

## MEDICARE ADVANTAGE REGULATORY REQUIREMENTS APPENDIX

### Ear Professionals International Corporation d/b/a UnitedHealthcare Hearing PROVIDER

**THIS MEDICARE ADVANTAGE REGULATORY REQUIREMENTS APPENDIX** (“Appendix”) supplements and is made part of the provider agreement (“Agreement”) between **Ear Professionals International Corporation d/b/a UnitedHealthcare Hearing**, its subsidiaries, and its affiliated companies (collectively, “Company”) and the provider named in the Agreement (“Provider”).

#### SECTION 1 APPLICABILITY

This Appendix applies to the Covered Services Provider provides to Medicare Advantage Customers. In the event of a conflict between this Appendix and other appendices or any provision of the Agreement, the provisions of this Appendix shall control except: (1) with regard to Benefit Plans outside the scope of this Appendix; or (2) as required by applicable law.

#### SECTION 2 DEFINITIONS

For purposes of this Appendix, the following terms shall have the meanings set forth below.

**2.1 Benefit Plan:** A certificate of coverage, summary plan description, or other document or agreement, whether delivered in paper, electronic, or other format, under which a Payer is obligated to provide coverage of Covered Services for a Customer. Benefit Plan may also be referred to as benefit contract, benefit document, plan, or other similar term under the Agreement.

**2.2 CMS Contract:** A contract between the Centers for Medicare & Medicaid Services (“CMS”) and a Medicare Advantage Organization for the provision of Medicare benefits pursuant to the Medicare Advantage Program under Title XVIII, Part C of the Social Security Act.

**2.3 Cost Sharing:** Those costs, if any, under a Benefit Plan that are the responsibility of the Customer, including deductibles, coinsurance, and copayments. Cost Sharing may also be referred to as patient expenses or other similar term under the Agreement.

**2.4 Covered Service:** A health care service or product for which a Customer is entitled to receive coverage from a Payer, pursuant to the terms of the Customer’s Benefit Plan with that Payer. A Covered Service may also be referred to as a health service or other similar term under the Agreement.

**2.5 Customer:** A person eligible and enrolled to receive coverage from a Payer for Covered Services. A Customer may also be referred to as an enrollee, member, patient, covered person, or other similar term under the Agreement.

**2.6 Dual Eligible Customer:** A Medicare Advantage Customer who is: (a) eligible for Medicaid; and (b) for whom the state is responsible for paying Medicare Part A and B Cost Sharing.

**2.7 Medicare Advantage Benefit Plans:** Benefit Plans sponsored, issued or administered by a Medicare Advantage Organization as part of the Medicare Advantage program or as part of the Medicare Advantage program together with the Prescription Drug program under Title XVIII, Part C and Part D, respectively, of the Social Security Act (as those program names may change from time to time).

**2.8 Medicare Advantage Customer or MA Customer:** A Customer eligible for and enrolled in a Medicare Advantage Benefit Plan in which Provider participates pursuant to the Agreement.

**2.9 Medicare Advantage Organization or MA Organization:** For purposes of this Appendix, MA Organization is an appropriately licensed entity that has entered into: (a) a CMS Contract; and (b) a contract with Company, either directly or indirectly, under which Company provides certain administrative services for Benefit Plans sponsored, issued, or administered by MA Organization.

**2.10 Payer:** An entity obligated to a Customer to provide reimbursement for Covered Services under the Customer's Benefit Plan and authorized to access Provider's services under the Agreement. A Payer may also be referred to as a payor, participating entity, or other similar term under the Agreement.

### **SECTION 3 PROVIDER REQUIREMENTS**

**3.1 Data.** Provider shall submit to Company or MA Organization, as applicable, all risk adjustment data as defined in 42 CFR § 422.310(a), and other Medicare Advantage program-related information as may be requested by MA Organization, within the timeframes specified and in a form that meets Medicare Advantage program requirements. By submitting data to Company or MA Organization, Provider represents to MA Organization, and upon MA Organization's request Provider shall certify in writing, that the data is accurate, complete, and truthful, based on Provider's best knowledge, information and belief.

**3.2 Policies.** Provider shall comply with MA Organization's policies and procedures.

**3.3 Customer Protection.** Provider agrees that in no event, including but not limited to, non-payment by Company, MA Organization or an intermediary, insolvency of Company, MA Organization or an intermediary, or breach by Company of the Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any MA Customer or person (other than MA Organization or an intermediary) acting on behalf of the MA Customer for Covered Services provided pursuant to the Agreement or for any other fees that are the legal obligation of MA Organization under the CMS Contract. This provision does not prohibit Provider from collecting from MA Customers allowable Cost Sharing. For the purpose of this provision, an "intermediary" is a person or entity authorized to negotiate and execute the Agreement on behalf of Provider or on behalf of a network through which Provider elects to participate. In the event of MA Organization's, Company's, or an intermediary's insolvency or other cessation of operations or termination of MA Organization's contract with CMS, Provider shall continue to provide Covered Services to an MA Customer through the later of the period for which premium has been paid to MA Organization on behalf of the MA Customer, or, in the case of an MA Customer who is hospitalized as of such period or date, the MA Customer's discharge.

This provision shall be construed in favor of the MA Customer, shall survive the termination of the Agreement regardless of the reason for termination, including Company or MA Organization's insolvency, and shall supersede any contrary agreement, oral or written, between Provider and an MA Customer or the representative of an MA Customer if the contrary agreement is inconsistent with this provision.

**3.4 Dual Eligible Customers.** Provider agrees that in no event including, but not limited to, non-payment by a state Medicaid agency or other applicable regulatory authority, other state source, or breach by Company of the Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Dual Eligible Customer, person acting on behalf of the Dual Eligible Customer, Company or MA Organization (unless notified otherwise) for Medicare Part A and B Cost Sharing. Instead, Provider will either: (a) accept payment made by or on behalf of MA Organization as payment in full; or (b) bill the appropriate state source for such Cost Sharing amount. If Provider imposes an excess charge on a Dual Eligible Customer, Provider is subject to any lawful sanction that may be imposed under Medicare or Medicaid.

**3.5 Eligibility.** Provider agrees to immediately notify Company and MA Organization in the event Provider is or becomes excluded from participation in any federal health care program under Section 1128 or 1128A of the Social Security Act or is or becomes included on the preclusion list under Part 422 of the Code of Federal Regulations. Provider shall not be eligible for payment from MA Organization after the date or during the time period specified by the applicable regulatory authorities. Provider also shall not employ or contract for the provision of health care services, utilization review, medical social work or administrative services, with or without compensation, with any individual or entity that is or becomes excluded from participation in any federal health care program under Section 1128 or 1128A of the Social Security Act or is or becomes included on the preclusion list under Part 422 of the Code of Federal

Regulations. MA Customers shall not have any financial liability and Provider shall not pursue MA Customers for financial liability for services or items furnished by an individual or entity that is excluded from participation in any federal health care program under Section 1128 or 1128A of the Social Security Act or is included on the preclusion list under Part 422 of the Code of Federal Regulations. Provider shall be financially liable for those services or items after the date or during the time period specified by the applicable regulatory authorities.

**3.6 Laws.** Provider shall comply with all applicable federal and Medicare laws, regulations, and CMS instructions, including but not limited to: (a) federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including but not limited to, applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. §3729 et seq.), and the anti-kickback statute (§1128B of the Social Security Act); and (b) HIPAA administrative simplification rules at 45 CFR Parts 160, 162, and 164.

**3.7 Federal Funds.** Provider acknowledges and agrees that MA Organization receives federal payments under the CMS Contract and that payments Provider receives from or on behalf of MA Organization are, in whole or in part, from federal funds. Provider is therefore subject to certain laws that are applicable to individuals and entities receiving federal funds.

**3.8 CMS Contract.** Provider shall perform the services set forth in the Agreement in a manner consistent and compliant with MA Organization's contractual obligations under the CMS Contract.

**3.9 Records.**

(a) Privacy and Confidentiality; Customer Access. Provider shall safeguard MA Customer privacy and confidentiality including, but not limited to, the privacy and confidentiality of any information that identifies a particular MA Customer, and shall comply with all federal and state laws regarding confidentiality and disclosure of medical records or other health and enrollment information. Provider shall ensure that MA Customers have timely access to medical records and information that pertain to them, in accordance with applicable law.

(b) Retention. Provider shall maintain records and information related to the services provided under the Agreement including, but not limited to, MA Customer medical records and other health and enrollment information, in an accurate and timely manner. Provider shall maintain such records for the longer of the following periods:

- (i) in the case of records containing information related to the medical loss ratio information reported to CMS by the MA Organization, including, for example, information related to incurred claims and quality improvement activities, at least ten (10) years from the date such medical loss ratio information is reported to CMS by the MA Organization, or
- (ii) in the case of all other records, at least ten (10) years from the final date of the CMS Contract period in effect at the time the records were created, or such longer period as required by law.

(c) Government Access to Records. Provider acknowledges and agrees that the U.S. Department of Health and Human Services, the Comptroller General, or their designees shall have the right (directly or through the MA Organization) to audit, evaluate, collect, and inspect any pertinent books, contracts, computer or other electronic systems (including medical records and documentation), and other records and information of Provider related to the CMS Contract. Provider shall make available to its premises, physical facilities, and equipment, records relating to MA Customers and any additional relevant information CMS may require. This right shall extend through the longer of the time periods identified in subsection 3.9(b)(i) and (ii), or ten (10) years from date of completion of any audit, whichever is later in time.

(d) MA Organization Access to Records. Provider shall grant MA Organization or its designees such audit, evaluation, collection and inspection rights identified in subsection 3.9(c) as are necessary for MA Organization to comply with its obligations under the CMS Contract. Whenever possible, MA Organization will give Provider reasonable notice of the need for such audit, evaluation, collection, or

inspection, and will conduct such audit, evaluation, collection, or inspection at a reasonable time and place. Provider shall submit medical records of MA Customers to the MA Organization as may be requested, within the timeframes specified, for (i) the purpose of CMS audits of risk adjustment data, and (ii) other purposes medical records from providers are used by MA Organization, as specified by CMS.

**3.10 MA Organization Accountability; Delegated Activities.** Provider acknowledges and agrees that MA Organization oversees and is accountable to CMS for any functions and responsibilities described in the CMS Contract and applicable Medicare Advantage regulations, including those that Company may sub-delegate to Provider. If Company has sub-delegated any of MA Organization's functions and responsibilities under the CMS Contract to Provider pursuant to the Agreement, the following shall apply in addition to the other provisions of this Appendix:

(a) Provider shall perform those delegated activities specified in the Agreement, if any, and shall comply with any reporting responsibilities as set forth in the Agreement.

(b) If Company has delegated to Provider any activities related to the credentialing of health care providers, Provider must comply with all applicable CMS requirements for credentialing, including but not limited to the requirement that the credentials of medical professionals must either be reviewed by MA Organization or its designee, or the credentialing process must be reviewed, pre-approved and audited on an ongoing basis by MA Organization or its designee.

(c) If Company has delegated to Provider the selection of health care providers to be participating providers in the MA Organization's Medicare Advantage network, MA Organization retains the right to approve, suspend or terminate the participation status of such health care providers.

(d) Provider acknowledges that MA Organization or its designee shall monitor Provider's performance of any delegated activities on an ongoing basis. If MA Organization or CMS determines that Provider has not performed satisfactorily, MA Organization may revoke any or all delegated activities and reporting requirements. Provider shall cooperate with MA Organization and Company regarding the transition of any delegated activities or reporting requirements that have been revoked by MA Organization.

**3.11 Subcontracts.** If Provider has any arrangements, in accordance with the terms of the Agreement, with affiliates, subsidiaries, or any other subcontractors, directly or through another person or entity, to perform any of the services Provider is obligated to perform under the Agreement that are the subject of this Appendix, Provider shall ensure that all such arrangements are in writing, duly executed, and include all the terms contained in this Appendix. Provider shall provide proof of such to Company or MA Organization upon request. Provider further agrees to promptly amend its agreements with subcontractors, in a manner consistent with the changes made to this Appendix by MA Organization or Company, to meet any additional CMS requirements that may apply to the services.

**3.12 Offshoring.** All services provided pursuant to the Agreement that are subject to this Appendix and that involve MA Customer's protected health information ("PHI") must be performed within the United States, the District of Columbia, or the United States territories, unless Provider previously notifies MA Organization in writing and submits required offshoring information to, and received approval from, MA Organization.

## **SECTION 4 OTHER**

**4.1 Payment.** MA Organization or its designee shall promptly process and pay or deny Provider's claim no later than sixty (60) days after MA Organization or its designee receives all appropriate information as described in MA Organization's administrative procedures. If Provider is responsible for making payment to subcontracted providers for services provided to MA Customers, Provider shall promptly process and pay or deny them no later than sixty (60) days after Provider receives request for payment for those services from subcontracted providers.

**4.2 Regulatory Amendment.** Upon the request of MA Organization, Company may unilaterally amend this Appendix to comply with applicable laws and regulations and the requirements of applicable regulatory authorities, including but not limited to CMS. Company or MA Organization shall provide written or electronic notice to Provider of such amendment and its effective date. Unless such laws, regulations, or regulatory authority(ies) direct otherwise, the signature of Provider will not be required in order for the amendment to take effect.