ONECARE VERMONT ACCOUNTABLE CARE ORGANIZATION, LLC
VERMONT MEDICARE ACO INITIATIVE PROGRAM ADDENDUM

THIS VERMONT MEDICARE ACO INITIATIVE PROGRAM ADDENDUM ("ACO Program Addendum") is attached and made part of the First Amended and Restated Risk Bearing Participant and Preferred Provider Agreement ("the Agreement") in place between ACO and Participant or Preferred Provider (collectively the "Parties"). To the extent any terms of this ACO Program Addendum conflict with terms of the Participant Agreement that are not explicitly amended herein, the applicable terms of this ACO Program Addendum or the ACO Program rules applicable to the Participant or Preferred Provider, shall control.

BACKGROUND

ACO has entered into the Vermont Medicare ACO Initiative Program Agreement with the Centers for Medicare and Medicaid Services ("CMS") and the Green Mountain Care Board ("GMCB") through which the ACO will participate in the Vermont Medicare ACO Initiative (the "Program"), an alternative payment and population health management program. The Vermont Medicare ACO Initiative succeeds the Medicare Next Generation Model. The Vermont Medicare ACO Initiative Program Agreement ("Program Agreement") will be available on the ACO Provider Portal and is incorporated by reference into this ACO Program Addendum. ACO, Participant and Preferred Provider agree to participate in the Program as provided herein and are committed to performing ACO Activities, as that term is defined in the Program Agreement.

NOW, THEREFORE, the Parties agree as follows:

1.0 VERMONT MEDICARE ACO INITIATIVE PROGRAM PARTICIPATION

1.1 Participation. Participant and Preferred Provider agree to participate in the Program, to engage in ACO Activities, to comply with the applicable terms of the Program as set forth in the Program Agreement and to comply with all applicable laws and regulations. This compliance includes, but is not limited to, compliance with the authorities listed below including the provisions in the Program Agreement relating to the following: (1) Participant exclusivity; (2) quality measure reporting; (3) continuous care improvement objectives for Participants and Preferred Providers; (4) voluntary alignment; (5) Beneficiary freedom of choice; (6) benefit enhancements; (7) the coordinated care reward; (8) participation in evaluation, shared learning, monitoring and oversight activities; (9) the ACO Compliance Plan; (10) ACO Policies; and (11) audit and record retention requirements.

1.2 Updating Information. Participant and Preferred Provider are each required to update its Medicare enrollment information (including the addition and deletion of Providers, identified at the NPI level, that have reassigned to the Participant or Preferred Provider

their right to Medicare payment) on a timely basis in accordance with Medicare program requirements.

1.3 Authority to Bind. Participant warrants that it has the authority to and does bind itself and employees, including each Provider with an NPI number billing under its TIN who is included on the Program Participant List, to the Participant Agreement and this Program Addendum. Preferred Provider warrants that it has the authority to and does bind itself and employees, including each Provider with an NPI number whose services are billed under Preferred Provider's TIN, to the Participant Agreement and this Program Addendum.

1.4 Providers in Good Standing with Vermont and Medicare. Participant and Preferred Provider will each, for itself and for each Provider associated with and billing individually or collectively under its TIN, maintain a current Medicare provider agreement in good standing and be duly licensed and remain in good standing with the appropriate state licensing board.

1.5 Patient Record Requests. Participant and Preferred Provider will provide a Beneficiary with a copy of his/her medical records at no charge upon request by the Beneficiary, and facilitate the transfer of Beneficiary's medical record to another provider at Beneficiary's request.

1.6 Required Notices. Participant and Preferred Provider will provide ACO with the following notices:

1.6.1 All relevant information about any changes to Medicare enrollment information within thirty (30) days after the change.

1.6.2 All pertinent information about any investigation or sanction by the government or any licensing authority (including, without limitation, the imposition of program exclusion, debarment, civil monetary penalties, corrective action plans, and revocation of Medicare billing privileges) that could materially impact the ability to perform under this Program Addendum, immediately upon becoming aware of the triggering event.

1.7 Exclusivity. The exclusivity of the ACO Participants and ACO Preferred Providers is based on Program exclusivity requirements. ACO Participants or ACO Preferred Provider Participants whose TIN includes NPIs of a "Primary Care Practitioner" who bills "Qualified Evaluation and Management" services (as both terms are defined by the Program Agreement) may not participate in more than one Medicare Alternative Payment Model or with any other accountable care organization in which they attribute or align Medicare lives. Nothing in this paragraph shall be interpreted to preclude a Participant or Preferred Provider whose TIN does not include NPIs of Primary Care Practitioners, from participation in more than one accountable care organization participating in the Program. These exclusivity provisions are based on the Program rules and are subject to

change if the Program rules change.

2.0 PAYMENT

2.1 Form of Payment. Participant and Preferred Providers will be paid according to Medicare's normal payment methodology unless otherwise provided in the Program of Payment. Annually, at least 60 days before the Performance Year termination or non-renewal deadline as set forth in the Agreement, ACO will develop and provide Participants and Preferred Providers with a Program of Payment. Participation in ACO may result in a change in the methodology or level of payment for delivering services to Beneficiaries whether payment is made by ACO, Medicare or a combination of the two or ACO's delegate. All payment methodologies and formulas will be made pursuant to a Program of Payment approved by the Board of Managers after receiving the necessary Program financial information from Medicare. The Board of Managers reserves the right to amend or alter the Program of Payment at any time as a result of material changes in ACO's circumstances, such as nonpayment by Medicare, Medicare revoking All Inclusive Population Health Payments or a regulatory directive to make changes.

2.1.1 Additionally, on the schedule set forth in section 2.1 above ACO will provide each non fee-for-service Participant, in writing, a description of the preliminary Program of Payment applied to the individual Participant and an estimated Maximum Risk and Sharing Limit specific for the individual Participant, based on the information available from Payer and other available data sources at that time. These estimates will contain sufficient data for an informed decision on participation and to be used for budgeting and planning by Participants. As soon as practical after the first day of a Performance Year when final attribution information has been provided to the ACO by Payer, the Board of Managers will approve a final budget and Program of Payment for Participants. Each Participant will then execute an Exhibit 1 to this Program Addendum encompassing its individual final payment model and Final Maximum Risk and Sharing Limit. A Participant's Final Maximum Risk and Sharing Limit may not be amended without the Participant's consent.

2.2 Payment in Full. Participant and Preferred Provider will collect applicable copayments, coinsurance and/or deductibles from Beneficiaries in accordance with their Medicare benefits which are not affected by this Program and agree to accept any applicable copayment, coinsurance and/or deductible together with the payments provided for under this ACO Program Addendum as full reimbursement for services rendered.

2.3 Claims Submission. Participant and Preferred Provider will submit claims to CMS for processing in accordance with Medicare's applicable policies, including Medicare's timely filing requirements, but will receive reimbursement for services within the Program, as

outlined in this Section 2.0 and the Program of Payment for the applicable Performance Year.

2.4 Beneficiary Appeals and/or Grievances. Beneficiaries retain their rights to appeal claims determinations in accordance with 42 C.F.R. § 405, Subpart I. Participant and Preferred Provider will direct all appeals and/or grievances or payment disputes, related to this Program, to ACO and ACO will manage them in accordance with an ACO Appeals Policy that complies with Program requirements. Participant and Preferred Provider will continue to cooperate with CMS in the resolution of an Attributed Beneficiary's appeal or grievance.

3.0 TERM, REMEDIAL ACTION AND TERMINATION

3.1 Term. The term of this Program Addendum shall commence on January 1, 2023 and shall run through the last date of the last Performance Year for the Program, or December 31, 2023. Thereafter, this Agreement may be extended as agreed by the Parties.

3.2 Remedial Action.

a. ACO may take remedial action against a Participant or Preferred Provider including, but not limited to, imposition of a corrective action plan ("CAP"), reduction of payments, elimination of payments, offset of payments, denied access to ACO data systems, and termination of the Participant Agreement or this Program Addendum with the Participant or Preferred Provider to address material noncompliance with the terms of the Program or program integrity issues identified by ACO, the Green Mountain Care Board or CMS.

b. Participant or Preferred Provider with a dispute relating to ACO's performance of its obligations under this ACO Program Addendum, may appeal through the ACO Appeals Policy, if applicable, or initiate a dispute under the dispute resolution process of the applicable Program Agreement. Participant or Preferred Provider may not appeal or dispute any matter that ACO may not appeal or dispute under the Vermont Medicare Initiative ACO Program Agreement.

3.3 Termination. This Program Addendum will automatically terminate if the Participant Agreement terminates or if the Participant or Preferred Provider becomes ineligible to participate in Medicare, for any reason. This Program Addendum will terminate prior to the end of the Term, if CMS, CMMI or the Green Mountain Care Board requires the ACO to remove the Participant or Preferred Provider from the approved list of providers.

a. Participant or Preferred Provider may non-renew this Program Addendum for any Performance Year, if it does not wish to participate after receiving the Program of Payment, by providing written notice to ACO on or before August

31st of the year before the Performance Year commences (should Payer provide additional time to ACO to provide a final list of participating providers, ACO will adjust that deadline as permitted by ACO Program). By way of example, if Participant wishes to non-renew for Performance Year 2019, and ACO does not extend the deadline, notice must be given by August 31, 2018. Should Participant or Preferred Provider terminate or non-renew for any Performance Year, it will have no financial obligation to ACO for the Performance Year as to which it terminated or non-renewed, but must comply with Section 3.4.

b. ACO may terminate this ACO Program Addendum if, after evaluating the network of participants and the final financial terms for the Program, it determines not to participate in the Program and provides that notice to CMS in accordance with its deadline for ACOs to decline participation.

3.4 Close-Out, Performance Year Obligations. In the event this Program Addendum is terminated, or expires, Participant and Preferred Provider agree to complete a close-out process by furnishing all quality measure reporting data, including all claims or encounters for services rendered to Beneficiaries, to ACO. Moreover, a Participant, Preferred Provider and ACO will be required to meet all financial obligations for any Performance Year in which it participated in ACO for any period of time, even if not the full Performance Year, including Shared Losses and Savings.

IN WITNESS WHEREOF, the Parties have caused this Agreement to be executed by the duly authorized officers to be effective as of January 1, 2023.

ONECARE VERMONT ACCOUNTABLE CARE ORGANIZATION, LLC

By: _____ Date: _____
Victoria E. Loner
Chief Executive Officer

PARTICIPANT/PREFERRED PROVIDER

By: _____ Date: _____
Authorized Signature

Print Name: _____
Title: _____
Legal Business Name:
TIN: