

City of Tipton, Iowa

Meeting: Tipton City Council Meeting
Place: Tipton Fire Station, 301 Lynn Street, Tipton, Iowa 52772
Date/Time: Monday, February 4, 2019, 5:30 p.m.
Web Page: www.tiptoniowa.org
Posted: Friday, February 1, 2019 (Front door of City Hall & City Website)

Mayor:	Bryan Carney		
Council At Large:	Leanne Boots	Council At Large:	Pam Spear
Council Ward #1:	Ross Leeper	Council Ward #2:	Dean Anderson
Council Ward #3:	Tim McNeill		
City Manager:	Brian Wagner	City Attorney:	Lynch Dallas, P.C.
Finance Director:	Melissa Armstrong	Gas Utilities Supt:	Virgil Penrod
City Clerk:	Amy Lenz	Electric Utilities Supt:	Floyd Taber
Dir. of Public Works:	Steve Nash	Water & Sewer:	Brian Brennan
Police Chief:	Lisa Kepford	Emergency Med Dir:	Brad Ratliff
Park & Recreation:	Adam Spangler	Economic Dev. Director:	Linda Beck

- A. **Call to Order**
- B. **Roll Call**
- C. **Pledge of Allegiance**
- D. **Agenda Additions/Agenda Approval**
- E. **Communications:**

If you wish to address the City Council regarding an issue, whether on the agenda or something not on the agenda, please approach the lectern at this time and give your name and address for the public record before discussing your item.

F. **Consent Agenda**

Note: These are routine items and will be enacted by one motion without separate discussion unless a Council Member requests separate consideration.

1. Approval – City Council Minutes, January 21, 2019
2. Approval – Tipton Development Director’s Report, January 2019
3. Approval – Library Minutes, December 20, 2018
4. Approval – Library Director’s Report, December 2018
5. Approval – Claims List

G. **Public Hearing**

1. Public Hearing on James Kennedy Family Aquatic Center project plans, specifications, form of contract, and engineer’s estimate.

H. **Old Business**

1. Resolution No. 020419A: Resolution approving the plans, specifications, form of contract, and estimated cost of the James Kennedy Family Aquatic Center renovation project.

I. New Business

1. Resolution No. 020419B: Resolution outlining the extent a former employee who is ineligible for re-hire may attend City or Departmental social functions.
2. Discussion and Possible Action Concerning Medicaid Iowa Total Care Agreement
3. Discussion and Possible Action Concerning a DRIP Reimbursement Request, \$7,500.00, 529 Cedar Street, Stuart Clark
4. Discussion and Possible Action Concerning a return to a time limit for the Communications section of the Council's agenda.

J. Reports of Mayor/ Council/ Manager/ Department Heads

1. Mayor's Report
2. Council Reports
3. Committee Reports
4. City Manager's Report
5. Department Heads

K. Adjournment

Pursuant to §21.4(2) of the Code of Iowa, the City has the right to amend this agenda up until 24 hours before the posted meeting time.

If anyone with a disability would like to attend the meeting, please call City Hall at 886-6187 to arrange for accommodations/transportation.

January 21, 2019
Tipton Fire Station
301 Lynn Street
Tipton, Iowa

The City Council of the City of Tipton, Cedar County, Iowa, met in regular session at 5:30 p.m. Mayor Pro-tem Spear called the meeting to order. Upon roll being called the following named council members were present: Leeper, McNeill, Anderson and Spear. Absent: Carney and Boots. Also present: Wagner, Armstrong, Lenz, Nash, Beck, Taber, Penrod, Baughan, S. Paustian, Goerdts, other visitors and the press.

Agenda:

Motion by Anderson, second by Leeper to approve the agenda as presented. Following the roll call vote the motion passed unanimously.

Communications:

1. Richard Kittleson, a Consulting Arborist/ISA Certified Arborist, shared the 2018 findings of the tree inventory in Tipton.
2. Larry Hodgden voiced his opinion on the possibility of a recycling charge being placed on the utility bills.

Consent Agenda:

Motion by McNeill, second by Leeper to approve the consent agenda which includes the January 7th Council Meeting Minutes, December 2018 Treasurer's and Investment Reports, and the following Claims List. Following the roll call vote the motion passed unanimously.

AUCA CHICAGO LOCKBOX	MATS	102.15
BOUND TREE MEDICAL LLC	MEDICAL SUPPLIES	136.42
CEDAR COUNTY CO-OP	FUEL DISCOUNT	2393.53
CEDAR COUNTY ENGINEER	34.70 GL DSL	1177.29
CINTAS LOC	UNIFORMS	535.96
CJ COOPER & ASSOC INC	RANDOM SCREEN & PRE EMPLOY	70.00
CLIFTON LARSON ALLEN LLP	PROGRESS BILLING FOR AUDIT	4900.00
CUSTOM BUILDERS INC	UPS CHARGES	74.08
D & R PEST CONTROL	PEST CONTROL	190.99
DORSEY & WHITNEY LLP	18-21 SANITARY SEWER PROJECT	3500.00
EASTERN IOWA LIGHT & POWER	EAST LAGOON	905.72
ECIA	GRANT WRITING CONTRACT	369.00
ELECTRICAL ENGINEERING & E	BLDG MAINT SUPPLIES	88.92
FASTENAL COMPANY	OVERHEAD SUPPLIES	292.36
FLETCHER-REINHARDT CO.	SAFETY GEAR	83.72
FOX APPARATUS REPAIR & MAI	FIRE TRUCK REPAIRS	1198.25
FREY, HAUFE & CURRENT PLC	LEMON STREET PROJECT	1292.00
GARDEN & ASSOCIATES INC	2018-19 STREET PROJECTS	10000.00
HBK ENGINEERING LLC	AQUATIC CENTER	909.75
IIW PC	CROOKED CREEK TRAIL	3081.00
IMAGE TREND INC	CLEARING HOUSE SERVICES	196.00
INTEGRATED TECHNOLOGY PART	TECH SERVICES	270.00
IOWA ASSOCIATION OF	TESTING	1480.00
IOWA DARE ASSOCIATION	MEMBERSHIP DUES LISA & DAVID	200.00

JOHNSON COUNTY AMBULANCE S	ALS INTERCEPT	400.00
KLOCKE'S EMERGENCY VEHICLE	20 AMP FEMALE CORD END	87.89
KUNDE OUTDOOR EQUIPMENT	HELMET SYSTEM	94.95
MC CLURE ENGINEERING COMPA	LEMON ST IMPROVEMENTS	31981.25
MISC. VENDOR	PROGRESSIVE:PRE-WORK SCREEN	475.00
MUNICIPAL SUPPLY INC	WATER MAIN REPAIR PARTS	1337.33
NILES CHIROPRACTIC	PRE EMPLOY SCREENINGS	50.00
OFFICE EXPRESS	OFFICE SUPPLIES	332.56
PCM/TIGERDIRECT	COMPUTER	854.98
PHYSIO-CONTROL INC	ANNUAL MAINT AGREEMENT	2599.20
POWER LINE SUPPLY	UNDERGROUND SUPPLIES	747.56
PRAXAIR DISTRIBUTION INC	OXYGEN	46.44
QC ANALYTICAL SERVICES LLC	WASTEWATER TESTING	1536.00
REPUBLIC SERVICES OF IOWA	CARDBOARD BALED	1035.50
SECRETARY OF STATE	NOTARY RENEWAL AMY	30.00
SPINUTECH INC	JANUARY EMAIL MARKETING	25.00
STATE HYGIENIC LABORATORY	WATER & POOL TESTING	52.00
STOREY KENWORTHY/MATT PARR	UTILITY BILLING ENVELOPES	736.46
STUELAND AUTO CENTER INC	REPAIR PARTS #13	225.00
TIPTON ELECTRIC MOTORS	WELD GAS EXCHANGE	65.44
TIPTON GREENHOUSE & FLORIS	FLOWERS SNAVELY	45.48
TIPTON PHARMACY	PHARMACEUTICALS	600.13
TIPTON STRUCTURAL FABRICAT	STEEL	39.20
TRANS IOWA EQUIPMENT	GRABBER BELTS #30	138.13
TYLER TECHNOLOGIES INC	UB NOTIFICATIONS	29.80
UNIFORM DEN INC	UNIFORM EQUIPMENT	109.47
VERMEER SALES & SERVICE IN	REPAIR PARTS #135	1560.31
** TOTAL **		78682.22
FUND TOTALS		
001 GENERAL GOVERNMENT		10,214.18
110 ROAD USE TAX FUND		13,273.25
315 JKFAC CP		909.75
600 WATER OPERATING		1,539.85
610 WASTEWATER/AKA SEWER REVE		36,123.45
630 ELECTRIC OPERATING		2,773.45
640 GAS OPERATING		1,175.98
670 GARBAGE COLLECTION		1,225.31
810 CENTRAL GARAGE		5,674.30
835 ADMINISTRATIVE SERVICES		5,772.70
GRAND TOTAL		78,682.22

New Business:

1. Closed Session:

Pursuant to Iowa Code Section 21.5 (1)(c) to "discuss strategy with counsel in matters that are presently in litigation or where litigation is imminent where its disclosure would be likely to prejudice or disadvantage the position of the governmental body in that litigation." Motion by Leeper, second by McNeill to adjourn from regular session to closed session at 5:55 p.m. Motion carried by the following roll call;

Aye: Spear, Leeper, McNeill, Anderson

Nay: None

Absent: Boots

Roll Call to return to regular session:

The council reconvened to regular session from closed session at 6:10 p.m. with the following named Council member's present; Leeper, McNeill, Anderson and Spear. Absent: Boots. Motion by Leeper, second by McNeill to reconvene to regular session from closed session. Motion carried by the following roll call;

Aye: Leeper, McNeill, Anderson, Spear

Nay: None

Absent: Boots

2. Retirement Letter from Fire Chief Scott Donohoe

Motion by McNeill, second by Leeper to accept Scott Donohoe's retirement effective January 8, 2019, with the understanding that Mr. Donohoe is not eligible for re-hire upon retirement and with direction to City Manager Wagner to work with the City's attorney to draft a resolution to be provided at the next council meeting outlining the extent to which an individual who is not eligible for re-hire can attend City social functions. Following the roll call vote the motion passed unanimously.

3. Resolution No. 012119A: A resolution to set a public hearing regarding the proposed plans, specifications, form of contract, and estimated cost of the James Kennedy Family Aquatic Center renovation project.

Motion by McNeill, second by Leeper to approve Resolution No. 012119A, the resolution to set a public hearing for Monday, February 4th at 5:30 p.m. regarding the proposed plans, specifications, form of contract, and estimated cost of the James Kennedy Family Aquatic Center renovation project. Following the roll call vote the motion passed unanimously.

4. Resolution No. 012119B: A resolution in support of the Cedar County Mural Project executed in partnership with the University of Iowa art students residency program.

Motion by McNeill, second by Anderson to approve Resolution No. 012119B, the resolution in support of the Cedar County Mural Project executed in partnership with the University of Iowa art students residency program. Following the roll call vote the motion passed unanimously.

5. Resolution No. 012119C: A resolution authorizing an application to the Wellmark Foundations' "Matching Assets to Community Health (large match) Grant Program" for the "Walkable, Playable and Accessible Tipton" Project in our City Park

Motion by Leeper, second by McNeill to approve Resolution No. 012119C, the resolution authorizing an application to the Wellmark Foundations' "Matching Assets to Community Health (large match) Grant Program" for the "Walkable, Playable and Accessible Tipton" Project in our City Park. Following the roll call vote the motion passed unanimously.

6. Authorizing the use of a limited amount of DRIP Funds for the Hardacre Theater Project, Part 2

Motion by Anderson, second by Leeper to approve authorizing the use of a limited amount of DRIP Funds up to \$10,000.00 for grant writing services for the Hardacre Theater Project, Part 2. Following the roll call vote the motion passed unanimously.

7. 2019 Fire Department Officers

Motion by McNeill, second by Leeper to approve the 2019 Fire Department officers. Following the roll call vote the motion passed unanimously.

8. Fire Station Boiler Bi-annual Preventative Maintenance Agreement

Motion by McNeill, second by Leeper to approve the fire station Bi-annual Preventative Maintenance agreement. Following the roll call vote the motion passed unanimously.

9. Purchase of new Street Light

Motion by Anderson, second by Leeper to approve the purchase of a new street light by the library on Hwy 38. Following the roll call vote the motion passed unanimously.

10. New Community Guide

Motion by McNeill, second by Leeper to approve a new format for the community guide showcased in Tipton. Following the roll call vote the motion passed unanimously.

11. Purchase of new Locator for the Electric Department

Motion by Leeper, second by Anderson to approve the purchase of a new locator from Irby in the amount of \$4,495.00. Following the roll call vote the motion passed unanimously.

12. Donation to Cedar County Fair

Motion by McNeill, second by Leeper to approve a \$500.00 donation to the Cedar County Fair. Following the roll call vote the motion passed unanimously.

Reports of Mayor/Council/Manager/Department Heads

Director of Public Works Nash shared information with the council about the increased cost of recycling and that we need to think about raising the garbage rate or adding a recycling rate.

Gas Superintendent Penrod shared information with the council about the rural development gas project regarding natural gas versus propane and the cost savings for the customers.

Electric Superintendent Taber stated he is working on a new rebate program.

Adjourn:

With no further business to come before the council a motion to adjourn was made by Leeper, second by Anderson. Following the roll call vote the motion passed unanimously. Meeting adjourned at 6:51 p.m.

Mayor_____

Attest:_____
City Clerk

Tipton Development Director –Report January 2019 – Linda Beck

- Wayfinding signage – Update with IIW – had a discussion with Jon Lutz and Jeri Vondera on January 18th
- Discussion on January 8th regarding a mural project. Met with Rod Ness - CCEDCO, Marla Quinn - ECIA and Maura Pilcher - University of Iowa Art Residency Program
- Chamber part-time position: Several applied for this position. Committee met on January 4th to discuss applicants. Interviews scheduled for January 14, 15, 22 and 24
- Working with Kim Anderson Counselor at the Tipton High School on a job fair slated for February 27th from 9-11 a.m. at the high school
- Meeting held regarding a DRIP application with 2 businesses
- Beginning to work on a new Community Guide for Tipton
- Meeting held with Beth Moores with BMF on January 8th and January 18th
- Meeting held with Greg Brown on January 4th
- Assisted taking down Christmas decorations downtown on January 4th
- Working on Wellmark grant for the park and Historical Preservation Grant and the Community Foundation Grant for the Hardacre
- Laken Hermiston – senior at Tipton High School began her internship on January 10th at my office
- Updated the Welcome Packets for new Tipton residents
- Finalized DRIP application for reimbursement
- Attended the Freedom Rock meeting on January 16th
- Working on an RLF for a new business owner

December 20 Library Meeting Minutes

Jamie called the meeting to order at 6:30 pm

In attendance: Sherry Hall, Jim McCollough, Jamie Meyer, Jen Johnson

Sherry motioned to approve last meeting's minutes

- Jim second, motion carried

Director's Report

- Library will be closed Jan. 11 for inventory
- Started working on Summer Reading program
 - Sent out letters asking for sponsors and already have new sponsors for 2019

Education

- Hiring the Library Director

Financial Reports

- Motion to accept financial report
 - Jim motioned, Sherry accepted

Finance Committee: NA

Personnel Committee: NA

Maintenance Committee:

- West Branch roofing was here
- Need to have plumber look at pipe in women's restroom

Friends of the Tipton Public Library: NA

Old Business:

- Get Absolute Dry on the calendar

New Business:

- Staff education and development
 - Jim motion to keep as is, Sherry second

Approve 2019-2020 Budget

- Total Budget \$219, 375 (without insurance and utilities)
- Jim motion to accept proposed budget, Sherry second

The city of Tipton is contracting out for the mowing

- Library is choosing to stay with current lawn care provider

Miscellaneous

- Set time and date for next meeting
 - January 23 and 6:30

Jim motion to adjourn meeting, Jen second, motion approved

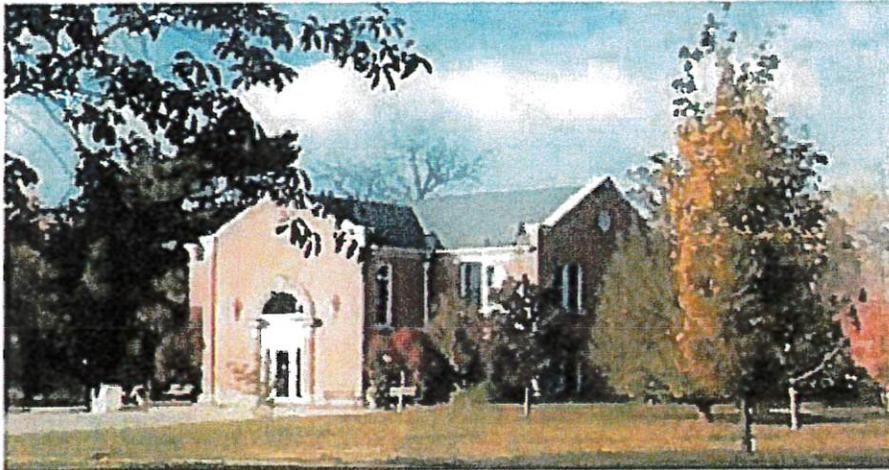
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TIPTON PUBLIC LIBRARY

Check it out!

December 2018

Director's Report



Prepared by Denise Smith

Library Director

To

Library Board, Mayor Carney, Council Members and City Manager

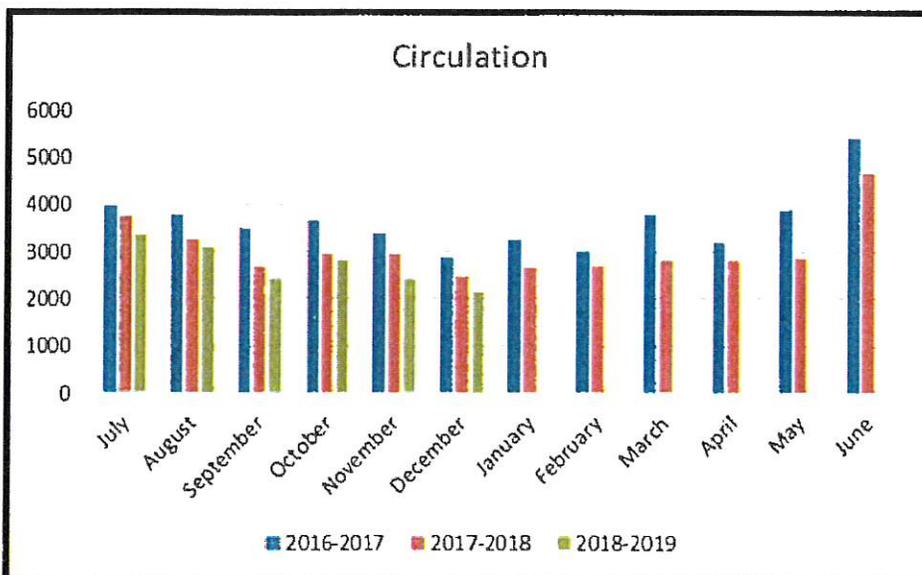
January 2019

Statistics December 2018

	Nov.	YTD
Total Circulation	2,146	16,217
Computer Use	295	2,133
WiFi Usage	104	780
Attendance of Programs	591	2,601
Transactions for Copies made	159	954
Transactions for Faxes Sent	23	107
Transactions for ILL checked out	27	176
Transactions for Keurig Drinks	33	103
Transactions for Friends of Library	33	215
Door Count	2,448	19,112

Circulation by Material Types

	Dec.	YTD
Adult books	517	3,920
Teen Books	122	781
Children's books	865	6,775
DVDs	563	4,124
CDs	54	466
Magazines	25	151



MISSION STATEMENT

The Tipton Public Library will provide all the people of its community, a welcoming place where access to a balanced collection, technology, programming and other resources will serve their educational, cultural and recreational needs.

Library Staff

Denise Smith
Director

Diane Wallick
Assistant Director

Tryeann Schultz
Library Assistant

Amy Wallace
Library Assistant

Matthew Smith
Library Assistant

Cindy Kunde
Library Assistant Sub

Melissa Zell
Library Assistant Sub

Karree Bandfield
Library Assistant Sub

John Barnum
Custodian

Library Board of Trustees

Jamie Meyer-President
Dale Jedlicka-Vice President
Heather Sloma-Weber
Jennifer Johnson-Secretary
Marcus Hertert
Jim McCollough
Sherry Hall

Tipton Public Library Patron Count

Date (Monday-Saturday)	Daily Activities	Count	Month Total
Sept 24th-Sept 29th	Library Board Meeting, 6th-8th grade book chat, FOTL open house	736 people	Month Total Sept: 2857
October 1st-October 6th	Large room use: Friends of the Library Meeting, Iowa Voc Rehab, (2) school meetings	757 people	
October 8th-October 13th	Large room use: Tipton Community School and early out Monarch Butterfly program	719 people	
October 15th-October 20th	Adult Book Chat, Halloween Story Time	844 people	
October 22nd-October 27th	Iowa Vocational Rehab large room use, 3rd-5th grade book chat	825 people	10/29-10/31 411 11/1-11/3 274
October 29th-November 3rd	Large room use: Tipton Community School Principal Meeting	685 people	Month Total October: 3556
November 5th-November 10th	Friends of the Library Book Sale	923 people	
November 12th-November 17th	CLOSED MONDAY. Large room use: Tipton Community School, Kent Ruppert, Library Pancake Program, Library Thanksgiving Story Time.	1100 people	
November 19th-November 24th	CLOSED THURSDAY AND FRIDAY. Large room use: Kent Ruppert, Adult book chat, board meeting, Iowa Vocational Rehab	513 people	11/26-11/30 565 12/1 61
November 26th-December 1st	Large Room use: Girl Scouts, Kent Ruppert and early out Board Games Fun	626 people	Month Total November: 3375
December 3rd-December 8th	Large Room use: Tipton Community School, early out activity Christmas Bingo	692 people	
December 10th-December 15th	Large Room use: Early out activity Christmas Suncatchers, Christmas Story Time	667 people	
December 17th-December 22nd	Large Room use: Iowa Vocational Rehab, Adult Book Chat, Board Meeting	622 people	
December 24th-December 29th	Closed Monday and Tuesday	334 people	12/31 72 1/1-1/5

Tipton Public Library Patron Count

Date (Monday-Saturday)	Daily Activities	Count
December 31st-January 5th	Large Room Use: TCSD. Closed early Monday and closed on Tuesday.	people
January 7th-January 12th		people
January 14th-January 19th		people
January 21st-January 26th		people
January 28th-February 2nd		people
February 4th-February 9th		people
February 11th-February 16th		people
February 18th-February 23rd		people
February 25th-March 2nd		people
March 4th-March 9th		people
March 11th-March 16th		people
March 18th-March 23rd		people
March 25th-March 30th		people
April 1st-April 6th		people

Month Total Dec: 2448

1/28-1/31
2/1-2/2

Month Total Jan:

2/25-2/28
3/1-3/2

Month Total Feb:

Month Total March:



Revenues

	December	YTD
Taxes	\$0	\$0
Rural Funding	\$0	\$12,478.54
Fines and Fees	\$262.36	\$1,588.57
Donations	\$444.00	\$6,595.56
D.State A/EI	\$1,126.92	\$3,127.70
Reimbursements	\$30.00	\$184.00
Refunds	\$0	\$0
Miscellaneous	\$291.25	\$1,424.25
Transfer	\$0	\$0
Utilities	\$980.54	\$2,941.70
Total Revenues	\$2,008.15	\$28,340.32



Expenses

	December	YTD
Staff	\$7,797.64	\$50,763.85
Staff Benefits	\$1,221.39	\$8,222.97
Materials	\$1,117.70	\$13,464.04
B. Maintenance	\$400.76	\$1,058.81
G. Maintenance	\$45.60	\$45.60
Technology	\$0	\$99.99
Programming	\$292.20	\$1,753.53
Miscellaneous	\$3,545.74	\$25,535.05
Software	\$799.00	\$799.00
Total Expenses	\$14,421.03	\$101,742.84

Monies Spent on Library Materials

	December	YTD
Books	\$476.61	\$7,859.08
DVDs	\$282.30	\$1,479.11
CDs	\$63.75	\$1,081.50
Mag./News.	\$0	\$379.99



Current Inventory 1/11/2019

JFIC/2415

BR-1/304

BR-2/226

BR-3/79

BC/365

FIC/4173

DVD/1276

BRD/19

JDVD/106

BB/218

CD/451

000-999/794

CP/10

MAG/144

JCD/35

JFIC-b/2585

E/140

ILL/7

J000-999/1039

JBIO/65

YAFIC/1360

TRAIN/1

TOTAL - 15812

1/11/2019 Inventory Medium Report

Cds: 486

Magazines: 144

Dvds: 1401

Books: 13763

Other: 18

Total: 15812

Patron	2446
Item Titles	15803
Item Copies	15812
Transactions	6967
Statistics Records	335677
Patron Policies	41
Item Policies	36
Circulation Policies	39
Orders	1
Vendors	8
Budgets	1
Subscriptions	1
Routes	1
Sites	1
Operations	179
Web Statistics	171
SIF	0
Inventory Sessions	0
Inventory Exceptions	0
Reports	131
Scheduled Reports	2

Alexandria DS Information:

Jan 11, 2019 2:18 pm

Version: 6.22.9 build 20160503

Library Name: Tipton Public Library

Product Codes: P5C1C2C3C4\$1F6F9S3F5H2A3

Serial Number: 7055510

Tipton Public Library

Librarian:

VENDOR SEQUENCE

VENDOR	ITEM NO#	DESCRIPTION	BANK	CHECK	STAT	DUE DT	DT	GROSS BALANCE	PAYMENT DISCOUNT	OUTSTANDING

01-0151	ARROW INTERNATIONAL INC									
I 9500893152		MEDICAL SUPPLIES	AP		R	1/31/2019		194.50	194.50CR	
		G/L ACCOUNT						194.50		
	001 5-160-2-65070	OPERATING SUPPLIES					194.50	MEDICAL SUPPLIES		
				REG. CHECK				194.50	194.50CR	0.00
								194.50	0.00	

01-0143	AUCA CHICAGO LOCKBOX									
I 1877104027		MATS	AP		R	3/02/2019		102.15	102.15CR	
		G/L ACCOUNT						102.15		
	001 5-650-2-63100	BUILDING MAINTENANCE & REPAIR					102.15	MATS		
				REG. CHECK				102.15	102.15CR	0.00
								102.15	0.00	

01-0253	BOUND TREE MEDICAL LLC									
I 83084686		MEDICAL SUPPLIES	AP		R	1/31/2019		309.18	309.18CR	
		G/L ACCOUNT						309.18		
	001 5-160-2-65070	OPERATING SUPPLIES					309.18	MEDICAL SUPPLIES		
I 83092436		MEDICAL SUPPLIES	AP		R	1/31/2019		23.40	23.40CR	
		G/L ACCOUNT						23.40		
	001 5-160-2-65070	OPERATING SUPPLIES					23.40	MEDICAL SUPPLIES		
				REG. CHECK				332.58	332.58CR	0.00
								332.58	0.00	

01-0317	BUSINESS RADIO SALES AND SE									
I 63763		5 RADIOS	AP		R	3/02/2019		4,800.50	4,800.50CR	
		G/L ACCOUNT						4,800.50		
	001 5-150-3-67270	OTHER CAPITAL EQUIPMENT					4,800.50	5 RADIOS		
				REG. CHECK				4,800.50	4,800.50CR	0.00
								4,800.50	0.00	

VENDOR SEQUENCE

VENDOR	ITEM NO#	DESCRIPTION	BANK	CHECK	STAT	DUE DT	DISC DT	GROSS BALANCE	PAYMENT DISCOUNT	OUTSTANDING	
		640 5-825-2-64350						44.47	UNIFORMS, SHOP TOWELS, MATS		
		630 5-820-2-65070						46.94	UNIFORMS, SHOP TOWELS, MATS		
I 342848073		UNIFORMS, SHOP TOWELS, MATS AP			R	2/01/2019		171.85	171.85CR		
		G/L ACCOUNT						171.85			
		630 5-820-2-64350						80.44	UNIFORMS, SHOP TOWELS, MATS		
		640 5-825-2-64350						44.47	UNIFORMS, SHOP TOWELS, MATS		
		630 5-820-2-65070						46.94	UNIFORMS, SHOP TOWELS, MATS		
								REG. CHECK	615.67	615.67CR	0.00
								615.67	0.00		

01-0840	ECIA										
I 17020		GRANT WRITING CONTRACT	AP		R	3/03/2019		1,435.00	1,435.00CR		
		G/L ACCOUNT						1,435.00			
		835 5-899-2-65980	MISCELLANEOUS					1,435.00	GRANT WRITING CONTRACT		
								REG. CHECK	1,435.00	1,435.00CR	0.00
								1,435.00	0.00		

01-1066	GARDEN & ASSOCIATES INC										
I 37594		2018-19 STREET PROJECTS	AP		R	3/03/2019		16,475.34	16,475.34CR		
		G/L ACCOUNT						16,475.34			
		110 5-210-2-64070	ENGINEERING					16,475.34	2018-19 STREET PROJECTS		
								REG. CHECK	16,475.34	16,475.34CR	0.00
								16,475.34	0.00		

01-1114	H.D. CLINE COMPANY										
I TI136008		SKID/SHOE	AP		R	2/01/2019		16.05	16.05CR		
		G/L ACCOUNT						16.05			
		630 5-820-2-65980	MISCELLANEOUS					16.05	SKID/SHOE		
								REG. CHECK	16.05	16.05CR	0.00
								16.05	0.00		

01-1117	HACH COMPANY										
I 11297789		FLOURIDE REAGENT	AP		R	2/01/2019		74.25	74.25CR		
		G/L ACCOUNT						74.25			
		600 5-810-2-65041	LAB EQUIPMENT/SUPPLIES					74.25	FLOURIDE REAGENT		

PACKET: 02910 COUNCIL MTG 020419

VENDOR SET: 01

VENDOR SEQUENCE

VENDOR	ITEM NO#	DESCRIPTION	BANK	CHECK	STAT	DUE DT	DISC DT	GROSS BALANCE	PAYMENT DISCOUNT	OUTSTANDING

				REG. CHECK				74.25	74.25CR	0.00
								74.25	0.00	

01-1154	HASTY AWARDS									
I 01191376	20	BB MEDALS	AP		R	3/03/2019		54.38	54.38CR	
		G/L ACCOUNT						54.38		
	001	5-446-2-65070	OPERATING SUPPLIES				54.38	20	BB MEDALS	
				REG. CHECK				54.38	54.38CR	0.00
								54.38	0.00	

01-1172	HAWKINS INC									
I 4428467		CHEMICALS	AP		R	2/01/2019		737.65	737.65CR	
		G/L ACCOUNT						737.65		
	600	5-810-2-65010	CHEMICALS				737.65		CHEMICALS	
				REG. CHECK				737.65	737.65CR	0.00
								737.65	0.00	

01-1289	INTEGRATED TECHNOLOGY PARTN									
I 111439		TECH SERVICES	AP		R	2/01/2019		247.50	247.50CR	
		G/L ACCOUNT						247.50		
	001	5-110-2-64190	TECHNOLOGY				247.50		TECH SERVICES	
I 111463		TECH SERVICES	AP		R	2/01/2019		45.00	45.00CR	
		G/L ACCOUNT						45.00		
	630	5-820-2-64190	TECHNOLOGY				45.00		TECH SERVICES	
I 111465		TECH SERVICES	AP		R	2/01/2019		180.00	180.00CR	
		G/L ACCOUNT						180.00		
	001	5-465-2-64190	TECHNOLOGY				180.00		TECH SERVICES	
				REG. CHECK				472.50	472.50CR	0.00
								472.50	0.00	

01-1270	IOWA ASSOCIATION OF									
I 18562		TESTING	AP		R	3/03/2019		185.00	185.00CR	
		G/L ACCOUNT						185.00		
	640	5-825-1-62300	TRAINING				185.00		TESTING	

VENDOR SEQUENCE

VENDOR	ITEM NO#	DESCRIPTION	BANK	CHECK	STAT	DUE DT	DISC DT	GROSS BALANCE	PAYMENT DISCOUNT	OUTSTANDING
I 18588		TESTING	AP		R	3/03/2019		105.00	105.00CR	
		G/L ACCOUNT						105.00		
	640 5-825-1-62300	TRAINING					105.00	TESTING		
				REG. CHECK				290.00	290.00CR	0.00
								290.00	0.00	

01-1319	IOWA DEPARTMENT OF REVENUE									
I 2019IDR		STATEWIDE PROPERTY TAX	AP		R	3/03/2019		47.42	47.42CR	
		G/L ACCOUNT						47.42		
	630 5-820-2-64180	TAXES					47.42	STATEWIDE PROPERTY TAX		
				REG. CHECK				47.42	47.42CR	0.00
								47.42	0.00	

01-1332	IOWA ONE CALL									
I 208264		LOCATES	AP		R	3/03/2019		10.80	10.80CR	
		G/L ACCOUNT						10.80		
	600 5-810-2-65307	SERVICE LINES					3.60	LOCATES		
	630 5-820-2-65304	UNDERGROUND SUPPLIES					3.60	LOCATES		
	640 5-825-2-65307	SERVICE LINES					3.60	LOCATES		
				REG. CHECK				10.80	10.80CR	0.00
								10.80	0.00	

01-1271	IPAA									
I 2019IPAA		MEMBERSHIP FEE	AP		R	3/03/2019		100.00	100.00CR	
		G/L ACCOUNT						100.00		
	660 5-835-1-62100	DUES/FEES					100.00	MEMBERSHIP FEE		
				REG. CHECK				100.00	100.00CR	0.00
								100.00	0.00	

01-1470	KIRKWOOD COMMUNITY COLLEGE									
I 27505		BLS RENEWAL	AP		R	3/03/2019		7.00	7.00CR	
		G/L ACCOUNT						7.00		
	001 5-160-1-62300	TRAINING					7.00	BLS RENEWAL		
				REG. CHECK				7.00	7.00CR	0.00
								7.00	0.00	

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VENDOR SET: 01

VENDOR SEQUENCE

VENDOR	ITEM NO#	DESCRIPTION	BANK	CHECK	STAT	DUE DT	DT	GROSS BALANCE	PAYMENT DISCOUNT	OUTSTANDING

01-1500	KUNDE OUTDOOR EQUIPMENT									
I 13868		SPARK PLUG	AP		R	3/03/2019		13.16	13.16CR	
		G/L ACCOUNT						13.16		
	001 5-150-2-63310	VEHICLE OPERATIONS					13.16	SPARK PLUG		
		REG. CHECK						13.16	13.16CR	0.00
								13.16	0.00	

01-2010	L L PELLING CO INC									
I 123928		7.26 TN COLD MIX	AP		R	3/03/2019		798.60	798.60CR	
		G/L ACCOUNT						798.60		
	001 5-210-2-65070	OPERATING SUPPLIES					798.60	7.26 TN COLD MIX		
		REG. CHECK						798.60	798.60CR	0.00
								798.60	0.00	

01-1514	LANDS' END BUSINESS OUTFITT									
I SIN7084171		5 SHIRTS - MANDY @ FAC	AP		R	2/01/2019		142.90	142.90CR	
		G/L ACCOUNT						142.90		
	001 5-465-2-64350	UNIFORMS/EQUIPMENT					110.73	5 SHIRTS - MANDY @ FAC		
	630 5-822-2-64350	UNIFORMS/EQUIPMENT					32.17	5 SHIRTS - MANDY @ FAC		
		REG. CHECK						142.90	142.90CR	0.00
								142.90	0.00	

01-1593	LYNCH DALLAS PC									
I 157307		LEGAL SERVICES	AP		R	2/01/2019		1,367.50	1,367.50CR	
		G/L ACCOUNT						1,367.50		
	835 5-899-2-64110	LEGAL EXPENSE					1,367.50	LEGAL SERVICES		
I 157308		LEGAL SERVICES	AP		R	2/01/2019		27.00	27.00CR	
		G/L ACCOUNT						27.00		
	640 5-825-2-64110	LEGAL EXPENSE					27.00	LEGAL SERVICES		
I 157309		LEGAL SERVICES	AP		R	2/01/2019		54.00	54.00CR	
		G/L ACCOUNT						54.00		
	630 5-820-2-64110	LEGAL EXPENSE					54.00	LEGAL SERVICES		
I 157310		LEGAL SERVICES	AP		R	2/01/2019		87.50	87.50CR	
		G/L ACCOUNT						87.50		
	835 5-899-2-64110	LEGAL EXPENSE					87.50	LEGAL SERVICES		

VENDOR SEQUENCE

VENDOR	ITEM NO#	DESCRIPTION	BANK	CHECK	STAT	DUE DT	DISC DT	GROSS BALANCE	PAYMENT DISCOUNT	OUTSTANDING

I 157311		LEGAL SERVICES	AP		R	2/01/2019		297.00	297.00CR	
		G/L ACCOUNT						297.00		
	835 5-899-2-64110	LEGAL EXPENSE					297.00	LEGAL SERVICES		
		REG. CHECK						1,833.00	1,833.00CR	0.00
								1,833.00	0.00	

01-1728	MIDWEST BREATHING AIR LLC									
I 22792		NFPA QUARTERLY AIR TEST	AP		R	3/03/2019		170.50	170.50CR	
		G/L ACCOUNT						170.50		
	001 5-150-2-63500	OPERATIONAL EQUIPT MAINT & REP					170.50	NFPA QUARTERLY AIR TEST		
		REG. CHECK						170.50	170.50CR	0.00
								170.50	0.00	

01-1734	MIDWEST SAFETY COUNSELORS I									
I 56332		INSTRUMENT CALIBRATION	AP		R	2/01/2019		85.00	85.00CR	
		G/L ACCOUNT						85.00		
	610 5-815-2-63500	OPERATIONAL EQUIPT MAINT & REP					85.00	INSTRUMENT CALIBRATION		
		REG. CHECK						85.00	85.00CR	0.00
								85.00	0.00	

01-1731	MIDWEST WHEEL COMPANIES									
I 1478683		REPAIR PARTS #29	AP		R	3/03/2019		149.95	149.95CR	
		G/L ACCOUNT						149.95		
	810 5-899-2-63321	REPAIR PARTS					149.95	REPAIR PARTS #29		
		REG. CHECK						149.95	149.95CR	0.00
								149.95	0.00	

01-1748	MITCHELL 1									
I 22512035		WEB BASED SUBSCRIPTIONS	AP		R	2/01/2019		253.05	253.05CR	
		G/L ACCOUNT						253.05		
	810 5-899-2-65065	COMPUTER SUPPLIES					253.05	WEB BASED SUBSCRIPTIONS		
		REG. CHECK						253.05	253.05CR	0.00
								253.05	0.00	

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VENDOR SET: 01

VENDOR SEQUENCE

VENDOR	ITEM NO#	DESCRIPTION	BANK	CHECK	STAT	DUE DT	DISC DT	GROSS BALANCE	PAYMENT DISCOUNT	OUTSTANDING
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01-1729 MMTG

I 1320		JAN - JUNE DUES	AP		R	2/01/2019		551.00	551.00CR	
		G/L ACCOUNT						551.00		
	630 5-820-1-62100	DUES/FEES					551.00	JAN - JUNE DUES		
				REG. CHECK				551.00	551.00CR	0.00
								551.00	0.00	

