UNITED BEHAVIORAL HEALTH
PROVIDER AGREEMENT

Alaska Regulatory Requirements Attachment

This Alaska 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 Alaska 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 Alaska and/or under Alaska HMO laws, as applicable.

1. Dispute Resolution Process. In the event of a dispute arising under this Agreement, Provider and UBH agree to utilize the applicable dispute resolution process provided in Alaska Statutes.

2. Advocacy. Provider shall not be penalized or the Agreement or this Attachment, terminated by United because Provider acts as an advocate for a Member in seeking appropriate, medically necessary healthcare services. Nothing in this Agreement shall be construed to infringe on Provider's ability to communicate openly with a Member about the appropriate diagnostic testing and treatment options.

3. Continuation of Care After Termination. Upon Termination of this Agreement, Members who are actively treating with Provider on the date of termination may continue to receive treatment, and the terms and conditions of this Agreement shall remain in full force and effect with respect to the continuing treatment for the longest of the following periods, presuming that the group managed care plan (as defined by applicable Alaska Statutes) remains in effect:

a. the end of the current plan year;

b. up to 90 days after the termination date, if the event triggering the right to continuing treatment is part of an ongoing course of treatment.

The requirements of this Section 3 do not apply to health care services covered by Medicaid.

4. Indemnification Prohibited. Nothing in this Agreement or this Attachment shall be construed to require Provider to indemnify or hold UBH harmless for the acts or conduct of UBH.

5. Financial Incentives Prohibited. Nothing in this Agreement or this Attachment shall be construed to create direct financial incentives to Provider for withholding Covered Services that are medically necessary. Incentives for efficient management of the utilization and cost of Covered Services are not prohibited.

6. Prompt payment of health care claims.

(a) Optum or Payor shall pay or deny a clean claim within 30 days after Optum receives such claim.

(b) If Optum or Payor does not pay or denies a health care insurance claim, Optum shall give notice to the Provider of the basis for denial or the specific information that I needed for Optum to adjudicate the claim within 30 calendar days after Optum or Payor receives the claim.

(c) If Optum or Payor does not provide the notice as required by (b) of this section, the claim is presumed a clean claim, and interest shall accrue at a rate of 15 percent annually beginning on the 31st day and continue to accrue until the date that the claim is paid.

(d) If Optum or Payor provides the notice required under (b) of this section and requests specific information that is needed to adjudicate the claim, Optum or Payor shall pay the claim no later than 15 calendar days after receipt of the information specified in the notice or within 30 days after receipt of the claim. If Optum or Payor does not pay the claim within the time period required under this subsection, the claim is presumed to be a clean claim, interest at a rate of 15 percent accrues, and interest continues to accrue until the date the claim is paid.

(e) For purposes of (c) and (d) of this section, if only a portion of a claim is covered under the term so Benefit Plan, interest accrues based only on the portion of the claim that was a covered benefit.

(f) For the purposes of this section, a claim is considered paid on the day payment is mailed or transmitted electronically.

(g) If interest is accrued on a claim under (c) or (d) of this section, Optum or Payor may not include the amount of interest accrued in calculating an applicable limit on benefits payable to a Customer or other person claiming payments under the Benefit Plan.

(h) Optum or Payor is not required to pay interest due as a result of the application of (c) or

(d) of this section if the amount of the interest is $1.00 or less.

(i) In this section, "clean claim" means a claim that does not have a defect or impropriety, including a lack of any required substantiating documentation, or a particular circumstance requiring special treatment that prevents timely payment of the claim.

7 Correction of Overpayments. Optum or Payor shall give written notice to Provider at least 30 calendar days before Optum or Payor seeks recovery of an overpayment. The notice must include adequate information for Provider to identify the specific claim and the specific reason for the recovery. Optum may not initiate recovery of an overpayment more than 365 days after the date the original payment was made to Provider or Provider's agents, unless Optum has clear and documented reason to believe that Provider or its agent has committed fraud or other intentional misconduct.

8. Medical Necessity/Utilization Review.

(j) In the event that Optum or Payor requires preauthorization for a covered medical procedure on the basis of medical necessity, payment may not be retroactively denied unless the preauthorization is based on materially incomplete or inaccurate information provided by or on behalf of Provider.

(k) In the event that Optum makes a utilization review decision regarding a service, such decision must be made within 72 hours after receiving the request for preapproval for nonemergency situations; for emergency situations, utilization review decisions for care following emergency services must be made as soon as is practicable but in any event not later than 24 hours after receiving the request for preapproval or for coverage determination.

(l) Any decision to deny, reduce, or terminate a health care benefit or to deny payment for a medical care service because that service is not medically necessary shall be made by an employee or agent of Optum who is a licensed health care provider.

(m) Provider may appeal such determination pursuant to Alaska Statutes Section 21.07.020.