



BlueCross BlueShield BluePlus of Minnesota

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Blue Plus 2015 Referral Health Professional Provider Service Agreement

Article I. Purpose

HMO Minnesota, d/b/a Blue Plus (Blue Plus) and the Provider hereby agree to the terms and provisions of this Agreement. Provider must maintain an Aware Provider Service Agreement in order to be offered this Referral Health Professional Provider Service Agreement. Hereinafter, Blue Plus and the Provider may be individually referred to as a "Party" and jointly referred to as the "Parties."

Article II. Definitions

A. "Affiliate" means (i) any entity now existing or hereafter organized that, directly or indirectly, through one or more intermediaries, controls or is controlled by or is under common control with Blue Plus, and/or (ii) any entity in which an entity described in "(i)" above holds not less than 33% of either the membership interest, voting interest or issued and outstanding voting securities thereof.

B. "Agreement" means this Referral Health Professional Provider Service Agreement, including (1) the signature page, which shall be binding upon all of Provider's Health Care Professionals, (2) the applicable fee schedule(s), (3) the Amendment to the Agreement – Medicare Programs, as applicable, (4) the Provider Policy & Procedure Manual as it may be amended from time to time (available at bluecrossmn.com), (5) any and all existing and effective Provider Bulletins (available at bluecrossmn.com) as well as any Provider Bulletins issued by Blue Plus during the term of this Agreement, (6) any and all existing and effective Exhibits, (7) the provisions of the Credentialing and Recredentialing Policy Manual as it may be amended by Blue Plus from time to time (available at bluecrossmn.com), and (8) any other Addenda or Amendments whose terms and provisions are incorporated into and made a part of this Agreement.

C. "Blue Plus" means HMO Minnesota d/b/a Blue Plus and may include at Blue Plus' discretion, one or more of its Affiliates.

D. "Concurrent Review" means ongoing review during the Subscriber's care, to ensure that the care meets established medical criteria in a timely manner and certifies the necessity, appropriateness and quality of Health Services.

E. "Health Care Professional" means an individual employed by Provider or an independent contractor of Provider who maintains the necessary state health care license, registration or certification appropriate to practice or perform a type of Health Service in the state in which it delivers the Health Services.

F. "Health Service" means any health care service, product, procedure, or item provided to a Subscriber regardless of whether or not the health care service, product, procedure or item is covered under the Subscriber Contract and subject to all terms of the Subscriber Contract.

G. "Medically Necessary" or "Medical Necessity" shall have the meaning as defined in the Subscriber Contract.

H. "Minnesota Health Care Programs" means prepaid public programs including Medical Assistance, MinnesotaCare, , or other prepaid public programs in which Blue Plus provides coverage under a contract with any Minnesota County or with the Minnesota Department of Human Services (DHS). This Agreement applies to Health Services provided to Minnesota Health Care Programs Subscribers where applicable. In the event of a government shutdown or lack of state funding which results in DHS ceasing to make payments to Blue Plus



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for Health Services provided to Minnesota Health Care Programs Subscribers, Blue Plus may, in its sole discretion, immediately terminate those portions of this Agreement which apply to Minnesota Health Care Programs Subscribers.

- I. "Plan Sponsor" means an employer or other party who provides benefits or administers the benefit plan for Subscribers under a plan which utilizes a Blue Plus participating provider network.
- J. "Pre-Certification" or "Pre-Service Review" or "Prior Authorization" means an advance review of a proposed facility admission or certain Health Services or procedures in order to determine whether the proposed admission, services or procedures meet the Medical Necessity criteria for payment and to ensure that the Subscriber receives the maximum benefits available under the Subscriber contract.
- K. "Primary Care Clinic" (PCC) means a physician or group of physicians who have entered into an Agreement with Blue Plus and who have the necessary health care resources available to function as a health care entry point in providing or arranging to provide covered Health Services to Subscribers pursuant to an Agreement as part of a managed care plan. A managed care plan is a health benefit plan in which Subscribers designate a primary care provider or other delivery system to provide or coordinate all health care services.
- L. "Primary Coverage Responsibility" means coverage under Blue Plus Subscriber Contracts which is not secondary pursuant to any coordination of benefits, auto insurance or similar provisions.
- M. "Protected Health Information" (PHI) means individually identifiable information transmitted or maintained in any format as further defined in 45 Code of Federal Regulations ("C.F.R.") Section 164.501.
- N. "Provider" means the individual or entity that is a Party to this Agreement and indicated on the Signature Page that is engaged in the delivery of, and is authorized to provide Health Services in the state in which it delivers the Health Services.
- O. "Self-Referral" means a Health Service, other than a medical emergency as defined by the applicable Subscriber Contract, which is not provided by or arranged by the PCC and which is covered under a wraparound coverage provision or direct access for coverage provision of the applicable Subscriber Contract.
- P. "Subscriber" refers to any person with whom or for whose benefit Blue Plus has entered any agreement to provide coverage, administer coverage, or provide access to a participating provider network for Health Services.
- Q. "Subscriber Contract" means the contract, agreement, or other arrangement under which Blue Plus or the Plan Sponsor provides benefits to Subscribers for Health Services.
- R. "Third Party Provider" means a provider other than the PCC receiving payment from Blue Plus for providing certain Health Services to Subscribers, as designated in this Agreement, or such other provider designated from time to time by Blue Plus as a Third Party Provider, provided notification of such designation shall be given to Provider.
- S. "Utilization Review Process" means Blue Plus' or the Plan Sponsor's process for evaluating the necessity, appropriateness, and efficacy of the provision of Health Services and use of facilities by a person or entity other than the attending Health Care Professional, for the purposes of determining Medical Necessity.

Article III. Authority and Covenants



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A. Verification of Eligibility. Before providing Health Services to a Subscriber, the Provider shall require a valid identification card and other positive photo identification, or shall otherwise verify with Blue Plus that the Subscriber is eligible to receive Health Services. The Provider shall not be entitled to payment from Blue Plus or the Plan Sponsor for Health Services provided to any person who is not in fact a Blue Plus Subscriber at the time the Health Services were rendered.

B. Claims Submission. Provider shall promptly submit claims for Health Services to Blue Plus or the Plan Sponsor as directed by Blue Plus. Blue Plus requires Providers to make a good faith effort to submit complete and accurate risk adjustment data as established by the state of Minnesota. Per the Affordable Care Act, Blue Plus may implement a financial penalty if the data is not timely, accurate and complete. Provider shall use its best efforts to submit claims within 30 days of the date of service. In no event may Provider submit claims later than 120 days from the date of service. Such claims shall include all Health Services provided to a Subscriber and all documented diagnoses must be submitted on the claim as specifically as possible. Provider must submit claims using electronic claims submission formats, process and procedures as set forth in the Provider Policy & Procedure Manual, Provider Bulletins or as required by the Plan Sponsor including the proper provider identification number. Provider shall have the right to review its claims which have been processed by Blue Plus at Blue Plus' offices during Blue Plus' regular business hours. Provider waives any right to collect for charges not included in the claim as submitted and agrees not to bill the Subscriber for any such omitted services, claim or late charges.

C. Additional Information. Provider shall promptly furnish at its own expense, any additional information that Blue Plus or the Plan Sponsor shall reasonably request as necessary to respond to claims, utilization review, coordination of benefits, credentialing, quality improvement and care management reviews, Pre-Certification reviews, Pre-Service Reviews, preadmission notification, prior authorizations, Medical Necessity reviews, and medical abstract reports if applicable. Provider shall be responsible for any penalties for failure to abide by required preadmission notifications, pre-certification requirements, or other such advance notice requirements. The Provider shall be responsible for obtaining any authorization required to release such information to Blue Plus and/or the Plan Sponsor. Provider shall comply with requests related to Risk Adjustment and other government required activities such as Medicare Advantage Star Ratings or requirements of the Affordable Care Act or other applicable rules or requirements.

D. Clinical Coding Requirements. Provider shall place appropriate diagnosis and procedure codes and other necessary codes on each claim prior to submission to Blue Plus or Plan Sponsor.

E. Medical Records. Provider shall at Provider's expense, maintain and submit when requested medical record documentation that is complete, clear, concise, consistent, and legible and which conforms with reasonable documentation standards as set forth in the Provider Policy & Procedure Manual. Health Services rendered to Subscribers with no corresponding documentation in the medical record are not eligible for payment, and will be the Provider's responsibility. Provider shall maintain all Subscriber medical records for a minimum of ten (10) years after the last date a Health Service was provided to the Subscriber under this Agreement. Provider shall ensure that all diagnoses are supported in the medical record documentation for each encounter.

F. Provider Bulletins. To promote efficiency and network consistency, Blue Plus shall have the right at any time to issue Provider Bulletins pursuant to this Agreement for the purpose of implementing certain policies, procedures and requirements relating to this Agreement, such as for claims submittal protocol or care management programs, and Provider shall comply with such Provider Bulletins that are in effect on the first date of the term (or renewal term, as applicable) of this Agreement or subsequently communicated to Provider. Blue Plus shall provide Provider with at least forty five (45) days' advance written notice from date of



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publication on bluecrossmn.com of any new Provider Bulletins, unless such Provider Bulletins are issued to comply with a state or federal regulatory or accreditation requirement or to address only minor administrative or operational clarifications, as reasonably determined by Blue Plus, in which case Blue Plus shall provide as much advance notice as is reasonably practical.

G. Access to Records. Provider shall allow Blue Plus or its designee to access, at Provider's offices during Provider's regular business hours, the treatment and billing records of Subscribers to verify claims information, and any aspect of services performed and to access such other records including but not limited to the charge master, for the purpose of verifying compliance with the terms of this Agreement including conducting a charge audit. Provider also agrees to allow any state or federal regulatory or governmental agency, including but not limited to the State of Minnesota, CMS or the Comptroller General, or their designees, peer review organizations, external quality review organizations and other entities with which Blue Plus has a contractual or legal obligation to allow access to Provider records or contracts to inspect, evaluate, and audit any pertinent books, documents, papers and records involving transactions related to this Agreement.

H. Quality Improvement/Managed Care Requirements; Nondiscrimination. Provider agrees to comply with quality improvement and care management requirements and procedures established by Blue Plus or the Plan Sponsor and communicated to Provider (for example, utilization of preferred prescription drugs, completion of Pre-certification reviews, Preauthorization, completion of Pre-Service Reviews, completion of a Utilization Review Process). Provider is responsible for obtaining any Pre-certification, prior authorization, Pre-Service Review or similar advance review required. If such advance authorization is required but not obtained, Provider shall be financially responsible and the Subscriber is held harmless. Provider shall support efforts to encourage the use of patient-centered shared decision making for appropriate conditions in an effort to improve health outcomes and health care value in accordance with Minnesota Statutes, § 256B.69, subd. 9, (c). Provider agrees not to withhold or delay treatment to Subscribers for reasons related to: 1) Blue Plus' payment allowances, including any withhold or other payment method; 2) managed care review requirements; or 3) the Subscriber's age, race, religion, gender, sexual orientation, disability, public assistance status, or suspected or actual presence of the HIV virus or other communicable disease. However, if Provider's practice is limited to a given specialty, Provider is not required to provide treatment outside of that specialty.

I. Referral Requirements. Whenever a referral is necessary, Provider shall refer Subscribers to Blue Plus participating providers in accordance with the referral policy guidelines set forth in the Provider Policy & Procedure Manual.

J. Limited Provider Networks. Blue Plus reserves the right to implement or discontinue limited provider networks (e.g. tiered networks, narrow networks, select networks or other limited networks) or services provided by such networks for certain Health Services or for certain Subscriber Contracts, which may or may not include Provider. Provider agrees to make referrals to such limited network providers, where applicable, subject to exceptions authorized by Blue Plus.

K. Coordination of Benefits. Provider agrees to abide by Blue Plus' benefit determinations and cooperate fully with Blue Plus in the administration of the Coordination of Benefits (COB) and subrogation provisions of the Subscriber Contract using procedures set forth in the Provider Policy & Procedure Manual.

L. Compliance with Laws. Provider and Blue Plus each agree to comply with all applicable state and federal laws, rules, regulations, orders and requirements. Provider further agrees to cooperate with Blue Plus with regard to Blue Plus' efforts to comply with any and all obligations imposed upon Blue Plus under any state and federal laws, rules, regulations, orders and requirements.



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M. Subcontracts. All subcontracts of Provider under this Agreement must be in writing. All subcontracts of Provider are subject to Blue Plus review and approval, upon request of Blue Plus. All subcontractors of Provider shall meet all applicable terms and conditions of this Agreement. Subcontracts shall not abrogate or alter Provider's responsibilities under this Agreement.

Article IV. Provider Payment

A. Payment Amount. Blue Plus shall assure prompt payment directly to Provider for Health Services covered under the Subscriber Contract and prompt response to Provider's claims and inquiries. Except as provided below, payment to Provider for Health Services shall be the lesser of 90% of Provider's regular billed charge or 90% of the Blue Plus fee schedule allowance as determined by Blue Plus (including consideration of Provider's and/or Health Care Professional's license and training), minus Subscriber or other party liabilities (e.g., deductible, coinsurance, non-covered Health Services, and coordination of benefits with other health plans, employer liability plans, Workers' Compensation, or automobile insurance plans) (collectively, "Other Party Liabilities"). Provider agrees to accept such payment amount as payment in full and shall not bill Subscriber for the remaining ten percent (10%). Payment to Provider for Health Services furnished by mid-level practitioners, if applicable and as detailed in the Provider Policy & Procedure Manual, shall be the lesser of 90% of Provider's regular billed charge or 85% of the applicable Blue Plus fee schedule allowance, less Subscriber or Other Party Liabilities. Provider agrees to accept such payment amount as payment in full and shall not bill Subscriber for the remaining fifteen percent (15%).

