Maryland Regulatory Appendix

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

This Appendix applies to all products or Benefit Plans sponsored, issued or administered by or accessed through UBH to the extent such products are regulated under Maryland laws.

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

If any of the capitalized terms in this Appendix are used or defined (or the equivalent terms are used or defined) in the Agreement, then the terms used in this Appendix will have the same meaning as the terms (or equivalent terms) used or defined in the Agreement. For example, "Benefit Plans," as used in this Appendix, will have the same meaning as "benefit contracts"; "Member," as used in this Appendix, will have the same meaning as "member," "enrollee," or "covered person"; "Payor," as used in this Appendix, will have the same meaning as "participating entity"; "Provider," as used in this Appendix, will have the same meaning as "Facility," "Medical Group," "Ancillary Provider," "Physician," or "Practitioner." Additionally, if the Agreement uses pronouns to refer to the contracted entities, then "UBH" will have the same meaning as "we" or "us," and "Provider" will have the same meaning as "you" or "your."

This Appendix will be deemed to be updated to incorporate any changes to the laws and regulations referenced herein, including any changes to definitions referenced herein, effective as of the date of such changes.

Unless otherwise defined in this Appendix, all capitalized terms contained in the Appendix shall be defined as set forth in the Agreement.

Provisions applicable to Benefit Plans regulated under Maryland HMO laws:

1. Period in Which to Submit Claims. Subject to Maryland Insurance Article § 15-1005, UBH or Payor will permit Provider a minimum of 180 days from the date a covered service is rendered to submit a claim for reimbursement. UBH, Payer and Provider shall comply with applicable Maryland laws that relate to the payment of claims, including Maryland Insurance

Articles § 15-1005, §15-1008, and Code of Maryland Regulations Title 31, Subtitle 10, Chapter 11, as may be amended.

2. Bonus Payments. UBH or Payor will pay a Provider, who is a Member's primary care physician, an additional bonus payment for providing Covered Services to a Member in a Provider location set forth in the Agreement when such Covered Services are provided after 6 p.m. and before 8 a.m., or on a Saturday, Sunday, or national holiday, and are in compliance with UBH's after hours and weekend care Reimbursement Policy, except that the policy's requirement that the Covered Services be an alternative to emergency room or urgent care center services does not apply. The policy is available on www.UBHhealthcareonline.com.

3. Group Practice Reimbursement. Subject to Maryland Code Section 15-112, UBH or Payor will reimburse a group practice on the provider panel at the participating provider rate for Covered Services provided by a physician or practitioner who is not a participating provider if:

(a) the physician or practitioner is employed by or a member of the group practice;

(b) the physician or practitioner has applied for acceptance on UBH's provider panel and has been notified of the UBH's intent to continue to process the application to obtain necessary credentialing information;

(c) the physician or practitioner has a valid license issued by a health occupations board to practice in the State; and

(d) the physician or practitioner:

(i) is currently credentialed by an accredited hospital in the State; or (ii) has professional liability insurance.

4. Continuation of Services. If Provider is a primary care provider as defined under applicable Maryland Statutes and is terminated from UBH's provider panel for reasons unrelated to fraud, patient abuse, incompetency, or loss of licensure status, Provider shall continue to furnish Covered Services to each Member for ninety (90) days after the date of the notice of termination:

(a) who was receiving Covered Services from Provider before the notice of termination; and

(b) who, after receiving notice of the termination of Provider, requests to continue receiving Covered Services from Provider.

UBH or Payer, as applicable, shall reimburse Provider for services provided pursuant to this Continuation of Services provision in accordance with this Agreement.

The provisions of this Section shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of Members. These Continuation of Services provisions shall supersede any oral or written contrary agreement, now existing or thereafter entered into, between Provider and a Member or a person acting on a Member's behalf.

5. Subcontractors. If Provider arranges for other health care professionals or facilities to render Covered Services to Members ("Subcontractor"), Provider agrees to comply with the conditions stated in the Subcontractor Attachment.

