Colorado Regulatory Requirements Appendix

This Colorado 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 Colorado 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 Health Insurance and Health Maintenance Organization Benefit Plans:

1.1. Non-discrimination. Provider will not discriminate, with respect to the provision of medically necessary Covered Services, against Memberss who are participants in a publicly financed program.

1.2. Preauthorization and referrals.

i) **Preauthorization.** The sole responsibility for obtaining any necessary preauthorization rests with Provider or the participating provider who recommends or orders said services, treatments, or procedures, not with the Members.

ii) **Standing referrals**. A Members may receive a standing referral for medically necessary treatment to a specialist or specialized treatment center participating in UBH's network. The primary care provider for the Members, in consultation with the specialist and Members, shall determine that the Members needs ongoing care from the specialist in order to make the standing referral. A time period for the standing referral of up to one year, or a longer period of time if authorized by UBH, shall be determined by the primary care provider in consultation with the specialist or specialized treatment center. The specialist or specialized treatment center shall refer the Members back to the primary care provider for primary care. To be reimbursed by UBH or Payor, treatment provided by the specialist shall be for a Members and must comply with provisions contained in the Member's Benefit Plan. The primary care physician shall record the reason, diagnosis, or treatment plan necessitating the standing referral.

UBH or an entity that contracts with UBH shall not penalize a primary physician who makes a standing referral of a Member to a specialist, nor shall the specialist treating the Member be penalized, with actions that include but are not limited to disincentives or disaffiliation, except for violations of Colorado Revised Statutes ("C.R.S.") Section 10-1128.

iii) **No financial disincentives for referrals.** Provider shall not be subjected to financial disincentives based on the number of referrals made to participating providers for Covered Services so long as Provider adheres to UBH's or UBH's intermediary's utilization review policies and procedures.

1.3. 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 with UBH's ability to administer its quality improvement, utilization management, and credentialing programs.

i) Provider is not prohibited from protesting or expressing disagreement with a medical decision, medical policy, or medical practice of UBH or an entity representing or working for UBH (e.g., a utilization review company).

ii) UBH or an entity representing or working for UBH, is not prohibited from protesting or expressing disagreement with a medical decision, medical policy, or medical practice of any provider covered by this Agreement.

iii) UBH may not take an Adverse Action as defined in C.R.S. §10-16-121, against Provider because Provider expresses disagreement with a decision by UBH or an entity representing or working for UBH to deny or limit benefits to a Member, or because Provider discusses with a current, former, or prospective patient any aspect

of the patient's medical condition, any proposed treatments or treatment alternatives, whether covered by the Member's Benefit Plan or not, policy provisions of a Member's Benefit Plan, or Provider's personal recommendation regarding selection of a health plan based on Provider's personal knowledge of the health needs of such patients.

iv) UBH may not take an Adverse Action against a Provider because Provider, acting in good faith;

a) communicates with a public official or other person concerning public policy issues related to health care items or services;
b) files a complaint, makes a report, or comments to an appropriate governmental body regarding actions, policies, or practices of UBH that the Provider believes might negatively affect the quality of, or access to, patient care;
c) provides testimony, evidence, opinion, or any other public activity in any forum concerning a violation or possible violation of any provision of C.R.S. §10-16-121;
d) reports what the Provider believes to be a violation of law to an appropriate authority; or
e) participates in any investigation into a violation or possible violation of any provision of C.R.S. §10-16-121.

v) UBH shall not penalize Provider because Provider, in good faith, reports to state or federal authorities any act or practice by UBH that jeopardizes patient health or welfare, or because Provider discusses the financial incentives or financial arrangements between Provider and UBH.

vi) UBH shall not take an adverse action against Provider or provide financial incentives or subject Provider to financial disincentives based solely on a patient satisfaction survey or other method of obtaining patient feedback relating to the patient's satisfaction with pain treatment.

vii) Notwithstanding subsections (i) through (vi) above, UBH prohibits Provider from making, publishing, disseminating, or circulating directly or indirectly or aiding, abetting, or encouraging the making, publishing, disseminating, or circulating of any oral or written statement or any pamphlet, circular, article, or literature that is false or maliciously critical of UBH and calculated to injure UBH.