- Payment to Provider for Health Services furnished by mid-level practitioners, if applicable and as detailed in the Provider Policy & Procedure Manual, shall be the lesser of 90% of Provider's regular billed charge or 85% of the applicable Blue Plus fee schedule allowance, less Subscriber or Other Party Liabilities; Provider agrees to accept such payment as payment in full.
- Payment for Health Services furnished by Certified Registered Nurse Anesthetists shall be the lesser of 90% of Provider's regular billed charge or 80% of the applicable Blue Plus fee schedule allowance, less Subscriber or Other Party Liabilities which Provider agrees to accept as payment in full.
- Payment for Health Services furnished by Masters Level practitioners shall be the lesser of 90% of Provider's regular billed charge or 80% of the applicable Blue Plus fee schedule allowance, less Subscriber or Other Party Liabilities which Provider agrees to accept as payment in full.
- Payment for Health Services furnished by PhD practitioners shall be the lesser of 90% of Provider's regular billed charge or 90% of the applicable Blue Plus fee schedule allowance, less Subscriber or Other Party Liabilities which Provider agrees to accept as payment in full.

B. Replacement of Medical Devices. No payment will be made by Blue Plus and neither Blue Plus nor the Subscriber shall be billed for the cost of a replacement device in excess of the actual cost paid by Provider for the replacement device.

C. Negligence, Omission or Errors. When the negligence, omission, or error on the part of Provider results in the Subscriber incurring additional medical expenses, no payment will be made by Blue Plus for, nor shall Provider bill either Blue Plus or the Subscriber for medical expenses resulting from negligence, omissions, or errors. Information regarding those situations for which no payment shall be made by Blue Plus or the Subscriber shall be set forth in the Provider Policy & Procedure Manual.

D. Minnesota Health Care Programs. For those Health Services provided to Minnesota Health Care



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Programs Subscribers, Blue Plus will pay Provider for Health Services at the lesser of 90% of Provider's regular billed charge or 101% of the applicable Minnesota Health Care Programs fee schedules as published by the Minnesota Department of Human Services and as determined by Blue Plus. For codes not on such fee schedules, payment will be made according to the applicable standard Blue Plus Minnesota Health Care Programs fee schedules as determined by Blue Plus.

E. CPIU Payment Increase. Blue Plus will limit its annual payment increase to the Maximum Increase as defined below. "Maximum Increase means the percentage of increase that Blue Plus will recognize from one year to the next, in which the Provider's actual aggregate percentage increase to regular billed charges will be CPI-U All Items Consumer Price Index for Urban Consumers, less one (1) percent.

F. Medicare Cost and Medicare Advantage Programs. When applicable for a Medicare Cost contract and/or Medicare Advantage Program, Blue Plus shall pay Provider according to the rates specified in the Amendment for Health Services provided to Medicare Cost and Medicare Advantage members and any such amendment shall be considered an attachment to this Agreement.

G. Overpayments. Provider shall promptly report and return overpayments of any kind to Blue Plus. If the overpayment is the result of data incorrectly submitted on a claim for Health Services provided, Provider must promptly send a replacement claim correcting the data and allowing Blue Plus to recoup such overpayment. Submission of replacement claims is limited to six (6) months from last remittance date. Blue Plus shall have the right to make, and Provider shall have the right to request, corrective adjustments to any previous payment for a claim for Health Services provided, however, that any corrective adjustments by Blue Plus, or requests for corrective adjustments by Provider that are approved by Blue Plus, shall be made within twelve (12) months from the date the claim for such Health Services was paid or denied by Blue Plus. No corrective adjustments shall be made by Blue Plus after such twelve (12) month period provided however, that corrective adjustments may be made by Blue Plus after such twelve (12) month period for adjustments related to fraud, coordination of benefits recovery, subrogation recovery and certain other payments as set forth in the Provider Policy & Procedure Manual.

H. ICD-10 Transition. Blue Plus may reduce payment to Provider proportionate to the impact, if any, resulting in additional reimbursement to Provider due to the implementation of ICD-10. The Parties have agreed upon reimbursement as detailed in the Agreement, but should implementing ICD-10 result in additional reimbursement above what Provider would have received under ICD-9, Blue Plus is permitted to adjust reimbursement.

I. Quality Care Delivery. Blue Plus and the Provider shall cooperate to assure the delivery of quality, Medically Necessary Health Services to Subscribers, and assure that no compensation or other incentives exist for the purpose of limiting care delivery. Provider and Blue Plus acknowledge that all decision-makers (practitioners, Providers, and staff including but not limited to medical directors, utilization management directors or managers, medical services management personnel, and utilization management staff members of Provider or Blue Plus) encourage appropriate utilization, assure measures to prevent under-utilization and over-utilization, and discourage inappropriate denials. Utilization management decision making is based only on appropriateness of care and Health Services, and no compensation is made for denials of coverage or Health Services. Blue Plus facilitates the delivery of appropriate care and has mechanisms in place to detect and correct potential under-utilization and over-utilization.

J. Insolvency. In the event a Plan Sponsor fails or is unable to meet its financial obligations in connection with its health benefit plan and the Health Services provided by the Provider are therefore determined not to be covered under the terms and conditions of the Subscriber Contract, the Provider may bill the Subscriber



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directly for such Health Services. In addition, Provider may exercise all remedies provided by law against a Plan Sponsor to collect amounts due Provider.

K. Subscriber Liability. Provider agrees to make a good faith effort to collect any deductible, coinsurance, and/or copayment amounts due from Subscribers. This provision shall not prohibit Provider from collecting a lesser amount on individual hardship cases as determined by Provider. This provision in no way obligates Provider to pass on to Blue Plus any discounted payment arrangements it has negotiated with other third party payers. Deductible and coinsurance liability of the Subscriber shall be calculated based upon the lesser of the Blue Plus Fee Schedule amounts or 90% of Provider's regular billed charge, as calculated by Blue Plus, unless otherwise authorized by Blue Plus. Blue Plus shall calculate the appropriate Subscriber liability amounts and notify Provider of the Subscriber's liability following submission of the claim by Provider. Provider shall abide by all applicable statutes and requirements, including 62Q.751 with respect to collection of and return of deductibles and coinsurance amounts. Further, Provider agrees that all terms of this Agreement apply to all Health Services provided to Subscribers, regardless of the Health Services provided. Provider further agrees not to charge Minnesota Senior Health Options (MSHO) Subscribers coinsurance or copayment amounts that would exceed amounts permitted under Medicaid.

L. Subscriber Hold Harmless. Pursuant to Minnesota law, except for applicable deductible, coinsurance and copayment amounts Provider agrees not to bill, charge, collect a deposit from, seek remuneration from, or have any recourse against a Subscriber or persons acting on their behalf for Health Services provided under this Agreement. This provision applies to, but is not limited to the following events: (1) nonpayment by or insolvency of Blue Plus (including nonpayment due to lack of timely filing of claims by Provider) or (2) breach of the Agreement. This provision does not prohibit Provider from collecting copayments or fees in the event that the Subscriber Contract, as interpreted by Blue Plus or the Plan Sponsor, does not cover the Health Services. This provision also does not prohibit Provider from billing the Subscriber for experimental, investigative or not Medically Necessary Health Services provided that the Subscriber is notified immediately prior to those Health Services being provided that those specific Health Services are experimental, investigative or not Medically Necessary and, after such notice (which must be provided before the Health Services are provided), the Subscriber agrees in writing to pay for those Health Services. Provider shall have the right to appeal initial Medical Necessity decisions through the Utilization Review Process. Provider further agrees not to charge MSHO Subscribers coinsurance or copayment amounts that would exceed the amounts permitted under Medicaid.

This provision survives the termination of this Agreement for authorized Health Services provided before this Agreement terminates, regardless of the reason for termination. This provision is for the benefit of Subscribers, and does not apply to Health Services provided after this Agreement terminates. This provision supersedes any contrary oral or written Agreement existing now or entered into in the future between the Provider and the Subscriber or persons acting on their behalf regarding liability for payment for Health Services provided under this Agreement.

Article V. Applicability

A. Scope of the Agreement. In addition to Health Services provided to Subscribers enrolled in health benefit plans underwritten or administered by Blue Plus, the Agreement applies to Health Services provided by other Blue Plus Blue Shield Plans approved by the Blue Plus Blue Shield Association or where Blue Plus provides access to a participating provider network, as further defined in the Provider Policy and Procedure Manual:

1. Health Services provided to Subscribers enrolled in health benefit plans in which Blue Plus or an Affiliate is responsible for administering the benefit plan provided to Subscribers. If a specific payment



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arrangement is mandated by law for some or all Health Services, such payment arrangement will apply to the extent applicable.

2. Health Services provided to Subscribers of Affiliates at Blue Plus' discretion. For the avoidance of doubt, such Affiliates are entitled to all rights of Blue Plus under this Agreement and shall comply with all terms and conditions of this Agreement. If Provider and an Affiliate have entered into a separate provider service agreement, the terms of such separate provider service agreement will control over this Agreement as long as such separate provider service agreement remains in effect. Nothing in this provision shall place additional risk or obligations on Provider not elsewhere stipulated in this Agreement. This provision allows the extension of this Agreement for Health Services provided to Subscribers enrolled with any applicable Blue Plus Affiliate.

B. Blue Cross and Blue Shield Association Branding. Pursuant to Blue Cross and Blue Shield Association (an association of independent Blue Cross and Blue Shield Plans) (the "Association") licensure requirements, Provider hereby expressly acknowledges its understanding that this Agreement constitutes a contract between Provider and Blue Plus, that Blue Plus is an independent corporation operating under a license from the Association permitting Blue Plus to use the Blue Cross and Blue Shield Service Marks in Minnesota, and that Blue Plus is not contracting as the agent of the Association. Provider further acknowledges and agrees that it has not entered into this Agreement based upon representations by any person other than Blue Plus and that no person, entity, or organization other than Blue Plus shall be held accountable or liable to Provider for any of Blue Plus' obligations to Provider created under this Agreement with respect to any plans underwritten or administered by Blue Plus. This paragraph shall not create any additional obligations whatsoever on the part of Blue Plus other than those obligations created under other provisions of this Agreement.



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Article VI. Provider Requirements

A. Credentialing. Provider shall bill only for Health Services personally performed by Provider's Health Care Professionals who meet the eligibility criteria defined by Blue Plus. Eligibility of Provider's Health Care Professionals will be based on Provider Participation Requirements as defined in the Credentialing and Recredentialing Policy Manual. All such Health Care Professionals must be successfully credentialed by Blue Plus prior to treating any Subscriber. Provider shall: (1) notify Blue Plus immediately if any Health Care Professional's license is ever revoked, suspended, or restricted; and (2) notify Blue Plus within 15 days from the date of hire or termination, as applicable of any additions or deletions of names of individuals who are subject to this Agreement through Provider.

B. Excluded Health Care Professionals. In the event one or more of Provider's Health Care Professionals are excluded from participation with Blue Plus, because he or she has not met the credentialing standards of Blue Plus or because Blue Plus has terminated or suspended the Health Care Professional as provided for in the Agreement, that Health Care Professional will be treated as a nonparticipating provider by Blue Plus. Provider agrees to provide prior written notice to any Subscriber receiving treatment from such Health Care Professional that he or she is nonparticipating. If such notice is not provided, neither Provider nor Provider's nonparticipating Health Care Professional may collect from the Subscriber more than the amount allowed by Blue Plus as set forth in the Subscriber Contract. This provision shall survive termination of this Agreement.

C. Contracted Employees. In the case where Provider contracts with a Health Care Professional at a different rate than that Health Care Professional is paid through employment by another provider holding an Agreement with Blue Plus, the Health Care Professional will be reimbursed at the lesser of the two rates.

D. Participating Provider Availability. Provider shall ensure that all Health Services provided to Subscribers are furnished by Health Care Professionals participating fully with Blue Plus at the time such Health Services are rendered.

Article VII. Insurance and Indemnification

A. Insurance. Provider shall have and continuously maintain adequate insurance for professional liability and personal injury, as determined from time to time by Blue Plus. Provider agrees to provide such evidence of coverage as required by Blue Plus, including but not limited to identification of the malpractice liability insurer, policy number, coverages and liability limits.

B. Indemnification. Each party (the "Indemnifying Party") agrees to hold the other party harmless from any and all claims, damages, and expenses of all kinds (including reasonable attorneys' fees) by reason of any act or omission caused by, or alleged to have been caused by, the Indemnifying Party or any agent or employee of the Indemnifying Party.

Article VIII. Conditions and Limitations

A. PCC Authorization. Health Services shall be provided to a Subscriber only upon the authorization of the Subscriber's PCC and only during such time as the Subscriber is under the treatment and care of such PCC except in the case of emergencies, or where the Subscriber Contract allows for Self-Referrals. If Provider performs services not authorized by the PCC, Provider shall be solely responsible for the cost of those



services, and will not bill or collect from Blue Plus, the PCC, or the Subscriber (except where the Provider has notified the Subscriber immediately prior to services being provided that those specific services have not been authorized by the PCC, and subsequent to such notice, the Subscriber agrees in writing to pay for those specifically identified services).



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Article IX. Quality Improvement and Utilization Review and Evaluation

A. Evaluation. Provider shall cooperate with Blue Plus in the ongoing evaluation of the delivery of Health Services and shall, if requested by Blue Plus, furnish relevant information and periodically participate in special studies which assess the availability, accessibility and appropriateness of Health Services rendered to Subscribers.

B. Second Opinions. Blue Plus may obtain independent medical advice and opinions concerning specific episodes of care or overall patterns of Health Services rendered or arranged by Provider.

C. Quality Care Delivery. Blue Plus and Provider shall cooperate to assure the delivery of quality, Medically Necessary care to Subscribers, and assure that no compensation or other incentives exist for the purpose of limiting care delivery. Provider and Blue Plus acknowledge that all decision-makers (practitioners, providers and staff including but not limited to medical directors, utilization management directors or managers, medical services management personnel, and utilization management staff members of Provider or Blue Plus) encourage appropriate utilization, assure measures to prevent under-utilization, and discourage inappropriate denials. Utilization management decision making is based on appropriateness of care and services, and no compensation is made for denials of coverage or services, nor are any incentives given to decision makers to encourage denials of coverage of services. Blue Plus facilitates the delivery of appropriate care and has mechanisms in place to detect and correct potential under-utilization and over-utilization.

Article X. Amendment and Termination; Arbitration

A. Term; Amendments. The initial term of this Agreement shall be as specified on the Signature Page, and this Agreement shall thereafter automatically renew for one-year terms commencing on July 1 for each subsequent renewal term. The Agreement may be modified and/or amended at any time by Blue Plus upon at least forty five (45) days' prior written notice to the Provider; provided however, that forty five (45) days' advance written notice shall not be required in those circumstances where Blue Plus modifies the fee schedule to correct errors or omissions or to reflect state or federal regulatory requirements, in which case Blue Plus shall provide as much advance notice as is reasonably practical. In the event of any amendment by Blue Cross, Provider shall have 45 days to reject the amendment and terminate the agreement in writing otherwise the parties will assume that the amendment has been accepted by the Provider.

B. Termination. This Agreement may be terminated by either Party according to any one or more of the following provisions.

1. This Agreement may be terminated without cause by a Party upon prior written notice to the other Party with termination to become effective 130 days after receipt of written notice. If the Agreement is so terminated, Blue Cross, at its discretion, may extend the terms of the current Agreement for a period of an additional 180 days, to allow Blue Cross proper notification to Subscribers and continuity of care practices. During such additional period of 180 days of participation, the Provider shall receive payment at the same rates that were in effect on the date termination notification was provided.
2. This Agreement may be terminated upon prior written notice in the event of a material breach of this Agreement and which breach remains uncured 30 days after written notice reasonably specifying the nature of the breach is given to the breaching Party, with termination to become effective on the 30th day after receipt of such notice.



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3. This Agreement may be terminated immediately upon written notice by Blue Plus to Provider in the event that Blue Plus acquires evidence of the potential for significant patient harm or of fraudulent or illegal conduct on the part of Provider or any of Provider's Health Care Professionals with regard to the practice of medicine, claim submission, health care professional eligibility, the delivery of care under this Agreement, or in the event of any sanction by CMS under the Medicare program.
4. Blue Plus reserves the right to terminate the Agreement upon 30 days' prior written notice to Provider with respect to any Provider or Health Care Professional of Provider which fails to complete the credentialing or recredentialing process or is sanctioned or reprimanded by any review organization.
5. Blue Plus shall have the right to terminate Provider's participation in benefit plans (including but not limited to the Minnesota Comprehensive Health Association, the Minnesota Advantage Health Plan, political subdivisions, and Workers' Compensation) if Provider is determined by DHS to be out of compliance with Minnesota Statutes, Section 256B.0644 (requiring providers to accept medical assistance patients) or any other applicable laws. Provider shall notify Blue Plus immediately in event of such non-compliance. The termination shall be effective as of the first date of such non-compliance.

C. Obligations. Termination shall not relieve Blue Plus or Provider of obligations with respect to Health Services furnished prior to the termination date. In certain cases, Subscribers have the right to continue care with Provider for up to 120 days after the effective date of termination, as permitted by Minnesota Statute 62Q.56. Provider shall also notify all Subscribers who are in an active course of treatment advance written notice of the termination of the Agreement prior to the effective date of termination. Such notice shall specify the effective date of such termination of this Agreement and shall indicate that Provider will become nonparticipating on the effective date of termination. If such notice is not provided, Provider may not collect from the Subscriber more than the amount allowed by Blue Plus. For Minnesota Advantage Health Plan Subscribers only, if the Agreement terminates during a calendar year, all the terms of the Agreement will continue until the end of the current calendar year.

D. Arbitration. The Parties agree that any disputes or controversies related to this Agreement shall be subject to mandatory binding arbitration. For all disputes or controversies that arise on or after the effective date of this Agreement and in any manner are related to this Agreement, the Parties agree that the exhaustion of all review and appeal rights set forth in the Provider Policy & Procedure Manual will first be completed prior to commencing arbitration. The Provider Policy & Procedure Manual sets forth the time limits for commencing arbitration, venue, source of arbitration rules, the process to invoke arbitration, and other limits on arbitration. The terms of this provision (including the terms included in the Provider Policy & Procedure Manual) will survive termination and/or expiration of the Agreement and supersede and replace any and all previous provisions regarding arbitration between the Parties.

Article XI. Complaint and Inquiry Procedures

A. Provider's Responsibilities. Provider shall report all Subscriber complaints it receives to Blue Plus and comply with Blue Plus' reporting requirements. Provider and Blue Plus shall cooperate in the resolution of all such complaints in accordance with the provisions of the Provider Policy & Procedure Manual.

B. Appeals. Provider and Subscriber shall have the right to appeal a Utilization Review decisions through Blue Plus' Utilization Review Process as set forth in the Provider Policy & Procedure Manual.

Article XII. Confidentiality; Non-Interference



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- A. Confidentiality Requirements. The Parties shall maintain in strict confidence during the term of this Agreement and subsequent thereafter, except as required by law or for reporting to any third party who has entered into, or proposed to enter into, a Subscriber Contract on behalf of the Subscriber: 1) all Subscriber information which identifies a specific Subscriber (including health and medical record information); 2) all quality improvement and utilization review information; and 3) all financial information related to this Agreement, except as otherwise authorized or required by law or required to administer this Agreement. The Parties agree to abide by any applicable state and federal laws regarding confidentiality and use best efforts to protect confidential information from any unauthorized and unwarranted disclosure. In the event that either Party breaches this confidentiality provision, the affected Party, in addition to all other remedies available under law, shall be entitled to injunctive or equivalent relief. The offending Party also agrees to pay reasonable attorney's fees incurred as a result of breach of this provision. This paragraph shall survive termination of this Agreement.
- B. HIPAA Compliance. Pursuant to the federal Health Insurance Portability and Accountability Act (HIPAA), and the requirements of the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009 (the "HITECH Act") that are applicable to business associates, Provider agrees to abide by all pertinent instructions in the Provider Policy and Procedure Manual, and to comply with those Acts and requirements in all respects.

Article XIII. Miscellaneous

- A. Transplant Services. Other than for kidney and cornea transplants, this Agreement shall not apply to any transplant services unless a separate agreement is fully executed between Blue Plus and Provider.
- B. Assignment. This Agreement shall inure to the benefit of and shall bind the successors of both Parties to the Agreement, but it shall not be assigned or transferred by Provider without the written consent of Blue Plus, such consent not to be unreasonably withheld. Provider agrees that the terms for payment under this Agreement may be assigned to a Plan Sponsor.
- C. Trademarks/Service Marks. Each Party to this Agreement reserves the right to, and control of the use of, its names and all symbols, trademarks and service marks presently existing or hereafter established with respect to it. Provider authorizes Blue Plus to use Provider's name or names, including address(es), and telephone number(s), in an ethical and reasonable manner for purposes of promotion and advertising. Except as authorized herein, each Party agrees that it will not use the names, symbols, trademarks or service marks of the other Party in advertising, promotion, on the Party's Web site(s), or in any other manner without the prior written consent of the other Party and will cease any and all usage immediately upon termination of this Agreement. Blue Plus shall have sole responsibility for all advertising and promotion and for solicitation of Subscribers for its programs, unless the Provider is given express prior written permission to do so by Blue Plus. Provider agrees to display notices of a size and with content approved by Blue Plus in appropriate places at each location where Subscribers are served, to indicate the Provider's business relationship with Blue Plus.
- D. Notices. Notices, reports and records sent to Blue Plus, unless otherwise requested by Blue Plus, shall be addressed to: Blue Plus, Attn: Provider Relations, R317, P. O. Box 64560, St. Paul, Minnesota 55164-0560

Notices, reports and records sent to Provider shall be sent to the street address (or e-mail address if applicable) Provider supplied to Blue Plus, as may be updated from time to time. Provider shall promptly advise Blue Plus of any changes to such address to ensure Blue Plus has current Provider information. The Provider Demographic Change Form is available at bluecrossmn.com. Select "for health care providers" then enter "provider demographic change form" in the search window. Completed forms can be e-mailed directly



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through the application, or printed and faxed to (651) 662-6684 or mailed to: Blue Plus, Attn: PDO, R316, P.O. Box 64560, St. Paul, MN 55164-0560

E. No Third Party Beneficiaries. Nothing herein contained shall be construed to confer any right or cause of action upon any person, group, firm, corporation or public official other than the Provider and Blue Plus (and in any event including with respect to Blue Plus, Blue Plus' Affiliates) or Plan Sponsor, and except for the Subscriber protection provisions of this Agreement.

F. Independent Contractors. Blue Plus and Provider are and shall continue to be independent entities and not agents or representatives of the other.

G. Invalid Provisions; Governing Law. In the event one or more provisions of this Agreement is invalidated, the remainder of the Agreement will remain enforceable. This Agreement shall be governed by the laws of the State of Minnesota and any applicable federal laws or rules.

H. Entire Agreement; Amendments. This Agreement and the documents referenced herein constitute the entire Agreement between Blue Plus and Provider regarding the specific subject matter of this Agreement. This Agreement supersedes any prior agreements and amendments, written or verbal, issued prior to the effective date of this Agreement and relating to the same specific subject matter. Except as expressly authorized in this Agreement, no amendments or modifications to this Agreement shall be valid unless in writing and signed by both Parties.

I. Force Majeure. Neither Party shall have any liability for any delay, failure to perform, or damages caused by acts of nature, war, terrorism, pandemic or any other causes reasonably beyond its control. In the event of pandemic influenza or other pandemic as declared by the U.S. Government or the World Health Organization, Blue Plus shall have the right to extend the term of the Agreement until 90 days after the pandemic has been declared over and Provider shall not terminate this Agreement prior to the expiration of this 90 day period.

J. Waiver. No waivers of or to this Agreement shall be valid unless in writing signed by the Party to be charged with such waiver. No waiver by either Party of any breach or violation of any provision of this Agreement shall operate as, or be construed to be, a waiver of any subsequent breach of the same or any other provisions.

K. Ambiguities. Each Party has participated fully in the review of this Agreement and has had the opportunity to review said Agreement with such Party's legal counsel. Any rule of construction to the effect that ambiguities are to be resolved against the drafting Party shall not apply in interpreting this Agreement. The language in this Agreement shall be interpreted as to its fair meaning and not strictly for or against any Party.

L. Survival. No termination or expiration of this Agreement shall affect the rights and obligations of the Parties which have accrued prior to the effective date of termination or expiration.

M. Cumulative Rights. All rights and remedies of Blue Plus and Provider, respectively, under this Agreement are cumulative, and the exercise by a Party hereto of any rights or remedy herein provided will be without prejudice to the right to exercise any other right or remedy of such Party herein provided all of which are expressly reserved.

N. Headings. Section headings are for reference only and shall not be used in construing this Agreement.



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O. Provider Acquisition. In the event Provider acquires, is acquired by, or merges into or with a third party health care provider that also has a participating provider agreement in effect with Blue Plus at the time of such acquisition or merger, then Blue Plus will in its sole discretion, determine whether or not, and the extent to which, this Agreement and/or the participating provider agreement of such third party health care provider, will be applicable, control and/or be effective.



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Addendum to the Blue Plus Referral Health Professional Provider Service Agreement for Interpreter Services

The Blue Plus Referral Health Professional Provider Service Agreement (Agreement) between Blue Plus and Provider (Provider), to which this Addendum is to be attached and by reference becomes a part thereof, shall be amended as provided in this Addendum.

The purpose of this Addendum is to establish the terms and conditions under which the Provider will provide Health Services for eligible Subscribers covered under a Minnesota Health Care Program. For purposes of the services detailed in this Addendum, Provider is not required to hold an Aware Provider Service Agreement.

Blue Plus and Provider agree that this Addendum and the Agreement apply only to Health Services as detailed herein and that Provider is considered a participating provider for these services only when providing such services to a Minnesota Health Care Program Subscriber.

Hereinafter, Blue Plus and Provider may be jointly referred to as the Parties. The Agreement, this Addendum, Rules and Regulations, and all other attachments constitute the entire Agreement between the Parties.

WHEREAS, Blue Plus, offers oral language and sign language interpretation services to certain eligible individuals enrolled in a Minnesota Health Care Program ("Subscribers") when the Subscribers seek and obtain medical and dental care;

WHEREAS, Provider has experience in providing interpretation services in a medical, behavioral health and/or dental context and desires to provide interpretation services to Minnesota Health Care Programs Subscribers;

NOW THEREFORE, and in consideration as set forth below, Blue Plus and Provider agree as follows:

Article I. Definitions.

A. "Provider" means the undersigned Provider who furnishes Health Services pursuant to this Agreement.

1. "Independent Interpreter " means an entity (individual or agency), which is fluent in two or more languages, and which operates with the primary purpose of aiding oral or sign communication between two or more parties who do not speak or sign the others' language.



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2. "Non-independent Interpreter" means an individual who is fluent in two or more languages, and who operates with the primary purpose of aiding verbal or sign communication between two or more parties who do not speak or sign the others' language. Interpreter is also contracted with or employed by a duly licensed physician or other eligible Health Care Professional as defined, credentialed and approved by Blue Plus, including certain paraprofessionals who are under the direct supervision of a physician and who are credentialed and approved by Blue Plus.

3. Interpreters may not operate in dual role of Interpreter and Health Care Professional.

Article II. Services

A. Upon request by Blue Plus, interpreters employed by or contracted with Provider shall provide timely, reliable and competent interpretation services to a Subscriber in the Subscriber's home for home care visits or at the locations specified by Blue Plus.

B. Only the services specified in this Addendum are eligible for reimbursement when provided to Subscribers. The reimbursement provisions detailed in this Addendum are applicable for eligible interpretation services provided in accordance with the provisions of the Agreement.

