; or (b) the Per Diem Payment(s)} **<<RETAIN FOR MH PART HOSP/DAY TX PER DIEM PAYMENT>>** set forth below, less any applicable Member Expenses.

Mental Health Partial Hospitalizations/Day Treatment			
Age Category (hours a day/days per wk)	Per Diem	Billing Code	(UBH use only) Room types
Adult (18 years or more)			
Adolescent (13 to 17 years)			
Child (12 years or less)			

<<CLEAN-UP AS NECESSARY>>

SECTION 4<<DELETE IF NO MH PART HOSP/DAY TX>>

**Payment for Substance Abuse
Partial Hospitalizations/Day Treatment Program**

4.1 <<CHANGE SECTION # AS APPROPRIATE>>Partial Hospitalizations/Day Treatment Programs for MHSA Services with a Substance Abuse Diagnosis. For MHSA Services with a substance abuse diagnosis that are authorized by UBH and provided to a Member during {an admission for a partial hospitalization/day treatment program, Provider shall be paid by Payor the lesser of (a) Provider's Customary Charge, less any applicable Member Expenses; or (b) the percentage of Eligible Expenses, less any applicable Member Expenses} **<<RETAIN FOR SA PART HOSP/DAY TX ELIGIBLE EXPENSE PAYMENT>>** {each day of an admission for a partial hospitalization/day treatment program, Provider shall be paid by Payor the lesser of (a) Provider's Customary Charge, less any applicable Member Expenses; or (b) the Per Diem Payment(s)} **<<RETAIN FOR SA PART HOSP/DAY TX PER DIEM PAYMENT>>** set forth below, less any applicable Member Expenses.

Substance Abuse Partial Hospitalizations/Day Treatment			
Age Category (hours a day/days per wk)	Per Diem	Billing Code	(UBH use only) Room types
Adult (18 years or more)			
Adolescent (13 to 17 years)			
Child (12 years or less)			

<<CLEAN-UP AS NECESSARY>>

**SECTION 5<<DELETE IF NO SA PART HOSP/DAY TX>>
 Payment for Intensive Outpatient
 Substance Abuse Treatment Programs**

5.1 <<CHANGE SECTION # AS APPROPRIATE>>Intensive Outpatient Substance Abuse Treatment Programs. For MHSA Services with a substance abuse diagnosis that are authorized by UBH and provided to a Member during each day of an admission for an intensive outpatient substance abuse treatment program, Provider shall be paid by Payor the lesser of (a) Provider's Customary Charge, less any applicable Member Expenses; or (b) the Per Diem Payment(s) set forth below, less any applicable Member Expenses.

Intensive Outpatient Substance Abuse Treatment Programs			
Age Category (hours a day/days per wk)	Per Diem	Billing Code	(UBH use only) Room types
Adult (18 years or more)			
Adolescent (13 to 17 years)			
Child (12 years or less)			

<<CLEAN-UP AS NECESSARY>>

The charges for the assessment are included in the Per Diem and shall not be billed separately by Provider.

**SECTION 6<<DELETE IF NO SA IOP>>
 Payment for Intensive Outpatient
 Mental Health Treatment Programs**

6.1 <<CHANGE SECTION # AS APPROPRIATE>>Intensive Outpatient Mental Health Treatment Programs. For MHSA Services with a mental health diagnosis that are authorized by UBH and provided to a Member during each day of an admission for an intensive outpatient mental health treatment program, Provider shall be paid by Payor the lesser of (a) Provider's Customary Charge, less any applicable Member Expenses; or (b) the Per Diem Payment(s) set forth below, less any applicable Member Expenses.

Intensive Outpatient Mental Health Treatment Programs			
Age Category (hours a day/days per wk)	Per Diem	Billing Code	(UBH use only) Room types
Adult (18 years or more)			
Adolescent (13 to 17 years)			
Child (12 years or less)			

<<CLEAN-UP AS NECESSARY>>

The charges for the assessment are included in the Per Diem and shall not be billed separately by Provider.

**SECTION 7<<DELETE IF NO MH IOP>>
Payment for Emergency MHSA Services**

7.1 <<CHANGE SECTION # AS APPROPRIATE>>Emergency MHSA Services Provided to a Member. Provider shall be paid for Emergency MHSA Services for which UBH is the Payor, the lesser of (a) Provider's Customary Charge, less any applicable Member Expenses; or (b) % of Eligible Expenses, less any applicable Member Expenses.

Payment for Emergency MHSA Health Services			
Age Category	Eligible Expenses	Billing Code	(UBH use only) Room types
Emergency Room Adult, Adolescent, Child			

In the event an inpatient admission of a Member occurs within 24 hours of the provision of Emergency MHSA Services, the Member shall not be charged any emergency room Member Expenses which would otherwise be applicable; and charges for such Emergency MHSA Services shall not be billed by Provider separately, but shall be included in the inpatient admission charges.} **<<DELETE IF NO EMERGENCY MHSA SERVICES>**

SECTION 8<<DELETE IF NO Other MH IOP>>

Payment for Other Outpatient MHSA Services

Section 8.1 Outpatient MHSA Health Services Provided to a Member. The MHSA Services authorized by UBH, described below and provided by Provider to Member on an outpatient basis of the diagnosis, testing and/or treatment of a mental health and/or substance abuse condition, other than Emergency MHSA Services or as part of a partial hospitalization or day treatment program, Provider shall be paid by Payor the lesser of (a) Provider's Customary Charge for such MHSA Services, less any applicable Member Expenses; or (b) the Per Diem Payment(s) set forth below, less any applicable Member Expenses.

Payment for Other Outpatient MHSA Services			
Category	Per Diem	Billing Code	(UBH use only) Room types

**UNITED BEHAVIORAL HEALTH
PROVIDER AGREEMENT**

Arkansas Regulatory Requirements Attachment

This Arkansas Regulatory Requirements Attachment (the "Attachment") is made part of this Agreement entered into between United Behavioral Health ("UBH") and the health care professional named in this Agreement ("Provider").

This Attachment applies to all products or Benefit Contracts sponsored, issued or administered by or accessed through UBH to the extent such products are regulated under Arkansas laws.

UBH and Provider each agree to be bound by the terms and conditions contained in this Attachment. In the event of a conflict or inconsistency between this Attachment and any term or condition contained in this Agreement, this Attachment shall control, except with regard to Benefit Contracts outside the scope of this Attachment, and be read in accordance with applicable Laws and Regulations.

Except as otherwise defined in this Attachment, all terms contained in the Attachment shall be as defined and set forth in the Agreement. Any undefined term herein shall have the meaning as defined in applicable state laws or regulations, as may be amended from time to time. Likewise, should any defined term herein conflict with applicable state law or regulation, the term as defined under applicable state law or regulation shall prevail.

Provisions to Benefit Contracts regulated by the State of Arkansas and/or under Arkansas HMO laws, as applicable.

1. Continued Provision of Covered Services.

(a) Following termination due to UBH Insolvency. Provider agrees that in the event this Agreement is terminated because of UBH's insolvency, Provider shall continue the provision of Covered Services to a Member who is receiving care from Provider for the duration of the period for which premiums have been paid to UBH on behalf of Member or until the Member's discharge from an inpatient facility if Member was confined to an inpatient facility on the date of UBH's insolvency.

(b) Continuity of Care After Termination. If this Agreement is terminated for any reason, Provider shall continue the provision of Covered Services to a Member who is receiving care from Provider in relation to a current episode of treatment for an acute condition on and after the effective date of such termination until the first to occur of: (i) the current episode of treatment is completed; (ii) the end of ninety (90) days; or (iii) the Member ceases to be covered by the Benefit Plan. Provider shall be reimbursed in accordance with this Agreement for all such Covered Services rendered subsequent to the termination of this Agreement.

2. Hold Harmless. In the event that Payor fails to pay for Covered Services as set forth in this Agreement, Member shall not be liable to Provider for any sums owed by the Payor. Provider shall not collect or attempt to collect from Member any sums owed by Payor. Provider (and Provider's agents, trustees, or assignees (may not maintain an action at law against a

Member to collect sums owed by Payor; nor make any statement, either written or oral, to any Customer that makes demand for, or would lead a reasonable person to believe that a demand is being made for payment of any amounts owed by the HMO or Payor.