1.4. Hold harmless. Members shall, in no circumstances, be liable for money owed to Providers by UBH or Payor and in no event shall Provider collect or attempt to collect from a Member any money owed to Provider by UBH or Payor. Nothing in this section shall prohibit Provider from collecting coinsurance, deductibles, or copayments as specifically provided in the Member's Benefit Plan.

1.5. Prompt payment of claims. UBH or Payor will pay clean claims in accordance with the provisions of C.R.S. 10-16-106.5. A "clean claim" means a claim for payment of health care expenses that is submitted to UBH on a uniform claim form (CMS-1500 and CMS-1450, otherwise known as Form UB-04) adopted pursuant to C.R.S. §10-16-106.3 with all required fields completed with correct and complete information in accordance with uniform elements

specified under Colorado law. A claim requiring additional information shall not be considered a "clean claim" and shall be paid, denied, or settled as set forth below. "Clean claim" does not include a claim for payment of expenses incurred during a period of time for which premiums are delinquent, except to the extent otherwise required by law. Clean claims shall be paid, denied, or settled within thirty (30) calendar days after receipt by UBH if submitted electronically and within forty-five (45) calendar days after receipt by UBH if submitted by any other means.

If the resolution of a claim requires additional information, UBH shall, within thirty (30) calendar days after receipt of the claim, give Provider or Member, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim. The person receiving a request for such additional information shall submit all additional information requested by UBH within thirty (30) calendar days after receipt of such request. Notwithstanding any provision of an indemnity policy to the contrary, UBH or Payor may deny a claim if Provider receives a request for additional information and fails to timely submit the additional information requested, subject to resubmission of the claim or the appeals process. If such person has provided all such additional information necessary to resolve the claim, the claim shall be paid, denied or settled by UBH or Payor within the applicable time period set forth in this Section.

Any contract providing for the performance of claims processing functions by an entity with which UBH contracts requires such entity to comply with C.R.S. §10-16-106.5 (3), (4), and (5).

Absent fraud, all claims except those described in the second paragraph of this Section shall be paid, denied, or settled within ninety (90) calendar days after receipt by UBH.

1.6. **Assignment**. The rights and responsibilities under this Agreement shall not be assigned or delegated by Provider without the prior written consent of UBH.

1.7. **Termination.** This Agreement may be terminated as follows:

i) by UBH upon thirty (30) days' prior written notice in the event Provider materially misrepresents the provisions, terms, or requirements of UBH's products.

ii) by UBH or Provider, if the Agreement permits a without cause termination, upon advance written notice in the form and for the length of time provided in the Agreement, but in no case upon less than sixty (60) days' written notice.

iii) If Provider is a "Health care provider" as defined by C.R.S. §25-37-102 and if the Agreement has a duration of less than two (2) years, UBH or Provider may terminate the Agreement without cause upon advanced written notice in the form and for the length of time provided in the Agreement, but in no case upon less than ninety (90) days' written notice.

iv) If Provider is a "Health care provider" as defined by C.R.S. §25-37-102, in accordance with section 1.13 of this Appendix.

1.8. Continuity of Care.

i) Provider agrees that in the event this Agreement is terminated without cause, Provider shall continue the provision of Covered Services to:

a) Members who are in their second or third trimester of pregnancy through the postpartum period;
b) Members who have seen Provider within the past twelve (12) months or are undergoing an active course of treatment until the earliest of:
   1. The termination of the course of treatment by the Member or the treating Provider;
   2. Ninety (90) days from the Provider's date of termination, unless UBH's Medical Director determines that a longer period is needed;
   3. The date that care is successfully transitioned to a Participating Provider;
   4. The time benefit limitations under the Benefit Plan are met or exceeded; or
   5. The service is no longer medically necessary; and
c) Members who remain confined in an inpatient facility on and after the effective date of such termination until the Member is discharged, provided that such termination occurs for any reason other than nonpayment of premium, fraud or abuse.

ii) Provider agrees to accept the same payment from and abide by the same terms and conditions under the Agreement, unless the parties agree otherwise;

iii) Provider agrees not to seek any payment from the Member for any amount for which the Member would not have been responsible if the provider were still a participating provider.

1.9. Member Notice Requirements. The following Member Notice Requirements apply when the Provider is terminated, regardless of the reason for termination:

i) If the Provider is a primary care provider, then UBH shall notify all Members who are patients of that primary care provider of the termination. Provider shall supply UBH with a list of those Members within five (5) business days of notice of termination. UBH shall supply Provider with a list of Provider's patients who are Members.

ii) UBH shall make a good faith effort to provide, within fifteen (15) business days after receipt of or issuance of a notice of termination, written notice of such termination to all Members who are identified as patients by the Provider, are on UBH's patient list for that Provider, or have been seen by the Provider within the last twelve (12) months.

1.10. Intermediaries. For each and every contract which an intermediary negotiates and executes with UBH, on behalf of the providers covered by the intermediary: (a) No individual or group of providers covered by the contract shall be prohibited from protesting or expressing disagreement with a medical decision, medical policy, or medical practice of UBH or an entity representing or working for UBH (e.g., a utilization review company); (b) UBH or an entity representing or working for UBH shall not be prohibited from protesting or expressing disagreement with a medical decision, medical policy, or medical practice of an individual or

group of providers covered by the contract; and (c) UBH shall not take an Adverse Action against any contract executed by an intermediary because any individual or group of providers covered by the contract (i) expresses disagreement with a decision by UBH or an entity representing or working for UBH to deny or limit benefits to a Member, or (ii) assists the Member to seek reconsideration of UBH's decision, or (iii) discusses with a current, former, or prospective patient any aspect of the patient's medical condition, any proposed treatments or treatment alternatives, whether covered by UBH or not, policy provisions of a plan, or a provider's personal recommendation regarding selection of a health plan based on Provider's personal knowledge of the health needs of such patients.

As required by C.R.S. §10-16-705, an intermediary must comply with the same standards, guidelines, medical policies, and benefit terms of UBH and Payors. Furthermore, an intermediary must indicate the name of the intermediary and UBH or Payor when making any payment to Provider on behalf of UBH or a Payor.

1.11. Adjustments to Claims. Provider, Payor and UBH shall comply with the requirements set forth in C.R.S. §10-16-704 (4.5) with regard to making adjustments to claims. Such requirements shall include, but not be limited to, (a) the requirement that such adjustments be made within the time period set forth in the contract between Provider and UBH; provided, however, that such time period shall be the same for Provider and UBH and (b) shall not exceed twelve (12) months after the date of the original explanation of benefits, except as otherwise set forth in C.R.S. §10-16-704 (4.5).

1.12. Fee Schedule Maintenance. UBH will implement routine and non-routine fee schedule changes in accordance with the Agreement. Routine updates to a fee schedule or compensation consistent with the methodology described in the Agreement shall be made after the date of publication of the source which causes a change in payment methodology; such changes are generally made within 90 days from the date of such publication. UBH will comply with the requirements of C.R.S. §25-37-104 for fee schedule changes that are "Material Changes" as defined by C.R.S. §25-37-102.

