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Washington Regulatory Requirements Addendum
to the Individual Participation Agreement

This Washington State Regulatory Requirements Addendum (this "Addendum") is made part of the Individual Participating Provider Agreement ("Agreement") entered into between UnitedHealthcare of Washington, Inc. ("United") and the health care professional or entity named in the Agreement ("Provider").

This Addendum applies to Benefit Plans sponsored, issued or administered by or accessed through United, to the extent such products are subject to regulation under Washington laws and for which Washington laws control. The requirements in this Addendum, however, do not apply to the extent they are preempted by the Medicare Modernization Act or other applicable law.

United, Payor, and Provider, as applicable, all agree to be bound by the terms and conditions contained in this Addendum. In the event of a conflict or inconsistency with any term or condition between this Addendum and any term or condition contained in the Agreement , this Addendum shall control, except with regard to Benefit Plans outside the scope of this Addendum.

United and Provider each acknowledge that Payors are obligated to comply with all state laws, statutes, and regulations that are applicable to entities such as Payor. United and Provider further acknowledge that certain Payors may not be parties to the Agreement and that any references to any obligations of Payor are an attempt by the parties to identify the Payor's obligations under applicable state law.

This Addendum 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 Addendum, all capitalized terms contained in this Addendum shall be defined as set forth in the Agreement.

1. **Section 1, "Definitions," "Emergency Services," of the Agreement shall be deleted in its entirety and replaced with the following:**

   Emergency Services: Services provided for an emergency medical condition manifesting itself by the acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health is serious jeopardy. Emergency Services are otherwise covered health care services medically necessary to evaluate and treat an emergency medical condition, provided in a hospital emergency department.

2. **A new definition, "Established Relationship," shall be added to Article 1, "Definitions" of the Agreement and shall be set forth as follows**:

   Established Relationship: As defined in RCW 48.43.735(9)(d)(i-ii), the provider providing audio-only telemedicine has access to sufficient health records to ensure safe, effective, and appropriate care services and:

(i) The covered person has had, within the past three years, at least one in-person appointment, or at least one real-time interactive appointment using both audio and video technology, with the provider providing audio-only telemedicine or with a provider employed at the same medical group, at the same clinic, or by the same integrated delivery system operated by a carrier licensed under chapter 48.44 or 48.46 RCW as the provider providing audio-only telemedicine; or

(ii) The covered person was referred to the provider providing audio-only telemedicine by another provider who has had, within the past three years, at least one in-person appointment, or at least one real-time interactive appointment using both audio and video technology, with the covered person and has provided relevant medical information to the provider providing audio-only telemedicine

3. **A new provision, "United and Payor Programs," shall be added as Section 3.6 of the Agreement and shall be set forth as follows:**

3.6 United and Payor Programs. Pursuant to Washington law, United shall notify Providers of their responsibilities with respect to the applicable administrative policies and programs of United and Payor, including but not limited to payment terms, utilization review, quality assessment and improvement programs, credentialing, grievance procedures, data reporting requirements, confidentiality requirements and any applicable federal or state requirements.

Applicable documents, procedures, and other administrative policies and programs referenced in the Agreement must be available for review by the Provider prior to contracting. These policies and programs will be made available, by United, to Provider online or upon request. Provider must be given reasonable notice of not less than 60 days of changes to policies and programs that affect Provider compensation and that affect health care service delivery unless changes to federal or state law or regulations make such advance notice impossible, in which case notice shall be provided as soon as possible. Subject to any termination and continuity of care provisions of the Agreement, a Provider may terminate the Agreement without penalty if the Provider does not agree with the changes. No change to the contract may be made retroactive without the express consent of the Provider.

4. **Section 2.8, "Employees and Contractors of Provider," of the Agreement is deleted in its entirety and replaced with the following:**

2.8 Employees and Contractors of Provider. Provider will ensure that its employees and contractors abide by the terms of this Agreement and in accordance with Washington law when providing Covered Services to Members. Provider understands that the employees and contractors of Provider may be restricted by United from providing Covered Services to Members in the event such employee or contractor does not meet credentialing requirements, or for otherwise failing to abide by the terms of this Agreement as requested by Provider.
All payments for Covered Services provided to Members shall be paid to Provider. Provider will make its own financial arrangements with its employees and contractors who have provided such Covered Services. Employees and contractors of Provider must look solely to Provider for reimbursement for Covered Services provided to Members. Payor will have no responsibility for payment beyond paying Provider the amounts required by this Agreement.

5. **A new provision, "Member Consent for Telemedicine" shall be added as Section 2.13 to the Agreement and shall be set forth as follows:**

2.13 Member Consent for Telemedicine. Patient consent is required for telemedicine services prior to rendering such services. Failure to obtain consent could result in disciplinary action pursuant to RCW 48.43.735. In addition, audio only telemedicine services may only be billed when provided to patients who have an established relationship with Provider.

6. Section 3.1, "Payment for Covered Services," of the Agreement is deleted in its entirety and replaced with the following:

3.1 Payment for Covered Services. Covered Services will be paid by Payor at the lesser of: (1) Provider's Customary Charge for such Covered Services, less any applicable Member Expenses; or (2) the Fee Maximum for such Covered Services, less any applicable Member Expenses, and in accordance with the Standard Payment Appendix(ces) attached hereto, if any. Payment will be made for Covered Services, in accordance with the claims payment standards contained in Washington state law, as set forth below in Section 3.1(a) – (h), provided they have been rendered and billed in accordance with United and Payor policies and procedures.

The obligation for payment for Covered Services provided to a Member is solely that of Payor, although United may arrange for claims processing services. For any claim United is obligated to pay as the Payor, when United has received all information necessary to process and pay a claim, payment will be made within the timeframes indicated by applicable Washington law.

a. Payment shall be made to Provider as soon as practical but subject to the following minimum standards: (1) 95% of the monthly volume of clean claims shall be paid within thirty 30 days of receipt by United or the Payor, as applicable; and (2) 95% of the monthly volume of all claims shall be paid or denied within 60 days of receipt by United or the Payor, as applicable, except as agreed to in writing by the parties on a claim-by-claim basis.

b. The receipt date of a claim is the date United or the Payor, as applicable, receives either written or electronic notice of the claim. United or Payor, as applicable, shall establish a reasonable method for confirming receipt of claims and responding to Provider inquiries about claims.

c. If Payor fails to pay claims within the standard established above, Payor shall pay interest on undenied and unpaid clean claims more than 61 days old until Payor meets the standard above. Interest shall be assessed at the rate of 1% per month, and shall be calculated monthly as simple interest prorated for any portion of a month. Payor shall add the interest payable to the amount of the unpaid claim without the necessity of the Provider submitting an additional claim. Any interest paid under this section shall not be applied by Payor to a Member's deductible, copayment, coinsurance or any similar obligation of the Member.

d. Payor shall not unreasonably delay payment of a claim by reason of the application of a coordination of benefits provision. The time limit after which payment should be made by reason of the application of a coordination of benefits provision is established as 6 months. When payment of a claim is necessarily delayed for reasons other than the application of a coordination of benefits provision, investigation of other plan coverage will be conducted concurrently so as to create no further delay in the ultimate payment of benefits. If Payor is required by the time limit to make payment as the primary plan because it then has insufficient information to make it a secondary plan, it reserves all rights to recover any excess payments made thereby.

e. When Payor issues payment in the Provider and Member names, Payor shall make claim checks payable in the name of the Provider first and the Member second.

f. For purposes of this section, "clean claim" means a claim that has no defect or impropriety, including any lack of any required substantiating documentation, or particular circumstances requiring special treatment that prevents timely payments from being made on the claim under this section.

g. These standards do not apply to claims about which there is substantial evidence of fraud or misrepresentation by Provider or Members, or instances where United or the Payor, as applicable, has not been granted reasonable access to information under the Provider's control.

h. Provider and United or Payor, as applicable, are not required to comply with the contract provisions contained in this section if the failure to comply is occasioned by any act of God, bankruptcy, act of a governmental authority responding to an act of God or other emergency, or the result of a strike, lockout or other labor dispute.

7. Section 3.5, "Member Protection Provision," of the Agreement is deleted in its entirety and replaced with the following:

3.5 Member Protection Provision.

a. Provider hereby agrees that in no event, including, but not limited to nonpayment by Payor, Payor's insolvency 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 person acting on the Member's behalf, other than Payor, for services provided pursuant to this Agreement. This provision shall not prohibit collection of copayments, co-insurance or deductibles, which have not otherwise been paid by a primary or secondary carrier in accordance with regulatory standards for coordination of benefits, from Members in accordance with the terms of the Member's Benefit Plan.

b. Provider agrees, in the event of the Payor's insolvency, to continue to provide the services promised in this Agreement to Members for the duration of the period for which premiums on behalf of the Member were paid or until the Member's discharge from inpatient facilities, whichever time is greater.

c. Notwithstanding any other provision of the Agreement, nothing in the Agreement shall be construed to modify the rights and benefits contained in the Member's Benefit Plan.

d. Provider may not bill the Member for Covered Services (except for copayments, coinsurance and deductibles) where United or Payor, as applicable, denies payments because Provider has failed to comply with the terms or conditions of this Agreement.

e. Provider further agrees: (i) that the provisions of (a), (b), (c), and (d) of this Section shall survive termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Members; and (ii) that this Section supersedes any oral or written or written contrary agreement now existing or hereafter entered into between Provider and Members or persons acting on the Members' behalf.

f. If Provider contracts with other health care providers who agree to provide Covered Services to Members with the expectation of receiving payment directly or indirectly from Payor, such providers must agree to abide by the provisions of (a), (b), (c), (d), and (e) of this section.

g. Collection of Amounts from Members. Provider is hereby notified that willfully collecting or attempting to collect an amount from a Member knowing that collection to be in violation of this Agreement constitutes a class C felony under the Revised Code of Washington.

h. No health carrier subject to the jurisdiction of the state of Washington may in any way preclude or discourage their providers from informing patients of the care they require, including various treatment options, and whether in their view such care is consistent with medical necessity, medical appropriateness, or otherwise covered by the patient's service agreement with the health carrier. No health carrier may prohibit, discourage, or penalize a provider otherwise practicing in compliance with the law from advocating on behalf of a patient with a health carrier. Nothing in this section shall be construed to authorize providers to bind health carriers to pay for any service.

i. No health carrier may preclude or discourage patients or those paying for their coverage from discussing the comparative merits of different health carriers with their providers. This prohibition specifically includes prohibiting or limiting providers participating in those discussions even if critical of a carrier.

8. Section 6.2, "Maintenance of and United Access to Records," of the Agreement is deleted in its entirety and replaced with the following:

6.2 Maintenance of and United Access to Records. Provider shall maintain adequate medical, financial and administrative records related to the ability of the Provider to deliver Covered Services to Member in a manner consistent with the accepted standards of medical care prevalent in the community and in accordance with all applicable statutes and regulations. Such records shall include all medical records, documents, evidences of coverage and other relevant information in Provider's possession upon which United relied to reach a decision concerning a Member complaint or grievance. Any such records shall be maintained for a period of six years and shall be readily available to United and Payor at all reasonable times during the term of this Agreement or a period of six years, whichever is longer.

To perform its utilization management and quality improvement activities, United shall have access to such information and records, including claims records, at all reasonable times, and in any event, within 14 days from the date the request is made, except that, in the case of an audit by United, such access shall be given at the time of the audit. Provider granting United access to medical records for audit purposes must be limited to only that necessary to perform the audit. If requested by United, Provider shall provide copies of such records free of charge. United shall have access to and the right to audit information and records during the term of this Agreement and for three years following its termination, whether by rescission or otherwise. It is Provider's responsibility to provide United with requested information and records or copies of records and to allow United to release such information or records to Payors as necessary for the administration of the Benefit Plan or compliance with any state or federal laws applicable to the Payors. In accordance with Washington law, Provider shall make medical records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of Members subject to applicable state and federal laws related to confidentiality of medical or health records. Such obligation survives the termination of this Agreement, whether by rescission or otherwise.

To the extent the Agreement allows United the right to audit Provider's billing records, Provider shall have the right to audit United's denial of Provider's claims under the same terms and conditions the Agreement sets forth for United's audit of Provider's billing records.

This section shall not be construed to grant United access to Provider's records that are created for purposes of assessing Provider's financial performance or for Provider's peer review activities,

except to the extent the federal and/or state government and any of their authorized representatives have access to such records pursuant to Section 6.3 of the Agreement.

9. **Section 7, "Resolution of Disputes," of the Agreement is deleted in its entirety and replaced with the following:**

Section 7 Resolution of Disputes

United and Provider will work together in good faith to resolve any disputes about their business relationship. Provider may submit a written request for review by United of a complaint or grievance relating to this Agreement. If United fails to grant or reject such request within 30 days after it is made, Provider may proceed as if the complaint or grievance had been rejected. A complaint or grievance that has been rejected by United may be submitted to non-binding mediation. Pursuant to Washington law, mediation shall be conducted under chapter 7.07 RCW or any other rules of mediation agreed to by the parties. If the parties are unable to resolve their dispute through mediation, the parties shall be free to pursue all legal and equitable remedies available under applicable law. In the case of a billing dispute that has been timely-made by Provider as required under Section 11, "Overpayment Recovery," of the Agreement (and added in this Washington Regulatory Requirements Addendum), United shall render a decision within 60 days of receipt of Provider's complaint.

10. **Section 8.3, "Information to Members," of the Agreement is deleted in its entirety and replaced with the following:**

8.3 Information to Members. Provider acknowledges the right of United to inform Members of Provider's termination and agrees to cooperate with United regarding the form of such notification. In the event of termination, United or Provider, as applicable, shall make a good faith effort to give written notice of such impending termination to Members who are seen by Provider on a regular basis, within 30 working days of receipt or issuance of a notice of termination.

11. **Section 8.4, "Continuation of Services after Termination," of the Agreement is deleted in its entirety and replaced with the following:**

8.4 Continuation of Covered Services after Termination. Upon request of United, or pursuant to applicable Washington law, Provider shall continue to provide Covered Services authorized by United to Members, who are receiving such services from Provider, as of the date of termination of the Agreement, until arrangements are completed for such Members to be transferred to another participating Provider. Payor shall pay Provider for such services at the Provider's contracted rate. In the event Provider is a primary care physician and this Agreement is terminated without cause by United, Provider agrees to continue providing Covered Services to Members currently receiving such Covered Services, for at least 60 days following termination as specified by United at the time of termination, or in group coverage arrangements involving periods of open enrollment, only until the end of the next open enrollment period. Provider's relationship with United will be continued on the same terms and conditions as those of the Agreement, except for any provision requiring that the United or Payor assign new enrollees to the terminated provider.

12. **Section 9.1, "Amendment," of the Agreement is deleted in its entirety and replaced with the following:**

9.1 Amendment. United shall provide no less than sixty days' notice to the Provider of a regulatory amendment, including without limitation any regulatory amendment that affects

compensation and that affects health care service delivery, unless changes to federal or state laws or regulations make such advance notice impossible, in which case notice shall be provided as soon as possible. Unless such regulatory authorities direct otherwise, the signature of Provider will not be required. Subject to any termination and continuity of care provisions of this Agreement, Provider may terminate the Agreement without penalty if Provider does not agree with such regulatory amendment.

United shall provide at least sixty days' notice of any other amendment, unless a shorter notice is necessary in order to accomplish compliance. No change to the Agreement may be made retroactive without the express written consent of Provider. Provider has the option of terminating the Agreement, pursuant to Section 9 of the Agreement, should Provider decide that the terms of any amendment are unacceptable.

Additionally, United shall provide no less than sixty days' notice to Provider of any proposed material amendment, as that term is defined by Washington law, which would result in requiring Provider to participate in Payor's product(s) with a lower fee schedule in order to continue to participate in a Payor's product(s) with a higher fee schedule. Provider shall advise United within sixty days of receipt should Provider reject participation in Payor's product(s) with a lower fee schedule. Provider's rejection of such material amendment does not affect the terms of Provider's existing Agreement.

13. Section 9.10, "Entire Agreement," of the Agreement is deleted in its entirety and replaced with the following:

9.1 Entire Agreement. On the effective Date, this Agreement is the entire agreement between the parties with regard to its subject matter, and supersedes any prior written or unwritten agreements between the parties or their affiliates with regard to the same subject matter. Nothing contained in this Agreement will have the effect of modifying benefits, terms, or conditions contained in a Benefit Plan. In the event of any conflict between this Agreement and a Benefit Plan, the benefits, terms, and conditions of the Benefit Plan will govern.

14. A new provision, "Overpayment Recovery," shall be added as Section 10 to the Agreement and shall be set forth as follows:

10. Overpayment Recovery.

a. Recovery by Provider.

(1) Except in the case of fraud, or as provided in subsection (2) of this section "**a**," Provider may not: (a) Request additional payment from United or Payor, as applicable, to satisfy a claim unless he or she does so in writing to United within 24 months after the date that the claim was denied or payment intended to satisfy the claim was made; or (b) request that the additional payment be made any sooner than 6 months after receipt of the request. Any such request must specify why Provider believes Payor owes the additional payment.

