Connecticut Regulatory Appendix

This Connecticut 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 Connecticut 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. Retaliation Prohibited. UBH shall not take or threaten to take any action against Provider in retaliation for Provider providing assistance to a Member under the provisions of Conn. Gen. Stat.
sections 38a-478h and 38a-591g.

2. Communications Regarding Treatment. Nothing in the Agreement shall be construed to prevent or prohibit Provider from discussing with a Member any treatment options and services available in or out of network, including experimental treatments.

3. Communications Regarding Compensation. Nothing in the Agreement shall be construed to prevent or prohibit Provider from disclosing to a Member who inquires, the method UBH uses to compensate Provider.

4. Member Protection Provision. In no event, including, but not limited to, nonpayment, insolvency of UBH or Payor, or breach by UBH of this Agreement, shall a Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Member or the Member's designee, other than Payor, for covered benefits provided, except that Provider may collect any copayments, deductibles or other out-of-pocket expenses that the Member is required to pay pursuant to the Benefit Plan.

5. Medical Protocols. UBH shall make UBH's medical protocols available to Provider on request during regular business hours. If UBH denies coverage for a treatment, service or procedure Provider provides to a Member under this Agreement, UBH will provide Provider with a copy of the relevant medical protocol, on Provider's request. Pursuant to Conn. Gen. Stat. § 38a472, if Provider is a "medical provider" licensed pursuant to chapters 370 to 373, inclusive, or chapter 375, 379, 380 or 383, this Agreement will not be construed to require that Provider must indemnify UBH or Payor, as applicable, for any expenses and liabilities including, without limitation, judgments, settlements, attorneys' fees, court costs and any associated charges incurred in connection with any claim or action brought against UBH or Payor on the basis of its determination of medical necessity or appropriateness of health care services if the information provided by Provider used in making the determination was accurate and appropriate at the time it was given. Notwithstanding the preceding sentence, Provider shall be responsible for his or her professional actions and related liability.

6. Provider Profiles. If UBH develop provider profiles, or otherwise develop measures for health care provider performance, UBH will:

i) make allowances for the severity of illness or condition of the patient mix;
ii) make allowances for patients with multiple illnesses or conditions;
iii) make available to the Connecticut Commissioner of Insurance documentation of how UBH makes such allowances; and
iv) inform Members and Provider, upon request, how UBH considers patient mix when profiling or evaluating providers.

7. No Limitation of Rights. Nothing in the Agreement shall be construed to prohibit or limit any cause of action or contract rights a Member otherwise has.

8. Laboratory or Testing Facilities. Provider agree that in utilizing laboratories and testing facilities for UBH's Members who have coverage for laboratory and testing services, Provider will use laboratories and testing facilities covered under the Member's Benefit Plan or Provider will notify the Member if Provider intend to utilize a laboratory or testing facility not covered under the Member's Benefit Plan.

9. Processing and Payment of Claims. UBH and Payor will comply with the requirements set forth in Sections 38a-816 and 381-478v of Connecticut General Statutes regarding the processing and payment of claims to the extent those are applicable.

For claims filed in paper format, Payor will pay claims not later than sixty (60) days after receipt by UBH of the claim filed in accordance with UBH's practices or procedures, except that when there is a deficiency in the information needed for processing a claim, as determined in accordance with section 38a-477 of the Connecticut General Statutes, (i) UBH will send written notice to Provider of all alleged deficiencies in information needed for processing a claim not later than thirty (30) days after UBH receives a claim for payment, and (ii) Payor will pay claims not later than thirty (30) days after UBH receives the information requested.

For claims filed in electronic format, Payor will pay claims not later than twenty (20) days after receipt by UBH of the claim filed in accordance with UBH's practices or procedures, except that when there is a deficiency in the information needed for processing a claim, as determined in accordance with section 38a-477 of the Connecticut General Statutes, (i) UBH will send written notice to Provider of all alleged deficiencies in information needed for processing a claim not later than ten (10) days after UBH receives a claim for payment, and (ii) Payor will pay claims not later than ten (10) days after UBH receives the information requested.

If Payor fails to pay such a claim within the above time periods, whether in paper or electronic format, Payor will pay Provider the amount of such claim plus interest at the rate of fifteen per cent (15%) per annum.

10. Facility Fees. Facility will not collect facility fees from Payors or Members for outpatient services with a CPT evaluation and management (E/M) code or assessment and management (A/M) code that are provided at a hospital-based facility located off-site from a hospital campus. Additionally, effective July 1, 2024, Facility will not collect facility fees from Payors or Members for outpatient services with a CPT E/M code or A/M code that are provided on a hospital campus, unless the outpatient services are provided in an emergency department or are for observation stays for wound care, orthopedics, anticoagulation, oncology, obstetrics, or solid organ transplant.

11. Fee Schedule Changes. UBH shall not make any material changes to the Provider's fee schedule except as follows:

i) Annually, provided UBH gives at least ninety (90) days' advance notice by mail, fax, or email. Upon receipt of notice, Provider may terminate the contract with at least sixty (60) days' written notice to UBH.
ii) At any time, provided UBH gives at least thirty (30) days' advance notice by mail, fax, or email, for any reason as set forth in Conn. Gen. Stat. § 38a-479.

12. Termination.

i) If either party terminates the Agreement, the terminating party will provide written notice in
the form and manner set forth in the Agreement, but in no case shall the notice be provided less than ninety (90) days prior to the effective date of the termination. This prior notice requirement shall not apply when: (a) lack of such notice is necessary for the health or safety of Members; (b) Provider is found to have entered

into this Agreement based on fraud or material misrepresentation; or (c) Provider has engaged in any fraudulent activity related to the terms of the Agreement between Provider and UBH.

Each Provider that receives or issues a termination notice must provide UBH a list of Provider's patients who are Members under a UBH Benefit Plan and have been treated within the last 12 months. This list must be provided within 30 days of issuing or receiving a notice of termination.

ii) UBH shall make a good faith effort to provide written notice, not later than thirty days after UBH receives or issues a written notice under subparagraph (A) of this subsection, to all Members who are patients being treated on a regular basis by Provider, irrespective of whether such removal or departure is for cause.

iii) For Providers that are hospitals, as defined in section 38a-493: If the Agreement is not renewed or is terminated by either UBH or Provider, UBH and Provider shall continue to abide by the terms of the Agreement, including reimbursement terms, for a period of sixty days from the date of termination or, in the case of a nonrenewal, from the end of the Agreement's term. Except as otherwise agreed between UBH and Provider, the reimbursement terms of any agreement entered into by UBH and Provider during said sixty-day period shall be retroactive to the date of termination or, in the case of a nonrenewal, the end date of the Agreement's term. This subparagraph shall not apply if UBH and participating provider agree, in writing, to the termination or nonrenewal of the Agreement, and UBH and Provider provide the notices required under subparagraphs (A) and (B) of this subsection.

13. Continuity of Care Following Termination. The following definitions apply to this section:

"Active course of treatment" means (a) a medically necessary, ongoing course of treatment for a life threatening condition, (b) a medically necessary, ongoing course of treatment for a serious condition, (c) medically necessary care provided during the second or third trimester of pregnancy, or (d) a medically necessary, ongoing course of treatment for a condition for which a treating health care provider attests that discontinuing care by such health care provider would worsen the Member's condition or interfere with anticipated outcomes.

"Life-threatening condition" means a disease or condition for which the likelihood of death is probable unless the course of such disease or condition is interrupted.

"Serious condition" means a disease or condition that requires complex ongoing care such as chemotherapy, radiation therapy or postoperative visits, which the Member is currently receiving.

"Treating provider" means a Member's treating health care provider or a facility at which a Member is receiving treatment that is removed from or leaves UBH's network.

The continuity of care period for a Member who is undergoing an active course of treatment must extend to the earliest of the following:

i) Termination of the course of treatment by the Member or the treating provider;

ii) 90 days after the date the treating provider is removed from or leaves the network, unless UBH's medical director determines that a longer period is necessary;

iii) The date that care is successfully transitioned to another participating provider; iv) The date benefit limitations under the Benefit Plan are met or exceeded; or v) The date UBH determines care is no longer medically necessary.

UBH may only grant a continuity of care period if the treating provider agrees, in writing:

i) To accept the same payment from UBH and abide by the same terms and conditions as provided in the participation agreement between UBH and treating provider when treating provider was a participating provider, and

ii) Not to seek any payment from the Member for any amount for which the Member would not have been responsible if the treating provider was still a participating provider.