6. Member Protection Provision. Provider may not, under any circumstances, including but not limited to nonpayment of moneys due to Provider from UBH or Payer, insolvency of UBH or Payer, or breach of this Agreement; bill, charge, collect a deposit, seek compensation, remuneration, or reimbursement from, or have any recourse against the Member, or any persons, other than UBH, acting on the Member's behalf, for services provided in accordance with this Agreement. Collection of co-payments or supplemental charges in accordance with the terms of the Member's Benefit Plan, or charges for services not covered under the Member's Benefit Plan, are excluded from this Hold Harmless clause. This Hold Harmless provision shall survive the termination of this Agreement, regardless of the cause of termination.

7. Indemnification Prohibited. Nothing in this Agreement shall be construed or interpreted as requiring Provider to indemnify UBH or hold UBH harmless for a coverage decision or negligent act of UBH.

8. Notification of Provider Panel Termination. UBH shall give to Provider advance written notice in the form and for the length of time as provided in the Agreement but in no case less than ninety (90) days before the date of the termination of Provider from UBH's provider panel if the termination is for reasons unrelated to fraud, patient abuse, incompetency, or loss of licensure status.

9. Provider Withdrawal. If Provider elects to terminate participation as a member of UBH's provider panel, Provider shall give to UBH advance written notice in the form and for the length of time as provided in the Agreement but in no case less than ninety (90) days before the date of termination. In addition, Provider shall continue to furnish health care services to Members for whom Provider was responsible for the delivery of health care services prior to the notice of termination for the period between the date of the Provider's notice of termination and the date on which the Provider's participation ends, which shall be no less than ninety days.

10. Communications. Nothing in this Appendix shall be construed or interpreted as prohibiting Provider from discussing with or communicating to a Member or other person information that is necessary or appropriate for the delivery of Covered Services, including:

(a) communications that relate to treatment alternatives;

(b) communications that are necessary or appropriate to maintain the provider-patient relationship while the patient is under Provider's care;

(c) communications that relate to a Member's right to appeal a coverage determination of UBH with which Provider or Member does not agree; and

(d) opinions and the basis of an opinion about public policy issues.

11. Definition of Experimental, Investigational, or Unproven Medical Care. When UBH is the Payer, and as otherwise required by applicable law, the following definition of Experimental, Investigational or Unproven Services shall be used in evaluating the availability of benefits under a Benefit Plan:

Medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by UBH (at the time UBH makes a determination regarding coverage in a particular case) to be: (1) not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service, the UBH States Pharmacopeia Dispensing Information, or the American Medical Association Drug Evaluations or in the medical literature as appropriate for the proposed use; or (2) subject to review and approval by the Institutional Review Board of the treating facility for the proposed use; or (3) the subject of a written protocol used by the treating facility for research, clinical trials, or other tests or studies to evaluate its safety, effectiveness, toxicity or efficacy, as evidenced in the protocol itself or in the written consent form used by the treating facility; or (4) not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

Benefit Plans administered by Payers other than UBH may contain a modified definition of Experimental Services, which is available upon request.

12. Assignment, Transfer, or Subcontracting. UBH may not, in any manner, assign, transfer, or subcontract this Agreement, wholly or partly, to an insurer that offers personal injury protection coverage under Maryland Insurance Article §19-505 without first informing Provider and obtaining Provider's express written consent. UBH may not terminate, limit, or otherwise impair Provider's participation with UBH on the basis that Provider refused to agree to an assignment, transfer, or subcontract of all or part of Provider's contract to an insurer that offers personal injury protection coverage under Maryland Insurance Article §19505.

13. Information Provided. UBH shall provide to Provider a schedule of applicable fees for up to the fifty (50) most common services billed by a health care practitioner in Provider's specialty, a description of the coding guidelines used by UBH that are applicable to the services billed by a health care practitioner in Provider's specialty, and the methodology that UBH uses to determine whether to increase or reduce Provider's level of reimbursement and

provide a bonus or other incentive-based compensation to Provider. UBH shall provide this information to Provider at the time this Agreement is executed, thirty (30) days prior to change in this Agreement, and upon Provider's request. UBH will not require as a condition of participation that the Provider accept each schedule of applicable fees included in this Agreement.

14. Denial for Preauthorized Care. If a Covered Service has been preauthorized or approved for a Member by UBH or its private review agent, UBH or Payer, as applicable, may not deny reimbursement to Provider for the preauthorized or approved service delivered to that Member unless:

(a) the information submitted to UBH regarding the service to be delivered to the Member was fraudulent or intentionally misrepresentative;

(b) critical information requested by UBH regarding the service to be delivered to the Member was omitted such that UBH's determination would have been different had it known the critical information;

(c) a planned course of treatment for the Member was approved by UBH but was not substantially followed by Provider; or

(d) on the date the preauthorized or approved service was delivered:

(i) the Member was not covered by UBH;

(ii) UBH maintained an automated eligibility verification system that was available to the contracting provider by telephone or via the Internet; and

(iii) according to the verification system, the Member was not covered by UBH.

15. "All Products" Clause Prohibited. Except as otherwise provided by Maryland Statutes (including but not limited to § 15-112.2(b)), if UBH or Payer offers coverage for Covered Services through one or more health benefit plans, or contracts with providers to offer Covered Services through one or more provider panels, UBH may not require Provider, as a condition of participation or continuation on a provider panel for one of UBH's health benefit plan to serve also on another of UBH's provider panels.

16. Carrier Panels. Subject to Maryland Code Section 15-112.2(c) those Maryland carriers that comprise the provider panel are as follows:

(a) Optimum Choice, Inc
(b) UnitedHealthcare of Mid-Atlantic, Inc.

This list is subject change. Additional carriers may be set forth in the Administrative Guide. Provider may contact UBH for any updates.

17. Provider Panels. Subject to Maryland Code Section 15-125(c)(3) Provider has the right to elect not to serve on a provider panel for workers' compensation services.

18. Authorization Requirements. Subject to all applicable terms and conditions found in the Maryland Insurance Code §15-802(d)(2), (3) and (4) and in accordance with the Provider Manual, Protocols and requirements of the Member's benefit Plan regarding authorization for non-routine services, provider must request authorization for certain non-routine MHSA services from UBH by telephone: (a)prior to providing any services to a Member when MHSA Services are performed during Provider's normal business hours Monday-Friday; and (B)within 24 hours if MHSA Services are provided on weekends or after Provider's normal weekday business hours (which shall be deemed to be requested as if requested during normal business hours.) 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 law. Any authorization resulting from wrongful, fraudulent or negligent actions of a Provider or a breach of this Agreement shall be null and void as of the time given. In the event of any conflict arising from this provision, the terms of Maryland Insurance Code §15-802(d)(2), (3), and (4) shall control.

19. Definition of Emergency Services: "Emergency services" means those health care services that are provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in:
(1) Placing the patient's health in serious jeopardy;
(2) Serious impairment to bodily functions; or
(3) Serious dysfunction of any bodily organ or part.

Provisions applicable to Benefit Plans regulated by the State of Maryland but not subject to Maryland HMO laws.

1. Period in Which to Submit Claims. UBH, Payer and Provider shall comply with applicable Maryland laws that relate to the payment of claims, including Maryland Insurance Articles § 15-1005,
§15-1008, and Code of Maryland Regulations Title 31, Subtitle 10, Chapter 11, as may be amended.

2. Bonus Payments. UBH or the Payor will pay a Provider, who is a Member's primary care physician, an additional bonus payment for providing Covered Services to a Member in a Provider location set forth in the Agreement when such Covered Services are provided after 6 p.m. and before 8 a.m., or on a Saturday, Sunday, or national holiday, and are in compliance with UBH's after hours and weekend care Reimbursement Policy, except that the policy's requirement that the Covered Services be an alternative to emergency room or urgent care center services does not apply. The policy is available on www.UBHhealthcareonline.com.

3. Group Practice Reimbursement. Subject to Maryland Code Section 15-112 UBH or Payor will reimburse a group practice on the provider panel at the participating provider rate for Covered Services provided by a physician or practitioner who is not a participating provider if:

(a) the physician or practitioner is employed by or a member of the group practice;

(b) the physician or practitioner has applied for acceptance on UBH's provider panel and has been notified of the UBH's intent to continue to process the application to obtain necessary credentialing information;

(c) the physician or practitioner has a valid license issued by a health occupations board to practice in the State; and

(d) the physician or practitioner:

(i) is currently credentialed by an accredited hospital in the State; or (ii) has professional liability insurance.

4. Continuation of Services. If Provider is a primary care provider as defined under applicable Maryland Statutes and is terminated from UBH's provider panel for reasons unrelated to fraud, patient abuse, incompetency, or loss of licensure status, Provider shall continue to furnish Covered Services to each Member for ninety (90) days after the date of the notice of termination:

(a) who was receiving Covered Services from Provider before the notice of termination; and

(b) who, after receiving notice of the termination of Provider, requests to continue receiving Covered Services from Provider.

UBH or Payer, as applicable, shall reimburse Provider for Covered Services provided pursuant to this Continuation of Services provision in accordance with this Agreement.

The provisions of this section shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of Members. These Continuation of Services provisions shall supersede any oral or written contrary agreement, now existing or thereafter entered into, between Provider and a Member or a person acting on a Member's behalf.

5. Notification of Provider Panel Termination. UBH shall give to Provider advance written notice in the form and for the length of time as provided in the Agreement but in no case less than ninety

(90) days before the date of the termination of Provider from UBH's provider panel if the termination is for reasons unrelated to fraud, patient abuse, incompetency, or loss of licensure status.

6. Provider Withdrawal. If Provider elects to terminate participation as a member of UBH's provider panel, Provider shall give to UBH advance written notice in the form and for the length of time as provided in the Agreement but in no case less than ninety (90) days before the date of termination. In addition, Provider shall continue to furnish health care services to Members for whom Provider was responsible for the delivery of health care services prior to the notice of termination for the period between the date of the Provider's notice of termination and the date on which the Provider's participation ends, which shall be no less than ninety days.

7. Communications. Nothing in this Appendix shall be construed or interpreted as prohibiting Provider from discussing with or communicating to a Member or other person information that is necessary or appropriate for the delivery of Covered Services, including:

(a) communications that relate to treatment alternatives;

(b) communications that are necessary or appropriate to maintain the provider-patient relationship while the patient is under Provider's care;

(c) communications that relate to a Member's right to appeal a coverage determination of UBH with which Provider or Member does not agree; and

(d) opinions and the basis of an opinion about public policy issues.

8. Definition of Experimental, Investigational, or Unproven Medical Care.
When UBH is the Payer, and as otherwise required by applicable law, the following definition of Experimental, Investigational or Unproven Services shall be used in evaluating the availability of benefits under a Benefit Plan:

Medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by UBH (at the time UBH makes a determination regarding coverage in a particular case) to be: (1) not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service, the UBH States Pharmacopoeia Dispensing Information, or the American Medical Association Drug Evaluations or in the medical literature as appropriate for the proposed use; or (2) subject to review and approval by the Institutional Review Board of the treating facility for the proposed use; or (3) the subject of a written protocol used by the treating facility for research, clinical trials, or other tests or studies to evaluate its safety, effectiveness, toxicity or efficacy, as evidenced in the protocol itself or in the written consent form used by the treating facility; or (4) not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

Benefit Plans administered by Payers other than UBH may contain a modified definition of Experimental Services, which is available upon request.

9. Assignment, Transfer, or Subcontracting. UBH may not, in any manner, assign, transfer, or subcontract this Agreement, wholly or partly, to an insurer that offers personal injury protection coverage under Maryland Insurance Article §19-505 without first informing Provider and obtaining Provider's express written consent. UBH may not terminate, limit, or otherwise impair Provider's participation with UBH on the basis that Provider refused to agree to an assignment, transfer, or subcontract of all or part of Provider's contract to an insurer that offers personal injury protection coverage under Maryland Insurance Article §19505.

10. Information Provided. UBH shall provide to Provider a schedule of applicable fees for up to the fifty (50) most common services billed by a health care practitioner in Provider's specialty, a description of the coding guidelines used by UBH that are applicable to the services billed by a health care practitioner in Provider's specialty, and the methodology that UBH uses to determine whether to increase or reduce Provider's level of reimbursement and provide a bonus or other incentive-based compensation to Provider. UBH shall provide this information to Provider at the time this Agreement is executed, thirty (30) days prior to change in this Agreement, and upon Provider's request.

11. Denial for Preauthorized Care. If a Covered Service has been preauthorized or approved for a Member by UBH or its private review agent, UBH or Payer, as applicable, may not deny reimbursement to Provider for the preauthorized or approved service delivered to that Member unless:

(a) the information submitted to UBH regarding the service to be delivered to the Member was fraudulent or intentionally misrepresentative;

(b) critical information requested by UBH regarding the service to be delivered to the Member was omitted such that UBH's determination would have been different had it known the critical information;

(c) a planned course of treatment for the Member was approved by UBH but was not substantially followed by Provider; or

(d) on the date the preauthorized or approved service was delivered:

(i) the Member was not covered by UBH;

(ii) UBH maintained an automated eligibility verification system that was available to the contracting provider by telephone or via the Internet; and

(iii) according to the verification system, the Member was not covered by UBH.

12. “All Products” Clause Prohibited. Except as otherwise provided by Maryland Statutes (including but not limited to § 15-112.2(b)), if UBH or Payer offers coverage for Covered Services through one or more health benefit plans, or contracts with providers to offer Covered Services through one or more provider panels, UBH may not require Provider, as a condition of participation or continuation on a provider panel for one of UBH’s health benefit plan to serve also on another of UBH’s provider panels.

13. Carrier Panels. Subject to Maryland Code Section 15-112.2(c) those Maryland carriers that comprise the provider panel are as follows:

(a) MAMSI Life and Health Insurance Company
(b) UnitedHealthcare of the Mid-Atlantic, Inc.
(c) United Healthcare Insurance Company

This list is subject change. Additional carriers may be set forth in the Administrative Guide. Provider may contact UBH for any updates.

14. Provider Panels. Subject to Maryland Code Section 15-125(c)(3) Provider has the right to elect not to serve on a provider panel for workers’ compensation services.

15. Authorization Requirements. Subject to all applicable terms and conditions found in the Maryland Insurance Code §15-802(d)(2), (3) and (4) and in accordance with the Provider Manual, Protocols and requirements of the Member’s benefit Plan regarding authorization for non-routine services, provider must request authorization for certain non-routine MHSA services from UBH by telephone: (a)prior to providing any services to a Member when MHSA Services are performed during Provider’s normal business hours Monday-Friday; and (B)within 24 hours if MHSA Services are provided on weekends or after Provider’s normal weekday business hours (which shall be deemed to be requested as if requested during normal business hours.) 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 law. Any authorization resulting from wrongful, fraudulent or negligent actions of a Provider or a breach of this Agreement shall be null and void as of the time given. In the event of any conflict arising from this provision, the terms of Maryland Insurance Code §15-802(d)(2), (3), and (4) shall control.

16. Definition of Emergency Services. "Emergency services" means those health care services that are provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in:
(1) Placing the patient's health in serious jeopardy;
(2) Serious impairment to bodily functions; or
(3) Serious dysfunction of any bodily organ or part.

SUBCONTRACTOR ATTACHMENT

This Attachment supplements the Agreement (the "Agreement"). This Attachment is limited to the terms and conditions governing the assurance of payment to Subcontractors for the provision of Covered Services to Members. For the purposes of this Appendix and Attachment, "Subcontractor" shall have the same meaning as "External Provider" as defined at Maryland Health-General Code §19-713.2(a)(4).

1. Payment of Covered Services. For the provision of Covered Services arranged by Provider and rendered to Members by Subcontractors, Provider will pay Subcontractors, pursuant to the applicable payment appendix attached to the Agreement and applicable claims payment laws, including Maryland Insurance Article § 15-1005, as may be amended.

