HEALTHPARTNERS
PARTICIPATING PROVIDER AGREEMENT

THIS AGREEMENT is made effective January 1, 2016 ("Effective Date"), by and between **HEALTHPARTNERS, INC.** ("HPI"), and **COUNTY OF AITKIN** ("PROVIDER").

RECITALS:

A. HPI is a duly licensed health maintenance organization which arranges for the provision of health care services to Members. HPI desires to engage PROVIDER for the provision of health care services to such Members.

B. PROVIDER is a duly licensed entity composed of appropriately licensed, registered, certified, accredited or otherwise duly authorized health care professionals. PROVIDER desires to provide certain health care services to Members, pursuant to the terms and conditions set forth herein.

NOW, THEREFORE, in consideration of the foregoing and the mutual covenants and agreements contained herein, the Parties agree as follows:

ARTICLE I
DEFINITIONS

The following definitions will apply to this Agreement and to all addenda, appendices, attachments and exhibits attached hereto:

Section 1.1. **"Affiliate"** means any entity or organization: (i) that has established one or more Plans ("Plan Sponsor") and is self-insured for such Plans, and such Plan Sponsor has purchased a Product from HPI or a Related Organization in connection with such Plans; (ii) that has purchased a Product from HPI or a Related Organization in connection with one or more Plans established, underwritten, offered, administered, provided or sponsored by one or more Plan Sponsors; or (iii) that has purchased a Product from HPI or a Related Organization where HPI or the Related Organization provides and/or arranges for health care services and supplies and/or administrative services, and such entity or organization is not otherwise described in (i) or (ii) above. Notwithstanding the foregoing, "Affiliate" does not include an entity or organization that has purchased a commercial Product insured by HPI or a Related Organization, nor does it include the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services, the Department of Human Services of the State of Minnesota, or the U.S. Office of Personnel Management for the Federal Employees Health Benefits Program. If the entity or organization has purchased a commercial Product insured by HPI or a Related Organization and is also a Plan Sponsor who has purchased a Product with HPI or a Related Organization in connection with a self-insured Plan, then such entity or organization is considered an "Affiliate" under this Agreement with respect to such self-insured Plan only.

Section 1.2. **"Affiliate Member"** means a Member enrolled in a Plan that is either administered by an Affiliate, or insured or self-insured by an Affiliate.

Section 1.3. **"Allied Health Professional"** means a non-physician health care professional who is appropriately licensed, registered, certified, accredited or otherwise duly authorized in the state or states in which he or she practices, is an employee, independent contractor or

agent of PROVIDER and has been accepted by HPI in accordance with HPI credentialing standards.

Section 1.4. "**Assigned Member**" means an individual eligible and enrolled to receive Covered Services through a Product that (i) requires the individual to be assigned to a primary care clinic, and (ii) for certain services rendered outside of the care system, as defined by the HPI Administrative Program, requires that the individual have a recommendation for services to access health care services from PROVIDER.

Section 1.5. "**Certificate of Coverage**" means the document and any amendments thereto that is issued to Members and which describes the benefits and Covered Services to which the member is entitled under the applicable Product. The term "Certificate of Coverage" includes, without limitation, summary plan descriptions.

Section 1.6. "**Clean Claim**" means a claim that (i) satisfies all applicable rules and requirements related to claims set forth in the HPI Administrative Program ("Medical Claim Policies") and (ii) meets all applicable state and federal laws and regulations as amended from time to time, including, without limitation, Minnesota Statutes §62Q.75 (the "Minnesota Prompt Pay Statute").

Section 1.7. "**Covered Services**" means those health care services and supplies available under the applicable Plan, as described in the applicable Certificate of Coverage.

Section 1.8. "**Coinsurance**" means the percentage of the total contract rate for a Covered Service, less any applicable Deductible amount that the Member is responsible for under the Member's Certificate of Coverage.

Section 1.9. "**Complaint**" means any grievance expressed by a Member regarding the provision of health care services, including, without limitation, grievances regarding the scope of coverage for health care services, retrospective denials or limitations of payment for services, eligibility issues, denials, cancellations, nonrenewals of coverage, administrative operations, and the quality, timeliness, and appropriateness of health care services rendered.

Section 1.10. "**Copayment**" means the flat dollar amount for a Covered Service that the Member is responsible for under the Member's Certificate of Coverage.

Section 1.11. "**Deductible**" means the dollar amount for which a Member is responsible per calendar year before benefits become payable under the Member's Certificate of Coverage.

Section 1.12. "**HPI Administrative Program**" means all administrative protocols, programs, policies and procedures developed, established and administered by HPI or another entity authorized by HPI, incorporated herein by reference, and as amended from time to time by HPI or such other authorized entity, and communicated, in writing or via electronic means, to PROVIDER or as made available to PROVIDER via electronic means. HPI shall communicate the HPI Administrative Program to PROVIDER in writing, via HPI's website at www.healthpartners.com/hpiadministrative, or via other electronic means. Such administrative protocols, programs, policies and procedures may address or pertain to, without limitation, quality assurance, quality improvement, risk management, credentialing, re-credentialing, utilization management, pre-certification, notification, prior authorization, recommendation for services, secondary recommendation for

services, benefit review, concurrent review, medical care guidelines and protocols, quality review, discharge planning, medical case management and claims processing.

Section 1.13. "**Member**" means any person eligible and enrolled to receive Covered Services through a Product.

Section 1.14. "**Participating Allied Health Professional**" means any duly licensed Allied Health Professional that has in force an effect an agreement with HPI or a Related Organization, or on whose behalf an agreement with HPI or a Related Organization has been entered into, to provide or arrange for the provision of Covered Services.

Section 1.15. "**Participating Hospital**" means any hospital or other health care facility that has in force and effect an agreement with HPI or a Related Organization to provide or arrange for the provision of Covered Services to Members.

Section 1.16. "**Participating Physician**" means any duly licensed physician: (a) who is employed by HPI or a Related Organization; (b) who has entered into an agreement with HPI or a Related Organization to provide or arrange for the provision of Covered Services to Members or who otherwise is authorized under a Product sold or administered by HPI, a Related Organization or an Affiliate, to provide Covered Services to Members; or (c) who practices with an entity that has entered into an agreement described in (b) above or which is authorized under a Product as in (b) above.

Section 1.17. "**Participating Provider**" means any health care provider or health care facility, including, PROVIDER, Participating Physicians, Participating Allied Health Professional and Participating Hospitals, that have in force and effect an agreement with HPI or a Related Organization to provide or arrange for the provision of Covered Services.

Section 1.18. "**Physician**" means a physician who is appropriately licensed in the state or states in which he or she practices, is an employee, independent contractor or agent of PROVIDER and has been accepted by HPI in accordance with HPI credentialing standards.

Section 1.19. "**Plan**" means a plan or program to pay and/or arrange for health care services and supplies, as may be amended from time to time. This term will not include any Medicare Advantage Private Fee For Service plan (the "MA PFFS Plan").

Section 1.20. "**Product**" means any contract where HPI or a Related Organization agrees to pay and/or arrange for health care services and supplies and/or provide administrative services including, without limitation, contracts involving governmental Plans, with the exception of any product governed by a contract between CMS and HealthPartners or its Related Organization for a Medicare Advantage Private Fee For Service product (the "MA PFFS Product"), as may be amended from time to time.

Section 1.21. "**Related Organization**" means:

(a) any organization now or hereafter formed: 1) which is controlled by HPI; 2) which controls HPI; 3) which is controlled by another organization that also controls HPI; 4) a majority of the board of directors of which consists of persons who are simultaneously directors of HPI; 5) the directors of which constitute a majority of the directors of HPI; or 6) which is controlled by any organization described in this subsection; or

(b) any association, joint venture or contractual arrangement entered into by any organization described in subsection (a) above, in which said organization can be said to control or have equal right to control the association, joint venture, or contractual arrangement.

For the purpose of this provision, "control" means the authority to elect, appoint, confirm, or remove fifty percent (50%) or more of the board of directors (or other governing body) of the organization, association, joint venture or contractual arrangement.

Section 1.22. **"Self Accessing Member"** means an individual eligible and enrolled to receive Covered Services through a Product that does not require the individual to have a recommendation for services to access health care services from PROVIDER.

ARTICLE II
PROVIDER SERVICES

Section 2.1 **Authority to Bind Physicians and Allied Health Professionals.** PROVIDER represents and warrants that PROVIDER is legally authorized to negotiate on behalf of and to bind Participating Providers to abide by the terms and conditions of this Agreement, as amended from time to time. Notwithstanding any contrary interpretation of this Agreement or any contracts between PROVIDER and Participating Providers, PROVIDER acknowledges and agrees that all provisions of this Agreement applicable to PROVIDER shall apply with equal force and effect to Participating Providers, unless clearly only applicable to PROVIDER. PROVIDER agrees that it is PROVIDER'S responsibility to ensure that the obligations of Participating Providers under this Agreement are fully satisfied, and PROVIDER shall take all steps necessary to cause Participating Providers to comply with and perform the terms and conditions of this Agreement. In addition, PROVIDER shall be bound, and Participating Providers shall be bound, by all applicable terms and conditions of Products and Certificates of Coverage, which HPI will provide to PROVIDER in writing or otherwise make available to PROVIDER. PROVIDER agrees, and shall require Participating Providers to agree, that in the event of any inconsistency between this Agreement and any contract entered into between PROVIDER and Participating Providers, the terms of this Agreement shall control. Upon request by HPI, PROVIDER shall provide HPI with copies of PROVIDER'S contracts with Participating Providers.

Section 2.2 **Provision of Services.**

(a) Provision of Covered Services. PROVIDER will, and will cause each Participating Provider to, provide Covered Services to Members consistent with the terms and conditions of the applicable Certificate of Coverage, this Agreement and applicable state and federal laws and regulations. PROVIDER will make available to Members all health care services that it makes available to the general public; provided, however, PROVIDER will not be obligated to provide any type or kind of Covered Services to a Member that it does not normally provide to others or which PROVIDER is not authorized by law to provide. All Covered Services provided hereunder will be provided in the same manner, in accordance with the same standards, and with at least the same level of quality, completeness, promptness and courtesy as services and care provided by PROVIDER to patients who are not Members.

(b) Standard. PROVIDER further will, and will cause each Participating Provider to, provide such Covered Services in accordance with the standard of practice in the community in which PROVIDER renders Covered Services and in a manner so as to assure quality of care and treatment.

(c) Change to Practice. PROVIDER will not make any changes to its present medical staff, administrative staff, organization or facilities that would render the PROVIDER incapable of carrying out its obligations under the terms of this Agreement. PROVIDER will immediately notify HPI of any anticipated or actual change in its capabilities that would diminish its ability to carry out its obligations under the terms of this Agreement.

Section 2.3 **Sites.** PROVIDER will notify HPI not less than sixty (60) days prior to adding a new location or prior to any changes to existing locations. HPI will have the right to refuse to include such new location or any change to existing locations subject to this Agreement by providing written notice to PROVIDER within sixty (60) days of receiving such notice.

Section 2.4 **Provider Liaison.** PROVIDER will designate a qualified Physician, or, in the absence of a Physician, an Allied Health Professional, to serve as PROVIDER's Liaison. PROVIDER will maintain an effective PROVIDER Liaison function, as evidenced by a commitment of the time necessary to perform the duties in a manner mutually satisfactory to PROVIDER and HPI. PROVIDER's Liaison will: (i) serve as the liaison between PROVIDER and HPI on all clinical and care management issues; (ii) ensure participation and cooperation in activities as referenced in Sections 2.6 (Credentialing; Recredentialing), 3.1 (Quality Improvement) and 3.2 (Utilization Management); and (iii) discharge other duties mutually agreed upon by PROVIDER and HPI.

Section 2.5 **Provider Qualifications.** PROVIDER will be, and will require all Participating Providers to remain during the term of this Agreement, licensed, registered, certified, accredited or otherwise duly authorized to practice and/or provide services in the state or states in which the PROVIDER practices and/or provides services. PROVIDER will notify HPI in writing within ten (10) days of: (i) any termination, restriction, suspension, revocation, stipulation, adverse limitation or other disciplinary action, corrective action plan or investigation regarding any Participating Provider's license, privileges, registration, certification, accreditation or other authorization; (ii) any other circumstance involving a Participating Providers required to be reported by the PROVIDER or its professional liability insurer to the National Practitioner Data Bank or any other reporting agency; or (iii) when a Participating Provider is no longer employed, contracted or otherwise affiliated with PROVIDER.

PROVIDER will ensure that each Participating Provider provides to Members only those Covered Services that are within his or her authorized scope of practice. No individual or entity, either employed by or otherwise associated, directly or indirectly, with the PROVIDER, will be involved or render health care services and/or supplies to Members without first being accepted by HPI in accordance with HPI credentialing standards, as applicable. PROVIDER will notify HPI of any material change to any information submitted by PROVIDER in connection with such credentialing (or re-credentialing) activities. PROVIDER represents and warrants that any such information will be true and correct at the time provided.

Upon request by HPI, PROVIDER will provide to HPI within ten (10) business days sufficient evidence, as determined by HPI, that each Participating Provider is in compliance with the requirements set forth in this Section 2.4. In the event HPI determines, in accordance with its credentialing standards, that an individual or entity employed by or otherwise associated with PROVIDER does not meet HPI credentialing standards including, without limitation, a Participating Provider who has previously been accepted by HPI but who subsequently fails to maintain satisfaction of HPI credentialing standards, HPI will notify PROVIDER, in writing, of such determination, and PROVIDER will ensure that such individual or entity does not render services to any Member. HPI will have the right, pursuant to Section 6.2(d) below, to terminate this Agreement in the event an unauthorized individual or entity renders services and/or supplies to a Member subsequent to such notification.

Notwithstanding anything in this Agreement to the contrary (including, without limitation, Section 4.6 below), PROVIDER will not be entitled to any payment under this Agreement for any services and/or supplies furnished by an individual or entity that does not currently satisfy HPI credentialing standards. Such services and/or supplies will be deemed a non-Covered Service. PROVIDER will be solely responsible for the costs of such non-Covered Services and will not bill HPI, its designee, or the Member; provided, however, that if all of the following requirements are satisfied, PROVIDER may bill the Member if: (i) the Member requests that the PROVIDER provide the non-Covered Service; (ii) PROVIDER notifies the Member immediately prior to providing the requested service or supply that the specific service or supply is a non-Covered Service and it is because the Participating Provider has not satisfied HPI credentialing standards; and (iii) subsequent to such notice, PROVIDER obtains written acknowledgment from the Member that such specifically identified service or supply is a non-Covered Service, that such service or supply will not be paid for under this Agreement, and that the Member will be liable for payment for such non-Covered Service.

Section 2.6 **Privileges.** PROVIDER will cause each Participating Provider to secure and maintain appropriate clinical privileges at one or more Participating Hospitals for the care of Members under this Agreement. If this Agreement or any of the Addenda attached hereto require that Covered Services be rendered in specific facilities, PROVIDER will cause the appropriate Participating Provider to secure appropriate clinical privileges in such facilities. Upon request by HPI, PROVIDER will provide HPI with a summary of each of the Participating Provider's health care facility clinical privileges. PROVIDER will notify HPI within ten (10) business days of any involuntary changes in any health care facility clinical privilege currently maintained or subsequently acquired by a Participating Provider after the Effective Date of this Agreement.

Section 2.7 **Credentialing; Recredentialing.** PROVIDER will participate in and comply with the credentialing and re-credentialing rules and requirements included in the HPI Administrative Program (the "HPI Credentialing Plan"). Pursuant to the HPI Credentialing Plan, PROVIDER will forward to HPI the professional resume of each Participating Provider, together with a completed Minnesota Uniform Credentialing Application and any additional information as HPI may request, including information related to credentialing and insurance. PROVIDER will notify HPI of any material change in such information submitted. PROVIDER represents and warrants such information is true and correct to the best of its knowledge.

Section 2.8 **Recommendation for Services.** PROVIDER will comply with all rules and requirements related to recommendations for services set forth in the HPI Administrative

Program including, without limitation, verifying with HPI the recommendation for services requirements for each Member.

Section 2.9 **Facilities and Equipment.** PROVIDER will maintain its facilities and equipment in excellent working condition, and at all times will satisfy HPI standards, as defined in the HPI Administrative Program, as well as any applicable governmental standards.

Section 2.10 **Management Responsibilities.** The operation and maintenance of the offices, facilities and equipment of PROVIDER will be solely and exclusively under the control and supervision of PROVIDER. HPI and its Affiliate will have no right of control over the selection of support staff, the supervision of personnel, or the financial operation of PROVIDER's practice. Nothing contained in this Agreement will be construed as giving HPI or any Affiliate any right to manage or conduct the operations of PROVIDER as manager, proprietor, lessor or otherwise.

Section 2.11 **Laboratory and Radiological Tests.** PROVIDER will accept the results of qualified and timely laboratory and radiological tests or other procedures provided by HPI in connection with a recommendation for services authorized by HPI, and will not require or render duplicate tests or procedures except as medically necessary and appropriate.

Section 2.12 **HPI Administrative Program.** PROVIDER shall cooperate and comply, and shall cause each Participating Provider to cooperate and comply with all rules and requirements of the HPI Administrative Program. PROVIDER shall be responsible for accessing the most current HPI Administrative Program rules and requirements via electronic connection at www.healthpartners.com/hpiadministrativeprogram. Upon request, HPI will provide the most current HPI Administrative Program to a PROVIDER without electronic connection capabilities. PROVIDER will also promptly provide to HPI such data as HPI may request in connection with the HPI Administrative Program, including, without limitation, an annual summary of PROVIDER quality assurance, quality improvement, and utilization management activities and credentialing and re-credentialing information.

ARTICLE III
CARE MANAGEMENT COOPERATION

Section 3.1 **Quality Improvement.** PROVIDER will participate in, and cooperate and assist with, quality management initiatives and data collection as defined in the HPI Administrative Program and as may be requested by HPI, an entity authorized by HPI or appropriate state or federal agencies. PROVIDER will provide HPI, such other authorized entity or appropriate state or federal agencies with all data that may be requested for said activities. Such data will be provided by PROVIDER at its sole expense and PROVIDER will not charge any Member for the cost of providing such data unless specifically authorized by law.

In addition, PROVIDER will establish and maintain a program of continuous quality improvement of clinical care that applies to Members to whom PROVIDER provides Covered Services pursuant to this Agreement. This program will use clinical practice guidelines that are developed by PROVIDER or obtained by PROVIDER from another source and formally approved by PROVIDER. These guidelines may be used together with methods of continuous quality improvement in cycles of planning, piloting, assessment and action which results in improved care provided for particular diseases or conditions. These improvement cycles may include measurement of health care

processes and their effects. The program will be supported by appropriate staff, including persons engaged in project management, facilitation of improvement processes, and measurement.

PROVIDER will develop and maintain a quality committee structure to implement and monitor its performance of and adherence to the quality assurance and quality improvement rules and requirements included in the HPI Administrative Program.

Upon request by HPI, PROVIDER will provide any related policies and procedures, as well as its peer review results related to care provided to Members and related information. HPI will maintain the confidentiality of any peer review results disclosed by PROVIDER to HPI in accordance with Section 9.2(f) below.

Upon request by HPI, PROVIDER will provide HPI with an annual report of its continuous quality management initiatives and results during the first quarter of the following year. This report will include, at HPI's option, a written or an oral report, or both, from PROVIDER.

The clinical practice guidelines and annual report requirements of this Section 3.1 may be met by participating in the Institute for Clinical Systems Improvement programs and upon request by reporting annually to HPI on PROVIDER's aims, actions, and results as a participant in such programs.

Section 3.2 **Utilization Management.** PROVIDER will participate in and comply with the utilization management rules and requirements included in the HPI Administrative Program ("Utilization Management Rules"). The Utilization Management Rules include, without limitation, prior authorization procedures, pre-certification programs, recommendation for services policies, benefit review procedures, concurrent review programs, medical care guidelines and protocols, discharge planning and medical case management policies and procedures, and the review and audit of PROVIDER's activities by HPI or an entity authorized by HPI to ensure compliance with such Utilization Management Rules. Notwithstanding the foregoing, nothing in this Section is intended nor will be construed as delegating to PROVIDER any of HPI's utilization management obligations required to be carried out by HPI under applicable law.

Section 3.3 **Member Medical Records and Other Records.** PROVIDER will obtain a signed, written consent, in accordance with applicable law, from each Member authorizing the release of patient information including, without limitation, demographic, medical and/or health care information, to HPI, its Related Organizations, Affiliates and their respective designees for purposes of treatment, payment, and health care operations including, without limitation, claims processing, reimbursement, utilization review, case management, disease management and/or quality review.

PROVIDER will maintain medical, financial and administrative records related to services provided to Members or any other PROVIDER obligations under this Agreement as required by applicable state or federal laws or regulations or as may be necessary to document care provided in the event of legal action. Upon request by HPI, PROVIDER will provide to HPI, its Related Organizations and/or its Affiliates and their respective designees, within seven (7) days of such request (or less if necessary to comply with laws pertaining to resolution of Member complaints), copies of such medical, financial and/or administrative records. PROVIDER's obligation to provide copies of records containing medical or other health care information that identifies a

Member will be subject to Member consent as outlined in the previous paragraph, to the extent such Member consent is required by applicable state or federal laws or regulations. Such records will be provided by PROVIDER at its sole expense and PROVIDER will not charge any Member for the cost of providing copies of such records, unless specifically authorized by law.

The provisions set forth in this Section 3.3 will survive any termination of this Agreement.

Section 3.4 **Member Complaints.** HPI directs Members to contact HPI if the Member has any grievance regarding the Member's care or service. Nevertheless, if a Member submits a Complaint to the PROVIDER, whether verbally or in writing, PROVIDER will immediately encourage the Member to contact HPI to resolve such Complaint. If a Member submits a Complaint, whether verbally or in writing, PROVIDER will investigate such Complaint and use its best efforts to resolve it in a fair and equitable manner. PROVIDER will notify HPI on a quarterly basis of all such Complaints, and such notification will be consistent in format and substance with complaint notification requirements set forth in the HPI Administrative Program to ensure compliance with applicable state and federal laws and regulations. PROVIDER will designate a person or persons who will be responsible for handling Complaints. PROVIDER will cooperate with HPI in resolving any Complaint submitted to PROVIDER by a Member, or any other grievance involving or impacting the PROVIDER and which is filed by a Member with HPI or a regulatory entity. The PROVIDER will be bound by resolution of such Complaints, as determined in accordance with the HPI Administrative Program and applicable state and federal laws and regulations.

Nothing in this Section is intended or will be construed as delegating to PROVIDER any of HPI's complaint resolution obligations required to be carried out by HPI under applicable state and federal laws and regulations.

Section 3.5 **Satisfaction Surveys.** From time to time, HPI will conduct and PROVIDER will participate in satisfaction surveys. PROVIDER may be requested to take any reasonable steps necessary to correct any deficiencies revealed by such surveys. HPI will allow PROVIDER an opportunity to review the results of the satisfaction survey specific to PROVIDER. If the level of satisfaction with PROVIDER, as measured by such surveys, deteriorates substantially or is substantially below the level of other providers affiliated with HPI, PROVIDER will, at the request of HPI and to HPI's satisfaction, promptly prepare and implement a corrective action plan. Upon request by HPI, PROVIDER also will conduct its own patient satisfaction surveys and provide HPI the opportunity to promptly review the results of such surveys.

Section 3.6 **Advertising and Promotion.** PROVIDER will cooperate with HPI in its marketing of Products. HPI, its Affiliates and/or Related Organizations may publish information regarding PROVIDER including, without limitation, PROVIDER's name, address and telephone number, specialty(ies), hospital affiliations, board certifications, languages spoken, as well as a description of its facilities, services and PROVIDER's inclusion in any preferred network, relative network data in HPI's, its Affiliates' or Related Organizations' Participating Provider directories and in other HPI, its Affiliates' or Related Organizations' brochures, publications, advertisements, promotions and other marketing materials (including, without limitation, advertising and promotion on the Internet and other paperless medium). PROVIDER and Participating Providers hereby authorize and consent to disclosure of PROVIDER's and Participating Providers'

National Provider Identifiers on HPI's website and in HPI's and Payors' or Related Organizations' Provider directories. PROVIDER may, with HPI's prior written consent, engage in marketing activities designed to promote PROVIDER as being a participating provider of HPI. Any materials PROVIDER uses in connection with its marketing activities related to the services rendered by PROVIDER under this Agreement shall be subject to prior approval by HPI.

All advertising, promotion, and marketing activities related to the services provided under this Agreement shall be done in accordance with all applicable state and federal laws and regulations.

Section 3.7 **HPI Drug Formulary Compliance.** When clinically appropriate, PROVIDER will encourage its Participating Providers to adhere to HPI's drug formulary when writing prescriptions. If a drug is not included on the HPI drug formulary, PROVIDER may, on behalf of a Member, submit a request to HPI to obtain an exception to the drug formulary, in accordance with applicable policies and procedures included in the HPI Administrative Program.

Section 3.8 **Member Communication.** Notwithstanding anything in this Agreement that could be interpreted as being to the contrary, HPI encourages and expects PROVIDER and all Participating Providers to communicate freely with Members regarding the treatment options available to them including, without limitation, alternative medications, regardless of benefit coverage.

Section 3.9 **Designated and/or Preferred Network Initiatives.** HPI may at any time designate and assign preferred and/or designated networks of providers or facilities to which Participating Providers may direct Members for specified procedures and/or services. Such designated and/or preferred networks may or may not include PROVIDER. HPI may at any time and from time to time require prior authorization or prior notification for specified procedures and/or services performed within or outside of such designated and/or preferred networks. HPI will notify PROVIDER, in writing, of such specified procedures and/or services, any prior authorization or prior notification requirements, and the respective designated and/or preferred network. For such specified procedures and/or services, when clinically and geographically appropriate, PROVIDER will utilize the HPI designated and/or preferred networks.

Section 3.10 **Patient Safety Program.** PROVIDER will develop and implement a patient safety program that establishes and monitors compliance with patient safety and medical error reduction policies and procedures that, at a minimum, are consistent with applicable industry standards. HPI also encourages PROVIDER to participate in local and national patient safety initiatives. Furthermore, PROVIDER will submit to HPI, upon request, documentation and/or performance improvement measurements related to PROVIDER's patient safety program.

Section 3.11 **Notification to Members When Physician Terminates.** PROVIDER will notify Members when a Physician terminates his or her employment or other affiliation with PROVIDER for any reason whatsoever. Notice will be given to all Members affected by, and prior to the effective date of, such termination.

Section 3.12 **Audit.** PROVIDER shall cooperate with the review and audit of PROVIDER's obligations under this Agreement by HPI or an entity authorized by HPI to ensure PROVIDER'S satisfaction of and compliance with state, federal, and HPI requirements

regarding such obligations. Within seven (7) business days following a written request by HPI, or sooner if required by state or federal law, PROVIDER shall provide access to HPI, a Related Organization, or Payor to PROVIDER's premises and financial, medical, and administrative records and policies relevant to the services provided under this Agreement, including, without limitation, any report PROVIDER is required to make to HPI under this Article III.

ARTICLE IV
COMPENSATION AND BILLING PROCEDURES

Section 4.1 **Compensation for Authorized Covered Services.**

(a) HPI or its designee will pay, and PROVIDER will accept as payment in full for Covered Services rendered pursuant to this Agreement, the amounts set forth in the applicable Payment Addendum attached hereto, in accordance with the terms set forth therein, which Payment Addendum is incorporated into this Agreement by reference, and as may be amended from time to time.

(b) Notwithstanding any term in this Agreement or in documents referenced in this Agreement to the contrary, the obligation to pay PROVIDER for Covered Services provided to an Affiliate Member is solely that of the Affiliate and neither HPI nor any Related Organization will be liable for such payment for Covered Services, even though HPI or a Related Organization may provide or arrange for administrative services including, without limitation, claims processing. HPI or a Related Organization will notify PROVIDER in writing if HPI or a Related Organization determines that an Affiliate has failed to maintain its responsibility to pay for services rendered. Any services which have been rendered by PROVIDER prior to and after such notification, and which were not paid for by the Affiliate, will be considered ineligible for reimbursement under this Agreement, and PROVIDER may bill the Affiliate Member directly for such services.

Section 4.2 **Copayment, Coinsurance and/or Deductible Plans.** It is understood and agreed that HPI, any Related Organization and any Affiliate may offer Products which require Member Copayment, Coinsurance and/or Deductibles. If a Member receives Covered Services from PROVIDER which are subject to a Copayment, Coinsurance and/or Deductible, PROVIDER's reimbursement for such services will be as follows:

(a) The Copayment, Coinsurance or Deductible for said Covered Services, will be the Member's responsibility and will be billed or collected by PROVIDER. PROVIDER shall use commercially reasonable efforts to collect directly from the Members all applicable Copayments, Coinsurance, and Deductibles for Covered Services;

(b) The total reimbursement amount for Covered Services which require Member Copayments, Coinsurance and/or Deductibles will be calculated pursuant to the terms specified in the applicable Addendum to this Agreement; and

(c) The amount calculated under subsection (b) minus the Copayment, Coinsurance and/or Deductible will be the amount owed to PROVIDER by HPI or its designee.

Section 4.3 **Notification and Prior Authorization.** PROVIDER will comply with the HPI notification and prior authorization requirements set forth in the HPI Administrative Program. Services and/or supplies provided without the applicable notification and prior authorization requirements will be deemed a non-Covered Service or an unauthorized Covered Service, as applicable. The terms addressing reimbursement and PROVIDER's ability to bill the Member for such unauthorized Covered Services and non-Covered Services are set forth in Section 4.7 below.

Section 4.4 **Billing Procedures.**

(a) PROVIDER will directly bill HPI or its designee (as specified by HPI) for Covered Services rendered in accordance with this Agreement. PROVIDER and HPI agree cooperatively to pursue technologies relating to the electronic exchange of billing, payment, and payment information, as well as other technologies or administrative procedures that enhance the uniformity and efficiency of information exchange between PROVIDER, HPI, its designees and its Affiliates.

(b) HPI or its designee will issue payment to PROVIDER for a Clean Claim or provide notification that a Clean Claim has been denied, within the time period required under applicable law.

(c) HPI or its designee may return claims to PROVIDER if HPI or the designee determines that the procedure and/or billing codes or other billing information is incorrect or missing, and PROVIDER will re-code, change, complete, or combine such codes as directed by HPI or its designee, in accordance with industry coding standards. HPI or its designee also may unilaterally change, combine or re-code procedure codes or other billing codes submitted by PROVIDER in accordance with industry coding standards, and will notify PROVIDER of any such change through HPI's or the designee's standard remittance advice.

(d) Furthermore, as a condition of receiving payment under this Agreement for a Clean Claim, PROVIDER must submit the Clean Claim, other than claims pended for coordination of benefits, to HPI or its designee within one hundred eighty (180) days of the date of service ("Prompt Billing Period"), unless otherwise provided by MN Stat. Section 16A.124, subdivision 4a or federal law. PROVIDER may request that the Prompt Billing Period be extended to twelve (12) months in cases where PROVIDER has experienced a significant disruption to normal operations that materially affects the ability to conduct business in a normal manner and to submit bills on a timely basis, as determined and substantiated by PROVIDER. HPI will review and act upon any request by PROVIDER for an extension to the Prompt Billing Period within the same time frame as the Prompt Billing Period. Payment will not be made on claims submitted beyond the Prompt Billing Period except for claims requiring coordination of benefits, and, effective January 1, 2011, PROVIDER shall not collect the payment from the Member, HPI or its designee, or any other payer. Claims requiring coordination of benefits will be submitted within sixty (60) days of determination by the PROVIDER that the claim should be submitted for payment under this Agreement.

(e) Notwithstanding any term in this Agreement or documents referenced in this Agreement to the contrary, if a Clean Claim is subject to Minnesota Statutes, Section 62Q.75, as amended from time to time (the "Prompt Pay Statute") and HPI or its designee fails to make timely payment for a Clean Claim or provide notice that a Clean Claim has been denied, as required under the Prompt Pay Statute, HPI's or the relevant Affiliate's liability for such failure will be limited solely to the interest payments set forth under the Prompt Pay Statute. HPI or its designee will pay such interest to PROVIDER on a quarterly basis.

Section 4.5 **Processing of Claims Adjustments.**

(a) Effective January 1, 2011, all adjustment and recoupment requests for Clean Claims which have been previously paid, whether initiated by HPI or by PROVIDER, will be initiated with reasonable specificity, within twelve (12) months of the date of service in question. Such claims adjustments initiated by HPI or PROVIDER may include, without limitation, requests for return of overpayments or payment errors.

(b) Notwithstanding the foregoing, Effective January 1, 2011, the twelve (12) months claims adjustment timeframe does not apply to: (1) Member related adjustments (including, but not limited to, retroactive terminations, (2) claims adjustments due to subrogation (3) claims adjustments due to claims subject to coordination of benefits (COB); (4) claims adjustments due to duplicate claims, and/or (5) claims adjustments due to fraud and abuse.

(c) The provisions set forth in this Section 4.5 will survive any termination of this Agreement.

Section 4.6 **Exclusive Payment (Non-Recourse).**

(a) PROVIDER agrees not to bill, charge, collect a deposit or upfront payment from, seek remuneration from, or have any recourse against a Member or persons acting on their behalf for services provided under this Agreement. This provision applies to but is not limited to the following events: (1) nonpayment by the health maintenance organization or (2) breach of this Agreement. This provision does not prohibit PROVIDER from collecting Copayments, Coinsurance, Deductibles, or fees for uncovered services.

(b) This provision survives the termination of this Agreement for authorized services provided before this Agreement terminates, regardless of the reason for termination. This provision is for the benefit of the health maintenance organization Members. This provision does not apply to services provided after this Agreement terminates.

(c) This provision does not prohibit PROVIDER from collecting Deductibles and Coinsurance from Members at or prior to the time of service. PROVIDER may not withhold a service to a Member based on the Member's failure to pay a Deductible or Coinsurance at or prior to the time of service. Overpayments by Members to PROVIDER must be returned to the Member by PROVIDER by check or electronic payment within thirty (30) days of the date in which the claim adjudication is received by PROVIDER.

(d) This provision supersedes any contrary oral or written agreement existing now or entered into in the future between the PROVIDER and the Member or persons acting on their behalf regarding liability for payment for services provided under this Agreement.

(e) If PROVIDER provides uncovered services (i.e., non-Covered Services) and seeks to bill the Member for such non-Covered Services under the terms of this Section 4.6, PROVIDER may do so, but only if the PROVIDER has obtained a written statement from the Member immediately prior to the service or, in case of any routine non-Covered services within the previous twelve (12) months from the date of service that acknowledges that the non-Covered Service will not be paid for under this Agreement, and that the Member will be liable for payment of such non-Covered Service.

Section 4.7 **Failure to Obtain Appropriate Authorization/Recommendation for Services.** Notwithstanding any term in this Agreement to the contrary (including, without limitation, Section 4.6 above):

(a) PROVIDER will not be entitled to payment under this Agreement if: (i) PROVIDER's failure to obtain or verify HPI authorization of the service or supply (including, without limitation, failure to obtain prior authorization or notify HPI) results in the service or supply provided being a non-Covered Service; (ii) for any Covered Service provided, PROVIDER failed to notify HPI and/or obtain HPI authorization as required under the terms of this Agreement and/or the HPI Administrative Program (including, without limitation, unauthorized services contemplated under Section 4.3 above); (iii) PROVIDER failed to comply with the recommendation for services and secondary recommendation for services requirements for Assigned Members outlined in the HPI Administrative Program; or (iv) except in the case of an emergency, PROVIDER failed to notify HPI upon admitting a Member to a hospital, outpatient surgery center, skilled nursing facility, or other inpatient facility; and

(b) in any circumstance set forth in subsections (a)(i), (a)(ii), (a)(iii) or (a)(iv) above, PROVIDER will be solely responsible for the costs of such non-Covered Service or unauthorized Covered Service and will not bill HPI, its designee or the Member; provided, however, that if all of the following requirements are satisfied, PROVIDER may bill the Member: (i) PROVIDER requested authorization from HPI, but HPI denied such authorization; (ii) the Member requested that PROVIDER provide the non-Covered Service or unauthorized Covered Service; (iii) PROVIDER notified the Member immediately prior to providing the requested service or supply that the specific service or supply is either a non-Covered Service or an unauthorized Covered Service and the reason such service or supply is considered to be a non-Covered Service or an unauthorized Covered Service; and (iv) subsequent to such notice, PROVIDER obtained written acknowledgment from the Member that such specifically identified service or supply is either a non-Covered Service or an unauthorized Covered Service, as applicable, that it will not be paid for under this Agreement, and that the Member will be liable for payment of such non-Covered Service or unauthorized Covered Service.

Section 4.8 **Insurance Information and Coordination of Benefits.** PROVIDER will make a good faith effort to secure information on the sources of third party coverage available to any

Member for whom PROVIDER provides Covered Services, and will forward such information to HPI. PROVIDER will coordinate benefits with other payors in accordance with health plan industry and Medicare procedures, and submit copies of all bills coordinated with other payors, upon request, to HPI or its Affiliate, except for certain Products administered by Affiliates. PROVIDER will cooperate with HPI and provide reasonable assistance requested by HPI in connection with HPI's subrogation efforts.

Section 4.9 **Other Payment Sources.** PROVIDER will accept the rates established hereunder as full payment under this Agreement in any coordination of benefits circumstance in which HPI or its Affiliate is secondary, except for Medicare-eligible services. If another party is primary but the billed charges are not paid in full, HPI's or its Affiliate's liability will be limited to the rate established hereunder, less the payment made by the primary payor(s), not to exceed the Member liability or the Member plan limits. PROVIDER will submit all charges for services for which another payor is primary to said primary payor prior to submitting said charges to HPI or its designee. If Covered Services are eligible for payment by Medicare, HPI's or its Affiliate's liability will not exceed the Medicare approved charge, less any payments made by Medicare.

ARTICLE V
INDEMNIFICATION AND INSURANCE

Section 5.1 **Indemnification by Provider.** PROVIDER will indemnify and hold harmless HPI, its Related Organizations and its Affiliates and their respective permitted assigns, officers, directors, employees and agents (each a "HPI Indemnified Party"), from and against any and all liabilities, damages, awards, obligations, costs, expenses and losses, or threat thereof, of whatever kind or nature, including, without limitation, reasonable attorneys' fees, expenses and court costs, which may be sustained or suffered by, or recovered or made against, a HPI Indemnified Party by any third party, and which is caused by, attributable to or has arisen in connection with PROVIDER's or any of its directors', officers', employees', independent contractors' or agents' performance, non-performance or delayed performance of the services contemplated by this Agreement or any act or omission of PROVIDER or any of its directors, officers, employees, independent contractors or agents that is attributable to or has arisen in connection with the services contemplated by this Agreement.

For the entire period that this Agreement is in force, PROVIDER will maintain insurance coverage for any liabilities that PROVIDER may incur due to contractual indemnification obligations, such as those set forth in this Section 5.1.

