Nebraska Regulatory Appendix

This Nebraska 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 Nebraska laws; provided, however, that the requirements in this Appendix will not apply to the extent they are preempted by the Medicare Modernization Act or other applicable law.

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.

1. Member Protection Provision. In no event, including, but not limited to, non-payment by Payor or an intermediary for Covered Services rendered to Members by Provider, insolvency of Payor or an intermediary, or breach 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, other than UBH, Payor, or an intermediary, as applicable, for Covered Services eligible for reimbursement under this Agreement; provided, however, that Provider may collect from a Member the copayment, deductible or coinsurance for which the Member is responsible under the Benefit Plan, or charges for services not covered under the Member's Benefit Plan. This Agreement does not prohibit Provider from agreeing to continue the provision of non-covered health care services solely at a Member's

expense, as long as Provider has clearly informed the Member that UBH or the Payor may not cover or continue to cover a specific health care service or health care services. The foregoing sentence does not apply to Provider when Provider is employed full-time on the staff of UBH or Payor and has agreed to provide health care services exclusively to their own Members and no others. Except as provided herein, this provision does not prohibit Provider from pursing any available legal remedy. The provisions of this section shall: (a) apply to all Covered Services rendered while this Agreement is in force; (b) with respect to Covered Services rendered while this Agreement is in force, survive the termination of this Agreement regardless of the cause of termination; (c) be construed to be for the benefit of Members; and (d) 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 Covered Services. Provider, or Provider's agent, trustee, or assignee, may not maintain any action at law against a Member to collect sums owed to Provider by UBH or Payor.

2. Continued Provision of Covered Services upon Insolvency and after Termination. In the event this Agreement is terminated due to the insolvency of UBH or Payor, or other cessation of operations, and a Member is receiving care from Provider under a prescribed treatment plan, Provider is obligated to continue the provision of Covered Services to that Member until the longer of (a) the completion of the period in which premium has been paid to UBH or Payor on behalf of the Member; or (b) the Member's discharge from an inpatient facility. Provider shall be reimbursed in accordance with this Agreement for all such Covered Services rendered subsequent to the termination of this Agreement.

Provider agrees that Member shall not be financially responsible for any medically necessary services provided during this period, and shall only be financially responsible for the copayment, deductible or coinsurance under the Benefit Plan or non-covered services as determined by UBH or Payor. This Section shall (a) survive the termination of this Agreement regardless of the cause of termination; (b) be construed to be for the benefit of Members; and (c) 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 Covered Services.

3. 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 UBH's ability to administer their quality improvement, care management/utilization management and credentialing programs. Provider shall not be penalized or this Agreement terminated by UBH because Provider acts as an advocate for the Member in seeking appropriate Covered Services.

4. Confidentiality of Member Information. Any data or information pertaining to the diagnosis, treatment, or health of any Member obtained from such person or from any provider by UBH shall be held in confidence and shall not be disclosed to any person except (a) to the extent that it may be necessary to carry out the purposes of the Nebraska

Health Maintenance Organization Act; (b) upon the express consent of the Member; (c) pursuant to statute or court order for the production of evidence or the discovery thereof; or (d) in the event of a claim or litigation between such person and UBH in which such data of information is pertinent. UBH shall be entitled to claim any statutory privileges against such disclosure which the provider who furnished such information to UBH is entitled to claim. UBH and Provider agree comply with and to cooperate with each other in an effort to comply with state and federal laws established to protect the security, confidentiality and integrity of customer information.

5. Equal Treatment of Members. UBH and Provider shall treat all Members equally, regardless of whether the Member's enrollment is through a private purchaser or a publicly funded program such as Medicare or Medicaid.

6. Termination. Either party terminating this Agreement without cause shall provide to the other party advance written notice in the form and for the length of time as provided in the Agreement but in no case less than sixty (60) days before the effective date of the termination. When applicable, UBH shall make a good faith effort to provide written notice of a termination within fifteen (15) business days of receipt or issuance of a termination to all Members who are patients seen on a regular basis by Provider, irrespective of whether the termination was for cause or without cause. When a contract termination involves a primary care professional, all Members who are patients of that primary care professional shall also be notified.

7. Corrective Action Plan and Appeal. (a) Corrective Action Plan. Prior to initiation of a proceeding to terminate Provider's participation status under the Agreement for cause, Provider will be given an opportunity to enter into and complete a corrective action plan, except in cases of fraud or imminent harm to patient health or when Provider's ability to provide services has been restricted by an action, including probation or any compliance agreements, by the Department of Health and Human Services or other governmental agency. (b) First Level Appeal. If UBH excludes Provider from its network or does not retain Provider in its network (for instance, because UBH terminated Provider's participation status under the Agreement), Provider shall be permitted to appeal the adverse decision. A person conducting the provider- appeal procedure may be employed by UBH if the person does not initially participate in the decision to take adverse action against Provider. The provider-appeal procedure will include, but not be limited to, notice of the date and time of the hearing, a statement of the criteria or standards on which the decision was based, an opportunity for Provider to review information upon which the adverse decision was based, an opportunity for Provider to appear personally at the hearing and present any additional information, and a timely decision on the appeal. (c) Second Level Appeal. If Provider disagrees with the decision made during the first level appeal, Provider will be permitted to appeal to an appeals committee consisting of one person selected by each party to the appeal and one person mutually agreeable to both parties. The parties to the appeal will pay to the appeal committee any costs associated with the person they select and shall share the costs of the person mutually agreeable to both parties, which costs shall not be recoverable by the other party.

8. No Termination or Penalty for Advocacy. This Agreement shall not be terminated by UBH to retaliate against or penalize a Provider in the event that Provider: (a) advocates in good faith on behalf of a Member; (b) files a complaint against UBH; or (c) appeals a decision of UBH.

9. Access to Clinical Records. Provider agrees that Member clinical records shall be available to the Nebraska Director of Regulation and Licensure or an authorized designee for examination and review to ascertain compliance with UBH's quality assurance program, or as deemed necessary by the Nebraska Director of Regulation and Licensure.

10. Health Care Professional Credentialing Verification Act. With respect to credentialing and recredentialing of providers that participate in UBH's network, UBH and Provider agree to comply with the terms and conditions of the Nebraska Health Care Professional Credentialing Verification Act. In the event UBH delegates any or all credentialing and/or recredentialing activities to Provider or an agent of Provider, Provider agrees that it, and its agent, if applicable, shall comply with the terms and conditions of the Nebraska Health Care Professional Credentialing and Recredentialing Verification Act.

11. Quality Assessment and Improvement Act. UBH and Provider agree to comply with the terms and conditions of the Nebraska Quality Assessment and Improvement Act. In the event UBH delegates any or all quality assurance or quality improvement activities to Provider or an agent of Provider, Provider agrees that Provider and its agent, if applicable, shall comply with the terms and conditions of the Nebraska Quality Assessment and Improvement Act.

12. No Inducement. UBH shall not offer an inducement to Provider to provide less than medically necessary health care services to Members.

13. No Delegation by Provider. Provider must obtain approval from UBH prior to delegating any of its rights and responsibilities under this Agreement.

14. Approval of Subcontractors. If Provider is an "intermediary" as defined in R.R.S. Neb. § 44-7103, Provider acknowledges that UBH has the right to approve or disapprove the participation in UBH's network of any subcontracted providers of Provider.

15. Member Disputes. Notwithstanding the Dispute Resolution section of the Agreement, a dispute relating to a Member's benefits or coverage between UBH and/or Provider on the one hand, and a Member, on the other hand (whether such dispute is brought by the Member or is brought by someone, including Provider and/or UBH, on the Member's behalf and the Member remains the true party in interest to the dispute) shall not be subject to such Dispute Resolution section and instead, shall be subject to the terms of that Member's Benefit Plan. Disputes between Provider and UBH relating to a Member's benefits or coverage where the Member is not the party in interest to the dispute shall proceed in accordance with the Dispute Resolution section of the Agreement.

16. Prompt Payment of Claims. Provider and UBH each agree to comply with the

provisions contained in the Nebraska Health Care Prompt Payment Act.

17. Utilization Review. UBH, Payor or Provider, as applicable, shall comply with applicable provisions of Nebraska laws and regulations as they relate to utilization review of health care services, including but not limited to those set forth in the Utilization Review Act at R.R.S Neb. § 44, Article 54.

18. Grievance. UBH, Payor or Provider, as applicable, shall comply with applicable provisions of Nebraska laws and regulations as they relate to resolution of grievances, including but not limited to those set forth in the Health Carrier Grievance Procedure Act at R.R.S Neb. § 44, Article 73.

19. Emergency Medical Services. UBH, Payor or Provider, as applicable, shall comply with applicable provisions of the Managed Care Emergency Services Act at R.R.S Neb. § 44, Article 68 and any applicable regulations enacted thereunder.