Wisconsin Regulatory Appendix

This Wisconsin 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 Wisconsin 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.

ARTICLE I
Provisions applicable to Benefit Contracts regulated under the State of Wisconsin HMO and/or Insurance laws:

1. **Provider Disclosure**. Nothing in this Agreement will be construed to limit Provider's ability to disclose information, to or on behalf of a Member, about the Member's medical condition. Provider may discuss, with or on behalf of a Member, all treatment options and any other information that Provider determines to be in the best interest of the Member and within the scope of Provider's professional license. UBH may not penalize Provider or terminate this Agreement because Provider makes referrals to other providers that participate in UBH's network or discusses

medically necessary or appropriate care with or on behalf of Member. UBH may not retaliate against Provider for advising a Member of treatment options that are not covered benefits under the Member's Benefit Contract.

2. **Continued Provision of Covered Services after Termination.** In the event this Agreement is terminated by Provider for any reason or in the event this Agreement is terminated by UBH for any reason other than (a) the Provider no longer practices in the UBH's geographic service area or (b) misconduct on the part of the Provider, Provider agrees to continue to provide Covered Services for the following periods:

(1) Member Care. If a Member is receiving care from Provider under a prescribed treatment plan and Provider is not a primary care physician, Provider is obligated to continue the provision of Covered Services to that Member until (a) the completion of the treatment; or (b) a period of 90 days after the effective date of Provider's termination, whichever is shorter, except that the continuation of Covered Services is not required to extend beyond (i) the end of the current plan year, for a Member who has coverage under a Benefit Contract that has no open enrollment period; or (ii) the end of the plan year for which it was represented that Provider was, or would be, a provider that participates in UBH's network for a Member with an open enrollment period. Provider agrees to accept and Payor is obligated to pay the amounts established by this Agreement for Covered Services rendered according to this section after termination of this Agreement.

(2) Maternity Care. If a Member is receiving maternity care from Provider and the Member is in her second or third trimester of pregnancy, Provider is obligated to continue the provision of Covered Services to that Member until the completion of the postpartum care. Provider agrees to accept and Payor is obligated to pay the amounts established by this Agreement for Covered Services rendered after termination of this Agreement.

(3) Primary Care Physician. If Provider is a primary care physician, Provider is obligated to continue the provision of Covered Services until the end of the current plan year for a Member with no open enrollment period; or until the end of the plan year for which it was represented that Provider was, or would be, a provider that participates in UBH's network for a Member with an open enrollment period. Provider agrees to accept and Payor is obligated to pay the amounts established by this Agreement for Covered Services rendered after termination of this Agreement.

Additionally, in the event Provider terminates the Agreement for any reason, Provider shall, within 30 days prior to the termination or 15 days following UBH's receipt of the termination notice, whichever is later, post a notification of such termination in Provider's office. This notice requirement applies only if Provider is a physician specialist and a referral is not required.

If Provider receives or is due reimbursement for services provided to a Member under this section, Provider is subject to Wis. Stat. § 609.91 with respect to the Member, regardless of whether the Member's Benefit Contract is a health maintenance organization. Such requirements include, but are not limited to the following: Provider may not, for any reason, including but not limited to termination of the Agreement, breach or default of the Agreement by UBH or UBH's insolvency or bankruptcy, bill, charge, collect a deposit from, seek remuneration or compensation from, file or threaten to file with a credit reporting agency or have any recourse against a Member, or any person acting on their behalf for costs that are covered under the Benefit Contract. This provision does not affect the liability of a Member for any copayments or premiums owed under a Benefit Contract.

3. **Grievances**. Provider must identify complaints and grievances in a timely manner and forward these complaints and grievances to UBH in a timely manner.

4. **Prompt Payment**. Provider, Payor and UBH shall comply with applicable sections of Wisconsin laws and regulations as they relate to the payment and processing of claims, including those set forth in Wisconsin Statute Section 628.46.