Section 5.2 **Indemnification by HPI.** HPI will indemnify and hold harmless PROVIDER and its permitted assigns, officers, directors, employees and agents (each a "PROVIDER Indemnified Party"), from and against any and all liabilities, damages, awards, obligations, costs, expenses and losses, or threat thereof, of whatever kind or nature, including, without limitation, reasonable attorneys' fees, expenses and court costs, which may be sustained or suffered by, or recovered or made against, a PROVIDER Indemnified Party by any third party, and which is caused by, attributable to or has arisen in connection with HPI's or any of its directors', officers', employees', independent contractors' or agents' performance, non-performance or delayed performance of the services contemplated by this Agreement or any act or omission of HPI or any of its directors, officers, employees, independent contractors or agents that is attributable to or has arisen in connection with the services contemplated by this Agreement.

Notwithstanding the foregoing, nothing in this paragraph will be construed as requiring HPI to indemnify any PROVIDER Indemnified Party for any performance, non-performance, delayed performance, act or omission by the PROVIDER and/or its directors, officers, employees, independent contractors or agents.

For the entire period that this Agreement is in force, HPI will maintain insurance coverage for any liabilities that HPI may incur due to contractual indemnification obligations, such as those set forth in this Section 5.2.

Section 5.3 **Provider's Insurance.** For the entire period that this Agreement is in force, PROVIDER will maintain, at its sole expense, general liability and professional liability insurance coverage in the amount of at least $500,000 per claim and $1,500,000 in the annual aggregate, as may be necessary to protect PROVIDER and each of its directors, officers, and employees against any and all claims related to the discharge of its or their respective responsibilities and obligations under this Agreement. If the insurance maintained is on a "claims made" as opposed to an "occurrence" basis, PROVIDER will ensure that PROVIDER and each of its directors, officers, and employees will obtain and maintain an extended reporting endorsement or purchase "prior acts" coverage in the amounts required above if the insurance lapses or is discontinued for any reason.

In addition, if not already covered by PROVIDER's insurance referenced above, PROVIDER will ensure that each Participating Provider maintains, at his, her or its expense, general liability and professional liability commercial insurance coverage in the amount of at least $500,000 per claim and $1,500,000 in the annual aggregate.

Upon request by HPI, PROVIDER will provide evidence of such insurance coverage. PROVIDER will notify HPI within ten (10) business days of any of the following events related to such insurance coverage: (i) changes in carriers, (ii) material changes in coverage or (iii) denials of, restrictions on, termination or cancellation of, or other material changes in such insurance coverage.

Section 5.4 **Notification.** The Parties will notify each other as soon as possible but in no event later than ten (10) days after either Party receives formal or informal notice of any actual or threatened incident, claim, action, suit or proceeding related to activities undertaken pursuant to this Agreement or which may be reasonably expected to affect the other Party (including, without limitation, any actual or threatened malpractice or professional disciplinary incident, claim, action, suit or proceeding), and will cooperate in all respects in the defense of any such incident, claim, action, suit or proceeding. This provision is not intended to influence, however, the content of any testimony that may be given in any such incident, claim, action, suit or proceeding. PROVIDER will comply with the notification requirements in this Section 5.4 notwithstanding the PROVIDER Complaint process outlined in Section 3.4 above.

Section 5.5 **Survival.** The provisions set forth in this Article V will survive any termination of this Agreement.

ARTICLE VI
TERM AND TERMINATION OF AGREEMENT

Section 6.1 **Initial Term; Termination; Renewal.** Unless earlier terminated pursuant to Section 6.2 of this Agreement, this Agreement will commence on the Effective Date and will continue thereafter for an initial term ("Initial Term") that ends on December 31, 2016 ("Termination Date"), and will automatically renew thereafter for successive terms of one (1) calendar year each (each a "Renewal Term").

Section 6.2 **Termination.** Subject to the continuing obligation of the Parties specifically set forth in other sections of this Agreement, this Agreement is subject to termination upon the occurrence of any one of the following events:

(a) by mutual written agreement of HPI and PROVIDER, provided the agreed upon effective termination date is at least one hundred and thirty (130) days later than the date of such mutual written agreement;

(b) by either HPI or PROVIDER, upon at least one hundred and thirty (130) days' written notice to the other Party prior to the end of the Initial Term or any Renewal Term, provided that such termination will be effective only on the last day of the Initial Term or such Renewal Term;

(c) by the non-breaching Party upon the other Party's failure to satisfy any material term, covenant or condition of this Agreement not otherwise addressed in this Section 6.2 and failure to cure such breach within sixty (60) days after receipt by the breaching Party of written notice specifying the details of the breach; in that event, and upon the breaching Party's failure to cure such breach to the reasonable satisfaction of the non-breaching Party, the non-breaching Party may terminate this Agreement upon ten (10) days written notice; or

(d) by HPI, immediately, in its sole discretion and upon PROVIDER's receipt of HPI's written notice, following the occurrence of one or more of the following events: (i) if PROVIDER or any Participating Provider is disqualified from practice, or has any license, registration, certification, accreditation or authorization terminated, restricted, suspended, revoked or otherwise adversely limited; (ii) failure to maintain insurance, and/or failure to provide to HPI satisfactory evidence of insurance, as required in Section 5.1 above; (iii) any material impairment of PROVIDER's ability to carry out its obligations under this Agreement; (iv) a determination by HPI that the health, safety or welfare of one or more Members is in immediate jeopardy if this Agreement is continued; (v) a determination by HPI that a Participating Provider has failed to satisfy applicable HPI credentialing standards; (vi) if the PROVIDER files a voluntary petition in bankruptcy, admits in writing its inability to pay its debts, makes a general assignment for the benefit of creditors, is adjudicated bankrupt or insolvent, or has an involuntary petition in bankruptcy or similar proceeding commenced against it, which continues undismissed and in effect for a period of thirty (30) days or more; (vii) if PROVIDER ceases or suspends providing services subject to this Agreement; or (viii) if HPI reasonably believes PROVIDER is or has been engaged in fraud and abuse with regard to the provision of services under this Agreement. This reasonable belief may be, but is not required to be, based upon the finding of a state or federal government agency, a state fraud control unit, HPI's fraud investigation unit, a court of law,

or other legal entity that PROVIDER is or has been engaged in fraud or abuse, with regard to services provided under this Agreement or similar services.

Section 6.3 **Effect of Termination.**

(a) Upon termination of this Agreement for any reason whatsoever, the Parties will continue to be bound by the terms of this Agreement in determining and enforcing their respective rights and in resolving all claims and disputes arising hereunder prior to the effective dates of termination. If this Agreement is terminated for any reason, PROVIDER will continue to provide Covered Services to Members under the terms of this Agreement, and pursuant to applicable rules and requirements set forth in the HPI Administrative Program, for up to 12 months after such effective termination date or such longer period of time as may be required under applicable law ("Run-Out Period"), provided, however, HPI or a Related Organization may, at its sole discretion, elect to transfer a Member's care to another provider or facility at any time during the Run-Out Period. This provision will apply to all Members for all Products. If PROVIDER provides Covered Services to Members during the Run-Out Period, the prohibition against billing Members as set forth in Sections 4.6 and 4.7 above will continue to apply notwithstanding any contrary language in Section 4.6.

(b) Upon termination of this Agreement, PROVIDER will turn over to HPI all tangible personal property, if any, belonging to HPI and will further make available to HPI, at HPI's expense, any and all information and copies of records as HPI reasonably may request concerning Members, subject to any Member consent requirements as set forth in Section 3.3 above. The original medical records of Members will remain the property of the PROVIDER. Similarly, HPI will turn over to the PROVIDER all tangible personal property, if any, belonging to PROVIDER.

(c) During the termination notice period, PROVIDER will not make any false or misleading statement in attempt to persuade, induce, solicit or otherwise suggest that Members terminate membership in HPI.

(d) In the event of HPI's insolvency, PROVIDER will continue to provide Covered Services to Members enrolled under any and all HPI agreements currently in effect for thirty-one (31) days following the date of insolvency. Furthermore, the services provided under this provision will be provided without any claim for compensation against Members except for permissible co-payments, coinsurance, deductibles or fees for services that are not Covered Services. This provision is for the benefit of Members.

(e) The provisions set forth in this Section 6.3 will survive any termination of this Agreement.

Section 6.4 **Termination of Participation Status.** In the event: (i) a Participating Provider is disqualified from practice, or has any license, registration, certification, accreditation or authorization terminated, restricted, suspended, revoked or otherwise adversely limited as contemplated in subsection 6.2(d)(i) above, (ii) HPI determines that continued treatment by a Participating Provider will result in immediate jeopardy to the health, safety or welfare of one or more Members, or (iii) HPI determines that a Participating Provider has failed to satisfy applicable HPI credentialing standards, then HPI, in its sole

discretion, may elect to terminate the participating status of such Participating Provider in lieu of terminating this Agreement with the PROVIDER. In such circumstances, PROVIDER will ensure that such Participating Provider does not render services to any Member. Notwithstanding anything in this Agreement to the contrary (including, without limitation, Section 4.6 above), PROVIDER will not be entitled to any payment under this Agreement for any services and/or supplies furnished by any individual or entity whose participating status has been terminated by HPI.

Section 6.5 **Review of Communication.** HPI and PROVIDER have the right to review any written communication proposed to be delivered by the other Party to Members or other Network Providers regarding termination or suspension prior to distribution of such communication.

ARTICLE VII
DISPUTE RESOLUTION

Section 7.1 **Informal Negotiation.** In the event of any dispute or controversy between the Parties hereto arising under, out of, in connection with, or in relation to this Agreement or the Parties' relationship (except those items set forth in Section 7.7) ("Dispute"), the complaining Party will provide written notice of the Dispute to the other Party. Notice will include reference to this Section 7.1. Within fifteen (15) days after the noncomplaining Party receives written notice of the Dispute, the Parties will, through a member of the senior management authorized to act on behalf of each Party, meet and make good faith efforts to settle the Dispute through negotiation.

Section 7.2 **Mediation.** If the Dispute is not resolved to the satisfaction of either Party through informal negotiation either Party may request nonbinding mediation by written notice given to the other Party no sooner than twenty (20) days but no later than thirty (30) days after the notice of Dispute referenced in Section 7.1 has been provided to the noncomplaining Party. The mediation will be before a neutral third Party mediator acceptable to both Parties. If the Parties are unable to agree upon a mediator, each Party will select one mediator whose sole purpose will be to appoint a third mediator who will act as the mediator. The mediation will occur within sixty (60) days of the notice of mediation unless a later date is mutually agreed to in writing by the Parties. Each Party will pay its own costs and expenses with respect to mediation, except the cost of the third Party mediator will be borne equally by the Parties. If neither Party requests mediation or mediation does not occur within sixty (60) days of the notice of mediation or the agreed upon date if later, the Dispute will automatically be submitted to binding arbitration as described in Section 7.3.

Section 7.3 **Submission to Arbitration.** The Dispute will be submitted to binding arbitration if the Dispute is not resolved to the satisfaction of either Party through the informal negotiation process outlined in Section 7.1 above, and (i) mediation is requested and held and the mediator certifies there is an impasse, (ii) neither Party requests mediation or (iii) mediation is requested but does not occur within the required time period. There will be one arbitrator (the "Arbitrator") who will act under the authority of the Federal Arbitration Act, 9 U.S.C. § 2, and in accordance with the commercial rules of the American Arbitration Association or other nationally recognized alternative dispute resolution association acceptable to both Parties. Any disagreement between the Parties as to whether a dispute is subject to the dispute resolution provisions of this Article will be resolved by the Arbitrator.

Section 7.4 **Selection of Arbitrator.** The Arbitrator will be selected as follows. If the Parties fail to select a mutually acceptable arbitrator within ten (10) days after submission of the Dispute to arbitration, each Party will select an arbitrator whose sole purpose will be to appoint a third arbitrator who will act as the Arbitrator. The Arbitrator will not be an employee or contractor of either Party or an affiliate of either Party.

Section 7.5 **Arbitration Procedure.** The arbitration will take place in Minneapolis, Minnesota, or such other place as may be mutually agreeable to the Parties. This Agreement and the commercial rules of the American Arbitration Association or other rules as mutually agreed to by the Parties will guide the arbitration and the Arbitrator will not be free to vary or ignore the express terms of this Agreement. If the express terms of this Agreement conflict with the rules of the American Arbitration Association or other rules as mutually agreed to by the Parties, the terms of this Agreement will control. The Arbitrator will issue its award no later than thirty (30) days from the date of the hearing. The arbitration award will be kept confidential in accordance with Section 9.2 of this Agreement. The award of the Arbitrator will be final and binding upon the Parties and will be a complete bar to any claims or demands of either Party against the other except that either Party may seek judicial enforcement of the award in accordance with Minnesota law.

Section 7.6 **Arbitration Expenses.** Each Party will pay its own costs and expenses with respect to arbitration, except the cost of the arbitrator will be borne equally by the Parties. Notwithstanding the foregoing, a Party seeking judicial enforcement of any award hereunder will be entitled to its reasonable attorneys' fees and costs incurred in connection therewith. The Arbitrator may not under any circumstances assess punitive or exemplary damages.

Section 7.7 **Disputes Not Subject to Dispute Resolution.** Notwithstanding any term or terms in this Agreement to the contrary, this Article VII will not apply to any disputes or issues: (1) pertaining to renegotiation of current or new reimbursement terms between the Parties; (2) pertaining to the Parties' respective obligations due to federal or state regulatory requirements or accreditation requirements; or (3) arising under or related to the following Sections or Articles of this Agreement:

(i) Section 2.4 (Provider Qualifications);
(ii) Section 2.6 (Credentialing; Recredentialing);
(iii) Section 3.3 (Member Medical Records and Other Records);
(iv) Sections 4.6 (Exclusive Payment (Non-Recourse));
(v) Article V (Indemnification and Insurance);
(vi) Article VIII (Excluded Individuals and Entities);
(vii) Section 9.1 (Compliance with Applicable Law);
(viii) Section 9.2 (Confidentiality);
(ix) Section 9.8 (Regulatory Amendment); or
(x) Section 9.14 (Approval by Department of Health)

Section 7.8 **Effect on Termination.** Nothing in this Article VII will limit the ability of either Party to terminate this Agreement in accordance with the terms and conditions set forth in Article VI above.

Section 7.9 **Survival.** The provisions set forth in this Article VII will survive any termination of this Agreement.

ARTICLE VIII
EXCLUDED INDIVIDUALS AND ENTITIES

For purposes of this Article VIII, the term "Sanctioned" will mean to be suspended, debarred, or excluded from participation in, convicted of any criminal offense related to the delivery of health care services under, or otherwise sanctioned by, any federally funded health care program (including, without limitation, Medicare or Medicaid). PROVIDER represents and warrants to HPI that neither it nor any Physician and/or Allied Health Professional has ever been Sanctioned. At no time during the term of this Agreement will PROVIDER or a Participating Provider (i) be Sanctioned, (ii) employ or contract with any entity or individual that has been Sanctioned or that has an ownership or controlling interest in any entity that has been Sanctioned, or (iii) contract with any entity that employs or contracts with a Sanctioned individual, for the provision of any of the following services: (a) health care; (b) utilization review; (c) medical social work; or (d) administrative services (collectively, "Designated Services"). PROVIDER will, and will cause each Participating Provider to, notify HPI, in writing, in the event any of the following individuals and/or entities are Sanctioned: (i) PROVIDER and/or a Participating Provider, (ii) an employee or agent of PROVIDER and/or Participating Provider who renders Designated Services, (iii) an entity with which an employee or agent of PROVIDER and/or Participating Provider has ownership or controlling interest, or (iv) an entity, or an employee or agent of an entity, with which PROVIDER and/or Participating Provider contracts to provide Designated Services. Notwithstanding anything in this Agreement to the contrary, PROVIDER will not be entitled to any payment under this Agreement for any services and/or supplies furnished by a Sanctioned individual or entity. PROVIDER will be solely responsible for the costs of such services and/or supplies and will not bill HPI, its designee, or the Member.

ARTICLE IX
MISCELLANEOUS PROVISIONS

Section 9.1 **Compliance with Applicable Laws.** Each Party represents that, to the best of its knowledge and belief, it is in compliance with, and during the term of this Agreement will continue to be in compliance with, all applicable state and federal laws and regulations. Without limiting the generality of the foregoing, PROVIDER will: (i) fully cooperate with HPI in connection with HPI's obligation regarding the administration of its government-sponsored Products, and (ii) comply with all applicable state and federal laws and regulations regarding government-sponsored Products, including, without limitation, the Anti-Kickback Act of 1986 (41 U.S.C. §§51-58) and the Anti-Kickback Procedures set forth in Federal Acquisition Regulation 52.203.7, which are hereby incorporated by reference into this Agreement. In particular, if there are Medicare Cost Members (as defined in the Medicare Cost Addendum), Medicare Advantage Members (as defined in the Medicare Advantage Addendum) and/or State Public Programs Members (as defined in the State Public Programs Addendum) subject to this Agreement, PROVIDER will comply with all applicable rules and requirements set forth in such Addenda, which are attached hereto and incorporated into this Agreement by reference.

Section 9.2 **Confidentiality.**

(a) **Member Information.** All information that identifies a Member or from which a Member can be identified that is derived from or obtained during the course of the performance of obligations under this Agreement, will be treated by the Parties as confidential so as to comply with all applicable state and federal laws and regulations, including without limitation the Health Insurance Portability and Accountability Act ("HIPAA") and the regulations promulgated thereunder, including the Security and Privacy requirements set forth in 45 CFR Parts 160

and 164 and the Administrative Simplification requirements set forth in 45 CFR Part 162 ("Confidential Member Information"). Confidential Member Information will not be used, released, disclosed, or published to any Party other than as required or permitted under applicable state and federal laws and regulations. PROVIDER shall implement appropriate safeguards to ensure confidentiality in the use and dissemination of all Member information so as to comply with generally recognized ethical standards and all state and federal laws, rules, and regulations regarding the confidentiality of patient records.

(b) **Other Confidential Information.** Neither Party will disclose to any third party: (i) the terms of this Agreement (including, without limitation, the reimbursement rates, fee schedules, and reimbursement methodologies set forth herein and in the Addenda attached hereto); or (ii) the other Party's nonpublic, confidential information (including, without limitation, the other Party's trade secrets and intellectual property).

Notwithstanding the foregoing, the disclosure prohibitions described in this Subsection 9.2(b) will not apply to disclosures: (i) permitted in Subsection 9.2(c) below; (ii) by HPI to its Related Organizations; (iii) required by applicable state or federal law including, without limitation, disclosures by HPI to Members and/or regulatory agencies regarding terms of the Agreement including, without limitation, reimbursement terms set forth herein; (iv) required pursuant to a court or other governmental body order; (v) required to perform the obligations set forth in this Agreement; or (vi) by HPI to its Affiliates, Members and/or employer groups, or their respective agents, concerning or related to PROVIDER's charges or reimbursement rates and methodologies applied hereunder for Covered Services.

(c) **Certain Permitted Disclosures.** Nothing in this Section 9.2 is intended to prohibit PROVIDER from informing a Member about care and treatment options, whether or not covered by a Product, or the reimbursement methodologies used by HPI to pay PROVIDER hereunder; provided, however, that such disclosure is neither false nor misleading and does not disclose specific reimbursement rates paid by HPI to PROVIDER.

(d) **Court and Governmental Orders; Return of Confidential Information.** If a court or other governmental body orders disclosure of Member information or the other Party's nonpublic, confidential information, the Party subject to the order will immediately notify such other Party.

(e) **Minnesota Review Organization Statute.** The Parties agree and acknowledge that they each have established one or more "review organizations," as such term is defined and used in Minnesota Statutes, Sections 145.61 through 145.67, as amended from time to time (the "Minnesota Review Organization Statute"), and that all information shared between the review organizations for purposes of resolving Member complaints pursuant to Section 3.4, exchanging quality information pursuant to Section 3.1 or exchanging patient safety information pursuant to Section 3.10 above will remain confidential to the fullest extent permissible under the Minnesota Review Organization Statute and any other applicable law.

(f) **Disposition of Confidential Information.** Upon termination of this Agreement for any reason, each Party will immediately return to the other Party or destroy all records or tangible documents still in the Party's possession that contain, embody or disclose, in whole or in part, Confidential Member Information or the other Party's nonpublic, confidential information. If return or destruction of confidential information is not feasible, each Party will extend the protections of this Agreement to the protected information and refrain from further use or disclosure of such information, except for those purposes that make return or destruction infeasible, for as long as the Party maintains the information.

(g) **Injunctive Relief.** Each Party will be entitled to seek injunctive relief to enforce the other Party's compliance with the obligations set forth in this Section 9.2, it being understood and agreed that the Parties will not have an adequate remedy at law if such obligations are not complied with fully.

(h) **Survival.** The provisions set forth in this Section 9.2 will survive any termination of this Agreement.

Section 9.3 **Discrimination.** PROVIDER will not discriminate in the provision of goods and services under this Agreement on the basis of race, color, age, sex, religion, national origin, marital status, sexual orientation, place of residence, health status, source of payment, the execution or failure to execute an advance directive, or on any other basis forbidden by law.

Section 9.4 **Choice of Law.** The validity, construction and enforcement of this Agreement will be determined in accordance with the laws of the State of Minnesota without reference to its conflicts of laws principles, and any action (whether by mediation, arbitration or in court) arising under this Agreement will be brought exclusively in the State of Minnesota. HPI and PROVIDER consent to the jurisdiction of the state and federal courts located in the State of Minnesota. Except as otherwise provided in this Section, the Parties and their employees hereby irrevocably consent, and submit themselves to the personal jurisdiction of said courts for all such purposes.

Section 9.5 **Relationship of Parties.** In making and performing this Agreement, the Parties hereto act and will act at all times as independent contractors, and nothing contained in this Agreement will be construed or implied to create a partnership or joint venture among the Parties. HPI and PROVIDER each expressly reserve the right to enter into the same or similar arrangements with other individuals or organizations.

Section 9.6 **Assignment.** PROVIDER's rights and obligations hereunder may not be assigned without HPI's prior written consent. HPI will have the right to assign any or all of its rights and/or obligations hereunder to one or more of its Related Organizations without PROVIDER's consent, in which case PROVIDER's rights and obligations hereunder will continue in full force and effect.

Section 9.7 **Passive Amendment.** This Agreement may be amended unilaterally by HPI upon giving ninety (90) days written notice to PROVIDER. It is agreed, however, that in the event PROVIDER makes a written objection postmarked within forty-five (45) calendar days after the date that the proposed amendment was postmarked and sent by HPI to PROVIDER, such amendment will not go into effect until mutually agreed to by PROVIDER and HPI. Notwithstanding the foregoing, nothing in this Section 9.7 will limit HPI's ability to amend this Agreement, any addenda, appendices, attachments or

exhibits attached hereto, or the HPI Administrative Program, pursuant to amendment rights otherwise set forth in such aforementioned documents.

Section 9.8 **Regulatory Amendment.** This Agreement may be amended unilaterally by HPI as required due to changes in state or federal law, regulations, rules and/or agency guidance, due to changes in accreditation standards and/or guidance, or upon demand by a state or federal agency or accrediting body. Any such amendment will be effective as of the date so required or demanded.

Section 9.9 **Entire Agreement.** This Agreement, including any addenda, appendices, attachments or exhibits attached hereto, and the HPI Administrative Program, constitute the entire agreement between the Parties regarding the subject matter contained herein and, except as otherwise set forth in the aforementioned documents, it cannot be amended, altered, supplemented, nor modified, except by a writing duly signed by all Parties. This Agreement supersedes and replaces any agreement previously entered into between HPI and PROVIDER relating to the same subject matter and no prior representations or agreements between the Parties relating to the same subject matter herein, oral or written, have any force or effect.

Section 9.10 **Headings and Captions.** The headings and captions of the articles and sections of this Agreement are inserted for convenience of reference only and will not constitute a part hereof.

Section 9.11 **Severability.** Each provision of this Agreement is intended to be severable. If any provision hereof is illegal, invalid or waived for any reason whatsoever, such illegality, invalidity or waiver will not affect the validity and enforceability of the remainder of this Agreement. The Parties will negotiate to achieve a comparable provision in the event such provision is ruled illegal or invalid.

Section 9.12 **Waiver.** The rights and remedies of the Parties are cumulative and not alternative. Neither the failure nor any delay by any Party in exercising any right, power, or privilege under this Agreement, the addenda, appendices, attachments or exhibits attached hereto, the HPI Administrative Program, or any other document referred to in this Agreement, will operate as a waiver of such right, power, or privilege, and no single or partial exercise of any such right, power, or privilege will preclude any further exercise of such right, power, or privilege or the exercise of any other right, power, or privilege. No right, power or privilege under this Agreement, the addenda, appendices, attachments or exhibits attached hereto, the HPI Administrative Program or any other document referred to in this Agreement may be waived except pursuant to a writing duly executed by the Party agreeing to waive such right, power or privilege.

Section 9.13 **Counterparts.** This Agreement may be executed in counterparts, each of which will be deemed to be an original and all of which will constitute one and the same instrument.

Section 9.14 **Approval by Department of Health.** The Parties acknowledge that the form of this Agreement is subject to review by the Minnesota Department of Health ("MDH") pursuant to Minnesota Statutes, Section 62D.08. If such review by MDH results in any necessary changes to this Agreement, the Parties agree that HPI may unilaterally amend this Agreement to incorporate such changes pursuant to Section 9.8 above.

Section 9.15 **Bind and Inure.** PROVIDER represents and warrants that this Agreement will be the valid and binding obligation of PROVIDER, enforceable in accordance with its terms; and (ii) PROVIDER has legal authority to act as an agent on behalf of all Physicians.

Section 9.16 **Notices.** All notices, requests, demands and other communications hereunder will be in writing and will be deemed to have been duly given upon actual delivery or three (3) business days subsequent to the mailing with postage prepaid and addressed:

(a) If to HPI, to:

HealthPartners, Inc.
Attention: Director, Professional Services Network Management
P. O. Box 1309
Minneapolis, Minnesota 55440-1309

with a **copy** to:

HealthPartners, Inc.
Attention: General Counsel
P.O. Box 1309
Minneapolis, Minnesota 55440-1309

(b) If to PROVIDER, to:

County of Aitkin
Attention: Administrator
204 1st St NW
Aitkin, MN 56431

(c) To such other person or place as either Party hereto will respectively designate in the foregoing manner to the other Party.

Section 9.17 **Governing Documents.** In the event of a conflict between this Agreement and any of the Addenda attached hereto, the terms and conditions of such Addendum will control.

IN WITNESS WHEREOF, the Parties hereto have caused this Agreement to be duly executed, effective as of the Effective Date.

HEALTHPARTNERS, INC.		COUNTY OF AITKIN	
By:	_____	By:	_____
Name:	Charles Abrahamson	Name:	_____
Its:	Vice President, Network Management and Provider Relations	Its:	_____
Date:	_____	Date:	_____
		Fed Tax ID:	41-6005749

MEDICARE COST ADDENDUM

A. SCOPE; APPLICATION

This Medicare Cost Addendum (this "Cost Addendum") governs the provision of Covered Services to Members who are enrolled in any of HPI's Medicare Cost Products and the PROVIDER's participation in HPI's Medicare Cost Network. Any default by either party of its respective obligations under this Cost Addendum will be treated in the same manner and have the same legal effect as any other default under the Agreement.

B. GOVERNING DOCUMENTS; DEFINITIONS

In the event of a conflict between the Agreement and this Cost Addendum, this Cost Addendum will control if such conflict involves a Medicare Cost Member. Unless otherwise specifically defined herein, all capitalized terms in this Cost Addendum will have the meanings ascribed to them in the Agreement. The following additional definitions apply to this Cost Addendum.

1. *"CMS"* will mean the Centers for Medicare and Medicaid Services of HHS.

2. *"GAO"* will mean the General Accounting Office of HHS.

3. *"HHS"* will mean the United States Department of Health and Human Services.

4. *"Medicare Cost"* means the health care program created pursuant to Section 1876 of the Social Security Act (as amended), by CMS through approved and contracted health plan organizations, such as HPI.

5. *"Medicare Cost Network"* means the network of health care providers with which HPI has contracted to provide Covered Services to its Medicare Cost Members.

6. *"Medicare Cost Product"* means a Product entered into by CMS and HPI or a Related Organization pursuant to which HPI or a Related Organization pays for, provides and/or arranges for health care services and supplies to seniors and other individuals eligible to participate in a Medicare Cost plan including, without limitation, HPI's HealthPartners 65+ Product.

7. *"Medicare Cost Member"* or *"Medicare Cost Members"* means the individual(s) eligible and enrolled in a Medicare Cost Product.

8. *"Rules"* means the Medicare Cost regulations promulgated by CMS, set forth in 42 C.F.R. 417.1 through 417.940, as now in force or as may hereafter be amended, supplemented or substituted.

C. ACCESS: RECORDS AND FACILITIES

During the term of the Agreement and for a period of ten (10) years following the termination of the Agreement, or ten (10) years following the completion of an audit by GAO, HHS or designees, whichever is later, PROVIDER will, and will cause each Subcontractor to, maintain and permit HPI, GAO, HHS, CMS, other relevant federal and state authorities and their respective designees the right to audit, evaluate and inspect the books, contracts, accounting records and procedures, medical records, patient care documentation and other records of the PROVIDER and its Subcontractors related to any aspect of the provision of health care services provided to Medicare Cost Members. For these same time periods, PROVIDER will, and will cause each Subcontractor to, make available its premises, physical facilities and equipment and

all records relating to the provision of health care services provided to Medicare Cost Members, as well as any other additional relevant information that GAO, HHS, CMS, other relevant applicable federal and state authorities and their respective designees may require.

D. ACCESS: BENEFITS AND COVERAGE

1. *No discrimination.* PROVIDER will not, and will cause each Subcontractor to not, discriminate against any Medicare Cost Member on the basis of membership with HPI, source of payment, race, color, sex, age, religion, national origin, any factor that is related to health status (including, without limitation, medical condition (including mental as well as physical illness), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), and/or disability) or any other basis forbidden by law.

2. *Access Standards.* PROVIDER will, and will cause each Subcontractor to, ensure that:

   a. the PROVIDER's and Subcontractor's hours of operation are convenient to, and do not discriminate against, Medicare Cost Members; and
   b. Covered Services are available 24 hours a day, 7 days per week, when medically necessary.

   PROVIDER will, and will cause each Subcontractor to, comply with procedures established by HPI from to time to ensure compliance with the above access standards.

3. *Continuity of Care.* PROVIDER will, and will cause each Subcontractor to, ensure that:

   a. Medicare Cost Member medical records are maintained in accordance with standards established by HPI;
   b. There is appropriate and confidential exchange of information among providers in the Medicare Cost Network in accordance with standards established by HPI; and
   c. Procedures are in place that ensure that Medicare Cost Members are informed of specific health care needs that require follow-up care and receive, as appropriate, training in self-care and other measures that such Medicare Cost Members may take to promote their own health.

4. *Direct Access to Certain Services.* PROVIDER will not, and will cause each Subcontractor to not, prohibit Medicare Cost Members from obtaining direct access (through self-referral) for the following Covered Services: (a) mammography screening; (b) influenza vaccine; and (c) preventive and routine services provided by a women's health specialist included in the Medicare Cost Network.

E. MEMBER PROTECTIONS

1. *Accuracy, Access and Confidentiality of Medical Records.* PROVIDER will, and will cause each Subcontractor to:

   a. prepare and maintain accurate and timely medical records and other information pertaining to Medicare Cost Members who receive services from PROVIDER and Subcontractor;
   b. ensure timely access by Medicare Cost Members to the records and information that pertain to them;
   c. abide by all state and federal laws and regulations regarding confidentiality and disclosure of medical records, or other health and enrollment information;

d. ensure that medical records, information from such medical records, or other health and enrollment information will be released only in accordance with applicable state or federal law, or pursuant to a court order; and

e. safeguard the privacy of any information that identifies a particular Medicare Cost Member and have procedures that specify: (i) for what purposes the information will be used within the PROVIDER's or Subcontractor's organization; and (ii) to whom and for what purposes the PROVIDER or Subcontractor will disclose the information outside of the PROVIDER's and Subcontractor's respective organizations.

2. *Exclusive Payment (Non-Recourse)* In no event, including but not limited to nonpayment by HPI, insolvency of HPI, or breach of the Agreement or this Cost Addendum, will PROVIDER or Subcontractor bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Medicare Cost Member or persons (other than HPI) acting on a Medicare Cost Member's behalf for Covered Services provided pursuant to this Cost Addendum. This provision does not prohibit the PROVIDER or Subcontractor from collecting deductibles, coinsurance or copayments, as specifically provided in the applicable certificates of coverage, or fees for non-Covered Services delivered on a fee-for-service basis to Medicare Cost Members.

These provisions supersede any oral or written contrary agreement now existing or hereafter entered into between PROVIDER or Subcontractor and a Medicare Cost Member or a person acting on the Medicare Cost Member's behalf insofar as such contrary agreement relates to liability for payment for, or continuation of, Covered Services provided pursuant to this Cost Addendum.

The terms set forth in this Section E.2 will survive the termination of this Cost Addendum, regardless of the cause giving rise to the termination, including insolvency of HPI, and will be construed to be for the benefit of Medicare Cost Members.

No change, modification or alteration of the terms set forth in this Section E.2 will be made by the parties without prior written approval of the appropriate HHS and/or CMS authorities.

3. *Continuation of Medicare Cost Members' Benefits.* Notwithstanding any term in this Cost Addendum to the contrary, PROVIDER and its Subcontractors will provide Covered Services to any Medicare Cost Member for the duration of any contract period for which premiums have been made to HPI for such Medicare Cost Member. Furthermore, in the event of HPI's insolvency, or if HPI's Medicare Cost contract with CMS is terminated, PROVIDER will, and will cause each Subcontractor to agree, that PROVIDER and its Subcontractors will continue to provide Covered Services to any Medicare Cost Member hospitalized on the date of such insolvency or termination until such Medicare Cost Member is discharged. PROVIDER will, and will cause each Subcontractor to agree the provisions in this Section: (a) will survive the any termination of this Cost Addendum, regardless of the cause giving rise to the termination, including, without limitation, insolvency of HPI and will be construed for the benefit of Medicare Members; and (b) supersede any oral or written contrary agreement now existing or hereafter entered into between the PROVIDER and/or Subcontractor and a Medicare Cost Member or a person acting on behalf of a Medicare Cost Member regarding liability for payment for Covered Services provided under the terms of this Cost Addendum. HPI and no change, modification or alteration of the terms set forth in this Section E.3 will be made by the parties without prior written

approval of the appropriate HHS and/or CMS authorities.

F. **ACCOUNTABILITY AND DELEGATION**

The parties hereby acknowledge that HPI, by offering a Medicare Cost Product, oversees and is accountable to CMS for the applicable functions and responsibilities described in the Rules. In the event that HPI has delegated any of its Medicare Cost Product functions or responsibilities to PROVIDER, such delegated arrangement will be set forth in Exhibits attached hereto and incorporated herein and will be consistent with all applicable requirements set forth in the Rules. In addition, if PROVIDER and/or Subcontractor carries out any of its obligations or duties under this Cost Addendum through a subcontracted arrangement (subject to HPI authorization as may be required under the assignment provision in the Agreement), such arrangement will be in writing, will be consistent with all applicable requirements set forth in the Rules and will contain a provision obligating such Subcontractor to comply with all applicable obligations imposed on PROVIDER and/or Subcontractor, including Medicare laws and regulations. PROVIDER will ensure that all written arrangements between PROVIDER and Subcontractors, either directly or indirectly, pursuant to which Subcontractors provide services to Medicare Cost Members will contain an acknowledgement that HPI, by offering a Medicare Cost Product, oversees and is accountable to CMS for the applicable functions and responsibilities described in the Rules, and that HPI will only delegate its Medicare Cost Product functions and responsibilities in a manner consistent with all applicable requirements set forth in the Rules.

G. **COMPLIANCE WITH APPLICABLE LAWS, REGULATIONS AND HPI POLICIES AND PROCEDURES**

1. PROVIDER will, and PROVIDER will cause each of its Subcontractors to, comply with all applicable Medicare laws, regulations and CMS instructions.

2. PROVIDER will, and PROVIDER will cause each of its Subcontractors to comply with HPI's contractual obligations with CMS and to furnish services to Medicare Cost Members in a manner consistent with such contractual obligations.

3. PROVIDER will, and PROVIDER will cause each of its Subcontractors to, comply with the following:

   a. Title VI of the Civil Rights Act of 1964, as implemented by regulations at 45 CFR part 84;
   b. The Age Discrimination Act of 1975, as implemented by regulations at 45 CFR part 91;
   c. The Rehabilitation Act of 1973;
   d. The Americans With Disabilities Act;
   e. Other laws applicable to recipients of federal funds; and
   f. All other applicable laws and rules.

4. PROVIDER will, and PROVIDER will cause each of its Subcontractors to, comply with all HPI policies and procedures, as amended from time to time by HPI, which are hereby incorporated herein by reference, including, without limitation HPI Medicare Cost policies and procedures and HPI policies and procedures relating to licensure, accreditation and Medicare certification.

H. **PHYSICIAN INCENTIVE PLAN DATA AND SURVEYS**

1. PROVIDER will, and will cause each Subcontractor to, submit to HPI all data necessary for HPI to carry out its disclosure obligations to CMS and to Medicare Cost Members with respect to physician incentive plans, as set forth and required under the Rules.

PROVIDER and Subcontractors will certify, in writing, the completeness, truthfulness and accuracy of all such data. PROVIDER will, and will cause each Subcontractor to, cooperate with HPI when it addresses any inquires from CMS regarding the accuracy of data submitted.

2. If the PROVIDER or any Subcontractor is at "substantial financial risk," as defined in the Rules, then PROVIDER will, and will cause each such Subcontractor to, obtain either aggregate or per-patient stop-loss protection, in the manner and in such amounts, as required under the Rules.

3. PROVIDER will, and will cause each Subcontractor to, cooperate with HPI in connection with HPI's obligations to conduct periodic surveys of current and former Medicare Cost Members in instances where PROVIDER and or any Subcontractor is at "substantial financial risk," as defined in the Rules.

4. PROVIDER will, and will cause each Subcontractor to, indemnify HPI for any penalty or fine assessed by CMS against HPI, resulting from the incompleteness, untruthfulness and/or inaccuracy of data required to be submitted to HPI, or resulting from the nonperformance of the stop-loss protection and Medicare Cost Member survey obligations, as required under this Section H.

I. REPORTING AND DISCLOSURE

PROVIDER will, and will cause each Subcontractor to, cooperate with HPI in connection with HPI's obligations to:

1. Carry out HPI's reporting obligations under the Rules including, without limitation, statistics and other information about: cost of HPI operations; patterns of utilization of its services; availability, accessibility and acceptability of services; developments in the health status of Medicare Cost Members; information demonstrating that HPI has a fiscally sound operation; and other matters required by CMS;

2. Disclose to Medicare Cost Members all information required under the Rules to be disclosed;

3. Make a good faith effort to notify all affected Medicare Cost Members of termination of this Cost Addendum at least thirty (30) calendar days prior to the termination effective date; and

4. Disclose to CMS Medicare Cost Product quality and performance indicators, including:

   a. disenrollment rates for Medicare Cost Members electing to receive benefits through the Medicare Cost Plan for the previous two years;
   b. information on Medicare Cost Member satisfaction; and
   c. information on health outcomes.

J. MEDICARE PARTICIPATION STATUS

Neither PROVIDER, nor any Subcontractor, will employ or contract with any individual who has opted out of Medicare by filing with a Medicare carrier an affidavit promising to furnish Medicare-covered services to Medicare beneficiaries only through private contracts with such beneficiaries. At all times during the term of this Agreement, PROVIDER will, and will cause each Subcontractor to, be certified for participation in Medicare.

K. **QUALITY AND UTILIZATION MANAGEMENT PROGRAMS**

PROVIDER will, and will cause each Subcontractor to:

1. participate in and fully cooperate with the activities of any independent quality review and improvement organization appointed by HPI pertaining to the provision of services to Medicare Cost Members; and

2. participate in and fully cooperate with HPI's medical policies, quality assurance programs, practice guidelines and utilization management programs and will consult with HPI, when so requested by HPI, regarding such policies, guidelines and programs.

L. **MEDICARE COST MEMBER COMPLAINTS**

PROVIDER will, and will cause each Subcontractor to, participate in and fully cooperate with HPI policies and procedures pertaining to Medicare Cost Member complaints, grievances, organization determinations involving benefits and Medicare Cost Member liability, appeals and expedited appeals.

M. **SUBCONTRACTORS**

PROVIDER represents and warrants that all arrangements with its Subcontractors are: (i) in writing and duly executed (except for those employment arrangements that are not pursuant to a written arrangement); and (ii) compliant with the terms of this Cost Addendum and all applicable Medicare laws and regulations. PROVIDER and each Subcontractor will promptly amend all of their respective subcontracted arrangements, in the manner requested by HPI, to meet any additional Medicare requirements or as may be requested by CMS.

MEDICARE ADVANTAGE ADDENDUM

A. SCOPE; APPLICATION

This Medicare Advantage Addendum (this "Addendum") governs the provision of Covered Services to Members who are enrolled in any of HPI's Medicare Advantage Plans and the Provider's participation in HPI's Medicare Advantage Network. Any default by either party of its respective obligations under this Addendum shall be treated in the same manner and have the same legal effect as any other default under the Agreement. Provider shall require Subcontractors to comply with this Addendum to the same extent applicable to PROVIDER.

B. GOVERNING DOCUMENTS; DEFINITIONS

In the event of a conflict between the Agreement and this Addendum, this Addendum shall control if such conflict involves a Medicare Advantage Member. In the event of a conflict between this Addendum and any HPI Medicare Advantage Plan policy, manual and/or procedure, this Addendum shall control. Unless otherwise specifically defined herein, all capitalized terms in this Addendum shall have the meanings ascribed to them in the Agreement. The following additional definitions apply to this Addendum.

1. *"Clean Claim"* means a claim that has no defect, impropriety, lack of any required substantiating documentation - including the substantiating documentation needed to meet the requirements for encounter data - or particular circumstance requiring special treatment that prevents timely payment; and a claim that otherwise conforms to the clean claim requirements for equivalent claims under original Medicare

2. *"CMS"* or "Centers for Medicare & Medicaid Services" means the agency within the Department of Health and Human Services ("DHHS") that administers the Medicare program.

3. *"Completion of Audit"* means the completion of audit by HHS, the Comptroller General, or their designees of a Medicare Advantage organization.

4. *"Comptroller General"* refers to the Comptroller General of the United States Government Accountability Office

5. "Final Contract Period" means the final term of the contract between CMS and the Medicare Advantage Organization..

6. *"HHS"* means the United States Department of Health and Human Services.

7. *"Medicare Advantage"* means the health care program established at 42 U.S.C. 1395w-21 through 1395w-28, and administered by CMS, pursuant to which CMS contracts with eligible organizations, such as HPI, to provide or arrange for Medicare covered services to eligible Medicare Beneficiaries.

8. *"Medicare Advantage Network"* means the network of health care providers with which HPI has contracted to provide Covered Services to its Medicare Advantage Members.

9. *"Medicare Advantage Plan"* means a plan approved by CMS through which HPI offers a managed health benefit to eligible Medicare beneficiaries.

10. *"Medicare Advantage Member" or "Medicare Advantage Members"* means an eligible individual(s) who has enrolled in a HPI Medicare Advantage Plan.

11. *"Rules"* means any of the following as now in force or as may hereafter be amended, supplemented or substituted (i) the Medicare Advantage regulations promulgated by CMS, set forth in 42 C.F.R. 422.1 through 422.760, (ii) the Medicare Managed Care

Manual located at http://cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326.html; and 9iii) subregulatory guidance or instructions issued by CMS.

12. *"Subcontractor"* means an individual health care provider with whom, or an entity organized to provide health care services through its employees, independent contractors or other agents with which, the Provider has contracted, either directly or indirectly, for the purposes of providing Covered Services to Medicare Advantage Members, and that have been accepted by HPI in accordance with HPI credentialing standards. The term "Subcontractor" shall include all "Downstream Entities" (as defined in the Rules) below the Provider, as well as the ultimate provider of Covered Services to Medicare Advantage Members in such "downstream" arrangements, so long as such entities and providers have been accepted by HPI in accordance with HPI credentialing standards.

C. ACCESS: RECORDS AND FACILITIES

Provider agrees that HPI, the United States Department of Health and Human Services, the Comptroller General, or their designees have the right to audit, evaluate, collect and inspect any books, contracts, computer or other electronic systems, including medical records of Provider, Subcontractors or transferees, related to CMS' Medicare Advantage contract with HPI. Provider further agrees that HHS, the Comptroller General or their designees have the right to audit, evaluate, collect, and inspect any records described in the preceding sentence directly from Provider. HHS', the Comptroller General's, or their designee's right to inspect, evaluate, and audit any pertinent information for any particular contract period will exist through ten (10) years from the Final Date of the contract period or from the date of Completion of Audit, whichever is later.

D. ACCESS: BENEFITS AND COVERAGE

1. *No discrimination.* Provider shall not, and shall cause each Subcontractor to not, discriminate against any Medicare Advantage Member on the basis of membership with HPI, source of payment, race, color, sex, age, religion, national origin, any factor that is related to health status (including, without limitation, medical condition (including mental as well as physical illness), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), and/or disability) or any other basis forbidden by law.

2. *Complex or Serious Medical Conditions.* For those Medicare Advantage Members that have been identified as having a complex or serious medical condition by HPI, Provider and/or Subcontractor, then Provider shall, and shall cause each Subcontractor to, cooperate with HPI to ensure that Provider (or Subcontractor), in collaboration with HPI and the Medicare Advantage Member, establish, implement and monitor a treatment plan for such Member's complex or serious medical condition that is appropriate for the diagnosed conditions that:

   a. Includes an adequate number of direct access visits to specialists consistent with the treatment plan;

   b. Is time-specific and periodically updated; and

   c. Ensures adequate coordination of care among providers.

3. *Access Standards.* Provider shall, and shall cause each Subcontractor to, ensure that:

   a. The Provider's and Subcontractor's hours of operation are convenient to, and do not discriminate against, Medicare Advantage Members; and

   b. Covered Services are available 24 hours a day, 7 days per week, when medically necessary.

   Provider shall, and shall cause each Subcontractor to, comply with procedures established by HPI from to time to ensure compliance with the above access standards.

4. *Continuity of Care.* Provider shall, and shall cause each Subcontractor to, ensure that:

   a. Medicare Advantage Member medical records are maintained in accordance with standards established by HPI;

   b. There is appropriate and confidential exchange of information among providers in the Medicare Advantage Network;

   c. Procedures are in place that ensure that Medicare Advantage Members are informed of specific health care needs that require follow-up care and receive, as appropriate, training in self-care and other measures that such Medicare Advantage Members may take to promote their own health;

   d. Procedures and systems are in place to address barriers to compliance with prescribed treatments or regimens by the Medicare Advantage Members; and

   e. Report to HPI any community or social services needs of a Medicare Advantage Member including, without limitation, nursing home and community-based services.

E. **MEMBER PROTECTIONS**

1. *Cultural Competency.* Provider shall, and shall cause each Subcontractor to, provide Covered Services in a culturally competent manner to all Medicare Advantage Members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. Provider shall, and shall cause each Subcontractor to, provide information regarding treatment options in a culturally-competent manner, including the option of no treatment if so elected by the Medicare Advantage Member. Provider shall, and shall cause each Subcontractor to, ensure that Medicare Advantage Members have effective communications with each of the Provider's or Subcontractors employees or agents in making decisions regarding treatment options.

2. *Advanced Directives.* Provider shall, and shall cause each Subcontractor to:

   a. Document, in a prominent part of the Medicare Advantage Member's current medical record whether or not the Medicare Advantage Member has executed an advanced directive;

   b. Not condition the provision of Covered Services or otherwise discriminate against a Medicare Advantage Member based on whether the Medicare Advantage Member has executed an advance directive; and

   c. Comply with Minnesota law regarding advance directives.

3. *Accuracy, Access and Confidentiality of Medical Records.* Provider shall, and shall cause each Subcontractor to:

   a. Prepare and maintain accurate and timely medical records and other information pertaining to Medicare Advantage Members who receive services from Provider and Subcontractor;

   b. Ensure timely access by Medicare Advantage Members to the records and information that pertain to them;

   c. Abide by all state and federal laws regarding confidentiality and disclosure of medical records, or other health and enrollment information;

   d. Ensure that medical records, information from such medical records, or other health and enrollment information will be released only in accordance with applicable state or federal law, or pursuant to a court order or subpoena; and

   e. Safeguard the privacy of any information that identifies a particular Medicare Advantage Member and have procedures that specify: (i) for what purposes the information will be used within the Provider's or Subcontractor's organization; and (ii) to whom and for what purposes the Provider or Subcontractor will disclose the information outside of the Provider's and Subcontractor's respective organizations.

4. *Exclusive Payment (Non-Recourse)*

   Provider agrees, and shall cause each Subcontractor to agree, that in no event, including but not limited to nonpayment by HPI, insolvency of HPI, or breach of the Agreement or this Addendum, shall Provider or Subcontractor bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Medicare Advantage Member or persons (or than HPI) acting on a Medicare Advantage Member's behalf for Covered Services provided pursuant to this Addendum. Provider agrees, and shall cause each Subcontractor to agree, that Medicare Advantage Members shall not be liable for payment of any fees that are the legal obligation of HPI. This provision does not prohibit the Provider or Subcontractor from collecting deductibles, coinsurance or copayments, as specifically provided in the applicable certificates of coverage, or fees for non-Covered Services delivered on a fee-for-service basis to Medicare Advantage Members.

   Provider agrees, and shall cause each Subcontractor to agree, that these provisions supersede any oral or written contrary agreement now existing or hereafter entered into between Provider and/or Subcontractor and a Medicare Advantage Member or a person acting on the Medicare Advantage Member's behalf insofar as such contrary agreement relates to liability for payment for, or continuation of, Covered Services provided pursuant to this Addendum.

   Provider agrees, and shall cause each Subcontractor to agree, that the provisions set forth in this Section E.4 shall survive the termination of this Addendum, regardless of the cause giving rise to the termination, including insolvency of HPI, and shall be construed to be for the benefit of Medicare Advantage Members.

   HPI and Provider agrees, and Provider shall cause each Subcontractor to agree, that no change, modification or alteration of the terms set forth in this Section E.4 shall be made by the parties without prior written approval of the appropriate HHS and/or CMS authorities.

   Medicare Advantage Members that are eligible for both Medicare and Medicaid will not be liable for Medicare Part A and B cost sharing when DHS is responsible for paying

such amounts. Provider will be informed of Medicare and Medicaid benefits and rules for Medicare Advantage Members eligible for Medicare and Medicaid. Neither Provider nor its Subcontractors may impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under title XIX if the individual were not enrolled in such a plan. Provider will: (1) accept the MA plan payment as payment in full or (2) bill the appropriate DHS source.

5. *Continuation of Medicare Advantage Members' Benefits.* Notwithstanding any term in this Addendum to the contrary, Provider agrees, and shall cause each Subcontractor to agree, that Provider and its Subcontractors shall provide Covered Services to any Medicare Advantage Member for the duration of any contract period for which CMS payments have been made to HPI for such Medicare Advantage Member. Furthermore, in the event of HPI's insolvency, or if HPI's Medicare Advantage contract with CMS is terminated, Provider agrees, and shall cause each Subcontractor to agree, that Provider and its Subcontractors shall continue to provide Covered Services to any Medicare Advantage Member hospitalized on the date of such insolvency or termination until such Medicare Advantage Member is discharged. Provider agrees, and shall cause each Subcontractor to agree, that the provisions in this Section E.5: (a) shall survive the any termination of this Addendum, regardless of the cause giving rise to the termination, including, without limitation, insolvency of HPI and shall be construed for the benefit of Medicare Advantage Members; and (b) supersede any oral or written contrary agreement now existing or hereafter entered into between the Provider and/or Subcontractor and a Medicare Advantage Member or a person acting on behalf of a Medicare Advantage Member regarding liability for payment for Covered Services provided under the terms of this Addendum. HPI and Provider agrees, and Provider shall cause each Subcontractor to agree, that no change, modification or alteration of the terms set forth in this Section E.5 shall be made by the parties without prior written approval of the appropriate HHS and/or CMS authorities.

6. *Additional Protections.*

   a. Provider shall provide Covered Services in a manner consistent with professionally recognized standards of health care.

   b. Provider acknowledges that Medicare Advantage Members may obtain covered mammography screening services and influenza vaccinations from a Participating Provider without a referral and that Medicare Advantage Members who are women may obtain women's routine and preventive health services from a participating women's health specialist without a referral.

   c. Provider acknowledges that covered influenza vaccines and pneumococcal vaccines are not subject to any cost share obligations.

   d. Provider shall provide Covered Services consistent with HPI's (1) standards for timely access to care and member services; (2) policies and procedures that allow for individual Medical Necessity determinations; and (3) policies and procedures for Provider consideration of Medicare Advantage Member input in the establishment of treatment plans.

F. ACCOUNTABILITY AND DELEGATION

The parties hereby acknowledge that HPI, as a Medicare Advantage Organization, oversees and is accountable to CMS for the applicable functions and responsibilities described in the Rules. If HPI has delegated any of its functions or responsibilities as a Medicare Advantage Organization to Provider (1) the arrangement regarding the delegated activities and reporting responsibilities

shall be set forth in Exhibits attached hereto and incorporated herein and shall be consistent with all applicable requirements set forth in the Rules. HPI may revoke any delegation including, if applicable, the delegated responsibility to meet CMS reporting requirements, and thereby terminate the Agreement and/or this Addendum if CMS or HPI determines that PROVIDER has not performed satisfactorily. In addition, if Provider carries out any of its obligations or duties under this Addendum through a subcontracted arrangement (subject to HPI authorization as may be required under the assignment provision in the Agreement), such arrangement shall be in writing, shall be consistent with all applicable requirements set forth in the Rules and shall contain a provision obligating such subcontractor to comply with all applicable obligations imposed on Provider, including Medicare laws and regulations. Provider shall ensure that all written arrangements between Provider and Subcontractors, either directly or indirectly, pursuant to which Subcontractors provide services to Medicare Advantage Members shall contain an acknowledgement that HPI, as a Medicare Advantage Organization, oversees and is accountable to CMS for the applicable functions and responsibilities described in the Rules, and that HPI will only delegate its functions and responsibilities as a Medicare Advantage Organization in a manner consistent with all applicable requirements set forth in the Rules.

G. CREDENTIALS OF PROVIDER AND ITS SUBCONTRACTORS

The credentials of the Provider and all Subcontractors, as applicable, shall be reviewed by HPI as set forth in the Agreement. If HPI has delegated its credentialing activities to Provider, such delegated arrangement shall be set forth in an Exhibit attached hereto and incorporated herein. Provider acknowledges and agrees that HPI retains the right to approve, suspend or terminate any arrangement with a provider selected by PROVIDER pursuant to such delegated credentialing activities. If HPI makes an adverse determination regarding the participation status of Provider and/or Subcontractor to provide services to Medicare Advantage Members, then HPI shall provide Provider and/or the affected Subcontractor: (i) with written notice of such adverse participation status decision; and (ii) an opportunity to present information and opinions about the decision.

H. COMPLIANCE WITH APPLICABLE LAWS, REGULATIONS AND HPI POLICIES AND PROCEDURES

1. Provider shall comply with all applicable Medicare laws, regulations and CMS instructions.
2. Provider shall comply with HPI's contractual obligations with CMS and agrees to furnish services to Medicare Advantage Members in a manner consistent with such contractual obligations.
3. Provider acknowledges that payments made by HPI to Provider for services rendered to Medicare Advantage Members are, in whole or in part, from federal funds and, as a result, Provider is subject to, and shall comply with, all laws that are applicable to individuals and entities receiving federal funds, including, but not limited to,
    a. Title VI of the Civil Rights Act of 1964, as implemented by 45 CFR part 80;
    b. The Age Discrimination Act of 1975, as implemented by 45 CFR part 91;
    c. Section 504 of the Rehabilitation Act of 1973 as implemented by 45 CFR Part 84;
    d. The Americans With Disabilities Act;
    e. Other laws applicable to recipients of federal funds; and

f. All other applicable laws and regulations applicable to recipients of federal funds.

4. Provider shall comply with 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 (32 U.S.C. 3729 et. seq.), and the anti-kickback statute (Section 1128B(b)) of the Act).

5. Provider shall comply with all HPI policies and procedures, as amended from time to time by HPI, which are hereby incorporated herein by reference, including, without limitation HPI Medicare Advantage policies and procedures and HPI policies and procedures relating to licensure, accreditation and Medicare certification.

I. ENCOUNTER DATA

Provider shall, and shall cause each Subcontractor to:

1. Submit to HPI all data including, without limitation, medical records, necessary to characterize the context, purpose and medical necessity of each encounter with a Medicare Advantage Member in the manner and to the extent required by CMS;

2. Certify, in writing, the completeness, truthfulness and accuracy of all such data;

3. Cooperate with HPI when it addresses any inquiries from CMS regarding the submission of encounter data and/or the accuracy of encounter data submitted; and

4. Indemnify HPI for any penalty or fine assessed by CMS against HPI, resulting from the incompleteness, untruthfulness and/or inaccuracy of data, or resulting from the nonconformance of applicable submission requirements for data, submitted by Provider for Medicare Advantage Members, as required under this Section.

J. PHYSICIAN INCENTIVE PLAN DATA AND SURVEYS

1. Provider shall, and shall cause each Subcontractor to, submit to HPI all data necessary for HPI to carry out its disclosure obligations to CMS and to Medicare Advantage Members with respect to physician incentive plans, as set forth and required under the Rules. Provider and Subcontractors shall certify, in writing, the completeness, truthfulness and accuracy of all such data. Provider shall cooperate with HPI when it addresses any inquires from CMS regarding the accuracy of data submitted.

2. If the Provider or any Subcontractor is at "substantial financial risk," as defined in the Rules, then Provider shall, and shall cause each such Subcontractor to, obtain either aggregate or per-patient stop-loss protection, in the manner and in such amounts, as required under the Rules.

3. Provider shall, and shall cause each Subcontractor to, cooperate with HPI in connection with HPI's obligations to conduct periodic surveys of current and former Medicare Advantage Members in instances where Provider and or any Subcontractor is at "substantial financial risk," as defined in the Rules.

4. Provider shall, and shall cause each Subcontractor to, indemnify HPI for any penalty or fine assessed by CMS against HPI, resulting from the incompleteness, untruthfulness and/or inaccuracy of data required to be submitted to HPI, or resulting from the nonperformance of the stop-loss protection and Medicare Advantage Member survey obligations, as required under this Section.

K. REPORTING AND DISCLOSURE

Provider shall cooperate with HPI in connection with HPI's obligations to:

1. Carry out HPI's reporting obligations under the Rules (§422.516) including, without limitation, statistics and other information about: cost of HPI operations; patterns of utilization of its services; availability, accessibility and acceptability of services; developments in the health status of Medicare Advantage Members; information demonstrating that HPI has a fiscally sound operation; and other matters required by CMS;
2. Disclose to CMS all information necessary for CMS to administer and evaluate HPI's Medicare Advantage Plan;
3. Disclose to CMS all information necessary for CMS to establish and facilitate a process for current and prospective Medicare Advantage Members to exercise choice and make an informed decision with respect to Medicare services;
4. Disclose to Medicare Advantage Members all information required under the Rules to be disclosed;
5. Make a good faith effort to notify all affected Medicare Advantage Members of termination of this Addendum at least thirty (30) calendar days prior to the termination effective date; and
6. Disclose to CMS Medicare Advantage Plan quality and performance indicators, including:
    a. Disenrollment rates for Medicare Advantage Members electing to receive benefits through the Medicare Advantage Plan for the previous two years;
    b. Information on Medicare Advantage Member satisfaction; and
    c. Information on health outcomes.
7. Disclose to CMS any books, contracts, medical records, patient care documentation, and other records of Provider, and any related entity, Subcontractor, or transferee of Provider that pertain to any aspect of the services performed, reconciliation of benefit liabilities, and determination of amounts payable under this Addendum, for the validation of risk adjustment data, as required by CMS , and any other information that CMS, other relevant federal and state authorities and their respective designees may require. (42 CFR 422.504(e)(2)
8. Provide to CMS a sample of medical records for the validation of risk-adjustment data, as required by CMS. (42 CFR 422.310(e)

L. EXCLUDED INDIVIDUALS AND ENTITIES

For purposes of this Section M, the term "Sanctioned" shall mean to be suspended, debarred or excluded from participation in, convicted of any criminal offense related to the delivery of health care services under, or otherwise sanctioned by, any federal health care program (including, without limitation, Medicare or Medicaid). Provider represents and warrants to HPI that it has never been Sanctioned. Provider hereby agrees that at no time during the term of this Agreement shall Provider (i) be Sanctioned, (ii) employ or contract with an individual that has been Sanctioned or that has an ownership or controlling interest in an entity that has been Sanctioned, or (iii) contract with an entity that employs or contracts with a Sanctioned individual, for the

provision of any of the following services: (a) health care; (b) utilization review; (c) medical social work; or (d) administrative services (collectively, "Designated Services"). Provider shall notify HPI, in writing, in the event any of the following individuals and/or entities are Sanctioned: (i) Provider, (ii) an employee or agent of Provider who renders Designated Services, (iii) an entity with which an employee or agent of Provider has an ownership or controlling interest, or (iv) an entity, or an employee or agent of an entity, with which Provider contracts to provide Designated Services. Provider shall review the Office of Inspector List of Excluded Individuals and Entities and the System for Award Management exclusion list and verify on a monthly basis or as often as required by CMS guidelines, that the persons and entities PROVIDER employs or contracts for the provision of services pursuant to this Addendum are in good standing.

M. MEDICARE PARTICIPATION STATUS

Provider shall not employ or contract with any individual who has opted out of Medicare by filing with a Medicare carrier an affidavit promising to furnish Medicare-covered services to Medicare beneficiaries only through private contracts with such beneficiaries. At all times during the term of this Agreement, Provider shall be approved by CMS as meeting the conditions for Medicare coverage of Provider's services.

N. QUALITY AND UTILIZATION MANAGEMENT PROGRAMS

Provider shall:

1. Participate in and fully cooperate with the activities of any independent quality review and improvement organization appointed by HPI pertaining to the provision of services to Medicare Advantage Members; and

2. Participate in and fully cooperate with HPI's medical policies, quality assurance programs, practice guidelines and utilization management programs and shall consult with HPI, when so requested by HPI, regarding such policies, guidelines and programs.

O. MEDICARE ADVANTAGE MEMBER COMPLAINTS

Provider shall participate in and fully cooperate with HPI policies and procedures pertaining to Medicare Advantage Member complaints, grievances, organization determinations involving benefits and Medicare Advantage Member liability, appeals and expedited appeals.

P. PROMPT PAYMENT OF CLAIMS

1. HPI or its Affiliate shall issue payment to Provider for a Clean Claim (as hereinafter defined), or provide notification that a Clean Claim has been denied, within the required timeframe set forth in Minnesota Statutes, Section 62Q.75, as amended from time to time (the "Prompt Pay Statute"). For purposes of this Section Q, "Clean Claim" shall mean a claim that satisfies all applicable requirements set forth in HPI policies and procedures, as amended by HPI, in its sole discretion, from time to time. As a condition of receiving payment for a Clean Claim, the Provider shall, or if applicable, shall cause each Subcontractor to, submit the Clean Claim within the applicable timeframe set forth in the Agreement. Notwithstanding any term in this Addendum or the Agreement or documents referenced therein to the contrary, Provider agrees that if HPI fails to make timely payment for a Clean Claim or provide notification that a Clean Claim has been denied, as

required under the Prompt Pay Statute, HPI's or Affiliate's liability for such failure shall be limited solely to the interest payments set forth under the Prompt Pay Statute.

2. In the event CMS reduces compensation to HPI as a result of a CMS directive or a change in applicable law, HPI may amend this Addendum and/or the Medicare Advantage Fee Schedule through written notice to PROVIDER to pass through the payment adjustment in the amount specified by CMS or, in the absence of such specification, in the same percentage amount as payment is adjusted by CMS. Such adjustment in payment to PROVIDER shall be effective concurrent with the effective date imposed on HPI by CMS.

Q. LIMITATIONS ON INDEMNIFICIATION

Notwithstanding anything in the Agreement to the contrary, Provider shall not be required to indemnify HPI against any civil liability for damage caused to an Medicare Advantage Member as a result of HPI's denial to pay for medically necessary care.

R. COMPLIANCE: TRAINING, EDUCATION AND COMMUNICATIONS.

In accordance with, but not limited to 42 CFR §§ 422.503(b)(4)(vi)(C)&(D) and the CMS Compliance Guidelines, Provider agrees and certifies that it, as well as its Subcontractors shall participate in applicable compliance training, education and/or communications as reasonably requested by HPI annually or as otherwise required by applicable law, and must be made a part of the orientation for a new employee or Subcontractor. Provider acknowledges and agrees that, for purposes of satisfying the training requirement, Provider shall take the training made available by CMS. HPI shall accept the certificate of completion of the CMS training as satisfaction of the training requirement. Provider and any Subcontractor who has met the fraud, waste and abuse certification requirements through enrollment into the Medicare program are deemed to have met the training and education requirements for fraud, waste and abuse. HPI shall establish and make available to Provider and Subcontractors lines of communication that are accessible to all and allow compliance issues to reported in accordance with 42 CFR § 422.503(b)(4)(vi)(D).

S. SUBCONTRACTORS

Provider represents and warrants that: (a) it has legal authority to act as an agent on behalf of all Subcontractors and to bind all Subcontractors to the duties, obligations and requirements set forth in this Addendum; and (b) all arrangements with its Subcontractors are in writing, duly executed and compliant with the terms of this Addendum and all applicable Medicare laws and regulations. Provider and each Subcontractor shall promptly amend all of their respective subcontracted arrangements, in the manner requested by HPI, to meet any additional Medicare requirements or as may be requested by CMS.

STATE PUBLIC PROGRAMS ADDENDUM

A. SCOPE; APPLICATION.

This State Public Programs Addendum (this "SPP Addendum") governs the provision of Covered Services to Members who are enrolled in any of the State's Prepaid Medical Assistance Program; Prepaid General Assistance Medical Care or MinnesotaCare Products; and the PROVIDER's participation in HPI's State Public Programs Network. Any default by either party of its respective obligations under this SPP Addendum shall be treated in the same manner and have the same legal effect as any other default under the Agreement.

B. GOVERNING DOCUMENTS; DEFINITIONS.

In the event of a conflict between the Agreement and this SPP Addendum, this SPP Addendum shall control if such conflict involves a State Public Programs Member. PROVIDER shall, and shall cause each Physician and/or Allied Health Professional to, comply with all rules and requirements of the HPI Administrative Program, including, but not limited to, any SPP Product requirements, which may be amended from time to time. Unless otherwise specifically defined herein, all capitalized terms in this SPP Addendum shall have the meanings ascribed to them in the Agreement. The following additional definitions apply to this SPP Addendum:

1. **"Clean Claim"** means one that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in the State's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

2. **"CMS"** shall mean the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services.

3. **"Comptroller General"** shall mean the Comptroller General of the U.S. Government Accountability Office.

4. **"Contract"** means the agreement between the State and HPI for Medical Care Services for Families and Children.

5. **"Contract Year"** means the calendar year for which the term of the Contract is effective.

6. **"Covered Services"** means the Medically Necessary preventive, diagnostic, therapeutic and rehabilitative services and supplies (other than a mental health care service) given to an SPP Member by a provider for a health related purpose, as defined under Minnesota Statutes, Section 256B.0625.

7. **"Emergency Performance Interruption"** or **"EPI"** means any event, including, but not limited to: wars, terrorist activities, natural disasters, pandemic or health

emergency, that the occurrence and effect of which is unavoidable and beyond the reasonable control of HP and/or the State, and which makes normal performance under the Contract impossible or impracticable.

8. **"Managing Employee"** shall mean a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency, as defined in 42 CFR § 455.101.

9. **"Medical Emergency"** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the physical or mental health of the SPP Member (or, with respect to a Pregnant Woman (as defined in 42 CFR § 435.4), the health of the woman and her unborn child) in serious jeopardy; (ii) continuation of severe pain; (iii) serious impairment to bodily functions; (iv) serious dysfunction of any bodily organ or part; or (v) death. Labor and delivery is a Medical Emergency if it meets this definition. The condition of needing a preventive health service is not a Medical Emergency.

10. **"Medical Emergency Services"** means inpatient and outpatient services covered under this Agreement that are furnished by a provider qualified to furnish emergency services and are needed to evaluate or stabilize an SPP Member's Medical Emergency.

11. **"Medically Necessary"** means, as defined under Minnesota Rules, Part 9505.0175, subpart 25, a health service that is:

    a. consistent with the SPP Member's diagnosis or condition;

    b. recognized as the prevailing standard or current practice by the provider's peer group;

    c. rendered (i) in response to a life threatening condition or pain; (ii) to treat an injury, illness or infection; or to treat a condition that could result in physical disability; (iii) to care for the mother and unborn child through the maternity period; (iv) to achieve a level of physical function consistent with prevailing community standards for diagnosis or condition; or

    d. is a preventive health service defined under Minnesota Rules, Part 9505.0355.

    In addition with respect to mental health services, pursuant to Minnesota Statutes Section 62Q.53, subdivision 2 (or any superseding law), Medically Necessary means health care services appropriate in terms of type, frequency, level, setting and duration, to the SPP Member's diagnosis or condition, and diagnostic testing and preventive services. Medically Necessary care must be consistent with generally accepted practice parameters as determined by health care providers in the same or similar general specialty as typically manages the condition, procedure or treatment at

issue, and must (i) help restore or maintain the SPP Member's health; or (ii) prevent deterioration of the SPP Member's condition.

12. **"MNCare"** or **"MinnesotaCare"** shall mean the MinnesotaCare program authorized under Minnesota Statutes, Chapter 256L.

13. **"MFCU"** shall mean the Minnesota Medicaid Fraud Control Unit of the Minnesota Attorney General's Office.

14. "**National Provider Identifier**" or **"NPI"** means the ten (10) digit number issued by CMS which is the standard unique identifier for health care providers, and which replaces the use of all legacy provider identifiers (e.g., UPIN, Medicaid Provider Number, Medicare Provider Number, Blue Cross and Blue Shield Numbers) in standard transactions.

15. **"Ownership Interest"** shall mean the possession of equity in the capital, the stock, or the profits of the Disclosing Entity, as defined in 42 CFR § 455.101.

16. **"PGAMC"** or **"Prepaid General Assistance Medical Care Program"** shall mean the Prepaid General Assistance Medical Care program authorized under Minnesota Statutes, Section 256D.03.

17. **"PMAP"** or **"Prepaid Medical Assistance Program"** shall mean the Prepaid Medical Assistance Program authorized under Minnesota Statutes, Section 256B.69, and Minnesota Rules, Parts 9500.1450 to 9500.1464.

18. **"SPP Member/s"** means an individual eligible and enrolled to receive Covered Services through an SPP Product.

19. **"SPP Network"** means the network of health care providers with which HPI has contracted to provide Covered Services to its SPP Members.

20. **"SPP Product/s"** shall mean a Product entered into by the Minnesota Department of Human Services ("MDH") or its agents and HPI or a Related Organization pursuant to which HPI or a Related Organization pays and/or arranges for health care services and supplies to individuals eligible to participate in a PMAP, PGAMC and/or MNCare plan including, without limitation, HPI's *HealthPartners Care Prepaid Medical Assistance and Prepaid General Assistance Medical Care* and *HealthPartners Care Prepaid Minnesota Care* products.

21. **"State"** shall mean the Minnesota Department of Human Services or its agents and the Commissioner of Human Services.

22. **"Person with an Ownership or Control Interest"** shall mean (as defined in 42 CFR § 455.101) a person or corporation that:

    a. has an Ownership Interest, directly or indirectly, totaling five percent (5%) or more in the MCO or a Disclosing Entity;

b. has a combination of direct and indirect Ownership Interests equal to five percent (5%) or more in the MCO or the Disclosing Entity;

c. owns an interest of five percent (5%) or more in any mortgage, deed of trust, note, or other obligation secured by the MCO or the Disclosing Entity, if that interest equals at least five percent (5%) of the value of the property or assets of the MCO or the Disclosing Entity; or

d. is an officer or director of the MCO or the Disclosing Entity (if it is organized as a corporation) or is a partner in the MCO or the Disclosing Entity (if it is organized as a partnership).

23. **"Physician Incentive Plan"** or **"PIP"** means any compensation arrangement between an organization and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided to SPP Members.

24. **"Post-Stabilization Care Services"** shall mean Medically Necessary Covered Services related to an Emergency medical condition, that are provided after an SPP Member is stabilized, in order to maintain the stabilized condition, and for which HPI is responsible when:

a. the services are Service Authorized;

b. the services are provided to maintain the SPP Member's stabilized condition within one (1) hour of a request to HPI for Service Authorization of further Post-Stabilization Services;

c. HPI could not be contacted;

d. HPI did not respond to a Service Authorization within one (1) hour; or

e. HPI and PROVIDER are unable to reach an agreement regarding the SPP Member's care.

25. **"Priority Services"** shall mean:

a. those services that must remain uninterrupted to ensure the life, health and/or safety of the SPP Member;

b. Medical Emergency Services, Post-Stabilization Care Services and Urgent Care;

c. other Medically Necessary services that may not be interrupted or delayed for more than fourteen (14) days;

d. a process to authorize the services described in paragraphs a through c;

e. a process for expedited appeals for the services described in paragraphs a through c; and

f. a process to pay providers who provide the services described in paragraphs a through c.

26. **"Service Authorization** means an SPP Member's request, or a provider's request on behalf of an SPP Member, for the provision of medical services, and HPI's determination of the Medical Necessity for the medical service prior to the delivery or payment of the service. A service that has received such authorization is a **"Service Authorized"** as used herein.

27. **"Urgent Care"** shall mean acute, episodic medical services available on a twenty-four (24) hour basis that are required in order to prevent a serious deterioration of the health of an SPP member.

C. MARKETING MATERIALS.

Except as provided by HPI, PROVIDER shall not market or promote to individuals who are not enrolled in an SPP Product for the purpose of encouraging the individual to enroll in an SPP Product. Such prohibited marketing shall include, but is not limited to, telephone, face-to-face, cold-calling or direct mail marketing. PROVIDER is not prohibited from providing information to SPP Members for the purpose of educating such members about provider choices through HPI so long as such information is not false or materially misleading.

D. ACCESS; RECORDS AND FACILITIES.

PROVIDER shall maintain and permit HPI, State, CMS, the Comptroller General, or their designees, the right to inspect, evaluate and audit any pertinent books, financial records, documents, papers, and records of the PROVIDER involving financial transactions related to Contract. The right under this section to information for any Contract period will extend through ten (10) years from the date of the final settlement for any Contract Year unless:

1. The State or CMS determines there is a special need to retain a particular record or records for a longer period of time and the State or CMS notify HPI at least 30 days prior to the normal record disposition date;

2. There has been a termination, dispute, fraud, or similar default by HPI or PROVIDER, in which case the record(s) retention may be extended to ten (10) years from the date of any resulting final settlement; or

3. The State or CMS determined that there is a reasonable possibility of fraud and the record may be reopened at any time.

E. MEMBER PROTECTIONS.

1. **Advance Directives.** PROVIDER shall:

   a. document in the SPP Member's current medical record whether or not the SPP Member has executed an advance directive;

b. not condition treatment of Covered Services or otherwise discriminate on the basis of whether the SPP Member has executed an advance directive;

c. comply with all applicable state and federal laws, rules and regulations related to advance directives; and

d. provide, individually or with others, education for staff on advance directives.

2. **Accuracy, Access and Confidentiality of Medical Records.** PROVIDER shall:

a. prepare and maintain accurate and timely medical records and other information pertaining to SPP Members who receive services from PROVIDER; and

b. ensure timely access by SPP Members to the records and information that pertain to them.

3. **SPP Member Rights**. PROVIDER shall consider, and shall ensure that Physicians and Allied Health Professionals consider, SPP Members' rights, including but not limited to the right to:

a. receive information pursuant to 42 CFR § 438.10;

b. be treated with respect and with due consideration for the SPP Member's privacy;

c. receive information on available treatment options and alternatives, including the risks, benefits, and consequences of treatment or non-treatment, presented in a manner appropriate to the SPP Member's condition and ability to understand;

d. participate in decisions regarding his or her health care, including the right to refuse treatment;

e. be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in Federal regulations on the use of restraints and seclusion;

f. request and receive a copy of his or her medical records pursuant to 45 CFR Part 160 and Part 164, subparts A and E, and request to amend or correct the record(s) as specified in 45 CFR §§164.524 and 164.526;

g. be furnished health care services in accordance with 42 CFR §§ 438.206 through 438.210; and

h. ensure that each SPP Member is free to exercise his or her rights and that the exercise of these rights will not adversely affect the way the SPP Member is treated.

4. **PROVIDER and SPP Member Communications.** HPI shall not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice from advising or advocating on behalf of an SPP Member, with respect to the following:

a. the SPP Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

b. any information the SPP Member needs in order to decide among all relevant treatment options;

c. the risks, benefits, and consequences of treatment or non-treatment; or

d. the SPP Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

5. **Payment of Copays and Provision of Services.** In accordance with 42 CFR §447.53, neither PROVIDER nor any Physician or Allied Health Professional shall deny Covered Services to an SPP Member because of the SPP Member's inability to pay the Copayment.

6. **Cultural Competency**. PROVIDER shall provide, and shall cause each Physician and Allied Health Professional to provide, Covered Services in a culturally competent manner to all SPP Members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. PROVIDER shall provide, and shall cause each Physician and Allied Health Professional to provide, information regarding treatment options in a culturally-competent manner, including the option of no treatment if so elected by the SPP Member. PROVIDER shall ensure, and shall cause each Physician and Allied Health Professional to ensure, that SPP Members have effective communications with each of PROVIDER's or Subcontractor's employees or agents in making decisions regarding treatment options. Further, PROVIDER shall comply with the recommendations of the revised policy guidelines published on August 4, 2003 by the Office for Civil Rights of the Department of Health and Human Services, titled "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons," and shall apply the four factors described therein to assess the language needs of SPP Members and decide what reasonable steps, if any, PROVIDER should take to ensure meaningful access to Covered Services by SPP Members who have limited English proficiency.

