Massachusetts Regulatory Appendix

This Massachusetts 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 Massachusetts 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. **Member Protection.** In no event, including, but not limited to, non-payment by Payor or an intermediary for Covered Services rendered to Members by Provider, insolvency of Payor or an intermediary, or breach of any term or condition of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member or persons acting on behalf of the Member, other than UBH or an intermediary, for Covered Services eligible for reimbursement under this Agreement; provided, however, that Provider may collect from the Member any copayment, 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. This Appendix does not prohibit Provider from agreeing to continue the provision of non-covered health care services solely at the Member's expense, as long as Provider has clearly informed the Member that UBH may not cover or continue to cover a specific health care service or health care services. The foregoing sentence does not apply to Provider if Provider is employed full-time on UBH's staff and has agreed to provide health care services exclusively to UBH's Members and no others. Except as provided herein, this provision does not prohibit Provider from pursing any available legal remedy. The provisions of this section shall: (a) apply to all Covered Services rendered while this Agreement is in force; (b) with respect to Covered Services rendered while this Agreement is in force, survive the termination of this 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. Provider or Provider's agent, trustee, or assignee may not maintain any action at law against a Member to collect sums owed to Provider by UBH.

2. Continued Provision of Covered Services After Termination.

(a) If Provider is a primary care physician, in the event this Agreement is terminated by Provider or in the event this Agreement and Appendix are terminated by UBH for reasons other than quality of care or fraud, and a Member is receiving care from Provider under a prescribed treatment plan for a particular injury or sickness, Provider is obligated to continue the provision of Covered Services to that Member for a period of at least thirty (30) days from the date of notice of termination of this Agreement and Appendix.

(b) In the event this Agreement is terminated by UBH for reasons other than quality of care or fraud, and a Member is in her second or third trimester of pregnancy and receiving care from Provider, Provider is obligated to continue the provision of Covered Services to that Member until the completion of the first postpartum visit.

(c) In the event this Agreement is terminated by UBH for reasons other than quality of care or fraud, and a Member is terminally ill and Provider is treating the Member for the terminal illness at the time of the termination, Provider is obligated to continue the provision of Covered Services to that Member until the Member's death.

Provider agrees to following terms with respect to the continued provision of Covered Services as described above:

(a) Provider shall be reimbursed in accordance with this Agreement for all such Covered Services rendered subsequent to the termination of this Agreement;

(b) Provider will not impose any cost-sharing with respect to a Member in an amount that would exceed the cost- sharing that could have been imposed if this Agreement had not terminated;

(c) Provider will adhere to UBH's quality standards and provide UBH with necessary medical information related to the care provided; and

(d) Provider will adhere with UBH's policies and procedures, including procedures, as applicable, regarding referrals, obtaining prior authorization and providing treatment pursuant to a treatment plan, if any, approved by UBH.

3. Communication and Clinical Decisions.

(a) Communications. 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 Provider's patients or UBH's ability to administer UBH's quality improvement, utilization management and credentialing programs. Provider shall not be penalized or this Agreement terminated by UBH because Provider has in good faith (i) communicated with or advocated on behalf of one or more of its prospective, current or former patients regarding the provisions, terms or requirements of UBH's health benefit plans as they relate to the needs of such Provider's patients; or (ii)communicated with one or more of its prospective, current or former patients with respect to the method by which Provider is compensated by UBH for services provided to the patient.

(b) Clinical Decisions. Provider shall be responsible for making all clinical decisions regarding medical treatment to be provided to Members, including the provision of durable medical equipment and hospital lengths of stay, consistent with generally accepted principles of professional medical practice and in consultation with the Member.

4. Confidentiality of Insurance Information. Provider and UBH shall comply with the confidentiality of insurance information provisions set forth in the Massachusetts Code.

5. Prompt Payment. Provider and UBH shall comply with the prompt payment requirements set forth in the Massachusetts Code.

Within forty-five (45) days after UBH's receipt of Provider's completed forms for reimbursement, UBH shall: (a) make payments for the provision of such services; (b) notify Provider in writing of the reason or reasons for nonpayment, or (c) notify Provider in writing of what additional information or documentation is necessary to complete the reimbursement forms.

If UBH fails to comply with these requirements, UBH shall pay, in addition to any reimbursement for health care services provided, interest on such benefits, which shall accrue beginning forty-five (45) days after UBH's receipt of request for reimbursement at the rate of 1.5% per month, not to exceed 18% per year.

The requirements set forth in this section do not apply to a claim or claims that UBH is

investigating because of suspected fraud.

6. **Prior Review and Approval of Provider Subcontracts.** Provider must obtain prior approval from UBH regarding any subcontractor utilized by Provider. Provider's subcontractors shall be required to comply with the provisions of this Agreement and all applicable provisions of Massachusetts law, including M.G.L. c. 176O.