ARTICLE II
Provisions applicable to Benefit Contracts regulated by the State of Wisconsin HMO laws:

1. **Acknowledgment of Receipt of Notice and Agreement Not to Elect Exemption from Wisconsin Statute Section 609.91.** Provider acknowledges receipt of the Notice, in the form attached as Exhibit A, required by Wisconsin Statute, Section 609.94(1). Provider agrees that Provider shall not exercise the right under Wisconsin Statute, Section 609.92 to elect to be exempt from Wisconsin Statute, Section 609.91(1)(b) for the purpose of recovering health care costs arising from health care furnished by Provider. Provider acknowledges that this agreement not to exercise this right shall mean that Provider shall remain subject to the restrictions on recovery of health care costs found in Wisconsin Statute, Section 609.91. In the event that Provider is not subject to the restrictions on recovery of health care costs found at Wisconsin Statute, Section 609.91(1)(a), (am), or (b), Provider agrees to elect to be subject to said restrictions pursuant to Wisconsin Statute 609.925 and any applicable regulations, and shall promptly take such action as is necessary to implement such election.

Exhibit A to the Wisconsin Regulatory Requirements Appendix

NOTICE REQUIRED BY WISCONSIN STATUTE 609.94

NOTICE

THIS NOTICE DESCRIBES RECENTLY ENACTED HOLD HARMLESS PROVISIONS WHICH AFFECT YOUR ABILITY TO SEEK RECOURSE AGAINST HMO ENROLLEES FOR PAYMENT FOR SERVICES.

Section 609.94, Wis. Stat., requires each health maintenance organization insurer (HMO) to provide a summary notice to all of its participating providers of the new statutory limitations and requirements in Sections 609.91 to 609.935, and Section 609.97(1).

SUMMARY

Under Wisconsin law, a health care provider may not hold HMO enrollees or policyholders ("enrollees") liable for costs covered under an HMO policy if the provider is subject to statutory provisions which "hold harmless" the enrollees. For most health care providers application of the statutory hold harmless is "mandatory" or it applies unless the provider elects to "opt out." A

provider permitted to "opt out" must file timely notice with the Wisconsin office of the Commissioner of Insurance ("OCI").

Some types of provider care are subject to the hold-harmless statutes only if the provider voluntarily "opts in." An HMO may partially satisfy its regulatory capital and surplus requirements if health care providers elect to remain subject to the statutory hold harmless provisions.

This notice is only a summary of the law. Every effort has been made to accurately describe the law. However, if this summary is inconsistent with a provision of the law or incomplete, the law shall control.

HOLD HARMLESS

A health care provider who is subject to the statutory hold harmless provisions is prohibited from seeking to recover health care costs from an enrollee. The provider may not bill, charge, collect a deposit from, seek remuneration or compensation from, file or threaten to file with a credit reporting agency or have any recourse against an enrollee or any person acting on the enrollee's behalf, for health care costs for which the enrollee is not liable. The prohibition on recovery does not affect the liability of an enrollee for any deductibles or copayments, or for the premiums owed under the policy, or certificate issued by the HMO.

A. MANDATORY FOR HOLD HARMLESS

An enrollee of an HMO is not liable to a health care provider for health care costs that are covered under a policy issued by that HMO if any of the following are met:

1. Care is provided by a provider who is an affiliate of the HMO, owns at least 5% of the voting securities of the HMO, is directly or indirectly involved with the HMO through direct or indirect selection of or representation by one or more board members, or is an Individual Practice Association (“IPA”) and is represented, or an affiliate is represented, by one of at least three HMO board members who directly or indirectly represent one or more IPAs or affiliates of IPAs; or,

2. Care is provided by a provider under a contract with or through membership in an organization identified in 1.; or

3. To the extent the charge exceeds the amount the HMO has contractually agreed to pay the provider for that health care service; or

4. The care is provided to an enrolled medical assistant recipient under a Department of Health and Social Services prepaid health care policy.

5. The care is required to be provided under the requirements of Wis. Admin. Code, Ins. 9.35.

B. "OPT OUT" HOLD HARMLESS

If the conditions described in A do not apply, the provider shall be subject to the statutory hold harmless unless the provider files timely election with OCI to be exempt if the health care meets any of the following:

1. Provided by a hospital or an IPA; or

2. A physician service, or other provider services, equipment, supplies or drugs that are ancillary or incidental to such services and are provided under a contract with the HMO or are provided by a provider selected by the HMO; or

3. Provided by a provider, other than a hospital, under a contract with or through membership in an IPA which has not elected to be exempt. Note that only the IPA may file election to exempt care provided by its member providers from the statutory hold harmless (See Exemptions and Elections; #4).