F. FRAUD AND ABUSE REQUIREMENTS.

1. PROVIDER acknowledges that payments made by HPI to PROVIDER for services rendered to SPP Members are, in whole or in part, from state and federal funds and, as a result, PROVIDER shall comply with all laws, rules and regulations applicable to individuals and entities receiving state and federal funds.

2. PROVIDER shall, upon the request of the MFCU, make available to the MFCU all administrative, financial, medical and any other records that relate to the delivery of items or services under the Contract. PROVIDER shall allow the investigating unit or office access to these records during normal business hours, except under special circumstances when after-hours admission shall be allowed. Such special circumstances shall be determined by the MFCU.

3. PROVIDER shall search monthly, and upon contract execution or renewal, and credentialing, the OIG List of Excluded Individuals/Entities ("LEIE") and the Excluded Parties List System (EPLS, with the HHS System for Awards Management) database (and may search the Medicare Exclusion Database), for any providers, agents, Persons with an Ownership or Control Interest, and Managing Employees to verify that these persons:

   a. are not excluded from participation in Medicaid under §§ 1128 or 1128A of the Social Security Act; and

   b. have not been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or programs under Title XX of the Social Security Act.

   PROVIDER assures HPI that no agreements exist with an excluded entity or individual for the provision of items or services related to HPI's obligation under the Contract.

   PROVIDER shall report to HPI within five (5) days any information regarding individuals or entities specified in the first paragraph of this Section F, who have been convicted of a criminal offense related to the involvement in any program established under Medicare, Medicaid, the programs under Title XX of the Social Security Act, or that have been excluded from participation in Medicaid under §§ 1128 or 1128A of the Social Security Act.

G. ENCOUNTER DATA.

PROVIDER shall cooperate with HPI when it addresses any inquiries from the State regarding the submission of encounter data and/or the accuracy of encounter data submitted.

H. PROVIDER SUBCONTRACTORS.

PROVIDER represents and warrants that all arrangements with its Physicians and/or Allied Health Professionals are: (i) in writing and duly executed (except for those employment arrangements that are not pursuant to a written arrangement); and (ii) compliant with the terms of this SPP Addendum and all applicable state and federal laws, rules and regulations. PROVIDER and each of its Physicians and/or Allied Health Professionals shall promptly amend all of their respective subcontracted arrangements, in the manner requested by HPI, to meet any additional SPP Products requirements or as may be requested by the State.

I. MINNESOTA DEPARTMENT OF HUMAN SERVICES DISCLOSURE REQUIREMENTS.

Prior to the effective date of this Addendum and renewal of the Agreement to which this Addendum is a part, PROVIDER shall report the following information to HPI, if applicable, in order to assure compliance with 42 CFR § 455.104:

1. The name address, date of birth, Social Security Number (in the case of an individual), and tax identification number (in the case of a corporation) of each Person with an Ownership or Control Interest in PROVIDER ("disclosing entity") or in any subcontractor (both as defined in 42 CFR § 455.101) in which the disclosing entity has direct or indirect ownership of five percent (5%) or more. The address for corporate entities must include primary business address, every business location and P.O. Box address;

2. A statement as to whether any Person with an Ownership or Control Interest in the disclosing entity as identified in paragraph I.1 above is related (if an individual) to any other Person with an Ownership or Control Interest as spouse, parent, child or sibling;

3. The name or any other organization in which a Person with an Ownership or Control Interest in disclosing entity also has an Ownership or Control Interest;

4. The name, address, date of birth, and Social Security Number of any Managing Employee of the disclosing entity; and

5. For purposes of Section I, "subcontractor" means an individual, agency, or organization to which a disclosing entity has contracted, or is a person with an employment, consulting or other arrangement with HPI for the provision of items and services that are significant and material to HPI's obligations under the Contract.

J. NATIONAL PROVIDER IDENTIFIER.

PROVIDER shall obtain, and shall require all Physicians and Allied Health Professionals to obtain, National Provider Identifier ("NPI") numbers. PROVIDER shall use the NPI to identify PROVIDER and Physicians and Allied Health Professionals. A claim shall not be considered a Clean Claim without the required NPI number(s).

K. PROMPT PAYMENT OF CLAIMS.

HPI or its designee shall promptly pay all Clean Claims, and applicable interest on Clean Claims, in accordance with 42 U.S.C. § 1396a(a)(37) and 42 CFR §§ 447.45 and 447.46. Notwithstanding any provision in the Agreement or this Addendum to the contrary, PROVIDER shall submit Clean Claims to HPI or its designee within twelve (12) months from the newborn SPP Member's date of birth for Covered Services rendered to the newborn SPP Member during the period of retroactive enrollment for newborns.

L. PHYSICIAN INCENTIVE PLAN DATA AND SURVEYS.

To the extent HPI operates a Physician Incentive Plan for the SPP Products, PROVIDER shall comply with the following:

1. PROVIDER shall submit to HPI all data necessary for HPI to carry out its disclosure obligations to the State and SPP Members with respect to PIPs, as set forth and required under 42 CFR § 422.208. PROVIDER shall certify, in writing, the completeness, truthfulness and accuracy of all such data. PROVIDER shall cooperate with HPI when it addresses any inquiries from the State regarding the accuracy of

data submitted. PROVIDER shall also ensure that subcontractors meet the same requirements;

2. If the PROVIDER is at "substantial financial risk," as defined in 42 CFR § 422.208, then PROVIDER shall obtain either aggregate or per-patient stop-loss protection, in the manner and in such amounts, as required under 42 CFR § 422.208; and

3. PROVIDER shall cooperate with HPI in connection with HPI's obligations to conduct periodic surveys of current and former SPP Members in instances where PROVIDER is at "substantial financial risk."

M. BUSINESS CONTINUITY PLAN.

1. If HPI contracts with PROVIDER for Priority Services, PROVIDER shall have in place a written Business Continuity Plan ("BCP"), which, among other things, identifies core people, functions, and skills and ensures the continuation of essential operations of HPI, including the production and delivery of Priority Services. Accordingly, the BCP, at a minimum, shall:

   a. appoint and identify an Emergency Preparedness Response Coordinator (EPRC) who shall serve as the contact for HPI with regard to emergency preparedness and response issues and shall provide updates to HPI as the EPI unfolds. PROVIDER shall notify HPI immediately whenever there is a change in PROVIDER's EPRC and must include the contact information of its new appointed EPRC;

   b. outline the procedures used for the activation of the BCP upon the occurrence of an EPI;

   c. ensure that PROVIDER operations continue to produce and deliver Priority Services under this Addendum. This includes, but is not limited to:

      i. outline the roles, command structure, decision making process, and emergency action procedures that will be implemented upon the occurrence of an Emergency Performance Interruption;

      ii. provide alternative operating plans for Priority Services;

      ii. provide procedures to move SPP Members to Fee-for-Service if HPI or the State determines such movement is necessary to properly provide service to the SPP Members; and

      iv. provide procedures to allow SPP Members to go to another clinic if PROVIDER's primary case clinic is not functioning.

   d. include procedures to reverse the process once the external environment permits PROVIDER to re-enter normal operations;

   e. be reviewed and revised as needed, at least annually. The BCP shall also be exercised on a regular basis, typically annually; and

f. upon written request, be available to HPI or the STATE during normal business hours for review and inspection at PROVIDER's location.

2. If PROVIDER uses a subcontractor to furnish Priority Services to SPP Members, PROVIDER shall ensure that all such subcontractors have a BCP in place that meets, at minimum, the requirements of Section M.1 above.

N. PROVIDER PREVENTABLE CONDITIONS.

PROVIDER acknowledges and agrees that PROVIDER shall not be entitled to compensation for provider-preventable conditions as defined in 42 CFR § 447.26; provided that no reduction in payment will be imposed for a provider preventable condition when the condition defined as provider preventable condition for a particular SPP Member existed prior to the initiation of treatment for that SPP Member by PROVIDER. PROVIDER shall identify provider preventable conditions that are associated with claims for payment under this SPP Addendum or courses of treatment furnished to SPP Members for which payment under this SPP Addendum would otherwise be available.

PAYMENT ADDENDUM

The Participating Provider Agreement (the "Agreement") between HealthPartners, Inc. ("HPI") and County of Aitkin ("PROVIDER"), dated January 1, 2016, shall be governed by the following reimbursement terms set forth in this Payment Addendum, including any Exhibit(s) and Attachment(s) attached hereto (collectively, "Payment Addendum").

A. Scope.

This Payment Addendum sets forth the reimbursement terms for Covered Services provided to Members subject to the Agreement.

B. Term.

This Payment Addendum shall be effective as of January 1, 2016. Notwithstanding the foregoing, nothing in this Payment Addendum shall alter in any way the term of the Agreement or the parties' rights to terminate the Agreement as provided therein. Any termination of the Agreement shall result in automatic termination of this Payment Addendum.

C. Governing Documents; Definitions.

In the event of a conflict between the Agreement and this Payment Addendum, this Payment Addendum shall control. Unless otherwise specifically defined herein, all capitalized terms in this Payment Addendum shall have the meanings ascribed to them in the Agreement. The following additional definitions apply to this Payment Addendum.

Section 1. "Medicare Member" means: an individual eligible and enrolled to receive Covered Services through (i) a Medicare Cost Product, as defined in the Medicare Cost Addendum, (ii) a Product entered into by HPI or a Related Organization for the purpose of issuing a Medicare supplemental policy or certificate, as set forth in Minnesota Statutes, Section 62A.31 *et. seq.*, and/or (iii) a Product entered into by HPI or a Related Organization for the purpose of issuing a Medicare select policy or certificate, as set forth in Minnesota Statutes, Section 62A.318.

Section 2. "State Public Programs Member" means an individual eligible and enrolled to receive Covered Services through a State Public Programs Product. "State Public Programs Product" means a Product entered into by the Minnesota Department of Human Services (or its agents) and HPI or a Related Organization pursuant to which HPI or a Related Organization pays for, provides and/or arranges for health care services and supplies to individuals eligible to participate in such governmental plans.

Section 3. "**Commercial Member**" means an individual eligible and enrolled to receive Covered Services through a product that is not a Medicare or State Public Programs Member.

Section 4. "**Commercial Network Access Only**" means any Covered Service provided to individuals enrolled in a commercial Product offered by an employer that contracts with a third party administrator ("TPA") that has access to an Affiliate, as defined in Section 1.1(ii) and Section 1.1(iii) of the Agreement, but for which Affiliate does not administer plan functions, but provides network access only.

D. ***Reimbursement Terms.***

Reimbursement for Covered Services rendered pursuant to the Agreement shall be governed by the following payment terms:

HPI shall pay PROVIDER the lower of PROVIDER's billed charges or the rates set forth in the then-current applicable HPI fee schedule as defined below, which are incorporated into this Addendum by reference:

Member	Fee Schedule
Commercial	HPI Maximum Fee Schedule
Commercial Network Access Only	125% of the HPI Maximum Fee Schedule
Medicare	HPI Medicare Fee Schedule
State Public Programs	HPI Public Programs Fee Schedule

If a fee has not been established by HPI for a particular service or procedure, PROVIDER shall be paid seventy percent (70%) of its billed charges.

The code S9123 will be reimbursed at the rate established in HPI Public Programs Fee Schedule.

PUBLIC PROGRAMS CAR SEAT FEE SCHEDULE

Car Seat Education Reimbursement	
S9445 Patient Education Individual	$80.00
S9446 Patient Education Group	$50.00
Car Seat Equipment Reimbursement	
E0700 Safety Equipment – device or accessory	$75.00

All of the above codes must be billed with diagnosis code Z71.89 – Car Seat and Car Seat Education. . In addition, providers are required to add "car seat" in the description next to S9445 and S9446.

Fee schedules and fee information, including the maximum fees payable for Covered Services, shall be as determined from time to time by HPI or an Affiliate. As new

Covered Services become available, HPI and PROVIDER shall negotiate payment rates to be included in the established HPI fee schedule. Upon request, HPI shall provide PROVIDER with a representative sample of applicable fee schedule information. HPI agrees annually to review its maximum fee schedule payment levels.

Section 1. Purchase Price. Purchase price for Covered Services shall include, but is not limited to, freight, postage, free delivery to Member's home or designated site, installation, set-up, Member education, Member follow-up, fitting and measurement, facility visit costs, manufacturer's warranties and loaner Covered Services should Covered Services need to be removed from the home or designated site.

E. Default from Billed Charges.

PROVIDER shall provide HPI with its fee schedule in effect as of the Effective Date of this Agreement. This fee schedule shall form the basis by which PROVIDER shall determine its billed charges to HPI and its Affiliates. PROVIDER shall provide HPI with written notice at least thirty (30) days prior to the effective date of any change to PROVIDER's billed charges for such services.

If written notice is not provided prior to implementation, any increases in billed charges will be reconciled to the appropriate default percentage.

F. MinnesotaCare Tax.

PROVIDER is subject to a tax on gross revenues in accordance with Minnesota Statutes 295.52, subd.1, as may hereafter be amended, substituted or supplemented ("MinnesotaCare"). MinnesotaCare allows PROVIDER to transfer the additional expense generated by MinnesotaCare taxation ("MinnesotaCare Tax") to third-party purchasers, such as HPI. The parties agree as follows:

Section 1. HPI will reimburse PROVIDER for MinnesotaCare Tax as defined in Minnesota Statute 295.52, subdivision 1.

Section 2. In the event PROVIDER is paid billed charges or on a discount from billed charges basis, HPI shall pay such billed charges or the agreed-upon discount percentage of PROVIDER's billed charges, as applicable, and the MinnesotaCare Tax shall be deemed to be included.

Section 3. Notwithstanding any term in this Section F that may be construed to be to the contrary, the PROVIDER shall be ultimately liable for the payment of any MinnesotaCare Taxes owed by the PROVIDER to the State of Minnesota.

G. ***Previous Terms.***

This Payment Addendum supersedes any agreement previously entered into between HPI and PROVIDER relating to the terms addressed in the Payment Addendum and no prior representations or agreements between the parties relating to the terms addressed in the Payment Addendum, whether oral or written, have any force or effect.

HEALTHPARTNERS, INC.		COUNTY OF AITKIN	
By:	_____	By:	_____
Name:	Charles Abrahamson	Name:	_____
Its:	Vice President, Network Management and Provider Relations	Its:	_____
Date:	_____	Date:	_____
		Fed Tax ID:	41-6005749

SERVICES ADDENDUM
INTAKE AND ELIGIBILITY FOR
TARGETED CASE MANAGEMENT

The Participating Provider Agreement (the "Agreement") between HealthPartners, Inc. ("HPI") and County of Aitkin ("PROVIDER"), dated January 1, 2016, shall be governed by the following reimbursement terms set forth in this Services Addendum, including any Exhibit(s) and Attachment(s) attached hereto (collectively, "Services Addendum").

A. ***Scope.***

This Services Addendum sets forth the terms for the provision of Intake and Eligibility for Targeted Case Management provided by PROVIDER to State Public Programs Members subject to the Agreement.

B. ***Term.***

This Services Addendum shall be effective as of January 1, 2016. Notwithstanding the foregoing, nothing in this Services Addendum shall alter in any way the term of the Agreement or the parties' rights to terminate the Agreement as provided therein. The termination of this Services Addendum shall not result in the termination of the Agreement. Any termination of the Agreement shall result in automatic termination of this Services Addendum.

C. ***Governing Documents; Definitions.***

In the event of a conflict between the Agreement and this Services Addendum, this Services Addendum shall control. Unless otherwise specifically defined herein, all capitalized terms in this Services Addendum shall have the meanings ascribed to them in the Agreement. The following additional definitions apply to this Services Addendum.

Section 2. **"State Public Programs Member"** means an individual eligible and enrolled to receive Covered Services through a State Public Programs Product. "State Public Programs Product" means a Product entered into by the Minnesota Department of Human Services (or its agents) and HPI or a Related Organization pursuant to which HPI or a Related Organization pays for, provides and/or arranges for health care services and supplies to individuals eligible to participate in such governmental plans.

Section 3. **"Intake and Eligibility"** or **"I&E"** means the process the Provider goes through in order to determine if a State Public Programs Member meets the criteria to receive Targeted Case Management. This may include, but is not limited to, obtaining medical and mental health records, visiting a State Public Programs Member in the hospital, scheduling appointments with a State Public Program Member or the family, obtaining a functional assessment, and determining the level of care a State Public Program Member may need.

Section 4. **"Targeted Case Management"** or **"TCM"** means services for adults who have a Severe and Persistent Mental Illness ("SPMI") and children/adolescents who are diagnosed with Severe Emotional Disturbance ("SED"). TCM consists of face-to-face contact between the Targeted Case Manager and the State Public Programs Member, at least monthly. Contacts may be supplemented by telephonic contact.

D. Members Eligible to Receive TCM.

To be eligible to receive TCM State Public Programs Members must meet the definitions specified in MN Stat. 245.4871, Subd. 5 and Subd. 6 (for children) or MN Stat. 245.462 subd. 3 (for adults).

E. I&E Coding and Documentation.

Section 1. Intake and Eligibility coding: Appropriate coding includes:

H0002 Behavioral health screening to determine eligibility for admission to Targeted Case Management.

Section 2. Intake and Eligibility documentation:

PROVIDER shall maintain documentation in members' file that is consistent with state and federal guidelines. Documentation will be subject to the annual review specified in Section F of this Services Addendum.

F. Annual Review Process.

HPI and PROVIDER shall meet on an annual basis to review the Intake and Eligibility services provided by PROVIDER. This review will include but is not limited to:

1. Adequate documentation to support claims;
2. Performance of county referral partners; and
3. Compliance with state and federal regulations.

G. Reimbursement Terms.

HPI will reimburse PROVIDER for rendering Intake and Eligibility to eligible State Public Programs Members pursuant to terms specified in Attachment A, which is attached to this Services Addendum.

H. Previous Terms.

This Services Addendum supersedes any agreement previously entered into between HPI and PROVIDER relating to the terms addressed in the Services Addendum and no prior representations or agreements between the parties relating to the terms addressed in the

Services Addendum, whether oral or written, have any force or effect. All other terms and conditions of the Agreement not expressly modified by this Services Addendum shall remain unchanged and in effect.

I. Counterparts; Binding Addendum

This Services Addendum may be executed in counterparts, each of which will be deemed an original, but all of which together constitute one and the same instrument. Notwithstanding anything in this Services Addendum to the contrary, upon acceptance of payment by PROVIDER this Services Addendum shall be deemed (a) accepted by and binding on the parties hereto, (b) valid and (c) enforceable even though not fully signed.

HEALTHPARTNERS, INC.		COUNTY OF AITKIN	
By:	_____	By:	_____
Name:	Charles Abrahamson	Name:	_____
Its:	Vice President, Network Management and Provider Relations	Its:	_____
Date:	_____	Date:	_____
		Fed Tax ID:	41-6005749

ATTACHMENT A TO
SERVICES ADDENDUM
INTAKE AND ELIGIBILITY FOR
TARGETED CASE MANAGEMENT

A. ***Reimbursement Rate.***

Pursuant to state requirements HPI will reimburse PROVIDER for the following TCM services at the corresponding rate specified below as agreed upon by PROVIDER and host county.

CODE	RATE
H0002	$450.00

B. ***MinnesotaCare Tax.***

PROVIDER is subject to a tax on gross revenues in accordance with Minnesota Statutes 295.52, subd.1, as may hereafter be amended, substituted or supplemented ("MinnesotaCare"). MinnesotaCare allows PROVIDER to transfer the additional expense generated by MinnesotaCare taxation ("MinnesotaCare Tax") to third-party purchasers, such as HPI. The parties agree as follows:

Section 1. HPI will reimburse PROVIDER for MinnesotaCare Tax as defined in Minnesota Statute 295.52, subdivision 1.

Section 2. In the event PROVIDER is paid billed charges or on a discount from billed charges basis, HPI shall pay such billed charges or the agreed-upon discount percentage of PROVIDER's billed charges, as applicable, and the MinnesotaCare Tax shall be deemed to be included.

