KAISER PERMANENTE®

Northwest Permanente PC, Physicians & Surgeons
Kaiser Foundation Hospitals
Kaiser Foundation Health Plan of the Northwest

CERTIFIED MAIL

October 19, 2018

Attention: Robert Torgusen
Centria Healthcare, LLC
1700 NW 167th Pl Suite 240
Beaverton, OR 97006

RE: Fully Executed Health Care Services Agreement

Dear Provider,

Enclosed please find for your files one fully executed original of the Health Care Services Agreement between Northwest Permanente, PC and your organization.

If you have any questions, please feel free to contact Kelly Dixon, Provider Contract Manager, at (503) 813-3833.

Sincerely,

Molly Phillips

Molly Phillips
Contract Coordinator
Provider Contracting & Relations Department

Enclosures: (1)

cc: Contract Manager
Contract File

Kaiser Permanente Building
500 N.E. Multnomah Street, Suite 100
Portland, OR 97232-2099
503-813-3860

HEALTH CARE SERVICES AGREEMENT

BETWEEN

KAISER FOUNDATION HOSPITALS, FOR THE NORTHWEST REGION

AND

CENTRIA HEALTHCARE, LLC

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HEALTH CARE SERVICES AGREEMENT

This Health Care Services Agreement (**"Agreement"**) is entered into between Kaiser Foundation Hospitals, for the Northwest Region (**"Network"**) and Centria Healthcare, LLC (**"Provider"**). This Agreement is effective for Services rendered on and after November 1, 2018 (**"Effective Date"**).

WHEREAS, Kaiser Foundation Hospitals has been retained by Kaiser Foundation Health Plan of the Northwest (**"KFHP-NW"**) to provide or arrange for institutional health care services to Members (as defined below); and

WHEREAS, Northwest Permanente, P.C. has been retained by KFHP-NW to provide or arrange for professional services to Members, and together, Kaiser Foundation Hospitals, Northwest Permanente, P.C. and KFHP-NW cooperate to form the Kaiser Permanente Medical Care Program in the Northwest Region (**"KP"**); and

WHEREAS, KFHP-NW shall be the corporation responsible for the obligations of a licensed health care services contractor with respect to Members with individual or group coverage issued by KFHP-NW and regulated by the applicable state insurance commissioner; and

WHEREAS, Network desires to enter into an arrangement for Provider to render Services to Members;

NOW THEREFORE, the parties agree as follows:

ARTICLE 1
DEFINITIONS

When used in this Agreement, these capitalized terms shall have the following meanings.

1.1 **"Clean Claim"** means a claim that (1) is completed with all data elements required by Payer, (2) if submitted electronically, is submitted using standard code sets as required by law, and (3) has no defect or error that prevents timely adjudication.

1.2 **"Covered Services"** means the health care services that a Member is entitled to receive under the terms and conditions of a Plan.

1.3 **"Kaiser Payer"** means Kaiser Foundation Hospitals, Northwest Permanente, P.C., KFHP-NW and any company controlling, controlled by, or under common control with KFHP-NW when a Member of such a company under any circumstance (such as, but not limited to, vacations, temporary work assignments, and direct referrals for specialty care), seeks care from Provider under a Plan regulated by a state insurance or managed care commissioner. With respect to applicable state laws regarding health care service contractors, KFHP-NW is responsible for the conduct of such companies and their compliance with the terms of this Agreement.

1.4 **"Member"** means an individual entitled to receive Covered Services.

1.5 **"Member Cost Share"** means a copayment, deductible, or coinsurance amount payable by a Member for Covered Services pursuant to the Member's Plan.

1.6 **"Other Payer"** means any public or private entity – including, without limitation, employers, insurers, third party administrators, labor unions, trusts, associations, and other

organizations, persons, and entities – that is responsible for funding a Plan and that enters into an administrative or management service arrangement with a Kaiser Payer to administer its Plan.

1.7 **"Payer"** means a Kaiser Payer or Other Payer.

1.8 **"Plan"** means a plan of health benefits administered, issued, sponsored or underwritten by either a Kaiser Payer or an Other Payer, as set forth in the Member's summary plan description, coverage agreement, evidence of coverage, certificate of coverage, or other written coverage document.

1.9 **"Policies"** means the policies and procedures of Kaiser Payer and Other Payers that relate to this Agreement including, but not limited to: (1) quality improvement/management; (2) utilization management and referral and authorization processes; (3) pre-admission testing guidelines; (4) claims submission, review and payment; (5) member grievances; (6) provider credentialing; and (7) electronic transmission of data. Policies include those policies and procedures set forth in manuals, bulletins, and newsletters, whether made available by postal mail, electronic mail, web site, or other media.

1.10 **"Proprietary Information"** means all information, whether prepared by Provider, Network, Plan, Payer, or their representatives, relating to itself or the development, execution or performance of this Agreement whether furnished or obtained prior to or after the Effective Date. Proprietary Information includes, but is not limited to, pricing, financial information, rate schedules, and Member information collected by Plans and Payers not otherwise set forth in medical records; provided, however, the following shall not constitute Proprietary Information: (1) information known prior to receipt from the other party; (2) information previously available to the public prior to receipt; or (3) Proprietary Information that subsequently becomes available to the public through no fault or omission on the part of the party receiving the Proprietary Information.

1.11 **"Services"** means those services, supplies and other resources described in Exhibit "Compensation and Services" that Provider customarily provides to its general patient population.

ARTICLE 2
PROVIDER'S RESPONSIBILITIES

2.1 **Provision of Services**. Provider shall make available to and provide Members with Services, along with any related facilities, equipment, personnel or other resources necessary to provide Services, according to generally accepted standards of practice. Services shall be readily available and accessible to Members and provided in a prompt and efficient manner without unreasonable delays.

2.2 **Non-Discrimination**. Provider shall provide Services to Members without discrimination on the basis of race, ethnicity, color, gender, sex, creed, religion, national origin, age, health status, physical or mental disability, genetic information, veteran's status, marital status, sexual orientation, gender identity, income, source of payment, participation in a government program, evidence of insurability, medical condition, claims experience, receipt of health care, conditions arising out of acts of domestic violence, status as a Member, or any other status protected by applicable law; and Provider shall ensure that Provider's facilities and equipment are accessible to persons with disabilities. Provider shall make Services available to

all classes of Members, in the same manner, in accordance with the same standards, and with the same availability, as with respect to Provider's other patients.

2.3 **Licensure and Credentials**. Provider represents and warrants that it (together with its employees, agents, and contractors providing Services) shall throughout the term of this Agreement: possess and maintain, without restriction, all applicable federal, state and local licenses, permits, certificates, approvals and authorizations required to render Services to Members (including, if applicable, medical staff membership and clinical privileges at facilities designated by Network); comply with KP credentialing requirements, as described in Policies; remain accredited or certified by the organizations designated by Network; be enrolled in, participate in, meet coverage conditions for and, where applicable under Centers for Medicare and Medicaid Services rules, be certified by the Medicare and Medicaid programs; and not (i) be "opted out" of Medicare, (ii) be sanctioned, debarred, suspended or excluded from any federal program, including Medicare or Medicaid, or (iii) be identified on any federal list of sanctioned or excluded entities and individuals, including lists maintained by the Department of Health and Human Services, General Services Administration, Office of Inspector General and Office of Foreign Assets Control. Provider shall comply with the standards of any organization accrediting KP as they apply to Services rendered to Members.

2.4 **Subcontracts**. If Provider arranges for the provision of Services to a Member by any individual or entity not a bona fide employee of Provider (**"Subcontractor"**), Provider shall enter into a written contract with such Subcontractor prior to the provision of Services to Members by the Subcontractor. Such contract shall require the Subcontractor to comply with the same terms applicable to Provider under this Agreement. Upon request, Provider shall promptly provide access to and copies of all contracts with Subcontractors. Unless otherwise required by law or arranged with Network, Provider shall retain responsibility for paying its Subcontractors (in accordance with any law applicable to subcontractors of health care service contractors), and such Subcontractors shall not seek reimbursement from or have any recourse against a Payer for Subcontractor's services provided to Members.

2.5 **Information**. Provider shall notify Network Promptly (as defined below) upon Provider's knowledge of any of the following involving Provider or any employee, agent or Subcontractor providing Services: (1) the revocation, suspension, restriction, or expiration of any license, permit, certification, approval, authorization, medical staff membership or clinical privilege required to render Services to Members or of any accreditation or certification specified in Section 2.3 (Licensure and Credentials); (2) sanction by or debarment, exclusion, suspension or "opt out" from any federal program, including Medicare or Medicaid, or identification on a federal list of sanctioned or excluded entities and individuals, including lists maintained by the Department of Health and Human Services, General Services Administration, Office of Inspector General and Office of Foreign Assets Control; (3) the submission of a formal report to a professional board, licensing agency, or the National Practitioner Data Bank of adverse credentialing or peer review action; (4) a material change in credentialing or privilege status; (5) any change in operations that will likely materially affect the manner in which Services are provided to Members; (6) any unusual occurrence involving a Member that is reported or required to be reported to a regulatory body or an accreditation organization; (7) any change in legal status, tax identification number, or Medicare or Medicaid number; (8) any material change in ownership, control, name, or location; (9) the initiation of any legal action, accreditation organization action, or, regulatory or governmental action that is likely to materially and

adversely affect Provider's or a Subcontractor's ability to perform its obligations under this Agreement; (10) any professional liability claim or other legal action filed or asserted by a Member against Provider or an employee, agent, or Subcontractor of Provider; (11) any event or circumstance that is likely to materially impair the ability to provide Services to Members, and (12) bankruptcy, dissolution or receivership of Provider, or an assignment by Provider for the benefit of creditors. However, Provider shall not be required to waive legal privilege in order to comply with subsections (3), (6), (9) and (10) of this Section, provided that Provider shall notify Network pursuant to these subsections to the extent Provider can do so without waiving legal privilege. "Promptly" means within 2 business days for subsections (1), (2), (3) and (6) and within 10 business days for the other subsections in this Section.

2.6 **Policies**. Provider shall cooperate and comply with Policies of which Provider knows or reasonably should have known. Policies may be modified by Payers from time to time, but no Policy change shall be retroactive without the express consent of Provider. In the event of any inconsistency between a Policy and this Agreement, this Agreement shall prevail.

A. Provider shall cooperate and comply with Payers' quality assurance and utilization management activities (including pre-service, concurrent and retrospective reviews), case management and disease management services, preauthorization steps required for Covered Services, member and provider grievance and appeals processes, pharmaceutical formularies, claims submission and payment procedures.

2.7 Law. Provider shall comply with all laws, rules and regulations applicable to Provider and Services under this Agreement, including those set forth in Exhibits.

ARTICLE 3
NETWORK'S RESPONSIBILITIES

Network and KFHP-NW shall ensure that Payers (a) provide Members with sufficient information to permit Provider to determine Plan benefits, Member eligibility for Plan benefits, and other necessary Plan information, and (b) appropriately designate Provider in directories.

ARTICLE 4
BILLING AND PAYMENT

4.1 **Compensation**. Compensation to Provider for Services that are Covered Services to Members shall be paid at the lesser of Provider's billed charges or the rates set forth in Exhibit "Compensation and Services," less any Member Cost Share. Provider accepts such amount as payment in full for all Services that are Covered Services and acknowledges that compliance with Section 2.3 (Licensure and Credentials) is a precondition to payment. Pursuant to the procedures in Section 4.4 (Member Billing), Provider shall also accept from the Member payment at the rates set forth in Exhibit "Compensation and Services" as payment in full for all Services that are not Covered Services.

4.2 **Claims**. Provider shall submit to the applicable Payer a Clean Claim for Covered Services rendered to Members. Provider shall maximize the use of electronic claims rather than paper claims. Provider agrees that Payers shall not be obligated to make payments for billings received more than 365 days from (1) the date of service or (2), when a Payer is the secondary payer, from the date of receipt by Payer of the primary payer's explanation of benefits. This requirement may be waived, in the discretion of the applicable Payer, in the event Provider

provides notice and appropriate evidence to the Payer of extraordinary circumstances outside the control of Provider that resulted in the delayed submission. If Provider does not timely submit a claim, or does not timely dispute any alleged underpayment, Provider's claim for payment shall be deemed waived, and Provider shall not seek payment from the Plan, Payer, Network, or Member.

4.3 **Prompt Payment**. Within 30 days of receipt of a Clean Claim from Provider, Network shall (1) cause Kaiser Payer to pay Provider for Services that are Covered Services rendered to Members of Kaiser Payer and (2) to the extent permitted by law, notify Other Payers to authorize payment to Provider for Services that are Covered Services rendered to an Other Payer's Members; provided, that such period shall be extended as reasonably necessary where benefits must be coordinated with another health plan. Network is not responsible for the promptness or ultimate payment of claims for services rendered to Members of any Plan other than KFHP-NW. Network shall, however, reasonably assist Provider in collecting delinquent or underpayments from Payers.

4.4 **Member Billing**. Provider shall bill Members for applicable Member Cost Share. Provider may bill Members, subject to Section 4.1 (Compensation), for Services that are not Covered Services if prior to the services being rendered, the Member agreed in writing to pay for such services after being advised the services may not be Covered Services. Provider may not bill Members for Services that are Covered Services where payment is denied based upon utilization management decisions of Payers or where Provider failed to comply with the terms or conditions of this Agreement. Provider may bill or charge individuals who were not Members at the time that services were rendered.

4.5 **Member Hold Harmless**. In no event including, but not limited to, nonpayment by or insolvency of Network, KFHP-NW or a Payer, or breach of this Agreement, shall Provider bill; charge; collect a deposit from; seek compensation, reimbursement, or remuneration from; impose surcharges; or have any recourse against any Member, person acting on the Member's behalf, or any person other than the responsible Payer for Covered Services provided under this Agreement, except for Member Cost Share payment. The terms of this Section shall survive the termination or expiration of this Agreement regardless of the cause giving rise to termination, shall be construed to be for the benefit of Members, and shall supersede any oral or written agreement to the contrary now existing or hereafter entered into between Provider and the Member or persons acting on the Member's behalf.

4.6 **Coordination of Benefits**. When a Payer accessing the rates under this Agreement is the primary payer under applicable coordination of benefit principles, that Payer shall pay in accordance with this Agreement. When such Payer is secondary under applicable coordination of benefit principles, Provider is owed an amount that, when added to the amount payable by the primary payer, equals the amount that would be owed under this Agreement without coordination of benefits, unless otherwise required by law. However, if Provider provides services for an employment-related injury or illness compensable under workers' compensation or employment liability law, Provider shall look to the applicable workers' compensation carrier or responsible employer for compensation and shall not be entitled to additional payment under this Agreement for such services paid under workers' compensation or employment liability law.

4.7 **Liens and Third Party Claims**. In instances of third party liability claims (involving, for example, liability carriers), Provider shall accept the amount payable under this Agreement as

payment in full. Provider shall not, directly or indirectly through assignment or otherwise, assert any lien claim, subrogation claim, or any other claim against a Member, or any other person or organization against which a Member may hold a potential claim for personal injury, or against the proceeds of a Member's personal injury recovery based on Services provided to a Member for an injury or illness allegedly caused by a third party.

4.8 **Audit, Recoupment, and Offset**. Unless otherwise required by law, Network, Provider, Plan, Payer, and their authorized agents may audit paid claims to verify the appropriateness and amount of payment so long as such audit takes place within two years of the date of payment or denial (or such longer period as may be set forth in an Other Payer's Plan or as required by a government program), except in cases of fraud, for which no time limit applies. Unless otherwise required by law, a refund or payment to correct an undisputed overpayment or underpayment shall be due upon demand, and failure to make such payment within 30 days of receipt of a demand shall entitle the Payer to offset, recoup or deduct the amount owed from any other amounts owed to Provider. To the maximum extent permitted by law, Payers are authorized to offset and recoup the amount of any debt owed by Provider to Payer against any debt or money owed Provider. This Section shall survive the termination or expiration of this Agreement.

ARTICLE 5
TERM AND TERMINATION

5.1 **Term**. This Agreement shall begin on the Effective Date and, subject to earlier termination as described in this Article 5, shall continue for an initial term of one year. At the expiration of this initial term, this Agreement shall automatically renew for one year periods thereafter unless any party gives the other prior written notice of non-renewal at least 90 days prior to the end of the initial term or a renewal term.

5.2 **Termination Without Cause**. Notwithstanding Section 5.1 (Term), this Agreement may be terminated by a party without cause at any time by giving the other party prior written notice of no less than ninety (90) days.

5.3 **Termination With Cause**. This Agreement may be terminated upon written notice by a party for material breach by the other party, provided that (a) such non-breaching party gives at least 60 days prior written notice of termination to the party in breach and a description of the other party's breach, and (b) such material breach is not cured during the 60 day notice period. Provider's failure to comply with Section 2.3 (Licensure and Credentials) or Section 2.6 (Policies) shall be deemed a material breach.

5.4 **Immediate Termination**. Any of the following events shall, at the sole discretion of Network, result in the immediate termination or suspension of this Agreement, upon written notice to Provider: (1) the withdrawal, debarment, suspension, expiration, restriction or non-renewal of any federal, state or local license, certificate, approval or authorization of Provider required to render Services; (2) the bankruptcy, dissolution or receivership of Provider, or an assignment by Provider for the benefit of creditors; (3) the loss or material limitation of Provider's liability insurance described in this Agreement; (4) a determination by Network that Provider's continued participation in this Agreement could result in imminent and substantial harm to Members; (5) sanction under, debarment, suspension, exclusion or "opt out" of Provider from participation in any governmental sponsored program including, but not limited to,

Medicare or Medicaid, or identification of Provider on a federal list of sanctioned or excluded entities and individuals, including lists maintained by the Department of Health and Human Services, General Services Administration, Office of Inspector General and Office of Foreign Assets Control; (6) the conviction of Provider of any crime; (7) the revocation or suspension of Provider's accreditation or credentialing status; or (8) a change of ownership or control of Provider.

5.5 **Effect of Termination**.

A. **Cooperation in Transfer of Members**. Upon termination or expiration of this Agreement, Provider shall cooperate in the timely and efficient transfer of Members to other facilities designated by the Payer. Network shall arrange for timely notification of Members of the termination or expiration of this Agreement.

B. **Survival**. Termination or expiration shall not affect those rights, powers, remedies, liabilities, and obligations that accrued or arose before termination or expiration. Termination or expiration shall also not affect those provisions of this Agreement expressly stated to survive termination or expiration.

C. **Continuation of Care**. Upon termination or expiration of this Agreement, Provider shall continue to provide (and Payer shall continue to compensate Provider for) Services pursuant to this Agreement and the Policies to Members who are under the care of Provider at the time of termination or expiration until the later to occur of the discharge or transfer of the Member in accordance with an appropriate professional standard of care or such time period as may be prescribed by applicable law.

5.6 **Suspension of Participation**. Any of the following events may result in Network's immediate suspension, until cured to Network's satisfaction, of a practitioner or site of Provider providing Services under this Agreement from participation in this Agreement (without terminating or suspending the Agreement), upon written notice to Provider: (1) the withdrawal, debarment, suspension, expiration, restriction or non-renewal of any federal, state or local license, certificate, approval, or authorization of such practitioner or site required to render Services; (2) the failure of the practitioner or site to comply with KP's credentialing requirements, and if applicable to practitioner, the loss or restriction of practitioner's medical staff membership or clinical privileges (3) sanction under, debarment, suspension, or exclusion of practitioner or site from participation in any governmental sponsored program including Medicare or Medicaid, "opt out" from any federal program including Medicare or Medicaid, or identification on a federal list of sanctioned or excluded entities and individuals, including lists maintained by the Department of Health and Human Services, General Services Administration, Office of Inspector General and Office of Foreign Assets Control; (4) the conviction of practitioner or site of any crime; (5) failure of practitioner or site to comply with law or Policies following a reasonable request for compliance by Network; or (6) a determination by Network that practitioner's or site's continued participation in this Agreement could result in imminent and substantial harm to Members.

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ARTICLE 6
DISPUTE RESOLUTION

6.1 **Member Grievance**. Provider agrees to (1) cooperate with and participate in Member appeal, grievance and external review procedures; (2) provide the Plan with the information necessary to conduct Member appeal, grievance and external review procedures; and (3) abide by decisions of Member appeals, grievance and review committees.

6.2 **Provider Appeals Process**. Each Plan shall provide an internal mechanism whereby Provider may raise issues, concerns, controversies or claims arising from or related to this Agreement. Specifically, each Plan shall maintain an appeals process pursuant to which Provider may seek to resolve disputes arising from this Agreement. This appeals process shall be exhausted before Provider may pursue further action against a Plan or Payer.

6.3 **Disputes Between the Parties**.

A. **Arbitration**. With respect to disputes, controversies, or claims arising from or related to this Agreement (**"Disputes"**), and except as stated in Section 6.3B below, Provider hereby waives the right to civil trial of any Dispute and agrees to bind itself to arbitration of such Disputes to the extent allowed by applicable law. Likewise, and except as stated in Section 6.3B below, Network shall waive the right to civil trial of any Dispute and agrees to bind itself to arbitration of such Disputes to the extent allowed by applicable law. Provider or Network may, by written notice to the other party, submit any Dispute to confidential arbitration administered by an Alternative Dispute Resolution (**"ADR"**) organization to which they mutually agree, including, but not limited to, JAMS. A party may initiate confidential arbitration by providing a written arbitration demand (**"Demand"**) to the other party by stating the nature of the Dispute and the damages sought. Upon tender of the Demand, the parties shall use their best efforts to agree on an ADR organization to administer the confidential arbitration. If the parties to the Dispute cannot agree on an ADR organization to administer the confidential arbitration within 30 calendar days from the date on which the Demand was tendered, the Dispute shall be administered by JAMS in accordance with the JAMS Comprehensive Arbitration Rules & Procedures, except this Agreement shall control should it conflict with the JAMS Rules. The parties shall sign a confidentiality agreement before arbitration that shall make the entire Dispute confidential (except as required by law). The Dispute shall be arbitrated before a single arbitrator, who may be chosen by the parties. If the parties are unable to agree on an arbitrator, the arbitrator shall be chosen pursuant to the rules of the ADR organization to which they have mutually agreed or, if there is no such agreement, the JAMS Comprehensive Arbitration Rule 15. In such instance where the parties are unable to agree upon an arbitrator, the potential arbitrators shall be retired judges; if no such retired judges are available, the potential arbitrators may be attorneys with at least fifteen (15) years of experience including some experience in managed health care and integrated health care delivery systems. The parties shall be responsible for their own attorneys' fees and costs incurred in preparing for and attending the arbitration. The parties to the arbitration (including, but not limited to, proper parties joined in the arbitration) shall share equally the fees of the arbitrator and the ADR process. The parties agree that any and all proper parties may be joined in the arbitration, but the parties agree to proceed with arbitration of all Disputes between them even if other parties refuse to participate. The arbitrator shall prepare the award in writing, including factual findings and the legal basis and other reasons on which the award is based. The decision and award shall be reviewable only pursuant to the Federal Arbitration Act or its state law equivalent. Judgment upon the award rendered may be entered in

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any court of competent jurisdiction. This provision shall survive the termination or expiration of this Agreement.

B. **Injunction**. Notwithstanding Section 6.3A, the parties agree that Disputes involving certain breaches of the Agreement, including without limitation a breach of the confidentiality obligations, would cause irreparable injury to the injured party that could not be compensated adequately in damages. The parties further agree that such injured party shall be entitled (in addition to any other remedies or damages) to remedies of injunction, specific performance, or restraining orders, which remedies do not require arbitration as a prerequisite. In such instance, the parties agree that the injured party may seek remedies of injunction, specific performance, or restraining orders in a civil court of competent jurisdiction.

ARTICLE 7
RECORDS AND CONFIDENTIALITY

7.1 **Maintenance of Records**. Provider shall maintain its financial, accounting, administrative, and patient medical records in a current, detailed, organized and comprehensive manner in accordance with prudent industry practice, applicable laws, and accreditation standards. All Member medical records shall be treated by Provider as confidential in accordance with applicable laws. Provider shall maintain these records with respect to a Member for the longer of six years after the last date Services were provided to the Member or the period required by law. Should Provider experience a disclosure of Member information impermissible under state privacy laws or the privacy rules of the Health Insurance Portability and Accountability Act, Provider shall notify Network of the nature of the disclosure and the identity of the Members involved and shall take all steps required by law and reasonable business practice to remedy, mitigate and report the disclosure. This Section shall survive the termination or expiration of this Agreement, regardless of the circumstances of termination or expiration.

7.2 **Access to Records**. In accordance with applicable law, Network, KP, the applicable Plan and Payer, their authorized agents, and authorized government and accreditation officials shall have access to (including electronic access where practicable), a right to photocopy, and upon reasonable notice, a right to perform site visits related to, all financial, accounting, administrative, and patient medical records (including electronic images that are part of medical records) pertaining to Members for the purpose of meeting legal, regulatory and accreditation requirements applicable to the Plans; assessing quality of care, conducting medical evaluations and audits; performing utilization management functions; verifying the accuracy of amounts paid or payable to Provider; and other functions of a Plan. In addition, Provider shall supply periodic reports pertaining to Services provided to Members as the parties may, from time to time, agree or as otherwise required for Plans to meet their legal and accreditation requirements. Photocopies of medical records and other files, reports, books, and records shall be without charge to Network, Payers and Plans unless otherwise required by law. Provider agrees to allow access to or supply copies of such records, as requested, within 14 days of the receipt of a request, where practicable, and in no event later than the date required by any applicable law or regulatory or accreditation authority. This Section shall survive the termination or expiration of this Agreement, regardless of the circumstances of termination or expiration.

ARTICLE 8
RELATIONSHIP OF PARTIES

8.1 **Communication with Members**. Nothing in this Agreement shall be construed to limit Provider's ability to freely communicate with a Member or the Member's authorized representative about the Member's treatment options.

8.2 **Independent Contractor**. Provider is an independent contractor to Network. Nothing in this Agreement is intended to create, nor shall it be construed to create, between Network and Provider a relationship of principal, agent, employee, partnership, joint venture or association. Network and Provider have no authorization to enter into any contracts, assume any obligations, or make any warranties or representations on behalf of the other. No individual through whom Provider renders Services shall be entitled to or shall receive from Network compensation for employment, employee welfare and pension benefits, fringe benefits, or workers' compensation, life or disability insurance or any other benefits of employment, in connection with providing Services. Provider represents and warrants that it shall be responsible for all legally required tax withholding for itself and its employees.

8.3 **Government Contractor**. As an organization with federal government contracts, Network and the Kaiser Payers are subject to various federal laws, regulations and executive orders (such as regarding equal opportunity and affirmative action), which may apply to Network's subcontractors. Notice of such laws, regulations, and executive orders is provided in Exhibit "Federal Program Compliance" in the Section on the Federal Employee Health Benefits Program. If Provider is not otherwise subject to compliance with such laws, regulations and executive orders, their reference in this Agreement shall not be deemed to impose such requirements upon Provider.

8.4 **Proprietary Information**. Provider and Network agree the Proprietary Information of the other is the exclusive property of the other and that they have no right, title or interest in the Proprietary Information of the other. Provider and Network agree to keep Proprietary Information strictly confidential and agree not to disclose any Proprietary Information to any third party, except (i) to governmental or accreditation authorities having jurisdiction, (ii) as required in legal proceedings or government administrative proceedings, (iii) in the case of Network's disclosure, to Members, Plans, Payers, affiliates in the Kaiser Permanente Medical Care Program, consultants and vendors under contract with Network, or (iv) as otherwise directed by the other party in writing. This Section shall survive the termination or expiration of this Agreement, regardless of the circumstances of termination or expiration.

8.5 **Insurance**.

A. **Provider's Insurance**. Provider, at Provider's sole cost and expense, shall procure and maintain such policies of general and professional liability and other insurance (or programs of self insurance that are adequately funded according to sound actuarial principles) at minimum levels required from time to time by Network, but in no event less than $1,000,000 per claim/ $3,000,000 annual aggregate for professional liability insurance and $1,000,000 per claim/ $2,000,000 annual aggregate for comprehensive general liability insurance. Such insurance coverage shall cover the acts and omissions of Provider as well as those of Provider's agents and employees. Provider may obtain one or more claims-made policies to fulfill its obligations under this Section so long as Provider obtains any extended reporting endorsements (tail coverage) for such policies as may be necessary to provide continuous coverage without

interruption throughout the term of this Agreement and for at least ten (10) years following termination or expiration of this Agreement. Provider shall also procure and maintain workers' compensation insurance and unemployment insurance to the extent required by law, as well as a fidelity bond to the extent Provider renders Services in Members' homes or custodial care locations. Provider agrees to deliver memorandum copies of such policies to Network upon request. Provider agrees to make best efforts to provide to Network at least 30 days advance notice, and in any event shall provide notice as soon as reasonably practicable, of any cancellation or material modification of these policies.

B. **Network's Insurance**. Network, at its sole cost and expense, shall procure and maintain such policies of general and professional liability and other insurance (or programs of self-insurance that are adequately funded according to sound actuarial principles) as shall be necessary to insure itself and its employees against any claim or claims for damages arising by reason of personal injuries or death occasioned directly or indirectly in connection with the performance of any service by Network under this Agreement.

8.6 **Mutual Indemnification**.

A. **Provider**. Provider shall indemnify and hold harmless Kaiser Foundation Hospitals, Northwest Permanente, P.C., KFHP-NW and their officers, agents and employees from and against all claims and damages for or in connection with, injury (including death) or damage to any person or property to the extent resulting from the negligent or otherwise wrongful act or failure to act or willful misconduct of Provider.

B. **Network**. Network shall indemnify and hold harmless Provider and its officers, agents, employees and partners from and against all claims and damages for or in connection with, injury (including death) or damage to any person or property to the extent resulting from the negligent or otherwise wrongful act or failure to act or willful misconduct of Network.

ARTICLE 9
MISCELLANEOUS

9.1 **Notice**. Any notices to be given under this Agreement shall be in writing, signed by an authorized signatory, and shall be deemed given upon receipt if sent to the addresses listed below as follows: (1) personally delivered; (2) sent by United States Postal Service, postage prepaid, certified, and return receipt requested; or (3) sent by a commercial delivery service with proof of delivery. Any party may change its address for notice purposes by written notice to the other party.

NETWORK

Director of Provider Contracting
Kaiser Foundation Hospitals, for the Northwest Region
500 N.E. Multnomah Street, Suite 100
Portland, Oregon 97232

PROVIDER

Administrator

9.2 **Assignment and Delegation**. Except as otherwise provided in this Agreement, Provider shall not assign this Agreement, subcontract or delegate any of its duties and obligations under this Agreement without the prior written consent of Network. Any change of ownership or control of Provider shall be deemed an assignment. Any succession or assignment shall not relieve or otherwise affect the liability of Provider, which shall remain jointly and severally liable with the successor or assignee.

9.3 **No Third Party Beneficiaries**. With the exception of Section 4.5 (Member Hold Harmless) and with respect to KP and Payers, nothing in this Agreement shall be construed to give any person other than Provider or Network any benefits, rights or remedies.

9.4 **Force Majeure**. The parties shall be excused from any inability to meet their obligations under this Agreement due to extraordinary circumstances beyond their reasonable control occasioned by war, acts of government, labor disputes, acts of terrorism, fire, flood, earthquake, extreme weather or other acts of nature. The affected party shall give notice to the other party as soon as practicable of any such circumstance.

9.5 **Use of Name**. Each party reserves to itself the right to, and the control of the use of, its own names, symbols, trademarks and service marks, presently existing or hereafter established, and no party shall use another party's names, symbols, trademarks or service marks in any advertising or promotional materials or communication of any type or otherwise without the latter party's prior written consent; provided, however, Network and Plans may use the name, address and telephone number of Provider in lists of contracting providers and other marketing materials.

9.6 **Governing Law**. Except as preempted by federal law, this Agreement shall be governed by the laws of the state in which Provider is located, without application of the conflict of laws provisions of such state.

9.7 **Severability**. Any determination that any provision of this Agreement or any application thereof is invalid, illegal, or unenforceable shall not affect the validity, legality, and enforceability of such provision in any other instance, or the validity, legality or enforceability of any other provision of this Agreement.

9.8 **Waiver**. A failure of any party to exercise any provision of this Agreement shall not be deemed a waiver. To be effective, any waiver of any provision of this Agreement shall be in writing and signed by the party against whom the waiver is sought to be enforced. Any such waiver shall not operate or be construed as a waiver of any other provision of this Agreement or a future waiver of the same provision.

9.9 **Amendment**. This Agreement constitutes the entire understanding of the parties, and no changes, amendments or alterations shall be effective unless in a writing signed by the parties. Notwithstanding any other provision of the Agreement, if either party reasonably determines that a modification of this Agreement is necessary to cause it to be in compliance with state or federal law or the requirements of an accrediting or regulatory agency or a government contract, that party shall give the other party written notice of the proposed modification, the justification for

the modification, and the date on which it is to go into effect, which shall not be less than 30 days following the date of the notice (unless a shorter period of time is required by law). The modification shall go into effect on that date. The party providing notice shall consider any objection made by the other party concerning the proposed modification during the notice period.