C. Communication and Related Skills: Provider shall ensure that its employed or contracted interpreters maintain and apply an understanding of the applicable cultural beliefs and barriers to medical and dental care of such Subscribers and have an understanding of medical and dental terms and procedures to ensure appropriate communications between Subscribers and their medical practitioners. Upon request by Blue Plus, Provider shall demonstrate that its employed or contracted interpreters have the skills to fulfill the Provider's obligations under this Addendum.

D. Neutrality and Accuracy: Provider shall ensure that its employed or contracted interpreters maintain neutrality and accuracy in performing interpretive services. Interpreters employed by or contracted with Provider shall not alter an interpretation, or refuse to interpret, when the reason for such decision or conduct is to affect a Subscriber's decisions or conduct regarding the Subscriber's health care, benefits, or relationship with Blue Plus, or when Provider knows or has reason to know that Provider's conduct may have such an effect. Any action in violation of this section shall be a material breach of the Agreement.

Article III. Administrative Services

A. Provider shall be responsible for scheduling and maintaining appointments in a timely and accurate manner, and for verifying that the Subscriber requesting services, or for whom services are requested, is a Subscriber in a Minnesota Health Care Program. Failure to comply with the provisions of this Article shall result in forfeiture of payment by Blue Plus to Provider and shall be a material breach of the Agreement.



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B. Any interpretation services provided to Blue Plus Minnesota Health Care Program members must be rendered by a registered and rostered interpreter with proper certification. All providers contracted with Blue Plus for provision of interpretation services are accountable for ensuring that interpreters employed by or contracted with their agency meet these requirements. Services provided by interpreters who do not meet the qualifications outlined in the statute are ineligible for payment and should not be billed to Blue Plus. Interpreters that are not properly qualified cannot bill either Blue Plus or the member.

C. Upon request, Provider shall provide to Blue Plus a written list of names of interpreters, by language, who are employed by or contracted with Provider and are covered under the terms of this Addendum.

D. Provider shall maintain appropriate record keeping systems.

1. Independent Interpreter shall provide quarterly reports to Blue Plus, containing the following information:

a. Name of Subscriber for whom interpreter services were provided. If interpreter services are provided to more than one member of a family, list names of all family members that received services during the appointment.

b. Subscriber's Blue Plus ID number. If services are being provided to a family, include all Blue Plus ID numbers.

c. Language interpreted

d. Date of Service

e. Appointment start and end times

f. Place that services were provided (including business and city)

g. Billed charges

2. Non-independent Interpreter will make records pertaining to Subscribers available to Blue Plus, upon reasonable request by Blue Plus, for purposes of administration of the Agreement.

E. Provider shall inform Blue Plus in writing within five (5) working days of all complaints made by Subscribers against Provider, its employees, independent contractors, and other agents. Provider shall provide Blue Plus with a copy of any and all correspondence from Subscribers as soon as possible and in no event later than five (5) days following receipt of the complaint.

F. Independent Interpreter Providers shall have a completed work order on file for each interpreter service billed to Blue Plus. The work order shall contain the name, address and phone number of Agency, date of service, appointment times, interpreter arrival and departure times, Subscriber name, Subscriber address, Subscriber Blue Plus ID number, name and address of the place where services occurred, and description of service provided. The work order must be reviewed for accuracy by a clinic staff member knowledgeable of the interpretation service performed, and shall be signed and dated by both a clinic staff member and the interpreter at the end of the appointment. Upon request, completed work orders shall be provided to Blue Plus.

Article IV. Billing and Reimbursement

A. Payment. Payment to Provider for services shall be in accordance with the Interpreter Rate Table, which shall supersede Article IV. A. (Payment Amount) and Article IV. D. (Minnesota Health Care Programs) of the Agreement. Blue Plus agrees to review the Rate Table on an annual basis.

B. Billing. Independent Interpreter must bill all services on unique lines with the applicable modifier and narrative and the appropriate rate.

C. Services for Families. Independent Interpreter providing interpretation services to members of one family on a single day, in a single location, may bill minimum charges for the first appointment only.

D. Minimum Charge. For Independent Interpreter, minimum charges, as stated below, include reimbursement for mileage, parking fees, wait time and incidental expenses incurred by the Independent Interpreter, unless otherwise specified in the Agreement.

- Sign Language: two (2) hours minimum charge applies
- Oral Language: one hour minimum charge applies.

E. Hospitalization and Patient Transport. Interpretation services provided to Subscribers while hospital inpatients or in patient transport settings are not eligible for reimbursement.

F. Interpreter Services by Health Care Practitioners. Interpretation services provided by a health care practitioner providing Health Care Services to a Subscriber are not eligible for reimbursement.

G. Reimbursement for Interpreter transportation:

1. Independent Interpreter traveling over 60 miles, round trip, to provide interpreter services must obtain prior approval by Blue Plus to bill for mileage.

2. Non-independent Interpreter is not eligible for reimbursement for transportation.

H. Reimbursement for Telephone Interpretation.

1. Independent Interpreter providing telephone interpretation may only bill in situations where the Subscriber, Interpreter and Provider are present on the call for a medical appointment. No charge may be made for telephone calls related to the scheduling of Interpreter services, appointment reminders or other situations where the Subscriber, Interpreter and Provider are not present on the call.

2. Non-independent Interpreter is not eligible to bill for telephone interpretation.

Article V. Term and Termination

A. Term. The term of this Addendum shall commence on the date assigned by Blue Plus, following signature by both parties, and terminate at the end of the contract term. The Addendum shall thereafter automatically renew for additional one-year terms. Blue Plus may amend the Agreement or this Addendum at any time, in accordance with the terms of the Agreement.

Blue Plus reserves the right to revise or terminate the Agreement upon 30 days' prior written notice to Provider in the event that the State of Minnesota changes or terminates the benefit under which Health Services are provided to Blue Plus Minnesota Health Care Program Subscribers under this Addendum.



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**Blue Plus Referral Health Professional Provider Signature Page
for Interpreter Services**

The undersigned Provider and Blue Plus, through their duly authorized representatives, hereby agree to the terms and conditions of the following documents: **Blue Plus Referral Health Professional Provider Service Agreement** ("Agreement"), including the **Addendum for Interpreter Services to the Blue Plus Referral Health Professional Provider Service Agreement**.

Initial Term of the Agreement: _____ through June 30, 20 ____; thereafter, the Agreement as amended shall automatically renew for one year terms on July 1 through June 30 of the subsequent year, unless terminated according to the Agreement.

**CITY OF BLOOMINGTON DIVISION OF
PUBLIC HEALTH**

**Blue Cross and Blue Shield of Minnesota, Blue
Plus and Affiliates**

(signature) (date)
Gene Winstead, Its Mayor

(typed or printed name)

(signature)
Eric Hoag

(name)
Vice President, Provider Relations

(signature) (date)
James D. Verbrugge, Its City Manager

(title)

(date)

(NPI)
1992869820

(Internal Reference Number)
416004990

(Provider Tax ID)
**1800 W OLD SHAKOPEE RD
BLOOMINGTON, MN 55431**

Please Return Signed Original to
Blue Cross and Blue Shield of Minnesota
P. O. Box 64560, Provider Contracting R317
St. Paul, Minnesota 55164-0560

(Provider Address)

Reviewed and approved by the City Attorney.



