UNITED BEHAVIORAL HEALTH
PROVIDER AGREEMENT

Nevada Regulatory Requirements Attachment

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

1. Prompt Pay. Unless UBH or Payor requires additional information with regard to a claim, UBH or Payor shall approve or deny a "Clean Claim" within thirty (30) days after receipt of the claim. For purposes of this Appendix, Clean Claim shall mean a claim that has no defect or impropriety, including a lack of any required substantiating documentation, or particular circumstance requiring special treatment that impedes prompt payment. If UBH or Payor requires additional information to determine whether to approve or deny a claim, UBH or Payor shall notify Provider within twenty (20) days after receipt of the claim; and, after receiving the required information, UBH or Payor shall approve or deny the claim within thirty (30) days. Payor shall pay an approved Clean Claim within thirty (30) days after it has been approved. Payor shall pay interest on an approved Clean Claim not paid within thirty (30) days after approval at a rate equal to the rate of interest established pursuant to Nevada Revised Statutes, Section 99.040, unless another rate is agreed to in writing. Interest shall be calculated from thirty (30) days after approval of the Clean Claim until the Clean Claim is paid. Upon Provider's request, UBH shall provide the schedule of payments applicable to Provider within seven (7) calendar days after receipt of Provider's request.

2. Quality Assurance. Provider acknowledges that UBH has provided information regarding the manner in which UBH's quality assurance program functions. Provider shall participate in such quality assurance program.

3. Provider Communication with Members. Nothing in this Agreement shall be construed as restricting or interfering with any communication between Provider and Member regarding any information that the Provider determines is relevant to the health care of the Member.

4. No Retaliatory Action. Nothing in this Agreement shall be construed as allowing UBH to terminate, demote or refuse to compensate Provider solely because Provider, in good faith: (a) advocates on behalf of a Member; (b) assists a Member in seeking reconsideration of a decision by UBH to deny coverage for a health care service; or (c) reports a violation of law to an appropriate authority.

5. No Financial Incentive to Deny Medically Necessary Services. Nothing in this Agreement shall be construed as allowing UBH to offer or pay any type of material inducement, bonus or other financial incentive to Provider to deny, reduce, withhold, limit or delay specific medically necessary health care services to a Member. Provider and UBH acknowledge that the use of capitation or other financial incentives, if any, is designed to provide an incentive to Provider to use health care services effectively and consistently in the best interest of the health care of the Member.

6. Obligations In the Event of Termination of the Agreement. In the event this Agreement is terminated, Provider shall continue the provision of Covered Services to Members who are actively undergoing a medically necessary course of treatment for up to the one hundred and twentieth (120th) day after the date of termination of the Agreement, as requested by UBH. Provider shall be reimbursed in accordance with this Agreement for all such Covered Services rendered subsequent to the termination of this Agreement.

Provider shall not be obligated to continue to provide or arrange for Covered Services to a Member at the time of termination of this Agreement if (i) UBH terminates this Agreement due to Provider's medical incompetence or professional misconduct and (ii) UBH does not enter into another agreement with Provider after this Agreement was terminated due to Provider's medical incompetence or professional misconduct.

7. Notice of Termination. Either party terminating this Agreement 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 ninety (90) days before the effective date of termination.

8. Limits on Member Expenses. UBH will comply with all limitations on Member Expenses (deductibles and co-payments) charged under policies that offer differences in payment between preferred providers of health care and providers who are not preferred.

9. Use of Provider's Name. UBH shall not charge the Provider a fee to include the name of Provider in its provider directory which is made available to Members, or any other fee related to establishing Provider as a Participating Provider for UBH.

10. Amendments. This Agreement may be amended at any time pursuant to a written agreement executed by both parties. This Agreement may also be amended by UBH upon giving Provider at least forty-five (45) days' written notice of the modification. If Provider fails to object in writing to the modification within the thirty-day period, the modification becomes effective at the end of that period. If Provider objects in writing to the modification within the forty-five day period, the modification must not become effective unless agreed to by both parties.

