First Choice Health™

Healthy Employees. Healthy Companies.℠

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First Choice Health Network

Preferred Provider/Group Agreement

This Agreement is entered into between First Choice Health Network, Inc., a Washington corporation, ("FCHN, Inc.") and First Choice Health Network of Oregon, Inc., an Oregon corporation, ("FCHN, Oregon") on one hand, and CENTRIA HEALTHCARE, LLC (hereinafter "Provider") on the other hand. The effective date of this Agreement is _____ ("Effective Date" to be completed by FCHN). FCHN, Inc. and FCHN, Oregon are collectively referred to herein as "FCHN".

In consideration of the mutual promises and covenants set forth herein, FCHN and Provider agree as follows:

1. DEFINITIONS

1.1 **Agreement** means this Preferred Provider Agreement for health services between FCHN and the Provider/Provider Group and any Amendments, Schedules and Exhibits hereto.

1.2 **Benefit Plan** means a program offered by or administered by a Payor for the payment of Covered Services provided to an eligible Participant. Benefit Plans may be insured or self-insured, and shall not include discount medical plan programs defined as including, but not limited to, programs that do not include an element of insurance risk and/or prepaid medical services.

1.3 **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.

1.4 **Coinsurance** means a cost-sharing obligation that requires the Participants to pay a percentage of the cost of specified Covered Services.

1.5 **Co-payment** means the amount that a Participant is responsible to pay under a Benefit Plan at the time of service.

1.6 **Covered Services** means those specified Medically Necessary health care benefits and services which a Participant is eligible to receive under the Participant's Benefit Plan. Covered Services is further defined as services for which a Provider is entitled to receive payment pursuant to the terms of this Agreement and for which benefits have not been exhausted.

1.7 **Deductible** means the amount a Participant must pay for Covered Services each calendar or contract year before a Payor commences payment for Covered Services as defined under the applicable Benefit Plan.

1.8 **Emergency Medical Condition** means the emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson, acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the Participant's health in serious jeopardy.

1.9 **Medical Director** means the officer of FCHN, the Payor, or other party who is in charge of the applicable Medical Management Program for the Participant.

1.10 **Medical Management Program** means a program consisting of but not limited to authorization; concurrent medical review; primary case management; and a quality assurance program, with the objective to assure that health care services provided to Participants are Medically Necessary and delivered in an appropriate setting.

1.11 **Medical Necessity or Medically Necessary** means a medical service or medical supply, as determined by Medical Management, which meets all of the following criteria:

1. It is required for the treatment or diagnosis of a covered medical condition;
2. It is the most appropriate supply or level of service that is essential for the diagnosis or treatment of the Participant's covered medical condition;
3. It is known to be effective in improving health outcomes for the Participant's covered medical condition in accordance with sufficient scientific evidence and professionally recognized standards;
4. It is not furnished primarily for the convenience of the Participant or the provider of services; **and**
5. It represents the most economically efficient use of medical services and supplies that may be provided safely and effectively to the Participant.

Medical Necessity alone does not determine coverage.

1.12 **Participant** means any person who is eligible to receive Covered Services under the terms and conditions of a specific Benefit Plan.

1.13 **Participating Provider or Provider** means a physician or other provider licensed to provide health care services under applicable federal and/or state laws who has entered into a written agreement with FCHN to provide Covered Services to Participants.

1.14 **Payor** means employers, insurance companies, associations, trusts, third-party administrators (TPA) and any other legal entity which (i) has an obligation to administer and pay for Covered Services provided to a Participant under a Benefit Plan, and (ii) has entered into or is subject to a written agreement with FCHN.

1.15 **Primary Care Provider ("PCP")** means a Participating Provider who is an allopathic or osteopathic physician or other licensed healthcare provider, practicing in the field of general practice, family practice, general internal medicine or general pediatrics, who meets FCHN's credentialing standards, and under the terms of this Agreement, agrees to provide Covered Services to Participants within the scope of his/her license.

1.16 **Provider Group** means a clinic or group (i) comprised of health care professionals all of whom are licensed and/or certified under applicable federal and/or state laws and who bill as one entity, and (ii) which has contracted with FCHN to provide Covered Services to Participants.

1.17 **Provider Policies and Procedures** means those policies and procedures established by FCHN which set forth FCHN's and Payors' policies and procedures including, but not limited to, billing and claims payment, provider credentialing, participant grievances, utilization review, and quality management.

1.18 **Specialist Provider** means a Participating Provider who is an allopathic or osteopathic physician or other licensed healthcare provider who (i) practices in a particular specialty, (ii) is either Board certified or obtains Board certification within five (5) years after completing residency training, (iii) meets FCHN's credentialing standards, and (iv) under the terms of this Agreement, agrees to provide Covered Services to Participants within the scope of his or her license.