14. Participating Provider Requirements.

Hold Harmless:

Provider agrees that in no event, including, but not limited to, nonpayment by UBH**,** the insolvency of UBH, or a 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 a person (other than UBH) acting on behalf of the Member for Covered Services provided pursuant to this Agreement. This Agreement does not prohibit Provider from collecting coinsurance, deductibles or copayments, as specifically provided in the Benefit Plan, or fees for uncovered services delivered on a fee-for-service basis to Members. Nor does this Agreement prohibit Provider and a Member from agreeing to continue services solely at the expense of the Member, as long as Provider has clearly informed the Member that the health carrier does not cover or continue to cover a specific service or services. Except as provided herein, this Agreement does not prohibit the provider from pursuing any available legal remedy.

In the event of UBH's insolvency or other cessation of operations, the Provider's obligation to deliver Covered Services to Members without requesting payment from a Member other than a coinsurance, copayment, deductible or other out-of-pocket expense for such services which will continue until the earlier of:

the termination of the Member's coverage under the Benefit Plan, including any extension of coverage provided under its terms or applicable state or federal law for Members who are in an active course of treatment, or are totally disabled, or the date the Agreement would have terminated if UBH had remained in operation, including any extension of coverage required under applicable state or federal law for Members who are in an active course of treatment or are totally disabled.

This section's terms must:

i) be construed in favor of the Member,

ii) survive the termination of the Agreement regardless of the reason for the termination, including UBH's insolvency, and

iii) supersede any oral or written agreement between Provider and a Member or a Member's authorized representative that is contrary to or inconsistent with these requirements.

Records:
Provider must make health records available to appropriate state and federal authorities involved in assessing the quality of care provided to, or investigating grievances or complaints of, Members, and Provider shall comply with applicable state and federal laws related to the confidentiality of medical and health records and Member's right to view, obtain copies of or amend such covered person's medical and health records.

Neither UBH nor Provider may assign or delegate any right or responsibility required under this section without the prior written consent of the other party.

15. Contracts - Disclosure of provisions and other documents.
At the time this Agreement is signed, UBH must disclose to a participating provider all provisions and other documents incorporated by reference in the contract.

While the Agreement is in force, UBH must timely notify Provider of any change to these provisions or other documents that will result in a material change to the Agreement.

16. Commissioner prohibited from arbitration, mediation or settlement of disputes. The Connecticut Commissioner of Insurance may not act to arbitrate, mediate or settle:

i) disputes regarding UBH's decision not to include a health care provider or facility in the

UBH's network or network plan, or ii) any other dispute between UBH or Provider, that arises under or by reason of this Agreement or the termination of this Agreement.

17. Incentives regarding treatment.
UBH may not:

i) Offer or provide an inducement to Provider that would encourage or otherwise incentivize a

Provider to provide less than medically necessary health care services to a Member; ii) Prohibit Provider from (a) discussing any specific or all treatment options with a Member, irrespective of UBH's position on such treatment options, or (b) advocating on behalf of a Member within the utilization review or grievance and appeals processes established by UBH or a person contracting with UBH or in accordance with any rights or remedies available to Members under sections 38a- 591a to 38a-591g, inclusive, or federal law relating to internal or external claims grievance and appeals processes; or iii) Penalize Provider because Provider reports in good faith to state or federal authorities any act or practice by UBH that jeopardizes patient health or welfare.

18. Unfair Trade Practice. Neither Provider, nor its agent, trustee or assignee thereof, may: (i) maintain any action at law against a Member to collect sums owed by the UBH or Payor; or (ii) request payment from a Member for such sums. For purposes of this section "request payment" includes, but is not limited to, submitting a bill for services not actually owed or submitting for such services an invoice or other communication detailing the cost of the

services that is not clearly marked with the phrase "THIS IS NOT A BILL." Provider acknowledges and agrees that, pursuant to Conn. Gen. Stat. § 20-7f, it is an unfair trade practice in violation of chapter 735a for any health care provider to request payment from a Member, other than a copayment or deductible, for Covered Services, or to report to a credit reporting agency a Member's failure to pay a bill for medical services when UBH or Payor has primary responsibility for payment of such services.

19. **Material Changes.** For any Agreement entered into or amended on or after July 1, 2022, UBH shall provide Provider with at least ninety (90) days' advance written notice of any change to the provisions of the contract or provider manuals, policies, other documents incorporated by reference into the Agreement that will result in a material change to the Agreement or procedures that a participating provider must follow pursuant to the Agreement. "Material change," as used in this section, will have the meaning as defined in Conn. Gen. State § 38-477. UBH will provide provisions affording the participating provider a right to appeal any proposed change to the provisions of the Agreement or provider manuals, policies or other documents incorporated by reference into the Agreement.