(2) Provider may not, if doing so for reasons related to coordination of benefits with another carrier or entity responsible for payment of a claim: (a) Request additional payment from United or Payor, as applicable, to satisfy a claim unless he or she does so in writing to United within 30 months after the date the claim was denied or payment intended to satisfy the claim was made; or
(b) request that the additional payment be made any sooner than 6 months after receipt of the request. Any such request must specify why Provider believes the Payor owes the additional payment, and

include the name and mailing address of any entity that has disclaimed responsibility for payment of the claim.

(3) If any provision of this Agreement conflicts with this section, this section shall prevail. However, nothing in this section prohibits United or Payor, as applicable, from choosing at any time to make additional payments to Provider to satisfy a claim.

(4) This section does not apply to claims for health care services provided through dental-only health carriers, health care services provided under Title XVIII (Medicare) of the social security act, or Medicare supplemental plans regulated under chapter 48.66 RCW. **b. Recovery by** United **or Payor, as Applicable.**

(1) Except in the case of fraud, or as provided in subsections (2) and (3) of this section "**b**," United or Payor, as applicable, may not: (a) Request a refund from Provider of a payment previously made to satisfy a claim unless it does so in writing to the Provider within 24 months after the date that the payment was made; or (b) request that a contested refund be paid any sooner than 6 months after receipt of the request. Any such request must specify why United or Payor, as applicable, believes Provider owes the refund. If Provider fails to contest the request in writing to United or Payor, as applicable, within 30 days of its receipt, the request is deemed accepted and the refund must be paid.

(2) United or Payor, as applicable, may not, if doing so for reasons related to coordination of benefits with another carrier or entity responsible for payment of a claim: (a) Request a refund from Provider of a payment previously made to satisfy a claim unless it does so in writing to Provider within 30 months after the date that the payment was made; or (b) request that a contested refund be paid any sooner than 6 months after receipt of the request. Any such request must specify why United or Payor, as applicable, believes Provider owes the refund, and include the name and mailing address of the entity that has primary responsibility for payment of the claim. If Provider fails to contest the request in writing to the United or Payor, as applicable, within 30 days of its receipt, the request is deemed accepted and the refund must be paid.

(3) United or Payor, as applicable, may at any time request a refund from Provider of a payment previously made to satisfy a claim if: (a) A third party, including a government entity, is found responsible for satisfaction of the claim as a consequence of liability imposed by law, such as tort liability; and (b) United or Payor, as applicable, is unable to recover directly from the third party because the third party has either already paid or will pay Provider for the health services covered by the claim.

(4) If any other provision of this Agreement conflicts with this section, this section shall prevail. However, nothing in this section prohibits Provider from choosing at any time to refund to United or Payor, as applicable, any payment previously made to satisfy a claim.

(5) For purposes of this section, "refund" means the return, either directly or through an offset to a future claim, of some or all of a payment already received by a health care provider.

(6) This section neither permits nor precludes United or Payor, as applicable, from recovering from a Member or beneficiary any amounts paid to a Provider for benefits to which the Member or beneficiary was not entitled under the terms and conditions of the Benefit Plan.

(7) This section does not apply to claims for health care services provided through dental-only health carriers, health care services provided under Title XVIII (Medicare) of the social security act, or Medicare supplemental plans regulated under chapter 48.66 RCW.

15. A new provision, "Retrospective Denial," shall be added as Section 11 to the Agreement and shall be set forth as follows:

11. Retrospective Denial. In the event Payor offers a Benefit Plan that is governed by Washington law, United will comply with the applicable retrospective claim denial requirements, as set forth in such Washington law, which prohibits retrospective denial of coverage for emergency and nonemergency care that had prior authorization under such Payor's written policies at the time the care was rendered.

16. A new provision, "Non-Discrimination," shall be added as Section 9.18 to the Agreement and shall be set forth as follows:

9.18 Non-Discrimination. Provider will not discriminate against any patient, with regard to quality or accessibility of services, on the basis that the patient is a Member. Provider will furnish Covered Services without regard to the Customer's enrollment in a Benefit Plan as a private purchaser or as a participant in publicly financed programs of health care services.

17. A new provision, "Presription Drug Exception Drug Process," shall be added as Section 3.6 to the Agreement and Shall be set forth as follows:

3.6 Prescription Drug Exception Process. United's process for requests for exceptions to Unites's drug utilization management process can be found at www.UHCProvider.com.

18. The following language is deleted from the Agreement in its entirety:

THIS AGREEMENT CONTAINS A BINDING ARBITRATION PROVISION THAT MAY BE ENFORCED BY THE PARTIES