1.19 **Urgent Services** means Covered Services provided when a Participant not residing in FCHN's Service Area is temporarily absent from his or her area of residence and (i) such services are Medically Necessary and immediately required as a result of unforeseen illness, injury, or condition, and (ii) it was not reasonable given the circumstances for the Participant to obtain the services through a provider network in the Participant's area of residence.

1.20 **Utilization Review** means the prospective, concurrent, or retrospective assessment of the necessity and appropriateness of the allocation of health care resources and services of a provider or facility given or proposed to be given to a Participant.

2. RESPONSIBILITIES OF PROVIDER

2.1 Provide or Arrange for Covered Services

For each Participant, Provider shall provide, or arrange for the provision of Covered Services on a timely basis, without regard to health status or medical condition, and in accordance with generally accepted medical practice guidelines and standards pursuant to the terms of this Agreement, and in accordance with applicable FCHN Provider Policies and Procedures. Except in the case of an Emergency Medical Condition, Provider agrees to verify each Participant's eligibility prior to providing Covered Services. In the case of an Emergency Medical Condition, Provider will notify FCHN or the appropriate Payor of the provision of Medically Necessary services to treat a Participant's Emergency Medical Condition during the first business day immediately following the provision of such services.

Provider agrees to furnish Covered Services to each Participant on the same basis as such services are made available to individuals who are not Participants, and without regard to the Participant's enrollment in FCHN as a private purchaser or as a participant in publicly financed programs of health care services. In providing services under this Agreement, Provider shall exercise the degree of care, skill, and knowledge expected of a reasonably prudent health care provider and in a manner consistent with currently approved methods and practices in Provider's medical specialty. Provider shall exercise his or her own professional medical judgment, free of any direction or control by FCHN, and shall remain solely responsible for the quality of services rendered.

2.2 Accessibility and Hours of Service

Provider shall arrange for the provision of Covered Services to Participants during normal business hours at the usual places of business of Provider. Provider shall ensure that Provider arranges for and maintains call schedules that provide appropriate call coverage to Participants in the event Participants are unable to contact their Participating Providers.

2.3 Primary Care Providers (PCP's)

For Participants enrolled in Benefit Plans requiring a referral, PCP's are intended to be the patient's first source of care. PCPs are required to comply with any applicable Medical Management and Quality Improvement programs as outlined in Section 2.9. Some Participant Benefit Plans may require the PCP to facilitate Medically Necessary Specialist Provider referrals via an approved process. In those instances, Provider agrees to provide referrals in accordance with the approved process. If the type of specialist needed for a specific condition is not represented in the Participant's Benefit Plan's panel of Participating Providers, the PCP will facilitate a referral to a medically appropriate non-participating specialist.

2.4 Specialist Providers

Specialist Providers shall adhere to the degree of responsibility requested by the referring FCHN PCP. For Participants enrolled in Benefit Plans requiring referrals by a PCP, the Specialist Provider shall also communicate to the referring PCP regarding the Participant's evaluation and treatment plan. Specialist Providers are required to comply with any applicable Medical Management, Utilization Review, and Quality Improvement programs as described in Section 2.9. The Primary Care Provider, in conjunction with the Specialist Provider, shall decide whether follow-up care shall be provided by the Primary Care Provider or through continued specialty referral.

2.5 Benefit Plan Participation

Provider hereby authorizes Payors contracting with FCHN to offer Provider's services to groups of employees or individuals in accordance with the provisions of any Benefit Plans offered by such Payors. Provider's services are not offered in connection with motor vehicle insurance, personal injury protection, workers compensation, or any

other program for the payment of healthcare services that is excluded from the definition of a benefit plan under applicable law.

2.6 Licensing Requirements

At all times during the term of this Agreement, Provider, or if Provider is a Provider Group, all of the licensed healthcare providers comprising the Provider Group, shall possess and maintain in good standing all necessary licenses, certifications, registrations, permits, or other approvals required by State and/or Federal law to provide or arrange for the provision of Covered Services to Participants. Provider shall submit evidence of such licenses, certifications, registrations, permits, or other approvals to FCHN upon request.

Provider shall immediately notify FCHN, in writing, if any of the following events occur with respect to Provider, or in the case of a Provider Group, with respect to any licensed healthcare provider that is a member of the Group:

a. Provider's license or certification to practice his or her profession in any state is terminated, revoked, suspended, restricted or expires, or Provider or is disciplined by the action of any state professional agency having jurisdiction or authority over a Provider;

b. Provider changes his or her scope of practice or does not obtain or maintain the Board certification required by this Agreement;

c. Provider's medical staff or other clinical privileges at any hospital, surgery center, or other facility are denied, terminated, suspended, restricted, revoked, or not renewed, or Provider ceases to be a fully qualified member of such a medical staff;

d. Provider suffers from physical or mental impairments which would significantly impair Provider's ability to carry out the responsibilities under this Agreement or may pose a risk of harm to patients;

e. Provider is or becomes excluded, terminated, or otherwise ineligible to bill one or more government healthcare programs; or

f. Provider is convicted of a crime related to healthcare.

2.7 Demographic Changes

Provider shall notify FCHN in advance of any demographic updates including, but not limited to, change of business address, billing address, practice locations, tax identification number, phone numbers, roster of Participating Providers, NPI numbers, or other information reasonably needed for claims processing. Failure to provide advance notice of such changes may result in delayed, inaccurate, or non-payment of claims.

2.8 Insurance

Provider shall provide and maintain, at its sole cost and expense at all times during the term of this Agreement, policies of general comprehensive liability and professional liability insurance, or a program of self-insurance compliant with applicable state law, all with minimum limits acceptable to FCHN. Such policies shall insure against any claim or claims for damage arising by reason of personal injury or death occasioned directly or indirectly in connection with the acts or omissions of Provider and Provider's agents or employees related to services rendered pursuant to this Agreement. Provider agrees to maintain the above described insurance after the expiration or termination of this Agreement for the periods contained in the applicable statutes of limitation.

Provider shall notify FCHN immediately but no more than two (2) business days from notification of any revocation, reduction in coverage, or termination of any such policy. Upon request, Provider shall provide FCHN with evidence of compliance with this insurance requirement in the form of a certificate of insurance or evidence of self-insurance in an amount and form acceptable to FCHN.

The provisions of this Section shall survive expiration or termination of this Agreement.

2.9 Medical Management, Utilization Review and Quality Improvement

Provider agrees to comply with and participate in FCHN's or Payors' Medical Management, Utilization Review, and quality improvement programs and requirements, whichever is applicable, which may include but are not limited to, pre-authorization, notification, concurrent review, retrospective review, case management, disease

management programs, pharmacy and specialty pharmacy programs, referral management, quality assurance and improvement programs and Medical Necessity oversight.

Provider further agrees to share Participant information as specifically related to the Medical Management Program and utilization management functions described above. Provider is required to allow access to Participant records, provide for copying and release of records, and to speak to the FCHN or Payor Medical Director or designee upon request, as allowed by applicable law and regulation, in a timely manner to facilitate the Medical Management and utilization review programs.

2.10 Subcontracts

If Provider subcontracts with any other provider to provide Covered Services to Participants hereunder, Provider understands and agrees that the subcontract and the subcontracting provider must comply with all terms of this Agreement and applicable state law and regulation.

2.11 Non-Covered Services/Exclusions

Provider shall provide notice to Participant of Participant's personal financial obligations for non-covered services, which includes services that are not Medically Necessary. Provider may bill a Participant for non-covered services only if Provider has, prior to the provision of non-covered services, obtained a written acknowledgment and acceptance of financial responsibility for such services from the Participant after full disclosure to Participant of (i) Provider's intent to bill Participant for non-covered services, and (ii) the non-liability of FCHN or Payors for such non-covered services.

2.12 FCHN Provider Policies and Procedures

Providers shall comply with all Provider Policies and Procedures, as updated with sixty (60) days advance notice to Provider, or if applicable, the notice described in Section 3.2 below, including, but not limited to, billing and claims payment, provider credentialing, Participant grievances, Utilization Review, and quality management. Subject to any continuation of care provisions of this Agreement, Provider may terminate this Agreement in accordance with Section 8.2.1 if Provider does not agree with such updates. In the event that any provision in the Provider Policies and Procedures or any amendment thereto is inconsistent with the terms of this Agreement, the terms of this Agreement shall control.

2.13 Claims Payment

Provider shall look only to Payors for payment of claims. FCHN is not a guarantor of, or in any way responsible to Provider for, any claim payments.

2.14 Acceptance of Payment

Provider shall accept payment for Covered Services as outlined in Schedule B to this Agreement. Provider shall have the right to bill, charge, or collect a deposit directly from the Participant for any applicable Deductible, Co-payment, or Coinsurance, or, consistent with Section 2.11, for any service that is not a Covered Service. In no event may Provider bill or collect from Participants any difference between Provider's charges and the amount of the FCHN fee schedule for Covered Services set forth in Schedule B.

2.15 Compliance

Provider agrees to comply with all of the terms of this Agreement, all applicable federal and state laws and regulations, all applicable rules and standards of accrediting agencies having jurisdiction over and designated by FCHN, and as applicable, the ethical standards of the American Medical Association, all of the above as they may be adopted, amended, revised, or renumbered.

2.16 Provider Group

Where Provider is a Provider Group, Provider agrees to ensure that the licensed physicians and other healthcare providers comprising the Provider Group are informed of, and agree to comply with and be bound by, the terms of this Agreement.