Provider will assure that Subcontractors will hold harmless Members for any claims for compensation by Subcontractors. Provider will assure that Subcontractors comply with the section of the Agreement entitled "Member Protection Provision."

2. Submission of Payment Reports. Provider will submit to UBH monthly reports within thirty
(30) days after the end of the month reported, identifying payments made or owed to Subcontractors. These reports shall be in a format satisfactory to UBH. The reports shall be certified by Provider's Chief Executive Officer and Chief Financial Officer and must contain sufficient detail for UBH to determine that the payments are being made in compliance with law. UBH shall have the right to contact Provider's Subcontractors directly to verify whether Provider is current in Provider's payment to them.

3. Submission of Annual Financial Statement. Provider shall submit to UBH a current annual financial statement within ninety (90) days following the close of Provider's fiscal year or an interim financial statement upon request by UBH.

4. Access to and Release of Books and Records. UBH, during regular business hours and upon reasonable notice and demand, shall have access to and the right to audit all information and records or copies of records, free of charge, related to Covered Services rendered by Subcontractors and payments made to Subcontractors by Provider for those Covered Services under the Agreement and this Attachment. Provider will, at the time of an audit, give UBH access to all records or copies of records related to the Covered Services rendered by Subcontractors and payments made to Subcontractors by Provider for those Covered Services being audited. Unless a longer period is required by law, UBH will have such access during the term of this Agreement and for three (3) years following its termination. Provider will use reasonable efforts to provide records or copies of records requested by UBH within fourteen (14) days from the date such request is made.

5. Monitoring. UBH will monitor Provider to ensure compliance with the Agreement, the regulatory requirements Appendix and this Attachment. If UBH determines that Provider is not complying with the terms of this Attachment, UBH will notify Provider of UBH's determination. If Provider does not comply after receiving notice, UBH will notify the Commissioner of the Maryland Insurance Administration and will assume the administration of payments due to Subcontractors on Provider's behalf, as required by law.

6. Creation of Segregated Fund. As required by law, UBH will establish a segregated fund as defined by Maryland Health-General Code § 19-713.2(d)(3), upon execution of this Agreement ("Segregated Fund"). The Segregated Fund will be held in trust for payment to Subcontractors and may not be considered Provider's asset or account for the purpose of determining Provider's assets or accounts if Provider declares bankruptcy. The form of the Segregated Fund shall be a certificate of deposit in an amount equal to at least sixty (60) days of claims. Provider and UBH must be joint owners of the certificate of deposit and Provider may not withdraw funds from the Segregated Fund without UBH's prior written consent, unless this Agreement terminates, in which case Provider may withdraw funds from the certificate of deposit only after UBH agrees that all claims to Subcontractors have been paid. The form and amount of the segregated fund must be approved by the Maryland Insurance Administration's Examination and Auditing Unit. UBH shall, at least quarterly, review and inspect the Provider's books, records, and operations. In accordance with §19-713.2(d)(4) the Provider is required to submit to UBH information demonstrating that the segregated fund is sufficient.

7. Administration of Payments. In instances where Member care, UBH's reputation, and/or the relationship between UBH and UBH's Members is jeopardized by Provider's nonpayment or late payment to Subcontractors for Covered Services rendered to Members, UBH or Payer shall have the right to make these payments directly to Subcontractors and to recover from Provider the full amount of any such payments by withdrawing the payment amount from the Segregated Fund. UBH must give Provider notice of UBH's intention to pay Subcontractor directly, ten (10) or more days before UBH does so.

8. Insurance Administration Review. This Attachment is subject to review by the Maryland Insurance Administration. Any changes requested by the Administration shall be incorporated into this Attachment by amendment. Provider will register as a Contracting Provider pursuant to the terms of Maryland Health-General Article § 19-713.3. UBH will file with the Maryland Insurance Administration a plan as may be required pursuant to the terms of Maryland Health-General Article § 19-713.2(c).