C. "OPT IN" HOLD HARMLESS

If a provider of health care is not subject to the conditions described in A or B, the provider may elect to be subject to the statutory hold harmless provisions by filing a notification with the OCI stating that the provider elects to be subject with respect to any specific HMO. A provider may terminate such a notice of election by stating the termination date in that notice or in a separate notification.

CONDITIONS NOT AFFECTING IMMUNITY

An enrollee's immunity under the statutory hold harmless is not affected by any of the following:

1. Any agreement entered into by a provider, an HMO, or any other person, whether oral or written, purporting to hold the enrollee liable for costs (except a notice of election or termination permitted under the statute);

2. A breach of or default on any agreement by the HMO, an IPA, or any other person to compensate the provider for health care costs for which the enrollee is not liable;

3. The insolvency of the HMO or any person contracting with the HMO, or the commencement of insolvency, delinquency or bankruptcy proceedings involving the HMO or other persons which would affect compensation for health care costs for which an enrollee is not liable under the statutory hold harmless;

4. The inability of the provider or other person who is owed compensation to obtain compensation for health care costs for which the enrollee is not liable;

5. Failure by the HMO to provide notice to providers of the statutory hold harmless provisions; or

6. Any other condition or agreement existing at any time.

EXEMPTIONS AND ELECTIONS

Hospitals, IPAs, and providers of physician services who may "opt out" may elect to be exempt

from the statutory hold harmless and prohibition on recovery of health care costs under the following conditions and with the following notifications:

1. If the hospital, IPA, or other provider has a written contract with the HMO, the provider must within thirty (30) days after entering into that contract provide a notice to the OCI of the provider's election to be exempt from the statutory hold harmless and recovery limitations for care under the contract.

2. If the hospital, IPA, or other provider does not have a contract with an HMO, the provider must notify OCI that it intends to be exempt with respect to a specific HMO and must provide that notice at least ninety (90) days in advance.

3. A provider who submits a notice of election to be exempt may terminate that election by stating a termination date in the notice or by submitting a separate termination notice to OCI.

4. The election by an IPA to be exempt from the statutory provisions, or the failure of an IPA to so elect, applies to costs of health care provided by any provider, other than a hospital, under contract with or through membership in the IPA. Such a provider, other than a hospital, may not exercise an election separately from the IPA. Similarly, an election by a clinic to be exempt from the statutory limitations and restrictions of the failure of the clinic to elect to be exempt applies to costs of health care provided by any provider through the clinic. An individual provider may not exercise an election to be exempt separate from the clinic.

5. The statutory hold-harmless “opt-out” provision applies to physician services only if the services are provided under a contract with the HMO or if the physician is a selected provider for the HMO, unless the services are provided by a physician for a hospital, IPA or clinic which is subject to the statutory hold-harmless “opt-out” provisions.

NOTICES

All notices of election and termination must be in writing and in accordance with rules promulgated by the Commissioner of Insurance. All notices of election or termination filed with OCI are not affected by the renaming, reorganization, merger, consolidation or change in control or the provider, HMO, or other person. However, OCI may promulgate rules requiring an informational filing if any of these events occur.

Notices to the Office of the Commissioner of Insurance must be written and received at the Office's current address:

Office of the Commissioner of Insurance
123 West Washington Avenue
P.O. Box 7873
Madison, WI 53707

HMO CAPITAL AND SECURITY SURPLUS

Each HMO is required to meet minimum capital and surplus standards ("compulsory surplus

requirements"). These standards are higher if the HMO has fewer than 90% of its liabilities covered by the statutory hold harmless. Specifically, the compulsory surplus requirements shall be at least the greater of $750,000 or 6% of the premiums earned by the HMO in the last 12 months if its covered liabilities are less than 90%, or 3% of the premiums earned by the HMO in the last 12 months if its covered liabilities are more than 90%.

In addition to capital and surplus, an HMO must also maintain a security surplus in the amount set by the Commission of Insurance.

FINANCIAL INFORMATION

An HMO is required to file financial statements with the OCI. You may request financial statements from the HMO. The OCI also maintains files of HMO financial statements that can be inspected by the public.