11. No Billing of Members (Member Hold Harmless Provision). With the exception of Member Expenses and charges for non-Covered Services delivered, Provider or agent, trustee, or assignee thereof, shall in no event, including, without limitation, non-payment by UBH or Payor, insolvency of UBH or Payor, or breach of this Agreement, bill, charge, request payments, collect a deposit from, seek compensation or remuneration or reimbursement from, or have any recourse against any Member or any person (other than UBH or Payor) acting on behalf of any Member or attempt to do any of the foregoing for Covered Services provided or arranged pursuant to this Agreement. Provider agrees that the contracted rate for Covered Services set forth in the Agreement is the total amount due for such services and UBH's Members are not responsible for amounts above the contracted rate provided for in this Agreement.

12. Notice of Insurance Against Loss. Provider shall give UBH evidence of a contract of insurance against loss resulting from injuries resulting to third persons from the practice of his/her profession.

13. Transfer of Medical Records. Provider shall transfer medical records to another physician or group practice when he/she leaves the panel of physicians associated with UBH.

Provisions applicable to Agreements with Intermediary Organizations for HMO products:

In addition to the requirements stated above, if Provider is a delivery system intermediary, as defined in NAC 695C.025, the following provisions will apply:

1. Provider will provide to UBH, and UBH will review, a written report, at least quarterly which identifies the total payments made or owed to its subcontracted providers in sufficient detail to enable UBH and the Nevada Insurance Commissioner ("Commissioner") to determine whether the payments have been made in a timely manner and in compliance with the applicable provisions of the Nevada Revised Statues.
2. UBH may, upon reasonable prior notice, audit, inspect and copy Provider's books, records and any other evidence of its operations which, in the discretion of UBH, are relevant to Provider's obligations under this Agreement.

3. The Commissioner, upon reasonable prior notice, may audit, inspect and copy Provider’s books, records and any other evidence of its operations to determine whether Provider has complied with the applicable provisions of the Nevada Revised Statutes or any regulations adopted pursuant thereto.

4. Provider will maintain working capital in the form of cash or equivalent liquid assets in an amount equal to at least: (a) Five hundred thousand dollars; or (b) The operating expenses paid for 2 months calculated by using the monthly average of the operating expenses for the prior 6 months, whichever is less. As used in this subsection, “operating expense” means the expenses of Provider, except money paid or owed to providers for Covered Services provided pursuant to this Agreement.

5. UBH will assume financial responsibility for any claim which are: (a) Presented for payment to Provider by its subcontracted providers for Covered Services; and (b) Not paid by Provider as required by law and this Agreement.

6. Benefit Plans will be entered into directly between UBH or the applicable Payor and the Customer and between Provider the Customer.

7. The Agreement sets forth the responsibilities which Provider will assume. Provider will comply with requirements of the quality assurance program established by UBH pursuant to NAC 595C.400.

8. UBH will review, not less than quarterly, Provider’s compliance with the provisions of this Agreement.

9. If Provider provides Covered Services on behalf of more than one HMO, Provider must maintain separate records for each entity.

10. UBHY may terminate its relationship with any subcontracted provider of Provider with appropriate notice as specified in the Agreement.

11. Each contract Provider has with a subcontracted provider must be assigned to UBH if the Provider fails to pay for Covered Services. This provision is binding on the subcontracted provider until the subcontracted provider renegotiates a contract with UBH.

12. A health care provider who has a financial interest of more than 10 percent in Provider is prohibited from participating on a utilization review committee or taking any action to change an authorization made by the utilization review committee or an authorized physician.

13. Provider will provide UBH, the Commissioner and the State Board of Health with a list of the names of those persons who have a financial interest in Provider and the amount of each person’s financial interest. Any change itn he financial interest of

Provider must be reported to UBH, the Commissioner and the State Board of Health within 10 working days after the change.

14. Provider is prohibited from assigning this Agreement to any other organization without the prior approval of UBH. The approval of UBH is subject to the filing of a material modification of operation pursuant to NRS 695C.140.

15. UBH and Provider expressly agree that UBH may enter into an agreement with a third party allowing the third party to obtain the rights and responsibilities of UBH under the provider network contract as if the third party were UBH. Any third party accessing the provider network contract is contractually obligated to comply with all applicable terms, limitations and conditions of the provider network contract.