3. Examinations. During the term of this Agreement and for three (3) years after termination, Provider agrees to allow examination of medical records of Members and records of Provider in conjunction with an examination of UBH conducted by the Arkansas Insurance Commissioner or Arkansas Director of the Department of Health, in accordance with Arkansas Statutes Section 23-76-122.

4. Confidentiality. Any data or information pertaining to the diagnosis, treatment, or health of a Member obtained from the Member or from any provider shall be held in confidence and shall not be disclosed to any person except to the extent that it may be necessary to carry out the purposes of applicable Arkansas law, upon the express consent of the Member, pursuant to statute or court order for the production of evidence or the discovery thereof of in the event of a claim or litigation between the Member and UBH wherein the data or information is pertinent. UBH shall be entitled to claim any statutory privileges against the disclosure that Provider (or provider who furnished the information to United) is entitled to claim.

5. Member Medical Records. Provider shall maintain an active record for each Customer who receives Covered Services from Provider. Such record shall be kept current, complete legible and available to UBH and Arkansas regulatory agencies. Each medical record shall contain sufficient information and data to support diagnosis, plan of treatment and other pertinent medical information such as medical history and progress notes. Each entry in a Member's medical record shall be indelibly added to the record, dated and signed or initialed by the person making the entry. Provider shall have a means of identifying the name and professional title of each individual who makes an entry into the record. At a minimum, the medical record shall include: identification of the Member, member history, known past surgical procedures, known past and current diagnoses and problems, and known allergies and untoward reactions to drugs. With regard to each episode of care, the Member's medical record shall include: the reason for the encounter, evidence of the Provider's assessment of the Member's health problems; current diagnosis of the Member, including the results of any diagnostic testing; plan of treatment, including any therapies and health education; and medical history relevant to the current episode of care. Provider shall document that Provider has reviewed all outcomes of ancillary reports and taken follow-up actions regarding report results that are deemed significant by the Provider.

6. Provider Communication with Members. Nothing in this Agreement shall be construed as prohibiting, restricting or penalizing Provider in any way for disclosing to a Member any health care information that Provider deems appropriate regarding the nature of treatment, risks or alternatives thereto, the availability of alternate therapies, consultations, or tests, the decision of utilization reviewers, or similar person, to authorize or deny services, the process that is used to authorize or deny health care services or

benefits or information on financial incentives and structures used by UBH or Payor in this Agreement.

7. Provider Input. As requested by UBH, Provider shall provide input to UBH's medical policy, utilization management procedures, quality and credentialing criteria and medical management procedures.

8. Prompt Pay. UBH and Payor shall pay claims in accordance with claims processing and payment provisions contained in Arkansas Insurance Department Rule and Regulation 43, Unfair Claims Settlement Practices, Section 11-15.

9. Recoupment. UBH, Payor and Provider shall comply with the applicable requirements as set forth in Arkansas Code Annotated Section 23-63-1801 *et seq* an Arkansas Rule 85 regarding recoupment of paid claims.

SERFF Tracking Number: UHLC-125822831 State: Arkansas
Filing Company: UnitedHealthcare of Arkansas, Inc. State Tracking Number: 40300
Company Tracking Number:
TOI: HOrg02G Group Health Organizations - Health Sub-TOI: HOrg02G.002B Any Size Group - POS
Maintenance (HMO)
Product Name: HMO
Project Name/Number: UBH Provider Agreements - IND,GRP, FAC, REGAPP/

Rate Information

Rate data does NOT apply to filing.

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Supporting Document Schedules

Review Status:
Bypassed -Name: Certification/Notice Approved-Closed 09/19/2008
Bypass Reason: Please refer to form schedule for pertinent documents.
Comments:

Review Status:
Bypassed -Name: Application Approved-Closed 09/19/2008
Bypass Reason: Please refer to form schedule for pertinent documents.
Comments:

Review Status:
Bypassed -Name: Health - Actuarial Justification Approved-Closed 09/19/2008
Bypass Reason: Please refer to form schedule for pertinent documents.
Comments: