UNITED BEHAVIORAL HEALTH
PROVIDER AGREEMENT

Louisiana Regulatory Requirements Attachment

This **Louisiana** 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 **Louisiana** 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 Louisiana and/or under Louisiana HMO laws, as applicable.

1. **Member Hold Harmless.** Provider agrees not to discount bill, dual bill, attempt to collect from, or collect from a Member any amount in excess of the amount set forth in the Agreement, and to only collect from Member coinsurance, copayments, deductibles, noncovered or noncontracted MHSA services, or other amounts identified by UBH or Payor on an explanation of benefits as an amount for which the Member is liable. Provider agrees that Members shall not be liable to Provider for any sums owed by UBH or Payor in the event that UBH or Payor, as applicable, fails to pay for Covered MHSA Services as set forth in that Member's Benefit Plan. Provider further agrees that neither Provider, its agent, trustee, nor assignee may bill or maintain any action at law against a Member to collect sums owed by Payor.

2. **Prohibited Incentives.** Provider and UBH agree that, pursuant to Louisiana law, nothing in this Agreement or Attachment shall be construed to provide an incentive or specific payment, directly or in any form, to Provider as an inducement to deny, reduce, limit, or delay specific, medically necessary, and appropriate services provided with respect to a specific Member or groups of Members with similar medical conditions. Nothing in this Agreement or Attachment shall be construed to prohibit incentive plans

that involve general payments, or shared-risk arrangements that are not tied to specific medical decisions involving a specific Member or groups of Members with similar medical conditions.

3. **Member Grievances.** UBH maintains a procedure for processing and resolving Member grievances as required by Louisiana law. Provider has been notified that Member grievances may be submitted by telephone or in writing to the appropriate telephone number and address provided to Provider.

4. **Noninterference with Communications**. Nothing in this Agreement or Attachment shall be construed to interfere with Provider's ability to communicate with a Member regarding his/her health care, including treatment options and medical alternatives, or other coverage arrangements, or prohibit Provider from advocating to UBH on behalf of a Member for approval or coverage of treatment or the provision of health care services. Additionally, UBH shall not refuse to contract, renew, cancel, restrict, or otherwise terminate a contract, including this Agreement, with Provider solely on the basis of a communication. UBH shall not refuse to refer Members to Provider, refuse to compensate Provider for MHSA Covered Services, or take other retaliatory action against Provider solely on the basis of a medical communication. Nothing in this Agreement or Attachment shall be construed to restrict Provider from filing a complaint, making a report, or commenting to an appropriate governmental body regarding UBH's policies or practices that may impact upon the quality of, or access to, patient care.

5. **Transfer of Liability**. Nothing in this Agreement or Attachment shall be construed to transfer to Provider by indemnification or otherwise any liability relating to activities, actions, or omissions of UBH.

6. **Prompt Payment**. Any non-electronic claim submitted by Provider within forty-five (45) days of the date of service or discharge shall be paid, denied or pended not more than forty-five (45) days from the date upon which a clean claim is received by UBH or its legal agent for a Covered MHSA Service unless just and reasonable grounds such as would put a reasonable and prudent businessman on his guard exist. Any non-electronic claim submitted by Provider more than forty-five (45) days after the date of service or discharge or resubmitted because the original claim was not an accepted claim or not a clean claim shall be paid, denied or pended not more than sixty (60) days from the date upon which a clean claim is received by UBH or its legal agent unless the service is not covered or just and reasonable grounds such as would put a reasonable and prudent businessman on his guard exist. UBH shall review all claims submitted electronically within five (5) working days of UBH's receipt of the claim. If the claim is not accepted, UBH shall issue an exception report to Provider indicating any defects or reasons known as to why the claim is not accepted. The exception report shall contain the minimum information, if known at the time, as required under Louisiana Revised Statute §22:1833. If UBH fails to so notify Provider, the claim shall be deemed as a timely submission of a claim for payment. Any electronic clean claim for a Covered Service submitted by Provider shall be paid, denied or pended not more than twenty-five (25) days from the date upon which a clean claim

form is received by UBH or its legal agent unless just and reasonable grounds such as would put a reasonable and prudent businessman on his guard exist.

7. Review and Audit. UBH shall perform any review or audit to reconsider the validity of a claim within the same time period following payment of a claim that Provider has to submit a claim pursuant to the Agreement. Notwithstanding any other provision of law to the contrary, UBH shall not limit the right of a rural hospital to receive payment for covered health care services as long as a claim for payment of such services is submitted within one year after the date on which the rural hospital provided the services. Notwithstanding any other provision of law to the contrary, for health services rendered in good faith and pursuant to the benefit plan, UBH or Payor may not retroactively deny payment or recoup any monies paid beyond ninety days from the expiration of the allowable thirty-day period for the payment of any claim when the denial or recoupment is based on a determination that the insured was no longer covered under the plan at the time of the service.

8. Continuation of Care. This Section 8 applies only when Provider is a physician. In the event this Agreement is terminated, Provider shall notify UBH of any Member who has begun a course of treatment by Provider before the termination is effective. Based on this notice from Provider, UBH shall notify the Member of Provider's termination and the Member's rights with respect to continuity of care. The following three provisions apply without regard to which party initiated the termination:

(a) in the event a Member has been diagnosed as being in a high risk pregnancy or is past the twenty fourth week of pregnancy, the Member shall be allowed to continue receiving MHSA Covered Services, subject to Provider's consent, through delivery and postpartum care related to the pregnancy and delivery.

(b) in the event a Member has been diagnosed with a life threatening illness (as that term is defined in Louisiana Revised Statute §22:1005(6), the Member shall be allowed to continue receiving MHSA Covered Services, subject to Provider's consent, until the course of treatment is completed, not to exceed three months from the effective date of termination.

(c) in the event Provider advises UBH of a Member who meets he criteria of paragraph (a) or (b) in this section 8, UBH shall continue to reimburse Provider under the terms of this Agreement. In addition, contractual requirements under this Agreement regarding utilization management and quality management policies and procedures, if any, shall remain in effect for the applicable period specified in paragraph (a) or (b) of this section 8.

This Section 8 does not apply when:

(a) The reason that the Agreement is terminated is due to suspension, revocation, or applicable restriction of Provider's license to practice in this state by the Louisiana State Board of Medical Examiners, or for another documented reason related to quality of care.

(b) The Member chooses to change health care providers.

(c) The Member moves out of our or your geographic service area.

(d) The Member requires only routine monitoring for a chronic condition but is not in an acute phase of the condition.

9. Records. Provider and UBH shall comply with all applicable requirements set forth in Louisiana Revised Statute 40:1299.96, including the furnishing of, and paying for, copies of medical records.

10. Network Rental. Provider and UBH expressly acknowledge the underlying Provider Agreement allows UBH to enter into an agreement with a third party allowing the third party to obtain UBH's rights and responsibilities under this Agreement.

11. Payment as a condition for verification of coverage. Provider may not require a Mmeber to consent to payment for healthcare services as a condition for verification of health insurance coverage for such healthcare services. Any provision in the Agreement that conflicts with the provisions of this paragraph shall be deemed null and void.

12. Recoupment of claim payment.

i) Prior to any recoupment (as defined in La. R.S. § 22:1838) unrelated to a claim for payment of services provided by Provider or any other amount owed by UBH or Payor to Provider, UBH shall provide Provider with written notification that includes the name of the Member, the date or dates of Covered Services rendered, and an explanation of the reason for recoupment. Provider shall be allowed 30 days from receipt of written notification of recoupment to appeal UBH's action and to provide UBH the name of the patient, the date or dates of Covered Services rendered, and an explanation for the appeal.

ii) When Provider fails to respond timely and in writing to UBH's written notification of recoupment, UBH may consider the recoupment accepted. If a recoupment is accepted, Provider may remit the agreed amount to UBH or Payor at the time of any written notification of acceptance or may permit UBH or Payor to deduct the agreed amount from future payments due to Provider. If Provider disputes UBH's written notification of recoupment, the dispute shall be resolved according to the general dispute resolution provisions of the Agreement.

iii) If the recoupment directly affects the payment responsibility of the Member, UBH shall provide at the same time a revised explanation of benefits to Provider and the Member for whose claim the recoupment is being made. Unless the recoupment of a UBH or Payor's payment directly affects the payment responsibility of the Member, such recoupment shall not result in any increased liability of a Member.

iv) UBH or Payor shall not retroactively deny, adjust, or seek recoupment or refund of a paid claim for Covered Service expenses submitted by Provider for Covered Services rendered in good faith and pursuant to the Benefit Plan for any reason after the expiration of 18 months from the date the initial claim was paid. This subsection 8(v) shall not be construed to supersede any provision of law that prescribes a time period less than 18 months for the retroactive denial of payment or recoupment of monies paid for a claim or the reconsideration of the validity of a claim.