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PROVIDER GENERAL INFORMATION

Please provide the following information for our files, or make corrections:

National Provider Identifier (Type 2) or Unique Minnesota Provider Identifier (UMPI):

Blue Cross Internal Reference Number: 5KX13CI

Provider Name: CITY OF BLOOMINGTON DIVISION OF PUBLIC HEALTH

Provider Address: 1800 W OLD SHAKOPEE RD
BLOOMINGTON, MN 55431

Provider Phone Number:

Satellite Offices and Associated National Provider Identifiers (Type 2):

Hospital Affiliations:



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Health Care Professionals:

Name	Specialty	National Provider Identifier (Type 1)	Blue Cross Internal Reference Number



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Addendum to the Blue Plus Referral Health Professional Provider Service Agreement for Public Health Nursing Clinic Services

The Blue Plus Referral Health Professional Provider Service Agreement (Agreement) between Blue Plus and Provider (Provider), to which this Addendum is to be attached and by reference becomes a part thereof, shall be amended as provided in this Addendum.

The purpose of this Addendum is to establish the terms and conditions under which Provider will provide Health Services for eligible Subscribers for Health Services covered under a Minnesota Health Care Program. For purposes of the services detailed in this Addendum, Provider is not required to hold an Aware Provider Service Agreement.

In the event of conflict between terms and provisions detailed in this Addendum with those occurring in the Agreement, such terms and provisions as stated in this Addendum shall take precedence.

Blue Plus and Provider agree that this Addendum and the Agreement apply only to Health Services as detailed herein and that the eligible Health Services as defined herein are applicable only to Subscribers who are covered under a Minnesota Health Care Program.

NOW, THEREFORE, it is agreed as follows:

ARTICLE I: DEFINITIONS

The following term as used in this Addendum shall have the meanings as ascribed to them below:

- A. "Certified Public Health Nurse (CPHN)" means a registered nurse who is licensed and providing services within the scope of practice as defined in Minnesota Statutes, and who is certified in public health nursing by the Minnesota Board of Nursing or who received certification from the Minnesota Department of Health prior to January 1990.



ARTICLE II: COVERED HEALTH SERVICES

- A. Services Provided. Only services performed by qualified Public Health Nurses as defined by DHS shall be eligible for reimbursement when provided to Subscribers. Provider will not be considered a participating provider for any other Health Services unless Blue Plus and Provider enter into a separate written agreement with regard to any such other Services.
- B. Eligible Providers. Provider will not be considered a participating provider for any other Health Services unless Blue Plus and Provider enter into a separate written agreement with regard to any such other services.
- C. Service Standards. Health Services shall be eligible for reimbursement by Blue Plus under the terms of the Agreement only when performed by a Certified Public Health Nurse or other qualified personnel or as otherwise agreed upon in writing by both parties. All eligible Health Care Professionals, as identified, performing these services must be employees of Provider.
- D. Provider agrees to abide by all terms and provisions of the complete Agreement, including but not limited to the Blue Cross Provider Policy & Procedure Manual. CMS delegation requirements are detailed in Chapter 3 of the Blue Cross Provider Policy & Procedure Manual.

ARTICLE III: CARE COORDINATION

- A. Consent. Provider shall secure, from each Subscriber treated, a signed consent form that gives Provider permission to share information on diagnosis, treatment and results of laboratory tests with the Subscriber's Primary Care Clinic. Upon receipt of such consent, Provider agrees to send a report to the Subscriber's Primary Care Clinic of all Health Services provided, and to refer the Subscriber to the Primary Care Physician for care as needed.



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B. Provider shall perform, as Blue Plus' delegate, in accordance to the Government Programs Care Coordination guidelines available at:

www.bluecrossmn.com/carecoordination/public/msho_index.html

ARTICLE IV: PAYMENT

A. Terms. Blue Plus will pay Provider for Health Services described in Article II.A. of this Addendum at the lesser of Provider's Regular Billed Charge or 100% of the then-current appropriate Medical Assistance fee schedule, as published by the Minnesota Department of Human Services (DHS). For service codes without prices on the appropriate Medical Assistance fee schedule, the standard Blue Plus fee schedule will apply.

ARTICLE V: TERM AND TERMINATION

A. Term. The term of this Addendum shall commence on the date assigned by Blue Plus, following signature by both parties, and terminate at the end of the contract term. The Addendum shall thereafter automatically renew for additional one-year terms, subject to the Addendum and termination provisions in Article VI.B. of this Addendum. Blue Plus may amend the Agreement or this Addendum at any time, in accordance with the terms of the Agreement.

Blue Plus reserves the right to revise or terminate the Agreement upon 30 days' prior written notice to Provider in the event that the State of Minnesota changes or terminates the benefit under which Health Services are provided to Blue Plus Minnesota Health Care Program Subscribers under this Addendum.



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**Blue Plus Referral Health Professional Provider Signature Page
for Public Health Nursing Clinic Services**

The undersigned Provider and Blue Plus, through their duly authorized representatives, hereby agree to the terms and conditions of the following documents: **Blue Plus Referral Health Professional Provider Service Agreement** ("Agreement"), including the **Addendum for Public Health Nursing Clinic Services to the Blue Plus Referral Health Professional Provider Service Agreement**.

Initial Term of the Agreement: _____ through June 30, 20 ____; thereafter, the Agreement as amended shall automatically renew for one year terms on July 1 through June 30 of the subsequent year, unless terminated according to the Agreement.

**CITY OF BLOOMINGTON DIVISION OF
PUBLIC HEALTH**

Blue Plus

(signature) (date)
Gene Winstead, Its Mayor
(typed or printed name)

(signature)
Eric Hoag
(typed name)
Vice President, Provider Relations

~~(X)~~(signature) (date)
James D. Verbrugge, Its City Manager

(title)

(date)

~~(X)~~
1992869820
(NPI)

Please Return Signed Original to
Blue Plus
P. O. Box 64560, Provider Contracting R317
St. Paul, Minnesota 55164-0560

4KW54CI
(Internal Reference Number)

416004990
(Provider Tax ID)
1800 W OLD SHAKOPEE RD
BLOOMINGTON, MN 55431

(Provider Address)
Reviewed and approved by the City Attorney.



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PROVIDER GENERAL INFORMATION

Please provide the following information for our files, or make corrections:

National Provider Identifier (Type 2) or Unique Minnesota Provider Identifier (UMPI):

Blue Cross Internal Reference Number: 4KW54CI

Provider Name: CITY OF BLOOMINGTON DIVISION OF PUBLIC HEALTH

Provider Address: 1800 W OLD SHAKOPEE RD
BLOOMINGTON, MN 55431

Provider Phone Number:

Satellite Offices and Associated National Provider Identifiers (Type 2):

Hospital Affiliations:



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Health Care Professionals:

Name	Specialty	National Provider Identifier (Type 1)	Blue Cross Internal Reference Number