Utah Regulatory Requirements Attachment

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

This Attachment applies to all products or Benefit Plans sponsored, issued or administered by or accessed through UBH to the extent such products are regulated under **Utah** laws; provided, however, that the requirements in this Attachment 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 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, and be read in accordance with applicable laws and regulations.

If any of the capitalized terms in this Attachment are used or defined (or the equivalent terms are used or defined) in the Agreement, then the terms used in this Attachment 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 Attachment, will have the same meaning as "benefit contracts"; "Member," as used in this Attachment, will have the same meaning as "member," "enrollee," or "covered person"; "Payor," as used in this Attachment, will have the same meaning as "participating entity"; "Provider," as used in this Attachment, 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 Attachment 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 Attachment, all capitalized terms contained in the Attachment shall be defined as set forth in the Agreement.

1. **Member Hold Harmless.** Provider shall be required to accept the specified payment for services, at prices specified in the contracts, as payment in full; relinquishing the right to collect amounts other than copayments, coinsurance, and deductibles from the Member. In addition:

   a. If UBH:
      i. fails to pay for Covered Services as set forth in the Agreement, the Member is not liable to Provider for any sums owed by UBH; and
      ii. becomes insolvent, the rehabilitator or liquidator may require Provider to:
         A. continue to provide Covered Services under the Agreement until the

earlier of:

- 90 days after the date of the filing of a petition for rehabilitation or a petition for liquidation; or
- the date the term of the Agreement ends; and

B. subject to subsection (c) of this section 1, reduce the fees Provider is otherwise entitled to receive from UBH under the Agreement during the time period described in subsection (a)(ii)(A) of this section 1.

b. If the conditions of subsection (c) are met, Provider:
   i. shall accept the reduced payment as payment in full; and
   ii. as provided in subsection (a)(i) of this section 1, may not collect additional amounts from UBH's Member, except as may be owed under subsection (c)(ii) of this section 1.

c. Notwithstanding subsection (a)(ii)(B) of this section 1:
   i. the rehabilitator or liquidator may not reduce a fee to less than 75% of the regular fee set forth in the Agreement; and
   ii. the Member shall continue to pay the same copayments, deductibles, and other payments for services received from Provider that the Member was required to pay before the filing of:
      A. the petition for rehabilitation; or
      B. the petition for liquidation.

d. Provider may not collect or attempt to collect from the Member sums owed by UBH or the amount of the regular fee reduction authorized under subsection (a)ii)(B) if the Agreement:
   i. is not in writing as required in subsection (1); or
   ii. fails to contain the language required by subsection (1).

e.
   i. A person listed in subsection (e)(ii) of this section 1 may not bill or maintain any action at law against a Member to collect:
      A. sums owed by UBH; or
      B. the amount of the regular fee reduction authorized under subsection (a)(ii)(B).
   ii. Subsection (e)(i) of this section 1 applies to:
      A. Provider;
      B. an agent;
      C. a trustee; or
      D. an assignee of a person described in subsections (e)(ii)(A) through (C).
   iii. In any dispute involving a Provider's claim for reimbursement, Provider's claim shall be determined in accordance with applicable law, the Agreement, the Member’s Benefit Plan, and UBH's written payment policies in effect at the time services were rendered.
   iv. If the parties are unable to resolve their dispute, the matter shall be subject to binding arbitration by a jointly selected arbitrator. Each party shall bear its own expense except that the cost of the jointly selected arbitrator shall be equally shared. This subsection (e)(iv) does not apply to the claim of a general acute hospital to the extent the claim is inconsistent with the

hospital's Agreement.

v. UBH may not penalize Provider solely for pursuing a claims dispute or otherwise demanding payment for a sum believed owing.

f. If UBH permits another private entity with which UBH does not share common ownership or control to use or otherwise lease one or more of UBH's networks that include network providers, UBH shall ensure, at a minimum, that the entity pays the network providers included in UBH's network in accordance with the same fee schedule and general payment policies as UBH would pay for those network providers, unless payment for services is governed by a public program's fee schedule.

2. **Prompt Payment of Claims.** UBH, Payor and Provider shall comply with the terms and conditions of the Utah Statutes, and the Utah Unfair Accident and Health Income Replacement Claim Settlement Practices Rule.

Within 30 days of receipt of the written claim, Payor will either pay the claim, or deny the claim and provide a written explanation for the denial. The above time period may be extended by 15 days if (a) UBH or Payor determines that the extension is necessary due to matters beyond the control of UBH or Payor; and (b) before the end of the above 30 day period UBH or Payor notifies Provider and/or the Member as applicable in writing of the circumstances requiring the extension of time, and the date by which Payor expects to pay or deny the claim. Provided, however, that if the extension is necessary due to a failure of Provider or the Member to submit the information necessary to decide the claim, the above notice of extension shall specifically describe the required information, and UBH or Payor shall give Provider or the Member at least 45 days from the day on which Provider or the Member receives the notice before UBH or Payor denies the claim for failure to provide the necessary information.

UBH or Payor shall pay all sums to the Provider or Member that UBH or Payor is obligated to pay on the claim, and provide a written explanation regarding any part of the claim that is denied within 20 days of receiving the information requested under this section.

Nothing in this provision may be construed as limiting the ability of Payor to:

a) recover any amount improperly paid to Provider or a Member: (i) in accordance with Utah Code Ann. § 31A-31-103 or any other provision of state or federal law; (ii) within 24 months of the amount improperly paid for a coordination of benefits error; (iii) within 12 months of the amount improperly paid for any other reason not identified in (i) or (ii) of this paragraph; or (iv) within 36 months of the amount improperly paid when the improper payment was due to a recovery by Medicaid, Medicare, the Children's Health Insurance Program, or any other state or federal health care program;

b) take any action against Provider that is permitted under the terms of the provider contract and not prohibited by this section

Provider may only seek recovery from Payor for an amount improperly paid by Payor within the same time frames as in (a) and (b), above.

3. **Uniform Claim Form.** Provider shall comply with the terms of the Utah Uniform Health Billing Rule as set forth in Utah Administrative Code R590-164-1 through R590-164-7.

4. **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 their quality improvement, care coordination and utilization management and credentialing programs.

5. **Notification of Admission.** UBH shall not require Provider by contract, reimbursement procedure, or otherwise to notify UBH of a hospital in-patient emergency admission in less than one business day of the hospital in-patient admission, if compliance with the notification requirement would result in notification by Provider on a weekend or federal holiday. This provision does not prohibit the applicability or administration of other contract provisions between UBH and Provider that require pre- authorization for scheduled in-patient admissions.

6. **Access to Health Records.** Provider shall be required to make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating grievances or complaints from Members subject to applicable stated and federal laws related to the confidentiality of medical or health records.

7. **Standing Referrals.** In accordance with Utah Code Ann. § 31A-22-628 (2), a Member shall be allowed to obtain a standing referral to a specialist provider.

8. **Termination.**
   a) For the first two years after the effective date of the Agreement, UBH may terminate the Agreement with or without cause upon giving the requisite amount of notice provided in the Agreement, but in no case shall it be less than 60 days.
   b) The Agreement may be terminated for cause as provided in the Agreement.
   c) Before termination for cause, UBH: (a) shall inform Provider of the intent to terminate and the grounds for doing so; (b) shall at the request of Provider, meet with Provider to discuss the reasons for termination; (c) if UBH has a reasonable basis to believe that Provider may correct the conduct giving rise to the notice of termination, may, at its discretion, place Provider on probation with corrective action requirements, restrictions, or both, as necessary to protect patient care; and (d) if UBH has a reasonable basis to believe that Provider has engaged in fraudulent conduct or poses a significant risk to patient care or safety, may immediately suspend Provider from further performance under the Agreement, provided that the remaining provisions of this section 8 are followed in a timely manner before termination may become final.
   d) UBH shall establish an internal appeal process for actions that may result in terminated participation with cause and make known to the provider the procedure for appealing such termination. If Provider is dissatisfied with the results of the appeal process Provider may, if both parties agree, submit the matters in dispute to

mediation. If the matters in dispute are not mediated, or should mediation be unsuccessful, the dispute shall be subject to binding arbitration by an arbitrator jointly selected by the parties, the cost of which shall be jointly shared. Each party shall bear its own additional expenses.

e) A termination under section 8(a) or 8(b) may not be based on: (a) Provider's staff privileges at a general acute care hospital not under contract with UBH; or (b) Provider's referral patterns for patients who are not Members.

f) Notwithstanding any other section of Utah Code Ann. § 31A-45-304, UBH may not take adverse action against or reduce reimbursement to Provider if Provider is not under a capitated reimbursement arrangement because of the decision of a Member to access health care services from a non-network provider in a manner permitted by the Member's Benefit Plan, regardless of how the plan is designated.