3. RESPONSIBILITIES OF FCHN

3.1 Payment for Covered Services

FCHN shall require all Payors contracting with it to pay Provider for Covered Services rendered to Participants in accordance with Section 4, Claims Submission and Payment, of this Agreement.

3.2 Provider Relations

FCHN shall provide Provider with certain administrative support including, but not limited to Provider orientation and ongoing education. FCHN agrees to furnish Provider electronic access to the FCHN Provider Policies and Procedures setting forth its policies on billing and claims payment, provider credentialing, Participant grievances, Utilization Review, and quality management. FCHN shall notify Provider at least sixty (60) days prior to the effective date of changes to policies or procedures that affect Provider compensation or 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. Provider may terminate this Agreement pursuant to Section 8.2.1 and subject to continuation of care provisions in Section 8.3 without penalty if Provider does not agree with such changes. FCHN shall review and give consideration to any Provider comments received prior to the effective date of any change.

3.3 Provider Directories and Promotion

FCHN agrees to include Provider in appropriate provider directories or website listings. In the event this Agreement is terminated, or the directory listing is incorrect or incomplete, FCHN shall update the listing and correct such errors when a new directory is published.

Provider shall not advertise or otherwise market Provider's status as a Participating Provider without FCHN's prior written approval of the form and content of such advertising or marketing, including the use by Provider of any names, logos, trademarks, service marks, copyrighted material, domain names, symbols, or other intellectual property of FCHN or a Payor. The foregoing shall not prevent Provider from using FCHN's name, during the term of this Agreement, to list Provider's participation with FCHN on Provider's website or in printed informational materials in a manner consistent with listings of other payors, networks, or managed care plans with which Provider participates. Provider shall discontinue any such usage of FCHN's name and any advertising or marketing related to FCHN and Payors immediately upon termination of this Agreement.

3.4 Liability Insurance

FCHN, at its sole cost and expense, shall procure and maintain such policies of general liability and professional liability insurance as it shall deem necessary to insure it against any claim arising from the performance or non-performance of its duties under this Agreement. To the extent possible, FCHN shall provide Provider with not less than fifteen (15) days advance written notice of any cancellation, expiration, reduction or other material change in the amount or scope of such insurance. FCHN shall provide evidence of compliance with this insurance requirement upon request by Provider.

3.5 Eligibility

FCHN shall require all Payors contracting with it to provide timely information on a Participant's eligibility for Covered Services upon request by Provider. FCHN shall require that during ordinary business hours, FCHN Payors shall assure reasonable access, through standard means of communication, or with respect to Payors doing in business in Oregon, using electronic transactions as required by applicable law, for the confirmation that services are Covered Services and a Participant is eligible under a Benefit Plan.

3.6 Provider's Right to Inform Patients

FCHN shall not in any way preclude or discourage Provider from informing Participants of the care they require, including various treatment options, and whether in Provider's view such care is consistent with Medical Necessity, medical appropriateness, or otherwise covered by the Participant's Benefit Plan, nor prohibit, discourage, or penalize a Provider otherwise practicing in compliance with the law from advocating on behalf of a Participant with FCHN or a Payor. Nothing in this Agreement shall be construed to authorize Provider to bind FCHN or its Payors to pay for any services.

FCHN may not preclude or discourage Participants or those paying for their coverage from discussing the comparative merits of different health carriers with their Providers. This prohibition specifically includes prohibiting or limiting Providers participating in those discussions even if critical of FCHN or its Payors.

3.7 Provider's Right to Report to Federal or State Authorities

FCHN shall not penalize a Participating Provider because the Provider, in good faith, reports to State or Federal authorities any act or practice by FCHN or its Payors that jeopardizes patient health or welfare, or that may violate State or Federal law.

3.8 Participants' Contracting for Services Outside of Benefit Plan

Notwithstanding any other provision of law, FCHN may not prohibit directly or indirectly Participants from freely contracting at any time to obtain any health care services outside FCHN on any terms or conditions the Participants choose. Nothing in this provision shall be construed to bind FCHN or Payors for any services delivered outside of a Participant's Benefit Plan.

FCHN expressly disclaims any and all responsibility on the part of FCHN and Payors for (i) the delivery of health care services pursuant to any contract to which FCHN or the Payor respectively is not a party or which are outside the terms of any Benefit Plan, and (ii) the payment of charges for such services. Provider agrees to look only to the Participant for payment of charges for such services.

3.9 ID Cards

FCHN shall require its Payors to provide each Participant with a Benefit Plan membership identification card displaying the First Choice Health logo, the Participant's name and identifier, group name and/or number, telephone number to confirm eligibility and benefit verification, any applicable Co-payment due at time of service, and utilization management vendor name and telephone number to confirm necessary pre-authorization for services.

Provider is obligated to accept any individual as a Participant:

a) when the First Choice Health logo appears on the individual's membership identification card,

b) where the Payor is identified as accessing the FCHN PPO Network on the FCHN website or Payor listing, and/or

c) in cases where the Participant of a FCHN Payor has an Emergency Medical Condition and/or requires Urgent Services and is traveling or out-of-area and does not have a FCHN logo.

3.10 List of Payors

FCHN shall provide Provider with access to a list of Payors, including employer groups, at the time of entering into this Agreement. This list shall be maintained and posted on the FCHN web site.

3.11 Explanation of Payment/Remittance Advice

FCHN shall ensure that Payors produce an Explanation of Payment (EOP) or Remittance Advice (RA) during the claim adjudication process which must, at a minimum, identify: FCHN, total billed charges, allowed amount in accordance with FCHN fee schedules, the amount the Payor is responsible to pay, the amount the Participant is responsible to pay, and an explanation for non-payment of a particular code or service. Provider may refuse to give the Payor the benefit of FCHN's fee schedule if the EOP/RA does not display minimum data elements and the FCHN names and/or logo.

4. CLAIMS SUBMISSION AND PAYMENT

4.1 Claims Submission

Provider agrees to submit Clean Claims for Covered Services rendered to Participants on standard UB-04 and CMS-1500 forms, or successors to such forms. Completed UB-04 and CMS-1500 forms shall be submitted electronically or to the address set forth on the Participant's Benefit Plan identification card. Provider agrees to bill its usual and customary charges for the services rendered, to properly and accurately complete all required Provider, Participant, service, and procedure information on the claim form, and to accept payment in full as described in Section 2.14 of this Agreement. In submitting claims pursuant to this Section, Provider shall certify that all data submitted is accurate and truthful.

4.1.1 Claims shall be submitted at the earliest possible date after the date Covered Services are rendered.

4.1.2 Payors shall be under no obligation to pay a claim if FCHN or the Payor receives the claim more than three-hundred-sixty-five (365) calendar days after the date the Covered Service was rendered, or sixty (60) calendar days after Provider first receives notice that Payor is a secondary payor under applicable coordination of benefits procedures, whichever shall be later.

4.1.3 Provider may submit, within the timely filing period described in Section 4.1.2 above, corrections to claims that were submitted with incomplete or invalid information. Incomplete means that information was missing from the claim, and invalid means that the information submitted was illogical, incorrect, or did not conform to the required claim format. Payors shall have no obligation to pay corrected claims received by FCHN or any Payor more than three hundred sixty-five (365) calendar days after the date the Covered Service was rendered, or sixty (60) calendar days after Provider first receives notice that Payor is a secondary payor under applicable coordination of benefits procedures, whichever shall be later.

4.1.4 Provider agrees that requests for adjustments to claims that have been paid or denied, where the claim submittal failed to include a particular item or service or was otherwise in error, must be received by Payors within three hundred sixty-five (365) calendar days after the date the claim was denied or an initial payment was made for the claim. Payors shall be under no obligation to make payments for claims adjustment requests received after such time. Provider shall be under no obligation to refund incorrect claims payments requested by Payors or FCHN more than three hundred sixty-five (365) calendar days after the date an initial payment was made for the claim.

4.2 Payment of Claims

FCHN shall require all Payors to pay Provider pursuant to Schedule B of this Agreement, as soon as practical, subject to the following minimum standards:

4.2.1 Ninety-five percent (95%) of the monthly volume of clean claims shall be paid within thirty (30) days of receipt; and

4.2.2 Ninety-five percent (95%) of the monthly volume of all claims shall be paid or denied within sixty (60) days of receipt, except as agreed to in writing by the parties on a claim-by-claim basis.

4.2.3 The receipt date of a claim is the date Payor receives either written or electronic notice of the claim.

4.2.4 Claims may be subject to code review software or correct coding edits. FCHN will request that Payors inform FCHN of code review or correct coding software and most frequent claims editing issues for FCHN as needed to facilitate Provider education and training.

FCHN is not the guarantor of, or in any way responsible to Providers for, any claims payments, including charges and interest due if applicable. FCHN shall meet with Provider as needed to review claims status of FCHN Payors and to assist Provider in collecting payments due and owing from any such Payor as determined by FCHN to be appropriate.

These standards do not apply to claims about which there is substantial evidence of fraud or misrepresentation by Provider or Participants, or instances where the Payor has not been granted reasonable access to information under the Provider's control.

4.3 Coordination of Benefits and Third Party Liability

Provider agrees to cooperate with Payors' coordination of benefits (COB) and third party liability policies and programs.

When Payor's Benefit Plan is primary, Provider shall accept payment of the amount for the Covered Services on the FCHN fee schedule set forth in Schedule B to this Agreement as payment in full from Payor, subject to Provider's right to collect Co-payments, Deductibles, Coinsurance and payments for non-covered services from the Participant. When Payor's Benefit Plan is secondary, Provider shall first look to and promptly bill and take

reasonable steps to collect payment from the primary plan. Provider may seek additional payment from a Payor whose Benefit Plan is secondary in accordance with this Agreement and applicable laws regarding COB; provided however that in no event shall a Payor be obligated to pay more than 100 percent of the amount on FCHN fee schedule set forth in Schedule B to this Agreement and in no event shall Provider be entitled to total compensation exceeding 100 percent of its billed charges.

When a Payor has a self-funded Benefit Plan, COB is determined by the Benefit Plan and is not subject to state insurance laws. A self-funded Benefit Plan may only be required to pay up to the primary payor's allowable expense depending on the terms of its COB provision. Provider has the right to request a copy of the Payor's documented COB and third party liability policies and programs.

If Provider receives payment from another plan which is primary under COB, and that payment is equal to or greater than the contracted rates set forth in this Agreement, Provider agrees to not seek additional reimbursement from Payor or to promptly refund any amounts already paid to Provider by Payor.

5. MAINTENANCE OF RECORDS, INSPECTION AND AUDIT

5.1 Maintenance of Records

Provider shall prepare and maintain all appropriate medical, administrative and financial records for each Participant who receives services from Provider. Such records shall be maintained in such form and manner as is required by law and generally accepted medical practice and professional ethics.

FCHN shall have the right to request, inspect and audit any and all records of Provider related to a Participant as permitted by law, and as may be necessary for FCHN or a Payor to perform its obligations under this Agreement. Where documents are requested by FCHN or a Payor for audit, accreditation and/or oversight review purposes, FCHN or the Payor shall reimburse Provider for reasonable costs incurred in providing copies of requested documents, not to exceed a rate of twenty-five cents ($.25) per page. FCHN or Payor shall not reimburse Provider for copies of documents requested for purposes of payment of claims, resolution of quality of care or service concerns, complaints and/or grievances, or Medical Management review and coverage determinations.

Provider shall have the right to request, inspect and audit any and all records of FCHN or Payor directly related to a Participant as permitted by law, and as may be necessary for Provider to perform its obligations under this Agreement.

5.2 Record Retention

Both parties shall retain all records relating to this Agreement for a minimum of seven (7) years.

5.3 External Audits

Both parties agree to cooperate with any external audits mandated by state or federal law, and shall make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of Participants, subject to applicable state and federal laws related to the confidentiality of medical records.

5.4 Claims Audit

Provider agrees that Payor will have the right to audit Provider's claims for Medical Necessity and/or review of Covered Services billed, including documentation and coding of such services. FCHN will require that the auditing Payor agree to be responsible for reimbursing Provider for any reasonable expenses incurred for an on-site audit. In all cases, FCHN will make commercially reasonable best efforts to facilitate the timely resolution of Payor audits.

5.4.1 With respect to audits for Covered Services billed, if no resolution occurs within 60 days after initiation of the audit, FCHN will direct the Payor to pay for such services, subject to Payor's right to recoup, pursuant to Section 4.1.4, the amounts corresponding to any charges later determined to be inappropriate or not payable.

5.4.2 With respect to Payor audits of claims for Medical Necessity, if no resolution occurs within 60 days after initiation of the audit, FCHN will direct the Payor to pay for such charges as are not in dispute.

5.4.3 With respect to any audit not resolved within 60 days after initiation, upon expiration of the 60 day period, either (i) the Payor and Provider may by mutual agreement continue to work with FCHN and each other toward resolution of the dispute using an informal good faith process or (ii) either of Payor or Provider may elect to resolve the matter pursuant to Section 9, Dispute Resolution, of this Agreement. Notwithstanding an election to resolve the dispute by way of an informal good faith process, either party may, at any time thereafter, seek resolution of the matter pursuant to the Dispute Resolution provisions of this Agreement.

6. CONFIDENTIAL AND PROPRIETARY INFORMATION

6.1 Information Relating to this Agreement

The existence of this Agreement is not considered to be confidential information. However, FCHN and Provider each agrees that it shall not, and shall ensure that its personnel do not, whether during or after the term of this Agreement, use, disclose, or communicate, orally or in writing or in electronic form, to any person or entity, other than in the proper performance of this Agreement, any Confidential Information, without the prior written consent of the other party. Nor shall FCHN or Provider, or their respective personnel permit any person to use, examine, or make copies of any documents, files, data or other information that contain or are derived from Confidential Information. For purposes of this Agreement, "Confidential Information" means any and all information of FCHN, Provider, or a Payor that is not generally available to the public, including, but not limited to, fee schedules, reimbursement rates, the business, strategic, financial, operations, or planning information of FCHN, Provider, or a Payor, and any other information identified by either party to this Agreement as confidential.

This provision shall not preclude access to information and records reasonably needed to perform either party's obligations under this Agreement, including the audits, Medical Management Program, and access afforded to Payors with respect to Covered Services delivered pursuant to this Agreement. In addition, the covenants of this provision shall not restrict disclosure required by law, court order, or other judicial process.

6.2 Participant Health Information

FCHN and Provider acknowledge that as a result of this Agreement, each party may have access to and receive from one another, individually identifiable health information ("Health Information") as that term is defined under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and applicable state law. Each party to this Agreement shall ensure that it and its personnel maintain confidentiality of all patient records, charts and other patient identifying information in accordance with HIPAA and applicable state law, and that it and its personnel implement and use appropriate safeguards to prevent any unauthorized use or unlawful disclosure of Protected Health Information ("PHI"), take appropriate action to ensure that other persons appropriately safeguard and use PHI, report any known improper disclosure or use of PHI, and return or destroy all PHI upon the termination of this Agreement for any reason. The parties will enter into FCHN's standard Business Associate Agreement set forth in Schedule A to this Agreement effective as of the Effective Date of this Agreement.

6.3 Effect of Termination

FCHN and Provider understand and agree that the requirements of this Section 6 shall survive the expiration or termination of this Agreement.

7. INDEMNIFICATION

To the extent consistent with applicable state law, FCHN and Provider (each an "Indemnifying Party") shall defend, indemnify, and hold the other party and its officers, directors, shareholders, members, employees, and agents (the "Indemnified Party") harmless from and against any and all liabilities and losses, together with any costs and expenses, including, but not limited to reasonable attorney's fees and costs (collectively, "Damages") arising from claims asserted by a third party as a result of the Indemnifying Party's, or its officers', directors', shareholders', members', employees', or agents' actual or alleged (i) negligent acts or omissions, (ii) intentional or wrongful acts or omissions, or (iii) breach or failure of

performance under this Agreement. To the extent consistent with applicable state law, Damages shall not include any amount resulting from the Indemnified Party's (i) negligent acts or omissions, (ii) intentional or wrongful acts or omissions, or (iii) breach or failure of performance under this Agreement. The indemnification obligations set forth in this Section 7 shall survive the expiration or termination of this Agreement.

8. TERM AND TERMINATION

8.1 Term of Agreement

This Agreement shall take effect on the Effective Date first set forth above and shall expire on December 31 of the year in which the Effective Date falls. On January 1 of the following year and of each year thereafter, this Agreement shall automatically renew for successive one (1) year terms unless terminated in accordance with the terms of this Agreement.

8.2 Termination

8.2.1 Termination Without Cause

Either party may terminate this Agreement without cause or penalty, by giving ninety (90) days prior written notice to the other party.

8.2.2 Termination by FCHN

FCHN may immediately terminate this Agreement with respect to any individual Provider upon the failure of Provider to meet any of the FCHN credentialing and recredentialing standards and criteria, including the occurrence of any of the events identified in (i) FCHN's Credentialing and Recredentialing Policies and Procedures, and (ii) FCHN's Criteria for Provider Denial or Termination. Written notice of such action shall be given to Provider by FCHN as provided for in such policies and procedures and shall specify the effective date of termination.

8.2.3 Termination for Cause

Except as otherwise set forth in Section 8.2.2 above, either party may terminate this Agreement for cause by giving the other party sixty (60) days prior written notice if the receiving party materially breaches any of the terms of this Agreement or fails to fulfill its obligations hereunder. Such notice shall specify the reasons for the termination and shall provide the breaching party opportunity to correct the cause to the reasonable satisfaction of the non-breaching party. Should the cause not be cured within this sixty (60) day period, this Agreement shall terminate on the last day of such period.

8.3 Effect of Termination – Continuation of Care

This Agreement shall be of no further force or effect as of the effective date of termination except that:

8.3.1 FCHN shall require that Payors pay to Provider any payments accrued to Provider for Covered Services rendered prior to the effective date of termination and properly billed to Payors within the time required under this Agreement.

8.3.2 Provider shall not seek compensation from the Participant for any Covered Services provided under the terms of this Agreement prior to the effective date of termination, except for any applicable Deductible, Co-payment, or Coinsurance amounts, as specified in Section 2.14 of this Agreement.

8.3.3 Provider shall continue the treatment of Participants who were receiving care in an inpatient facility at the time this Agreement terminated, until one of the following events occurs: (i) the Participant is discharged from the facility, (ii) the FCHN or Payor's Medical Director determines that the care of the Participant can be safely transferred to another facility, or (iii) Payor makes arrangements to transfer the Participant's care to another Participating Provider.