01-1873 NEOFUNDS

I 11281606		POSTAGE FOR METER	AP		R	2/01/2019		2,000.00	2,000.00CR	
		G/L ACCOUNT						2,000.00		
	835 5-899-2-65080	POSTAGE/SHIPPING					2,000.00	POSTAGE FOR METER		
				REG. CHECK				2,000.00	2,000.00CR	0.00
								2,000.00	0.00	

01-2070 POWER LINE SUPPLY

I 56331332		2 FR SWEATSHIRTS	AP		R	2/01/2019		235.40	235.40CR	
		G/L ACCOUNT						235.40		
	630 5-820-2-64350	UNIFORMS/EQUIPMENT					235.40	2 FR SWEATSHIRTS		
I 56331850		4 PAIRS GLOVES	AP		R	2/01/2019		89.88	89.88CR	
		G/L ACCOUNT						89.88		
	630 5-820-2-64350	UNIFORMS/EQUIPMENT					89.88	4 PAIRS GLOVES		
				REG. CHECK				325.28	325.28CR	0.00
								325.28	0.00	

01-2057 PRAXAIR DISTRIBUTION INC

I 87170227		OXYGEN	AP		R	3/03/2019		47.99	47.99CR	
		G/L ACCOUNT						47.99		
	001 5-160-2-65070	OPERATING SUPPLIES					47.99	OXYGEN		
				REG. CHECK				47.99	47.99CR	0.00
								47.99	0.00	

VENDOR SEQUENCE

VENDOR	ITEM NO#	DESCRIPTION	BANK	CHECK	STAT	DUE DT	DT	GROSS BALANCE	PAYMENT DISCOUNT	OUTSTANDING

01-2084	QC ANALYTICAL SERVICES LLC									
I	1901138	WATER TESTING FEES	AP		R	2/01/2019		76.00	76.00CR	
		G/L ACCOUNT						76.00		
	600 5-810-2-64920	TESTING FEES					76.00	WATER TESTING FEES		
				REG. CHECK				76.00	76.00CR	0.00
								76.00	0.00	

01-1690	STOREY KENWORTHY/MATT PARRO									
I	654141	W2'S, 1099'S, ENVELOPES	AP		R	3/03/2019		214.44	214.44CR	
		G/L ACCOUNT						214.44		
	835 5-899-2-65060	OFFICE SUPPLIES					214.44	W2'S, 1099'S, ENVELOPES		
				REG. CHECK				214.44	214.44CR	0.00
								214.44	0.00	

01-2260	STUART C IRBY CO									
I	S011143064.005	HARNES	AP		R	2/01/2019		405.00	405.00CR	
		G/L ACCOUNT						405.00		
	630 5-820-2-65100	SAFETY					405.00	HARNES		
I	S011144917.002	4 PAIRS OF SLEEVES & TESTIN	AP		R	2/01/2019		2,310.53	2,310.53CR	
		G/L ACCOUNT						2,310.53		
	630 5-820-2-65100	SAFETY					2,310.53	4 PAIRS OF SLEEVES & TESTING		
				REG. CHECK				2,715.53	2,715.53CR	0.00
								2,715.53	0.00	

01-2340	TERRY DURIN COMPANY									
I	20806-00	7515' PRIMARY WIRE	AP		R	3/03/2019		14,729.40	14,729.40CR	
		G/L ACCOUNT						14,729.40		
	630 5-820-2-65304	UNDERGROUND SUPPLIES					14,729.40	7515' PRIMARY WIRE		
				REG. CHECK				14,729.40	14,729.40CR	0.00
								14,729.40	0.00	

VENDOR SEQUENCE

VENDOR	ITEM NO#	DESCRIPTION	BANK	CHECK	STAT	DUE DT	DISC DT	GROSS BALANCE	PAYMENT DISCOUNT	OUTSTANDING

01-1	THE U OF I									
I 190116RD1		SHIELD & TARGETS	AP		R	2/01/2019		185.00	185.00CR	
		G/L ACCOUNT						185.00		
	001 5-110-2-65070	OPERATING SUPPLIES					185.00	THE U OF I:SHIELD & TARGETS		
				REG. CHECK				185.00	185.00CR	0.00
								185.00	0.00	

01-2519	ULINE									
I 104770022		SHELVING KIT	AP		R	2/01/2019		416.60	416.60CR	
		G/L ACCOUNT						416.60		
	630 5-820-2-65070	OPERATING SUPPLIES					416.60	SHELVING KIT		
				REG. CHECK				416.60	416.60CR	0.00
								416.60	0.00	

01-2523	UNITED LABORATORIES									
I 245392		DISINFECTANT	AP		R	2/01/2019		263.44	263.44CR	
		G/L ACCOUNT						263.44		
	810 5-899-2-65070	OPERATING SUPPLIES					263.44	DISINFECTANT		
				REG. CHECK				263.44	263.44CR	0.00
								263.44	0.00	

01-2574	WALMART COMMUNITY									
I 1496		OFFICE SUPPLIES	AP		R	3/03/2019		29.03	29.03CR	
		G/L ACCOUNT						29.03		
	600 5-810-2-65060	OFFICE SUPPLIES					29.03	OFFICE SUPPLIES		
I 4269		OFFICE SUPPLIES	AP		R	3/03/2019		36.82	36.82CR	
		G/L ACCOUNT						36.82		
	600 5-810-2-65060	OFFICE SUPPLIES					36.82	OFFICE SUPPLIES		
I 4575		OFFICE & MISC SUPPLIES	AP		R	3/03/2019		54.64	54.64CR	
		G/L ACCOUNT						54.64		
	001 5-160-2-65060	OFFICE SUPPLIES					22.14	OFFICE & MISC SUPPLIES		
	001 5-160-2-65980	MISCELLANEOUS					32.50	OFFICE & MISC SUPPLIES		
I 5214		MISC SUPPLIES	AP		R	3/03/2019		4.78	4.78CR	
		G/L ACCOUNT						4.78		
	001 5-110-2-65980	MISCELLANEOUS					4.78	MISC SUPPLIES		

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VENDOR SET: 01

VENDOR SEQUENCE

VENDOR	ITEM NO#	DESCRIPTION	BANK	CHECK	STAT	DUE DT	DISC DT	GROSS BALANCE	PAYMENT DISCOUNT	OUTSTANDING
I 6182		PROGRAM SUPPLIES	AP		R	3/03/2019		124.33	124.33CR	
		G/L ACCOUNT						124.33		
	001	5-410-2-65021	PROGRAMMING				124.33	PROGRAM SUPPLIES		
I 7048		OFFICE & MISC SUPPLIES	AP		R	3/03/2019		98.43	98.43CR	
		G/L ACCOUNT						98.43		
	001	5-110-2-65980	MISCELLANEOUS				40.70	OFFICE & MISC SUPPLIES		
	001	5-650-2-65980	MISCELLANEOUS				40.70	OFFICE & MISC SUPPLIES		
	835	5-899-2-65060	OFFICE SUPPLIES				17.03	OFFICE & MISC SUPPLIES		
I 7756		OFFICE SUPPLIES	AP		R	3/03/2019		24.18	24.18CR	
		G/L ACCOUNT						24.18		
	001	5-525-2-65060	OFFICE SUPPLIES				24.18	OFFICE SUPPLIES		
			REG. CHECK					372.21	372.21CR	0.00
								372.21	0.00	

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R E P O R T T O T A L S =====

F U N D D I S T R I B U T I O N

FUND NO#	FUND NAME	AMOUNT
001	GENERAL GOVERNMENT	7,776.44CR
110	ROAD USE TAX FUND	16,475.34CR
600	WATER OPERATING	1,088.44CR
610	WASTEWATER/AKA SEWER REVE	85.00CR
630	ELECTRIC OPERATING	19,264.67CR
640	GAS OPERATING	409.54CR
660	AIRPORT OPERATING	100.00CR
670	GARBAGE COLLECTION	24.75CR
810	CENTRAL GARAGE	807.95CR
835	ADMINISTRATIVE SERVICES	5,418.47CR
** TOTALS **		51,450.60CR

----- TYPE OF CHECK TOTALS -----

	NUMBER	GROSS BALANCE	PAYMENT DISCOUNT	OUTSTANDING
HAND CHECKS		0.00	0.00	0.00
		0.00	0.00	
DRAFTS		0.00	0.00	0.00
		0.00	0.00	
REG-CHECKS		51,450.60	51,450.60CR	0.00
		51,450.60	0.00	
EFT		0.00	0.00	0.00
		0.00	0.00	
NON-CHECKS		0.00	0.00	0.00
		0.00	0.00	
ALL CHECKS		51,450.60	51,450.60CR	0.00
		51,450.60	0.00	

TOTAL CHECKS TO PRINT: 38

ERRORS: 0 WARNINGS: 0

RESOLUTION NO. 020419A

RESOLUTION APPROVING THE PLANS, SPECIFICATIONS, FORM OF CONTRACT, AND ESTIMATED COST OF THE JAMES KENNEDY FAMILY AQUATIC CENTER RENOVATION PROJECT

WHEREAS, the City Council of the City of Tipton hired HBK Engineering to oversee the James Kennedy Family Aquatic Center Renovation Project; and

WHEREAS, the Project will include repair and upgrades to the Natatorium HVAC system, roof replacement, exterior door replacement(s) and interior repair and upgrades; and

WHEREAS, the Engineer has presented the Project's plans, specifications, form of contract, and final estimated project cost by in a timely fashion; and

WHEREAS, the estimated cost is \$497,041.65 (base bid) or \$542,213.65 (base bid plus alternates.)

NOW, THEREFORE, Be It Resolved, the City Council of the City of Tipton does approve the Project's plans, specifications, form of contract, and final estimated cost so that the City can proceed with the bidding process.

PASSED AND APPROVED this 4th day of February 2019.

Bryan Carney, Mayor

ATTEST:

Amy Lenz, City Clerk

CERTIFICATION

I, Amy Lenz, City Clerk, do hereby certify the above is a true and correct copy of Resolution No. 020419A which was passed by the Tipton City Council this 4th day of February 2019.

Amy Lenz, City Clerk

RESOLUTION NO. 020419B
RESOLUTION OUTLINING THE EXTENT
A FORMER EMPLOYEE WHO IS INELIGIBLE FOR RE-HIRE
MAY ATTEND CITY OR DEPARTMENTAL SOCIAL FUNCTIONS

WHEREAS, the City of Tipton and the Tipton City Council strive to ensure all City employees are treated fairly and with respect; and,

WHEREAS, the City of Tipton and the Tipton City Council recognizes that certain requirements and expectations should be in place addressing the extent to which a former employee who is ineligible for re-hire may attend City or Departmental social functions.

NOW, THEREFORE, BE IT RESOLVED that any former City employee whose employment with the City terminated voluntarily or involuntarily and who is ineligible for re-hire, as determined by the City and/or the City Council, is prohibited from attending any official City and/or Departmental social functions that are not open to the general public, unless the former employee receives written permission from the City Manager to attend the specific social function.

BE IT FURTHER RESOLVED that any former City employee whose employment with the City terminated voluntarily or involuntarily and who is ineligible for re-hire, as determined by the City and/or the City Council, shall contact the City Manager prior to attending any unofficial City and/or Departmental social functions that are not open to the general public and that occur within any City building or on any City grounds to determine the appropriateness of doing such.

PASSED AND APPROVED this 4th day of February, 2019.

Bryan Carney, Mayor

ATTEST:

Amy Lenz, City Clerk

CERTIFICATION

I, Amy Lenz, City Clerk, do hereby certify the above is a true and correct copy of Resolution No. 020419B which was passed by the Tipton City Council this 4th day of February, 2019.

Amy Lenz, City Clerk

**AGENDA INFORMATION
TIPTON CITY COUNCIL COMMUNICATION**

DATE:	2/4/2019
AGENDA ITEM:	Medicaid – Iowa Total Care Agreement
ACTION:	Council consideration, motion to approve. Roll call vote to approve, amend, table or deny.

SYNOPSIS:

As the State of Iowa continues to privatize Medicaid a new insurance provider/ administrator has been created called Iowa Total Care. The ambulance service regularly transports patients with Medicaid insurance, and in order to be reimbursed for such services the City must become an in-network provider.

It is therefore recommended that the City of Tipton, D.B.A the Tipton Ambulance Service enter into an agreement with Iowa Total Care.

BUDGET ITEM: N/A

RESPONSIBLE DEPARTMENT: Ambulance

MAYOR/COUNCIL ACTION: Consideration, motion and roll call vote to approve, table or deny.

ATTACHMENTS: Iowa Total Care Agreement

PREPARED BY: Brad Ratliff

DATE PREPARED: 1/30/2019

PARTICIPATING PROVIDER AGREEMENT

This Participating Provider Agreement (together with all Attachments and amendments, this "Agreement") is made and entered by and between City of Tipton Iowa dba Tipton Ambulance Service ("Provider") and Iowa Total Care, Inc. ("Health Plan") (each a "Party" and collectively the "Parties"). This Agreement is effective as of the date designated by Health Plan on the signature page of this Agreement ("Effective Date").

WHEREAS, Provider desires to provide certain health care services to individuals in products offered by or available from or through a Company or Payor (as hereafter defined), and Provider desires to participate in such products as a Participating Provider (as defined herein), all as hereinafter set forth.

WHEREAS, Health Plan desires for Provider to provide such health care services to individuals in such products, and Health Plan desires to have Provider participate in certain of such products as a Participating Provider, all as hereinafter set forth.

NOW, THEREFORE, in consideration of the recitals and mutual promises herein stated, the Parties hereby agree to the provisions set forth below.

ARTICLE I - DEFINITIONS

When appearing with initial capital letters in this Agreement (including an Attachment), the following quoted and underlined terms (and the plural thereof, when appropriate) have the meanings set forth below.

1.1. "Affiliate" means a person or entity directly or indirectly controlling, controlled by, or under common control with Health Plan.

1.2. "Attachment" means any document, including an addendum, schedule or exhibit, attached to this Agreement as of the Effective Date or that becomes attached pursuant to Section 2.2 or Section 8.7, all of which are incorporated herein by reference and may be amended from time to time as provided in this Agreement.

1.3. "Clean Claim" has, as to each particular Product, the meaning set forth in the applicable Product Attachment or, if no such definition exists, the Provider Manual.

1.4. "Company" means, as appropriate in the context, Health Plan and/or one or more of its Affiliates, except those specifically excluded by Health Plan.

1.5. "Compensation Schedule" means at any given time the then effective schedule(s) of maximum rates applicable to a particular Product under which Provider and Contracted Providers will be compensated for the provision of Covered Services to Covered Persons. Such Compensation Schedule(s) will be set forth or described in one or more Attachments to this Agreement, and may be included within a Product Attachment.

1.6. "Contracted Provider" means a physician, hospital, health care professional or any other provider of items or services that is employed by or has a contractual relationship with Provider. The term "Contracted Provider" includes Provider for those Covered Services provided by Provider.

1.7. "Coverage Agreement" means any agreement, program or certificate entered into, issued or agreed to by Company or Payor, under which Company or Payor furnishes administrative services or other services in support of a health care program for an individual or group of individuals, and which may include access to one or more of Company's provider networks or vendor arrangements, except those excluded by Health Plan.

1.8. "Covered Person" means any individual entitled to receive Covered Services pursuant to the terms of a Coverage Agreement.

1.9. “Covered Services” means those services and items for which benefits are available and payable under the applicable Coverage Agreement and which are determined, if applicable, to be Medically Necessary.

1.10. “Medically Necessary” or “Medical Necessity” shall have the meaning defined in the applicable Coverage Agreement or applicable Regulatory Requirements.

1.11. “Participating Provider” means, with respect to a particular Product, any physician, hospital, ancillary, or other health care provider that has contracted, directly or indirectly, with Health Plan to provide Covered Services to Covered Persons, that has been approved for participation by Company, and that is designated by Company as a “participating provider” in such Product.

1.12. “Payor” means the entity (including Company where applicable) that bears direct financial responsibility for paying from its own funds, without reimbursement from another entity, the cost of Covered Services rendered to Covered Persons under a Coverage Agreement and, if such entity is not Company, such entity contracts, directly or indirectly, with Company for the provision of certain administrative or other services with respect to such Coverage Agreement.

1.13. “Payor Contract” means the contract with a Payor, pursuant to which Company furnishes administrative services or other services in support of the Coverage Agreements entered into, issued or agreed to by a Payor, which services may include access to one or more of Company’s provider networks or vendor arrangements, except those excluded by Health Plan. The term “Payor Contract” includes Company’s or other Payor’s contract with a governmental authority (also referred to herein as a “Governmental Contract”) under which Company or Payor arranges for the provision of Covered Services to Covered Persons.

1.14. “Product” means any program or health benefit arrangement designated as a “product” by Health Plan (e.g., Health Plan Product, Medicaid Product, PPO Product, Payor-specific Product, etc.) that is now or hereafter offered by or available from or through Company (and includes the Coverage Agreements that access, or are issued or entered into in connection with such product, except those excluded by Health Plan).

1.15. “Product Attachment” means an Attachment setting forth requirements, terms and conditions specific or applicable to one or more Products, including certain provisions that must be included in a provider agreement under the Regulatory Requirements, which may be alternatives to, or in addition to, the requirements, terms and conditions set forth in this Agreement or the Provider Manual.

1.16. “Provider Manual” means the provider manual and any billing manuals, adopted by Company or Payor which include, without limitation, requirements relating to utilization management, quality management, grievances and appeals, and Product-specific, Payor-specific and State-specific requirements, as may be amended from time to time by Company or Payor.

1.17. “Regulatory Requirements” means all applicable federal and state statutes, regulations, regulatory guidance, judicial or administrative rulings, requirements of Governmental Contracts and standards and requirements of any accrediting or certifying organization, including, but not limited to, the requirements set forth in a Product Attachment.

1.18. “State” is defined as the state identified in the applicable Attachment.

ARTICLE II – PRODUCTS AND SERVICES

2.1. Contracted Providers. Provider shall, and shall cause each Contracted Provider, to comply with and abide by the agreements, representations, warranties, acknowledgements, certifications, terms and conditions of this Agreement (including the provisions of Schedule A that are applicable to Provider, a Contracted Provider, or their services, and any other Attachments), and the Provider Manual, and fulfill all of the duties, responsibilities and

obligations imposed on Provider and Contracted Providers under this Agreement (including each Attachment), and the Provider Manual.

2.2. Participation in Products. Subject to the other provisions of this Agreement, each Contracted Provider may be identified as a Participating Provider in each Product identified in a Product Attachment designated on Schedule B of this Agreement or added to this Agreement in accordance with Section 2.2 hereof.

2.2.1. Provider shall, at all times during the term of this Agreement, require each of its Contracted Providers to, subject to Company's approval, participate as Participating Providers in each Product identified in a Product Attachment that is designated on Schedule B to this Agreement or added to this Agreement in accordance with Section 2.2 hereof.

2.2.2. Contracted Provider may only identify itself as a Participating Provider for those Products in which the Contracted Provider actually participates as provided in this Agreement. Provider acknowledges that Company or Payor may have, develop or contract to develop various Products or provider networks that have a variety of provider panels, program components and other requirements. No Company or Payor warrants or guarantees that any Contracted Provider: (i) will participate in all or a minimum number of provider panels, (ii) will be utilized by a minimum number of Covered Persons, or (iii) will indefinitely remain a Participating Provider or member of the provider panel for a particular network or Product.

2.2.3. Attached hereto as Schedule C is the initial list of the Contracted Providers as of the Effective Date. Provider shall provide Health Plan, from time to time or on a periodic basis as requested by Health Plan, with a complete and accurate list containing the names, office telephone numbers, addresses, tax identification numbers, hospital affiliations, specialties and board status (if applicable), State license number, and National Provider Identifier of Contracted Providers and such other information as mutually agreed upon by the Parties, and shall provide Health Plan with a list of modifications to such list at least thirty (30) days prior to the effective date of such changes, when possible. Provider shall provide such lists in a manner and format mutually acceptable to the Parties.

2.2.4. Provider may add new providers to this Agreement as Contracted Providers. In such case, Provider shall provide written notice to Health Plan of the prospective addition(s), and shall use best efforts to provide such notice at least sixty (60) days in advance of such addition. Provider shall maintain written agreements with of its Contracted Providers (other than Provider) that require the Contracted Providers to comply with the terms and conditions of this Agreement and that address and comply with the Regulatory Requirements.

2.2.5. If Company desires to add one or more Contracted Providers to an additional Product, Company or Payor, as applicable, will provide advance written notice (electronic or paper) thereof to Provider, along with the applicable Product Attachment and the new Compensation Schedule, if any. The applicable Contracted Providers will not be designated as Participating Providers in such additional Product if Provider opts out of such additional Product by giving Company or Payor, as applicable, written notice of its decision to opt-out within thirty (30) days of Company's or Payor's, as applicable, giving of written notice. If Provider timely provides such opt-out notice, the applicable Contracted Providers will not be considered Participating Providers in such Product. If Provider does not timely provide such opt-out notice, then each applicable Contracted Provider shall be a Participating Provider in such additional Product on the terms and conditions set forth in this Agreement and the applicable Product Attachment.

2.3. Covered Services. Each Contracted Provider shall provide Covered Services described or referenced in the applicable Product Attachment(s) to Covered Persons in those Products in which the Contracted Provider is a Participating Provider, in accordance with this Agreement. Each Contracted Provider shall provide Covered Services to Covered Persons with the same degree of care and skill as customarily provided to patients who are not Covered Persons, within the scope of the Contracted Provider's license and in accordance with generally accepted standards of the Contracted Provider's practice and business and in accordance with the provisions of this Agreement, the Provider Manual, and Regulatory Requirements.

2.4. Provider Manual; Policies and Procedures. Provider and Contracted Providers shall at all times cooperate and comply with the requirements, policies, programs and procedures (“Policies”) of Company and Payor, which may be described in the Provider Manual and include, but are not limited to, the following: credentialing criteria and requirements; notification requirements; medical management programs; claims and billing, quality assessment and improvement, utilization review and management, disease management, case management, on-site reviews, referral and prior authorization, and grievance and appeal procedures; coordination of benefits and third party liability policies; carve-out and third party vendor programs; and data reporting requirements. The failure to comply with such Policies could result in a denial or reduction of payment to the Provider or Contracted Provider or a denial or reduction of the Covered Person’s benefits. Such Policies do not in any way affect or remove the obligation of Contracted Providers to render care. Health Plan shall make the Provider Manual available to Provider and Contracted Providers via one or more designated websites or alternative means. Upon Provider’s reasonable request, Health Plan shall provide Provider with a copy of the Provider Manual. In the event of a material change to the Provider Manual, Health Plan will use reasonable efforts to notify Provider in advance of such change. Such notice may be given by Health Plan through a periodic provider newsletter, an update to the on-line Provider Manual, or any other written method (electronic or paper).

2.5. Credentialing Criteria. Provider and each Contracted Provider shall complete Company’s and/or Payor’s credentialing and/or recredentialing process as required by Company’s and/or Payor’s credentialing Policies, and shall at all times during the term of this Agreement meet all of Company’s and/or Payor’s credentialing criteria. Provider and each Contracted Provider represents, warrants and agrees: (a) that it is currently, and for the duration of this Agreement shall remain: (i) in compliance with all applicable Regulatory Requirements, including licensing laws; (ii) if applicable, accredited by The Joint Commission or the American Osteopathic Association; and (iii) a Medicare participating provider under the federal Medicare program and a Medicaid participating provider under applicable federal and State laws; and (b) that all Contracted Providers and all employees and contractors thereof will perform their duties in accordance with all Regulatory Requirements, as well as applicable national, State and local standards of professional ethics and practice. No Contracted Provider shall provide Covered Services to Covered Persons or identify itself as a Participating Provider unless and until the Contracted Provider has been notified, in writing, by Company that such Contracted Provider has successfully completed Company’s credentialing process.

2.6. Eligibility Determinations. Provider or Contracted Provider shall timely verify whether an individual seeking Covered Services is a Covered Person. Company or Payor, as applicable, will make available to Provider and Contracted Providers a method, whereby Provider and Contracted Providers can obtain, in a timely manner, general information about eligibility and coverage. Company or Payor, as applicable, does not guarantee that persons identified as Covered Persons are eligible for benefits or that all services or supplies are Covered Services. If Company, Payor or its delegate determines that an individual was not a Covered Person at the time services were rendered, such services shall not be eligible for payment under this Agreement. In addition, Company will use reasonable efforts to include or contractually require Payors to clearly display Company’s name, logo or mailing address (or other identifier(s) designated from time to time by Company) on each membership card.

2.7. Referral and Preauthorization Procedures. Provider and Contracted Providers shall comply with referral and preauthorization procedures adopted by Company and or Payor, as applicable, prior to referring a Covered Person to any individual, institutional or ancillary health care provider. Unless otherwise expressly authorized in writing by Company or Payor, Provider and Contracted Providers shall refer Covered Persons only to Participating Providers to provide the Covered Service for which the Covered Person is referred. Except as required by applicable law, failure of Provider and Contracted Providers to follow such procedures may result in denial of payment for unauthorized treatment.

2.8. Treatment Decisions. No Company or Payor is liable for, nor will it exercise control over, the manner or method by which a Contracted Provider provides items or services under this Agreement. Provider and Contracted Providers understand that determinations of Company or Payor that certain items or services are not Covered Services or have not been provided or billed in accordance with the requirements of this Agreement or the Provider Manual are administrative decisions only. Such decisions do not absolve the Contracted Provider of its responsibility to exercise independent judgment in treatment decisions relating to Covered Persons. Nothing in this Agreement (i) is intended to interfere with Contracted Provider’s relationship with Covered Persons, or (ii) prohibits or restricts a

Contracted Provider from disclosing to any Covered Person any information that the Contracted Provider deems appropriate regarding health care quality, medical treatment decisions or alternatives.

2.9. Carve-Out Vendors. Provider acknowledges that Company may, during the term of this Agreement, carve-out certain Covered Services from its general provider contracts, including this Agreement, for one or more Products as Company deems necessary or appropriate. Provider and Contracted Providers shall cooperate with and, when medically appropriate, utilize all third party vendors designated by Company for those Covered Services identified by Company from time to time for a particular Product.

2.10. Disparagement Prohibition. Provider, each Contracted Provider and the officers of Company shall not disparage the other during the term of this Agreement or in connection with any expiration, termination or non-renewal of this Agreement. Neither Provider nor Contracted Provider shall interfere with Company's direct or indirect contractual relationships including, but not limited to, those with Covered Persons or other Participating Providers. Nothing in this Agreement should be construed as limiting the ability of either Health Plan, Company, Provider or a Contracted Provider to inform Covered Persons that this Agreement has been terminated or otherwise expired or, with respect to Provider, to promote Provider to the general public or to post information regarding other health plans consistent with Provider's usual procedures, provided that no such promotion or advertisement is specifically directed at one or more Covered Persons. In addition, nothing in this provision should be construed as limiting Company's ability to use and disclose information and data obtained from or about Provider or Contracted Provider, including this Agreement, to the extent determined reasonably necessary or appropriate by Company in connection with its efforts to comply with Regulatory Requirements and to communicate with regulatory authorities.

2.11. Nondiscrimination. Provider and each Contracted Provider will provide Covered Services to Covered Persons without discrimination on account of race, sex, sexual orientation, age, color, religion, national origin, place of residence, health status, type of Payor, source of payment (e.g., Medicaid generally or a State-specific health care program), physical or mental disability or veteran status, and will ensure that its facilities are accessible as required by Title III of the Americans With Disabilities Act of 1991. Provider and Contracted Providers recognize that, as a governmental contractor, Company or Payor may be subject to various federal laws, executive orders and regulations regarding equal opportunity and affirmative action, which also may be applicable to subcontractors, and Provider and each Contracted Provider agree to comply with such requirements as described in any applicable Attachment.

2.12. Notice of Certain Events. Provider shall give written notice to Health Plan of: (i) any event of which notice must be given to a licensing or accreditation agency or board; (ii) any change in the status of Provider's or a Contracted Provider's license; (iii) termination, suspension, exclusion or voluntary withdrawal of Provider or a Contracted Provider from any state or federal health care program, including but not limited to Medicaid; or (iv) any settlements or judgments in connection with a lawsuit or claim filed or asserted against Provider or a Contracted Provider alleging professional malpractice involving a Covered Person. In any instance described in subsection (i)-(iii) above, Provider must notify Health Plan or Payor in writing within ten (10) days, and in any instance described in subsection (iv) above, Provider must notify Health Plan or Payor in writing within thirty (30) days, from the date it first obtains knowledge of the pending of the same.

2.13. Use of Name. Provider and each Contracted Provider hereby authorizes each Company or Payor to use their respective names, telephone numbers, addresses, specialties, certifications, hospital affiliations (if any), and other descriptive characteristics of their facilities, practices and services for the purpose of identifying the Contracted Providers as "Participating Providers" in the applicable Products. Provider and Contracted Providers may only use the name of the applicable Company or Payor for purposes of identifying the Products in which they participate, and may not use the registered trademark or service mark of Company or Payor without prior written consent.

2.14. Compliance with Regulatory Requirements. Provider, each Contracted Provider and Company agree to carry out their respective obligations under this Agreement and the Provider Manual in accordance with all applicable Regulatory Requirements, including, but not limited to, the requirements of the Health Insurance Portability and Accountability Act, as amended, and any regulations promulgated thereunder. If, due to Provider's or Contracted Provider's noncompliance with applicable Regulatory Requirements or this Agreement, sanctions or

penalties are imposed on Company, Company may, in its sole discretion, offset such amounts against any amounts due Provider or Contracted Providers from any Company or require Provider or the Contracted Provider to reimburse Company for such amounts.

2.15. Program Integrity Required Disclosures. Provider agrees to furnish to Health Plan complete and accurate information necessary to permit Company to comply with the collection of disclosures requirements specified in 42 C.F.R. Part 455 Subpart B or any other applicable State or federal requirements, within such time period as is necessary to permit Company to comply with such requirements. Such requirements include but are not limited to: (i) 42 C.F.R. §455.105, relating to (a) the ownership of any subcontractor with whom Provider has had business transactions totaling more than \$25,000 during the 12-month period ending on the date of the request and (b) any significant business transaction between Provider and any wholly owned supplier or subcontractor during the five (5) year period ending on the date of the request; (ii) 42 C.F.R. §455.104, relating to individuals or entities with an ownership or controlling interest in Provider; and (iii) 42 C.F.R. §455.106, relating to individuals with an ownership or controlling interest in Provider, or who are managing employees of Provider, who have been convicted of a crime.

ARTICLE III – CLAIMS SUBMISSION, PROCESSING, AND COMPENSATION

3.1. Claims or Encounter Data Submission. As provided in the Provider Manual and/or Policies, Contracted Providers shall submit to Payor or its delegate claims for payment for Covered Services rendered to Covered Persons. Contracted Provider shall submit encounter data to Payor or its delegate in a timely fashion, which must contain statistical and descriptive medical and patient data and identifying information, if and as required in the Provider Manual. Payor or its delegate reserves the right to deny payment to the Contracted Provider if the Contracted Provider fails to submit claims for payment or encounter data in accordance with the Provider Manual and/or Policies.

3.2. Compensation. The compensation for Covered Services provided to a Covered Person (“Compensation Amount”) will be the appropriate amount under the applicable Compensation Schedule in effect on the date of service for the Product in which the Covered Person participates. Subject to the terms of this Agreement and the Provider Manual, Provider and Contracted Providers shall accept the Compensation Amount as payment in full for the provision of Covered Services. Subject to the terms of this Agreement, Payor shall pay or arrange for payment of each Clean Claim received from a Contracted Provider for Covered Services provided to a Covered Person in accordance with the applicable Compensation Amount less any applicable copayments, cost-sharing or other amounts that are the Covered Person’s financial responsibility under the applicable Coverage Agreement.

3.3. Financial Incentives. The Parties acknowledge and agree that nothing in this Agreement shall be construed to create any financial incentive for Provider or a Contracted Provider to withhold Covered Services.

3.4. Hold Harmless. Provider and each Contracted Provider agree that in no event, including but not limited to non-payment by a Payor, a Payor’s insolvency, or breach of this Agreement, shall Provider or a Contracted Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Covered Person or person acting on the Covered Person’s behalf, other than Payor, for Covered Services provided under this Agreement. This provision shall not prohibit collection of any applicable copayments, cost-sharing or other amounts that are the Covered Person’s financial responsibility under the applicable Coverage Agreement. This provision survives termination or expiration of this Agreement for any reason, will be construed for the benefit of Covered Persons, and supersedes any oral or written agreement entered into between Provider or a Contracted Provider and a Covered Person.

3.5. Recovery Rights. Payor or its delegate shall have the right to immediately offset or recoup any and all amounts owed by Provider or a Contracted Provider to Payor or Company against amounts owed by the Payor or Company to the Provider or Contracted Provider. Provider and Contracted Providers agree that all recoupment and any offset rights under this Agreement will constitute rights of recoupment authorized under State or federal law and that such rights will not be subject to any requirement of prior or other approval from any court or other government authority that may now have or hereafter have jurisdiction over Provider or a Contracted Provider.

ARTICLE IV – RECORDS AND INSPECTIONS

4.1. Records. Each Contracted Provider shall maintain medical, financial and administrative records related to items or services provided to Covered Persons, including but not limited to a complete and accurate permanent medical record for each such Covered Person, in such form and detail as are required by applicable Regulatory Requirements and consistent with generally accepted medical standards.

4.2. Access. Provider and each Contracted Provider shall provide access to their respective books and records to each of the following, including any delegate or duly authorized agent thereof, subject to applicable Regulatory Requirements: (i) Company and Payor, during regular business hours and upon prior notice; (ii) appropriate State and federal authorities, to the extent such access is necessary to comply with Regulatory Requirements; and (iii) accreditation organizations. Provider and each Contracted Provider shall provide copies of such records at no expense to any of the foregoing that may make such request. Each Contracted Provider also shall obtain any authorization or consent that may be required from a Covered Person in order to release medical records and information to Company or Payor or any of their delegates. Provider and each Contracted Provider shall cooperate in and allow on-site inspections of its, his or her facilities and records by any Company, Payor, their delegates, any authorized government officials, and accreditation organizations. Provider and each Contracted Provider shall compile information necessary for the expeditious completion of such on-site inspection in a timely manner.

4.3. Record Transfer. Subject to applicable Regulatory Requirements, each Contracted Provider shall cooperate in the timely transfer of Covered Persons' medical records to any other health care provider, at no charge and when required.

ARTICLE V – INSURANCE AND INDEMNIFICATION

5.1. Insurance. During the term of this Agreement and for any applicable continuation period as set forth in Section 7.3 of this Agreement, Provider and each Contracted Provider shall maintain policies of general and professional liability insurance and other insurance necessary to insure Provider and such Contracted Provider, respectively; their respective employees; and any other person providing services hereunder on behalf of Provider or such Contracted Provider, as applicable, against any claim(s) of personal injuries or death alleged to have been caused or caused by their performance under this Agreement. Such insurance shall include, but not be limited to, any "tail" or prior acts coverage necessary to avoid any gap in coverage. Insurance shall be through a licensed carrier acceptable to Health Plan, and in a minimum amount of one million dollars (\$1,000,000) per occurrence, and three million dollars (\$3,000,000) in the aggregate unless a lesser amount is accepted by Health Plan or where State law mandates otherwise. Provider and each Contracted Provider will provide Health Plan with at least fifteen (15) days prior written notice of cancellation, non-renewal, lapse, or adverse material modification of such coverage. Upon Health Plan's request, Provider and each Contracted Provider will furnish Health Plan with evidence of such insurance.

5.2. Indemnification by Provider and Contracted Provider. Provider and each Contracted Provider shall indemnify and hold harmless (and at Health Plan's request defend) Company and Payor and all of their respective officers, directors, agents and employees from and against any and all third party claims for any loss, damages, liability, costs, or expenses (including reasonable attorney's fees) judgments or obligations arising from or relating to any negligence, wrongful act or omission, or breach of this Agreement by Provider, a Contracted Provider, or any of their respective officers, directors, agents or employees.

5.3. Indemnification by Health Plan. Health Plan agrees to indemnify and hold harmless (and at Provider's request defend) Provider, Contracted Providers, and their officers, directors, agents and employees from and against any and all third party claims for any loss, damages, liability, costs, or expenses (including reasonable attorney's fees), judgments, or obligations arising from or relating to any negligence, wrongful act or omission or breach of this Agreement by Company or its directors, officers, agents or employees.

ARTICLE VI – DISPUTE RESOLUTION

6.1. Informal Dispute Resolution. Any dispute between Provider and/or a Contracted Provider, as applicable (the "Provider Party"), and Health Plan and/or Company, as applicable (including any Company acting as Payor) (the "Administrator Party"), with respect to or involving the performance under, termination of, or interpretation of this Agreement, or any other claim or cause of action hereunder, whether sounding in tort, contract or under statute (a "Dispute") shall first be addressed by exhausting the applicable procedures in the Provider Manual pertaining to claims payment, credentialing, utilization management, or other programs. If, at the conclusion of these applicable procedures, the matter is not resolved to satisfaction of the Provider Party and the Administrator Party, or if there are no applicable procedures in the Provider Manual, then the Provider Party and the Administrator Party shall engage in a period of good faith negotiations between their designated representatives who have authority to settle the Dispute, which negotiations may be initiated by either the Provider Party or the Administrator Party upon written request to the other, provided such request takes place within one year of the date on which the requesting party first had, or reasonably should have had, knowledge of the event(s) giving rise to the Dispute. If the matter has not been resolved within sixty (60) days of such request, either the Provider Party or the Administrator Party may, as its sole and exclusive forum for the litigation of the Dispute or any part thereof, initiate arbitration pursuant to Section 6.2 below by providing written notice to the other party.

6.2. Arbitration. If either the Provider Party or the Administrator Party wishes to pursue the Dispute as provided in Section 6.1, such party shall submit it to binding arbitration conducted in accordance with the Commercial Arbitration Rules of the American Arbitration Association ("AAA"). In no event may any arbitration be initiated more than one (1) year following, as applicable, the end of the sixty (60) day negotiation period set forth in Section 6.1, or the date of notice of termination. Arbitration proceedings shall be conducted by an arbitrator chosen from the National Healthcare Panel at a mutually agreed upon location within the State. The arbitrator shall not award any punitive or exemplary damages of any kind, shall not vary or ignore the provisions of this Agreement, and shall be bound by controlling law. The Parties and the Contracted Providers, on behalf of themselves and those that they may now or hereafter represent, agree to and do hereby waive any right to pursue, on a class basis, any Dispute. Each of the Provider Party and the Administrator Party shall bear its own costs and attorneys' fees related to the arbitration except that the AAA's Administrative Fees, all Arbitrator Compensation and travel and other expenses, and all costs of any proof produced at the direct request of the arbitrator shall be borne equally by the applicable parties, and the arbitrator shall not have the authority to order otherwise. The existence of a Dispute or arbitration proceeding shall not in and of itself constitute cause for termination of this Agreement. Except as hereafter provided, during an arbitration proceeding, each of the Provider Party and the Administrator Party shall continue to perform its obligations under this Agreement pending the decision of the arbitrator. Nothing herein shall bar either the Provider Party or the Administrator Party from seeking emergency injunctive relief to preclude any actual or perceived breach of this Agreement, although such party shall be obligated to file and pursue arbitration at the earliest reasonable opportunity. Judgment on the award rendered may be entered in any court having jurisdiction thereof. Nothing contained in this Article VI shall limit a Party's right to terminate this Agreement with or without cause in accordance with Section 7.2.

ARTICLE VII – TERM AND TERMINATION

7.1. Term. This Agreement is effective as of the Health Plan Effective Date, and will remain in effect for an initial term ("Initial Term") of three (3) year(s), after which it will automatically renew for successive terms of one (1) year each (each a "Renewal Term"), unless this Agreement is sooner terminated as provided in this Agreement or either Party gives the other Party written notice of non-renewal of this Agreement not less than one hundred eighty (180) days prior to the end of the then-current term. In addition, either Party may elect to not renew a Contracted Provider's participation as a Participating Provider in a particular Product for the next Renewal Term, by giving Provider written notice of such non-renewal not less than one hundred eighty (180) days prior to the, as applicable, last day of the Initial Term or applicable Renewal Term; in such event, Provider shall immediately notify the affected Contracted Provider of such non-renewal. Termination of any Contracted Provider's participation in a particular Product will not have the effect of terminating either this Agreement or the Contracted Provider's participation in any other Product in which the Contract Provider participates under this Agreement.

7.2. Termination. This Agreement, or the participation of Provider or a Contracted Provider as a Participating Provider in one or more Products, may be terminated or suspended as set forth below.

7.2.1. Upon Notice. This Agreement may be terminated by either Party giving the other Party at least one hundred eighty (180) days prior written notice of such termination. The participation of any Contracted Provider as a Participating Provider in a Product may be terminated by either Party giving the other Party at least one hundred eighty (180) days prior written notice of such termination; in such event, Provider shall immediately notify the affected Contracted Provider of such termination.

7.2.2. With Cause. This Agreement, or the participation of any Contracted Provider as a Participating Provider in one or more Products under this Agreement, may be terminated by either Party giving at least ninety (90) days prior written notice of termination to the other Party if such other Party (or the applicable Contracted Provider) is in breach of any material term or condition of this Agreement and such other Party (or the Contracted Provider) fails to cure the breach within the sixty (60) day period immediately following the giving of written notice of such breach. Any notice given pursuant to this Section 7.2.2 must describe the specific breach. In the case of a termination of a Contracted Provider, Provider shall immediately notify the affected Contracted Provider of such termination.

7.2.3. Suspension of Participation. Unless expressly prohibited by applicable Regulatory Requirements, Health Plan has the right to immediately suspend or terminate the participation of a Contracted Provider in any or all Products by giving written notice thereof to Provider when Health Plan determines that (i) based upon available information, the continued participation of the Contracted Provider appears to constitute an immediate threat or risk to the health, safety or welfare of Covered Persons, or (ii) the Contracted Provider's fraud, malfeasance or non-compliance with Regulatory Requirements is reasonably suspected. Provider shall immediately notify the affected Contracted Provider of such suspension. During such suspension, the Contracted Provider shall, as directed by Health Plan, discontinue the provision of all or a particular Covered Service to Covered Persons. During the term of any suspension, the Contracted Provider shall notify Covered Persons that his or her status as a Participating Provider has been suspended. Such suspension will continue until the Contracted Provider's participation is reinstated or terminated.

7.2.4. Insolvency. This Agreement may be terminated immediately by a Party giving written notice thereof to the other Party if the other Party is insolvent or has bankruptcy proceedings initiated against it.

7.2.5. Credentialing. The status of a Contracted Provider as a Participating Provider in one or more Products may be terminated immediately by Health Plan giving written notice thereof to Provider if the Contracted Provider fails to adhere to Company's or Payor's credentialing criteria, including, but not limited to, if the Contracted Provider (i) loses, relinquishes, or has materially affected its license to provide Covered Services in the State, (ii) fails to comply with the insurance requirements set forth in this Agreement; or (iii) is convicted of a criminal offense related to involvement in any state or federal health care program or has been terminated, suspended, barred, voluntarily withdrawn as part of a settlement agreement, or otherwise excluded from any state or federal health care program. Provider shall immediately notify the affected Contracted Provider of such termination.

7.3. Effect of Termination. After the effective date of termination of this Agreement or a Contracted Provider's participation in a Product, this Agreement shall remain in effect for purposes of those obligations and rights arising prior to the effective date of termination. Upon such a termination, each affected Contracted Provider (including Provider, if applicable) shall (i) continue to provide Covered Services to Covered Persons in the applicable Product(s) during the longer of the ninety (90) day period following the date of such termination or such other period as may be required under any Regulatory Requirements, and, if requested by Company, each affected Contracted Provider (including Provider, if applicable) shall continue to provide, as a Participating Provider, Covered Services to Covered Persons until such Covered Persons are assigned or transferred to another Participating Provider in the applicable Product(s), and (ii) continue to comply with and abide by all of the applicable terms and conditions of this Agreement, including, but not limited to, Section 3.4 (Hold Harmless) hereof, in connection with the provision of such Covered Services during such continuation period. During such continuation period, each affected Contracted Provider (including Provider, if applicable) will be compensated in accordance with this Agreement and shall accept such compensation as payment in full.

7.4. Survival of Obligations. All provisions hereof that by their nature are to be performed or complied with following the expiration or termination of this Agreement, including without limitation Sections 2.8, 2.10, 3.2, 3.4, 3.5, 4.2, 5.1, 5.2, 5.3, 6.2, 7.3, and 7.4 and Article VIII, survive the expiration or termination of this Agreement.

ARTICLE VIII - MISCELLANEOUS

8.1. Relationship of Parties. The relationship between or among Health Plan, Company, Provider, and any Contracted Provider hereunder is that of independent contractors. None of the provisions of this Agreement will be construed as creating any agency, partnership, joint venture, employee-employer, or other relationship. References herein to the rights and obligations of any Company under this Agreement are references to the rights and obligations of each Company individually and not collectively. A Company is only responsible for performing its respective obligations hereunder with respect to a particular Product, Coverage Agreement, Payor Contract, Covered Service or Covered Person. A breach or default by an individual Company shall not constitute a breach or default by any other Company, including but not limited to Health Plan.

8.2. Conflicts Between Certain Documents. If there is any conflict between this Agreement and the Provider Manual, this Agreement will control. In the event of any conflict between this Agreement and any Product Attachment, the Product Attachment will control as to such Product.

8.3. Assignment. This Agreement is intended to secure the services of and be personal to Provider and may not be assigned, sublet, delegated, subcontracted or transferred by Provider without Health Plan's prior written consent. Health Plan shall have the right, exercisable in its sole discretion, to assign or transfer all or any portion of its rights or to delegate all or any portion of its interests under this Agreement or any Attachment to an Affiliate, successor of Health Plan, or purchaser of the assets or stock of Health Plan, or the line of business or business unit primarily responsible for carrying out Health Plan's obligations under this Agreement.

8.4. Headings. The headings of the sections of this Agreement are inserted merely for the purpose of convenience and do not limit, define, or extend the specific terms of the section so designated.

8.5. Governing Law. The interpretation of this Agreement and the rights and obligations of Health Plan, Company, Provider and any Contracted Providers hereunder will be governed by and construed in accordance with applicable federal and State laws.

8.6. Third Party Beneficiary. This Agreement is entered into by the Parties signing it for their benefit, as well as, in the case of Health Plan, the benefit of Company, and in the case of Provider, the benefit of each Contracted Provider. Except as specifically provided in Section 3.4 hereof, no Covered Person or third party, other than Company, will be considered a third party beneficiary of this Agreement.

8.7. Amendment. Except as otherwise provided in this Agreement, this Agreement may be amended only by written agreement of duly authorized representatives of the Parties.

8.7.1. Health Plan may amend this Agreement by giving Provider written notice of the amendment to the extent such amendment is deemed necessary or appropriate by Health Plan to comply with any Regulatory Requirements. Any such amendment will be deemed accepted by Provider upon the giving of such notice.

8.7.2. Health Plan may amend this Agreement by giving Provider written notice (electronic or paper) of the proposed amendment. Unless Provider notifies Health Plan in writing of its objection to such amendment during the thirty (30) day period following the giving of such notice by Health Plan, Provider shall be deemed to have accepted the amendment. If Provider objects to any proposed amendment to either the base agreement or any Attachment, Health Plan may exclude one or more of the Contracted Providers from being Participating Providers in the applicable Product (or any component program of, or Coverage Agreement in connection with, such Product).

8.8. Entire Agreement. All prior or concurrent agreements, promises, negotiations or representations either oral or written, between Health Plan and Provider relating to a subject matter of this Agreement, which are not expressly set forth in this Agreement, are of no force or effect.

8.9. Severability. The invalidity or unenforceability of any terms or provisions hereof will in no way affect the validity or enforceability of any other terms or provisions.

8.10. Waiver. The waiver by either Party of the violation of any provision or obligation of this Agreement will not constitute the waiver of any subsequent violation of the same or other provision or obligation.

8.11. Notices. Except as otherwise provided in this Agreement, any notice required or permitted to be given hereunder is deemed to have been given when such written notice has been personally delivered or deposited in the United States mail, postage paid, or delivered by a service that provides written receipt of delivery, addressed as follows:

To Health Plan at:

Attn: President

Iowa Total Care, Inc.

1080 Jordan Creek Pkwy, Suite 100 South

West Des Moines, IA 50266

To Provider at:

Attn: Brad

City of Tipton Iowa dba Tipton Ambulance Service

407 Lynn St.

Tipton, IA 52772

tiptonambulance@tiptoniowa.org

or to such other address as such Party may designate in writing. Notwithstanding the previous paragraph, Health Plan may provide notices by electronic mail, through its provider newsletter or on its provider website.

8.12. Force Majeure. Neither Party shall be liable or deemed to be in default for any delay or failure to perform any act under this Agreement resulting, directly or indirectly, from acts of God, civil or military authority, acts of public enemy, war, accidents, fires, explosions, earthquake, flood, strikes or other work stoppages by either Party's employees, or any other similar cause beyond the reasonable control of such Party.

8.13. Proprietary Information. Each Party is prohibited from, and shall prohibit its Affiliates and Contracted Providers from, disclosing to a third party the substance of this Agreement, or any information of a confidential nature acquired from the other Party (or Affiliate or Contracted Provider thereof) during the course of this Agreement, except to agents of such Party as necessary for such Party's performance under this Agreement, or as required by a Payor Contract or applicable Regulatory Requirements. Provider acknowledges and agrees that all information relating to Company's programs, policies, protocols and procedures is proprietary information and Provider shall not disclose such information to any person or entity without Health Plan's express written consent.

8.14. Authority. The individuals whose signatures are set forth below represent and warrant that they are duly empowered to execute this Agreement. Provider represents and warrants that it has all legal authority to contract on behalf of and to bind all Contracted Providers to the terms of the Agreement with Health Plan. Provider and each Contracted Provider acknowledges that references herein to the rights and obligations of any "Company" or a "Payor" under this Agreement are references to the rights and obligations of each Company and each Payor individually and not of the Companies or Payors collectively. Notwithstanding anything herein to the contrary, all such rights and obligations are individual and specific to each such Company and each such Payor and the reference to Company or Payor herein in no way imposes any cross-guarantees or joint responsibility or liability by, between or among such individual Companies or Payors. A breach or default by an individual Company or Payor shall not constitute a breach or default by any other Company or Payor, including but not limited to Health Plan.

* * * * *

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

IN WITNESS WHEREOF, the Parties hereto have executed this Agreement, including all Product Attachments noted on Schedule B, effective as of the date set forth beneath their respective signatures.

HEALTH PLAN:

Iowa Total Care, Inc. _____

Authorized Signature: _____

Print Name: _____

Title: _____

Signature Date: _____

ECM #: 416304 _____

To be completed by Health Plan only:
Effective Date: _____

PROVIDER:

City of Tipton Iowa dba Tipton Ambulance Service
(Legibly Print Name of Provider) _____

Authorized Signature: _____

Print Name: _____

Title: _____

Signature Date: _____

Tax Identification Number: 42-6005280 _____

State Medicaid Number: 0009225 _____

National Provider Identifier: 114290461 _____

Medicare Number: 00922 _____

PARTICIPATING PROVIDER AGREEMENT
SCHEDULE A
CONTRACTED PROVIDER-SPECIFIC PROVISIONS

Provider and Contracted Providers shall comply with the applicable provisions of this Schedule A.

1 Hospitals. If Provider or a Contracted Provider is a hospital (“Hospital”), the following provisions apply.

1.1 24 Hour Coverage. Each Hospital shall be available to provide Covered Services to Covered Persons twenty-four (24) hours per day, seven (7) days per week.

1.2 Emergency Care. Each Hospital shall provide Emergency Care (as hereafter defined) in accordance with Regulatory Requirements. The Contracted Provider shall notify Company’s medical management department of any emergency room admissions by electronic file sent within twenty-four (24) hours or by the next business day of such admission. “Emergency Care” (or derivative thereof) has, as to each particular Product, the meaning set forth in the applicable Coverage Agreement or Product Attachment. If there is no definition in such documents, “Emergency Care” means inpatient and/or outpatient Covered Services furnished by a qualified provider that are needed to evaluate or stabilize an Emergency Medical Condition. “Emergency Medical Condition” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

1.3 Staff Privileges. Each Hospital shall assist in granting staff privileges or other appropriate access to Company’s Participating Providers who are qualified medical or osteopathic physicians, provided they meet the reasonable standards of practice and credentialing standards established by the Hospital’s medical staff and bylaws, rules, and regulations.

1.4 Discharge Planning. Each Hospital agrees to cooperate with Company’s system for the coordinated discharge planning of Covered Persons, including the planning of any necessary continuing care.

1.5 Credentialing Criteria. Each Hospital shall (a) currently, and for the duration of this Agreement, remain accredited by the Joint Commission or American Osteopathic Association, as applicable; and (b) ensure that all employees of Hospital perform their duties in accordance with all applicable local, State and federal licensing requirements and standards of professional ethics and practice.

1.6 National Committee for Quality Assurance (“NCQA”) Accreditation of Health Plans Standards. Each Hospital agrees to: i) cooperate with Quality Management and Improvement (“QI”) activities; ii) maintain the confidentiality of a Covered Persons information and records pursuant to the Agreement; and iii) allow the Company to use Hospital’s performance data.

2 Practitioners. If Provider or Contracted Provider is a physician or other health care practitioner (including physician extenders) (“Practitioner”), the following provisions apply.

2.1 Contracted Professional Qualifications. At all times during the term of this Agreement, Practitioner shall, as applicable, maintain medical staff membership and admitting privileges with at least one hospital that is a Participating Provider (“Participating Hospital”) with respect to each Product in which the Practitioner participates. Upon Company’s request, Practitioner shall furnish evidence of the foregoing to Company. If Practitioner does not have such admitting privileges, Provider or the Practitioner shall provide Company with a written statement from another Participating Provider who has such admitting privileges, in good standing, certifying

that such individual agrees to assume responsibility for providing inpatient Covered Services to Covered Persons who are patients of the applicable Practitioner.

2.2 Acceptance of New Patients. To the extent that Practitioner is accepting new patients, such Practitioner must also accept new patients who are Covered Persons with respect to the Products in which such Practitioner participates. Practitioner shall notify Company in writing forty-five (45) days prior to such Practitioner's decision to no longer accept Covered Persons with respect to a particular Product. In no event will an established patient of any Practitioner be considered a new patient.

2.3 Preferred Drug List/Drug Formulary. If applicable to the Covered Person's coverage, Practitioners shall use commercially reasonable efforts, when medically appropriate under the circumstances, to comply with formulary or preferred drug list when prescribing medications for Covered Persons.

2.4 National Committee for Quality Assurance ("NCQA") Accreditation of Health Plans Standards. Each Practitioner agrees to: i) cooperate with Quality Management and Improvement ("QI") activities; ii) maintain the confidentiality of a Covered Persons information and records pursuant to the Agreement; and iii) allow the Company to use Practitioner's performance data.

3 Ancillary Providers. If Provider or Contracted Provider is an ancillary provider (including but not limited to a home health agency, durable medical equipment provider, sleep center, pharmacy, ambulatory surgery center, nursing facility, laboratory or urgent care center)("Ancillary Provider"), the following provisions apply.

3.1 Acceptance of New Patients. To the extent that Ancillary Provider is accepting new patients, such Ancillary Provider must also accept new patients who are Covered Persons with respect to the Products in which such Ancillary Provider participates. Ancillary Provider shall notify Company in writing forty-five (45) days prior to such Ancillary Provider's decision to no longer accept Covered Persons with respect to a particular Product. In no event will an established patient of any Ancillary Provider be considered a new patient.

3.2 National Committee for Quality Assurance ("NCQA") Accreditation of Health Plans Standards. Each ancillary provider agrees to: i) cooperate with Quality Management and Improvement ("QI") activities; ii) maintain the confidentiality of a Covered Persons information and records pursuant to the Agreement; and iii) allow the Company to use ancillary provider's performance data.

4 FQHC. If Provider or a Contracted Provider is a federally qualified health center ("FQHC"), the following provision applies.

4.1 FQHC Insurance. To the extent FQHC's employees are deemed to be federal employees qualified for protection under the Federal Tort Claims Act ("FTCA") and Health Plan has been provided with documentation of such status issued by the U.S. Department of Health and Human Services (such status to be referred to as "FTCA Coverage"), Section 5.1 of this Agreement will not apply to those Contracted Providers with FTCA Coverage. FQHC shall provide evidence of such FTCA Coverage to Health Plan at any time upon request. FQHC shall promptly notify Health Plan if, any time during the term of this Agreement, any Contracted Provider is no longer eligible for, or if FQHC becomes aware of any fact or circumstance that would jeopardize, FTCA Coverage. Section 5.1 of this Agreement will apply to a Contracted Provider immediately upon such Contracted Provider's loss of FTCA Coverage for any reason.

5 Facility Providers. If Provider or a Contracted Provider is a facility (including but not limited to Clinic, FQHC, LTAC, Nursing Home, Rehab, Rural Health Clinic, Skilled Nursing) ("Facility Provider") the following provision applies.

5.1 National Committee for Quality Assurance ("NCQA") Accreditation of Health Plans Standards. Each facility agrees to: i) cooperate with Quality Management and Improvement ("QI") activities; ii) maintain the confidentiality of a Covered Persons information and records pursuant to the Agreement; and iii) allow the Company to use facility's performance data.

6 Long Term Services and Supports (“LTSS”) and Home and Community-Based Services (“HCBS”) Providers. If Provider or a Contracted Provider is a provider of LTSS and/or HCBS services, the following provisions apply.

6.1 Definition. LTSS generally includes assistance with daily self-care activities (e.g., walking, toileting, bathing, and dressing) and activities that support an independent lifestyle (e.g., food preparation, transportation, and managing medications). The broad category of LTSS also includes care and service coordination for people who live in their own home, a residential setting, a nursing facility, or other institutional setting. Home and community-based services (“HCBS”) are a subset of LTSS that functions outside of institutional care to maximize independence in the community.

6.2 HCBS Waiver Authorization. Provider shall not provide HCBS Covered Services to Covered Person without the required HCBS waiver authorization.

6.3 Conditions for Reimbursement. No payment shall be made to the Provider unless the Provider has strictly conformed to the policies and procedures of the HCBS Waiver Program, including but not limited to not providing HCBS Covered Services without prior authorization of Health Plan. For the purposes of this Exhibit, “HCBS Waiver Program” shall mean any special Medicaid program operated under a waiver approved by the Centers for Medicare and Medicaid Services which allows the provision of a special package of approved services to Covered Person.

6.4 Acknowledgement. Health Plan acknowledges that Provider is a provider of LTSS and is not necessarily a provider of medical or health care services. Nothing in this Agreement is intended to require Provider to provide medical or health care services that Provider does not routinely provide, but would not prohibit providers from offering these services, as appropriate.

6.5 Notification Requirements. Provider or the applicable Contracted Provider shall provide the following notifications to Health Plan, via written notice or via telephone contact at a number to be provided by Health Plan, within the following time frames:

6.5.1 Provider or the applicable Contracted Provider shall notify Health Plan of a Covered Person’s visit to urgent care or the emergency department of any hospital, or of a Covered Person’s hospitalization, within 24 hours of becoming aware of such visit or hospitalization.

6.5.2 Provider or the applicable Contracted Provider shall notify Health Plan of any change to the designated/assigned services being provided under a Covered Person’s plan of care and/or service plan, within 24 hours of becoming aware of such change.

6.5.3 Provider or the applicable Contracted Provider shall notify Health Plan if a Covered Person misses an appointment with Provider, within 24 hours of becoming aware of such missed appointment.

6.5.4 Provider or the applicable Contracted Provider shall notify Health Plan of any change in a Covered Person’s medical or behavioral health condition, within 24 hours of becoming aware of such change. (Examples of changes in condition are set forth in the Provider Manual.)

6.5.5 Provider or the applicable Contracted Provider shall notify Health Plan of any safety issue identified by Provider or Contracted Provider or its agent or subcontractor, within 24 hours of the identification of such safety issue. (Examples of safety issues are set forth in the Provider Manual.)

6.5.6 Provider or the applicable Contracted Provider shall notify Health Plan of any change in Provider’s or Contracted Provider’s key personnel, within 24 hours of such change.

6.6 Minimum Data Set. If Contracted Provider is a nursing facility, Provider or such Contracted Provider shall submit to Health Plan or its designee the Minimum Data Set as defined by CMS and required under federal law and Health Plan policy as it relates to all Covered Persons who are residents in Contracted Provider's facility. Such submission shall be via electronic mail, facsimile transmission, or other manner and format reasonably requested by Health Plan.

6.7 Quality Improvement Plan. Each Contracted Provider shall participate in Health Plan's LTSS quality improvement plan. Each Contracted Provider shall permit Health Plan to access such Contracted Providers' assessment and quality data upon reasonable advance notice, which may be given by electronic mail.

6.8 Electronic Visit Verification. If Contracted Provider provides in-home services, Contracted Provider shall comply with Health Plan's electronic visit verification system requirements where applicable and accessible.

6.9 Criminal Background Checks. Provider shall conduct a criminal background check on each Contracted Provider prior to the commencement of services under this Agreement and as requested by Health Plan thereafter. Provider shall provide the results of such background checks to Health Plan and member, if self-directed, upon request. Provider agrees to immediately notify Health Plan of any criminal convictions of any Contracted or sub-contracted Provider. Provider shall pay any costs associated with such criminal background checks.

6.10 Person-Centered Planning, Care/Service Plan, and Services ("PCSP"). Provider shall comply with all state and federal regulatory requirements related to person-centered planning, care/service plans, and services including, but not limited to:

6.10.1 Members shall lead the person-centered planning process and can elect to include, and/or consult with, any of their LTSS providers in the care/service plan development process.

6.10.2 The care/service plan must be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation through the mechanism required by state and federal requirements. Non-medical service providers (such as meals or assistive technology) can signify their agreement through this contract or written agreement in lieu of directly in the plan, if permitted by the member.

6.10.3 LTSS providers shall be aware of, respect, and adhere to a member's preferences for the delivery of services and supports.

6.10.4 LTSS providers shall ensure services and supports are culturally appropriate, provided in plain language (where applicable), and accessible to members and the person(s) supporting them who have disabilities and/or are limited English proficient.

6.10.5 Health Plan agrees to complete the care/service plan in a timely manner (within at least 120 days of enrollment or annually, or less if state requirements differ) and provide a copy to all LTSS providers responsible for implementation.

PARTICIPATING PROVIDER AGREEMENT

**SCHEDULE B
PRODUCT PARTICIPATION**

Provider will be designated as a “Participating Provider” in the Product Attachments listed below as of the date of successful completion of credentialing in accordance with this Agreement.

List of Product Attachments:

Attachment A: Medicaid

Attachment B: [Reserved]

Attachment C: Commercial-Exchange

Attachment A: Medicaid

MEDICAID PRODUCT ATTACHMENT

This PRODUCT ATTACHMENT (“*Attachment*”) is made and entered between Iowa Total Care, Inc. (“*Health Plan*”) and City of Tipton Iowa dba Tipton Ambulance Service (“*Provider*”).

WHEREAS, Health Plan and Provider entered into that certain Participating Provider Agreement, as the same may have been amended and supplemented from time to time (the “*Agreement*”), pursuant to which Provider and its Contracted Providers participate in certain Products offered by or available from or through a Company;

WHEREAS, pursuant to the provisions of the Agreement, this Attachment is identified on the signature page of the Agreement and, as such, the Contracted Providers identified herein will be designated and participate as “*Participating Providers*” in the Product described in this Attachment; and

WHEREAS, the Agreement is modified or supplemented as hereafter provided.

NOW THEREFORE, in consideration of the recitals, the mutual promises herein stated, the parties hereby agree to the provisions set forth below.

1. Defined Terms. For purposes of the Medicaid Product (as herein defined), the following terms (and the plural thereof, when appropriate) have the meaning set forth below. All capitalized terms not specifically defined in this Attachment will have the meaning given to such terms in the Agreement.

1.1 “*Agency*” means the Iowa Department of Human Services.

1.2 “*Clean Claim*” means a claim that has no defect or impropriety (including any lack of required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment of the claim. It does not include a claim from a provider who is under investigation for fraud or abuse or a claim under review for Medical Necessity.

1.3 “*Medicaid Product*” (sometimes this “*Product*”) refers to those programs and health benefit arrangements offered by Company pursuant to contract(s) with one or more state Medicaid agency(ies), or any successors thereto, to provide specified services and goods to covered beneficiaries under state Medicaid-funded programs and to meet certain performance standards while doing so (each a “*State Contract*”). The Medicaid Product does not apply to Coverage Agreements that are specifically covered by another Product Attachment to the Agreement.

1.4 “*Medically Necessary*” or “*Medical Necessity*” means those Covered Services that are, under the terms and conditions of the State Contract, determined through Health Plan or Payor utilization management to be:

A. appropriate and necessary for the symptoms, diagnosis or treatment of the condition of the Covered Person;

B. provided for the diagnosis or direct care and treatment of the condition of Covered Person enabling the Covered Person to make reasonable progress in treatment;

C. within standards of professional practice and given at the appropriate time and in the appropriate setting;

D. not primarily for the convenience of the Covered Person, the Covered Person’s physician or other provider; and

E. the most appropriate level of Covered Services, which can safely be provided.

1.5 “*State*” means Iowa.

1.6 “*Subcontractor*” means a third party who contracts with the Health Plan or another subcontractor to perform a portion of the duties in the Scope of Work under the State Contract. This does not include providers who solely provide medical services to Covered Persons pursuant to a provider agreement.

2. Product Participation.

2.1 Medicaid and/or CHIP Product. This Product Attachment constitutes the “*Medicaid Product Attachment*” and is incorporated into the Agreement between Provider and Health Plan. It supplements the Agreement by setting forth specific terms and conditions that apply to the Medicaid Product with respect to which a Participating Provider has agreed to participate, and with which a Participating Provider must comply in order to maintain such participation. This Attachment applies only to the provision of health care services, supplies or accommodations (including Covered Services) to Covered Persons enrolled in or covered by a Medicaid Product.

2.2 Participation. Except as otherwise provided in this Product Attachment or the Agreement, Provider and all Contracted Providers under the Agreement will participate as Participating Providers in the Medicaid Product and will provide to Covered Persons enrolled in the Medicaid Product, upon the same terms and conditions contained in the Agreement, as supplemented or modified by this Product Attachment, those Covered Services that are provided by Contracted Providers pursuant to the Agreement. In providing such services, Provider shall, and shall cause Contracted Providers to, comply with and abide by the provisions of this Product Attachment and the Agreement (including the Provider Manual).

2.3 Attachment. This Attachment constitutes the Product Attachment and Compensation Schedule for the Medicaid Product.

2.4 Construction. This Product Attachment supplements and forms a part of the Agreement. Except as expressly provided herein or in the terms of the Agreement, the terms and conditions of the Agreement will remain unchanged and in full force and effect. In the event of a conflict between the provisions of the Agreement and the provisions of this Attachment, this Attachment will govern with respect to health care services, supplies or accommodations (including Covered Services) rendered to Covered Persons enrolled in or covered by a Medicaid Product. To the extent Provider or any Contracted Provider is unclear about its, his or her respective duties and obligations, Provider or the applicable Contracted Provider shall request clarification from the Company. To the extent any provision of this Agreement (including any exhibit, attachment, or other document referenced herein) is inconsistent with or contrary to any provision of the State Contract, the relevant provision of the State Contract shall have priority and control over the matter.

3. Term. This Attachment will become effective as of the Effective Date, and will be coterminous with the Agreement unless a party or a Contracted Provider terminates the participation of the Contracted Provider in this Product in accordance with the applicable provisions of the Agreement or this Attachment.

4. State Mandated Program Requirements. Schedule A to this Attachment, which is incorporated herein by this reference, sets forth the provisions that are required by the applicable State Contract with respect to the Medicaid Product. Any additional requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product may be set forth in the Provider Manual or another Attachment and are incorporated herein by this reference.

5. Other Terms and Conditions. Except as modified or supplemented by this Attachment, the compensation hereunder for the provision of Covered Services by Contracted Providers to Covered Persons enrolled in or covered by the Medicaid Product is subject to all of the other provisions in the Agreement (including the Provider Manual) that affect or relate to compensation for Covered Services provided to Covered Persons.

Attachment A: Medicaid

SCHEDULE A GOVERNMENTAL CONTRACT REQUIREMENTS

This Schedule sets forth the special provisions that are specific to the Iowa Medicaid Product under the State Contract.

1. Definitions. As used in this Schedule A to Attachment A, the following terms shall be defined as set forth below.

1.1. “*Agency*” means the Iowa Department of Human Services.

1.2. “*Clean Claim*” means one in which all information required for processing is present.

1.3. “*Covered Services*” means the services provided under Medicaid, and provided, or arranged to be provided by Health Plan to Covered Persons pursuant to the State Contract.

1.4. “*Department*” means the Iowa Department of Human Services or its designee.

1.5. “*DHS*” means the Iowa Department of Human Services.

1.6. “*HCBS*” means home and community based services.

1.7. “*IDPH*” means the Iowa Department of Public Health.

1.8. “*LTSS*” means long term services and supports.

1.9. “*PCP*” means a primary care physician or other licensed health practitioners practicing in accordance with State law who is responsible for providing preventive and primary health care to patients; for initiating referrals for specialist care; and for maintaining the continuity of patient care.

1.10. “*State*” means the State of Iowa.

2. Federal and State Laws and Regulations. Provider shall comply with all applicable federal and State Regulatory Requirements pertinent to Covered Person confidentiality and rights, and shall ensure that its staff and subcontractors, including but not limited to Contracted Providers, take those rights into account when furnishing services to Covered Persons.

3. Ownership Disclosures. Provider shall make full disclosure of ownership, management and control information as required by 42 CFR 455.100 through 455.106 to Health Plan, within such timeframes as necessary to allow Health Plan to comply with the disclosure obligations set forth in the State Contract, including but not limited to providing such information to Health Plan within twenty-five (25) days after any change in ownership.

4. EPSDT Services. If Provider is a PCP, Provider, as applicable, must provide early and periodic screening, diagnosis and treatment (EPSDT) services to all Covered Persons under twenty-one (21) years of age in accordance with the applicable Regulatory Requirements. Provider, as applicable, shall comply with Health Plan’s strategies to ensure the completion of health screens and preventive visits in accordance with the Care for Kids (EPSDT) periodicity schedule. Screening exams consist of a health history, developmental history, complete physical exam, vision screening, hearing test, appropriate laboratory tests, immunizations, nutrition screen, health education including anticipatory guidance, oral health assessment, other tests as needed and referrals for treatment. All records requested by State or federal personnel, including medical and peer review records, must be available for inspection by State or federal personnel or their representatives. Provider shall make available to Health Plan those data

necessary for Health Plan to record health screenings and examination-related activities. Provider acknowledges that Health Plan is required to periodically report such findings to the State.

5. Subcontractor Insurance. If Participating Provider is a Subcontractor, it, he or she shall maintain in full force and effect, throughout the term of the Agreement, the types of insurance in the minimum amounts specified in the State Contract with insurance companies licensed by the State, including insurance against all general liabilities, product liability, personal injury, property damage, and (where applicable) professional liability.

6. Subcontracts. If Provider is a Subcontractor, this Section will apply.

6.1 Delegation. If any of Health Plan's activities or obligations under the State Contract are delegated to Provider:

(a) the delegated activities or obligations, and related reporting responsibilities, are specified in the Agreement;

(b) Provider shall perform the delegated activities and reporting responsibilities specified in compliance with the Health Plan's obligations under the State Contract; and

(c) the Agreement either provides for revocation of the delegation of activities or obligations, or specifies other remedies in instances where the Agency or the Health Plan determines that the Provider has not performed satisfactorily.

6.2 Compliance with Medicaid Law. Each Participating Provider agrees to comply with all applicable Medicaid laws, regulations, including applicable sub-regulatory guidance and contract provisions.

6.3 Audits and Access to Records. Each Participating Provider agrees that the Agency, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the Participating Provider, or of the Participating Provider's contractors, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Health Plan's State Contract with the Agency. Each Participating Provider will make available, for purposes of an audit, evaluation, or inspection under this paragraph, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid members. The right to audit under this paragraph will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. If the Agency, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the Agency, CMS, or the HHS Inspector General may inspect, evaluate, and audit the Participating Provider at any time.

7. Protecting Members Against Liability for Payment. In compliance with 42 C.F.R. § 438.106, each Participating Provider agrees that Covered Persons will not be held liable for any of the following: (a) the Health Plan's or Payor's debts, in the event of insolvency; (b) Covered Services provided to the Covered Person, for which (i) the Agency does not pay the Health Plan, or (ii) the Agency, or the Health Plan does not pay the individual or Participating Provider that furnished the services under a contractual, referral, or other arrangement; or (c) payments for Covered Services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the Covered Person would owe if the Health Plan covered the services directly.

8. Maintenance of Records. In accordance with 42 C.F.R. §438.3(u), if Provider is a Subcontractor, Provider shall retain, and require its subcontractors to retain, as applicable, the following information: member grievance and appeal records in 42 C.F.R. § 438.416, base data in 42 C.F.R. § 438.5(c), MLR reports in 42 C.F.R. § 438.8(k), and the data, information, and documentation specified in 42 C.F.R. §§ 438.604, 438.606, 438.608, and 438.610 for a period of no less than 10 years.

9. Response to Record Requests. In accordance with 42 C.F.R. 438.3(h), the Agency, CMS, the Office of the Inspector General, the Comptroller General, and their designees may, at any time, inspect and audit any records or

documents of the Health Plan, or its subcontractors (including Participating Provider), and may, at any time, inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. The right to audit under this section exists for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. Participating Provider shall furnish duly authorized and identified agents or representatives of the State and federal governments with such information as they may request regarding payments claimed for Medicaid services.

10. Prohibited Status. Each Participating Provider warrants and represents that it, he or she is not:

10.1 an entity that could be excluded under section 1128(b)(8) of the Social Security Act as being controlled by a sanctioned individual;

10.2 an entity that has a substantial contractual relationship as defined in 42 C.F.R. § 431.55(h)(3), either directly or indirectly, with an individual convicted of certain crimes as described in section 1128(b)(8)(B) of the Social Security Act or an individual described in 42 C.F.R. § 438.610(a) and (b);

10.3 an entity that employs or contracts, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services, with one of the following: (i) any individual or entity described in 42 C.F.R. § 438.610(a) and (b); or (ii) any individual or entity that would provide those services through an individual or entity described in 42 C.F.R. § 438.610(a) and (b);

10.4 excluded from participation in federal health care programs under either section 1128 or section 1128A of the Social Security Act; or

10.5 excluded from participation by the Department of Health and Human Services (“DHHS”), Office of Inspector General (OIG) under section 1128 of the Social Security Act, or by the Agency from participating in the Iowa Medicaid program for fraud or abuse.

Upon the giving of written notice, the Health Plan may immediately terminate its relationship with any Participating Provider identified as in continued violation of law by the Agency.

11. Disclosure of Information on Ownership and Control. If Participating Provider is a disclosing entity, fiscal agent, or network provider (as defined by federal regulation), this Section applies.

11.1 Ownership Information. Participating Provider must provide the name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity, fiscal agent, or network provider. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.

11.2 Provider Information. Participating Provider must provide the date of birth and social security number (in the case of an individual).

11.3 Provider Tax Identification Number. Participating Provider must provide other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or network provider) or in any Subcontractor in which the disclosing entity (or fiscal agent or network provider) has a 5 percent or more interest.

11.4 Related Party Information. Participating Provider must disclose information regarding whether the person (individual or corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or network provider) is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any Subcontractor in which the disclosing entity (or fiscal agent or network provider) has a five percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.

11.5 Other Disclosing Entity Information. Participating Provider must provide the name of any other disclosing entity (or fiscal agent or network provider) in which an owner of the disclosing entity (or fiscal agent or network provider) has an ownership or control interest.

11.6 Managing Employee Information. Participating Provider must provide the name, address, date of birth, and social security number of any managing employee of the disclosing entity (or fiscal agent or network provider).

11.7 Timing of Disclosures for Disclosing Entity. If Participating Provider is a network provider or disclosing entity, it, he or she shall provide such disclosures at the following times: (a) upon submitting the provider application; (b) upon executing the Agreement; (c) upon request of the Agency during the re-validation of enrollment process; and (d) within 35 days after any change in ownership of the disclosing entity or network provider.

11.8 Timing of Disclosures for Fiscal Agent. If Participating Provider is a fiscal agent, it shall provide such disclosures at the following times: (a) upon the fiscal agent submitting the proposal in accordance with the procurement process; (b) upon the fiscal agent executing the Agreement; (c) upon renewal or extension of the contract with a fiscal agent; and (d) within 35 days after any change in ownership of the fiscal agent.

11.9 Failure to Disclose. Federal financial participation (“FFP”) is not available in payments made to a disclosing entity that fails to disclose ownership or control information as required by this Section.

12. Provider Business Transactions.

12.1. Business Transaction Information. Each Participating Provider agrees to furnish to Health Plan, the Agency or the DHHS Secretary on request information related to business transactions in accordance with this Section. Each Participating Provider must submit, within 35 days of the date on a request by the Secretary, the Agency or the Health Plan, full and complete information about the following: (a) the ownership of any Subcontractor with whom the Participating Provider has had business transactions totaling more than \$25,000 during the 12-month period ending on the date of the request; and (b) any significant business transactions between the Participating Provider and any wholly owned supplier, or between the Participating Provider and any Subcontractor, during the 5-year period ending on the date of the request.

12.2. Failure to Disclose. FFP is not available in expenditures for services furnished by providers who fail to comply with a request made by the Secretary, the Agency, or the Health Plan under this section or under 42 C.F.R. § 420.205. FFP will be denied in expenditures for services furnished during the period beginning on the day following the date the information was due to the Secretary, the Agency, or the Health Plan and ending on the day before the date on which the information was supplied.