Section 3. Notwithstanding any term in this Section F that may be construed to be to the contrary, the PROVIDER shall be ultimately liable for the payment of any MinnesotaCare Taxes owed by the PROVIDER to the State of Minnesota.

PAYMENT ADDENDUM

The Participating Provider Agreement (the "Agreement") between HealthPartners, Inc. ("HPI") and County of Aitkin ("PROVIDER"), dated January 1, 2016, shall be governed by the following reimbursement terms set forth in this Payment Addendum, including any Exhibit(s) and Attachment(s) attached hereto (collectively, "Payment Addendum").

A. Scope.

This Payment Addendum sets forth the reimbursement terms for Covered Services provided to Members subject to the Agreement.

B. Term.

This Payment Addendum shall be effective as of January 1, 2016. Notwithstanding the foregoing, nothing in this Payment Addendum shall alter in any way the term of the Agreement or the parties' rights to terminate the Agreement as provided therein. Any termination of the Agreement shall result in automatic termination of this Payment Addendum.

C. Governing Documents; Definitions.

In the event of a conflict between the Agreement and this Payment Addendum, this Payment Addendum shall control. Unless otherwise specifically defined herein, all capitalized terms in this Payment Addendum shall have the meanings ascribed to them in the Agreement. The following additional definitions apply to this Payment Addendum.

Section 1. "Medicare Member" means: an individual eligible and enrolled to receive Covered Services through (i) a Medicare Cost Product, as defined in the Medicare Cost Addendum, (ii) a Product entered into by HPI or a Related Organization for the purpose of issuing a Medicare supplemental policy or certificate, as set forth in Minnesota Statutes, Section 62A.31 et. seq., and/or (iii) a Product entered into by HPI or a Related Organization for the purpose of issuing a Medicare select policy or certificate, as set forth in Minnesota Statutes, Section 62A.318.

Section 2. "State Public Programs Member" means an individual eligible and enrolled to receive Covered Services through a State Public Programs Product. "State Public Programs Product" means a Product entered into by the Minnesota Department of Human Services (or its agents) and HPI or a Related Organization pursuant to which HPI or a Related Organization pays for, provides and/or arranges for health care services and supplies to individuals eligible to participate in such governmental plans.

Section 3. "Commercial Member" means an individual eligible and enrolled to receive Covered Services through a product that is not a Medicare or State Public Programs Member.

Section 4. "Commercial Network Access Only" means any Covered Service provided to individuals enrolled in a commercial Product offered by an employer that contracts with a third party administrator ("TPA") that has access to an Affiliate, as defined in Section 1.1(ii) and Section 1.1(iii) of the Agreement, but for which Affiliate does not administer plan functions, but provides network access only.

D. Reimbursement Terms.

Reimbursement for Covered Services rendered pursuant to the Agreement shall be governed by the following payment terms:

HPI shall pay PROVIDER the lower of PROVIDER's billed charges or the rates set forth in the then-current applicable HPI fee schedule as defined below, which are incorporated into this Addendum by reference:

Member	Fee Schedule
Commercial	HPI Chemical Health Fee Schedule
Commercial Network Access Only	125% of the HPI Chemical Health Fee Schedule
Medicare	HPI Chemical Health Fee Schedule
State Public Programs	HPI Chemical Health Fee Schedule

If a fee has not been established by HPI for a particular service or procedure, PROVIDER shall be paid seventy percent (70%) of its billed charges.

Fee schedules and fee information, including the maximum fees payable for Covered Services, shall be as determined from time to time by HPI or an Affiliate. Upon request, HPI shall provide PROVIDER with a representative sample of applicable fee schedule information. HPI shall annually review its maximum fee schedule payment levels.

E. Default from Billed Charges.

PROVIDER shall provide HPI with its fee schedule in effect as of the Effective Date of this Agreement. This fee schedule shall form the basis by which PROVIDER shall determine its billed charges to HPI and its Affiliates. PROVIDER shall provide HPI with written notice at least thirty (30) days prior to the effective date of any change to PROVIDER's billed charges for such services.

If written notice is not provided prior to implementation, any increases in billed charges will be reconciled to the appropriate default percentage.

F. ***MinnesotaCare Tax.***

PROVIDER is subject to a tax on gross revenues in accordance with Minnesota Statutes 295.52, subd.1, as may hereafter be amended, substituted or supplemented ("MinnesotaCare"). MinnesotaCare allows PROVIDER to transfer the additional expense generated by MinnesotaCare taxation ("MinnesotaCare Tax") to third-party purchasers, such as HPI. The parties agree as follows:

Section 1. HPI will reimburse PROVIDER for MinnesotaCare Tax as defined in Minnesota Statute 295.52, subdivision 1.

Section 2. In the event PROVIDER is paid billed charges or on a discount from billed charges basis, HPI shall pay such billed charges or the agreed-upon discount percentage of PROVIDER's billed charges, as applicable, and the MinnesotaCare Tax shall be deemed to be included.

Section 3. Notwithstanding any term in this Section F that may be construed to be to the contrary, the PROVIDER shall be ultimately liable for the payment of any MinnesotaCare Taxes owed by the PROVIDER to the State of Minnesota.

G. ***Previous Terms.***

This Payment Addendum supersedes any agreement previously entered into between HPI and PROVIDER relating to the terms addressed in the Payment Addendum and no prior representations or agreements between the parties relating to the terms addressed in the Payment Addendum, whether oral or written, have any force or effect.

HEALTHPARTNERS, INC.		County of Aitkin	
By:	_____	By:	_____
Name:	_____	Name:	_____
Its:	Vice President,	Its:	_____
	Network Management and Provider Relations		_____
Date:	_____	Date:	_____
		Fed Tax ID:	41-6005749

SERVICES ADDENDUM
TARGETED CASE MANAGEMENT

The Participating Provider Agreement (the "Agreement") between HealthPartners, Inc. ("HPI") and County of Aitkin ("PROVIDER"), dated January 1, 2016, shall be governed by the following reimbursement terms set forth in this Services Addendum, including any Exhibit(s) and Attachment(s) attached hereto (collectively, "Services Addendum").

A. Scope.

This Services Addendum sets forth the terms for the provision of Targeted Case Management provided by PROVIDER to State Public Programs Members subject to the Agreement.

B. Term.

This Services Addendum shall be effective as of January 1, 2016. Notwithstanding the foregoing, nothing in this Services Addendum shall alter in any way the term of the Agreement or the parties' rights to terminate the Agreement as provided therein. The termination of this Services Addendum shall not result in the termination of the Agreement. Any termination of the Agreement shall result in automatic termination of this Services Addendum.

C. Governing Documents; Definitions.

In the event of a conflict between the Agreement and this Services Addendum, this Services Addendum shall control. Unless otherwise specifically defined herein, all capitalized terms in this Services Addendum shall have the meanings ascribed to them in the Agreement. The following additional definitions apply to this Services Addendum.

Section 1. **"State Public Programs Member"** means an individual eligible and enrolled to receive Covered Services through a State Public Programs Product. "State Public Programs Product" means a Product entered into by the Minnesota Department of Human Services (or its agents) and HPI or a Related Organization pursuant to which HPI or a Related Organization pays for, provides and/or arranges for health care services and supplies to individuals eligible to participate in such governmental plans.

Section 2. **"Targeted Case Management"** or **"TCM"** means services for adults who have a Severe and Persistent Mental Illness ("SPMI") and children/adolescents who are diagnosed with Severe Emotional Disturbance ("SED"). TCM consists of face-to-face contact between the Targeted Case Manager and the State Public Programs Member, at least monthly. Contacts may be supplemented by telephonic contact. TCM consists of the following four core services:

1. Assessment of an eligible individual to determine service needs

2. Development of a specific care plan based on the information collected through the assessment.
3. Referral and related activities to help an individual obtain needed services.
4. Monitoring and follow up activities to ensure that the care is effectively implemented and adequately addresses the needs of the individual. Monitoring and follow up activities may be with the individual, family members, providers or other entities.

Services excluded from TCM include but may not be limited to the following:

1. Direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred, for example, helping an individual move to new housing.
2. Activities integral to the administration of foster care programs
3. Activities for which third parties are liable to pay
4. Skills training and rehabilitation services
5. Therapy
6. Adult Rehabilitative Mental Health Services
7. Child Therapeutic Support Services
8. Diagnostic assessment
9. Medication management or administration
10. Transportation services
11. Legal services
12. Community support services
13. Determination of eligibility

D. ***Providers Eligible to Render TCM.***

The following providers are eligible to render TCM:

1. Case management supervisors
2. Case manager associates (CMAs)
3. Case managers
4. Immigrant case manager

Qualifications of above providers shall be consistent with the qualifications required by the Minnesota Department of Human Services ("DHS"). All providers who render TCM are subject to the same continuing education requirements as specified by DHS.

E. ***Members Eligible to Receive TCM.***

To be eligible to receive TCM State Public Programs Members must meet the definitions specified in MN Stat. 245.4871, Subd. 5 and Subd. 6 (for children) or MN Stat. 245.462 subd. 3 (for adults).

F. ***Annual Review Process***

HPI and PROVIDER will meet on an annual basis to review the Targeted Case Management services provided by PROVIDER. This review will include but is not limited to:

1. Case load size requirements as defined by state and federal regulations;
2. Adequate documentation to support claims;
3. Performance of county referral partners; and
4. Compliance with state and federal regulations

G. ***Collaboration with HPI.***

PROVIDER shall collaborate with HPI regarding the TMC implementation process. PROVIDER and HPI agree to work together to put processes into place to address the needs of the member and keep administration of the TCM benefit as streamlined as possible. This collaboration includes defining reporting requirements, standardization of forms and documentation requirements.

H. ***Coding and Documentation.***

Section 1. TCM coding: Appropriate coding for TCM includes:

T2023 HA targeted case management per month under 18 years
T2023 HE targeted case management per month 18 years and older
T2023 HE U4, telephonic contact 18 years or older

Section 2. TCM documentation:

PROVIDER agrees to maintain documentation in members' file that is consistent with state and federal guidelines. Documentation will be subject to the annual review specified in Section F of this Services Addendum.

I. ***Government Audit Process.***

If as a result of a government audit, including but not limited to a CMS audit, payment for TCM services are disallowed and HPI is required to return funds, PROVIDER shall reimburse HPI for all such funds paid by HPI to PROVIDER for such disallowed services.

For purposes of this Section funds would only be paid to HPI if HPI's obligation to return the funds is a result of PROVIDER's failure to meet the TCM requirements specified in this Services Addendum.

J. ***Reimbursement Terms.***

HPI will reimburse PROVIDER for rendering TCM to eligible State Public Programs Members pursuant to terms specified in Attachment A, which is attached to this Services Addendum.

K. ***Previous Terms.***

This Services Addendum supersedes any agreement previously entered into between HPI and PROVIDER relating to the terms addressed in the Services Addendum and no prior representations or agreements between the parties relating to the terms addressed in the Services Addendum, whether oral or written, have any force or effect.

HEALTHPARTNERS, INC.		COUNTY OF AITKIN	
By:	_____	By:	_____
Name:	Charles Abrahamson	Name:	_____
Its:	Vice President, Network Management and Provider Relations	Its:	_____
Date:	_____	Date:	_____
		Fed Tax ID:	41-6005749

ATTACHMENT A TO
SERVICES ADDENDUM
TARGETED CASE MANAGEMENT

A. ***Reimbursement Rate.***

Pursuant to state requirements HPI will reimburse PROVIDER for the following TCM services at the corresponding rate specified below as agreed upon by PROVIDER and host county.

CODE	RATE
T2023 HA-Child	$996.00
T2023 HE-Adult	$371.00
T2023 U4 HE-Adult Telephonic	$371.00

On an annual basis PROVIDER will notify HPI in writing of the rates agreed upon by PROVIDER and host county for the TCM services corresponding to each of the codes specified above. HPI will implement the new rates within 30 days of receipt of the written notice.

B. ***MinnesotaCare Tax.***

PROVIDER is subject to a tax on gross revenues in accordance with Minnesota Statutes 295.52, subd.1, as may hereafter be amended, substituted or supplemented ("MinnesotaCare"). MinnesotaCare allows PROVIDER to transfer the additional expense generated by MinnesotaCare taxation ("MinnesotaCare Tax") to third-party purchasers, such as HPI. The parties agree as follows:

Section 1. HPI will reimburse PROVIDER for MinnesotaCare Tax as defined in Minnesota Statute 295.52, subdivision 1.

Section 2. In the event PROVIDER is paid billed charges or on a discount from billed charges basis, HPI shall pay such billed charges or the agreed-upon discount percentage of PROVIDER's billed charges, as applicable, and the MinnesotaCare Tax shall be deemed to be included.

Section 3. Notwithstanding any term in this Section F that may be construed to be to the contrary, the PROVIDER shall be ultimately liable for the payment of any MinnesotaCare Taxes owed by the PROVIDER to the State of Minnesota.

PAYMENT ADDENDUM

Compensation for Home Care Services

The Participating Provider Agreement (the "Agreement") between HealthPartners, Inc. ("HPI") and County of Aitkin ("PROVIDER"), dated January 1, 2016, shall be governed by the following reimbursement terms set forth in this Payment Addendum, including any Exhibit(s) and Attachment(s) attached hereto (collectively, "Payment Addendum").

A. **Scope.** This Payment Addendum sets forth the reimbursement terms for Covered Services provided to Members subject to the Agreement.

B. **Term.** This Payment Addendum shall be effective as of January 1, 2016. Notwithstanding the foregoing, nothing in this Payment Addendum shall alter in any way the term of the Agreement or the parties' rights to terminate the Agreement as provided therein. Any termination of the Agreement shall result in automatic termination of this Payment Addendum.

C. **Governing Documents; Definitions.** In the event of a conflict between the Agreement and this Payment Addendum, this Payment Addendum shall control. Unless otherwise specifically defined herein, all capitalized terms in this Payment Addendum shall have the meanings ascribed to them in the Agreement. The following additional definitions apply to this Payment Addendum.

Section 1. "Commercial Member" includes:

1.1 **"Assigned Member"**: means an individual eligible and enrolled to receive Covered Services through a Product that (i) requires the individual to be assigned to a primary care clinic, and (ii) for certain services rendered outside of the care system, as defined by the HPI Administrative Program, requires that the individual have a recommendation for services to access health care services from PROVIDER.

1.2 **"Self Accessing Member":** means an individual eligible and enrolled to receive Covered Services through a Product that does not require the individual to have a recommendation for services to access health care services from PROVIDER.

Section 2. "Medicare Member" means: an individual eligible and enrolled to receive Covered Services through (i) a Medicare Cost Product, as defined in the Medicare Cost Addendum, (ii) a Product entered into by HPI or a Related Organization for the purpose of issuing a Medicare supplemental policy or certificate, as set forth in Minnesota Statutes, Section 62A.31 *et. seq.*, and/or (iii) a Product entered into by HPI or a Related Organization for the purpose of issuing a Medicare select policy or certificate, as set forth in Minnesota Statutes, Section 62A.318.

Section 3. "State Public Programs Member" means an individual eligible and enrolled to receive Covered Services through a State Public Programs Product. "State Public Programs Product" means a Product entered into by the Minnesota Department of Human Services (or its agents) and HPI or a Related Organization pursuant to which HPI or a Related Organization pays for, provides and/or arranges for health care services and supplies to individuals eligible to participate in such governmental plans.

Section 4. "Commercial Network Access Only" means any Covered Service provided to individuals enrolled in a commercial Product offered by an employer that contracts with a third party administrator ("TPA") that has access to an Affiliate, as defined in Section 1.1(ii) and Section 1.1(iii) of the Agreement, but for which Affiliate does not administer plan functions, but provides network access only.

D. **Reimbursement Terms.** Reimbursement for Covered Services rendered pursuant to the Agreement shall be governed by the following payment terms:

HPI shall pay PROVIDER the lower of PROVIDER's billed charges or the rates set forth in the then-current applicable HPI fee schedule as defined below, which are incorporated into this Addendum by reference:

Member	Fee Schedule
Commercial	HPI Maximum Fee Schedule
Commercial Network Access Only	125% of the HPI Maximum Fee Schedule
Medicare	HPI Maximum Fee Schedule
State Public Programs	HPI Public Programs Fee Schedule

HPI will not reimburse PROVIDER for any therapies, products, or services not listed in the HPI Maximum Fee Schedule.

It is understood and agreed that said Fee Schedule sets forth the full amounts PROVIDER may claim for payment of Covered Services provided hereunder. Miscellaneous fees or charges which are incidental to, or not directly related to PROVIDER's provision of Covered Services, including but not limited to, pick-up and delivery services, supervisory or case management services, internal transfer charges, and charges directly related to academic teaching, research or experimentation, shall not qualify for reimbursement under this Agreement. PROVIDER will coordinate laboratory services, including drawing and delivery of required samples to a PROVIDER as designated by HPI and communication of the results to the Member's Physician who recommends PROVIDER's services; provided, however, that this provision will not require nor be construed to require PROVIDER to bear financial responsibility for the cost of such laboratory services.

Fee schedules and fee information, including the maximum fees payable for Covered Services, shall be as determined from time to time by HPI or an Affiliate. Upon request, HPI shall provide PROVIDER with a representative sample of applicable fee schedule information. HPI shall annually review its maximum fee schedule payment levels.

E. **MinnesotaCare Tax.** PROVIDER is subject to a tax on gross revenues in accordance with Minnesota Statutes 295.52, subd.1, as may hereafter be amended, substituted or supplemented ("MinnesotaCare"). MinnesotaCare allows PROVIDER to transfer the additional expense generated by MinnesotaCare taxation ("MinnesotaCare Tax") to third-party purchasers, such as HPI. The parties agree as follows:

Section 1. In the event PROVIDER is paid on a HPI fee schedule, HPI shall add a percentage equal to the then-current MinnesotaCare Tax to the applicable HPI fee schedule rate.

Section 2. In the event PROVIDER is paid billed charges or on a discount from billed charges basis, HPI shall pay such billed charges or the agreed-upon discount percentage of PROVIDER's billed charges, as applicable, and the MinnesotaCare Tax shall be deemed to be included.

Section 3. Notwithstanding any term in this Section E. that may be construed to be to the contrary, the PROVIDER shall be ultimately liable for the payment of any MinnesotaCare Taxes owed by the PROVIDER to the State of Minnesota.

F. **General Responsibilities of PROVIDER and Special Services.**

1. PROVIDER warrants that it is, and during the course of this Agreement will continue to be, operating as a duly qualified home health agency certified pursuant to U.S.C., Title 42, Section 186(o) and appropriately licensed by the state wherein services are being provided. PROVIDER agrees to meet the Medicare and/or state licensing qualifications.

2. PROVIDER agrees to educate and provide required training to Members upon initiation of Covered Services. All such member education will be conducted by appropriate professional staff. Upon request, PROVIDER shall submit documentation of the completion of such training to HPI including an acknowledgment from the Member and the Practioner that adequate information and training has been provided.

3. PROVIDER agrees to have the services of professional staff available on a twenty-four (24) hour on-call emergency basis to respond to requests for assistance by Members receiving Covered Services and requests for services that must be handled outside the routine hours of business.

G. **Previous Terms.** This Payment Addendum supersedes any agreement previously entered into between HPI and PROVIDER relating to the terms addressed in the Payment Addendum and no prior representations or agreements between the parties relating to the terms addressed in the Payment Addendum, whether oral or written, have any force or effect.

HEALTHPARTNERS, INC.		**COUNTY OF AITKIN**	
By:		By:	
Name:	Charles Abrahamson	Name:	
Its:	Vice President, Network Management and Provider Relations	Its:	
Date:		Date:	
		Fed Tax ID:	41-6005749