UnitedHealthcare®
Medicare Solutions

MEDICAL CONDITION ASSESSMENT INCENTIVE PROGRAM FOR OUT OF NETWORK PROVIDERS TERMS AND CONDITIONS EFFECTIVE JANUARY 1, 2018

These Medical Condition Assessment Incentive Program for Out of Network Providers[1] Terms and Conditions ("Terms and Conditions") govern the Medical Condition Assessment Incentive Program ("MCAIP"). As a precondition for the Provider to participate in the MCAIP Program pursuant to these Terms and Conditions and to be eligible for the payments described below, one of the following must have occurred: (a) UnitedHealthcare ("United") presented an MCAIP Program Participation Acknowledgement ("Acknowledgment") to Provider and Provider signed and returned the Acknowledgement to United in accordance with the deadline established by United, or (b) United notified Provider of Provider's enrollment in the MCAIP Program via a unilateral amendment to Provider's participation agreement with United.

The parties acknowledge that Provider is participating in MA-PCPi for the 2018 MA-PCPi Term.

A Provider that participates in the MCAIP will receive a payment from United if the requirements and conditions described in these Terms and Conditions are met.

1. **Eligibility:** With respect to the MCAIP Term, to be eligible to receive a MCAIP Bonus and the Medical Condition Assessment Superior Bonus, Provider must have access to UHC Transitions™ (HealthBI) (hereinafter "HealthBI").

2. **Medical Condition Assessment Incentive Bonus:** Provider will be eligible to receive the MCAIP Bonus for those Suspect Medical Conditions identified in reporting furnished by United that Provider Physician assesses during a care visit with the MCAIP Customer during the MCAIP Term as described below:

    a. If, after completing a care visit with the MCAIP Customer, Provider Physician determines that the Suspect Medical Condition is present, Provider must submit a claim that includes the complete and accurate ICD10 code(s). Claims are considered timely if they are processed and/or paid by United no later than March 31st following the end of the applicable MCAIP Term; or
    b. If, after completing a care visit with the MCAIP Customer, Provider Physician determines that he or she is unable to diagnose the Suspect Medical Condition at that time, Provider must report that fact and the date of the care visit in a timely manner through HealthBI. Data submitted through HealthBI will be considered timely if submitted to United no later than January 10th following the end of the applicable MCAIP Term. United, in its sole discretion, may use other supplemental data sources that meet CMS documentation requirements and have been timely submitted to United no later than January 10th following the end of the applicable MCAIP Term.

    If, for a given MCAIP Term, Provider qualifies for the MCAIP Bonus, United will calculate Provider's MCAIP Bonus as $20.00 multiplied by the total number of Suspect Medical Conditions, which Provider Physicians assessed for the MCAIP Customers during the MCAIP Term. United will pay the MCAIP Bonus to Provider as set forth in the table below.

[1] This version of the MCAIP program is for use with providers who are not participating in United's network for Medicare Advantage benefit plans.

MCAIP Date of Service	Suspect Medical Conditions Assessed using HealthBI or Claims Processed and Paid Through	Payment Date*
January 1 –March 31	5/31/2018	7/31/2018
April 1- June 30	8/31/2018	10/31/2018
July 1-September 30	11/30/2018	1/31/2019
October 1-December 31	2/28/2019	5/31/2019

* To ensure Provider is reimbursed as outlined above, United will review Provider's claims and HealthBI submissions for the previous quarter(s) and make additional payments, if applicable.

3. **Medical Condition Assessment Superior Bonus:** Provider will be eligible to receive a Medical Condition Assessment Superior Bonus if Provider i) achieves an Average Star Rating within MA-PCPi of at least 3.76, and ii) addresses at least 75% of the Suspect Medical Conditions, for the MCAIP Customers during the MCAIP Term. United will calculate Provider's Medical Condition Assessment Superior Bonus as the payment amount from the table below multiplied by the total number of MCAIP Customers as identified on the final report. United will pay the Suspect Medical Condition Assessment Superior Bonus no later than 150 days after the end of the MCAIP Term.

Provider MA-PCPi Average Star Rating	Medical Condition Assessment Superior Bonus *(PMPY: Per member per year)*
4.75 and above	$125.00 PMPY
4.74-4.50	$100.00 PMPY
4.49 - 4.00	$75.00 PMPY
3.99 - 3.76	$50.00 PMPY
3.75 and below	$0.00

4. **Reporting:** United will make available, on a monthly basis, reporting to reflect Provider's activity in assessing the Suspect Medical Conditions.

   United will also update HealthBI on a monthly basis to allow Provider to document Suspect Medical Conditions that Provider Physician determines that he or she is unable to diagnose the at the time of a care visit.

   No later than 120 days after the end of a MCAIP Term, United will make available to Provider the following information:

   a. List of MCAIP Customers that United has identified as having Suspect Medical Conditions;
   b. For each MCAIP Customer, information about whether each Suspect Medical Condition has been assessed; and
   c. Percentage of Suspect Medical Conditions Provider Physician assessed during the MCAIP Term.

5. **Electronic Medical Record Access or Chart Request:** Provider will allow identified United employees to have access to Electronic Medical Records or alternatively, Provider will permit United or its designee to conduct chart reviews of Provider's records, specifically for the CMS required data submission, for any or all

MCAIP Customers. If charts or records are not furnished within the timeframe specified and/or are incomplete, United reserves the right to reduce or withhold the MCAIP Bonus.

6. **Training:** United will offer training, at no cost to Provider, regarding required medical record documentation and appropriate coding. The purpose of the training is to improve the accuracy and completeness of United's information and the information United provides to CMS regarding the health status of MCAIP Customers. United will identify any Provider employees who United believes will benefit from this training and notify providers in writing that they have been identified and of the details of the required training. Identified individuals must attend a training session within 60 calendar days of the date of the written notice from United. If the identified individuals fail to timely complete requested training, United reserves the right to reduce or withhold the MCAIP Bonus.

7. **Overpayment:** If United notifies Provider of an overpayment under the MCAIP, Provider will repay overpayments within 30 days of written or electronic notice. In addition, Provider will promptly report any overpayment under the MCAIP and will return the overpayment to United within 30 days of discovery. If Provider fails to repay overpayments as specified above, United may recover overpayments by offsets against future payments.

8. **Quality Review:** United reserves the right to conduct quality reviews and withhold payment for assessments if United determines that the Provider Physician has failed to conduct the assessments or if Provider has not complied with relevant risk adjustment standards and requirements related to complete and accurate coding. If Provider fails to timely comply with the requirements of this section, United reserves the right to reduce or withhold any or all of the bonus payments under these Terms and Conditions.

9. **Reconsideration:** Within 30 days after receiving the final reports for the MCAIP Term, Provider agrees to notify United electronically or in writing of any disagreements with their MCAIP performance results. Provider's written notification must include the following: a) the MCAIP Customer and Suspect Medical Condition at issue; b) detailed information, including any relevant dates, copies from the member's medical chart, and any other relevant information to support the review request. United will only consider complete review requests and will respond to Provider within 45 days after receiving Provider's notification. If the parties are unable to reach agreement, either party may initiate dispute resolution in accordance with Paragraph 14D Dispute Resolution. If United does not receive notification within 30 days from the date United provided the final reports, Provider will have been deemed to waive any rights to pursue any dispute relating to that MCAIP Term.

10. **Termination:**

    a. Provider has the right to terminate Provider's participation in the MCAIP, effective for the next MCAIP Term, by giving notice electronically or in writing within 60 days after the Terms & Conditions for the next MCAIP Term have been communicated/published. Such termination will not affect the MCAIP payment determination for the MCAIP Term in effect prior to such termination.

    b. United has the right to terminate Provider's participation in the MCAIP, effective for the next MCAIP Term, by giving notice electronically or in writing at least 30 days prior to the start of the next MCAIP Term. Such termination will not affect the MCAIP payment determination for the MCAIP Term in effect prior to such termination.

    c. United and Provider each shall have the right to terminate Provider's participation in the MCAIP immediately upon notice electronically or in writing to the other if the other party fails to comply with any requirement of these Terms and Conditions.

11. **Amendment of the MCAIP Terms and Conditions:** United, in its sole discretion, may amend these Terms and Conditions for any future MCAIP Term by providing to Provider a copy of and/or electronic access to the new Terms and Conditions no later than 30 days prior to the first day of the MCAIP Term to which the new

Terms and Conditions will apply. If Provider does not wish to continue participation in the MCAIP Program after review of the new Terms and Conditions, Provider has the option to terminate participation in the MCAIP as set forth in Paragraph 10 above.

12. **Agreement:** If Provider and United are parties to a participation agreement, United and Provider agree and acknowledge that the terms of the participation agreement are separate and distinct from the terms of the Program. The terms of the participation agreement do not apply to and have no impact on the terms of the Program and are not binding on the parties with respect to the Program. Conversely, the terms of the Program do not apply to and have no impact on the terms of the participation agreement and are not binding on the parties with respect to the participation agreement.

13. **Defined Terms:** As used in these Terms and Conditions, these capitalized terms have the following meanings:

    Agreement: The participation agreement or provider contract to which Provider and United are parties and under which Provider has agreed to participate in United's network for Benefit Plans other than Medicare Advantage Benefit Plans.

    Benefit Plan: A certificate of coverage, summary plan description, or other document or agreement, whether delivered in paper, electronic, or other format, under which United is obligated to provide coverage for a Customer.

    Customer: A person eligible for, enrolled in and entitled to receive coverage from United for a health care service or product, according to the terms of the United Benefit Plan.

    MCAIP Bonus: For a given MCAIP Term, the payment available to Provider if all of the requirements described in the Medical Condition Assessment Incentive Bonus Section of these Terms and Conditions are met with respect to that MCAIP Term.

    MCAIP Customer: Each Customer eligible for and enrolled in a Medicare Advantage Benefit Plan who is assigned and/or attributed, for a given MCAIP Term, by United to one of Provider Physicians for the MCAIP described in these Terms and Conditions.

    MCAIP Term: A calendar year during which Provider is eligible to participate in the MCAIP described in these Terms and Conditions (for example, January 1, 2018 through December 31, 2018).

    Medical Condition Assessment Superior Bonus: For a given MCAIP Term, the payment available to Provider if all of the requirements described in the Medical Condition Assessment Superior Bonus Section of these Terms and Conditions that are met with respect to that MCAIP Term.

    Provider: A physician, medical group, clinic, IPA, or PHO, that has met the requirements set forth in the opening paragraph of these Terms and Conditions.

    Provider Physician: A physician who is a doctor of medicine or osteopathy, duly licensed and qualified under the laws of the jurisdiction in which he/she provides health services to Customers or a registered nurse practitioner or physician assistant as permitted by United's credentialing plan and state law, who meets one of the following: (i) is a Provider, or (ii) practices as a shareholder, partner, employee, or subcontractor of a Provider. Each Provider Physician is assigned to a specific Provider based on the criteria above.

    Suspect Medical Condition: A potential condition that United believes that a MCAIP Customer has but that has not been reported during the MCAIP Term on a claim or encounter.

    United: UnitedHealthcare Insurance Company and/or the UnitedHealthcare Insurance Company affiliate(s) named in the Agreement, including the Care Improvement Plus entities, (if Provider is a party to an Agreement)

or in the MCAIP Program Participation Acknowledgment or Amendment (if Provider is not a party to an Agreement).

14. **Additional Terms and Conditions:** The additional terms and conditions of this Paragraph apply to Provider because Provider is not party to a participation agreement to participate in a network for United's Medicare Advantage Benefit Plans.

A. Authority to Contract. Provider agrees and acknowledges that it (i) has all requisite corporate power and authority to conduct its business as presently conducted, and to agree to be bound by these Terms and Conditions, and (ii) has the unqualified authority to bind, and does bind, itself and its Provider Physicians to all of these Terms and Conditions.

B. Compliance with Laws and Regulations. Provider and United shall comply with applicable state and federal laws and regulations, including but not limited to the requirements set forth in the Medicare Advantage Regulatory Requirements Appendix attached to these Terms and Conditions and those laws and regulations relating to confidentiality of individually identifiable health information derived from or obtained during the course of the performance of the MCAIP.

C. Confidentiality. Except as required by an agency of the government or by law, neither United nor Provider will disclose to any third party, including Customers, (i) any proprietary business information, not available to the general public, that it obtains from the other party; or (ii) the specific initiatives and related payment provided for under the MCAIP Program. Provider shall assure that its Provider Physicians are likewise bound by this confidentiality obligation.

D. Dispute Resolution. United and Provider, with its Provider Physicians, will work together in good faith to resolve any and all disputes between them (hereinafter referred to as "Disputes") relating to the MCAIP. If the parties are unable to resolve any such Dispute within 60 days following the date one party sent written notice of the Dispute to the other party, and if either party wishes to pursue the Dispute, it shall thereafter be submitted to binding arbitration in accordance with the Commercial Dispute Procedures of the American Arbitration Association, as they may be amended from time to time (see http://www.adr.org). Unless otherwise agreed to in writing by the parties, the party wishing to pursue the Dispute must initiate the arbitration within one year after the date on which notice of the Dispute was given or shall be deemed to have waived its right to pursue the dispute in any forum.

Any arbitration proceeding under the MCAIP shall be conducted in Hennepin County, Minnesota. The arbitrator(s) may construe or interpret but shall not vary or ignore the terms of the MCAIP and shall be bound by controlling law. The arbitrator(s) shall have no authority to award punitive, exemplary, indirect or special damages, except in connection with a statutory claim that explicitly provides for such relief. The decision of the arbitrator(s) on the points in dispute will be binding, and judgment on the award may be entered in any court having jurisdiction thereof. The parties acknowledge that because the MCAIP affects interstate commerce the Federal Arbitration Act applies.

In the event that any portion of this Paragraph or any part of the Terms and Conditions is deemed invalid or unenforceable, such unlawfulness, invalidity or unenforceability shall not serve to invalidate any other part of this Paragraph or the Terms and Conditions. In the event any court determines that this arbitration procedure is not binding or otherwise allows litigation involving a Dispute to proceed, the parties hereby waive any and all right to trial by jury in, or with respect to, such litigation. Such litigation would instead proceed with the judge as the finder of fact.

E. Entire Agreement. These Terms and Conditions and the Acknowledgment or Amendment, as applicable, are the entire agreement between Provider and United with regard to the subject matter herein, and supersede any prior written or unwritten agreements between Provider and United with regard to the same subject matter.

F. Relationship Between Parties. The relationship between United and Provider is solely that of independent contractors and nothing in the Terms and Conditions or otherwise shall be construed or deemed to create any other relationship, including one of employment, agency or joint venture.

G. Notice. Any notice required to be given under the MCAIP shall be in writing and shall be deemed to have been given when delivered in person, by electronic communication, by facsimile or, if delivered by first-class United States mail, on the date mailed, proper postage prepaid and properly addressed to Provider or to United, as appropriate.

H. Governing Law. These Terms and Conditions and the Acknowledgment or Amendment, as applicable, shall be construed in accordance with the laws of the State of Minnesota.

I. Participation Status. Provider's participation in this Program does not change Provider's status as a non-participating provider in United's network for Medicare Advantage Benefit Plans. United will treat Provider as an out-of-network provider under all circumstances including, but not limited to, excluding Provider from all United Medicare Advantage Provider directories.

J. Non-Assignability. These Terms and Conditions will not be assigned, sublet, delegated or transferred by Provider without United's written consent. These Terms and Conditions may be assigned, sublet, delegated or transferred by United.

K. Severability. Any provision of these Terms and Conditions that is unlawful, invalid, or unenforceable by the binding decision of any court or administrative agency of competent jurisdiction shall not affect the validity or enforceability of the remaining provisions of these Terms and Conditions or the lawfulness, validity or enforceability of the offending provision in any other situation or jurisdiction.

L. Survival. Subparagraphs B, C, D, and H of this Paragraph will survive termination of the MCAIP.

THIS PARAGRAPH CONTAINS A BINDING ARBITRATION PROVISION THAT MAY BE ENFORCED BY THE PARTIES.

MEDICARE ADVANTAGE REGULATORY REQUIREMENTS APPENDIX

THIS MEDICARE ADVANTAGE REGULATORY REQUIREMENTS APPENDIX (this "Appendix") supplements and is made part of the Medical Condition Assessment Incentive Program for Out of Network Providers Terms and Conditions (the "Terms and Conditions") between United and Provider.

SECTION 1
APPLICABILITY

This Appendix applies to the services performed by Provider pursuant to the Terms and Conditions as such services relate to the provision of Covered Services to Medicare Advantage Customers. In the event of a conflict between this Appendix and other appendices or any provision of the Terms and Conditions, the provisions of this Appendix shall control except: (1) as noted in Section 2 of this Appendix; or (2) as required by applicable law.

SECTION 2
DEFINITIONS

For purposes of this Appendix, the following terms shall have the meanings set forth below; provided, however, in the event any definition set forth in this Appendix is in conflict with any definition in the Terms and Conditions for the same or substantially similar term, the definition for such term in the Terms and Conditions shall control. All other capitalized terms not otherwise defined in this Appendix shall be as defined in the Terms and Conditions.

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

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

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

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

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

2.6 **Medicare Advantage Organization or MA Organization:** For purposes of this Appendix, MA Organization is either United or Payer.

2.7 **Payer:** An entity obligated to a Customer to provide reimbursement for Covered Services under the Customer's Benefit Plan. A Payer may also be referred to as a payor, participating entity or other similar term under the Terms and Conditions.

SECTION 3
PROVIDER REQUIREMENTS

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

3.2 **Policies.** Provider shall cooperate and comply with MA Organization's policies and procedures to the extent communicated by the MA Organization to the Provider.

3.3 **Customer Protection.** Provider agrees that in no event, including but not limited to, non-payment by MA Organization or an intermediary, insolvency of MA Organization or an intermediary, or breach by United of the Terms and Conditions, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any MA Customer or person (other than MA Organization or an intermediary) acting on behalf of the MA Customer for Covered Services provided pursuant to the Terms and Conditions or for any other fees that are the legal obligation of MA Organization under the CMS Contract. This provision does not prohibit Provider from collecting from MA Customers allowable Cost Sharing. This provision also does not prohibit Provider and an MA Customer from agreeing to the provision of services solely at the expense of the MA Customer, as long as Provider has clearly informed the MA Customer, in accordance with applicable law, that the MA Customer's Benefit Plan may not cover or continue to cover a specific service or services.

In the event of MA Organization's or an intermediary's insolvency or other cessation of operations or termination of MA Organization's contract with CMS, Provider shall continue to provide Covered Services to an MA Customer through the later of the period for which premium has been paid to MA Organization on behalf of the MA Customer, or, in the case of MA Customers who are hospitalized as of such period or date, the MA Customer's discharge.

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

For the purpose of this provision, an "intermediary" is a person or entity authorized to negotiate and execute the Terms and Conditions on behalf of Provider.

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

the Dual Eligible Customer, as long as Provider has clearly informed the Dual Eligible Customer, in accordance with applicable law, that the Dual Eligible Customer's Benefit Plan may not cover or continue to cover a specific service or services.

3.5 **Eligibility.** Provider agrees to immediately notify MA Organization in the event Provider is or becomes excluded from participation in any federal or state health care program under Section 1128 or 1128A of the Social Security Act. Provider also shall not employ or contract for the provision of health care services, utilization review, medical social work or administrative services, with or without compensation, with any individual or entity that is or becomes excluded from participation in any federal or state health care program under Section 1128 or 1128A of the Social Security Act.

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

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

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

3.9 **Records.**

(a) Maintenance; Privacy and Confidentiality; Customer Access. Provider shall maintain records and information related to the services provided under the Terms and Conditions, including but not limited to MA Customer medical records and other health and enrollment information, in an accurate and timely manner. Provider shall maintain such records for the longer of the following periods:

(i) in the case of records containing information related to the medical loss ratio information reported to CMS by the MA Organization, including, for example, information related to incurred claims and quality improvement activities, at least ten (10) years from the date such medical loss ratio information is reported to CMS by the MA Organization, or

(ii) in the case of all records, at least ten (10) years from the final date of the CMS Contract period in effect at the time the records were created, or such longer period as required by law.

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

(b) Government Access to Records. Provider acknowledges and agrees that the Secretary of Health and Human Services, the Comptroller General, or their designees shall have the right to audit, evaluate and inspect any pertinent books, contracts, computer or other electronic systems (including medical records), patient care documentation and other records and information belonging to Provider that involve

transactions related to the CMS Contract. This right shall extend through the longer of the following periods:

(i) in the case of records containing information related to the medical loss ratio information reported to CMS by the MA Organization, including, for example, information related to incurred claims and quality improvement activities, at least ten (10) years from the date such medical loss ratio information is reported to CMS by the MA Organization, or

(ii) in the case of all records, at least ten (10) years from the later of the final date of the CMS Contract period in effect at the time the records were created or the date of completion of any audit, or longer in certain instances described in the applicable Medicare Advantage regulations.

For the purpose of conducting the above activities, Provider shall make available its premises, physical facilities and equipment, records relating to MA Customers, and any additional relevant information CMS may require.

(c) MA Organization Access to Records. Provider shall grant MA Organization or its designees such audit, evaluation, and inspection rights identified in subsection 3.9(b) as are necessary for MA Organization to comply with its obligations under the CMS Contract. Whenever possible, MA Organization will give Provider reasonable notice of the need for such audit, evaluation or inspection, and will conduct such audit, evaluation or inspection at a reasonable time and place. Provider shall submit medical records of MA Customers to the MA Organization as may be requested, within the timeframes specified, for the purpose of (i) CMS audits of risk adjustment data and (ii) for other purposes medical records from providers are used by MA Organization, as specified by CMS. Provision of medical records must be in the manner consistent with HIPAA privacy statute and regulations.

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

3.11 **Offshoring.** Unless previously authorized by MA Organization in writing, all services provided pursuant to the Terms and Conditions that are subject to this Appendix must be performed within the United States, the District of Columbia, or the United States territories.

SECTION 4
OTHER

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