**UNITED BEHAVIORAL HEALTH**
**PROVIDER AGREEMENT**

## West Virginia Regulatory Requirements Attachment

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

For purposes of this Attachment, Benefit Contract has the same meaning as Benefit Plan and Subscriber and Person have the same meaning as Member.

This Attachment applies to all products or Benefit Contract sponsored, issued or administered by or accessed through UBH to the extent such products are subject to regulation under West Virginia 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 the Agreement, this Attachment shall control, except with regard to Benefit Plans outside the scope of this Attachment.

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 and regulations, as may be amended from time to time. Likewise, should any defined term herein conflict with applicable state law or regulations, the term as defined under applicable state law or regulation shall prevail.

**Provisions to Benefit Contracts regulated by the State of West Virginia and/or under West Virginia HMO laws, as applicable.**

**1. No Billing of Members**. The obligation of payment under the Agreement is solely that of Payor and not that of Member. Payment as provided under the Agreement, together with any copayment, deductible or coinsurance for which the Member is responsible under the Benefit Plan, is payment in full for a Covered Service. Provider will not seek to recover, and will not accept any payment from Member or anyone acting in their behalf, in excess of such payment in full, regardless of whether such amount is less than Provider's billed charge or customary charge.

In no event, including, but not limited to, non-payment by Payor for Covered Services rendered to Members by Provider, insolvency of Payor, or breach by UBH of any term or condition of the Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member, persons acting on behalf of the Member, or the employer or group contract holder for Covered Services eligible for reimbursement under the Agreement; provided, however, that Provider may collect from the Member any copayments, deductibles or coinsurance for which the Member is responsible under the Benefit Plan or charges for services not covered under the Member's Benefit Plan.

The provisions of this section shall: (a) apply to all Covered Services rendered while the Agreement is in force; (b) with respect to Covered Services rendered while the Agreement is in force, survive the termination of the Agreement regardless of the cause of termination; (c) be construed to be for the benefit of the 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.

Should Provider collect or attempt to collect from Member any money for Covered Services provided by Provider to Member other than any copayment, deductible or coinsurance for which the Member is responsible under the Benefit Plan, Provider may be subject to a civil money penalty imposed by the West Virginia Commissioner of Insurance pursuant to West Virginia Code Annotated § 33-25A-23a.

**2. Notice of Termination.** Provider shall give 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 to UBH and the West Virginia Commissioner of Insurance before terminating the Agreement for any reason. Nonpayment by Payor for services rendered by Provider to Members is not a valid reason for avoiding this no-less-than-sixty (60) day advance notice of cancellation provision. Upon receipt by UBH of a no-less-than-sixty (60) day termination notice, UBH may, if requested by Provider, terminate the Agreement earlier than the no-less-than-sixty (60) day period if UBH is not financially impaired or insolvent.

**3. Examinations.** Pursuant to West Virginia Code Annotated § 33-25A-17, the Commissioner of Insurance may make examination of the affairs of UBH and providers with whom UBH has contracts, agreements or other arrangements. In the event of such an examination, UBH and Provider shall submit its books and records to the Commissioner and in every way facilitate the examination.

**4. No Inducement**. Nothing in the Agreement is intended to or shall be construed to give Provider an incentive or disincentive plan that includes specific payment made directly or indirectly, in any form, to Provider that acts directly or indirectly as an inducement to deny, reduce, limit, or delay specific medically necessary and appropriate services with respect to a specific Member or group of Members with similar medical conditions.

**5. Immunity Prohibited**. Nothing in the Agreement shall be construed or interpreted as requiring Provider to indemnify UBH or hold UBH harmless for the acts or conduct of UBH that are set forth in West Virginia Code Annotated § 33-27C-7(b).

**6. Continuation of Services.** If the Agreement is terminated by UBH without cause and Provider provides primary care physician services, Provider shall continue providing Covered Services to a Member who has requested continuation of such services for at least sixty (60) days following notice of Provider's termination to the Member. The continuation of such primary care services is contingent upon Provider's acceptance and compliance with the same terms and conditions as those of the Agreement except for any provision requiring that UBH assign new Members to Provider.

**7. Processing and Payment of Claims.** UBH, Payor and Provider shall comply with the minimum fair business standards in the processing and payment of claims for health care services as set forth in West Virginia Code Annotated § 33-45-2, including the forty (40) day prompt payment clause for manually submitted clean claims and the thirty (30) day prompt payment clause for electronically submitted clean claims.

**8. Facility Discounts.** If Provider is a hospital or other institutional provider, Provider represents and warrants that Provider has filed for and received any regulatory approval required under West Virginia law to contract for the discounted reimbursement provided for in the Agreement. Provider will give timely notice to UBH of the loss of any such regulatory approval. In the event Provider loses such regulatory approval, UBH may terminate the Agreement effective immediately by giving written notice of termination.

**9. Procedures.** UBH shall establish and implement reasonable policies to permit Provider (i) to confirm in advance during normal business hours by free telephone or electronic means if available whether the health care services to be provided are medically necessary and a covered benefit and (ii) to determine UBH's requirements applicable to Provider (or to the type of health care services which Provider has contracted to deliver under this Agreement) for

(a) pre-certification or authorization of coverage decisions,

(b) retroactive reconsideration of a certification or authorization of coverage decision or retroactive denial of a previously paid Claim,

(c) Provider-specific payment and reimbursement methodology, coding levels and methodology, downcoding, and bundling of Claims, and

(d) other Provider-specific, applicable Claims processing and payment matters necessary to meet the terms and conditions of this Agreement, including determining whether a Claim is a Clean claim. (Please see the Network Manual and/or our website at www.providerexpress.com for further information.)

**10. Claim Settlement Practices.** Provider and UBH shall comply with the provisions of West Virginia Code Annotated § 33-11-4(9), as amended.

**11. Intermediaries**. The provisions of this Section 11 shall apply if Provider is an "intermediary" or "health service intermediary" as those terms are defined in West Virginia Code of State Rules § 114-43-1 et seq.

a. Provider shall provide UBH with regular written reports prepared on a West Virginia statutory accounting basis, at least quarterly, that state Provider's current assets and identify in the aggregate all payments made or owed to its contracted providers in sufficient detail for UBH and the West Virginia Commissioner of Insurance ("Commissioner") to determine if the payments are being made in a timely manner and which identify in the aggregate the reasonably estimated incurred but not reported health care costs ("IBNR").

b. UBH shall monitor Provider's reports required under paragraph a of this Section 9.

c. Provider shall permit UBH and the Commissioner, both singularly and jointly, upon reasonable prior notice, to audit, inspect and copy Provider's books, records, and other evidence of its operations which are, in the discretion of UBH and the Commissioner, relevant to Provider's obligations under this Agreement for the purpose of determining Provider's compliance with all requirements legally mandated by statute, rule or this Agreement. Any review is subject to any confidentiality requirements imposed by State or Federal law.

d. Provider shall maintain working capital in the form of cash or equivalent liquid assets at least equal to one month's claims calculated by using the monthly average of actual and estimated claims for the prior six months for all health care services provided under this Agreement.

e. Provider shall create a segregated fund, which may be aggregated, equal to the entire monthly IBNR as of the first day of each month as actuarially determined by UBH.

f. UBH shall assume the full financial responsibility for any valid claims presented for payment to Provider by its contracted providers for Covered Services rendered to a Customer and which are not paid by Provider as provided by law and by the contract between the Provider and its contracted provider;

g. UBH shall require that all Customer Benefit Plans must be directly with UBH and not with Provider.

h. Provider shall provide services on behalf of UBH only in counties where UBH is authorized by the Commissioner to operate.

i. Provider shall adhere to all responsibilities of Provider as set forth in this Agreement along with adhering to all quality and accessibility standards to which UBH is subject.

j. Unless this Agreement prohibits Provider from sub-contracting the provision of health care services to other entities, Provider's sub-contracts with such entities must adhere to quality and accessibility standards to which UBH is subject.

k. UBH shall continuously monitor Provider's compliance with the requirements of this Agreement.

l. UBH shall be responsible for maintaining appropriate levels of capital, surplus, claims reserves, and other financial criteria as established pursuant to statute or rule.
m. Provider and any entities with which Provider sub-contracts for the provision of health care services shall obtain and provide to UBH no later than the first day of June of each year an annual audited financial report prepared by an independent certified public accountant.

n. If Provider provides health care services on behalf of more than one entity, Provider shall maintain records which are adequate to clearly differentiate the transactions which relate to the provision of health care services on behalf of UBH.