HEALTHPARTNERS
VENDOR AGREEMENT

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

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 VENDOR for the provision of health care services to such Members.

B. VENDOR is a duly licensed entity and VENDOR desires to provide certain health care services and supplies 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 **"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 to under the applicable Product. The term "Certificate of Coverage" includes, without limitation, summary plan descriptions.

Section 1.4 **"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 1.5 **"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 1.6 **"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 1.7 **"Copayment"** means the flat dollar amount for a Covered Service that a Member is responsible for under the Member's Certificate of Coverage.

Section 1.8 **"Covered Services"** means those health care services and supplies available under the applicable Plan, as described in the applicable Certificate of Coverage.

Section 1.9 **"Deductible"** means the dollar amount for a Covered Service that the Member is responsible for under the Member's Certificate of Coverage.

Section 1.10 **"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 VENDOR or as made available to VENDOR via electronic means. HPI shall communicate the HPI Administrative Program to VENDOR 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 1.11 **"Member"** means any person eligible and enrolled to receive Covered Services through a Product.

Section 1.12 **"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 1.13 **"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 PFSS Product"), as may be amended from time to time.

Section 1.14 **"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.

ARTICLE II
VENDOR SERVICES

Section 2.1 **Provision of Services.**

(a) Provision of Covered Services. VENDOR will 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. VENDOR will make available to Members all health care services that it makes available to the general public; provided, however, VENDOR 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 VENDOR is not authorized by law to provide. All Covered Services will be provided in accordance with Medicare requirements and accepted standards of care. 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 VENDOR to patients who are not Members.

(b) Standard. VENDOR will provide such Covered Services in accordance with the standard of practice in the community in which VENDOR renders Covered Services and in a manner so as to assure quality of care and treatment.

(c) Change to Practice. VENDOR will not make any changes to its present staff, organization or facilities that would render the VENDOR incapable of carrying out its obligations under the terms of this Agreement. VENDOR 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.

(d) Member Education. VENDOR will 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, VENDOR will submit documentation of the completion of such training to HPI including an acknowledgement of the Member and the HPI physician that adequate information and training has been provided.

Section 2.2 **Availability of Services.** VENDOR will provide Covered Services 24-hours a day, 365 days a year. After office hours (evenings, weekends, and holidays) will be covered by VENDOR's staff. VENDOR will respond to phone requests within one (1) hour if necessary and same day delivery if order is placed by 2:00 p.m.

Section 2.3 **Sites.** VENDOR 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 VENDOR within thirty (30) days of receiving such notice.

Section 2.4 **VENDOR Qualifications.** VENDOR will be and 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 VENDOR practices and/or provides services. VENDOR will notify HPI in writing within ten (10) days of any termination, restriction, suspension, revocation, stipulation, adverse limitation or other disciplinary action, corrective action plan or investigation regarding any license, privileges, registration, certification, accreditation or other authorization.

Section 2.5 **Recommendation for Services.** VENDOR 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.

Notwithstanding the foregoing, nothing in this Section 2.5 is intended or will be construed as delegating to VENDOR any of HPI's utilization review obligations required to be carried out by HPI under applicable law.

Section 2.6 **Facilities and Equipment.** VENDOR 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 2.7 **Management Responsibilities.** The operation and maintenance of the offices, facilities and equipment of VENDOR will be solely and exclusively under the control and supervision of VENDOR. 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 VENDOR'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 VENDOR as manager, proprietor, lessor or otherwise.

Section 2.8 **HPI Administrative Program.** VENDOR will cooperate and comply with all rules and requirements of the HPI Administrative Program. VENDOR will 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 VENDOR without electronic connection capabilities. VENDOR 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 VENDOR quality assurance, quality improvement, and utilization management activities.

Section 2.9 **Warranty.** VENDOR represents and warrants that Covered Services are in compliance with all applicable laws, including without limitation, the applicable sections of Title 21 of the Food, Drug and Cosmetic Act and regulations thereto. This warranty includes, but is not limited to, a warranty by VENDOR that Covered Services are not "adulterated" or "misbranded" as set forth in 21 U.S.C. §312, 351-352. Further, VENDOR warrants that it has good title which is free and clear of all encumbrances. No applicable warranties, whether express or implied, are intended to be disclaimed or diminished by the terms of this Agreement.

Section 2.10 **Return Policy.** VENDOR will have a return policy applicable to Covered Services purchased by a Member under this Agreement, and VENDOR will provide a copy of such policy to HPI for approval, which approval will not be unreasonably withheld.

ARTICLE III
CARE MANAGEMENT COOPERATION

Section 3.1 **Quality Improvement.** VENDOR 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. VENDOR 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 VENDOR at its sole expense and VENDOR will not charge any Member for the cost of providing such data unless specifically authorized by law.

Both HPI and VENDOR mutually and cooperatively agree to practice the principles and philosophy of Continuous Quality Improvement (CQI) in the spirit of developing an improved working relationship to better understand and service HPI member needs. Both Parties agree to explore any mutual interest in joint outcomes studies as well as looking at referral guidelines and process improvement opportunities.

In addition, VENDOR will establish and maintain a program of continuous quality improvement of clinical care that applies to Members to whom VENDOR provides Covered Services pursuant to this Agreement. This program will use clinical practice guidelines that are developed by VENDOR or obtained by VENDOR from another source and formally approved by VENDOR. 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.

VENDOR 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, VENDOR 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 VENDOR.

Section 3.2 **Utilization Management.** VENDOR 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, and medical case management policies and procedures, and the review and audit of VENDOR'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 VENDOR 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.** VENDOR 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.

VENDOR will maintain medical, financial and administrative records related to services provided to Members or any other VENDOR obligations under this Agreement for a minimum of seven (7) years from the date service is rendered to a Member or such longer period as may be 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, VENDOR 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. VENDOR'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 VENDOR at its sole expense and VENDOR 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 VENDOR, whether verbally or in writing, VENDOR will immediately encourage the Member to contact HPI to resolve such Complaint. If a Member submits a

Complaint, whether verbally or in writing, VENDOR will investigate such Complaint and use its best efforts to resolve it in a fair and equitable manner. VENDOR 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. VENDOR will designate a person or persons who will be responsible for handling Complaints. VENDOR will cooperate with HPI in resolving any Complaint submitted to VENDOR by a Member, or any other grievance involving or impacting the VENDOR and which is filed by a Member with HPI or a regulatory entity. The VENDOR 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 VENDOR 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 VENDOR will participate in satisfaction surveys. VENDOR may be requested to take any reasonable steps necessary to correct any deficiencies revealed by such surveys. HPI will allow VENDOR an opportunity to review the results of the satisfaction survey specific to VENDOR. If the level of satisfaction with VENDOR, as measured by such surveys, deteriorates substantially or is substantially below the level of other VENDORs affiliated with HPI, VENDOR will, at the request of HPI and to HPI's satisfaction, promptly prepare and implement a corrective action plan. Upon request by HPI, VENDOR 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.** VENDOR will cooperate with HPI in its marketing of Products. HPI, its Affiliates and/or Related Organizations may publish information regarding VENDOR including, without limitation, VENDOR'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 VENDOR 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). VENDOR hereby authorizes and consents to disclosure of VENDOR's National Provider Identifiers on HPI's website and HPI's and Related Organizations' Provider directories.

VENDOR may, with HPI's prior written consent, engage in marketing activities designed to promote VENDOR as being a participating VENDOR of HPI. Any materials VENDOR uses in connection with its marketing activities related to the services rendered by VENDOR 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, VENDOR will adhere to HPI's drug formulary when filling prescriptions. If a drug or Covered Service 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 VENDOR to communicate freely with Members regarding the treatment options available to them including, without limitation, alternative products and services, 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 vendors or facilities to which vendors may direct Members for specified procedures. Such designated and/or preferred networks may or may not include VENDOR. HPI may at any time and from time to time require prior authorization or prior notification for specified procedures performed within or outside of such designated and/or preferred networks. HPI will notify VENDOR, in writing, of such specified procedures, any prior authorization or prior notification requirements, and the respective designated and/or preferred network. For such specified procedures, when clinically and geographically appropriate, VENDOR will utilize the HPI designated and/or preferred networks.

Section 3.10 **Patient Safety Program.** VENDOR 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 VENDOR to participate in local and national patient safety initiatives. Furthermore, VENDOR will submit to HPI, upon request, documentation and/or performance improvement measurements related to VENDOR's patient safety program.

Section 3.11 **Audit.** VENDOR shall cooperate with the review and audit of VENDOR's obligations under this Agreement by HPI or an entity authorized by HPI to ensure VENDOR'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, VENDOR shall provide access to HPI or Related Organization to VENDOR's premises and financial, medical, and administrative records and policies relevant to the services provided under this Agreement, including, without limitation, any report VENDOR is required to make to HPI under this Article III.

ARTICLE IV
COMPENSATION AND BILLING PROCEDURES

Section 4.1 **Compensation for Authorized Covered Services.** HPI or its designee will pay, and VENDOR 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.

Notwithstanding any term in this Agreement or in documents referenced in this Agreement to the contrary, the obligation to pay VENDOR 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 VENDOR 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 VENDOR 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 VENDOR 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 Copayments, Coinsurance and/or Deductibles. If a Member receives Covered Services from VENDOR which are subject to a Copayment, Coinsurance and/or Deductible, VENDOR'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 VENDOR. VENDOR 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 VENDOR by HPI or its designee.

Section 4.3 **Services Rendered Outside the Scope of Applicable Authorization.** In the event VENDOR performs services different from or in addition to those authorized by HPI as required under a Member's Certificate of Coverage, or in the event a Member seeks services beyond those so-authorized, VENDOR will bill Member for such services, but only upon first obtaining the Member's written acknowledgement in advance of rendering such services, that the services are not Covered Services and will not be paid by HPI or its Affiliates. However, if Member is an SPP Member, as defined in the attached SPP Addendum, VENDOR will be entitled to bill Member, as provided above, only for "add-ons" but not "upgrades." Any upgrades provided to an SPP Member will be at the sole expense of VENDOR.

Section 4.4 **Notification and Prior Authorization.** VENDOR 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 VENDOR's ability to bill the Member for such unauthorized Covered Services and non-Covered Services are set forth in Section 4.8 below.

Section 4.5 **Billing Procedures.** VENDOR will directly bill HPI or its designee directly (as specified by HPI) for Covered Services rendered in accordance with this Agreement. VENDOR 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 VENDOR, HPI, its designees and its Affiliates.

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

HPI or its designee may return claims to VENDOR if HPI or the designee determines that the procedure and/or billing codes or other billing information is incorrect or missing, and VENDOR 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 VENDOR in accordance with industry coding standards, and will notify VENDOR of any such change through HPI's or the designee's standard remittance advice.

Furthermore, as a condition of receiving payment under this Agreement for a Clean Claim, VENDOR 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. VENDOR may request that the Prompt Billing Period be extended to twelve (12) months in cases where VENDOR 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 VENDOR. HPI will review and act upon any request by VENDOR 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, VENDOR 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 VENDOR that the claim should be submitted for payment under this Agreement.

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 VENDOR on a quarterly basis.

Section 4.6 **Processing of Claims Adjustments.** Effective January 1, 2011, all adjustment and recoupment requests for Clean Claims which have been previously paid, whether initiated by HPI or by VENDOR, will be initiated with reasonable specificity, within twelve (12) months of the date of service in question. Such claims adjustments initiated by HPI or VENDOR may include, without limitation, requests for return of overpayments or payment errors.

Notwithstanding the foregoing, Effective January 1, 2011, the 12-month 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.

The provisions set forth in this Section 4.6 will survive any termination of this Agreement.

Section 4.7 **Exclusive Payment (Non-Recourse).** VENDOR 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 VENDOR from collecting Copayments, Coinsurance, Deductibles, or fees for uncovered services.

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.

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

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

If VENDOR 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 4.7, VENDOR may do so, but only if the VENDOR 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 4.8 **Failure to Obtain Appropriate Authorization/Recommendation for Services.** Notwithstanding any term in this Agreement to the contrary (including, without limitation, Section 4.7 above):

(a) VENDOR will not be entitled to payment under this Agreement if: (i) VENDOR'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, VENDOR 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 4.4 above); or (iii) VENDOR failed to comply with the recommendation for services and secondary recommendation for services requirements for Assigned Members outlined in the HPI Administrative Program; and

(b) in any circumstance set forth in subsections (a)(i), (a)(ii), or (a)(iii) above, VENDOR 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, VENDOR may bill the Member: (i) VENDOR requested authorization from HPI, but HPI denied such authorization; (ii) the Member requested that VENDOR provide the non-Covered Service or unauthorized Covered Service; (iii) VENDOR 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, VENDOR 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 4.9 **Insurance Information and Coordination of Benefits.** VENDOR will make a good faith effort to secure information on the sources of third party coverage available to any Member for whom VENDOR provides Covered Services, and will forward such information to HPI. VENDOR 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. VENDOR will cooperate with HPI and provide reasonable assistance requested by HPI in connection with HPI's subrogation efforts.

Section 4.10 **Other Payment Sources.** VENDOR 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. VENDOR 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 VENDOR.** VENDOR 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 VENDOR'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 VENDOR 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, VENDOR will maintain insurance coverage for any liabilities that VENDOR 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 VENDOR and its permitted assigns, officers, directors, employees and agents (each a "VENDOR 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 VENDOR 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 VENDOR Indemnified Party for any performance, non-performance, delayed performance, act or omission by the VENDOR 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 **VENDOR's Insurance.** For the entire period that this Agreement is in force, VENDOR will maintain, at its sole expense, general liability and product liability insurance coverage in the amount of at least $1,000,000 per claim and $3,000,000 in the annual aggregate, as may be necessary to protect VENDOR 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, VENDOR will ensure that VENDOR 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.

Upon request by HPI, VENDOR will provide evidence of such insurance coverage. VENDOR 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 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. VENDOR will comply with the notification requirements in this Section 5.4 notwithstanding the VENDOR 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 VENDOR, 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 VENDOR, 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 VENDOR's receipt of HPI's written notice, following the occurrence of one or more of the following events: (i) if VENDOR 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 VENDOR'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) if the VENDOR 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; (vi) if VENDOR ceases or suspends providing services subject to this Agreement; or (vii) if HPI reasonably

believes VENDOR 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 on the findings 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 VENDOR 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.** 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.

Upon termination of this Agreement, VENDOR 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 VENDOR. Similarly, HPI will turn over to the VENDOR all tangible personal property, if any, belonging to VENDOR.

In the event of HPI's insolvency, VENDOR 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.

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

Section 6.4 **Review of Communication.** HPI and VENDOR 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

In the event any dispute arises between the Parties concerning this Agreement, the concerned Party will notify the other Party in writing of the existence of the dispute and the notifying Party's desire to try informally to resolve the dispute. Following such notice, the Parties will meet and confer in good faith to resolve such dispute. In the event such efforts do not succeed in resolving the dispute within thirty (30) days from the date the Parties first met to confer, the Parties will submit the dispute to informal mediation before a mediator mutually agreeable to the Parties. If the Parties are unable to agree upon a mediator, or if such mediation does not resolve the dispute, it will be submitted to binding arbitration pursuant to the Commercial Arbitration Rules of the American Arbitration Association. The award of the arbitrator(s) will be final and binding upon the Parties, and either Party may have judgment entered upon the award by any court of competent jurisdiction. This provision will survive 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). VENDOR represents and warrants to HPI that it has never been Sanctioned. At no time during the term of this Agreement will VENDOR (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"). VENDOR will notify HPI, in writing, in the event any of the following individuals and/or entities are Sanctioned: (i) VENDOR, (ii) an employee or agent of VENDOR who renders Designated Services, (iii) an entity with which an employee or agent of VENDOR has ownership or controlling interest, or (iv) an entity, or an employee or agent of an entity, with which VENDOR contracts to provide Designated Services. Notwithstanding anything in this Agreement to the contrary, VENDOR will not be entitled to any payment under this Agreement for any services and/or supplies furnished by a Sanctioned individual or entity. VENDOR 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.** VENDOR represents that all of its Covered Services offered through this Agreement have been manufactured and packaged by VENDOR under all the rules and regulations set forth by the United States Food and Drug Administration. 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, VENDOR 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, VENDOR 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. VENDOR 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 VENDOR'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 VENDOR 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 VENDOR hereunder; provided, however, that such disclosure is neither false nor misleading and does not disclose specific reimbursement rates paid by HPI to VENDOR.

