UNITED BEHAVIORAL HEALTH
PROVIDER AGREEMENT

Kentucky Regulatory Requirements Attachment

This **Kentucky** 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 Plans sponsored, issued or administered by or accessed through UBH to the extent such products are regulated under **Kentucky** 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 Plans 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 Plans regulated by the State of KENTUCKY and/or under KENTUCKY HMO laws, as applicable.

1. Member Hold Harmless. Provider may not, under any circumstance, including: (a) nonpayment of amounts due Provider by UBH Or Payor; (b) insolvency of UBH or Payor; or (c) breach of this Agreement, bill, charge, collect a deposit, seek compensation, remuneration or reimbursement from, or have any recourse against Member or any person acting on Member's behalf, for Covered Services provided in accordance with this Agreement. This provision shall not prohibit collection of copayments, deductibles or coinsurance for which the Member is responsible under the Benefit Plan and amounts for non-covered services. This provision shall survive termination of this Agreement.

2. Continuity of Care. . If this Agreement is terminated for any reason, other than a quality of care issue or fraud, UBH or Payor as applicable shall continue to provide coverage and reimburse Provider for Covered Services in accordance with this Agreement until the later of (a) the Member's discharged from an inpatient facility, or (b) the completion of the Member's active course of treatment. With regard to Covered Services being provided to a Member who is a pregnant woman in her fourth or later

month of pregnancy at the time the Agreement is terminated, Provider shall continue to provide Covered Services to such Member through the end of the post-partum period. This provision shall survive termination of this Agreement.

3. Continued Care for Members with Special Circumstances. As requested by Provider and Member and approved by UBH following termination of this Agreement, Provider shall continue to provide Health Services to a Member with special circumstances until the latest to occur of: (a) the ninetieth (90th) day after the effective date of termination; or (b) nine months following termination of this Agreement in the case of a Member who has been diagnosed with a terminal illness at the time of the termination. During such time, Provider shall deliver Health Services under the same guidelines and payment schedule as required by this Agreement and shall report to UBH on the care being provided.

For purposes of this Section, Kentucky law defines a "Special Circumstances" as a circumstance in which a Member has a disability, a congenital condition, a life-threatening illness or is past the twenty-fourth week of pregnancy where disruption of the Member's continuity of care could cause medical harm. This provision shall not apply with respect to a Provider who has been terminated for a reason related to quality.

4. Termination Provisions. The following provisions are In addition to the termination provisions identified in the Termination Section of the underlying Provider Agreement of the Provider Participation Agreement.

(a) United Behavioral Health Policy. Provider acknowledges that UBH has informed Provider of UBH's removal and withdrawal policy.

(b) Termination Resulting from Professional Review Action. If this Agreement is terminated as a result of a professional review action, such termination shall be effective only after adequate notice and hearing procedures, or such other procedures as are fair to the Provider, are afforded to the Provider in accordance with Title 42, United States Code, Section 11112. Unless circumstances indicate otherwise, UBH shall use the following procedure:

(i) UBH shall provide notice to Provider (A) that a professional review action has been proposed to be taken against the Provider, (B) reasons for the proposed action, (C) that Provider has the right to request a hearing on the proposed action within thirty (30) days, and (D) a summary of Provider's rights in the hearing.

(ii) If Provider makes a timely request for a hearing, UBH shall notify Provider (A) of the place, time, and date, of the hearing, which date shall not be less than thirty (30) days after the date of the notice, and (B) a list of the witnesses (if any) expected to testify at the hearing on behalf of the professional review body.

(iii) As determined by UBH, the hearing shall be held before a mutually acceptable arbitrator, a hearing officer appointed by UBH who is not in direct economic competition with Provider, or a panel of individuals appointed by UBH who are not in direct economic competition with Provider.

(iv) Provider may forfeit the right to the hearing if the Provider fails, without good cause, to appear. During the hearing, Provider has the right (A) to representation by an attorney or other person of Provider's choice, (B) to have a record made of the proceedings, copies of which may be obtained by Provider upon payment of any reasonable charges associated with the preparation thereof, (C) to call, examine, and cross-examine witnesses, (D) to present relevant evidence, and (E) to submit a written statement at the close of the hearing. Upon completion of the hearing, Provider has the right to receive the written recommendation of the arbitrator, hearing officer, or panel, including a statement of the basis for the recommendations, and to receive a written decision of UBH including a statement of the basis for the decision.

Notification of Licensing Board. If UBH finds that Provider represents an imminent danger to a Member or to the public health, safety or welfare, UBH's medical director shall promptly notify the appropriate professional licensing board.

5. Provider Communications with Member. Nothing in this Agreement shall be construed to limit Provider's disclosure of any (a) information relating to Member's medical condition, (b) treatment options or (c) other information determined by the Provider to be in the best interests of the Member to a Member or another person on Member's behalf. Nothing in this Agreement shall be construed to penalize or allow for termination of the Agreement because Provider discusses medically necessary or appropriate care with a Member or another person on Member's behalf. Nothing in this Agreement shall be construed to penalize Provider for discussing with a Member financial incentives and financial arrangements between Payor or UBH and Provider.

6. No Most-Favored-Nation Provision. Nothing in this Agreement shall be construed as a most-favored-nation provision, as that term is used in Kentucky Statutes, Section 304.17A-560. UBH and Provider agree that they may negotiate payment rates and performance based terms that might result in UBH receiving a rate that is as favorable as or more favorable than the rates negotiated between Provider and other health insurance issuers.

7. Hospitalist Not Required. If Provider is a physician, this Agreement shall not require the mandatory use of a hospitalist.

8. No Requirement to Participate in Other Products. Provider is not required, as a condition of participation in a benefit plan offered by UBH, to participate in any of UBH's other benefit plans.

9. Prompt Pay. UBH and Payor shall comply with the applicable provisions of Kentucky law regarding claims processing and payment provisions. In accordance with KRS 304.17A-702, UBH and Payor shall reimburse a clean claim or send a written or an electronic notice denying or contesting a claim within thirty (30) calendar days from the date that the claims is received by UBH or Payor. UBH, Payor and Provider shall follow all requirements

10. Claims Attachments. Provider shall comply with the provisions in 806 KAR 17:370 regarding standardized health claim attachments. UBH may routinely request certain additional health claim attachments in accordance with KRS 304.17A-706(2), as applicable.

11. Claims Processing. Provider acknowledges that Payor or UBH has disclosed to Provider:

(i) the mailing or electronic address where claims should be sent for processing;
(ii) the phone number Provider may call to have questions and concerns regarding claims addressed;
(iii) any entity to which Payor or UBH has delegated claim payment functions; and
(iv) the address of any separate claims processing centers for specific types of services.

Any change to such information shall be provided in writing to Provider at least sixty (60) calendar days prior to the effective date of such change.

12. Discounted Fee Reimbursement. If this Agreement allows Payor to reimburse Provider on a discounted fee basis, Provider acknowledges Payor's or UBH's disclosure of such discounted fee.

13. Subcontractor Agreements. If Provider enters into a subcontract agreement with another provider to provide Health Services to a Member where the subcontracted provider will bill UBH or Payor directly for the subcontracted services, the subcontract agreement must meet all requirements of KRS 304.17A and that all such subcontract agreements shall be filed with the commissioner in accordance with the KRS 304.17A-527.

14. Corrective Adjustments. UBH or Payor shall comply with the requirements set forth in Kentucky Revised Statutes 304.17A-708 and 304.17A-714 with regard to making adjustments to claims where there has been an overpayment or underpayment to Provider or when retroactively denying reimbursement to Provider. UBH and/or Payor shall not be required to correct a payment error to a Provider if the Provider's request for

a payment correction is filed more than twenty-four (24) months after the date the Provider received payment for the claim from UBH and/or Payor. Not withstanding any time frames set forth in the aforementioned statutes, if UBH or Payor determines that fraud has led to an overpayment or the retroactive denial of a reimbursement, UBH or Payor may recover an overpayment amount or a reimbursement at any time, including after any statutory time frames.

15. Payment Information. Upon request by Provider, UBH or Payor will provide or make available to Provider, when contracting or renewing this Agreement, the payment or fee schedules or other information sufficient to enable Provider to determine the manner and amount of payments under this Agreement prior to the final execution or renewal of this Agreement, and shall provide any change in such schedules at least ninety (90) days prior to he effective date of the change. This information may be made available electronically or via a Web site. This section shall not apply to changes in standard codes and guidelines developed by the American Medical Association or a similar organization. Provider will not share information received under this section with an unrelated person without the prior written consent of UBH.

16. Amendment. If UBH makes a material change to this Agreement, UBH shall provide Provider with at least ninety (90) days' written notice of the material change. The notice shall include a description of the material change and a statement that Provider has the option to withdraw from the Agreement prior to the material change becoming effective. "Material charge", as used in this Section, will have the meaning defined in KRS 304.17A-235. If Provider opts to withdraw following notice of the material change Provider will send written notice of withdrawal to UBH no later than forty-five (45) days prior to the effective date of the material change. If UBH makes a change to this Agreement that charges an existing prior authorization, precertification, notification, or referral program, or changes an edit program or specific edits, UBH shall provide no0tice of the change to Provider at least fifteen (15) days prior to the change.

In the event of three material changes in a 12 month period, the Provider may request a copy of the contract with material changes consolidated into it. OHCS providing a copy of the contract to Provider is for informational purposes only and has no effect on the terms and conditions of the contract. Provider notices will be prepared and mailed in accordance with KRS 304.17A-235,

17. Discrimination. UBH acknowledges and is in full compliance with KRS 304.17A-270 and shall not discriminate against any provider who is located within the geographic coverage area of the Plan and who is willing to meet the terms and conditions for inclusion in the UBH Network, including the Kentucky state Medicaid program and Medicaid partnerships.

18. Grievances. UBH and Payor acknowledge that they shall not request or require a Provider to pursue any other course of action regarding the payment of health care claims

outside of the provisions set forth in KRS 304.17A-700 to 304.17A-730 and KRS 205.593, 304.14-135, and 304.99-123.

KENTUCKY REGULATORY REQUIREMENTS ADDENDUM: EXHIBIT 1a
Benefit Plan Descriptions

Provider shall participate in the network of Participating Providers established by United Behavioral Health ("UBH") for the Benefit Plan types identified below (except as otherwise prohibited by applicable state or federal law):

Benefit Plans sponsored or issued by a licensed Health Maintenance Organization, where Members are offered a network of Participating Providers and must select a Primary Physician. The Primary Physician coordinates the Member's care and approves the rendering of Health Services to Members by other providers. An option for this Benefit Plan allows the Member to receive Health Services from a Participating or non-Participating Provider, without the approval of the Primary Physician.

Benefit Plans sponsored or issued by a licensed Health Maintenance Organization (Benefit Plans described in this bullet and the preceding bullet are "HMO" Contracts), where Members are offered a network of Participating Providers but are not required to select a Primary Physician. The Member may receive Health Services from a Participating Provider of his or her choice. An option for this Benefit Plan allows the Member to receive Health Services from non-Participating Providers.

Benefit Plans not sponsored or issued by a licensed Health Maintenance Organization, where Members are offered a network of Participating Providers and must select a Primary Physician. The Primary Physician coordinates the Member's care and approves the rendering of Health Services to Members by other providers. An option for this Benefit Plan allows the Member to receive Health Services from a Participating or non-Participating Provider, without the approval of the Primary Physician.

Benefit Plans not sponsored or issued by a licensed Health Maintenance Organization (Benefit Plans described in this bullet and the preceding bullet are "PPO" Contracts), where Members are offered a network of Participating Providers but are not required to select a Primary Physician. The Member may receive Health Services from a Participating Provider of his or her choice. An option for this Benefit Plan allows the Member to receive Health Services from non-Participating Providers.

Benefit Plans where Members are not offered a network of Participating Providers from which they may receive Health Services.

Benefit Plans for Medicaid Members.

Benefit Plans for Medicare Advantage Members.

Provider shall not be required to participate in the following networks:

Benefit Plans for Medicaid Members.
Benefit Plans for Medicare Advantage Members.
Benefit Plans for workers' compensation benefit programs.

Note: References in this Exhibit 1a to "Licensed Health Maintenance Organization" also apply to comparable entities licensed in a state other than Kentucky, even if that state's law uses different terminology to describe such entities (for instance, an entity licensed in Ohio as a Health Insuring Corporation).