7. **Emergency Care.** Provider and UBH agree that the following requirements apply with regard to the delivery of emergency Covered Services to UBH's Members. An emergency medical condition means: a medical condition, whether physical, behavioral, related to substance use disorder, or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of the insured or another person in serious jeopardy, serious impairment to body function or serious dysfunction of any body organ or part or, with respect to a pregnant woman, as further defined in section 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. section 1395dd(e)(1)(B).

Provider acknowledges that:

(a) In an emergency, Members have the option to call 911 (or the local equivalent).

(b) In the event of an emergency, emergency Covered Services are covered as described in the Member's Certificate of Coverage and that such coverage extends to the point at which a Member has been stabilized for discharge or transfer.

Provider's notification requirements relating to emergency Covered Services are set forth in UBH's Administrative Guide.

8. **Utilization Review, Quality, Credentialing and Utilization Management Programs.**

(a) Utilization Review Requirements. Provider shall comply with applicable utilization review requirements set forth in the Massachusetts Code and Regulations, and to the extent necessary, obtain and maintain a utilization review license in the Commonwealth of Massachusetts.

(b) Quality Management, Credentialing, Preventive Care. Provider shall comply with UBH's requirements with respect to quality management and improvement, credentialing, and the delivery of preventive Covered Services.

Provider acknowledges that as part of UBH's quality improvement program, an annual survey of Members to assess satisfaction with access to specialist services, ancillary services, hospitalization services, durable medical equipment and other Covered Services is conducted.

(c) Utilization Management. Under certain circumstances, for the purpose of determining coverage, UBH's utilization management staff and medical directors may evaluate applicable medical and clinical information. Such information, if used by UBH to determine coverage, is: (i) updated at least biennially or more

often as new treatments, applications and technologies are adopted as generally accepted professional medical practice; and (ii) uses generally accepted medical criteria that have been reviewed by local, participating physicians. Final coverage decisions are made after verifying Member eligibility and reviewing the Certificate of Coverage.

(i) Notification Requirements. Notification requirements may be applied to a small number of inpatient or outpatient services. An initial determination regarding a proposed admission, procedure or service that requires such a determination will be made within two (2) working days of obtaining all necessary information. In the case of a determination to approve an admission, procedure or service, UBH will notify Provider by telephone within twenty-four (24) hours, and will provide written or electronic confirmation of the telephone notification to the Member and to Provider within two (2) working days thereafter. In the case of an adverse determination, UBH will notify Provider by telephone within twenty-four (24) hours, and will provide written or electronic confirmation of the telephone notification to the Member and Provider within one (1) working day thereafter.

(ii) Concurrent Review. Concurrent review processes address the appropriateness of an admission, continued stay setting and level of care as well as identify and prevent delays in care, clinical coverage decisions and discharge planning. UBH makes concurrent review determinations within one (1) working day of obtaining all necessary information. In the case of a determination to approve an extended stay or additional services, UBH will notify Provider by telephone and provide written or electronic confirmation to the Member and Provider within one (1) working day thereafter. Written or electronic notification shall include the number of extended days or the next review date, the new total number of days or services approved, and the date of admission or initiation of services. In the case of an adverse determination, within 24 hours UBH will notify Provider by telephone and will provide written or electronic notification to the Member and Provider within one (1) working day thereafter. The service will continue without liability to the Member until the Member has been notified of the determination.

(iii) Adverse Determinations. An adverse determination notification as the result of notification requirements or a concurrent medical review will:

(A) be issued by a medical director only after the medical director has contacted and discussed the case with the ordering physician or designee (or made a reasonable attempt to contact);

(B) include a substantive clinical justification that is consistent with generally accepted principles of professional medical practice;

(C) identify the specific information upon which the adverse determination was based;

(D) discuss the Member's presenting symptoms or condition, diagnosis and treatment interventions and the specific reasons such medical evidence fails to meet the relevant medical review criteria;

(E) specify any alternative treatment option offered by us, if any;

(F) reference and include applicable clinical practice guidelines and

review criteria;

(G) specify whether or not a Member has any liability;

(H) include appeal and reconsideration rights.

(iv) Reconsideration. Provider may request a reconsideration of UBH's adverse determination, Reconsideration regarding a notification requirement decision or concurrent adverse determination will be performed by a clinical peer reviewer, will occur within one (1) working day of the receipt of the request and shall be conducted between Provider and the clinical peer reviewer or a clinical peer designated by the clinical peer reviewer if said reviewer cannot be available within one (1) working day.

If the adverse determination is not reversed by the reconsideration process, the Member, or Provider on behalf of the Member, may pursue the grievance process. The reconsideration process will not be required as a prerequisite to the grievance process or a request for an expedited appeal.

9. **No Indemnification.** UBH shall not require Provider to indemnify UBH for any expenses and liabilities, including, without limitation, judgments, settlements, attorney's fees, court costs and any associated charges, incurred in connection with any claim or action brought against UBH based on UBH's management decisions, utilization review provisions or other policies, guidelines or actions.

10. **Compliance with Confidentiality and Reporting Laws.** Provider and UBH shall comply with all applicable state, commonwealth and federal laws regarding confidentiality and reporting.