(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) **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 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, or as long as the Party maintains the information.

(f) **Injunctive Relief.** Each Party will be entitled to 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.

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

Section 9.3 **Discrimination.** VENDOR 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 VENDOR 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 VENDOR each expressly reserve the right to enter into the same or similar arrangements with other individuals or organizations.

Section 9.6 **Assignment.** VENDOR'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 VENDOR's consent, in which case VENDOR'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 VENDOR. It is agreed, however, that in the event VENDOR 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 VENDOR, such amendment will not go into effect until mutually agreed to by VENDOR 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 VENDOR 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.** VENDOR represents and warrants that this Agreement will be valid and binding obligation of VENDOR , enforceable in accordance with its terms; and (ii) VENDOR 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 Service 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 VENDOR, 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 J. Abrahamson	Name:	_____
Its:	Vice President,	Its:	_____
	Network Management and Provider Relations		_____
Date:	_____	Date:	_____
		Fed Tax ID:	41-6005749

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.

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 VENDOR'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, VENDOR 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 VENDOR and its Subcontractors related to any aspect of the provision of health care services provided to Medicare Cost Members. For these same time periods, VENDOR 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.*** VENDOR 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.*** VENDOR will, and will cause each Subcontractor to, ensure that:
   a. the VENDOR'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.

   VENDOR 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.*** VENDOR 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.*** VENDOR 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.*** VENDOR 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 VENDOR 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 VENDOR's or Subcontractor's organization; and (ii) to whom and for what purposes the VENDOR or Subcontractor will disclose the information outside of the VENDOR'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 VENDOR 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 VENDOR 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 VENDOR 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, VENDOR 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, VENDOR will, and will cause each Subcontractor to agree, that VENDOR 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. VENDOR 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 VENDOR 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 Facility, 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 VENDOR 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 VENDOR and/or Subcontractor, including Medicare laws and regulations. VENDOR will ensure that all written arrangements between VENDOR 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. VENDOR will, and VENDOR will cause each of its Subcontractors to, comply with all applicable Medicare laws, regulations and CMS instructions.

2. VENDOR will, and VENDOR 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. VENDOR will, and VENDOR 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. VENDOR will, and VENDOR 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. VENDOR 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. VENDOR and Subcontractors will certify, in writing, the completeness, truthfulness and accuracy of all such data. VENDOR 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 VENDOR or any Subcontractor is at "substantial financial risk," as defined in the Rules, then VENDOR 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. VENDOR 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 VENDOR and or any Subcontractor is at "substantial financial risk," as defined in the Rules.

4. VENDOR 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.

VENDOR 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 Facility, 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, VENDOR will, and will cause each Subcontractor to, be certified for participation in Medicare.

K. QUALITY AND UTILIZATION MANAGEMENT PROGRAMS.

VENDOR 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.

VENDOR 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.

Facility 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. Facility 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.

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 VENDOR'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. VENDOR 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; and

    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 VENDOR 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, VENDOR 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. VENDOR 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.

VENDOR 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 VENDOR 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 VENDOR, 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.** VENDOR 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.** VENDOR shall:

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

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

3. SPP Member Rights. VENDOR 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. **VENDOR** 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 VENDOR 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. VENDOR 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. VENDOR 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. VENDOR shall ensure, and shall cause each Physician and Allied Health Professional to ensure, that SPP Members have effective communications with each of VENDOR's or Subcontractor's employees or agents in making decisions regarding treatment options. Further, VENDOR 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, VENDOR should take to ensure meaningful access to Covered Services by SPP Members who have limited English proficiency.

F. **FRAUD AND ABUSE REQUIREMENTS.**

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

2. VENDOR 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. VENDOR 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. VENDOR 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.

   VENDOR 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.

   VENDOR 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.**

VENDOR 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. **VENDOR SUBCONTRACTORS.**

VENDOR 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. VENDOR 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, VENDOR 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 VENDOR ("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.

VENDOR shall obtain, and shall require all Physicians and Allied Health Professionals to obtain, National Provider Identifier ("NPI") numbers. VENDOR shall use the NPI to identify VENDOR 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,

VENDOR 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, VENDOR shall comply with the following:

1. VENDOR 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. VENDOR shall certify, in writing, the completeness, truthfulness and accuracy of all such data. VENDOR shall cooperate with HPI when it addresses any inquiries from the State regarding the accuracy of data submitted. VENDOR shall also ensure that subcontractors meet the same requirements;

2. If the VENDOR is at "substantial financial risk," as defined in 42 CFR § 422.208, then VENDOR 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. VENDOR shall cooperate with HPI in connection with HPI's obligations to conduct periodic surveys of current and former SPP Members in instances where VENDOR is at "substantial financial risk."

M. BUSINESS CONTINUITY PLAN.

1. If HPI contracts with VENDOR for Priority Services, VENDOR 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. VENDOR shall notify HPI immediately whenever there is a change in VENDOR'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 VENDOR 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 VENDOR's primary case clinic is not functioning.

d. include procedures to reverse the process once the external environment permits VENDOR 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 VENDOR's location.

2. If VENDOR uses a subcontractor to furnish Priority Services to SPP Members, VENDOR 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.

VENDOR acknowledges and agrees that VENDOR 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 VENDOR. VENDOR 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 Vendor Agreement (the "Agreement") between County of Aitkin (Vendor) and HealthPartners, Inc. (HPI) will be governed by the following reimbursement terms. These reimbursement terms will govern payment for all Covered Services rendered to all Members by Vendor.

Section 1. 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.

Section 2. Governing Documents; Definitions.

In the event of a conflict between the Agreement and this Addendum, the terms and conditions of this Addendum will control. In the event of a conflict between this Addendum and the HPI Administrative Program, the terms and conditions of this Addendum will control. Unless otherwise specifically defined in this Addendum, all capitalized terms in this Addendum will have the meaning ascribed to them in the Agreement. This Addendum is hereby incorporated into the Agreement and is an integral part thereof.

Section 3. Reimbursement Rates.

Reimbursement for Covered Services rendered pursuant to the Agreement will be governed by the terms set forth in this Addendum below:

HCPC	Description	Fee
T2003-RP	Pick up	$5.00
T2003-PR	Drop off	$5.00
A0080	Rate per mile	$0.85

Section 4. Definition of Government Products.

Government Products includes all HealthPartners Care plans, MinnesotaCare programs and all HPI sponsored Medicare Products.

Section 5. Lesser of Billed.

All payments for all Covered Services outlined in this Addendum will be at the lesser of the contracted rates established herein or eligible billed charges.

Section 6. Affiliates.

At HPI's option, Covered Services rendered to Members covered by Affiliates will be reimbursed at the rates set forth herein.

Section 7. E Codes Reporting Requirement.
Vendor agrees, for any Member's injury, to E Code in the Vendor medical record and on the UB92 submitted to HPI (i.e., the external cause of injury and specific place of occurrence).

Section 8. Vendor Charge Master Increase.
Vendor will notify HPI in writing thirty (30) days in advance of any change in the overall Vendor charge master for services provided to HPI Members during the term of this Agreement. For services paid as a percent of billed charges, the applicable discount rate will be increased at any time during the term of this Agreement when the charge master increase is greater than National CPI-U based on the weighted average of care volume for those services provided in the prior year. There will be no adjustment if the difference is less than one-half percent. Upon HPI's request, Vendor will provide any and all necessary information to HPI or an independent third party engaged by HPI for the purpose of verifying the underlying calculation of the overall charge master change for total services.

HealthPartners, Inc.	County of Aitkin
By:_____	By: _____
Printed Name: _____	Printed Name:_____
Title: Vice President, Health and Care Management	Title:_____
Date: _____	Date: _____
	Federal Tax ID# 41-6005749