EXHIBIT 1
SERVICES AND DEFINITIONS

Acute Inpatient Review - Medical/Surgical:

This is precertification and concurrent review of the medical necessity of an inpatient admission in an acute care hospital. An admission is classified inpatient when the provider charges an actual "Room and Board" rate, rather than an "Observation" rate for each night the patient is confined.

Acute Inpatient Review - Behavioral Health:

This is precertification and concurrent review for acute hospital confinement for patients with a behavioral health disorder or drug or alcohol abuse. This does not include partial hospitalization, sub-acute or residential treatment programs.

BABE℠ Critical Care Program:

Specialty high-risk neonatal care management by board certified neonatologist(s) and specialty NICU nurse(s). Service includes peer-to-peer consultations with Hines' perinatologist and attending physician to promote successful outcomes and efficient care.

Behavioral Health Case Management:

The process of working directly with patients, their families, and providers to coordinate the delivery of cost effective, quality care to promote optimal outcomes for patients with acute behavioral health conditions requiring alternative levels of care, such as partial hospitalization and residential care.

Behavioral Health Residential Stays:

Residential treatment stays are done at state licensed facilities that provide short term 24-hour subacute inpatient care for people with mental health and/or chemical dependency disorders in a residential treatment setting when outpatient services do not provide enough structure and safety for treatment of the condition.

Carved-Out Services:

Utilization review and other health care management services provided by a third party vendor under a contractual arrangement with THE GROUP that is separate and distinct from this Agreement.

Carved-Out Services Vendor:

A third party vendor which provides a subset of utilization review and health care management services similar or substantially similar to HINES under a contractual arrangement with THE GROUP.

Case Management Prescreen:

An evaluation of the merits of the case to determine if active case management will likely result in cost savings to the health plan. This prescreen includes a review of notifications and may include review of diagnostic code and/or contact with the patient, provider and/or claim payer.

Claim Payer:

A designation given to those professionals who review and adjudicate medical, dental, and/or disability claims. Designated by THE GROUP to act on their behalf.

Concurrent Review:

The process of validating the medical necessity and appropriateness of continued acute inpatient stay after the initial certification has expired.

Consultant:

An agent or broker designated by THE GROUP to consult on their behalf with regard to securing benefits, insurance, claims payer, managed care SERVICES or other SERVICES as designated by THE GROUP.

Covered Person:

Any person satisfying the plan definition of a covered person under a specific plan or policy for whom health insurance benefits are provided in whole or in part by THE GROUP. Covered Persons whose primary coverage is to be provided by another health program, Medicare or Workers' Compensation will not be included in the category of Covered Persons for which SERVICES are performed.

Dialysis Case Management:

The process of working directly with patients, their families and their physicians to coordinate the delivery of cost-effective, quality care to promote optimal outcomes for patients needing dialysis.

Discharge Planning:

The process of anticipating home or aftercare needs of patients confined in the hospital. Case management handles all discharge planning when the case is open to case management for continuity.

External Appeals:

A peer review that is performed by an entity that is not associated with THE CLAIM PAYER or HINES.

Health Care Provider:

An organization that provides Health Care services for or on behalf of a claimant.

Health Insurance Portability and Accountability Act of 1996 (HIPAA):

A federal law establishing certain standards that parties intend to satisfy including requirements of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and codified at 45 C.F.R. parts 160 and 164 (Privacy Rule) to the extent applicable to each party and as may be amended from time to time.

Hospital Admission:

Acute level inpatient care with assignment to room and bed, not outpatient or observation care unit.

Large Case Management:

The process of working directly with patients, their families and their physicians to coordinate the delivery of cost-effective, quality care to promote optimal outcomes for patients with catastrophic conditions.

Large Case Management Identification:

The process of screening potentially catastrophic cases to determine if case management can positively impact the cost or health outcome for the patient.

Maternity Management Program:

A program that screens all pregnant women early in their pregnancy in an attempt to identify those who are at risk for complications or premature delivery. The patient will call upon confirmation of pregnancy in order to precertify for the anticipated hospital confinement. The nurse reviewer will speak with the mother and conduct an initial assessment and complete a high-risk questionnaire. If the questionnaire indicates that the mother is high-risk, the mother is called on a monthly basis to assess problems and monitor needs. Full case management may be required and will be requested if significant needs are found, such as confinement before delivery for pre-term labor, hyperemesis, or implementation of a home care program to monitor blood pressure, diabetes, or contractions. The focus on the program is education and prevention of complications. Non-high-risk mothers are contacted each trimester. Educational material is sent to the expectant mother.

Medical Peer Review:

The process of reviewing medical necessity by a board certified, licensed physician of like specialty. It may also include other questions requested by the payer to assist with claims determinations, coding or billing issues and opinions. This process is typically a paper review based on records provided by the attending physician or provider of care.

Medically Necessary:

Services or items reasonable and necessary for the diagnosis or treatment of illness or injury according to accepted standards of medical practice.

Network Channeling:

Part of the precertification process by which the UR team educates the provider or patient to the benefits of utilizing a network provider, upon request for precertification of services at a non-network facility.

Nominal Defendant:

A nominal defendant shall refer to Contractor's participation in a lawsuit by being named as a defendant not because any specific relief is requested against Contractor and/or not because Contractor is liable in damages under any applicable and tested legal theory, but because Contractor is connected with subject-matter giving rise to the lawsuit.

Nurse Consultation:

Review of claims or requests for services for medical necessity or cost effectiveness as requested by THE CLAIM PAYER, onsite evaluations and shock loss reports.

Observation Confinement:

An observation confinement is a short stay in an acute care hospital where the patient is observed to determine the need for full inpatient admission. These confinements are generally 23 hours in length or less and billed by the facility at less than the normal room & board rate.

Oncology Case Management:

The process of working directly with patients, their families and their physicians to coordinate the delivery of cost-effective, quality care to promote optimal outcomes for patients with cancer.

Outpatient Behavioral Health Review:

The process of reviewing non-acute levels of care, where the condition does not require an acute inpatient stay. This review includes partial hospitalization programs (PHP), also referred to as day hospitals. Treatment usually is six hours per day and at least five days per week. This level is usually used post-acute inpatient to transition the patient to home in a structured level of care. This review also includes intensive outpatient treatment (IOP). Usually three hours in the evening. Number of days per week varies from three to six. This is less restrictive than PHP, but gives the patient intense education and therapy. The service can also be used post inpatient for those that do not require the more restrictive, structured PHP. Review may include outpatient therapy sessions. See Exhibit 2 for identified services.

Outpatient Surgical Review:

The process of validating the medical necessity or a proposed outpatient surgical procedure.

Potential Shock Loss Notification:

Written notification to THE CLAIM PAYER only, of potential high dollar claims cases, when such cases are identified and based solely upon the information made available to HINES. Identification is not made based on claim history, but rather on the diagnosis or information made available to HINES regarding the potential treatment plan. By providing this Notification, HINES is not assuming any obligation for THE GROUP or the administrator/THE CLAIM PAYER to notify the MGU/stop loss carrier or reinsurer of a potential high dollar claim. This Notification is sent as a courtesy only and does not imply that HINES is assuming, or intends to assume, any liability for the Notification or the failure to provide such Notification.

Preadmission Review or Precertification or Utilization Review:

The process of validating the medical necessity of a proposed or emergent acute inpatient hospital admission.

Provider Network:

A provider network is a list of the doctors, other health care providers, and hospitals that a plan has contracted with to provide medical care to its members. These providers are called "network providers" or "in-network providers".

Quarterly Data Reports:

Reports compiled from the data accumulated during a given "quarter" reflecting the utilization review activity of a specific employee group or claims administrator. Reports can be customized to meet specific needs of the customer.

Retrospective Review:

The process of validating the medical necessity and appropriateness of a hospital confinement or a procedure after the patient has been confined or the procedure has been completed. Retrospective reviews are generally done by medical record review. Retrospective reviews for dates of service prior to the contract start date or after the member or group has termed will be charged hourly.

Second Surgical Opinion:

The process of recommending or assisting with arranging a physical examination and appropriate review by an independent surgeon to provide an opinion on the medical necessity of a designated procedure or surgery.

Skilled Nursing Facility:

An institution or distinct part of an institution designed for the person who needs short-term, comprehensive inpatient care following an acute illness, injury, exacerbation of an existing disease process, or post operative care. The patient must require the services on a daily basis, the care must be prescribed by a physician, and must require the skills of qualified technical or professional health personnel.

Service Agreement Exhibits

The Exhibits to the Agreement, whereby THE GROUP agrees to pay HINES its fee in exchange for receiving the SERVICES described herein.

Stop Loss Research Report:

A prospective detailed report that anticipates Health Care needs and estimates the cost of expected services over a designated period of time, for a specific enrollee with a specific diagnosis. This report is provided at an additional fee as requested by THE CLAIM PAYER.

Transplant Case Management:

The process of working directly with patients, their families and their physicians to coordinate the delivery of cost-effective, quality care to promote optimal outcomes for patients with organ transplant conditions.

EXHIBIT 2
COUNTY OF DAKOTA COUNTY

This Exhibit of the Service Agreement is effective beginning March 1, 2022.

$2.05 Utilization Review Per Employee Per Month Billing**

Acute Inpatient Medical/Surgical and Behavioral Health Review
- Preadmission Review
- Concurrent Review
- Retrospective Review

Discharge Planning Support
Outpatient Surgical Review
Voluntary Second Surgical Opinion
Skilled Nursing Facility
Behavioral Health Residential Stays
Behavioral Health Partial Hospitalization

Large Case Management Identification
Network Channeling
Quarterly Data Reports

**The Utilization Review PEPM is bundled pricing with case management services. Frequent case management refusal by THE GROUP will result in an increase adjustment to the Utilization Review PEPM similar to Utilization Review only clients.

Utilization Management Services handled by UM Team (nurses, physicians, UM assistants and call center staff). Certain services may not have clinical review.

REPORTING:
- Quarterly Reports Included
- Ad Hoc Reports – Varying Pricing

OTHER SERVICE FEES AS OF March 1, 2022:
- **Large Case Management fee (in 10 minute increments)–$125.00 per hour**
  If at any point a physician review is required, SERVICES will be charged at the current Physician Review Fee rate. Charges for record acquisition will be passed through to THE GROUP/THE CLAIM PAYER.
- **Maternity Management Program fee (per occurrence)–$350.00 for Normal Pregnancy/$500.00 for High-Risk Pregnancy**
- **Stop Loss Research Report fee (in 10 minute increments)–$135.00 per hour**
- **Nurse Consultation fee (in 10 minute increments)–$135.00 per hour**
- **Physician Review fees (in 15 minute increments)–$450.00 per hour**
  Includes all UR appeals, all UR reviews related to oncology, spinal or transplant services, and other physician reviews not included in the UR pepm. Minimum 60 minute charge.

SPECIALTY CASE MANAGEMENT SERVICE FEES AS OF March 1, 2022:
- **BABE℠ Critical Care Neonatal Case Management fee (in 10 minute increments)–$135.00 per hour**
- **Dialysis Case Management fee (in 10 minute increments)–$135.00 per hour**
- **High Risk Obstetrical Case Management fee (in 10 minute increments)–$135.00 per hour**
- **Oncology Case Management fee (in 10 minute increments)–$135.00 per hour**
- **Behavioral Health Case Management fee (in 10 minute increments)–$135.00 per hour**
- **Transplant Case Management fee (in 10 minute increments)–$135.00 per hour**

RECORD ACQUISITION

Charges for record acquisition from a provider or record company will be passed through.

****These are the contracted SERVICES as relayed to HINES.**
Any additional SERVICES included in the plan document may affect the pricing structure.

THE GROUP agrees to notify HINES of any changes
in Stop Loss carrier, broker, consultants and/or plan documents.

EXHIBIT A

ADMINISTRATIVE SERVICES AGREEMENT FEE SCHEDULE

Renewed: March 1, 2022

The administrative services agreement entered into by **County of Dakota County** and **Mid-American Benefits, LLC** lists below the fees as required by The Employee Retirement Income Security Act of 1974 (ERISA). The Claims Administrator will receive and pay, in accordance with the following schedule, fees, and commissions as reasonable compensation for services conducted in the ordinary course of business.

For: **Claims Administration**	**Rates**	**Paid To:**
Medical Admin Fee*	$27.00/EE/MO	Claims Administrator
Dental Admin Fee	$ 3.50/EE/MO	Claims Administrator
Network Access Fee	$ 5.25/EE/MO	Claims Administrator
Utilization Review (UR) Services	$ 2.05/EE/MO	Claims Administrator
Telemedicine	$ 1.25/EE/MO	Claims Administrator
(Fees may change during a plan year depending upon access fees charged by the contracted vendors)		
COBRA Admin Fee	$ 1.00/EE/MO	Claims Administrator

*Includes Broker Fees

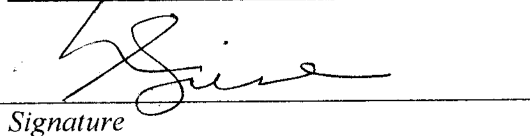
The following are expressed as a percentage of total savings, discounts, recoveries and applicable fees:

- Subrogation Recovery Fee — 30% of Recovery
- Over Payment Recovery Fee — 30% of Recovery
- Out-of-Network Claim Negotiation — 30% of Savings
- Forensic Claim Audit/Review Fee — 50% of Savings
- PBM Administration Fees — $35.00 per pharmacist-mediated Prior Authorization; $.16 per eligibility check for E-prescribing; $1.50 per claim + postage for member paper claim

COMMISSIONS: **POLICY**	**CARRIER**	**% OF PREMIUM**	**PAID TO**
Stop Loss Insurance	USBenefits/American Nat'l	None	N/A

I certify that the above represents a true and accurate disclosure of the distribution of fees and commissions for the Plan Year beginning March 1, 2022.

County of Dakota County



Signature

Robert J. Giese

Printed Name

Board Chair

Title

03/21/2022

Date

Mid-American Benefits, LLC

Signature

Matt Wullenwaber

Printed Name

President

Title

March 1, 2022

Date