11. **No Incentive Plans/No Inducement.** Nothing in this Agreement is intended or shall be construed to offer an incentive plan or inducement to Provider to provide less than medically necessary health care services to Members.

12. **Risk Arrangements.** If this Agreement contains risk arrangements, Provider acknowledges that the following are in place: (a) Provider maintains stop loss protection; (b) there are a minimum number of Members covered under the risk arrangement; and (c) the Covered Services covered under the risk arrangement are clearly identified.

13. **No Disclosure to Consumer Reporting Agencies Regarding Grievances and Appeals.** Provider or Provider's agent shall not provide information relative to unpaid charges for health care services to a consumer reporting agency while an internal or external review is pending, or for fifteen
(15) days following the resolution of such grievance/appeal.

14. **Referrals.** If a Member's Benefit Plan requires the selection of a primary physician, a referral from that physician is not required for specialty care obtained directly from a network obstetrician, gynecologist, nurse, midwife or family practitioner for the following Covered Services:

(a) Annual preventive gynecologic exams and other gynecologic care.

(b) Maternity care.

The primary provider may authorize a standing referral for other specialty care obtained

directly from a network provider whenever (1) the primary care physician determines that such referrals are appropriate;

(2) the provider of specialty health care agrees to a treatment plan for the Member and provides the primary care physician with all necessary clinical and administrative information on a regular basis; and

(3) the health care services to be provided are consistent with the terms of the Benefit Contract.

No higher copayments, coinsurance, deductibles or additional cost sharing will apply for such services.

15. **Modifications.** UBH shall notify Provider in writing of modifications in payments, Covered Services or in UBH's procedures, documents or requirements, including those associated with utilization review, quality management and improvement, credentialing and preventative Covered Services, that have a substantial impact on the rights or responsibilities of providers. UBH will also inform Provider of the effective date of such modifications. Notice shall be provided sixty (60) days before the effective date of such modification unless such other date for notice is mutually agreed upon between Provider and UBH.

16. **Dispute Resolution.** Nothing in the Dispute Resolution Section of this Agreement is intended to limit the authority of the Massachusetts Attorney General as set forth in M.G.L. c. 93, § 9 of the laws of Massachusetts.

17. **Termination.** Neither party shall terminate the Agreement without cause but may non-renew this Agreement without cause upon advance written notice to the other party in the form and for the length of time as provided in the Agreement but in no case less than ninety (90) days. If UBH terminates this Agreement for cause, UBH shall provide a written statement to Provider of the reason(s) for the termination.

18. **Administrative Services.** With respect to Members enrolled in a Benefit Plan under which UBH provides administrative services only, UBH's obligations under M.G.L. 176O §16(c) shall be limited to recommending to a third party Payor that coverage should be authorized.

19. **Additional Fee Arrangements.** If the Provider is a physician, other professional, or medical group, such Provider must give UBH advance written notice of any arrangements Provider makes to charge an additional fee to individuals seeking health care services from Provider as a condition for those individuals to be or continue to be part of Provider's panel of patients. If a Provider does not provide such notice and UBH learns that Provider is charging additional fees as a condition of participation in their panel of patients, UBH may terminate Provider's agreement with UBH for cause in breach of contract. In the event Provider puts such an arrangement in place, Provider will not charge individuals who are Members any additional fees for the services provided by Provider, other than the applicable co- pay, coinsurance or deductible amount for which Member is responsible to pay for those services which are covered services under the Member's Benefit Plan. In the event Provider puts such an arrangement in place, Provider may seek and collect payment from Members for services that are not covered services under their Benefit Plan, provided

that Provider first enters into a service agreement with the Member or otherwise obtains the Member's written consent.

20. **Utilization Review.** For the purposes of this agreement, "utilization review" shall mean a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include, but are not limited to, ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review" as defined under M.G.L. c. 176O and CMR 52.03.

21. **Copies of Medical Records.** Provider and UBH shall comply with Massachusetts laws regarding reasonable fees Provider may charge for copying medical records, when applicable.

22. **Limited, Regional and Tiered Provider Networks**. Provider has the right to opt out of any new Health Benefit Plan (HBP) that uses a Limited, Regional or Tiered Provider Network as those terms are defined in 211 CMR 152.02. HBP contracts must be signed at least sixty (60) days before being submitted to the Commissioner for approval. UBH will notify Provider at least sixty (60) days in advance of any of the following modifications;

- The process used to classify providers by benefit tier
- The timelines that UBH will use to make decisions and implement any reclassifications of Providers by benefit tier.
- Modification in the information collected from Providers to make classification decisions, and
- Modification in the criteria or methodology used to make classifications UBH shall provide Provider;
- Notification of UBH's classification of Provider to a benefit tier
- An explanation of the information and criteria used to make classification decisions
- The ability to appeal the classification decision to UBH and receive a decision on the appeal prior to the new classification being made available on UBH's website and in materials made available to employers and individuals.