9.10 **Interpretation**. The headings contained in this Agreement are included for purposes of convenience only, and shall not affect in any way the meaning or interpretation of any of the terms or provisions of this Agreement. This Agreement shall be interpreted according to its fair intent and not for or against any one party on the basis of whether such party drafted the Agreement. All references to "including" or "include(s)" shall mean "including, without limitation" and "include(s) without limitation," respectively. The omission of a particular example or the inclusion of any examples shall not be construed to broaden or limit the effect of the language. Any reference to a statute, regulation, government agency or program, regulatory body, accreditation standard or accreditation organization refers to the statute, regulation, government agency or program, regulatory body, accreditation standard or accreditation organization as amended from time to time, and to any successor statute, regulation, government agency or program, regulatory body, accreditation standard or accreditation organization. References to Provider shall include references to Provider, any employees or agents of Provider, and any Subcontractors.

9.11 **Counterparts**. This Agreement may be executed in separate counterparts, none of which need contain the signatures of all parties, and each of which, when so executed, shall be deemed an original and all together constitute and be one of the same instrument. Facsimile or electronic signatures shall be as valid as original signatures.

9.12 **No Exclusivity**. This is not an exclusive agreement. Provider and Network may enter into similar agreements with other parties.

9.13 **No Guarantee**. There is no representation, warranty, guarantee, or covenant that any minimum volume or value of business will be referred to Provider. Provider does not have a right to participate in any particular Plan, line of business, product, or network of a Plan.

9.14 **Remedies Cumulative**. The rights and remedies of this Agreement shall not be exclusive and are in addition to any other rights and remedies provided by law.

9.15 **Entire Agreement**. This Agreement and its Exhibits constitute the complete and sole contract between the parties regarding the subject hereof and supersede all prior or contemporaneous oral or written representations, communications, proposals, or agreements not expressly included herein. This Agreement and its Exhibits may not be contradicted or varied by evidence of prior, contemporaneous or subsequent oral representations, communications, proposals, agreements, prior course of dealings or discussions of the parties. There are no oral agreements among the parties. Provider has not relied on any data, financial analysis, reports, notes, proposals, conclusions or projections, whether made orally or in writing, made by Network or any of its representatives, agents, employees or advisors, in connection with negotiation, acceptance, execution or delivery of this Agreement by Provider.

[next page is signature page]

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed by their respective duly authorized representatives.

NETWORK	**PROVIDER**
Kaiser Foundation Hospitals, for the Northwest Region	**Centria Healthcare, LLC**
By:	By:
Print Name: Jenny Smith	Print Name: R. G TORGUSEN
Title: CFO	Title: Regional Vice President
Date: 10/18/18	Date: 10/16/2018

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LIST OF EXHIBITS

The exhibits applicable to this Agreement are marked below.

Name of Exhibit	Applicable	Not Applicable
Compensation and Services	X	
Federal Program Compliance	X	
National Committee for Quality Assurance ("NCQA") Required Provisions	X	
Washington State Compliance	X	
Washington State Medicaid Program Compliance	X	
Oregon State Compliance	X	
Oregon State Medicaid Program Compliance	X	
Oregon OEBB and PEBB Requirements	X	
Tax Identification		X
Oregon Workers' Compensation Managed Care Organization Provider Panel		X

EXHIBIT

COMPENSATION AND SERVICES

1. **Definitions**

A. **"Billed Charges"** means Provider's total charges based on its commercial fee schedule effective as of the encounter date.

B. **"Board Certified Assistant Behavior Analyst"** (or **"BCaBA"**) means an undergraduate-level certification in behavior analysis. Professionals who are certified at the BCaBA level may not practice independently, but must be supervised by someone certified at the BCBA level. In addition, BCaBAs can supervise the work of RBTs, and others who implement behavior-analytic interventions.

C. **"Board Certified Behavior Analyst"** (or **"BCBA"**) means a graduate-level certification in behavior analysis. Professionals who are certified at the BCBA level are independent practitioners who provide behavior-analytic services. In addition, BCBAs supervise the work of MLPs, RBTs, and others who implement behavior-analytic interventions.

D. **"CMS"** means the Centers for Medicare and Medicaid Services.

E. **"Commercial Member"** means a Member who is not a Medicaid Member or a Medicare Member. Typically, a Commercial Member's primary source of funding for health care services is derived from an insurance product or an employer-based self-funded group.

F. **"CPT Code"** means the Current Procedural Terminology (CPT) code assigned by the American Medical Association to a medical procedure of providers.

G. **"Do Not Bill Events"** (or **"DNBEs"**) mean:

(1) a Hospital Acquired Condition addressing foreign objects retained after surgery, as identified by Centers for Medicare and Medicaid Services (**"HAC"**) - summarized at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/wPOA-Fact-Sheet.pdf - when such HAC is not identified and documented as having been present upon admission; and

(2) the three surgical errors described in the CMS National Coverage Determination dated June 12, 2009 and documented at https://www.cms.gov/transmittals/downloads/R101NCD.pdf, which include surgery on the wrong patient, surgery on the wrong body part, and wrong surgery performed on a patient (**"SEs"**); and

(3) if CMS subsequently adds a new Hospital Acquired Condition applicable to Medicare fee-for-service claims and KP's policy on DNBEs is amended to include such new condition, Provider agrees that the term HAC shall include such new condition within 90 days of written notice from KP.

H. **"Medicaid Member" means** a Member enrolled in the Medicaid program through a Medicaid contract between KFHP-NW (or another Kaiser Payer) on the one hand and a state (or organization under contract with a state) on the other hand.

I. **"Medicare Member"** means a Member enrolled in the Medicare program through a Medicare Advantage contract or a Medicare Cost contract between KFHP-NW (or another Kaiser Payer) and CMS.

J. **"Mid-Level Provider"** (or **"MLP"**) means a BCaBA or an undergraduate-level certification in behavior analysis. Professionals who are certified at the MLP level may not practice independently, but must be supervised by someone certified at the BCBA level. In addition, MLPs can supervise the work of RBTs, and others who implement behavior-analytic interventions.

K. **"Qualified Health Care Professional"** (or **"QHCP"**) means an individual provider with expertise in adaptive behavior treatment, typically a behavioral analyst (also known as a BCBA) or licensed psychologist.

L. **"Registered Behavior Technician"** (or **"RBT"**) is a paraprofessional who practices under the close, ongoing supervision of a BCBA or MLP. The RBT is primarily responsible for the direct implementation of behavior-analytic services. The RBT does not design intervention or assessment plans. It is the responsibility of the RBT supervisor to determine which tasks an RBT may perform as a function of his or her training, experience, and competence. The RBT supervisor is responsible for the work performed by the RBT on the cases they are overseeing.

M. **"Services"** mean all ordinary and necessary outpatient professional applied behavioral analysis services normally rendered by Provider's practitioners and for which Provider may submit a professional bill for reimbursement.

2. **Compensation**

A. Compensation varies based on the type of Member receiving Services:

(1) **Commercial and Medicare Members.** Services that are Covered Services rendered to Commercial and Medicare Members (non-Medicaid Members) shall be paid at the lesser of (a) Billed Charges or (b) or at the rates shown in the fee schedule below. Services that are billed but not listed in the fee schedule shall be denied. Except as otherwise indicated, the parties intend to follow CMS Medicare payment rules for Medicare Members.

CPT Code	Modifier	Description of Service	Unit of Time	Provider of Service	Rate	Billing Comments
0359T	HO or HO-GT	Behavior identification assessment by the qualified healthcare professional, face-to-face with patient and caregiver(s), includes administration of standardized and non-standardized tests, detailed behavioral history, patient observation and caregiver interview,	Untimed	BCBA	$525.00	This is an untimed Service that can only be billed one time by authorization.

CPT Code	Modifier	Description of Service	Unit of Time	Provider of Service	Rate	Billing Comments
		interpretation of test results, discussion of findings and recommendations with the primary guardian(s)/caregiver(s), and preparation of report.				
0360T	HO or HO-GT	Observational behavioral follow-up assessment, includes qualified healthcare professional direction with interpretation and report, administered by one RBT; first 30 minutes of RBT time, face-to-face with the patient.	30 Minutes	BCBA	$70.00	This follow-up assessment includes QHCP direction, interpretation, and report with administration by an RBT.
0361T	HO or HO-GT	Observational behavioral follow-up assessment, includes qualified healthcare professional direction with interpretation and report, administered by one RBT; each additional 30 minutes of RBT time, face-to-face with the patient.	30 Minutes	BCBA	$70.00	List separately in addition to code for primary service.
0362T	HO	Exposure behavioral follow-up assessment, includes qualified healthcare professional direction with interpretation and report, administered by qualified health care professional with the assistance of one or more RBTs; first 30 minutes of RBT(s) time, face-to-face with the patient.	30 Minutes	BCBA	$95.00	This follow-up assessment includes QHCP direction, interpretation, and report with administration by an RBT.
0363T	HO	Exposure behavioral follow-up assessment, includes qualified healthcare professional direction with interpretation and report, administered by qualified healthcare professional with the assistance of one or more RBTs; each additional 30 minutes of RBT(s) time, face-to-face with the patient.	30 Minutes	BCBA	$95.00	List separately in addition to code for primary service.
0364T	--	Adaptive behavior treatment by protocol, administered by RBT, face-to-face with one patient; first 30 minutes of RBT time.	30 Minutes	RBT	$30.00	
0365T	--	Adaptive behavior treatment by protocol, administered by RBT, face-to-face with one patient; each additional 30 minutes of RBT time.	30 Minutes	RBT	$30.00	List separately in addition to code for primary service.
0366T	UN	Group adaptive behavior treatment by protocol, administered by RBT, face-to-face with two or more patients; first 30 minutes of RBT time.	30 Minutes	RBT	$22.00	
0366T	UP	Group adaptive behavior treatment by protocol, administered by RBT, face-to-face with three or more patients; first 30 minutes of RBT time.	30 Minutes	RBT	$20.50	
0366T	UQ	Group adaptive behavior treatment by protocol, administered by RBT, face-to-face with four or more patients; first 30 minutes of RBT time.	30 Minutes	RBT	$18.75	

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CPT Code	Modifier	Description of Service	Unit of Time	Provider of Service	Rate	Billing Comments
0366T	UR	Group adaptive behavior treatment by protocol, administered by RBT, face-to-face with five or more patients; first 30 minutes of RBT time.	30 Minutes	RBT	$17.25	
0366T	US	Group adaptive behavior treatment by protocol, administered by RBT, face-to-face with six or more patients; first 30 minutes of RBT time.	30 Minutes	RBT	$15.75	
0367T	UN	Group adaptive behavior treatment by protocol, administered by RBT, face-to-face with two or more patients; each additional 30 minutes of RBT time.	30 Minutes	RBT	$22.00	List separately in addition to code for primary service.
0367T	UP	Group adaptive behavior treatment by protocol, administered by RBT, face-to-face with three or more patients; each additional 30 minutes of RBT time.	30 Minutes	RBT	$20.50	List separately in addition to code for primary service.
0367T	UQ	Group adaptive behavior treatment by protocol, administered by RBT, face-to-face with four or more patients; each additional 30 minutes of RBT time.	30 Minutes	RBT	$18.75	List separately in addition to code for primary service.
0367T	UR	Group adaptive behavior treatment by protocol, administered by RBT, face-to-face with five or more patients; each additional 30 minutes of RBT time.	30 Minutes	RBT	$17.25	List separately in addition to code for primary service.
0367T	US	Group adaptive behavior treatment by protocol, administered by RBT, face-to-face with six or more patients; each additional 30 minutes of RBT time.	30 Minutes	RBT	$15.75	List separately in addition to code for primary service.
0368T	HO or HO-GT	Adaptive behavior treatment with protocol modification administered by qualified health care professional with one patient; first 30 minutes of patient face-to-face time.	30 Minutes	BCBA	$50.00	Performed by a BCBA or MLP, and includes supervision of the RBT. **An RBT who delivers services under the direction of the QHCP or MLP** may not concurrently bill for their Services. The time of the QHCP or MLP is considered practice expense. All supervised Services should be billed by the QHCP or MLP. **An MLP who delivers services under the direction of the QHCP** may not concurrently bill for their Services. The time of the MLP is considered practice expense for the QHCP. All supervised Services should be billed by the QHCP.
	HN or HN-GT			MLP	$40.00	
0369T	HO or HO-GT	Adaptive behavior treatment with protocol modification administered by qualified health care professional with one patient; each additional 30 minutes of patient face-to-face time (list separately in addition to code for primary service).	30 Minutes	BCBA	$50.00	
	HN or HN-GT			MLP	$40.00	

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CPT Code	Modifier	Description of Service	Unit of Time	Provider of Service	Rate	Billing Comments
0370T	HO or HO-GT	Family adaptive behavior treatment guidance, administered by qualified health care professional (without the patient present).	Untimed	BCBA	$65.00	
	HN or HN-GT			MLP	$50.00	
0371T	HO	Multiple-family group adaptive behavior treatment guidance, administered by qualified health care professional (without the patient present), two or more families.	Untimed	BCBA	$40.00	
	HN			MLP	$30.00	
0372T	HO	Adaptive behavior treatment social skills group, administered by qualified health care professional face-to-face with multiple patients, two or more families.	Untimed	BCBA	$45.00	
	HN			MLP	$35.00	
0373T	--	Exposure adaptive behavior treatment with protocol modification requiring two or more RBTs for severe maladaptive behavior(s); first 60 minutes of RBTs' time, face-to-face with patient.	60 Minutes	RBT	$88.00	Should be billed when two or more RBTs are providing service to Member, and time is based on a single RBT's face-to-face time with the patient and not the combination of multiple RBTs. RBTs should not bill separately for their services.
0374T	--	Exposure adaptive behavior treatment with protocol modification requiring two or more RBTs for severe maladaptive behavior(s); each additional 30 minutes of RBTs' time face-to-face with patient (list separately in addition to code for primary service).	30 Minutes	RBT	$44.00	

(2) **Medicaid Members.** When applicable, Services that are Covered Services rendered to Medicaid Members shall be paid at the applicable rates described in state statutes or in promulgated regulations.

B. If there is a question related to appropriateness of CPT or diagnosis codes being used by Provider to bill for Services, Provider shall work with Network to assure that acceptable codes and rates are used.

3. **Performance-Based Compensation Program.** Provider and Network may, as a future next phase of this Agreement, work collaboratively to develop a compensation program (**"Performance-Based Compensation Program"**) to align Provider's care delivery model to that of Network, and to encourage the effective measurement and improvement of health outcomes for Members.

4. **Billing and Reimbursement Related to Do Not Bill Events**

In the event any Member experiences a DNBE while receiving Covered Services under the Agreement, Provider agrees to the following:

A. **Report the DNBE.** Provider shall report the DNBE to the applicable Payer: For Kaiser Payers, to Network Risk Management at (503) 813-2000 and for Other Payers, to the Self-Funded Customer Service phone number at (866) 213-3062. However, Provider shall not

be required to waive any privilege or confidentiality rights under law in order to comply with this subsection.

B. **Waive or Reimburse Fees.** Provider shall waive fees otherwise owed by Payers and Members (or reimburse such fees that may have already been paid by Payers or Members) that are directly related to the DNBE, whether the DNBE is reported by the Provider or later discovered by KP. "Directly related" fees mean fees associated with medically necessary health care services required to treat the DNBE, taking into account all relevant factors.

By way of example for HACs: If a HAC occurs and Provider is reimbursed according to a CMS MS-DRG methodology, then Provider's reimbursement shall be the applicable MS-DRG payment assuming the absence of the HAC as a secondary diagnosis; if a HAC occurs and Provider is reimbursed according to a case rate, then Provider's reimbursement shall be the case rate that would have applied absent the HAC; and if a HAC occurs and Provider is reimbursed according to a per diem or percent of charges, then the days or charges directly related to the HAC shall be waived (or later reimbursed).

In addition, Provider shall consider, on a case-by-case basis at its discretion, waiving (or later reimbursing) fees otherwise owed by Payers or Members for medically necessary health care services required to treat the DNBE subsequent to the encounter at which the DNBE occurred.

C. **Claims Submission.** Where Provider submits Claims on a UB-04 to Payers, Provider shall (a) include on all inpatient Claims to Payers for Covered Services to Members, present on admission ("POA") indicators in the manner required by CMS for Medicare fee-for-service claims and (b) for any DNBEs recognized prior to submitting a Claim, include on all Claims to Payers for Covered Services to Members, the applicable International Classification of Diseases ("ICD") codes and all applicable standard modifiers (including CMS National Coverage Determination ("NCD") modifiers for SEs) in the manner required by CMS for Medicare fee-for-service claims.

Where Provider submits Claims on a CMS 1500 to Payers and recognizes that a DNBE has occurred prior to submitting a Claim, Provider shall include on all Claims to Payers for Covered Services to Members, the applicable ICD codes and all applicable standard modifiers (including CMS NCD modifiers for SEs) for any DNBE in the manner required by CMS for Medicare fee-for-service claims.

Where Provider recognizes that a DNBE has occurred prior to submitting a Claim to a Payer, Provider's Claim to the Payer shall reflect all services provided (including those related to the DNBE) and all associated fees (including those related to the DNBE), with an adjustment in fees to reflect the waiver of fees directly related to the DNBE.

D. **Process for Resolving DNBE Reimbursement Issues.** Payers and Provider shall work collaboratively to resolve promptly DNBE determinations and corresponding reimbursement issues. Any disputes related to DNBE reimbursement shall be resolved according to the dispute resolution process in the Agreement.

E. **Reimbursement.** Reimbursement by Provider to Payers or Members for fees directly related to a DNBE that were already paid to Provider, shall be deemed an overpayment subject to Section 4.8 (Audit, Recoupment, and Offset) of the Agreement and made within 30 days of the parties' resolution of DNBE determinations and reimbursement issues, unless otherwise required by law.

F. **Compensation Determination.** The parties acknowledge that this Section 4 is solely for the purpose of determining compensation to Provider and shall not constitute or imply any admission of liability.

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EXHIBIT

FEDERAL PROGRAM COMPLIANCE

A. Medicare Advantage Program

Kaiser Foundation Health Plan of the Northwest ("KFHP-NW") has entered into a Medicare Advantage Organization contract with the Centers for Medicare and Medicaid Services ("CMS"). KFHP-NW has contracted with Network to provide certain services under such CMS contract. CMS and KFHP-NW require Network to include the provisions of Section A of this Exhibit in any subcontracts. This Section A is incorporated by reference into and made part of the Agreement with respect to Services rendered to Members enrolled in the Medicare Advantage program ("MA Members"). In the event of a conflict or inconsistency with any term or condition in the Agreement relating to Services rendered to MA Members, this Section A shall control.

Network shall itself, or shall cause KFHP-NW to, satisfy the obligations of KFHP-NW under Section A of this Exhibit. With respect to MA Members, KFHP-NW is the entity ultimately responsible for the obligations under this Section A.

1. **Records.** [42 CFR §422.118, §§422.504(a)(13), (d), and (i)(3)(iii), MMCM Ch. 11, §100.4] Provider shall (a) abide by all federal and state laws regarding confidentiality and disclosure of medical records, or other health and enrollment information; (b) ensure that medical information is released only in accordance with applicable federal or state law, or pursuant to court orders or subpoenas; (c) maintain medical records and related information in an accurate and timely manner and for ten years after termination or expiration of this Agreement or the date of completion of any audit, whichever is later; and (d) ensure timely access by MA Members to the records and information that pertain to them.

2. **Prompt Payment.** [42 CFR §422.520(b)(1), §422.504(c), MMCM Ch. 11, §100.4] Provider shall be paid for Covered Services rendered to MA Members within the lesser of 45 days of receipt of a properly submitted, supported and undisputed claim or the time period set forth elsewhere in this Agreement.

3. **Member Hold Harmless.** [42 CFR §§422.504(g)(1)(i)&(iii), §422.504(i)(3)(i), §422.105(a), §422.100(g), MMCM Ch. 11, §100.4, 42 USC 1395w-22(a)(7)] Provider agrees that in no event including, without limitation, nonpayment by or insolvency of KFHP-NW or Network or breach of this Agreement, shall Provider bill; charge; collect a deposit from; seek compensation, reimbursement, or remuneration from; impose surcharges; or have any recourse against a MA Member or a person acting on behalf of a MA Member for fees that are the legal obligation of KFHP-NW or Network. This Agreement does not prohibit Provider from collecting Member Cost Share or fees for non-Covered Services to the extent permitted by the applicable health benefit plan; however, Member Cost Share may not be imposed for influenza and pneumococcal vaccines that are Covered Services. If a person who correctly identifies himself as a MA Member seeks Services from Provider without an applicable authorization or referral, Provider may only charge the MA Member for customary in-plan Member Cost Share

unless Provider notified the MA Member in advance that the Services would be Covered Services only if further action is taken by the MA Member per applicable health benefit plan rules. If a MA Member is also enrolled in Medicaid and Medicaid is responsible for the Member Cost Share, Provider shall not hold MA Member liable for such Member Cost Share, and Provider shall accept payment pursuant to this Agreement as payment in full or bill Medicaid for such Member Cost Share. Sections A.3 and A.4 shall be construed in favor of the MA Member as an intended third party beneficiary, shall survive the termination of the Agreement, the insolvency of KFHP-NW or Network, and shall supersede any oral or written agreement between Provider and a MA Member.

4. **Continuation of Benefit.** [42 CFR §422.504(g)(2), MMCM Ch. 11, §100.4, MA Agreement, Article V, Section C.1] In the event of the termination or expiration of this Agreement, KFHP-NW's or Network's insolvency, or other cessation of business, Provider shall continue to provide Covered Services for all MA Members through the period for which premium was paid and, for MA Members who are confined in an inpatient facility on the date of insolvency or other cessation of business, through the date of discharge.

5. **Audit and Inspection.** [42 CFR §§422.504 (e)(1), (e)(2), (e)(4) & (i)(2), MMCM Ch. 11, §100.4, MMCM Ch. 21, Section 50.6.1] The Department of Health and Human Services, the U.S. Comptroller General, or their designees have the right audit, evaluate, collect and inspect any pertinent contracts, books, documents, papers, records, facilities and computer/electronic systems of Provider involving transactions related to KFHP-NW's Medicare Advantage contract during the period of this Agreement and for ten years after termination or expiration of this Agreement or the date of completion of any audit, whichever is later. Provider shall retain such contracts, books, documents, papers, and records for this period.

6. **Accountability and Delegation.** [42 CFR §§422.504(i)(1),(3),(4)&(5), 42 CFR §422.562(a)(3), MMCM Ch. 11, §100.4, MMCM Ch. 21, §§ 40 and 50.6.6, MA Agreement, Article V, Sections D and E] KFHP-NW shall only delegate activities or functions to Provider pursuant to a written delegation agreement in compliance with CMS rules, which require, among other things, a covenant of Provider that it will comply with all applicable Medicare laws, regulations, and CMS instructions. To the extent KFHP-NW delegates any functions for which it is responsible, KFHP-NW is ultimately responsible to CMS for oversight and compliance and shall retain the right to monitor performance of the delegated functions and to revoke such delegation if KFHP-NW or CMS determines that performance is unsatisfactory. If KFHP-NW delegates the selection of providers, KFHP-NW retains the right to approve, suspend or terminate any such selection.

7. **Exclusion/Sanction.** [42 CFR §422.752(a)(8), §422.204(b)(3), §422.220, §423.120(c)(5)&(6), 42 USC §1320a-7 & §1320a-7a, MMCM, Ch. 6 §§60.2 & 70, MMCM Ch. 11 §100.4, MMCM Ch. 21 §50.6.8] Provider represents that (a) it is not excluded, debarred, sanctioned, suspended or otherwise ineligible from, by or for participation in any federal or state program, including Medicare and Medicaid, (b) with respect to Covered Services provided to MA Members, it does not knowingly employ or contract with an individual or entity so excluded, debarred, sanctioned, suspended, or otherwise ineligible, and (c) no practitioner

providing Covered Services to a MA Member has opted out of Medicare. Provider and any of its practitioners providing Covered Services to a MA Member shall be enrolled in Medicare. These representations shall be continuing throughout the term of this Agreement, and Provider shall promptly notify KFHP-NW if any representation can no longer be made.

8. **Certification of Data.** [42 CFR §422.504(l)(3), MMCM Ch. 11, §100.4] The chief executive officer of Provider, the chief financial officer, or an individual delegated the authority to sign on behalf of one of these officers, shall certify from time to time, as requested by KFHP-NW or Network, that the encounter data and other data supplied by Provider (based on its best knowledge, information, and belief) are accurate, complete and truthful.

9. **Termination.** [42 CFR §422.202(d)(4), §422.506(b), §422.510, §422.111(e), MMCM Ch. 6, §60.4, MMCM Ch. 11, §100.4] If this Agreement may be terminated without cause, the minimum period of notice shall be at least 60 days, but shall be greater if provided in this Agreement. If the Medicare Advantage contract between KFHP-NW and CMS is terminated or not renewed, this Agreement will be terminated as to MA Members, except to the extent KFHP-NW enters into a different form of contract with CMS, in which case Provider agrees to cooperate with KFHP-NW in meeting its requirements under the new contract until such time as this Agreement may be amended. If Provider provides primary care services to MA Members, Provider shall provide at least 30 days' notice before terminating the Agreement.

10. **Access to Books and Records.** [42 USC §1395x(v)(1)(I), 42 CFR §420.302(b)] If this Agreement is determined to be subject to the provisions of 42 USC §1395x(v)(1)(I), which governs access to books and records of contractors of Covered Services to MA Members, Provider agrees to permit representatives of the Secretary of the U.S. Department of Health and Human Services and the U.S. Comptroller General to have access to this Agreement and to the books, documents, and records of Provider, as necessary to verify the costs of this Agreement in accordance with criteria and procedures contained in applicable federal law.

11. **Advance Directives.** [42 CFR §§422.128(b)(1)(ii)(E)&(F), MMCM Ch. 11 §100.4] The MA Member's medical record shall reflect, in a prominent part, whether or not the MA Member has executed an advance directive. Provider may not condition the provision of care or otherwise discriminate against a MA Member based on whether or not the MA Member has executed an advance directive.

12. **Compliance.** [42 CFR §422.2, §§422.504(a)(8), (h),(i) & (j), §422.310(b), §422.562(a), §422.516, §422.503(b)(4)(vi), §422.2268, MMCM, Ch. 4 §10.6, MMCM Ch. 11, §§100.4 and 120, MMCM Ch. 21, §§ 30, 40, 50.1.3, 50.3.1, 50.3.2, 50.4.2, 50.6.6, 50.6.11 and 50.7.2] Provider shall comply and shall require any subcontractors providing services to MA Members, to comply with all applicable Medicare laws and regulations (including without limitation those designed to prevent or ameliorate fraud, waste and abuse), state and federal laws (including criminal laws, the False Claims Act, Anti-Kickback statute, Health Insurance Portability and Accountability Act or HIPAA, Civil Rights Act of 1964, Age Discrimination Act of 1975, Rehabilitation Act of 1973, Americans with Disabilities Act, Genetic Information Nondiscrimination Act of 2008), with CMS guidance and instructions, with KFHP-NW's policies and procedures, with applicable elements of KFHP-NW's compliance program

(including, without limitation, reporting of compliance issues, cooperation with KFHP-NW's routine monitoring and auditing of providers, and annual training and education, e.g., related to fraud, waste and abuse), and with applicable contractual obligations under KFHP-NW's Medicare Advantage contract, as amended from time to time. Failure to comply with KFHP-NW's compliance program may result in a corrective action or other appropriate action under the Agreement. In the event of changes to the governing laws, regulations, or CMS requirements applicable to the Medicare Advantage program, this Exhibit shall be amended to the extent required by any such later required changes. Provider shall cooperate, assist and provide records, data and information, as requested by KFHP-NW or Network, for KFHP-NW's compliance with Medicare requirements.

A. Provider shall provide information to KFHP-NW about disclosure of MA Members' Protected Health Information ("PHI," as defined by HIPAA) to entities outside the United States so that KFHP-NW may complete CMS's required Offshore Subcontractor Information and Attestation form; and if Provider discloses MA Members' PHI to entities outside the United States, Provider shall inform KFHP-NW of the fact of such disclosures within 15 days of contract execution or amendment, shall implement reasonable security policies and procedures auditable by KFHP-NW to protect such PHI, and shall report actual or suspected security breaches to KFHP-NW.

B. Provider acknowledges that funds received from KFHP-NW and/or Network are in whole or in part derived from federal funds.

C. Provider shall also cooperate with KFHP-NW's grievance and appeals procedures for MA Members.

D. If Provider engages in any marketing activities related to MA Members or the Medicare Advantage program (including distribution of any materials related to the Medicare Advantage program), Provider shall comply with all applicable Medicare Advantage marketing rules.

13. **Credentialing.** [42 CFR §422.204, §422.112(a)(5), §422.504(i)(4), MMCM Ch. 6, §70, MA Agreement, Article V, Section D.4] Provider agrees to cooperate with KFHP-NW's credentialing process for providers rendering Covered Services to MA Members (including recredentialing at least every 3 years). Provider agrees that KFHP-NW will review the credentials of Provider and (as applicable) its medical professionals or allow KFHP-NW to review, approve and audit Provider's credentialing process.

14. **Access to Services.** [42 CFR §§422.100(b)&(g), §§422.112(a)(1),(3),(6),(7),(8), §422.110(a), §422.206(a)(2), MMCM Ch. 11, §100.4, MMCM Ch.6, §40] Covered Services shall be available and accessible in a timely manner, during hours of operation convenient to the population served, and in a manner that does not discriminate against MA Members. Provider shall not discriminate against MA Members on the basis of health status (including medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, conditions arising out of acts of domestic violence and disability), race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, or

source of payment. Services and information about treatment options shall be provided to MA Members in a culturally competent manner, including the option of no treatment, and with appropriate assistance for MA Members with limited communication skills and disabilities. Provider shall allow direct access (a) for all MA Members to influenza vaccines and (b) for women MA Members to screening mammography and women's health specialists for women's routine and preventive health care services. KFHP-NW shall assume financial responsibility for emergency and urgently needed services to MA Members in accordance with applicable law and health benefit plan rules, regardless of whether there is a prior authorization for the services.

15. **Quality Assurance.** [42 CFR §422.112(b)(5), §422.152, §§422.504(a)(3)(iii)&(5), MMCM Ch. 11, §100.4] Provider shall participate in and cooperate with KFHP-NW's quality assurance and improvement programs, including cooperating with any independent or external review organization retained by KFHP-NW as part of its quality assurance and improvement programs. Provider shall render Covered Services in a manner consistent with professionally recognized standards of care. Provider shall inform MA Members of specific health care needs that require follow-up and shall provide, as appropriate, training in self-care and other measures for MA Members to promote their own health.

16. **Subcontractors.** [42 CFR §422.504(i)(3)(iii)] If Provider provides Covered Services to MA Members through a subcontractor, Provider shall require such subcontractor to provide Services to MA Members consistent with KFHP-NW's contractual obligations.

17. **Encounter Reporting.** [42 CFR §422.310] In the event Provider does not submit standard claims for payment, Provider shall provide the information necessary for KFHP-NW to report to CMS all encounters for MA Members on a standard CMS 1500 or UB-04 form (or its successor form).

18. **Hospital Provisions.** [42 CFR §422.620] If Provider is a hospital, Provider shall provide MA Members with advance notice of hospital discharge appeal rights and cooperate with KFHP-NW and/or the applicable Quality Improvement Organization regarding appeals or grievances related to the discharge.

19. **Physician Provisions.** [42 CFR §422.208(c), §422.202(d)(1), §422.210, MMCM Ch. 11, §100.4, MMCM Ch.6 §80] Where Provider is a physician or physician group: (a) if the compensation arrangement places physician(s) at "substantial financial risk" as defined under the Physician Incentive Plan rules, the parties shall comply with such rules; and (b) if this Agreement is suspended or terminated, physician(s) shall be given written notice of the reasons for suspension or termination and, if applicable, the right to appeal.

B. Federal Employee Health Benefits Program

Kaiser Foundation Health Plan of the Northwest ("KFHP-NW") has entered into a contract with the U.S. Office of Personnel Management ("OPM") to provide or arrange health care services for persons enrolled in the Federal Employees Health Benefits Program ("FEHBP"). KFHP-NW has contracted with Network to provide certain services under such FEHBP contract. OPM and KFHP-NW require Network to include the provisions of this Section B of this Exhibit in any

subcontracts. This Section B is incorporated by reference into and made part of the Agreement with respect to Services rendered to Members enrolled in FEHBP ("FEHBP Members"). In the event of a conflict or inconsistency with any term or condition in the Agreement relating to Services rendered to FEHBP Members, this Section B shall control.

Network shall itself, or shall cause KFHP-NW to, satisfy the obligations of KFHP-NW under Section B of this Exhibit. With respect to FEHBP Members, KFHP-NW is the entity ultimately responsible for the obligations under this Section B.

1. **Service Obligations.** [FEHBP contract §§1.9, 1.11, 1.20, and 1.26] Provider and its health care providers shall cooperate with KFHP-NW quality standards, implementation of patient safety improvement programs and disaster recovery plans, and assist KFHP-NW with collection of data for quality assurance records.

2. **Hold Harmless.** [FEHBP contract §2.9] In the event of (a) insolvency of KFHP-NW, Network or Provider, or (b) KFHP-NW's, Network's or Provider's inability to pay expenses for any reason, Provider shall not look to FEHBP Members for payment, and shall prohibit health care providers from looking to FEHBP Members for payment.

3. **Billing and Payment.** [FEHBP contract §§2.3(g), 2.6(b), and 2.11] Provider shall cooperate with KFHP-NW and Network in the performance of its obligations under the FEHBP contract to administer and coordinate benefits, pay claims and recoup erroneous payments (for which no time limit applies to such recoupments). Provider shall submit claims on the appropriate CMS 1500 form or UB-04 form (or the appropriate successor form) and shall make all reasonable efforts to submit claims electronically.

4. **Termination of FEHBP Contract.** [FEHBP contract §5.49] If the FEHBP contract is terminated by OPM, the Agreement and all subcontracts shall be terminated with respect to FEHBP Members, and the parties shall assign to the government, as directed by OPM, all right, title, and interest of KFHP-NW under the Agreement and subcontracts terminated.

5. **Continuation of Care.** [FEHBP contract §1.24] In the event KFHP-NW terminates its FEHBP contract with OPM or terminates this Agreement other than for cause, Provider, KFHP-NW, and Network agree that specialized care shall continue to be rendered and paid under the terms of this Agreement for those FEHBP Members who are undergoing treatment for a chronic or disabling condition or who are in the second or third trimester of pregnancy for up to 90 days, or through their postpartum period, whichever is later. Provider shall also promptly transfer all medical records to the designated new provider during or upon completion of the transition period, as authorized by the FEHBP Member and shall give all necessary information to KFHP-NW and Network for quality assurance purposes.

6. **Confidentiality.** [FEHBP contract §1.6(b)] Provider shall hold confidential all medical records of FEHBP Members, and information relating thereto, except (a) as may be reasonably necessary for administration of the FEHBP contract, (b) as authorized by the FEHBP Member or his or her guardian, (c) as disclosure is necessary to permit government officials having authority to investigate and prosecute alleged civil or criminal actions, (d) as necessary to audit the

FEHBP contract, (e) as necessary to carry out the coordination of benefit provisions of the FEHBP contract, or (f) for bona fide medical research or educational purposes (only if aggregated).

7. **Maintenance and Audit of Records.** [FEHBP contract §§3.4, 5.7 and 48 CFR §§2.101, 52.215-2] OPM and other government officials have the right to inspect and evaluate the work performed or being performed under the FEHBP contract, records involving work or transactions related to the FEHBP contract, and the premises where the work is being performed, at all reasonable times and in a manner that will not unduly delay the work. If government officials or their authorized representatives request access, inspection or evaluation of such Provider records or premises, Provider shall cooperate by providing access to records and facilities until six years after final payment or settlement under the FEHBP contract.

8. **Notice of Significant Events.** [FEHBP contract §1.10 and 48 CFR §1652.222-70] Provider agrees to notify KFHP-NW and Network of any Significant Event within seven business days after the Provider becomes aware of it. A "Significant Event" is any occurrence or anticipated occurrence that might reasonably be expected to have a material effect upon Provider's ability to meet its obligations under the Agreement.

9. **Compliance.** [FEHBP contract §§ 1.20, 2.7, 5.5, 5.19, 5.22, 5.23, 5.45, 5.47, 5.55, 5.56, 5.57, 5.59, 5.61, 5.64, 5.65, 5.69, 5.70, 5.71]

Provider and KFHP-NW shall comply with the Health Care Consumer Bill of Rights (at http://www.opm.gov/insure/archive/health/cbrr.htm), as amended from time to time, which addresses Members' ability to participate fully in treatment decisions, respecting Members' rights (including nondiscrimination), and protecting Members' privacy. [FEHBP §1.20] Provider shall not employ or contract with any providers that provide Services to FEHBP Members and have been debarred, suspended or proposed for debarment by the federal government during the term of the Agreement. [FEHBP §5.47 and 48 CFR §52.209-6 (OCT 2015)] Neither KFHP-NW nor Network shall be liable for payment to Provider for services rendered by a provider debarred, excluded or suspended from participation in any federal program. [FEHBP §2.7] In addition, as requested, Provider shall cooperate with, assist, and provide information to KFHP-NW as needed for KFHP-NW's compliance with all FEHBP contract requirements.

A. KFHP-NW is subject to various federal laws, executive orders and regulations regarding equal opportunity and affirmative action. This subsection 9A constitutes notice that Provider may be subject to the following Federal Acquisition Regulations (each a "FAR") at 48 CFR Part 52 and the Office of Federal Contract Compliance Regulations at 41 CFR Part 60, which are incorporated herein by reference: (i) FEHPB §5.19 corresponding to FAR 52.222-26 – Equal Opportunity (APR 2015) and 41 CFR 60.1.4(a); (ii) FEHBP §5.59 corresponding to FAR 52.222-21 – Prohibition of Segregated Facilities (APR 2015) and 41 CFR 60-1.8; (iii) FEHBP §5.55 corresponding to FAR 52.222-37 – Employment Reports on Veterans (OCT 2015); (iv) FEBHP §5.22 corresponding to FAR 52.222-35 – Equal Opportunity for Veterans (OCT 2015) and 41 CFR 60-300.5(a) and FEHBP §5.23 corresponding to FAR 52.222-36 – Equal Opportunity for Workers with Disabilities (JUL 2014) and 41 CFR 60-741.5(a), which provide

(and are required to be stated in bold print): "**This contractor** [KFHP-NW] **and subcontractor** [Provider, if covered] **shall abide by the requirements of 41 CFR 60-300.5(a) and 60-741.5(a). These regulations prohibit discrimination against qualified individuals on the basis of protected veteran status or disability, and require affirmative action by covered prime contractors and subcontractors to employ and advance in employment qualified protected veterans and qualified individuals with disabilities.**" In addition, per FEHBP §§5.19 and 5.61, Executive Order 11246 regarding nondiscrimination in employment decisions, as amended by Executive Order 13665 regarding non-retaliation for disclosure of compensation information, and Executive Order 13496 (codified at 29 CFR Part 471, Appendix A to Subpart A) concerning the obligations of federal contractors and subcontractors to provide notice to employees about their rights under Federal labor laws shall be incorporated herein by reference. As part of KFHP-NW's efforts to comply with these requirements, KFHP-NW has developed and implemented equal employment opportunity and affirmative action policies and programs designed to ensure that all qualified applicants and employees are treated without regard to such factors as race, color, religion, sex, sexual orientation, gender identify, national origin, disability, veteran status, or any other reason prohibited by law. As one of KFHP-NW's subcontractors, KFHP-NW requests that Provider take appropriate action, as necessary, to support KFHP-NW's commitment to these requirements, as required by 41 CFR 60-300.44(f)(1)(ii) and 60-741.44(f)(1)(ii).

In addition, this subsection 9A constitutes notice that Provider may be subject to additional FARs, which are incorporated herein by reference: (a) FEHBP §5.56 corresponding to FAR 52.227-1 – Authorization and Consent (DEC 2007) and FEHBP §5.57 corresponding to FAR 52.227-2 – Notice and Assistance Regarding Patent and Copyright Infringement (DEC 2007); (b) FEBHP §5.69 corresponding to FAR 52.223-18 – Encouraging Contractor Policies to Ban Text Messaging While Driving (AUG 2011); (c) FEHBP §5.64 corresponding to FAR 52.203-13 – Code of Business Ethics and Conduct (OCT 2015); (d) FEHBP §5.5 corresponding to FAR 52.203-7 – Anti-Kickback Procedures (MAY 2004); (e) FEHBP §5.45 corresponding to FAR 52.203-12 – Limitation on Payments to Influence Certain Federal Transactions (OCT 2010); (f) FEHBP §5.70 corresponding to FAR 52.203-17 – Employee Whistleblower Rights and Requirement to Inform Employees of Whistleblower Rights (APR 2014); and (g) FEHBP §5.71 corresponding to FAR 52.222-50 – Combatting Trafficking in Persons (MAR 2015).

If Provider is not otherwise subject to compliance with the laws and executive orders specified in this subsection 9A, the inclusion of this subsection 9A shall not be deemed to impose such requirements upon Provider.

10. **Health Information Technology.** [FEHBP contract §1.27] As Provider implements, acquires, or upgrades health information technology systems, it shall use reasonable efforts to utilize, where available, certified health information technology systems and products that meet interoperability standards recognized by the Secretary of Health and Human Services ("Interoperability Standards"), have already been pilot-tested in a variety of live settings, and demonstrate meaningful use of health information technology in accordance with the HITECH ACT. Provider shall also encourage its subcontracted providers to comply with applicable Interoperability Standards.

11. **Licensure and Other Credentials.** [FEHBP contract §1.9(f)] Provider shall require that all physicians providing Services to FEHBP Members comply with KFHP-NW's credentialing requirements.

EXHIBIT

NATIONAL COMMITTEE FOR QUALITY ASSURANCE ("NCQA") REQUIRED PROVISIONS

This Exhibit is incorporated by reference into and made part of the Agreement with respect to Services rendered to Members of Kaiser Foundation Health Plan of the Northwest ("KFHP-NW"), as required by NCQA. Network shall itself, or shall cause KFHP-NW to, satisfy the obligations of KFHP-NW under this Exhibit. With respect to Members of KFHP-NW, KFHP-NW is the entity ultimately responsible to NCQA.

1. Quality Improvement. Provider shall participate in KFHP-NW's Quality Improvement ("QI") program, including cooperating with QI activities, providing applicable performance data, and tracking and regular reporting on mutually agreed upon quality indicators, all in accord with KFHP-NW's expectations and NCQA standards.

2. Communications with Members. Provider's physicians and other personnel licensed or certified to provide services to Members hereunder may freely communicate with a Member or a Member's authorized representatives about the Member's treatment options, without regard to benefit coverage limitations, while maintaining confidentiality consistent with the confidentiality provisions set forth in this Agreement.

3. Utilization Management Decisions. Utilization management decision-making is based on appropriateness of care and service and existence of coverage. Individuals responsible for utilization management decision-making do not receive financial incentives that specifically reward them for issuing denials of coverage or service, or that encourage decisions that result in underutilization.

4. Credentialing. Provider shall comply, and shall cause its physicians and other personnel to comply, with KFHP-NW's credentialing requirements. KFHP-NW retains the right, based on quality issues, to approve new practitioners, providers and sites and to terminate or suspend the right of individual practitioners, providers or sites to treat Members.

5. Confidentiality. Provider shall maintain the confidentiality of Member information and records, and all other protected health information, in compliance with the confidentiality provisions set forth in this Agreement and KFHP-NW's Policies regarding protected health information. Data shared with employers, whether self-insured or insured, shall not implicitly or explicitly identify a Member without the written consent of the Member, except as permitted by law.

6. Site Visits and Medical Records Reviews. Provider shall permit and cooperate with, at reasonable times with reasonable notice, initial and follow-up inspection of its site(s) by representatives of KFHP-NW, Network, NCQA and other accrediting or licensing organizations on a biannual basis or more frequently as requested by KFHP-NW. Provider shall cause all physicians and other personnel to permit and cooperate with such inspections and medical record reviews.

7. Subcontracts. Provider shall require all provisions of this Exhibit to be included in any contract or agreement between Provider and any subcontractor providing services for Members.

EXHIBIT

WASHINGTON STATE COMPLIANCE

This Exhibit is incorporated by reference into and made part of the Agreement with respect to Services rendered to Members enrolled under Washington group or individual coverage issued by Kaiser Foundation Health Plan of the Northwest ("KFHP-NW"). In the event of a conflict or inconsistency with any term or condition in the Agreement relating to Services rendered to Members enrolled under Washington group or individual coverage issued by KFHP-NW, this Exhibit shall control.

Network shall itself, or shall cause KFHP-NW to, satisfy the obligations of KFHP-NW under this Exhibit. With respect to Members of KFHP-NW, KFHP-NW is the entity ultimately responsible for the obligations under this Exhibit.

With respect to Services rendered to Members enrolled under Washington group or individual coverage issued by KFHP-NW, this Agreement shall be governed by the laws of the state of Washington, without application of the conflict of laws provisions of the state of Washington.

1. **Administrative Policies.** [WAC 284-170-421(5) & (6)] KFHP-NW shall notify Provider of Provider's responsibilities with respect to KFHP-NW's applicable administrative policies and programs including, but not limited to, payment terms, utilization review, quality assessment and improvement programs, credentialing, prior authorizations and method used to accept prior authorization requests, grievance, appeal and adverse benefit determination procedures, data reporting requirements, pharmacy benefit substitution processes, confidentiality requirements and any applicable federal or state requirements. Documents, procedures, and other administrative policies and programs referenced in the Agreement shall be available for review by Provider prior to the Effective Date of this Agreement.

2. **Audit Guidelines.** [WAC 284-170-460] KFHP-NW shall not have access to health information and other similar records of Provider unrelated to Members. This provision shall not limit KFHP-NW's right to ask for and receive information relating to the ability of the Provider to deliver health care services that meet the accepted standards of medical care prevalent in the community. Any access to patient records of Provider by KFHP-NW shall be limited to only that necessary to perform the audit. Provider shall have claims audit rights that are reciprocal to KFHP-NW's claims audit rights in the Agreement.

3. **Clean Claims.** [WAC 284-170-431] Provider shall be paid as soon as practical, subject to the following minimum standards: (a) 95% of the monthly volume of clean claims shall be paid within 30 days of receipt, and (b) 95% of the monthly volume of all claims shall be paid or denied within 60 days of receipt, except as agreed to in writing by the parties on a claim-by-claim basis. The receipt date of a claim is the date KFHP-NW or its designee receives either written or electronic notice of the claim. KFHP-NW or its designee shall establish a reasonable method for confirming receipt of claims and responding to provider inquires about claims. If clean claims are not paid within the standard established under the Agreement, KFHP-NW shall

pay interest on undenied claims and unpaid clean claims more than 61 days old until the standard established under the Agreement is met. Interest shall be assessed at the rate of one percent per month, and shall be calculated monthly as simple interest prorated for any portion of a month. KFHP-NW shall add the interest payable to the amount of the unpaid claim without the necessity of the Provider submitting an additional claim. Any interest paid under this section shall not be applied by KFHP-NW to a Member's deductible, copayment, coinsurance, or any similar obligation of the Member. When KFHP-NW or its designee issues payment in the Provider's and the Member's names, KFHP-NW shall make claim checks payable in the name of the Provider first and the Member second. For purposes of this section, "clean claim" means a claim that has no defect or impropriety, including any lack of any required substantiating documentation, or particular circumstances requiring special treatment that prevents timely payments from being made on the claim under this section. Denial of a claim shall be communicated to the Provider and shall include the specific reason why the claim was denied. If the denial is based upon medical necessity or similar grounds, then KFHP-NW or its designee upon request of the Provider shall also promptly disclose the supporting basis for the decision. KFHP-NW shall be responsible for ensuring that any person acting on behalf of or at the direction of KFHP-NW complies with these billing and claim payment standards. These standards do not apply to claims about which there is substantial evidence of fraud or misrepresentation by Provider or the Member, or instances where KFHP-NW has not been granted reasonable access to information under the Provider's control. Provider, KFHP-NW, and KFHP-NW's designees are not required to comply with these contract provisions if the failure to comply is occasioned by any act of God, bankruptcy, act of a governmental authority responding to an act of God or other emergency, or the result of a strike, lockout, or other labor dispute.

4. **Compensation Notification.** [WAC 284-170-421(6)] Provider shall be given reasonable notice of not less than 60 days of changes to documents, procedures or administrative policies referenced in the Agreement that affect Provider's compensation or that affect health care service delivery unless changes to federal or state law or regulations make such advance notice impossible, in which case notice shall be provided as soon as possible. Subject to any termination and continuity of care provisions of the Agreement, a Provider may terminate this Agreement without penalty if Provider does not agree with the changes. No change to the Agreement may be made retroactive without the express written consent of the Provider.

5. **Contracting Outside Plan.** [RCW 48.43.085; RCW 48.43.016] Notwithstanding any other provision of law, KFHP-NW may not directly or indirectly prohibit Members from freely contracting at any time to obtain any health care services outside their health care plan on any terms or conditions the Members choose. Nothing in this section shall be construed to bind KFHP-NW for any services delivered outside the health plan. KFHP-NW may not require Provider to provide a discount from usual and customary rates for health care services that are not Covered Services, and any such provision in the Agreement shall not apply to Members addressed by this Exhibit.

6. **Contract Termination.** [WAC 284-170-421(9)&(10)] The minimum period of notice of termination without cause by either party shall be at least 60 days, but shall be greater if so provided in this Agreement. At least 30 days prior to the effective date of termination, or

immediately for a termination for cause that results in less than thirty days' notice, KFHP-NW shall make a good faith effort to ensure that written notice of the termination is provided to all Members who are patients seen on a regular basis by a specialist provider, or who have a standing referral to Provider, or in the case of a primary care provider, to all Members who are patients of Provider, irrespective of whether the termination was for cause or without cause.

7. **Continuity of Care following Contract Termination.** [RCW 48.43.515(7)] KFHP-NW must cover services of a primary care provider whose contract with the plan or whose contract with a subcontractor is being terminated without cause under the terms of that contract for at least 60 days following notice of termination to Members or, in group coverage arrangements involving periods of open enrollment, only until the end of the next open enrollment period.

8. **Member Coverage; Non-discrimination.** [WAC 284-170-421(11)] Provider shall furnish Covered Services to Members without regard to the Member's enrollment in the plan as a private purchaser of the plan or as a participant in publicly financed programs of health care services. This requirement does not apply to circumstances when Provider should not render services due to limitations arising from lack of training, experience, skill, or licensing restrictions.

9. **Member Eligibility Notification.** [WAC 284-170-421(1)&(6)(d); RCW 48.43.525(1)] KFHP-NW shall provide Provider with a means to obtain timely information on Member eligibility and benefits. KFHP-NW shall not retrospectively deny coverage for emergency and nonemergency care that had prior authorization under a plan's written policies at the time the care was rendered.

10. **Disputes.** [WAC 284-170-421(13); WAC 284-170-440; RCW 48.43.055]

a. **Disputes.** This Section 10 applies to all claims and disputes between KFHP-NW or Network on the one hand, and Provider on the other hand, arising from, relating to, or in connection with this Agreement. While the informal and formal processes of alternative dispute resolution described below are not binding and are not required to the exclusion of judicial remedies, Provider shall exhaust both the informal and formal processes described in this Section 10 prior to seeking any judicial remedy.

b. **Informal Process.** Provider shall follow the internal provider appeals process described in Article 6 of the Agreement. If after exhausting such appeals process, the matter still remains in dispute, Provider shall submit, within 30 days, a complaint initiating an informal dispute resolution process in writing, pursuant to the notice provision requirements of this Agreement. KFHP-NW or Network, as applicable, shall make best efforts to render a decision on the matter within 30 days of receiving the complaint, with the exception of billing disputes where the decision shall be rendered within 60 days of receiving the complaint. Failure of KFHP-NW or Network, as applicable, to decide the matter within these time periods shall allow Provider to proceed as if the complaint had been rejected.

c. **Formal Process.** Any party may submit the dispute to non-binding arbitration as described in Article 6 of the Agreement. Any reference to "binding arbitration" in Article 6 of the Agreement shall instead be to "non-binding arbitration."

11. **Hold Harmless and Insolvency.**

a. **Hold Harmless.** [WAC 284-170-421(3)(a)] Provider hereby agrees that in no event, including, but not limited to nonpayment by KFHP-NW, KFHP-NW's insolvency, or breach of the Agreement will Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against Members or persons acting on their behalf, other than KFHP-NW, for Services provided pursuant to this Agreement. This provision does not prohibit collection of deductibles, copayments, coinsurance, and/or payment for non-Covered Services, which have not otherwise been paid by a primary or secondary health carrier in accordance with regulatory standards for coordination of benefits, from Members in accordance with the terms of the Member's plan.

b. **Insolvency.** [WAC 284-170-421(3)(b)] Provider agrees, in the event of KFHP-NW's insolvency, to continue to provide the Services promised in the Agreement to Members of KFHP-NW for the duration of the period for which premiums on behalf of the Member were paid to KFHP-NW or until the Member's discharge from inpatient facilities, whichever time is greater.

c. **Modification.** [WAC 284-170-421(2)&(3)(c)] Notwithstanding any other provision of the Agreement, nothing in the Agreement shall be construed to modify the rights and benefits contained in the Member's health plan. In the event of any conflict between the Agreement and a Member's health plan, the benefits, terms and conditions of the health plan shall govern with respect to coverage provided to Members.

d. **No Billing.** [WAC 284-170-421(3)(d)] Provider may not bill the Member for Covered Services (except for deductibles, copayments, or coinsurance) where KFHP-NW denies payments because the Provider has failed to comply with the terms or conditions of the Agreement.

e. **Survival.** [WAC 284-170-421(3)(e)] Provider further agrees (1) that the provisions of Sections 11 a, b, c & d of this Exhibit shall survive termination of the Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of KFHP-NW's Members, and (2) that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Members or persons acting on their behalf.

f. **Subcontracting.** [WAC 284-170-421(3)(f)] If Provider contracts with other providers or facilities who agree to provide Covered Services to Members of KFHP-NW with the expectation of receiving payment directly or indirectly from Network or KFHP-NW, such providers or facilities shall agree to abide by the provisions of Sections 11 a through e, above.

12. **Payment Collection.** [WAC 284-170-421(4)] Provider acknowledges that willfully collecting or attempting to collect an amount from a Member knowing that collection to be in violation of the Agreement constitutes a Class C felony under RCW 48.80.030(5) and (6).

13. **Overpayment Recovery-KFHP-NW.** [RCW 48.43.600] This Section 13 applies only if Provider is a "health care provider" as defined in RCW 48.43.005(23).

a. Except in the case of fraud, or as provided in Sections 13(b)&(c), KFHP-NW may not: (1) request a refund from Provider of a payment previously made to satisfy a claim unless it does so in writing to Provider within 24 months after the date that the payment was made; or (2) request that a contested refund be paid any sooner than six months after receipt of the request. Any such request shall specify why KFHP-NW believes the provider owes the refund. If Provider fails to contest the request in writing to KFHP-NW within 30 days of its receipt, the request is deemed accepted and the refund shall be paid.

b. KFHP-NW may not, if doing so for reasons related to coordination of benefits with another payer or entity responsible for payment of a claim: (1) request a refund from Provider of a payment previously made to satisfy a claim unless it does so in writing to Provider within 30 months after the date that the payment was made; or (2) request that a contested refund be paid any sooner than six months after receipt of the request. Any such request shall specify why KFHP-NW believes Provider owes the refund, and include the name and mailing address of the entity that has primary responsibility for payment of the claim. If Provider fails to contest the request in writing to KFHP-NW within 30 days of its receipt, the request is deemed accepted and the refund shall be paid.

c. KFHP-NW may at any time request a refund from Provider of a payment previously made to satisfy a claim if: (1) a third party, including a government entity, is found responsible for satisfaction of the claim as a consequence of liability imposed by law, such as tort liability; and (2) KFHP-NW is unable to recover directly from the third party because the third party has either already paid or will pay Provider for the health services covered by the claim.

d. If this Agreement or any other agreement between KFHP-NW and Provider conflicts with this Section 13, this Section 13 shall prevail. However, nothing in this section prohibits Provider from choosing at any time to refund to a KFHP-NW any payment previously made to satisfy a claim.

e. For purposes of this Section 13, the term "refund" means the return, either directly or through an offset to a future claim, of some or all of a payment already received by Provider.

f. This Section 13 neither permits nor precludes KFHP-NW from recovering from a Member or beneficiary any amounts paid to a health care provider for benefits to which the Member or beneficiary was not entitled under the terms and conditions of the health plan, insurance policy, or other benefit agreement.

g. This Section 13 does not apply to claims for health care services provided through dental-only health carriers, services provided under Title XVIII (Medicare) of the Social Security Act, or Medicare supplemental plans regulated under Chapter 48.66 RCW.

14. **Overpayment Recovery-Provider.** [RCW 48.43.605] This Section 14 applies only if Provider is a "health care provider" as defined in RCW 48.43.005(23).

a. Except in the case of fraud, or as provided in Section 14(b), Provider may not: (1) Request additional payment from Network or KFHP-NW to satisfy a claim unless Provider does so in writing to KFHP-NW within 24 months after the date that the claim was denied or payment intended to satisfy the claim was made; or (2) request that the additional payment be made any sooner than six months after receipt of the request. Any such request shall specify why Provider believes KFHP-NW owes the additional payment.

b. Provider may not, if doing so for reasons related to coordination of benefits with another payer or entity responsible for payment of a claim: (1) Request additional payment from Network or KFHP-NW to satisfy a claim unless Provider does so in writing to KFHP-NW within thirty months after the date the claim was denied or payment intended to satisfy the claim was made; or (2) request that the additional payment be made any sooner than six months after receipt of the request. Any such request shall specify why Provider believes KFHP-NW owes the additional payment, and include the name and mailing address of any entity that has disclaimed responsibility for payment of the claim.

c. If this Agreement or any other agreement between KFHP-NW and Provider conflicts with this Section 14, Section 14 shall prevail. However, nothing in this section prohibits Network or KFHP-NW from choosing at any time to make additional payments to Provider to satisfy a claim.

d. This Section 14 does not apply to claims for health care services provided through dental-only health carriers, services provided under Title XVIII (Medicare) of the Social Security Act, or Medicare supplemental plans regulated under Chapter 48.66 RCW.

15. **Provider/Patient Care.** [WAC 284-170-421(7); RCW 48.43.510(6)&(7)] KFHP-NW may not in any way preclude or discourage its providers from informing patients of the care they require, including various treatment options, and whether in their view such care is consistent with medical necessity, medical appropriateness, or otherwise covered by the Member's plan with KFHP-NW. KFHP-NW shall not prohibit, discourage, or penalize a provider otherwise practicing in compliance with the law from advocating on behalf of a patient with KFHP-NW. Nothing in this section shall be construed to authorize providers to bind health plans to pay for any service. Furthermore, KFHP-NW shall not preclude or discourage patients or those paying for their coverage from discussing the comparative merits of different health plans with their providers. This prohibition specifically includes prohibiting or limiting providers participating in those discussions even if critical of KFHP-NW.

16. **Record Retention.** [WAC 284-170-421(8)] Provider shall make health records available to appropriate state and federal authorities involved in assessing the quality of care or

investigating complaints, grievances, appeals, or review of any adverse benefit determination of Members subject to applicable state and federal laws related to the confidentiality of medical or health records. Provider shall also cooperate with audit reviews of encounter data in relation to the administration of health plan risk adjustment and reinsurance programs.

17. **Subcontractors.** [WAC 284-170-401; WAC 284-170-240] If Provider subcontracts with other providers or facilities who agree to provide Covered Services to Members of KFHP-NW, such subcontracts shall require each such provider or facility to abide by all requirements of WAC 284-170 Subchapter C. If Provider is permitted to delegate functions to be performed by it under this Agreement, Provider (a) shall include the applicable requirements of WAC 284-170 Subchapter B in its subcontract(s) addressing delegation, including providing the Washington State Office of the Insurance Commissioner with access to any pertinent information related to the subcontract during the contract term, for up to 10 years from the final date of the contract period, and in certain instances, where required by federal or state law, periods in excess of 10 years and (b) agrees that KFHP-NW has the right to approve, suspend or terminate any such delegation.

18. **Coordination of Benefits.** [WAC 284-51; 284-51-215] The adjudication practices of KFHP-NW pursuant to Section 4.6 (Coordination of Benefits) of the Agreement shall be administered to reflect WAC 284-51. KFHP-NW shall not unreasonably delay payment of a claim by reason of the application of a coordination of benefits provision.

19. **Utilization Review.** [RCW 48.43.520; WAC 284-43-2000]

a. KFHP-NW shall maintain a documented utilization review program description and written clinical review criteria based on reasonable medical evidence. The program shall include a method for reviewing and updating criteria. KFHP-NW shall make clinical protocols, medical management standards, and other review criteria available upon request to Provider. KFHP-NW need not use medical evidence or standards in its utilization review of religious nonmedical treatment or religious nonmedical nursing care.

b. The utilization review program shall meet accepted national certification standards such as those used by the National Committee for Quality Assurance except as otherwise required by Washington Administrative Code Chapter 284-43 and shall have staff who are properly qualified, trained, supervised, and supported by explicit written clinical review criteria and review procedures.

c. When conducting utilization review KFHP-NW shall follow all procedures and requirements specified in WAC 284-43-2000, including the following.

(1) For retrospective review, base review determinations solely on the medical information available to the provider at the time the health service was provided;

(2) Not retrospectively deny coverage for emergency and nonemergency care that had prior authorization under the plan's written policies at the time the care was rendered unless the prior authorization was based upon a material misrepresentation by the provider;

d. KFHP-NW shall reimburse reasonable costs of medical record duplication for reviews.

e. KFHP-NW shall have written procedures to assure that reviews and second opinions are conducted in a timely manner in accordance with the time frames specified in WAC 284-43-2000, including within 30 calendar days for postservice review requests.

f. KFHP-NW shall not penalize nor threaten Provider with a reduction in future payment or termination of Provider or participating provider status because Provider disputes KFHP-NW's determination with respect to coverage or payment for health care services.

20. **Reporting.** [WAC 284-170-421(12)] KFHP-NW shall not penalize Provider because the Provider, in good faith, reports to state or federal authorities any act or practice by the health plan that jeopardizes patient health or welfare or that may violate state or federal law.

21. **Prior Authorization.** [WAC 284-43-2050, WAC 284-43-2060]

a. KFHP-NW shall maintain a documented prior authorization program description and use evidence-based clinical review criteria. KFHP-NW shall make determinations in accordance with the current clinical review criteria and use the medical necessity definition stated in the Member's plan. The program shall include a method for reviewing and updating criteria. KFHP-NW need not use medical evidence or standards in its prior authorization of religious nonmedical treatment or religious nonmedical nursing care.

b. The prior authorization program shall meet accepted national certification standards such as those used by the National Committee for Quality Assurance except as otherwise required by Washington Administrative Code Chapter 284-43 and shall have staff who are properly qualified, trained, supervised, and supported by explicit written clinical review criteria and review procedures.

c. KFHP-NW shall follow all prior authorization procedures and requirements specified in WAC 284-43-2050 and WAC 284-43-2060, including the following.

(1) KFHP-NW shall have written policies and procedures to assure that prior authorization determinations and are made within the appropriate time frames specified in WAC 284-43-2050. Time frames shall be appropriate to the severity of the Member condition and urgency of the need for treatment as documented in the prior authorizations request.

(2) KPHP-NW shall have an extenuating circumstances policy and procedure which eliminates the administrative requirement for a prior authorization of services when an extenuating circumstance prevents Provider from obtaining a required prior authorization before a service is delivered.

EXHIBIT

WASHINGTON STATE MEDICAID PROGRAM COMPLIANCE

Kaiser Foundation Health Plan of the Northwest ("KFHP-NW"), has entered into a Provider Services Agreement (the "Participation Agreement") with Molina Healthcare of Washington, Inc. ("Molina") to manage the care of certain Molina Medicaid managed care members. Molina has entered into a Managed Care Contract, Basic Health and Healthy Options (the "Medicaid Contract"), with the Washington State Health Care Authority ("HCA") to manage the care of Washington Medicaid managed care members. The Medicaid Contract and the Participation Agreement require that the provisions in this Exhibit be included in any subcontracts with respect to goods and services rendered under those agreements.

This Exhibit is incorporated by reference into and made part of the Agreement with respect to products provided and services rendered under the Agreement by Provider to enrollees of the HCA Medicaid managed care program via Network's Participation Agreement with Molina ("Medicaid Members"). In the event of a conflict or inconsistency with any term or condition in the Agreement relating to goods and services rendered to Medicaid Members, this Exhibit shall control. Capitalized terms used in this Exhibit, but not otherwise defined in the Agreement or this Exhibit, shall have the same meaning as those terms in the Medicaid Contract.

1. **Access.** [Medicaid Contract, Section 2.14 and 42 CFR 438.6(g)] Provider shall provide reasonable access to facilities and financial and medical records for duly authorized representatives of the Center for Medicare and Medicaid Services ("CMS"), HCA, Department of Social & Health Services ("DSHS") or the Department of Health & Human Services ("DHHS") for audit purposes, and immediate access for Medicaid fraud investigators.

2. **Reporting.** [Medicaid Contract Section 8.4.7] Provider shall completely and accurately report encounter data to Network. Provider shall have the capacity to submit all required data to enable Network to meet the requirements in the Encounter Data Transaction Guide published by HCA.

3. **Fraud and Abuse.** [Medicaid Contract Section 11.4] Provider shall comply with Network's fraud and abuse policies and procedures.

4. **Assignment.** [Medicaid Contract Section 2.2] Provider shall not assign this Agreement without HCA's written agreement.

5. **Medicaid Contract.** [Medicaid Contract Section 8.4.11 and 42 CFR 438.6(1)] Provider shall comply with any term or condition of the Medicaid Contract with HCA that is applicable to the services to be performed by Provider.

6. **Member Hold Harmless.** [Medicaid Contract Section 8.5.6] Provider shall accept payment from Network as payment in full and shall not request payment from HCA or any Medicaid Member for Covered Services performed under this Agreement.

7. **HCA Hold Harmless.** [Medicaid Contract Section 8.5.7] Provider agrees to hold harmless HCA and its employees, CMS and its employees, and all Medicaid Members served under the terms of this Agreement in the event of non-payment by Network. Provider further agrees to indemnify and hold harmless HCA and its employees against all injuries, deaths,

losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against HCA or its employees through the intentional misconduct, negligence, or omission of Provider, its agents, officers, employees or contractors.

8. **Appointments.** [Medicaid Contract Section 8.5.11 and 42 CFR 438.206(c)(1)] To the extent applicable, Provider agrees to comply with the HCA appointment wait time standards. Provider agrees to Network's regular monitoring of timely access to Provider's services, and agrees to corrective action up to and including termination for cause in the event that Provider fails to comply with the appointment wait time standards.

9. **Sterilizations.** [Medicaid Contract Section 14.2] Provider shall assure that all sterilizations and hysterectomies performed under this Agreement are in compliance with 42 CFR 441 Subpart F, and that the Sterilization Consent Form (DSHS 13-364(x)) or its equivalent is used.

10. **Disabilities.** [Medicaid Contract Section 2.4.13.13] Provider shall make reasonable accommodation for Medicaid Members with disabilities, in accord with the Americans with Disabilities Act, for all Covered Services and shall assure physical and communication barriers shall not inhibit Medicaid Members with disabilities from obtaining Covered Services.

11. **Program Integrity.** [Medicaid Contract Section 11.1.3 and 42 CFR 438.608(a)] Provider shall comply with all Program Integrity provisions as documented in Network's Policies and as set forth by 42 CFR 438.608 and the Medicaid Contract.

EXHIBIT

OREGON STATE COMPLIANCE

This Exhibit is incorporated by reference into and made part of the Agreement with respect to Services rendered to Members of Kaiser Foundation Health Plan of the Northwest ("KFHP-NW") under the jurisdiction of the Oregon State Division of Financial Regulation (formerly, Oregon Insurance Division). In the event of a conflict or inconsistency with any term or condition in the Agreement relating to Services rendered to Members of KFHP-NW under the jurisdiction of the Oregon State Division of Financial Regulation, this Exhibit shall control.

Network shall itself, or shall cause KFHP-NW to, satisfy the obligations of KFHP-NW under this Exhibit. With respect to Members of KFHP-NW, KFHP-NW is the entity ultimately responsible for the obligations under this Exhibit.

With respect to Services rendered to Members of KFHP-NW under the jurisdiction of the Oregon State Division of Financial Regulation, the Agreement shall be governed by the laws of the state of Oregon, without application of the conflict of laws provisions of the state of Oregon.

Oregon Law

1. **Hold Harmless.** [ORS 750.095(2) and ORS 743B.204] If KFHP-NW or Network fails to pay for Covered Services, the Member is not liable to Provider for any amounts owed by KFHP-NW or Network, and Provider shall not bill or attempt to collect from Members any amounts owed by KFHP-NW or Network.

2. **Annual Accounting.** [ORS 743B.405(2)(c)] No more than once per year upon the request of Provider, KFHP-NW shall deliver to Provider an annual accounting accurately summarizing the financial transactions under the Agreement for that year.

3. **Provider Withdrawal from Patient Care.** [ORS 743B.405(2)(d)] Provider may withdraw from the care of a Member when, in the professional judgment of Provider, it is in the best interest of the Member to do so; provided however that Provider shall give advance notice of withdrawal whenever reasonably feasible to KFHP-NW and shall cooperate with KFHP-NW to facilitate a medically appropriate transfer of care of the Member. Nothing in this paragraph shall relieve Provider of Provider's professional obligations in connection with withdrawal from the care of a patient.

4. **Retention.** [ORS 743B.405(2)(e)] KFHP-NW shall retain a doctor of medicine or osteopathy licensed in Oregon who shall be responsible for all final medical and mental health decisions relating to coverage or payment made pursuant to the Agreement.

5. **No Retaliation.** [ORS 743B.405(2)(f)] A physician who is practicing in conformity with ORS 677.095 may advocate a decision, policy or practice without being subject to termination or penalty under the Agreement for the sole reason of such advocacy.

6. **Assumption of Financial Risk.** [ORS 743B.405(2)(g)] If Provider is paid under the Agreement on a basis that includes financial risk withholds, KFHP-NW shall deliver to Provider a full accounting of health benefits claims data and related financial information on no less than a quarterly basis, as follows: (a) The data shall include all pertinent information relating to the health care services provided, including related provider and patient information,

reimbursements made and amounts withheld under the financial risk withhold provisions of the Agreement for the period of time under reconciliation and settlement between the parties; (b) any reconciliation and settlement undertaken pursuant to the Agreement shall be based directly and exclusively upon data provided to Provider; and (c) all data, including supplemental information or documentation, necessary to finalize the reconciliation and settlement provisions of the Agreement relating to financial risk withholds shall be provided to Provider no later than 30 days prior to finalizing the reconciliation and settlement. Nothing in this section shall prevent KFHP-NW or Provider from mutually agreeing to alternative reconciliation and settlement policies and procedures.

7. **Continuity of Care.** [ORS 743B.405(2)(h)] When continuity of care is required to be provided under a KFHP-NW health benefit plan by ORS 743B.225, KFHP-NW and Provider shall provide continuity of care to Members as provided in ORS 743B.225.

8. **Grievance Procedures.** [ORS 743B.405(2)(a)] KFHP-NW shall provide Provider adequate notice and hearing procedures, or other such procedures as are fair to Provider under the circumstances, in accordance with ORS 743.405(2)(a), prior to termination or non-renewal of the Agreement when such termination or renewal is based upon issues relating to the quality of patient care rendered by Provider.

9. **Contract Termination.** [ORS 743B.405(2)(b)] The criteria for termination or nonrenewal of the Agreement are set forth in Sections 5.2, 5.3, and 5.4 of the Agreement.

10. **Refunds of Paid Claims.** [ORS 743B.451] Notwithstanding anything to the contrary in the Agreement, except in case of fraud or abuse of billing, a request for refund of a payment previously made to Provider shall be made in writing within 18 months (unless a shorter time period is specified in Section 4.8 of the Agreement), or if for reasons relating to coordination of benefits within 30 months, after payment was made, and shall specify why the applicable Payer believes the refund is owed. If the refund is claimed for reasons relating to coordination of benefits, Payer will include in the written request the name and mailing address of the other insurer or entity that has primary responsibility for payment of the claim. If a request for a refund is not disputed in writing within 30 days after the request is received, the Provider must pay the refund within 60 days after receiving the request. If a request for a refund is disputed in writing within 30 days after the request is received, KFHP-NW shall not request that such disputed refund be paid earlier than six months after the request for a refund was received. Notwithstanding the foregoing, Payer may request a refund of a claim previously paid at any time if liability is imposed by law on a third party and Payer is unable to recover from the third party because the third party has paid or will pay Provider for the services covered by the claim.

Patient Protection and Affordable Care Act – Federally Facilitated Marketplace

In providing and/or arranging certain professional medical services, KFHP-NW is a Qualified Health Plan ("**QHP**") issuer that is certified and contracted to offer QHPs on the State-Based Exchange that is using the Federally-facilitated Marketplace technology platform (hereafter "**FFM**") in Oregon. As a QHP issuer, KFHP-NW is subject to certain statutory and regulatory requirements under the Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. No. 111-152) (hereafter "**ACA**"), including but not limited to the requirements stated in 45 C.F.R.

§156.340 (hereafter "**Regulation**") governing KFHP-NW's arrangement with contractors, such as Provider, providing health care and/or administrative services to Members who are enrolled in a QHP through the FFM (hereafter "**FFM Members**"). By virtue of the Agreement, Provider acts as a downstream entity or delegated entity (as those terms are defined in 45 C.F.R. §156.10) to KFHP-NW within the scope of the Regulation and is subject to the following provisions required by the Regulation:

1. As a downstream entity or delegated entity, as applicable, Provider shall comply with all applicable ACA standards including but not limited to the requirements set forth in the Regulation, statute, other regulations and/or subregulatory guidance issued by CMS that, with respect to KFHP-NW's QHPs offered through the FFM and the FFM Members enrolled in such QHPs, (a) are relevant to Provider's performance of its duties and obligations under the Agreement and (b) any reporting responsibilities regarding such duties and obligations (collectively hereafter "**Activities**").

2. Provider's Activities are those stated in the Agreement and Provider shall perform the Activities in accordance with the standards of the Regulation including but not limited to those pertaining to maintenance of records and compliance reviews (as set forth in §§156.705 and 156.715 of Title 45 of the Code of Federal Regulations, respectively).

3. Provider agrees that, notwithstanding any terms and conditions pertaining to audits and/or termination of the Agreement for cause including but not limited to any right to cure any breach(es) of the Agreement, the Agreement will terminate for cause with respect to KFHP-NW's QHPs offered through the FFM and the FFM Members enrolled therein if the U.S. Department of Health and Human Services (hereafter "**HHS**") and/or KFHP-NW determine that Provider has not performed satisfactorily.

4. Notwithstanding any provisions of the Agreement related to audit and/or access to records, premises or the like, Provider agrees to permit access by the Secretary of, and the Office of the Inspector General of, HHS or their designees in connection with their right to evaluate through audit, inspection, or other means, Provider's books, contracts, computers, or other electronic systems, including medical records and documentation, relating to KFHP-NW's obligations and responsibilities under the Regulation until ten (10) years after the final date of Provider's performance of the Activities.

EXHIBIT
OREGON STATE MEDICAID PROGRAM COMPLIANCE

(Multnomah, Clackamas and Washington Counties)

Kaiser Foundation Health Plan of the Northwest ("KFHP-NW"), has entered into a Risk Accepting Entity Participation Agreement (the "Participation Agreement"), with Health Share of Oregon (formerly known as Tri-County Medicaid Collaborative), an Oregon nonprofit corporation ("Health Share") serving Multnomah, Clackamas and Washington counties. Health Share has entered into a Health Plan Services Contract, Coordinated Care Organization Contract (as the same may be updated, amended, modified or supplemented from time to time, the "Core Contract") with the State of Oregon, acting by and through its Oregon Health Authority ("OHA"), pursuant to which Health Share acts as a Coordinated Care Organization. The Core Contract and the Participation Agreement require that the provisions in this Exhibit be included in any subcontracts with respect to goods and services rendered under those agreements. This Exhibit is incorporated by reference into and made part of the Agreement with respect to products provided and services rendered under the Agreement by Provider to enrollees of the Oregon Health Plan ("OHP") Medicaid managed care program ("Medicaid Members"). In the event of a conflict or inconsistency with any term or condition in the Agreement relating to goods and services rendered to Medicaid Members, this Exhibit shall control.

Provider shall comply with the provisions in this Exhibit to the extent that they are applicable to the goods and services provided by Provider under the Agreement. Capitalized terms used in this Exhibit but not otherwise defined in the Agreement shall have the same meaning as those terms in the Participation Agreement, including definitions incorporated therein by reference.

1. **Applicable Provisions from Core Contract or Participation Agreement.** [Participation Agreement VI; Ex. D §§ 18(a)(4), 20(b)] The Agreement is subject to, and shall be interpreted and administered in accordance with, the terms and conditions of the Core Contract and the Participation Agreement. If any provision in the Core Contract or the Participation Agreement applies to the Agreement (each, an "Applicable Provision"), KFHP-NW and Provider agree to abide by the Applicable Provision as the Core Contract or the Participation Agreement, as applicable, intended for the Applicable Provision to apply to the Agreement. In the event of a conflict between an Applicable Provision and a provision in the Agreement, the Applicable Provision shall control. KFHP-NW and Provider agree to cooperate in good faith and take best efforts to amend the Agreement (a) to comply with an Applicable Provision, if any provision in the Agreement conflicts with such Applicable Provision, and (b) to set forth the Applicable Provision in the Agreement as the Core Contract or Participation Agreement, as applicable, intended for the Applicable Provision to apply to the Agreement, if the Applicable Provision is not set forth in the Agreement or if the Agreement does not address the Applicable Provision as intended by the Core Contract or Participation Agreement. If the Participation Agreement is amended or modified, then, upon the direction of Health Share, KFHP-NW and Provider agree to cooperate in good faith and take best efforts to amend the Agreement within 30 calendar days to be consistent with such amendments or modifications.

2. **Termination for Cause.** [Core Contract Ex. B, Pt 4, § 10(a)(8)(a); Participation Agreement Ex. B, Pt 4, § 10, Ex. D, §§ 10, 18(b)(7)] In addition to pursuing any other remedies allowed at law or in equity or by the Agreement, the Agreement may be terminated by KFHP-

NW, or KFHP-NW may impose other sanctions against Provider, if Provider's qualifications or performance are inadequate to meet the requirements of the Core Contract or the Participation Agreement.

3. **Federal Medicaid Managed Care.** [Core Contract Ex. B, Pt 4, § 10(a)(8)(b); Participation Agreement Ex. B, Pt 4, § 10] Provider shall comply with the requirements of 42 CFR § 438.6 that are applicable to the Work required under the Agreement.

4. **Billing and Payment.** [Core Contract Ex. B, Pt 4, § 10(a)(4); Participation Agreement Ex. B, Pt 4, § 10; Participation Agreement Ex. D, § 18(a) and (b)(2); Group Provider Agreement § 5.3.4; OAR 410-120-1280(3)(c)] Provider shall, and shall require all Sub-Subcontractors to, look solely to KFHP-NW for payment for Covered Services rendered to Medicaid Members. Provider shall not bill Medicaid Members for services that are not covered under the Core Contract unless there is a full written disclosure or waiver on file signed by the Medicaid Member, in advance of the service being provided, in accordance with OAR 410-141-0420. Provider shall, and shall require all Sub-Subcontractors to, comply with the provisions of the Participation Agreement related to billing Medicaid Members. Provider shall not, and Provider shall require all Sub-Subcontractors to not, bill Medicaid Members for missed appointments.

5. **Access to Records.** [Core Contract Ex. D, §§ 13, 18; Participation Agreement Ex. D, § 13; OAR 410-141-3180; 42 CFR § 434.6(5)] Provider shall, and shall require each Sub-Subcontractor to, maintain all financial records related to the Core Contract, the Participation Agreement, or the Agreement in accordance with generally accepted accounting principles or National Association of Insurance Commissioners accounting standards. In addition, Provider shall, and shall require each Sub-Subcontractor to, maintain any other records, books, documents, papers, plans, records of shipment and payments, and writings of Provider, whether in paper, electronic or other form, that are pertinent to the Core Contract (the "Records") in such a manner to clearly document Provider's performance or Sub-Subcontractor's performance, as applicable. Provider shall, and shall require each Sub-Subcontractor to, provide timely and reasonable access to Records to (a) OHA; (b) the Secretary of State's Office; (c) CMS; (d) the Comptroller General of the United States; (e) the Oregon Department of Justice Medicaid Fraud Control Unit; (f) other authorized state or federal reviewers; and (g) all duly authorized representatives of any of the foregoing (the "Reviewers"), to perform examinations and audits, make excerpts and transcripts, and evaluate the quality, appropriateness and timeliness of services performed. Provider shall, and shall require each Sub-Subcontractor to, cooperate with the Reviewers for audits, inspection and examination of Medicaid Members' clinical records. Provider's and Sub-Subcontractor's documentation must be sufficiently complete and accurate to permit evaluation and confirmation that coordinated care services were authorized and provided, referrals made, and outcomes of coordinated care and referrals sufficient to meet professional standards applicable to the health care professional and meet the requirements for health oversight and outcome reporting in the Oregon Administrative Rules. Provider shall, and shall require each Sub-Subcontractor to, upon request and without charge, provide a suitable work area and copying capabilities to facilitate such a review or audit. This right also includes timely and reasonable access to Provider's and Sub-Subcontractor's personnel for the purpose of interview and discussion related to such documents. Provider shall, and shall require each Sub-Subcontractor to, retain and keep accessible all Records, including Medicaid Members' clinical records, for the longer of (a) seven years following final payment and termination of the Core

Contract or the date of services for which claims are made, whichever is later (or, if an audit, litigation, research and evaluation, or other action involving the records is started before the end of the seven-year period, until all issues arising out of the action are resolved); (b) the period as may be required by applicable law, including the records retention schedules set forth in OAR Chapters 410 and 166; or (c) until the conclusion of any audit, controversy or litigation arising out of or related to the Core Contract or the Records. The rights of access in this Section 5 are not limited to the required retention period, but shall last as long as the Records are retained.

6. **Information Privacy/Security/Access.** [Core Contract Ex. D, §§ 14, 18; Participation Agreement Ex. D, § 14] If the items or services provided under the Agreement permit Provider or any Sub-Subcontractor to have access to or use of any OHA computer system or other OHA Information Asset for which OHA imposes security requirements, and OHA grants Provider or Sub-Subcontractor access to such OHA Information Assets or Network and Information Systems, Provider shall, and shall require each Sub-Subcontractor to, comply with OAR 943-014-0300 through OAR 943-014-0320, as such rules may be revised from time to time.

7. **Governing Law, Consent to Jurisdiction.** [Core Contract Ex. D, §§ 1, 18; Participation Agreement Ex. D, § 1] The Agreement shall be governed by and construed in accordance with the laws of the State of Oregon without regard to principles of conflicts of law. Any claim, action, suit or proceeding between (i) the OHA (or any other agency or department of the State of Oregon) and Provider or (ii) the OHA (or any other agency or department of the State of Oregon) and any Sub-Subcontractor that arises from or relates to the Agreement shall be brought and conducted solely and exclusively within the Circuit Court of the County where the claim arises or relates; provided, that if a claim must be brought in a federal forum, then it shall be conducted solely and exclusively within the United States District Court for the District of Oregon. In no event shall this Section 7 be construed as a waiver of the State of Oregon of the jurisdiction of any court or of any form of defense to or immunity from any claim whether sovereign immunity, governmental immunity, immunity based on the Eleventh Amendment to the Constitution of the United States or otherwise. Any claim, action, suit or proceeding that arises from or relates to the Participation Agreement shall be brought and conducted solely and exclusively within the Circuit Court of the County where the claim arises or relates; provided, that if a claim must be brought in a federal forum, then it shall be conducted solely and exclusively within the United States District Court for the District of Oregon. **PROVIDER, BY EXECUTION OF THE AGREEMENT, HEREBY CONSENTS TO THE IN PERSONAM JURISDICTION OF SAID COURTS.** Provider shall cause all Sub-Subcontractors under the Agreement to comply with the requirements of this Section 7.

8. **Independent Contractor.** [Core Contract Ex. D, §§ 3, 18; Participation Agreement Ex. D, § 3(b)] Provider agrees that it shall be subject to the "Independent Contractor" provisions that apply to "Contractor" with respect to work performed under contract or subcontract for the State of Oregon or the federal government as stated in the Core Contract, Exhibit D, Section 3, which shall be incorporated herein by reference.

9. **Compliance with Applicable State and Local Law.** [Core Contract Ex. D, §§ 2(a), 18; Participation Agreement Ex. D, §§ 2, 30] Provider shall, and shall cause all Sub-Subcontractors to, comply with all State and local laws, rules, regulations, executive orders, and ordinances (as they may be adopted, amended or repealed from time to time) applicable to the Core Contract,

the Participation Agreement, the Agreement or to the performance of Work under any of the foregoing, including, but not limited to, the following: (a) ORS Chapter 659A.142; (b) all other applicable requirements of State civil rights and rehabilitation statutes, rules and regulations; (c) OHA rules pertaining to the provision of prepaid capitated health care and services, OAR Chapter 410, Division 141; (d) all other OHA rules in OAR Chapter 410; (e) rules in OAR Chapter 309 pertaining to the provisions of mental health services; (f) rules in OAR Chapter 415 pertaining to the provision of Substance Use Disorders services; (g) state law establishing requirements for Declaration for Mental Health Treatment in ORS 127.700 through 127.737; and (h) all protective services, investigation and reporting requirements described in OAR 943-045-0250 through 943-045-0370; ORS 430.735 through 430.765; ORS 124.005 through 124.040; and ORS 441.650 through 441.680. These laws, rules, regulations, executive orders and ordinances are incorporated by reference herein to the extent that they are applicable to the Core Contract, the Participation Agreement or the Agreement and required by law to be so incorporated. Provider shall, and shall require each Sub-Subcontractor to, to the maximum extent economically feasible in the performance of the Agreement pertinent to the OHP Contact, use recycled paper (as defined in ORS 279A.010(1)(gg)), recycled PETE products (as defined in ORS 279A.010(1)(hh)), and other recycled products (as "recycled products" is defined in ORS 279A.010(1)(ii)).

10. **Americans with Disabilities Act.** [Core Contract Ex. D, §§ 2(b), 18; Participation Agreement Ex. D, § 2] In compliance with the Americans with Disabilities Act, any written material that is generated and provided by Provider under the Core Contract, the Participation Agreement, or the Agreement to Medicaid Members, including Medicaid-Eligible Individuals, shall, at the request of such individuals, be reproduced in alternative formats of communication, to include Braille, large print, audiotape, oral presentation, and electronic format. Provider shall not be reimbursed for costs incurred in complying with this provision. Provider shall cause all Sub-Subcontractors to comply with the requirements of this provision as if each Sub-Subcontractor was Provider under this provision.

11. **Representations and Warranties.** [Core Contract Ex. D, §§ 4, 18; Participation Agreement Ex. D, § 4] The representations and warranties set forth in this Section 11 are in addition to, and not in lieu of, any other representations or warranties provided under the Agreement. Provider represents and warrants to KFHP-NW and OHA that (a) Provider has the power and authority to enter into and perform the Agreement; (b) the Agreement, when executed and delivered, shall be a valid and binding obligation of Provider enforceable in accordance with its terms; (c) Provider has the skill and knowledge possessed by well-informed members of its industry, trade or profession and Provider will apply that skill and knowledge with care and diligence to perform the Work in a professional manner and in accordance with standards prevalent in Provider's industry, trade or profession; (d) Provider shall, at all times during the term of the Agreement, be qualified, professionally competent, and duly licensed to perform the Work; and (e) Provider prepared its application related to the Agreement, if any, independent from all other applicants, and without collusion, fraud or other dishonesty. Provider covenants to immediately notify KFHP-NW if any of the foregoing representations or warranties becomes untrue after the effective date of the Agreement. Provider shall cause all Sub-Subcontractors to (i) make the representations and warranties of this Section 11 to KFHP-NW and OHA as if each Sub-Subcontractor was Provider under this Section 11, and (ii)

covenant to notify KFHP-NW if any of the foregoing representations or warranties becomes untrue with respect to such Sub-Subcontractor after the effective date of the subcontract.

12. **Assignment; Successor in Interest.** [Core Contract Ex. D, §§ 17, 18; Participation Agreement Ex. D, § 17] Provider shall not assign or transfer its interest in the Agreement, voluntarily or involuntarily, whether by merger, consolidation, dissolution, operation of law, or in any other matter, without prior written consent of KFHP-NW and OHA. Any such assignment or transfer, if approved, is subject to such conditions and provisions as KFHP-NW or OHA may deem necessary, including, but not limited to, Exhibit B, Part 8, Section 14 of the Core Contract. No approval by KFHP-NW or OHA of any assignment or transfer of interest shall be deemed to create any obligation of KFHP-NW or OHA in addition to those, if any, set forth in the Agreement. The provisions of the Agreement shall be binding upon and inure to the benefit of the parties and their respective successors and permitted assigns. Provider shall cause all Sub-Subcontractors to comply with the requirements of this Section 12 as if each Sub-Subcontractor was Provider under this Section 12.

13. **Severability.** [Core Contract Ex. D, §§ 22, 18] If any term or provision of the Agreement is declared by a court of competent jurisdiction to be illegal or in conflict with any law, the validity of the remaining terms and provisions shall not be affected, and the rights and obligations of the parties shall be construed and enforced as if the Agreement did not contain the particular term or provision held to be unlawful.

14. **Subcontracts.** [Core Contract Ex. D, § 18; Participation Agreement Ex. B, Pt 4, § 10; Participation Agreement Ex. D, § 18]

a. *In General.* Where Provider is permitted to subcontract certain functions of the Agreement, Provider shall notify KFHP-NW, in writing, prior to subcontracting such work. Provider shall ensure that all subcontracts are (i) in writing; (ii) include all the requirements set forth in the Agreement that are applicable to the service or activity delegated under the subcontract; and (iii) are available for inspection upon request by KFHP-NW. In addition, Provider shall subcontract in accordance with Exhibit D, Section 18 of the Participation Agreement and Exhibit B, Part 4, Section 10.a.(3) through 10.a.(9) of the Core Contract. Provider shall expressly assume the duties and obligations applicable to KFHP-NW as described in Exhibit B, Part 4, Sections 10.a.(3) through 10.a.(9) of the Core Contract. KFHP-NW's consent to any subcontract shall not relieve Provider of any of its duties or obligations under the Agreement. Provider shall comply with the requirements of Exhibit B, Part 8, Section 14 of the Core Contract as if Provider was KFHP-NW under that section.

b. *Miscellaneous.*

i. Provider shall participate in Health Share's quality initiatives described in Exhibit B, Part 9 of the Participation Agreement.

ii. Provider shall provide Covered Services to Medicaid Members for the period in which Health Share paid KFHP-NW for such services.

iii. The term of the Agreement shall be not less than one year, subject to the termination provisions as may be set forth in the Agreement (including this Exhibit).

iv. Provider shall carry insurance as required by Health Share or KFHP-NW and shall provide proof of insurance to Health Share or KFHP-NW upon request.

v. Each subcontract that Provider enters into shall set forth provisions consistent with Exhibit D, Section 10 of the Participation Agreement and Section 2 of this Exhibit and pertaining to the termination of the Participation Agreement, the Agreement or the subcontract between Provider and Sub-Subcontractor.

15. **Compliance with Applicable Federal Laws.** [Core Contract Ex. D, §§ 2(c), 18; Participation Agreement Ex. D, § 2] Provider shall comply, and shall cause each Sub-Subcontractor to comply, with federal laws as set forth or incorporated, or both, in the Core Contract, the Participating Agreement and the Agreement, including, without limitation, all applicable standards, policies, orders, or requirements that apply to KFHP-NW as stated in the Core Contract, Exhibit E, and all other federal laws applicable to Provider's performance relating to the Core Contract, the Participation Agreement, or the Agreement. For purposes of the Core Contract, the Participation Agreement, or the Agreement, all references to federal laws are references to federal laws as they may be adopted or amended from time to time.

16. **Payment Types and Rates.** [Participation Agreement Ex. C, § 1(c)] If Provider is a designated Type A, Type B, or Rural critical access hospital, Provider represents and warrants to Health Share (i) that the Agreement establishes the total reimbursement for the services provided to the persons whose medical assistance benefits are administered by KFHP-NW and (ii) Provider is not entitled to any additional reimbursement from OHA for services provided to persons whose medical assistance benefits are administered by KFHP-NW.

17. **All Payers All Claims Reporting Program.** [Participation Agreement Ex. B, Pt 8, § 13; Core Contract Ex. B, Part 4, § 10(a)(8)(c)] Provider shall cooperate and assist KFHP-NW in its participation in the All Payers All Claims reporting system established under ORS 442.464 and 442.466.

18. **Prevention / Detection of Fraud and Abuse.** [Participation Agreement Ex. B, Pt 8, § 14; Core Contract Ex. B, Part 4, § 10(a)(8)(c)] Provider shall comply with all fraud and abuse prevention and detection requirements as set forth in Participation Agreement Ex. B, Part 8, Section 14, as such requirements are communicated to Provider by KFHP-NW.

19. **Valid Claims.** [Core Contract Ex. B, Part 4, § 10(a)(8)(d); Participation Agreement Ex. B, Part 4, § 10] Provider shall submit Valid Claims for services including all the fields and information needed to allow the claim to be processed without further information from Provider or Sub-Subcontractors, and within time frames that assure all corrections have been made within four months of the Date of Service. Provider and its Sub-Subcontractors may, by mutual agreement establish an alternative payment schedule not to exceed the minimum requirements.

EXHIBIT

OREGON OEBB AND PEBB REQUIREMENTS

This Exhibit is incorporated by reference into and made a part of the Agreement with respect to Services rendered to Members of Kaiser Foundation Health Plan of the Northwest ("KFHP-NW") under the jurisdiction of the State of Oregon, acting by and through its Oregon Educators Benefit Board ("OEBB") and its Public Employees' Benefit Board ("PEBB"). In the event of a conflict or inconsistency with any term or condition in the Agreement relating to Services rendered to Members of KFHP-NW under the jurisdiction of the OEBB or the PEBB ("OEBB Members" and "PEBB Members," respectively), this Exhibit shall control.

Network shall itself, or shall cause KFHP-NW to, satisfy the obligations of KFHP-NW under this Exhibit. With respect to Members of KFHP-NW, KFHP-NW is the entity ultimately responsible for the obligations under this Exhibit.

OEBB and PEBB. The following provisions apply with respect to Services rendered to Members of KFHP-NW under the jurisdiction of either the OEBB or the PEBB.

1. **Quality Guidelines.** Provider shall cooperate with KFHP-NW with respect to KFHP-NW's adoption of clinical guidelines in collaboration with the Oregon Healthcare Quality Corporation ("OHQC") and the Oregon Health Authority ("OHA") Health Evidence Review Commission ("HERC"), as mutually agreed to by KFHP-NW and OEBB or PEBB (with respect to OEBB and PEBB Members), or KFHP-NW's use of other guidelines that closely align with them (with respect to OEBB Members). [OEBB Exh. E, Part VI, Sec. 2, and Exh. I, Sec, 3, 3-b; PEBB Exh. B, Sec. VIII.e.]

2. **Administrative Simplification.** Provider shall make best efforts to, with respect to OEBB Members, and shall take reasonable steps to, with respect to PEBB Members, conduct all administrative transactions electronically, in accordance with standards promulgated or adopted from time to time by the federal Department of Health and Human Services, the Oregon Health Authority, and the uniform standards adopted by the Oregon Department of Consumer and Business Services. [OEBB Exh. E, Part VI, Sec. 9; PEBB Exh. B, Sec. X.b.3.]

3. **Non-Payment for HACs.** If Provider is a hospital, Provider shall not charge KFHP-NW or a Member for hospital-acquired conditions ("HACs") as identified by Medicare regulations (with respect to PEBB Members) or Medicare guidelines as identified at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/index.html, as updated by CMS from time to time (with respect to OEBB Members). [OEBB Exh. E, Part VI, Sec. 7.b.1; PEBB Exh. B, Sec. VIII.c.1.]

4. **Serious Adverse Events: Guidelines for Non-Payment.** If Provider is a hospital (with respect to both OEBB and PEBB Members) or an applicable provider, ambulatory surgical center ("ASC") or facility (with respect to PEBB Members), Provider shall make best efforts to adopt the "Guidelines for Non-Payment of Serious Adverse Events" developed by the Oregon Association of Hospitals and Health Systems (or similar guidelines for providers outside Oregon). [OEBB Exh. E, Part VI, Sec. 7.b.4; PEBB Exh. B, Sec. VIII.c.2.]

5. **Serious Adverse Events: Reporting.** If Provider is a hospital (with respect to both OEBB and PEBB Members) or an ASC, nursing facility or retail pharmacy (with respect to

OEBB Members), Provider shall make best efforts to participate in the applicable Oregon Patient Safety Commission's Adverse Events Reporting Program (or similar program if Provider is located outside of Oregon). If Provider is a hospital (with respect to OEBB Members), Provider also shall cooperate with KFHP-NW in working collaboratively with the Oregon Patient Safety Commission and others to advance patient safety. [OEBB Exh. E, Part VI, Sec. 7.b.2 and 7.d; PEBB Exh. B, Sec. VIII.c.3.]

a. With respect to OEBB Members, if Provider is an ASC, nursing facility or retail pharmacy, Provider shall make best efforts to meet or exceed the quantity targets and at least one of the targets for quality or timeliness for the Oregon Patient Safety Commission's Adverse Events Reporting Program. [OEBB Exh. E, Part VI, Sec. 7.e.]

b. With respect to OEBB Members, if Provider is an ASC, nursing facility or retail pharmacy, Provider shall make best efforts to provide timely written notification to patients and families when a serious adverse event occurs (in accordance with ORS 442.837). [OEBB Exh. E, Part VI, Sec. 7.f.]

6. **Surgical Checklist.** If Provider is a hospital (with respect to OEBB and PEBB Members) or an applicable provider, ASC or facility (with respect to PEBB Members), Provider shall make best efforts to use a surgical checklist that is consistent with the Oregon Surgical Safety Checklist (or similar checklist for providers outside Oregon) and that shall include critical elements appropriate to the patient population. With respect to OEBB Members, the checklist shall require full communication among the surgical staff regarding patient needs in the following three phases of care: prior to administration of anesthesia; prior to the first surgical incision; and prior to the patient leaving the operating room. [OEBB Exh. E, Part VI, Sec. 7.b.3; PEBB Exh. B, Sec. VIII.c.4.]

OEBB. The following additional provisions apply only with respect to Services rendered to Members of KFHP-NW under the jurisdiction of the OEBB.

1. **Meaningful Use of Electronic Medical Records; Health Information Exchange.** Provider shall make reasonable efforts to adopt and demonstrate the use of certified Electronic Medical Records. [OEBB Exh. E, Part VI, Sec. 5.]

2. **Leap Frog.** If Provider is a hospital, Provider shall make best efforts to participate in the Leap Frog Hospital Survey. [OEBB Exh. E, Part VI, Sec. 3; Exh. I, Sec. 3, 3-b.]

3. **"Baby Friendly" Certification.** If Provider is a birthing hospital, it shall make best efforts to pursue "Baby Friendly" Certification. [OEBB Exh. E, Part VI, Sec. 12.]