13. Persons Convicted of Crimes; Denial or Termination of Participation. Before the Health Plan enters into or renews a provider agreement, or at any time upon written request by DHHS, the Agency, or the Health Plan, each Participating Provider shall disclose to Health Plan and the Agency the identity of any person who: (a) has ownership or control interest in the Participating Provider, or is an agent or managing employee of the Participating Provider; and (b) has been convicted of a criminal offense related to that person’s involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs. The Health Plan may refuse to enter into or renew an agreement with a Participating Provider, and the Agency may refuse to allow the Health Plan to renew or enter into such an agreement if any person who has an ownership or control interest in the Participating Provider, or who is an agent or managing employee of the Participating Provider, has been convicted of a criminal offense related to that person’s involvement in any program established under Medicare, Medicaid or the Title XXI Services Program. The Health Plan may refuse to enter into or may terminate a provider agreement and the Agency may refuse to allow the Health Plan to renew or enter into such an agreement if any of the Health Plan, Agency or DHHS determines that the Provider did not fully and accurately make any disclosure required under this Section.

14. Use of Third Parties. All restrictions, obligations, and responsibilities of the Health Plan under the State Contract also apply to the subcontractors of Health Plan (including each Participating Provider). The Agency has the right to request the removal of a subcontractor (including a Participating Provider) from participating under the State Contract for good cause.

15. Cost Sharing and Patient Liability. Participating Provider (and its, his or her subcontractors) shall not require any cost sharing or patient liability responsibilities for Covered Services except to the extent that cost sharing or patient liability responsibilities are required for those services in accordance with law and as described in the State Contract. Further, Participating Provider (and its, his or her subcontractors) shall not charge Covered Persons for missed appointments.

16. Community-Based Care Management Requirements. Provider shall comply with the following requirements with respect to those Covered Persons receiving home and community-based long term services and supports to whom Health Plan has assigned to a community-based case manager:

16.1 External Communication and Coordination. Provider shall, as applicable, notify a community-based case manager, as expeditiously as warranted by the Covered Person's circumstances, of any significant changes in the Covered Person's condition or care, hospitalizations, or recommendations for additional services.

16.2 Transitions Between Facilities. Subject to approval by the Agency, Provider shall not, as applicable, engage in the involuntary discharge of a Covered Person that may lead to a placement in an inappropriate or more restrictive setting.

17. Copayments - Exempt Populations. In accordance with 42 CFR 447.56, Provider shall not impose copayments for the following populations:

17.1. Individuals between ages one (1) and eighteen (18) who are eligible under 42 CFR 435.118;

17.2. Individuals under age one (1) who are eligible under 42 CFR 435.118;

17.3. Disabled or blind individuals under age eighteen (18) who are eligible under 42 CFR 435.120 or 42 CFR 435.130;

17.4. Children for whom child welfare services are made available under Part B of title IV of the Social Security Act on the basis of being a child in foster care and individuals receiving benefits under Part E of that title, without regard to age;

17.5. Disabled children eligible for Medicaid under the Family Opportunity Act;

17.6. Pregnant women, during pregnancy and through the postpartum period which begins on the last day of pregnancy and extends through the end of the month in which the sixty (60) day period following termination of pregnancy ends;

17.7. Any individual whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than required for personal needs;

17.8. An individual receiving hospice care, as defined in section 1905(o) of the Social Security Act;

17.9. An Indian (as defined at 42 CFR 447.51) who is currently receiving or has ever received an item or service furnished by an Indian health care provider or through referral under contract health services; and

17.10. Individuals who are receiving Medicaid by virtue of their breast or cervical cancer diagnosis under 42 CFR §435.213.

18. Copayments - Exempt Services. Provider shall not impose co-payments for the following: (i) preventive services provided to children under age eighteen (18); (ii) pregnancy-related services, including those defined at 42 CFR 440.210(a)(2) and 440.250(p) and counseling for cessation of tobacco use; (iii) provider preventable services as defined at 42 CFR 447.26(b); and (iv) family planning services and supplies described in section 1905(a)(4)(C) of the Social Security Act.

19. Non-Emergency Use of Emergency Room. If Provider is a hospital, before providing non-emergency treatment and imposing cost-sharing for such services on a Covered Person, Provider shall:

19.1 Inform the Covered Person of the amount of his or her cost sharing obligation for non-emergency services provided in the emergency department;

19.2 Provide the Covered Person with the name and location of an available and accessible alternative non-emergency services provider. If geographical or other circumstances prevent Provider from meeting this requirement, cost-sharing may not be imposed;

19.3 Determine that the alternative provider can provide services to the Covered Person in a timely manner with the imposition of a lesser cost sharing amount. The assessment of access to timely services must be based on the medical needs of the Covered Person; and

19.4 Provide a referral to coordinate scheduling for treatment by the alternative provider.

20. Inability to Pay. Provider may not deny care or services to any Covered Person because of his or her inability to pay an applicable copayment.

21. Provider Network. Each Participating Provider shall: (a) meet Agency standards for timely access to care and services, taking into account the urgency of the need for services; (b) ensure that it offers hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the Participating Provider serves only Medicaid enrollees; (c) make services included in the State Contract available 24 hours a day, 7 days a week, when Medically Necessary; (d) establish mechanisms to ensure compliance with the State Contract; and (e) monitor its operations regularly to determine compliance with the State Contract.

22. Provider Agreements Generally.

22.1. Governing Documents. Each Participating Provider agrees that all applicable terms and conditions set out in the State Contract, any incorporated documents and all applicable State and federal laws, as amended, govern the duties and responsibilities of the Participating Provider with regard to the provision of services to Covered Persons.

22.2. Continuation of Benefits. Each Participating Provider agrees to ensure continuation of benefits in accordance with the terms of the Agreement and the State Contract.

22.3. Agency Enrollment. Each Participating Provider warrants and represents that it is enrolled with the Agency, which is a condition for participation in the Health Plan's network.

22.4. Business Associate Agreement. When applicable, Provider agrees to execute a business associate agreement.

22.5. Third Party Liability. Each Participating Provider's responsibility regarding third party liability is set forth in the Agreement or the Provider Manual. At a minimum, Participating Provider shall identify third party liability coverage, including Medicare and long-term care insurance as applicable, and except as otherwise required, seek such third party liability payment before submitting claims to Payor.

22.6. Claim Submission. Each Participating Provider shall submit claims in accordance with the terms of the Agreement and the Provider Manual, and, for those that do not involve a third party payer, within one hundred eighty (180) days of the date of service.

22.7. Encounter Data. If Participating Provider is paid on a capitated basis, Participating Provider shall submit encounter data within ninety (90) days of the date of service. As applicable, the Agreement will comply with the requirements set forth for subcontracts as outlined in this Attachment and in accordance with 42 C.F.R. § 434.6.

23. Nursing Facility Provider Agreements. If Participating Provider is a nursing facility, this Section applies.

23.1 Notice of Admissions. Participating Provider shall promptly notify the Health Plan or Payor, as applicable, of a Covered Person's admission or request for admission to the nursing facility as soon as Participating Provider has knowledge of such admission or request for admission.

23.2 Health Plan Notice of Discharges. Participating Provider shall notify the Health Plan or Payor, as applicable, immediately if the nursing facility is considering discharging a Covered Person and shall consult with the Covered Person's care coordinator.

23.3 Covered Person Notice of Discharges. Participating Provider shall notify the Covered Person and/or the Covered Person's representative (if applicable) in writing prior to discharge in accordance with State and federal requirements.

23.4 Collection of Patient Liability. Participating Provider agrees to collect patient liability (also referred to as client participation) amounts. The Health Plan or Payor will notify the Participating Provider of the patient liability amounts that Participating Provider must collect from the Covered Person before Medicaid reimbursement for services is available. Payor is only responsible for paying Participating Provider net of the applicable patient liability amount and otherwise in accordance with the terms of the Agreement.

23.5 Notice of Change in Condition. Participating Provider shall notify the Health Plan or Payor, as applicable, of any change in a Covered Person's medical or functional condition that could impact the Covered Person's level of care eligibility for the currently authorized level of nursing facility services.

23.6 PASRR Requirements. Participating Provider shall comply with federal Preadmission Screening and Resident Review (PASRR) requirements to provide or arrange to provide specialized services and all applicable State law governing admission, transfer and discharge policies.

23.7 Termination Due to Decertification. If Participating Provider is involuntarily decertified by the State or CMS, the Agreement is automatically terminated in accordance with federal requirements.

24. HCBS Providers. If Participating Provider is a Home and Community-Based Services ("HCBS") provider, this Section applies.

24.1 Notice of Provider Change. Participating Provider shall provide at least thirty (30) days advance notice to Health Plan or Payor, as applicable, when the provider is no longer willing or able to provide services to a Covered Person, and shall cooperate with the Covered Person's care coordinator to facilitate a seamless transition to alternate providers.

24.2 Continuation of Services. In the event that a HCBS provider change is initiated for a Covered Person, regardless of any other provision in the Agreement, the transferring Participating Provider will continue to provide services to the Covered Person in accordance with the Covered Person's plan of care until the Covered Person has been transitioned to a new provider, as determined by the Health Plan, or as otherwise directed by the Health Plan, which may exceed thirty (30) days from the date of notice to the Health Plan.

24.3 Notice of Deviations. Participating Provider shall immediately report any deviations from a Covered Person's service schedule to the Covered Person's care coordinator.

24.4 Critical Incident Reporting. Participating Provider shall comply with the critical incident reporting requirements as described in this Attachment.

24.5 Abuse Reporting. Participating Provider shall comply with child and dependent adult abuse reporting requirements.

25. LTSS Providers. If Provider is an LTSS provider, Provider's service delivery site or services shall meet all applicable requirements of State Regulatory Requirements and have the necessary and current licenses, certification, accreditation, and/or designation approval per State requirements. When individuals providing LTSS are not required to be licensed, accredited or certified, Provider shall ensure that such individuals are appropriately educated, trained, qualified, and competent to perform their job responsibilities based on applicable State licensure rules and/or program standards.

26. Substance Use Disorder Providers. If Provider will provide substance use disorder services to Covered Persons hereunder, Provider shall ensure that such substance use disorder treatment services are provided by programs licensed by IDPH in accordance with Iowa Code chapter 125 or by hospital-based substance use disorder treatment programs licensed and accredited in accordance with Iowa Code section 125.13.2(a).

27. Non-Licensed Providers. If Provider or any Contracted Provider is not required to be licensed or certified to provide Covered Services hereunder, Provider shall ensure, based on applicable State licensure rules and/or program standards, that Provider and/or Contracted Provider, as applicable, is appropriately educated, trained, qualified and competent to perform their job responsibilities.

28. Critical Incidents. Each Participating Provider shall: (a) report critical incidents; (b) respond to critical incidents; (c) document critical incidents; and (d) to cooperate with any investigation conducted by the Health Plan, Payor or outside agency.

29. Medical Records. Each Participating Provider shall comply with Health Plan's policies and procedures for medical records content and documentation, including the requirements of Iowa Admin. Code 441 Chapter 79.3. Each Participating Provider shall document all medical services that the Covered Person receives in accordance with law and consistent with utilization control requirements in 42 C.F.R. Part 456. Each Participating Provider shall maintain Covered Persons' medical records in a detailed and comprehensive manner that conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and facilitates an accurate system for follow-up treatment. Each Participating Provider shall ensure that medical records are legible, signed, dated and maintained as required by law. Each Participating Provider shall protect and maintain the confidentiality of mental health information, including by releasing mental health information only as allowed by Iowa Code §228. Further, each Participating Provider shall protect and maintain the confidentiality of substance use disorder information, including by releasing substance use disorder information only in compliance with policies set forth in 42 C.F.R. Part 2 and other applicable State and federal law and regulations.

30. Member Rights. Each Participating Provider shall provide a copy of a Covered Person's medical record upon reasonable request by the Covered Person at no charge, and the Participating Provider shall facilitate the transfer of the Covered Person's medical record to another provider at the Covered Person's request. Confidentiality of, and access to, medical records shall be provided in accordance with the standards mandated in the Health Insurance Portability and Accountability Act (HIPAA) and all other State and federal requirements.

31. Access to Medical and Financial Records. Within the timeframe designated by the Agency or other authorized entity, each Participating Provider will permit the Health Plan, Payor, representatives of the Agency, and other authorized entities to review Covered Persons' records for the purposes of monitoring the Participating Provider's compliance with the record standards, capturing information for clinical studies, monitoring quality or any other reason.

32. Availability of Services. Provider shall offer hours of operation that are no less than the hours of operation offered to commercial members, or, if Provider serves only the Medicaid population, to comparable Medicaid members. Provider shall make Covered Services available twenty four (24) hours a day, seven (7) days a week, when medically necessary.

33. Rights of Covered Person. Provider shall comply with federal and State Regulatory Requirements and regulations that pertain to the rights of Covered Persons and shall take those rights into account when furnishing services to Covered Persons.

34. Provider Incentive Program. Provider acknowledges and agrees that Health Plan is required under the terms of the State Contract to provide information concerning any physician incentive plan with Provider to Covered Persons upon request and in any marketing materials, in accordance with the disclosure requirements stipulated in federal regulations. Provider hereby waives any confidentiality obligations with respect to such disclosure of such information.

35. Critical Incidents. Provider shall: (i) report critical incidents; (ii) respond to critical incidents; (iii) document critical incidents; and (iv) cooperate with any investigation conducted by Health Plan or an outside agency and with any strategy implemented by Health Plan to reduce the occurrence of critical incidents and improve the quality of care delivered to Covered Persons.

36. Provider Preventable Conditions. In accordance with 42 CFR 438.6(f)(2) and 42 CFR 434.6(a)(12), Health Plan shall make no payment to Provider or any Contracted Provider for any provider-preventable condition as identified in the State Plan. As a condition of payment, in accordance with 42 CFR 447.26(d), Provider shall comply with the reporting requirements set forth at 42 CFR 447.26(d).

37. Twenty four (24) Hour Availability Audit. Provider must be available to Covered Persons twenty-four (24) hours-a-day, seven (7) days-a-week. Provider shall comply with any corrective actions implemented by Health Plan in the event an audit shows that Provider fails to meet this standard.

38. Provider's Duties Upon Termination of State Contract. In the event of termination of the State Contract, Provider shall arrange for the orderly transfer of patient care and patient records to those providers who will assume care for each applicable Covered Person. For those Covered Persons who are in a course of treatment for which a change of providers could be harmful, Provider shall continue to provide Covered Services to such Covered Persons until that treatment is concluded or appropriate transfer of care can be arranged.

39. Provider Access and Appointment Times. Provider shall provide necessary and appropriate services to Covered Persons within a timely period, as indicated below.

39.1 PCP Services. If Provider is a PCP, appointment times shall not exceed four (4) to six (6) weeks from the date of a Covered Person's request for a routine appointment; forty-eight (48) hours for persistent symptoms; and one (1) day for urgent care.

39.2 Specialty Services. If Provider provides specialty services, appointment times shall not exceed thirty (30) days from the date of a Covered Person's request or one (1) day for urgent care.

40. Behavioral Health Services. If Provider is a behavioral health provider, Provider shall have procedures for the scheduling of Covered Person appointments in accordance with the following requirements:

40.1. Emergency. Covered Persons with emergency needs shall be seen within fifteen (15) minutes of presentation at a service delivery site.

40.2. Mobile Crisis. Covered Persons in need of mobile crisis services shall receive services within one (1) hour of presentation or request.

40.3. Urgent. Covered Persons with urgent non-emergency needs shall be seen by an appropriate provider within one (1) hour of presentation at a service delivery site or within twenty-four (24) hours of telephone contact with Participating Provider or the Health Plan.

40.4. Persistent Symptoms. Covered Persons with persistent symptoms shall be seen by an appropriate provider within forty-eight (48) hours or reporting symptoms.

40.5. Routine. Covered Persons with need for routine services shall be seen by an appropriate provider within three (3) weeks of the request for an appointment.

40.6. Substance Use Disorder and Pregnancy. Covered Persons who are pregnant women in need of routine substance use disorder services must be admitted within forty-eight (48) hours of seeking treatment.

40.7. Intravenous Drug Use. Covered Persons who are intravenous drug users must be admitted not later than fourteen (14) days after making the request for admission, or one-hundred and twenty (120) days after the date of such request if no program has the capacity to admit the individual on the date of such request and if interim services are made available to the individual not later than forty-eight (48) hours after such request.

41. Emergency Services. If Provider is a hospital, all Emergency Care shall be provided immediately at the nearest facility available regardless of whether the facility or provider is under contract with Health Plan.

42. Optometry Services. If Provider provides general optometry services, appointment times shall not exceed three (3) weeks from the date of a Covered Person's request for a regular appointment and forty-eight (48) hours for urgent care.

43. Laboratory and X-Ray Services. If Provider or provides laboratory or X-ray services, appointment times shall not exceed three (3) weeks from the date of a Covered Person's request for a regular appointment and forty-eight (48) hours for urgent care.

44. Fraud, Waste and Abuse. If Provider is a Subcontractor that is delegated responsibility by the Health Plan for coverage of services and payment of claims under the State Contract, Provider shall implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse. Such arrangements or procedures will, at a minimum, include the requirements set forth in the State Contract.

45. Overpayments. Each Participating Provider shall report to the Payor, when it has received an overpayment, return the overpayment to the Payor within 60 calendar days after the date on which the overpayment was identified, and notify the Payor in writing of the reason for the overpayment.

Attachment A: Medicaid

**SCHEDULE B
REGULATORY REQUIREMENTS**

This Schedule B to Attachment A, State-Mandated Provisions, (“*Attachment A*”) is incorporated into the Participating Provider Agreement (“*Agreement*”) entered into by and between City of Tipton Iowa dba Tipton Ambulance Service (“*Provider*”) and Iowa Total Care, Inc. (“*Health Plan*”) as of the Effective Date. Health Plan and Provider shall comply with the following provision, which is required by State law to be included in this Agreement, to the extent applicable and as such, this provision may be amended from time to time in accordance with the Agreement. In the event of a conflict between the terms and conditions of the Agreement and the terms and conditions of this Attachment A, this Attachment A will govern.

1. Definitions. For purposes of this Attachment A, the following terms have the meanings set forth below. Capitalized terms used in this Attachment A and not defined below will have the same meaning set forth in the Agreement.

1.1 “*State*” means the State of Iowa.

2. Hold Harmless. Contracted Provider or its assignee or subcontractor, hereby agrees that in no event, including, but not limited to nonpayment by the Health Plan, Health Plan insolvency or breach of this agreement, shall Contracted Provider, or its assignee or subcontractor, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against enrollee or persons other than the Health Plan acting on their behalf for services provided pursuant to this Agreement. This provision shall not prohibit collection of supplemental charges or copayments on Health Plan’s behalf made in accordance with terms of the High Quality Healthcare Initiative Agreement between Health Plan and the State. Contracted Provider, or its assignee or subcontractor, further agrees that (1) this provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Health Plan enrollee and that (2) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Contracted Provider and enrollee or persons acting on their behalf. (IAC 191-40.18(514B))

Attachment A: Medicaid

**EXHIBIT 1
COMPENSATION SCHEDULE
ANCILLARY SERVICES
AMBULANCE**

City of Tipton Iowa dba Tipton Ambulance Service

This compensation schedule (“Compensation Schedule”) sets forth the maximum reimbursement amounts for Covered Services provided by Contracted Providers to Covered Persons enrolled in a Medicaid Product. Where the Contracted Provider’s tax identification number (“TIN”) has been designated by the Payor as subject to this Compensation Schedule, Payor shall pay or arrange for payment of a Clean Claim for Covered Services rendered by the Contracted Provider according to the terms of, and subject to the requirements set forth in, the Agreement and this Compensation Schedule. Payment under this Compensation Schedule shall consist of the Allowed Amount as set forth herein less all applicable Cost-Sharing Amounts. All capitalized terms used in this Compensation Schedule shall have the meanings set forth in the Agreement, the applicable Product Attachment, or the Definitions section set forth at the end of this Compensation Schedule.

The maximum compensation for ambulance Covered Services rendered to a Covered Person shall be the “Allowed Amount.” Except as otherwise provided in this Compensation Schedule, the Allowed Amount for ambulance Covered Services is the lesser of: (i) Allowable Charges; or (ii) one hundred percent (100%) of the State’s Medicaid fee schedule in effect on the date of service.

Additional Provisions:

1. **Code Change Updates.** Payor utilizes nationally recognized coding structures (including, without limitation, revenue codes, CPT codes, HCPCS codes, ICD codes, national drug codes, ASA relative values, etc., or their successors) for basic coding and descriptions of the services rendered. Updates to billing-related codes shall become effective on the date (“Code Change Effective Date”) that is the later of: (i) the first day of the month following sixty (60) days after publication by the governmental agency having authority over the applicable Product of such governmental agency’s acceptance of such code updates, (ii) the effective date of such code updates as determined by such governmental agency or (iii) if a date is not established by such governmental agency or the applicable Product is not regulated by such governmental agency, the date that changes are made to nationally recognized codes. Such updates may include changes to service groupings. Claims processed prior to the Code Change Effective Date shall not be reprocessed to reflect any such code updates.
2. **Fee Change Updates.** Updates to the fee schedule shall become effective on the effective date of such fee schedule updates, as determined by the Payor (“Fee Change Effective Date”). The date of implementation of any fee schedule updates, i.e. the date on which such fee change is first used for reimbursement (“Fee Change Implementation Date”), shall be the later of: (i) the first date on which Payor is reasonably able to implement the update in the claims payment system; or (ii) the Fee Change Effective Date. Claims processed prior to the Fee Change Implementation Date shall not be reprocessed to reflect any updates to such fee schedule, even if service was provided after the Fee Change Effective Date.
3. **Fee Sources.** In the event the State’s Medicaid fee schedule contains no published fee amount (e.g., a zero or a blank), alternate (or “gap fill”) fee sources may be used to supply the fee basis amount for deriving fee amount (the “Alternative Fee Source Amount”). Health Plan will utilize such Alternative Fee Source Amount until such time that the State’s Medicaid fee schedule publishes its own RBRVS value. At such time in the future as the State’s Medicaid fee schedule publishes its own RBRVS value for that CPT/HCPCS code, Payor will use the State’s Medicaid fee schedule fee amount for that code and no longer use the Alternate Fee Source Amount. If there is no established payment amount on the current State’s Medicaid fee schedule for a gap fill fee source is not available for a Covered Service provided to a Covered Person, Payor may establish a payment amount to

apply in determining the Allowed Amount. Until such time as Payor establishes such a payment amount, the maximum compensation shall be twenty five percent (25%) of Allowable Charges.

4. Billing Requirements. Contracted Provider must bill HCPCS codes in addition to revenue code for services specified within this Compensation Schedule. Failure to submit a HCPCS code may result in a claim denial.
5. Date of Service Requirements. Contracted Provider is required to identify each date of service on claims for multiple dates of service.
6. Carve-Out Services. With respect to any "Carve-Out" Covered Services as contemplated in this Agreement, any payment arrangement entered into between Provider and a third party vendor of such services shall supersede compensation hereunder.
7. Payment under this Compensation Schedule. All payments under this Compensation Schedule are subject to the terms and conditions set forth in the Agreement, the Provider Manual and any applicable billing manual and claims processing policies.

Definitions:

1. **Allowed Amount** means the amount designated in this Compensation Schedule as the maximum amount payable to a Contracted Provider for any particular Covered Service provided to any particular Covered Person, pursuant to this Agreement or its Attachments.
2. **Allowable Charges** means a Contracted Provider's billed charges for services that qualify as Covered Services.
3. **Cost-Sharing Amounts** means any amounts payable by a Covered Person, such as copayments, cost-sharing, coinsurance, deductibles or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement, if applicable.

Attachment C: Commercial-Exchange

PRODUCT ATTACHMENT (INCLUDING REGULATORY REQUIREMENTS AND COMPENSATION SCHEDULE)

THIS PRODUCT ATTACHMENT (this “*Product Attachment*”) is made and entered between Iowa Total Care, Inc. (“*Health Plan*”) and Provider.

WHEREAS, Health Plan and Provider entered into that certain Participating Provider Agreement, as the same may have been amended and supplemented from time to time (the “*Agreement*”), pursuant to which Provider and its Contracted Providers participate in certain Products offered by or available from or through a Company;

WHEREAS, pursuant to the provisions of the Agreement, this Product Attachment is identified on Schedule B of the Agreement and, as such, the Contracted Providers identified herein will be designated and participate as “Participating Providers” in the commercial and exchange Products described in this Product Attachment as Downstream Entities as defined in this Product Attachment; and

WHEREAS, the Agreement is modified or supplemented as hereafter provided.

NOW THEREFORE, in consideration of the recitals, the mutual promises herein stated, the parties hereby agree to the provisions set forth below.

1. Defined Terms. For purposes of the Commercial-Exchange Product, the following terms have the meanings set forth below. All capitalized terms not specifically defined in this Attachment will have the meanings given to such terms in the Agreement.

1.1 “*Commercial-Exchange Product*” refers to those programs and health benefit arrangements offered by a Company that provide incentives to Covered Persons to utilize the services of certain contracted providers. The Commercial-Exchange Product includes those Coverage Agreements entered into, issued or agreed to by a Payor under which a Company furnishes administrative services or other services in support of a health care program for an individual or group of individuals, which may include access to one or more of the Company’s provider networks or vendor arrangements, and which may be provided in connection with a state or governmental-sponsored, employer-sponsored or other private health insurance exchange, except those excluded by Health Plan. The Commercial-Exchange Product does not apply to any Coverage Agreements that are specifically covered by another Product Attachment to the Agreement.

1.2 “*Delegated Entity*” means any party, including an agent or broker, that enters into an agreement with Health Plan to provide administrative services or health care services to qualified individuals, qualified employers or qualified employees and their dependents (as such terms are defined in 45 C.F.R. §156.20).

1.3 “*Downstream Entity*” means any party, including an agent or broker, that enters into an agreement with a Delegated Entity or with another Downstream Entity for purposes of providing administrative or health care services related to the agreement between the Delegated Entity and Health Plan. The term “Downstream Entity” is intended to reach the entity that directly provides administrative services or health care services to qualified individuals, qualified employers, or qualified employees and their dependents (as such terms are defined in 45 C.F.R. §156.20).

1.4 “*Emergency*” or “*Emergency Care*” has the meaning set forth in the Covered Person’s Coverage Agreement.

1.5 “*Emergency Medical Condition*” has the meaning set forth in the Covered Person’s Coverage Agreement.

1.6 “State” means the State of Iowa, or such other state to the extent that a Coverage Agreement or Covered Person is subject to such other state’s law.

2. Commercial-Exchange Product. This Product Attachment constitutes the “Commercial-Exchange Product Attachment” and is incorporated into the Agreement between Provider and Health Plan. It supplements the Agreement by setting forth specific terms and conditions that apply to the Commercial-Exchange Product with respect to which a Participating Provider has agreed to participate, and with which a Participating Provider must comply in order to maintain such participation. This Product Attachment applies with respect to the provision of health care services, supplies or accommodations (including Covered Services) to Covered Persons enrolled in or covered by a Commercial-Exchange Product.

3. Participation. Except as otherwise provided in this Product Attachment or the Agreement, all Contracted Providers under the Agreement will participate as Participating Providers in this Commercial-Exchange Product, and will provide to Covered Persons enrolled in or covered by a Commercial-Exchange Product, upon the same terms and conditions contained in the Agreement, as supplemented or modified by this Product Attachment, those Covered Services that are provided by Contracted Providers pursuant to the Agreement. In providing such services, Provider shall, and shall cause Contracted Providers, to comply with and abide by the provisions of this Product Attachment and the Agreement (including the Provider Manual).

4. Attachments. This Product Attachment includes, at Schedule A, the Regulatory Requirements with which Participating Providers are required to comply based on State laws governing the applicable Coverage Agreement or Covered Person and at the Compensation Schedule Exhibit(s) for the Commercial-Exchange Product, each of which are incorporated herein by reference.

5. Construction. This Product Attachment supplements and forms a part of the Agreement. Except as otherwise provided herein or in the terms of the Agreement, the terms and conditions of the Agreement will remain unchanged and in full force and effect as a result of this Product Attachment. In the event of a conflict between the provisions of the Agreement and the provisions of this Product Attachment, this Product Attachment will govern with respect to health care services, supplies or accommodations (including Covered Services) rendered to Covered Persons enrolled in or covered by a Commercial-Exchange Product. To the extent Provider or any Contracted Provider is unclear about its, his or her respective duties and obligations, Provider or the applicable Contracted Provider shall request clarification from the Company.

6. Term. This Product Attachment will become effective as of the Effective Date, and will be coterminous with the Agreement unless a Party terminates the participation of the Contracted Provider in this Commercial-Exchange Product in accordance with the applicable provisions of the Agreement or this Product Attachment.

7. Federal Requirements. The following requirements apply to Delegated and Downstream Entities under this Commercial Exchange Product Attachment, which includes but is not limited to Provider and all Contracted Providers.

7.1 Provider’s delegated activities and reporting responsibilities, if any, are specified in the Agreement or applicable attachment to the Agreement (e.g., Delegated Credentialing Agreement, Delegated Services Agreement, Statement of Work, or other scope of services attachment) attached to this Agreement. If such attachment is not executed, no administrative functions shall be deemed as delegated.

7.2 CMS, Health Plan and Payor reserve the right to revoke the delegation activities and reporting requirements or to specify other remedies in instances where CMS, Health Plan or the Payor determine that Provider or any Downstream Entity has not performed satisfactorily.

7.3 Provider and all Downstream Entities must comply with all applicable laws and regulations relating to the standards specified under 45 CFR §156.340(a);

7.4 Provider and all Downstream Entities must permit access by the Secretary and OIG or their designees in connection with their right to evaluate through audit, inspection or other means, to the Provider's or Downstream Entities' books, contracts, computers, or any other electronic systems including medical records and documentation, relating to Health Plan's obligations in accordance with federal standards under 45 CFR §156.340(a) until ten (10) years from the termination date of this Product Attachment.

8. Other Terms and Conditions. Except as modified or supplemented by this Attachment, the compensation hereunder for the provision of Covered Services by Contracted Providers to Covered Persons enrolled in or covered by this Product is subject to all of the other provisions in the Agreement (including the Provider Manual) that affect or relate to compensation for Covered Services provided to Covered Persons.

Attachment C: Commercial-Exchange

SCHEDULE A REGULATORY REQUIREMENTS

This Schedule sets forth the provisions that are required by State law to be included in the Agreement with respect to this Product. Any additional Regulatory Requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product are or will be set forth in the Provider Manual or another Attachment. To the extent that a Coverage Agreement, or a Covered Person, is subject to the law cited in the parenthetical at the end of a provision on this Schedule A, such provision will apply to the rendering of Covered Services to a Covered Person with such Coverage Agreement, or to such Covered Person, as applicable.

IA-1 Records Available. Participating Provider agrees that the Commissioner shall have access to make an examination of Participating Providers as often as the Commissioner deems necessary for the protection of the interests of the people of Iowa, but not less frequently than once every five years. Participating Provider shall submit its books and records to the Commissioner and in every way facilitate the examination. (IOWA CODE § 514B.24)

IA-2 Provider Assurances. Participating Provider shall ensure that they meet applicable licensure requirements by the appropriate state agency where they are located, and Participating Provider shall be either accredited by The Joint Commission or the American Osteopathic Association; or they shall be certified as a provider for Medicare or Medicaid, as applicable. (IOWA ADMIN CODE § 191-40.5(4))

IA-3 Contract Submission. Participating Provider acknowledge and agree that all arrangements of Payor for health care services must be by written contract; initial provider contracts are subject to prior approval; and any provider contract deviating from previously submitted or approved contracts must be submitted to (and in certain cases approved by) the Insurance Division. (IOWA ADMIN CODE §§ 191-40.18; 191-27.5(3))

IA-4 Hold Harmless. Participating Provider agrees that in no event, including but not limited to nonpayment by the Payor, Payor insolvency or breach of the Agreement, shall Participating Provider, or their respective assignees or subcontractors, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Covered Persons other than the Payor acting on their behalf for Covered Services provided pursuant to the Agreement. This provision will not prohibit the collection of supplemental charges or copayments on the Payor's behalf made in accordance with terms of the Coverage Agreement. Participating Provider agrees that this provision will survive the termination of the Agreement or this Exhibit regardless of the cause giving rise to termination, and shall be construed to be for the benefit of the Covered Persons. Participating Provider further agrees that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Participating Provider and Covered Persons or persons acting on Covered Persons' behalf. (IOWA ADMIN CODE § 191-40.18)

IA-5 No Discouragement. Participating Provider is not prohibited from and will not be penalized for discussing treatment options with Covered Persons, irrespective of a Payor's position on the treatment options. Participating Provider is not prohibited from and will not be penalized for advocating on behalf of Covered Persons within the utilization review or grievance processes established by a Payor or a person contracting with a Payor. (IOWA ADMIN CODE §§ 191-40.22(1); 191-27.8(1))

IA-6 No Penalization. Participating Provider will not be penalized for reporting, in good faith, to State or federal authorities any act or practice by a Payor that, in the opinion of Participating Provider, jeopardizes patient health or welfare. (IOWA ADMIN CODE §§ 191-40.22(2); 191-27.8(2))

IA-7 Preferred Provider Arrangements. Participating Provider acknowledges and agrees that this Agreement: (i) establishes the amount and manner of payment to Participating Provider; (ii) includes mechanisms that are designed to minimize the cost of the Coverage Agreement, which may include, but are not limited to, the review or control of utilization of health care costs and a procedure for determining whether services rendered are

Medically Necessary; and (iii) ensures reasonable access to Covered Services. Participating Provider further acknowledges and agrees that this Agreement does not and shall not be construed to unfairly deny health benefits for Medically Necessary Covered Services. (IOWA ADMIN CODE § 191-27.3(1), (2))

IA-8 Prescription Drug Formulary. Participating Provider hereby acknowledges the existence of a prescription drug formulary applicable to Coverage Agreements. (IOWA ADMIN CODE § 191-40.23)

Attachment C: Commercial-Exchange

**EXHIBIT 1
COMPENSATION SCHEDULE
ANCILLARY SERVICES
AMBULANCE**

City of Tipton Iowa dba Tipton Ambulance Service

This compensation schedule (“Compensation Schedule”) sets forth the maximum reimbursement amounts for Covered Services provided by Contracted Providers to Covered Persons enrolled in a Commercial-Exchange Product. Where the Contracted Provider’s tax identification number (“TIN”) has been designated by the Payor as subject to this Compensation Schedule, Payor shall pay or arrange for payment of a Clean Claim for Covered Services rendered by the Contracted Provider according to the terms of, and subject to the requirements set forth in, the Agreement and this Compensation Schedule. Payment under this Compensation Schedule shall consist of the Allowed Amount as set forth herein less all applicable Cost-Sharing Amounts. All capitalized terms used in this Compensation Schedule shall have the meanings set forth in the Agreement, the applicable Product Attachment, or the Definitions section set forth at the end of this Compensation Schedule.

The maximum compensation for ambulance Covered Services rendered to a Covered Person shall be the “Allowed Amount.” Except as otherwise provided in this Compensation Schedule, the Allowed Amount for ambulance Covered Services is the lesser of: (i) Allowable Charges; or (ii) one hundred percent (100%) of the Payor’s Medicare fee schedule.

Additional Provisions:

1. **Code Change Updates.** Payor utilizes nationally recognized coding structures (including, without limitation, revenue codes, CPT codes, HCPCS codes, ICD codes, national drug codes, ASA relative values, etc., or their successors) for basic coding and descriptions of the services rendered. Updates to billing-related codes shall become effective on the date (“Code Change Effective Date”) that is the later of: (i) the first day of the month following sixty (60) days after publication by the governmental agency having authority over the applicable Product of such governmental agency’s acceptance of such code updates, (ii) the effective date of such code updates as determined by such governmental agency or (iii) if a date is not established by such governmental agency or the applicable Product is not regulated by such governmental agency, the date that changes are made to nationally recognized codes. Such updates may include changes to service groupings. Claims processed prior to the Code Change Effective Date shall not be reprocessed to reflect any such code updates.
2. **Fee Change Updates.** Updates to the fee schedule shall become effective on the effective date of such fee schedule updates, as determined by the Payor (“Fee Change Effective Date”). The date of implementation of any fee schedule updates, i.e. the date on which such fee change is first used for reimbursement (“Fee Change Implementation Date”), shall be the later of: (i) the first date on which Payor is reasonably able to implement the update in the claims payment system; or (ii) the Fee Change Effective Date. Claims processed prior to the Fee Change Implementation Date shall not be reprocessed to reflect any updates to such fee schedule, even if service was provided after the Fee Change Effective Date.
3. **Billing Requirements.** Contracted Provider must bill HCPCS codes in addition to revenue code for services specified within this Compensation Schedule. Failure to submit a HCPCS code may result in a claim denial.
4. **Date of Service Requirements.** Contracted Provider is required to identify each date of service on claims for multiple dates of service.

5. Carve-Out Services. With respect to any “Carve-Out” Covered Services as contemplated in this Agreement, any payment arrangement entered into between Provider and a third party vendor of such services shall supersede compensation hereunder.
6. Payment under this Compensation Schedule. All payments under this Compensation Schedule are subject to the terms and conditions set forth in the Agreement, the Provider Manual and any applicable billing manual and claims processing policies.

Definitions:

1. **Allowed Amount** means the amount designated in this Compensation Schedule as the maximum amount payable to a Contracted Provider for any particular Covered Service provided to any particular Covered Person, pursuant to this Agreement or its Attachments.
2. **Allowable Charges** means a Contracted Provider’s billed charges for services that qualify as Covered Services.
3. **Cost-Sharing Amounts** means any amounts payable by a Covered Person, such as copayments, cost-sharing, coinsurance, deductibles or other amounts that are the Covered Person’s financial responsibility under the applicable Coverage Agreement, if applicable.

AGENDA ITEM I3

AGENDA INFORMATION
TIPTON CITY COUNCIL COMMUNICATION

DATE:	2/4/2019
AGENDA ITEM:	DRIP Program Reimbursement
ACTION:	Motion to approve, deny or table

**SYNOPSIS: Downtown Revitalization Incentive Program (DRIP) Reimbursement request:
Applicant: Stuart Clark 529 Cedar Street. Amount: \$7,500.00**



417 Cedar
Street
Tipton, IA 52772
(563) 886-4597
www.tiptoniowa.org

Re: Stuart Clark - DRIP Reimbursement

Dear City Council Members:

The Tipton Commission met on January 24, 2019 to consider a Downtown Revitalization Incentive Program (DRIP) reimbursement request. Below is the recommendation from the Tipton Development Commission.

Reimbursement request:

Applicant: Stuart Clark – 529 Cedar Street

- **Project Total: \$31,591.91 – Project remove old aluminum from the 1970’s and replace with new windows on the east and north side of the building and install a new door to look similar to the original 1894 construction**
- **Reimbursement amount: \$7,500.00**
- **Recommendation: The project has met its requirements and is recommended for reimbursement in the above amount of \$7,500.00**

Respectfully Submitted,

Linda Beck

Tipton Development Director

BUDGET ITEM: 125-5-590-2-5800

RESPONSIBLE DEPARTMENT: Economic Development – Linda Beck

MAYOR/COUNCIL ACTION: Motion to approve, deny or table request.

ATTACHMENTS: Pictures

PREPARED BY: Linda Beck

DATE PREPARED: 1/25/2019

Stuart Clark 529 Cedar Street DRIP Reimbursement 2019 Final Photos

