FIRST AMENDED AND RESTATED
ONECARE VERMONT ACCOUNTABLE CARE ORGANIZATION, LLC
RISK-BEARING PARTICIPANT & PREFERRED PROVIDER AGREEMENT

Legal Business Name:
Contractual Address:

TIN:

This First Amended and Restated RISK-BEARING PARTICIPANT / PREFERRED PROVIDER AGREEMENT (the "Agreement") is by and between OneCare Vermont Accountable Care Organization, LLC ("ACO"), a Vermont limited liability company, and Participant or Preferred Provider, a health care provider or organization eligible to participate with ACO as defined below and organized under Vermont or New Hampshire law (each a "Party" and collectively, the "Parties") and is effective the date signed by the ACO. This Agreement replaces any Participant or Preferred Provider ("Affiliate") Agreement between the Parties for Performance Years 2019 through 2022.

WHEREAS, ACO is an accountable care organization that participates in alternative payment programs ("ACO Programs") with governmental and private payers (collectively referred to as "Payers ") and conducts ACO Activities;

WHEREAS, ACO and Participants and Preferred Providers agree to participate in an Organized Health Care Arrangement ("OHCA") as that term is defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA");

WHEREAS, Participant and Preferred Provider agree to participate in ACO Programs and all Parties are committed to being accountable for the quality, cost and overall care of the patients attributed to the ACO and will, with ACO's support, implement population health management processes to support that accountability; and

WHEREAS, the Parties agree to share in the financial outcomes from their joint efforts in population health management.

NOW, THEREFORE, the Parties agree as follows:

1.0 DEFINITIONS

The following terms shall have the meanings indicated. In the event an ACO Program Addendum varies from these definitions, the ACO Program Addendum definition will control for that ACO Program.

1.1 "ACO" means OneCare Vermont Accountable Care Organization, LLC, and more generally refers to a legal entity that is recognized and authorized under applicable State, Federal or Tribal law, is identified by a TIN, and is formed by one or more Providers that agree to work together to be accountable for the ACO Activities, as established by an ACO Program.

1.2 "ACO Activities" means activities related to promoting accountability for the quality, cost, and overall care for a patient population of beneficiaries aligned or attributed to the ACO under an ACO Program, including managing and coordinating care; encouraging investment in infrastructure and redesigned care processes for high quality and efficient service delivery; and carrying out any other obligation or duty of the ACO under this Agreement. Additional examples of these activities include, but are not limited to, providing direct patient care to ACO Program Beneficiaries in a manner that reduces costs and improves quality promoting evidence-based medicine and patient engagement; reporting on quality and cost measures under this Agreement; coordinating care for ACO Program Beneficiaries, such as through the use of telehealth, remote patient monitoring, and other enabling technologies; establishing and improving clinical and administrative systems for the ACO; meeting ACO Program performance standards by evaluating health needs of ACO Program Beneficiaries; communicating clinical knowledge and evidence-based medicine to ACO Program Beneficiaries; and developing standards for ACO Program Beneficiary access and communication, including ACO Program Beneficiary access to medical records.

1.3 "ACO Other Entity" means any entity that performs functions or services on behalf of an ACO or that works in collaboration with the ACO to accomplish ACO Activities, when that entity is not enrolled as a Participant or Preferred Provider but has entered into a contractual arrangement to collaborate or perform services with ACO, including, if applicable, a Business Associate Agreement. ACO Other Entities include, but are not limited to, contractors and consultants.

1.4 "ACO Policies" means generally ACO policies and procedures applicable to participation in ACO Programs. ACO Policies include, but are not limited to, privacy and security and data use policies, appeals policies, and the Clinical Model and its supporting policies.

1.5 "ACO Program" means a program between ACO and a Payer for population health management through an alternative payment arrangement or otherwise.

1.6 "ACO Program Addendum" means an addendum, attached hereto, that describes the program terms that govern the parties' obligations for that particular ACO Program.

1.7 "ACO Program Beneficiary" "Beneficiary" or "Attributed Life" means an individual that receives healthcare benefits from a Payer in an ACO Program and is attributed to ACO in accordance with the terms of an ACO Program Agreement.

1.8 "ACO Provider Portal" means the secure interface between ACO and Participant and Participant's Providers and Preferred Providers where ACO provides access to policies, procedures and other program information.

1.9 "Clinical Model" means the written ACO guidelines, processes and procedures for quality and cost effectiveness founded on three inter-related and mutually supporting elements of: (1) quality performance measure management; (2) care coordination; and (3) clinical data sharing.

1.10 "Health Care Services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

1.11 "NPI" means the National Provider Identifier unique ten-digit identification number required for all licensed health care providers.

1.12 "OHCA" means an "organized health care arrangement" recognized under HIPAA that allows two or more Covered Entities who are clinically or operationally integrated, to share protected health information about their patients to manage and benefit their joint operations.

1.13 "Participant" means an individual or group of Providers that is: (1) identified by a TIN; (2) included on any list of Participants submitted by ACO to Payers; (3) qualifies to attribute lives in ACO Programs; and (4) that has entered into a Risk Bearing Participant & Preferred Provider Agreement with ACO. Participant may be more particularly defined in each ACO Program.

1.14 "Payer" means the entity, which may be the ACO under certain ACO Programs, responsible for making financial payments or collecting Shared Risk under an ACO Program.

1.15 "Performance Year" means the twelve (12) month period measured by each ACO Program to determine financial reimbursement.

1.16 "Preferred Provider" or "Affiliate" means an individual or an entity that: (1) is identified by a TIN; (2) if required by ACO Payer(s), is included on the list of Preferred Providers submitted by ACO to Payer(s); (3) does not qualify to attribute lives in ACO Programs; and (4) has entered into a Risk Bearing Participant and Preferred Provider Agreement with ACO. Preferred Provider may be more particularly defined in each ACO Program.

1.17 "Provider" means a health care practitioner or entity that: (1) meets the terms of participation in ACO Programs; (2) bills for items and services furnished to ACO Program Beneficiaries under a Participant or Preferred Provider's TIN; and (3) is included on the list of Participants or Preferred Providers (if required by Payers) submitted by ACO to Payers.

1.18 "Shared Risk" or "Shared Loss" is more particularly defined by each ACO Program, but generally means the portion of Performance Year spending that was greater than expected spending that must be returned to Payer.

1.19 "Shared Savings" is more particularly defined by each ACO Program, but generally means the portion of Performance Year spending that was less than the expected spending.

1.20 "TIN" means a Federal taxpayer identification number or employer identification number or social security number for providers who bill Payers under their social security numbers.

2.0 ACO PROGRAM PARTICIPATION

2.1 Participation. Participants and Preferred Providers agree to be accountable for the quality, cost and overall care of ACO Program Beneficiaries by complying with the terms of this Agreement and following ACO Program rules and regulations, ACO Policies, and the Clinical Model. ACO will provide support services to Participants and Preferred Providers to facilitate efficient participation in the ACO Programs. Such support may include, but is not limited to, data reporting software and support, training, data analysis, data reporting and clinical leadership.

2.2 Qualification to Participate. Participant and Preferred Provider shall participate in each ACO Program that qualifies for All Payer Model Scale Targets, for which a Program Addendum is provided within the time frames set forth in paragraph 3.1 ("Core ACO Programs") and that is offered by a Payer for which Participant or Preferred Provider is an enrolled provider and in good standing, by signing an ACO Program Addendum for each such ACO Program. A Participant or Preferred Provider may, with ACO's approval, choose not to participate in a Core ACO Program if: (1) it shows good cause as determined by the ACO Core Program Exceptions Policy; (2) it demonstrates to the Board's reasonable satisfaction that the financial risk would jeopardize financial solvency thresholds established by Payer, ACO Program or the ACO; or (3) it demonstrates to the Board's reasonable satisfaction that the operational demands would materially negatively impact its operations or there is no resource capacity to fully participate in the clinical and quality programs of ACO. Additionally, ACO may offer non-Core ACO Programs which Participant and Preferred Provider may choose not to participate in for any reason. Participants, Providers and Preferred Providers will maintain good standing to provide services with each ACO Program Payer for which it is enrolled and will remain duly licensed in good standing to practice their professions in each state in which they practice. Any Participant who is eligible to align or attribute lives may only participate in one ACO Program per Payer, for example if an eligible aligning Participant is in Medicare NextGen or Vermont Medicare ACO Initiative, it may not be in MSSP. Nothing in this Agreement supersedes any of the terms and conditions of Participant's or Preferred Provider's enrollment in a Payer's insurance program unless the Payer's requirements have been waived or modified

in the Program Agreement between ACO and Payer. ACO, may, in its discretion, require additional reasonable verification of professional qualifications. Providers who are denied status as Participants or Preferred Providers, those who are not renewed for any reason and those who are terminated from OneCare will receive a written notice explaining the reason for denied status with instruction on how to appeal the decision to ACO, consistent with the ACO's Appeals Policy.

2.3 Authority to Bind Employees. Participant and Preferred Provider represent and warrant that it has the authority, as an employer, to require its Providers and employees to comply with the applicable terms of this Agreement, ACO Programs, and ACO Policies.

2.4 Management of Provider List. ACO retains the right to approve or disapprove new Providers and to terminate or suspend Participants, Providers and Preferred Providers for cause, in accordance with the applicable ACO Program Addendums, Clinical Model or ACO Policies. Participants and Preferred Providers agree to manage their lists of participating Providers with ACO by providing timely notices of changes, as required by Section 5. To the extent that any Provider or employee identified by an NPI linked to Participant's or Preferred Provider's TIN is excluded from an ACO Program, Participant or Preferred Provider will cooperate in de-linking or disassociating that Provider's NPI from the Participant's or Preferred Provider's TIN or ACO Program for purposes of billing applicable Payers.

2.5 Grievances and Appeals. Participants and Preferred Providers may submit grievances and appeal qualified ACO decisions in accordance with the ACO Appeals Policy, available on the ACO Provider Portal and incorporated herein by reference.

2.6 Participation in ACO Governance. Participants and Preferred Providers agree to participate in the ACO's governance by participating in the election or appointment of the Participant and Preferred Provider representative(s) to ACO's Board of Managers and participating in the selection of member(s) of the ACO clinical and quality committees and/or any sub-geographic or sub-specialty components of those committees.

3.0 PAYMENT

3.1 Payment. Annually, beginning for Performance Year 2020 at least sixty (60) days prior to the Performance Year non-renewal deadline as set forth in Section 4.1.1, ACO will implement a Program of Payment and supporting ACO Policies that will determine the methodology of payment to Participants and Preferred Providers for health care services, supplemental payments through the ACO and risk and sharing arrangements for ACO Programs. The Program of Payment is attached as Exhibits A, A1 and A2 and will be replaced by ACO each Performance Year with supporting ACO Policies at least sixty (60) days prior to the non-renewal deadline, except for PY 2019 in which it will be provided at least thirty (30) days

before the non-renewal deadline. Notwithstanding anything to the contrary herein, the Program of Payments will, subject to non-renewal and termination rights, be replaced by ACO annually on this schedule and will be effective as an amendment without requiring the Parties' signatures.

The ACO may, notwithstanding anything to the contrary in this Agreement, amend the Program of Payments to add available payments at any time (but not to remove or reduce any payments) which shall be effective as an Amendment without requiring the Parties' signatures. The ACO may amend the Program of Payments consistent with the terms of each ACO Program Addendum which shall control in the event of a conflict with this Agreement.

3.2 Supplemental Payments. As part of the Program of Payments, ACO may make supplemental payments to support ACO Activities, such as care coordination, for Participants and Preferred Providers who meet established criteria for those payments as set forth more fully in Exhibit A1. Consistent with Section 3.1, ACO will provide the supplemental payments policy as part of the Program of Payments for each Performance Year. Participants, Preferred Providers and Providers who accept these payments certify that they meet the requirements to receive the payments.

3.3 Risk/Savings Methodology. ACO will provide the Shared Risk/Savings Policy, as adopted by the ACO Board of Managers, as part of the Program of Payments in accordance with Section 3.1.

4.0 TERM AND TERMINATION

4.1 Term. This Agreement shall commence on the Effective Date and continue until the earlier of: (1) when Participant or Preferred Provider is no longer participating in an ACO Program; or (2) December 31, 2022. In the event that one ACO Program is terminated, but others remain in effect, this Agreement shall continue to be effective as it pertains to the remaining ACO Programs.

4.1.1 Program Year Non-Renewal. As more specifically set forth in each ACO Program Addendum, and consistent with the Core ACO Program requirements set forth in Paragraph 2.2 above, annually Participants and Preferred Providers may elect to terminate this Agreement or non-renew specific ACO Programs effective the first day of the next Performance Year by providing ACO with notice of termination or non-renewal before August 31st of the prior Performance Year (the "non-renewal" or "termination" deadline"). By way of example if a Participant's request to be excluded from a Core ACO Program is refused by the Board, the Participant may terminate the Agreement in its entirety or continue participation in all Core ACO Programs. ACO will, during the Modeling Period (as defined in Exhibit A) provide risk bearing Participants with sufficient financial detail to facilitate an informed decision for participation in ACO Programs including estimates

of expected payment and risk to support their participation decisions.

4.2 Termination with Cause. Either Party may terminate this Agreement upon a material breach by the other Party by providing sixty (60) days' prior written notice to the Party alleged to be in breach identifying, with specificity, such breach, but only in the event that the alleged breaching Party fails to cure same within the sixty (60) day notice period. In the event an ACO Program Agreement between ACO and a Payer terminates, or in the event Participant or Preferred Provider non-renews an ACO Program Addendum in accordance with paragraph 4.1.1. above, this Agreement shall only terminate with respect to those terminated ACO Programs and all others shall remain in full force and effect. ACO Program obligations for the last Performance Year of participation, such as quality reporting, obligations for Shared Risk and opportunities for Shared Savings will survive termination.

5.0 NOTICES

5.1 Required Notices. In addition to the disclosures that are required in an ACO Program Addendum, Participant and Preferred Provider shall notify ACO and ACO shall notify Participant and Preferred Provider, in writing, as provided below. To the extent a notice requirement in an ACO Program Addendum conflicts with or is more stringent than the notice requirements below, the shorter of the timeframes shall apply.

5.2 Immediate Notices.

5.2.1 ACO shall provide Participant and Preferred Provider with immediate written notice of the termination of ACO's participation in an ACO Program;

5.2.2 Each Party shall provide the other with immediate written notice in the event they or any Provider associated with their TIN is convicted of a fraud or felony, or suspended, barred or excluded from participation in a federal health care program (as defined in 42 U.S.C. § 1320a-7b(f));

5.2.3 Each Party shall provide the other with immediate written notice in the event of investigation or issuance of formal charges by any governmental agency or accrediting agency that could materially impair that Party's ability to perform its obligations under this Agreement;

5.2.4 Each Party shall provide the other with immediate written notice in the event of any lawsuit related to services under this Agreement or that might materially impair the Party's ability to perform its obligations under this Agreement;

5.2.5 Each Party shall provide the other with immediate written notice in the event it receives a written notice of any cancellation, non-renewal or change to any

insurance policy required under this Agreement that would affect the coverage required of the party under this Agreement; and

5.2.6 Participant and Preferred Provider shall provide ACO with immediate written notice in the event Participant or Preferred Provider are subject to discipline from or terminated from participation with any Payer.

5.3 Other Notices.

5.3.1 ACO shall provide Participant and Preferred Provider with thirty (30) business day's written notice prior to making any changes to the terms of ACO Program Addendums, unless the changes are made to comply with an applicable law or regulation, as more fully set out in Section 12.3.

5.3.2 Each Party shall provide the other notice, as soon as reasonably possible but no later than ten (10) days, in the event of a voluntary surrender or termination of any of Participant's, a Provider's, Preferred Provider's or ACO's licenses, certifications, or accreditations;

5.3.3 Each Party shall provide the other notice, as soon as reasonably possible after the occurrence of an act of nature or any event beyond its reasonable control which substantially interrupts all or a portion of its business or practice, or that has a materially adverse effect on its ability to perform its or his/her obligations hereunder; and

5.3.4 Participant and Preferred Provider shall provide ACO notice, as required by the applicable ACO Program Addendum, if any Provider becomes disassociated with Participant's or Preferred Provider's TIN for any reason.

6.0 RECORDS

6.1 Beneficiary and ACO Program Records. The Parties shall prepare, maintain, and protect the confidentiality, security, accuracy, completeness and integrity of all appropriate medical and other records related to the provision of care to ACO Program Beneficiaries (including, but not limited to, medical, encounter, quality, financial, accounting, administrative and billing records) in accordance with: (i) applicable state and federal laws and regulations including, but not limited to, applicable confidentiality requirements of HIPAA; and (ii) ACO Program billing, reimbursement, and administrative requirements. For Participants and Preferred Providers, such records shall include such documentation as may be necessary to monitor and evaluate the quality of care and to conduct medical or other health care evaluations and audits to determine, on a

concurrent or retrospective basis, the medical necessity and appropriateness of care provided.

6.2 Financial Records. The Parties shall maintain such financial and accounting records as shall be necessary, appropriate or convenient for the proper administration of this Agreement, in accordance with generally accepted accounting principles or another acceptable basis of financial accounting, including, but not limited to, income-tax-basis financial statements, cash-basis or modified-cash-basis financial statements, or another basis that is otherwise generally accepted by the accounting industry.

6.3 Sharing Records. Participant and Preferred Provider acknowledge that by becoming a Participant or Preferred Provider they are agreeing to participate in an OHCA and further acknowledge that Beneficiary records may be shared with other Participants, Preferred Providers, or ACO Other Entities for ACO Activities. In addition to OHCA sharing, Participant and Preferred Provider shall make the records available to and communicate as appropriate with each Participant, Preferred Provider, or ACO Other Entity, as needed, for the purpose of facilitating the delivery of appropriate Health Care Services to each ACO Program Beneficiary. Subject to applicable laws regarding confidentiality, Participant or Preferred Provider hereby authorizes ACO to release any and all information, records, summaries of records and statistical reports specific to Participant or Preferred Provider, including but not limited to utilization profiles, encounter data, treatment plans, outcome data and other information pertinent to Participant's or Preferred Provider's performance of services and professional qualifications to federal or state governmental authority(ies) with jurisdiction, or any of their authorized agents, accreditation agencies, or ACO Program Payers without receiving Participant's or Preferred Provider's prior consent.

6.4 Survival. The provisions of this Section 6 shall survive termination of this Agreement.

7.0 REPORTING AND MONITORING

7.1 Reporting. Participant and Preferred Provider shall, consistent with any limitations arising from 42 CFR Part II, report such data from its Electronic Health Records ("EHR") system or medical records as ACO may reasonably require to monitor the cost and quality of services, including care coordination services. By way of example and not limitation, ACO expects that it will require clinical data from electronic or paper health records, scheduling data, patient satisfaction survey data, and care coordination data. Participant and Preferred Provider will, consistent with any limitation arising from 42 CFR Part II, cooperate in connecting its information systems to ACO, or ACO's designee, in order to facilitate the exchange of clinical and cost related data in furtherance of the requirements of the applicable ACO Program. Participant and Preferred Provider, consistent with any limitation arising from 42 CFR Part II, each agree to enter into an agreement with

Vermont Information Technology Leaders, or a successor health information exchange provider ("HIE"), to forward clinical information regarding ACO Program Beneficiaries from Participant's or Preferred Provider's EHR to a third-party data repository designated by ACO, or any successor data repository, analytics, or case management system provider ("Data Repository"). Participant and Preferred Provider authorize ACO to direct HIE to forward clinical information to the Data Repository and authorizes Data Repository to de-identify protected health information sent by Participant and Preferred Provider, aggregate that de-identified data with other de-identified data and use the aggregated, de-identified data for Data Repository's data reporting, analytics purposes, and other data purposes. Participant and Preferred Provider authorize ACO to seek individually identifiable health information ("IIHI") regarding ACO Program Beneficiaries from any sources to be directed through the Data Repository for ACO purposes.

7.2 Data from ACO. ACO will provide Participant and Preferred Provider with data and information to support their participation in ACO Programs. Such data and information will include access to and reports from WorkBench One or any successor platform, the ACO analytics platform for benchmarking and evaluating clinical, quality and financial performance in ACO Programs. Additionally, Participant and Preferred Provider may request data reports at no cost from ACO to evaluate performance. ACO will promptly provide an acknowledgement of the request and work in good faith with Participant or Preferred Provider to accurately and timely provide responsive information.

7.3 Monitoring. ACO and ACO Program Payers may make requests of Preferred Provider under this section. Risk bearing Participants may make requests of ACO under this section. Subject to applicable confidentiality laws and standards of reasonable conduct in monitoring activities, within twenty (20) business days following a written request reasonably identifying the reason for and scope of the monitoring audit, the requesting party shall provide the other or its designees (which may include an independent auditor), access during regular business hours for: (i) inspection and copying of all records maintained by the party subject to the request relating to the ACO Program services, including, but not limited to, medical, financial, quality accounting, administrative and billing records); (ii) access to records to assess the quality of care or investigating grievances and complaints of ACO Program Beneficiaries; (iii) policies and procedures for quality assurance, utilization review, financial policies, fraud and abuse investigation; and (iv) inspection of Participant's or Preferred Provider's facilities, policies and procedures for verification of professional qualifications, claims payment verification, and other activities reasonably necessary for the efficient administration of the ACO, and as reasonably necessary for compliance with federal and state law or requirements.

Any monitoring audit costs will be borne by the requesting party.

7.4 Survival. The provisions of this Section 7 shall survive termination of the

Agreement.

8.0 COMPLIANCE

8.1 ACO Program Rules, Clinical Model and ACO Policies. Participant and Preferred Provider agree to support, comply with, and implement the Clinical Model, the ACO Compliance Program and ACO Policies. The Parties acknowledge that the Clinical Model is an iterative, data driven model developed with the participation of the ACO's network of Providers that will include ACO-wide initiatives as well as HSA specific initiatives and that may vary over the course of this Agreement.

Participant and Preferred Provider shall cooperate with ACO's care coordination protocols, which may include: permitting ACO to conduct telephonic and on-site utilization management and quality assurance activities; and/or requiring Participant or Preferred Provider to coordinate with ACO or other Participant or Preferred Provider hospital's or facility's care coordinators regarding the care of ACO Program Beneficiaries. Participant and Preferred Provider acknowledge that sharing of provider identifiable quality and cost data is a core component of ACO's Programs and consent to the sharing of such information. Participant and Preferred Provider shall implement such cost and quality control protocols or other interventions as may be adopted by ACO regarding the care of ACO Program Beneficiaries.

ACO shall make new or revised policies available to Participants on the ACO Provider Portal at least thirty (30) days prior to their implementation unless those policies are changed to achieve regulatory or legal compliance for which immediate effectiveness is required. For changes that are not legal or regulatory in nature and that present material administrative burden or material expense to Participants or Preferred Providers, ACO will work collaboratively on the methods and timing for implementation. Changes to ACO Policies supporting the Program of Payment may only be made in accordance with Section 3 of this Agreement.

Participant and Preferred Provider also agree to participate in the ACO's Compliance Program including, but not limited to, participating in audits, attending compliance training, ensuring Participant's and Preferred Provider's policies are consistent or do not conflict with the ACO Program Rules, Clinical Model or ACO Policies, educating Participant's and Preferred Provider's staff and reporting instances of non-compliance.

8.2 Applicable Law. Participant, Preferred Provider and ACO shall comply with all applicable laws and regulations governing participation with the ACO which include, but are not limited to, federal laws such as the False Claims Act, Anti-Kickback Laws, Civil Monetary Penalties Laws, Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), HITECH and Stark. Participant and Preferred Provider shall comply with the provisions set forth in the Business Associate and Qualified Service Organization Agreement, attached hereto as **Exhibit B**. Participant, Preferred Provider, and their Providers also agree to comply with the ACO Policies which are incorporated herein by reference and will

be made available to Participant and Preferred Provider. Compliance may include Participant, Preferred Provider, and Provider compliance training.

8.3 Failure to Comply. Failure to comply with the terms of this Agreement, the applicable ACO Program Addendum or ACO Policies may result in remedial processes and penalties including progressive discipline, reductions of payment, elimination of payments, offsets in payment for amounts owed or termination of this Agreement as to the Participant, Preferred Provider or a Provider.

9.0 CONFIDENTIALITY

9.1 Beneficiary Information. Beneficiary information, which may or may not include individually-identifiable protected health information, will be managed in accordance with ACO's HIPAA-compliant Privacy and Security Policy, ACO's Data Use Policy, and the Business Associate and Qualified Service Organization Agreement, attached hereto as **Exhibit B**.

9.2 Proprietary Information. The Parties acknowledge that each may disclose confidential and proprietary information (by way of example and not limitation, policies and procedures, records, formulas) to the other in the course of performance of this Agreement. All information so disclosed which is not otherwise publicly available shall be deemed confidential and shall not be further disclosed by the receiving Party without the prior written consent of the original disclosing Party. Upon termination of this Agreement, for any reason, each party shall return to the other all electronic and printed materials containing confidential or proprietary information received from the others, that it is not required to retain pursuant to this Agreement or law or certify to the other that those materials have been destroyed.

9.3 Survival. The obligations of this Section 9 shall survive termination of this Agreement.

10.0 INSURANCE

10.1 Professional Insurance. Participant or Preferred Provider who is not a hospital, ambulatory service center, or a Federally Qualified Health Center enjoying the privileges of Federal Tort Claim Act immunity, at its sole cost and expense, shall procure and maintain such professional liability insurance as is necessary to insure Participant, Preferred Provider and each of its respective Providers, employees, agents and representatives with coverage limits of not less than one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) in annual aggregate in the performance of any act relating to this Agreement. Upon request, Participant, Preferred Provider or Provider, as appropriate, agree to submit to ACO a certificate of insurance as evidence of such coverage. In the event any such professional liability policy is a "claims made" policy, Participant or Preferred Provider will purchase a "tail" policy, effective upon the termination of the primary

policy, or obtain replacement coverage which insures for prior acts, insuring for losses arising from occurrences during the term of this Agreement, which tail policy or prior acts coverage shall have the same policy limits as the primary policy and shall extend the claims reporting period for the longest period for which coverage is available. Participant and Preferred Provider agree to provide ACO with immediate written notice of any cancellation, non-renewal or change to such policy.

10.2 Hospital Insurance. Participant or Preferred Provider who is a hospital or ambulatory service center, at its sole cost and expense, shall procure and maintain such policies of insurance as are necessary to insure Participant or Preferred Provider and all Providers, employees, agents and representatives with coverage limits of not l**e**ss than one million dollars ($1,000,000) per occurrence, three million dollars ($3,000,000) in annual aggregate, and five million dollars ($5,000,000) excess coverage in the performance of any act relating to this Agreement. Upon request, Participant or Preferred Provider agrees to submit to ACO a certificate of insurance as evidence of such coverage. In the event any such liability policy is a "claims made" policy, Participant or Preferred Provider will purchase a "tail" policy, effective upon the termination of the primary policy, or obtain replacement coverage which insures for prior acts, insuring for losses arising from occurrences during the term of this Agreement, which tail policy or prior acts coverage shall have the same policy limits as the primary policy and shall extend the claims reporting period for the longest period for which coverage is available.

10.3 ACO Insurance. ACO, at its sole cost and expense, shall procure and maintain such policies of insurance in such amounts as are customarily maintained by ACOs or as required by ACO Programs. This shall include, at a minimum, general liability and property coverage with limits no less than one million dollars ($1,000,000) per occurrence, two million dollars ($2,000,000) in annual aggregate.

11.0 INDEMNIFICATION

Unless prohibited by Federal Tort Claim immunity or other law(s), Participant or Preferred Provider, on behalf of itself and its Providers, shall indemnify, defend and hold harmless ACO, its subsidiaries and Preferred Providers and each of their respective officers, directors, agents, representatives, successors, assigns and employees (the “ACO Parties”) from and against any and all claims, suits, actions, liabilities, losses, injuries, damages, costs and expenses, interest, awards or judgments, incurred by ACO (including reasonable attorney’s fees) as a result of any claim made by a third party in connection with the performance of this Agreement or any negligence or breach of the obligations and/or warranties of Participant or Preferred Provider, except to the extent the claims or losses are caused by the negligence or willful misconduct of ACO.

ACO shall defend, indemnify and hold harmless Participant or Preferred Provider, its subsidiaries and Providers and each of their respective officers, directors, agents, representatives, successors, assigns and employees (the “Participant

Party/ies") from and against any and all claims, suits, actions, liabilities, losses, injuries, damages, costs and expenses, interest, awards or judgments, incurred by Participant Party/ies (including reasonable attorneys' fees) as a result of any claim made by a third party against Participant Party/ies to the extent arising out of or relating to the ACO's negligence or breach of its obligations, representations or warranties set forth in this Agreement, except to the extent such claims or losses are caused by or result from the negligence or willful misconduct of any Participant Party.

If any claim or action is asserted that would entitle a Party to indemnification, the Parties shall give written notice thereof to the indemnifying party promptly; provided however, that the failure of the Party seeking indemnification to give timely notice hereunder shall not affect rights to indemnification, except to the extent that the indemnifying party is materially prejudiced by such failure. The indemnifying party shall have sole control over the defense of the claim, provided that the indemnifying party shall not settle, or make any admission of liability or guilt without first obtaining the Indemnified Party's written consent which shall not be unreasonably withheld or delayed. The obligations of this Indemnification provision shall survive expiration or termination of the Agreement.

12.0 GENERAL PROVISIONS

12.1 Entire Agreement. This Agreement, including Exhibits, ACO Program Addendums and any documents incorporated by reference constitute the entire agreement between the Parties regarding participation in ACO Programs and supersedes any agreements prior its execution. In the event of any conflict between this Agreement and an ACO Program Addendum, the terms of the ACO Program Addendum shall control.

12.2 Successors and Assigns. This Agreement shall not be assigned by either Party without the written consent of the other Party, which consent shall not be unreasonably withheld.

12.3 Amendments This Agreement may be amended or modified in writing as mutually agreed upon by the Parties, unless otherwise stated herein. ACO may unilaterally modify any provision of this Agreement upon thirty (30) days prior written notice to Participant or Preferred Provider if the amendment is reasonably needed to comply with federal or state laws or regulations.

12.4 Independent Contractor Relationship. None of the provisions of this Agreement between or among ACO, Participant, Preferred Provider, Providers, or Payers is intended to create any relationship other than that of an independent contractor relationship.

12.5 No Third-Party Beneficiaries. Except as specifically provided herein by express language, no person or entity shall have any rights, claims, benefits, or powers

under this

Agreement, and this Agreement shall not be construed or interpreted to confer any rights, claims, benefits or powers upon any third party.

12.6 Section Headings. All Section headings contained herein are for convenience and are not intended to limit, define or extend the scope of any provisions of this Agreement.

12.7 Severability. In the event any part of this Agreement is determined to be invalid, illegal or unenforceable under any federal or state law or regulation, or declared null and void by any court of competent jurisdiction, then such part shall be reformed, if possible, to conform with the law and, in any event, the remaining parts of this Agreement shall be fully effective and operative so far as reasonably possible to carry out the contractual purposes and terms set forth herein.

12.8 Waiver of Breach. The waiver by either Party of a breach or violation of any provision of this Agreement shall not operate as, or be construed to be, a waiver of any subsequent breach or violation of this Agreement.

12.9 Notices. Notices and other communications required by this Agreement shall be deemed to have been properly given if emailed or mailed by first-class mail, postage prepaid, or hand delivered to the following address:

ACO: OneCare Vermont Accountable Care Organization, LLC
356 Mountain View Drive, Suite 301, Colchester, VT 05446
Attn: Director of ACO Program Operations
Email: ACONetworkOperations@onecarevt.org

Participant/Preferred Provider: Address located on title page of this Agreement

12.10 Counterparts, Signatures: This Agreement may be executed in multiple counterparts, each of which shall be deemed an original, but all of which shall constitute one and the same instrument. Any signature delivered by facsimile machine, or by .pdf, .tif, .gif, .jpeg or other similar attachment shall be treated in all manner and respect as an original executed counterpart and shall be considered to have the same binding legal effect as if it were the original signed version thereof delivered in person.

IN WITNESS WHEREOF, the Parties have caused this Agreement to be executed by the duly authorized officers to be effective as of the date executed by ACO indicated below.

ONECARE VERMONT ACCOUNTABLE CARE ORGANIZATION, LLC

By: _____ Date: _____
Todd B. Moore
Chief Executive Officer

PARTICIPANT/PREFERRED PROVIDER

By: _____ Date: _____
Authorized Signature

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

Exhibit A
PERFORMANCE YEAR 2019 PROGRAM OF PAYMENT

Definitions.

"Deductions from Payment" means the financial contributions to OneCare for administrative funding, population health management and care coordination fees, payment pilots, the Value Based Incentive Fund, and other OneCare board-approved programs that are retained by ACO from a risk bearing Participant's Gross Fixed Payments.

"Gross Fixed Payments" means the total prospective, fixed payments payable to a risk bearing Participant as calculated for each ACO Program before incorporating the Deductions from Payment.

"Hospital Service Area" or "HSA" means the local health care markets for hospital care that are measured by collections of zip codes whose residents receive most of their hospitalizations from the hospitals in that area. Zip codes are assigned to the hospital area where the greatest proportion of their Medicare residents were hospitalized.

"Initial Attribution" means the attribution to the ACO at the beginning of the Performance Year. Attribution may decline during the course of the Performance Year, due to attrition or other factors, but it may not increase beyond the Initial Attribution level. Payments that are based on Attribution will vary during the course of the Performance Year.

"Maximum Risk and Sharing Limit" or "MRL" means the limit of the financial settlement payment exchange between Participant and ACO, either to or from the Participant, that a Participant will be required to assume in an ACO Program for a Performance Year. The total MRL is the sum of all individual ACO Program MRLs. By way of example, if a Participant's Final MRL for Medicare NextGen were $100,000; for Medicaid NextGen were $50,000 and for Blue Cross were $75,000 the total Final MRL would be $225,000 and Participant would not be required to pay more than $225,000 for Shared Losses and would not receive more than $225,000 in Shared Savings.

"Modeling Period" means the time period in advance of the beginning of a Performance Year, during which ACO will provide its best estimates of the expected attribution, payments and risk that will be finalized after the beginning of the Performance Year. During the Modeling Period ACO uses its best judgment as to expected ACO Program terms, attribution, and risk corridors based on all available data that it continues to update ACO-wide models and Participant specific data during this period.

"Supplemental Care Coordination Payments" means payments that are made to qualifying Participants and Preferred Providers by OneCare to support care coordination activities that generally do not receive reimbursement from Payers.

"Supplemental Population Health Management Payments" means payments that are made to qualifying Participants or Preferred Providers by OneCare to support population health management activities that generally do not receive reimbursement from Payers.

"Total Cost of Care" means, generally, the Payer's financial cost of providing qualifying health care services to ACO's Attributed Lives for a Performance Year. An Estimated Total Cost of Care is set between ACO and Payers before the Performance Year, and the ACO's performance is measured by the difference between ACO Program Estimated Total Cost of Care and ACO Program Actual Total Cost of Care (the Payer's actual cost). Each Program Agreement between ACO and a Payer will more particularly describe components of Total Cost of Care for that Program, for example, pharmacy may be excluded from some Programs' calculations of Total Cost of Care.

"Total Cost of Care PMPM Benchmark" means the Estimated Total Cost of Care expressed on a per attributed life per month, risk adjusted basis and that is used as the basis for calculating the Estimated Total Cost of Care to evaluate spending performance for the ACO.

"Value Based Incentive Fund" or "VBIF" means funding that is set aside by ACO during the Performance Year to incentivize and reward the network. The funds are reserved by ACO from Risk Participants' prospective payments at levels required by the ACO Program Agreements. The funds are earned under each ACO Program by meeting set criteria (usually performance on designated quality measures) established in each ACO Program Agreement and unearned funds may revert to the Payers. Once earned by the ACO, the VBIF funds will be distributed to the network with 70% allocated to attributing primary care providers based on attribution. The remaining 30% will be distributed to the remainder of the network based on proportions of Performance Year Total Cost of Care allocable to qualified providers.

Calculations.

Deductions from Payments are established by the Finance Committee, recommended to and adopted by the Board of Managers and are subject to the Green Mountain Care Board's budget authority for ACOs and hospitals. Deductions from Payments are intended to be equitably determined and are generally calculated by:

1. Determining the revenue sources and expected revenue amounts for the ACO's Performance Year.
2. Determining the expected expenses for the ACO's Performance Year, including Population Health Management and Care Coordination fees to the network; administrative expenses; Board approved payment pilots and other programs and the Value Based Incentive Fund.
3. Subtracting #2 from #1 to determine the difference between the expected expenses and the expected revenues, or the revenues required to balance the budget.
4. Determining the expected amount of Population Health Management and Care

Coordination (collectively hereinafter “PHM”) fees participating hospitals will receive as a result of participation during the Performance Year.

5. Subtracting #4 from #3 to determine the “net hospital contribution.”
6. Allocating #5 between risk bearing hospital Participants based on Net Patient Services Revenue as reported in the latest approved Green Mountain Care Board filing.
7. Adding each hospital’s specific expected PHM receipts to their allocation of #6 to calculate each hospital’s “gross fixed payment deduction.”
8. Dividing each hospital’s “gross fixed payment deduction” between risk based ACO Programs for each hospital based on the HSA’s attribution proportion.
9. Making equitable adjustments to the model as the Finance Committee and Board determine are appropriate and compliant.

The Gross Fixed Payments are calculated differently for each program:

Medicare: Calculated by CMS in an AIPBP calculation file provided to ACO.

Medicaid: By calculating each hospital’s historical spend for OneCare Attributed Lives on a PMPM basis for each applicable Medicaid aid category using available modeling data for the Performance Year network composition, trending that spend profile forward in alignment with the overall program TCOC benchmarks, and factoring in any observed shifts in service delivery patterns or Attribution mix between hospitals. The resulting PMPMs are multiplied by the attribution for the corresponding aid category and added together to determine the Gross Fixed Payment to begin the Performance Year. Payments for future months will reflect the Attribution attrition experienced throughout the network and adjust payments based on the HSA from which the life was formerly attributed.

BCBSVT: By calculating each hospital’s historic spend for OneCare Attributed Lives on a PMPM basis for each aid category using available modeling data for the Performance Year network composition, trending that spend profile forward in alignment with the overall Program TCOC benchmarks, and factoring in any observed shifts in service delivery patterns or attribution mix between hospitals. The resulting PMPMs are multiplied by the attribution for the corresponding aid category and added together to determine Gross Fixed Payment to begin the Performance Year. Payments for future months will reflect the Attribution attrition experienced throughout the network and adjust payments based on the HSA from which the life was formerly attributed.

The Maximum Risk and Sharing Limit is calculated by applying the ACO Program risk corridors and sharing arrangements to each HSA’s calculated TCOC for the lives initially attributed. The HSA TCOC is determined by calculating each HSA’s historical spend on a PMPM basis for each aid category (if applicable) using available modeling data for the Performance Year network composition, trending that spend forward in alignment with the overall program TCOC benchmarks, and factoring in any observed shifts in service delivery patterns or attribution mix

between HSAs. The resulting PMPMs are multiplied by the attribution for the corresponding aid categories and added together (if applicable) to determine the TCOC. The Maximum Risk and Maximum Savings potentials are symmetrical.

The Initial Attribution is calculated by the Payer and reflects the starting number of Attributed Lives to OneCare as a whole. The Attributed Lives are subsequently assigned to Providers or Practices based on their relationships for health care services. Attribution will change throughout the year based on continued eligibility of the patients.

Performance Year 2019 Program of Payment - Risk

Provider Type – TIN	Payment
Hospitals	• **At Financial Risk Quantified in ACO Program Addendums and Maximum Risk Sharing Level Exhibit** • All Inclusive Population Based Payment (or equivalent prospective payment) where ACO Program allows • If not AIPBP or equivalent, according to Payer's normal payment methodology • Supplemental Population Health Management payments for Attributed Lives[1] • Potential supplemental Care Coordination payments for Attributed Lives[2] • Shared Risk/Loss Potential[3] • Shared Savings Opportunity[4] • Value Based Incentive Fund Opportunity[5]
Independent Primary Care	• **NOT at Financial Risk** • According to Payer's normal payment methodology • Supplemental Population Health Management payments for Attributed Lives • Potential supplemental Care Coordination payments for Attributed Lives • Shared Savings Opportunity • Value Based Incentive Fund Opportunity
FQHCs	• **NOT at Financial Risk** • According to Payer's normal payment methodology • Supplemental Population Health Management payments for Attributed Lives • Potential supplemental Care Coordination payments for Attributed Lives

[1] See Exhibit A1.
[2] See Exhibit A1.
[3] See Exhibit A2.
[4] See Exhibit A2.
[5] See Exhibit A1.

	• Shared Savings Opportunity • Value Based Incentive Fund Opportunity
Independent Specialty Care	• **NOT at Financial Risk** • According to Payer's normal payment methodology • Shared Savings Opportunity • Value Based Incentive Fund Opportunity
Continuum of Care - Home Health & Hospice - Designated Agencies - Skilled Nursing Facilities	• **NOT at Financial Risk** • According to Payer's normal payment methodology • Potential supplemental payments for Care Coordination • Shared Savings Opportunity Value Based Incentive Fund Opportunity

2019 Performance Year Program of Payment – Upside Savings Only

Provider Type – TIN	Payment
Hospitals	• According to Payer's normal payment methodology • Supplemental Population Health Management payments for Attributed Lives • Potential supplemental Care Coordination payments for Attributed Lives • Shared Savings Opportunity • Value Based Incentive Fund Opportunity
Independent Primary Care	• According to Payer's normal payment methodology • Supplemental Population Health Management payments for Attributed Lives • Potential supplemental Care Coordination payments for Attributed Lives • Shared Savings Opportunity • Value Based Incentive Fund Opportunity
FQHCs	• According to Payer's normal payment methodology • Supplemental Population Health Management payments for Attributed Lives • Potential supplemental Care Coordination payments for Attributed Lives • Shared Savings Opportunity • Value Based Incentive Fund Opportunity
Independent Specialty Care	• According to Payer's normal payment methodology • Shared Savings Opportunity • Value Based Incentive Fund Opportunity
Continuum of Care - Home Health & Hospice - Designated Agencies - Skilled Nursing Facilities	• According to ACO Program Payer's normal payment methodology • Potential supplemental payments for Care Coordination • Shared Savings Opportunity • Value Based Incentive Fund Opportunity

Exhibit A1

2019 Performance Year Supplemental Payments

1. Population Health Management - $3.25 Per Attributed Life Per Month

Paid monthly to a Participant that is or whose TIN contains, a primary care practice(s) that routinely meet(s) the following criteria for those ACO Programs in which Payers fund this payment. While this is paid on a TIN level, it is measured on the Practice level and each Practice, as reflected on the TIN's roster of providers will be measured separately as follows:

(a) Each Practice will respond to a survey as to their compliance with the requirements for this payment before the beginning of the Performance Year;
(b) Practices that certify they comply with all requirements will be eligible for payments;
(c) Practices that certify that they do not comply with one or more requirements will work with ACO to develop a remediation plan aimed at having the Practice be able to certify compliance with all requirements before the beginning of the Performance Year:
    a. Practices under remediation plans will be eligible for payments as of the first day of the month after they certify compliance with all requirements. For example, a Practice certifying compliance on July 15, would be eligible as of August 1.
(d) Practices may be asked to provide reasonable documentation to show progress toward or meeting standards.

1. Practice is currently certified by NCQA as a Patient Centered Medical Home (PCMH) or, if not certified, all PCMH concepts are successfully maintained
2. Practice conducts patient outreach to ensure patients have had a preventive care visit and/or a disease specific visit with a specialist in the past 12 months (status reports and worklists available via Care Navigator)
3. Practice accesses and reviews data reports (e.g. patient registry reports, disease-specific panels, ACO quality measure performance) and/or self-service analytics tools to assess current performance, gaps in care, and patient worklists to address these opportunities for improvement
4. Practice maintains and monitors ACO quality measure performance and uses quality improvement strategies to address gaps in quality measure performance.
5. Practice is actively assessing and improving all coding accuracy, including Hierarchical Condition Categories.

2. Care Coordination for High/Very High Risk Patients - $15 Per Attributed Life Per Month

Paid monthly to a Participant that is, or whose TIN contains, primary care practice(s) that routinely meet(s) the following criteria, for those ACO Programs that fund this payment. While this is paid on a TIN level, it is measured on the Practice level and each Practice, as reflected on the TIN's roster of providers will be measured separately as follows:

(a) Each Practice will respond to a survey as to their compliance with the requirements for this payment before the beginning of the Performance Year;
(b) Practices that certify they comply with all requirements will be eligible for payments;
(c) Practices that certify that they do not comply with one or more of the requirements will work with OneCare to develop a remediation plan aimed at having the Practice be able to certify compliance with all requirements before the beginning of the Performance Year:
    a. Practices under remediation plans will be eligible for payments as of the first day of the month after they certify compliance with all requirements. For example, a Practice certifying compliance on July 15, would be eligible as of August 1.
(d) Practices may be asked to provide reasonable documentation to show progress toward or meeting standards.

1. Practice has identified one or more employed or community-shared resource staff whose role is to provide care coordination services for its attributed patient panel. Identified care coordination staff will: a. have each attended at least one care coordination training session in the past 12 months or Practice can attest that all care coordination staff will participate in at least one training session in the current Performance Year; and b. utilize Care Navigator or other methods agreed upon with OneCare to create shared care plans and communicate among care team members.
2. Practice routinely reviews lists of high/very high-risk patients and conducts outreach to engage patients in care coordination (OneCare estimates practice(s) will achieve a 15-30% patient engagement rate).
3. Practice facilitates regular effective outreach (e.g. 12x/yr for very high risk 4x/yr for high risk, 2x/yr for medium risk) for patients engaged in care coordination as per OneCare's care coordination model and documents this outreach in Care Navigator or in other methods agreed upon with OneCare.

4. Practice's team-based care model includes defined roles and relationships with continuum of care partners (e.g. home health, designated agencies, skilled nursing facilities) and human services organizations (e.g. DCF, nutrition, housing, transportation).
5. Practice participates in person-centered shared care planning and care conferences as necessary to facilitate the patient's goals of care.
6. Practice's team-based care model supports effective transitions of care by providing follow-up calls with patients following emergency department visits within two days and post-hospital discharge in-person visits between 7-14 days depending on acuity.

3. Care Coordination, Community Support - $15.00 per HSA Attributed Life Per Month

Paid monthly to community-based providers with a qualifying relationship to Attributed Lives within their HSAs for those ACO Programs that fund this payment. This applies to home health, designated agencies for mental health and substance abuse, and agencies on aging. It is based on a proportion of the high and very high risk population served by the community-based provider.

4. Patient Activation Payment - One Time Annual Payment of $150 and an additional $10.00 per Attributed Life Per Month

One time annual payment of $150 to the TIN of a OneCare Participating Provider who establishes a lead care coordinator relationship and shared care plan with the Attributed Life for those ACO Programs that fund this payment. The additional $10 per Attributed Life Per Month for the Attributed Life is paid monthly beginning for the month the lead care coordinator and shared care plan are designated in OneCare's care coordination software system. For example, if the designations are made on July 15th, payment is earned as of July and made in August.

5. Value Based Incentive Fund

The Board will adopt a Value Based Incentive Fund Model (VBIF) for Performance Year 2019, subject to any required regulatory approvals. The VBIF will be presented to the Participants and Preferred Providers on or before the start of the Performance Year(s). In addition, the model will be posted and available on the ACO Provider Portal. The 2019 VBIF is incorporated herein and will be as follows:

ACO will accumulate funds in a separate designated account earmarked for VBIF, as negotiated in each ACO Program Agreement. The VBIF is to reward designated Participants and Preferred Providers who meet quality goals in each ACO Program.

Distributions will be calculated separately for each ACO Program after the close of the Program Year when quality measure performance is reported to ACO by the Payer. Participants and Preferred Providers may only receive VBIF funding for ACO Programs in which they participate. The fund will be distributed by a methodology established by the Board and consistent with ACO strategy, 70% to attributing primary care providers based on attribution and 30% to the remainder of the network who qualify based on proportion of TCOC spend during the Performance Year. VBIF payments shall be of a minimum $100.

Exhibit A2

2019 Performance Year Shared Risk and Savings Policy

1. The Board will adopt a Shared Risk and Savings Policy for Performance Year 2019 which will be available on the ACO Provider Portal and is incorporated herein. Subject to amendment by the Board and any required regulatory approvals, the Performance Year 2019 policy for allocating risk and sharing savings shall be as follows.
2. Performance standards for the ACO (spending targets, risk corridors) will be set in each ACO Program.
3. Each Participant hospital will bear the risk of losses and receive savings on the Attributed Lives within their Healthcare Service Areas (HSA) up to a Maximum Risk Limit and Maximum Sharing Limit (MRL). The MRL will be calculated based on potential total risk allocated to each HSA's attributed population and the spending targets that are established in the ACO Programs.
4. Losses within the MRL will be paid by the Participant hospital within the HSA regardless of ACO wide performance.
5. If a Participant hospital HSA exceeds its Maximum Risk Limit, the excess liability shall be covered by the Participant hospitals in other HSAs proportional to their own MRLs, but never to exceed any hospital's individual MRL.
6. Responsibility for losses and opportunities for shared savings will be symmetric:
    a. If ACO wide savings are earned, then each Participant hospital that bears risk within its HSA will earn savings up to its Maximum Sharing Limit;
    b. If an HSA earns savings in excess of the Participant hospital's Maximum Sharing Limit, the excess will be distributed to other Participant hospitals proportional to their Maximum Sharing Limits, but never exceeding the MRLs; and
    c. Any additional savings will be distributed across the network in such manner as the Board directs:
        i. Half shall be allocated to independent primary care providers;
        ii. Half shall be allocated to other, non-hospital, non-primary care providers.

ONECARE VERMONT ACCOUNTABLE CARE ORGANIZATION, LLC
DEPARTMENT OF VERMONT HEALTH ACCESS MEDICAID NEXT GENERATION MODEL
ACO PROGRAM ADDENDUM

THIS DEPARTMENT OF VERMONT HEALTH ACCESS MEDICAID NEXT GENERATION MODEL ACO PROGRAM ADDENDUM ("ACO Program Addendum") is attached to and made part of the First Amended and Restated Risk Bearing Participant and Preferred Provider Agreement ("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 Agreement, the applicable terms of this ACO Program Addendum or the ACO Program rules applicable to the Participant or Preferred Provider shall control. To the extent any of the terms of this ACO Program Addendum conflict with the Department of Vermont Health Access ("DVHA") General Provider Agreement (between the Participant or Preferred Provider and DVHA), the DVHA General Provider Agreement shall control.

BACKGROUND

ACO has entered into an agreement with DVHA through which the ACO will participate in the Vermont Medicaid Next Generation Model (the "Program"), an alternative payment and population health management program with Medicaid, as described in Vermont Medicaid Next Generation Participation Agreement that 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 Agreement.

NOW, THEREFORE, the Parties agree as follows:

1.0 MEDICAID NEXT GENERATION ACO 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 Vermont Medicaid Next Generation Participation Agreement between ACO and DVHA and to comply with all applicable laws and regulations. This compliance includes, but is not limited to, compliance with the provisions of the Vermont Medicaid Next Generation Participation Agreement relating to the following: (1) participant exclusivity; (2) quality measure reporting; (3) continuous care improvement objectives for Participants and Preferred Providers; (4) voluntary attribution; (5) Beneficiary freedom of choice; (6) benefit enhancements; (7) participation in evaluation, shared learning, monitoring and oversight activities; (8) the ACO Compliance Plan; (9) continuity of benefits; (10) ACO Policies and (11) audit and record retention requirements. Participant and Preferred Provider further agree that as part of their participation in the Program

and their Vermont Medicaid provider agreements that they will not terminate a patient for any cause related to his/her health status or his/her need for medical services that result in utilization risk for the Participant or Preferred Provider.

1.2 Updating Information. Participant and Preferred Provider are each required to update its Medicaid 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 Medicaid payment) on a timely basis in accordance with Medicaid program requirements.

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

1.4 Providers in Good Standing with Vermont and Medicaid. 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 DVHA General Provider Agreement in good standing and be duly licensed and remain in good standing with the appropriate state licensing board.

1.5 Contracting Exclusivity. Subject to the Program exclusivity requirements, ACO will not prohibit a Participant, Preferred Provider or Provider from contracting with other state contractors.

1.6 Patient Record Requests. Participants and Preferred Providers 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.

1.7 Required Notices. Participants and Preferred Providers will provide ACO with the following notices:

1.7.1 All relevant information about any changes to Medicaid enrollment information, within thirty (30) days after the change.

1.7.2 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 Medicaid billing privileges) that could materially impact the ability to perform under this Program Addendum immediately upon becoming aware of the triggering event.

1.8 Exclusivity. Participants whose TIN includes NPIs of a "Primary Care Practitioner" who bills "Qualified Evaluation and Management Services" (as both terms are defined by the Vermont Medicaid Next Generation Participation Agreement) may not participate in more than one Medicaid Next Generation Model Program, or any other Medicaid ACO-based payment reform program or with any other accountable care organization in which they attribute or align lives. Nothing in this paragraph shall be interpreted to preclude a Participant, whose TIN does not include NPIs of Primary Care Practitioners, from membership 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. Preferred Provider will be paid according to Medicaid's normal payment methodology. Annually, 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 to the methodology or level of payment for delivering services to Beneficiaries whether payment is made by ACO, Medicaid, 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 DVHA. 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 DVHA changing its financial commitments to ACO mid-Performance Year 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. During the Modeling Period, ACO may update these estimates based on material events. As soon as practical after the first day of a Performance Year when final attribution information has been provided to 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 Medicaid benefits which are not affected by this ACO Program and agree to accept any applicable copayment, coinsurance and/or deductible together with the payments provided for under this Agreement as full reimbursement for services rendered.

2.3 Claims Submission. Participants and Preferred Providers will submit claims to DVHA in accordance with timely filing rules and in accordance with DVHA's applicable policies, but will receive reimbursement for services within the Program, as outlined in this Section 2.0.

2.4 Services Outside the Program. The following services are excluded by DVHA from Program payments, and will be excluded from the payments by ACO and will be reimbursed by DVHA directly to Participants:

2.4.1 Services Not Covered in the Program. The following services are paid for by DVHA but are not included in the Program:

2.4.1.1 Pharmacy;
2.4.1.2 Nursing Facility Care;
2.4.1.3 Psychiatric Treatment in State Psychiatric Hospital;
2.4.1.4 Level 1 (involuntary placement) Inpatient Psychiatric Stays (in any hospital when paid for by DVHA);
2.4.1.5 Dental Services;
2.4.1.6 Non-emergency Transportation (ambulance transportation not included);
2.4.1.7 Smoking Cessation Services.

2.4.2 Other Services Not Covered. Other services offered to Beneficiaries but paid for by Vermont government departments other than DVHA are not covered in the program. This includes, but is not limited to, the following services:

2.4.2.1 Services delivered through Designated Agencies (DAs), Specialized Service Agencies (SSAs) and Parent Child Centers (PCCs) paid for by agencies other than DVHA;
2.4.2.2 Other services administered and paid for by the Vermont Department of Mental Health;
2.4.2.3 Services administered and paid for by the Vermont Division of Alcohol and Drug Abuse Programs through a preferred provider network;
2.4.2.4 Services administered by the Vermont Department of Disabilities, Aging and Independent Living;
2.4.2.5 Services administered and paid for by the Vermont Agency of Education;

2.4.2.6 Services administered and paid for by the Vermont Department of Health, including smoking cessation services.

2.5 Beneficiary Appeals and/or Grievances. Beneficiaries retain their rights to appeal claims determinations in accordance with the terms of the DVHA Member Handbook and Participant and Preferred Provider remain bound by the terms of the DVHA General Provider Agreement as to Beneficiary grievances and appeals. 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. The appeals policy includes a written initial appeal and a second level of appeal with the opportunity to be heard in person. Participant and Preferred Provider will continue to cooperate with DVHA in the resolution of Beneficiary grievances and disputes.

2.6 Shared Savings. Shared Savings, if earned, will be distributed according to the Performance Year Shared Risk and Savings Policy as set forth in the Agreement and each Participant's Maximum Risk and Sharing Limit.

2.7 Shared Losses. Losses, if incurred, will be paid by ACO and Participants according to the Performance Year Shared Risk and Savings Policy as set forth in the Agreement and each Participant's Maximum Risk and Sharing Limit.

3.0 TERM, REMEDIAL ACTION AND TERMINATION

3.1 Term. The term of this Program Addendum shall commence on the Effective Date. The Initial Term shall be from the Effective Date through the last date of the last Performance Year for the Program, or December 31, 2022. Thereafter, this Agreement may be extended for additional one (1) year terms, as agreed by the Parties.

3.2 Remedial Action.

a. ACO may take remedial action against the 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 ACO's 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 DVHA.

b. Participant or Preferred Provider with a dispute relating to ACO's performance of its obligations under this Agreement may appeal through the ACO Appeals Policy, if applicable, or initiate a dispute under the dispute resolution clause 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 Medicaid Next Generation Program Agreement.

3.3 Termination. This Program Addendum will automatically terminate if the Agreement terminates or if the Participant or Preferred Provider becomes ineligible to participate in Vermont Medicaid, for any reason. This Program Addendum will terminate prior to the end of the Term if DVHA requires the ACO to remove the Next Generation Participant from the approved list of providers.

a. Participant or Preferred Provider may terminate this Program Addendum, consistent with the Agreement's provisions relating to Core ACO Programs, for any Performance Year, if after receiving the initial Program of Payment and preliminary Maximum Risk and Sharing Limit, it does not wish to remain in this ACO Program. To terminate under this provision, Participant or Preferred Provider must provide written notice to ACO on or before August 31st of the year before the Performance Year commences (should DVHA provide additional time to ACO to provide a final list of participating providers, ACO will adjust that deadline as permitted by the ACO Program). By way of example, if a Participant wishes to terminate effective 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 ACO Program from DVHA, it determines not to participate in the ACO Program and provides that notice to DVHA in accordance with their deadline for ACOs to decline participation.

3.4 Close-Out, Performance Year Obligations. In the event this Program Addendum is terminated, non-renewed or expires, ACO, 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 and to DVHA's fiscal agent. Moreover, 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 the date executed by ACO indicated below.

ONECARE VERMONT ACCOUNTABLE CARE ORGANIZATION, LLC

By: _____ Date: _____
Todd B. Moore
Chief Executive Officer

PARTICIPANT/PREFERRED PROVIDER

By: _____ Date: _____
Authorized Signature

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

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 Agreement, 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 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 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 Vermont Medicare ACO Initiative Agreement and to comply with all applicable laws and regulations. This compliance includes but is not limited to, compliance with the provisions in the Vermont Medicare ACO Initiative 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 Vermont Medicare ACO Initiative Participant List, to the 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 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. Participants whose TIN includes NPIs of a "Primary Care Practitioner" who bills "Qualified Evaluation and Management" services (as both terms are defined by the Vermont Medicare ACO Initiative 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. Preferred Providers will be paid according to Medicare's normal payment methodology. Annually, 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. 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. During the Modeling Period ACO may update these estimates based on material events. 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 and agree to accept any applicable copayment, coinsurance and/or deductible together with the payments provided for under this Agreement as full reimbursement for services rendered.

2.3 Claims Submission. Participant and Preferred Provider will submit claims to CMS or ACO's delegate for processing in accordance with Medicare's applicable policies, including Medicare's timely filing requirements, but may receive reimbursement from ACO, as outlined in this Section 2.0.

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.

2.5 Shared Savings. Shared Savings if earned will be distributed according to the Performance Year Shared Risk and Savings Policy as set forth in the Agreement and each Participant's Maximum Risk and Sharing Limit.

2.6 Shared Losses. Losses, if incurred, will be paid by ACO and Participants according to the Performance Year Shared Risk and Savings Policy as set forth in the Agreement and each Participant's Maximum Risk and Sharing Limit.

3.0 TERM, REMEDIAL ACTION AND TERMINATION

3.1 Term. The term of this Program Addendum shall commence on the Effective Date. The Initial Term shall be from the Effective Date through the last date of the last Performance Year for the Program, or December 31, 2022. Thereafter, this Agreement may be extended for additional one (1) year terms, 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 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 Agreement 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 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 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 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 ACO Program, it determines not to participate in the ACO Program and provides that notice to Payer 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, non-renewed, or expires, ACO, 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 the date executed by ACO indicated below.

ONECARE VERMONT ACCOUNTABLE CARE ORGANIZATION, LLC

By: _____ Date: _____
Todd B. Moore
Chief Executive Officer

PARTICIPANT/PREFERRED PROVIDER

By: _____ Date: _____
Authorized Signature

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

ONECARE VERMONT ACCOUNTABLE CARE ORGANIZATION, LLC
BLUE CROSS BLUE SHIELD OF VERMONT NEXT GENERATION MODEL
ACO PROGRAM ADDENDUM

THIS BLUE CROSS BLUE SHIELD OF VERMONT ("BCBSVT") NEXT GENERATION MODEL ACO PROGRAM ADDENDUM ("ACO Program Addendum") is attached to and made part of the First Amended and Restated Risk Bearing Participant and Preferred Provider Agreement ("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 Agreement, the applicable terms of this ACO Program Addendum shall control.

BACKGROUND

ACO has entered into an agreement with BCBSVT through which the ACO will participate in an alternative payment and population health management program with BCBSVT (the "Program"), as described in the BCBSVT Next Generation Program Agreement ("Program Agreement") available on the ACO Provider Portal and 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 Agreement.

NOW, THEREFORE, the Parties agree as follows:

1.0 BCBSVT NEXT GENERATION ACO 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 BCBSVT Next Generation Participation Agreement and to comply with all applicable laws and regulations. This compliance includes, but is not limited to, compliance with the provisions of the BCBSVT Next Generation Participation Agreement relating to the following: (1) participant exclusivity; (2) quality measure reporting; (3) continuous care improvement objectives for Participants and Preferred Providers; (4) voluntary attribution; (5) Beneficiary/Member freedom of choice; (6) participation in evaluation, shared learning, monitoring and oversight activities; (7) the ACO Compliance Plan; (8) continuity of benefits; (9) ACO Policies; and (10) audit and record retention requirements. Participant and Preferred Provider further agree that as part of their participation in the Program and their BCBSVT provider agreements they will not terminate a Beneficiary for any cause related to his/her health status or his/her need for medical services that result in utilization risk of the Participant or Preferred Provider.

1.2 Updating Information. Participant and Preferred Provider are each required to update its BCBSVT 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 BCBSVT payment) on a timely basis in accordance with BCBSVT requirements.

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

1.4 Providers in Good Standing with BCBSVT. 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 BCBSVT provider agreement in good standing and to be duly licensed and remain in good standing with the appropriate state licensing board.

1.5 Contracting Exclusivity. Subject to the Program exclusivity requirements, ACO will not prohibit a Participant, Preferred Provider or provider from contracting with other state or commercial contractors.

1.6 Required Notices. Participants and Preferred Providers will provide ACO with the following notices:

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

1.6.2 All pertinent information about any investigation or sanction by the government, BCBSVT or any licensing authority (including, without limitation, the imposition of program exclusion, debarment, civil monetary penalties, corrective action plans, and revocation of 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 BCBSVT Next Generation Program exclusivity requirements. ACO Participants or ACO Preferred Provider Participants that are themselves, or who include within their TIN, Providers who are "Primary Care Providers", as defined by the BCBSVT Next Generation Program Agreement, may not participate in any other BCBSVT Next Generation participating ACO while a party to this Program Addendum. By way of examples, an individual Primary Care Provider who bills primary care services under an individual TIN must be exclusive to a single ACO. An individual Primary Care Provider who assigns billing or collection to a group practice with a separate TIN must be exclusive to the same ACO and the ACO Participant that contains the Primary Care Provider must also be exclusive to the same ACO. If an ACO Participant and the associated Providers who assign

billings to the ACO Participant do not contain Primary Care Providers, the ACO Participant and the non-Primary Care Providers are not required to be exclusive.

2.0 PAYMENT

2.1 Form of Payment. Preferred Provider will be paid according to the BCBSVT normal payment methodology. Annually, 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 to the methodology or level of payment for delivering services to Beneficiaries whether payment is made by ACO, BCBSVT, 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 BCBSVT. 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 BCBSVT changing its financial commitments to ACO mid-Performance Year or a regulatory directive to make changes.

a. 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. During the Modeling Period, ACO may update these estimates based on material events. As soon as practical after the first day of a Performance Year when final attribution information has been provided to 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/Members in accordance with their BCBSVT benefits which are not affected by this ACO Program and agree to accept any applicable copayment, coinsurance and/or deductible together with the payments provided for under this Agreement as full reimbursement for services rendered.

2.3 Claims Submission. Participants and Preferred Providers will submit claims to BCBSVT in accordance with timely filing rules and in accordance with BCBSVTs applicable policies, but will receive reimbursement for services within the Program, as outlined in this Section 2.0.

2.4 Services Outside the Program. The services included in the Program will be based on the allowed claims incurred for each Exchange-offered product in a manner consistent with ACO strategy and approved by the Board of Managers Exclusions include claims allowable under separate benefit riders.

2.5 Beneficiary Appeals and/or Grievances. Beneficiaries/Members retain their rights to appeal claims determinations in accordance with the terms of their benefit policies and Participant and Preferred Provider remain bound by the terms of their BCBSVT provider agreements as to Beneficiary/Member grievances and appeals.

2.6 Shared Savings. Shared Savings, if earned, will be distributed according to the Performance Year Shared Risk and Savings Policy as set forth in the Agreement and each Participant's Maximum Risk and Sharing Limit.

2.7 Shared Losses. Losses, if incurred, will paid by ACO and Participants according to the Performance Year Shared Risk and Savings Policy as set forth in the Agreement and each Participant's Maximum Risk and Sharing Limit.

3.0 TERM, REMEDIAL ACTION AND TERMINATION

3.1 Term. The term of this Program Addendum shall commence on the Effective Date and shall run through the last date of the last Performance Year for the Program, or December 31, 2019. Thereafter, this Agreement may be extended as agreed by the Parties.

3.2 Remedial Action.

a. ACO may take remedial action against the 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 ACO's 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 BCBSVT.

b. Participant or Preferred Provider with a dispute relating to ACO's performance of its obligations under this Agreement 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 BCBSVT Next Generation Program Agreement.

3.3 Termination. This Program Addendum will automatically terminate if the Participation Agreement terminates or if the Participant or Preferred Provider becomes ineligible to participate in BCBSVT, for any reason. This Program Addendum will terminate prior to the end of Term, if BCBSVT requires the ACO to remove the Next Generation Participant from the approved list of providers.

a. Participant or Preferred Provider may terminate this Program Addendum, consistent with the Agreement's provisions relating to Core ACO Programs, for any Performance Year, if after receiving the initial Program of Payment and preliminary Maximum Risk and Sharing Limit, it does not wish to remain in this ACO Program. To terminate under this provision, Participant must provide written notice to ACO on or before August 31st of the year before the Performance Year commences (should BCBSVT 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 a Participant wishes to terminate effective 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 ACO Program from BCBSVT, it determines not to participate in the ACO Program and provides that notice to BCBSVT in accordance with their 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/Members, to ACO and to BCBSVT. Moreover, Participant, Preferred Provider and ACO will be required to meet all financial obligations for the Performance Year when notice is given, 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 the date executed by ACO indicated below.

ONECARE VERMONT ACCOUNTABLE CARE ORGANIZATION, LLC

By: _____ Date: _____
Todd B. Moore
Chief Executive Officer

PARTICIPANT/PREFERRED PROVIDER

By: _____ Date: _____
Authorized Signature

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

356 Mountain View Drive
Suite 301
Colchester, VT 05446
802-847-7220 PHONE
877-644-7176 TOLL-FREE
802-847-6214 FAX
onecarevt.org

AMENDMENT #3
TO THE FIRST AMENDED AND RESTATED ONECARE VERMONT ACCOUNTABLE CARE ORGANIZATION, LLC RISK BEARING PARTICIPANT & PREFERRED PROVIDER AGREEMENT TOGETHER WITH: (1) the VERMONT MEDICARE ACO INITIATIVE PROGRAM ADDENDUM; (2) the DEPARTMENT OF VERMONT HEALTH ACCESS MEDICAID NEXT GENERATION MODEL ACO PROGRAM ADDENDUM AND (3) the BLUE CROSS BLUE SHIELD OF VERMONT NEXT GENERATION MODEL ACO PROGRAM ADDENDUM

RESOLUTION OF CONFLICTS BETWEEN FQHC REQUIREMENTS AND ACO REQUIREMENTS

Legal Business Name:

Contractual Address:

TIN:

WHEREAS, Participant is a Federally Qualified Health Center ("FQHC") and a party to the Agreements (collectively "Agreement") with OneCare to participate in three Next Generation Model Programs: (1) Medicare, (2) Medicaid and (3) Blue Cross Blue Shield of Vermont; and

WHEREAS, Participant is required to follow certain federal and programmatic rules and regulations as an FQHC (collectively "FQHC Requirements"); and

WHEREAS, Participant is required to follow OneCare's ACO Policies and Program requirements (collectively "ACO Requirements"); and

WHEREAS, the Parties wish to establish a forum to discuss and resolve any conflicts that may arise between FQHC Requirements and ACO Requirements.

NOW THEREFORE, the Parties agree as follows:

1. Notwithstanding any provisions to the contrary in the Agreement and with the intent to modify the Agreement, in the event that Participant reasonably believes that an ACO Requirement is in conflict with an FQHC Requirement, the following process will apply:
    a. Participant will immediately notify OneCare by providing a written notice specifying the nature of the conflict with reasonable detail in accordance with the Notice requirements of the Agreement.
    b. OneCare will suspend application of the ACO Requirement to Participant during this resolution process.
    c. OneCare's Chief Operating Officer will gather information about the issues raised by Participant and attempt to resolve any conflict.
    d. If the conflict cannot be resolved with the Chief Operating Officer, the Executive Committee will consider the issues and provide advice.
    e. The Parties agree to act diligently and promptly to raise and resolve issues in this process.

ONECARE VERMONT ACCOUNTABLE CARE ORGANIZATION, LLC

By: _____ Date: _____
Todd B. Moore
Chief Executive Officer

PARTICIPANT

By: _____ Date: _____
Authorized Signature

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