1.13. Material Change to Contract. This section is applicable to "Health care providers" and "Material Changes" as those terms are defined by C.R.S. §25-37-102. UBH shall give a Provider ninety (90) days' notice of a Material Change to the Agreement in accordance with C.R.S. §2537-104. Provider may object to the Material Change within 15 days, and if there is no resolution of the objection, either party may terminate this Agreement upon written notice of termination provided to the other party no later than sixty (60) days before the effective date of the Material Change. If a Material Change is the addition of a new Category of Coverage, as defined by C.R.S. §25-37-102, the Provider may object to the Material Change, and such change will not take effect as it pertains to Provider; the objection shall not be a basis by which either party may terminate this Agreement.

1.14. Waiver. This section is applicable to "Health care providers" as defined by C.R.S. §25-37-102. UBH shall not require a Provider, as a condition of contracting, to waive or forego any rights or benefits to which they may be entitled under state or federal law or regulation that provides legal protections to a person solely based on the person's status as a health care provider providing health care services.

1.15. Enforcement of Article 37-Contract with Health Care Providers. This section is applicable to "Health care providers" as defined by C.R.S §25-37-102. With respect to the enforcement of C.R.S. §25-37-101 and pursuant to C.R.S. §25-37-114, the parties shall have available: (1) binding arbitration; (2) private rights of action at law and in equity; (3) equitable relief, including injunctive relief; (4) reasonable attorney fees when a Provider is the prevailing parting in an action to enforce C.R.S. §25-37-101, except to the extent that the violation consists of a mere failure to make payment to Provider pursuant to this Agreement; (5) the option to introduce as persuasive authority prior arbitration awards regarding a violation of C.R.S. §25-37-101.

This Agreement does not preclude its use or disclosure to a third party for the purpose of enforcing C.R.S. §25-37-101. The third party shall be bound by the confidentiality requirements set forth in the Agreement. Any arbitration awards related to the enforcement of C.R.S. §25-37-101 may be disclosed to those who have a bona fide interest in the arbitration.

1.16. Dispute Resolution. UBH and Provider, as applicable, will comply with the resolution of disputes procedures as required by C.R.S. §10-16-705 and 3 CCR 702-4 (4-2-23, as amended).

For Colorado Option plans only, if UBH or Provider anticipates that UBH will not meet network adequacy standards or the premium rate requirements under C.R.S. 10-16-1305 due to a reimbursement rate dispute, UBH or Provider may engage in nonbinding arbitration pursuant to C.R.S. 10-16-1306.

Article II Provisions Applicable to Health Maintenance Organization Benefit Plans:

2.1. Confidentiality. Any data or information pertaining to the diagnosis, treatment, or health of any Member or applicant obtained from such person or from any Provider by UBH shall be held in confidence and shall not be disclosed to any person except to the extent that it may be necessary to carry out the purposes of any applicable law; or upon the express consent of the Member or applicant; or pursuant to statute or court order for the production of evidence or the discovery thereof; or in the event of claim or litigation between such person and UBH wherein such data or information is pertinent. UBH shall be entitled to claim any statutory privileges against such disclosure which Provider, who furnished such information to UBH, is entitled to claim.

2.2 Hold harmless – HMO. Provider agrees that in no event, including but not limited to nonpayment by Payor, insolvency of UBH or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Member or persons (other than UBH or Payor) acting on the Member's behalf for Covered Services provided pursuant to this Agreement. This provision does not prohibit Provider from collecting supplemental charges or co-payments or fees for uncovered services delivered on a "fee-for-service" basis to a Member.

Provider agrees that this provision shall survive the termination of this Agreement for Covered Services rendered prior to the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Member. This provision is not intended to apply to services provided after this Agreement has been

terminated, except to the extent that the in-network relationship is extended to provide continuity of care.

Provider agrees that this provision supersedes any oral or written contrary agreement now or existing hereafter entered into between Provider and the Member or persons acting on his/her behalf insofar as such contrary agreement relates to liability for payment of services provided under the terms and conditions of this Agreement.

Any modification, addition, or deletion to this provision shall become effective on a date no earlier than thirty (30) days after the Colorado Commissioner of Insurance has received written notification of proposed changes.