8.3.4 FCHN shall require Payor to cover Covered Services of a Primary Care Provider whose agreement with FCHN is terminated by FCHN without cause under the terms of this Agreement for at least sixty (60) days following notice of termination to the Participants or, in group coverage arrangements involving

periods of open enrollment, only until the end of the next open enrollment period. The Provider's relationship with FCHN or Payor must be continued on the same terms and conditions as those of the agreement FCHN is terminating, except for any provision requiring that Payor assign new enrollees to the terminated Provider.

8.4 Notice to Participants

If this Agreement is terminated, FCHN shall require Payors to make a good faith effort to provide written notice of the termination to all Participants who are patients seen on a regular basis by Provider within fifteen (15) working days of receipt or issuance of the notice of termination, irrespective of whether the termination was for cause or without cause. If Provider is a PCP, FCHN shall require Payors to make a good faith effort to assure that notice is provided to all Participants who are patients of Provider.

9. DISPUTE RESOLUTION

9.1 Dispute Resolution Process

Except as otherwise provided in Section 9.2, the following dispute resolution process will be used to resolve disputes between Provider and FCHN as well as disputes between Provider and Payors.

9.1.1 Informal Process

Disputes between Provider and FCHN with regard to performance by either party under this Agreement, including questions regarding existence, enforceability, interpretation, or validity of this Agreement, shall be resolved, to the extent possible, by informal meetings and discussions between Provider and FCHN.

Provider shall promptly notify FCHN of any failure by a Payor to pay Provider in accordance with the requirements of Section 4.2 of this Agreement, to provide information regarding Participant eligibility and benefit confirmation, to provide any other information required under the terms of this Agreement, or of any disagreement with a determination of Medical Necessity made pursuant to Provider's billing for Covered Services pursuant to this Agreement. Disputes related to the foregoing issues, as well as other disputes between Provider and Payors regarding performance under this Agreement shall be resolved, to the extent possible, by informal meetings and discussions between Provider and the Payor.

9.1.2 Formal Process

Where either (i) Provider or FCHN, in the case of a dispute between them, or (ii) Provider or a Payor, in the case of a dispute between them, desires to pursue resolution of a dispute beyond such informal meetings and discussions, either party to the dispute in question may provide the other party to the dispute with written notice, describing the nature of the dispute and the proposed resolution with reasonable particularity, and requesting a response within thirty (30) days after receipt of the notice, or if the dispute involves a billing dispute, within sixty (60) days after receipt of the notice. If the party in receipt of a notice of dispute fails to respond in writing within the above described timeframes or responds in writing disagreeing with the proposed resolution within such timeframes, the party giving notice of the dispute may request mediation of the dispute as set forth below.

9.1.3 Nonbinding Mediation

Any party giving notice of a dispute which is not resolved pursuant to Section 9.1.2 may submit the dispute to nonbinding mediation. After either party to the dispute gives the other a notice of election to mediate, the parties to the dispute will confer and appoint a mutually acceptable mediator. If the parties are unable to agree upon the selection of a mediator within five (5) days after notice of election to mediate is given, they shall jointly petition to the Presiding Judge of a state court of competent jurisdiction to appoint a mediator. Mediation shall be conducted pursuant to the mediation rules and procedures of the mediator as consistent with applicable state law, or according to any other rules of mediation agreed to by the parties. Following selection, the mediator shall schedule a mediation conference with the parties, the duration of which shall be one day, or such longer period as the parties to the dispute may agree. Unless otherwise agreed, the mediation conference shall be held within twenty (20) days after appointment of the mediator. The place of mediation shall be a location mutually agreed upon by the parties to the dispute; however, if the parties cannot agree, the mediation will be

held in Seattle, Washington. The fees and expenses of the mediator shall be borne equally by the parties to the dispute. Each party shall be responsible for its own costs and expenses incurred in connection with the mediation.

9.1.4 Other Remedies

In the event the parties to a dispute cannot resolve the dispute through nonbinding mediation, either party may pursue judicial remedy in a court of competent jurisdiction. The parties agree to exhaust the dispute resolution process set forth in Sections 9.1.1, 9.1.2, and 9.1.3 above before pursuing judicial remedies, however by mutual consent the parties may agree to forego non-binding mediation and proceed directly to a judicial remedy. The parties consent to the jurisdiction of the Superior Court of the State of Washington, King County, and the United States District Court for the Western District of Washington, for all purposes in connection with this Agreement.

9.2 Provider Disputes Involving Participant Benefit Claims

Disputes between Provider and a Payor with a Benefit Plan subject to the Employee Retirement Income Security Act of 1974 (ERISA) and not "grandfathered" under the Patient Protection and Affordable Care Act (PPACA) about an adverse benefit determination as defined in applicable regulations implementing PPACA shall be handled in accordance with ERISA and PPACA, and applicable implementing regulations, under the Payor's reasonable claim procedure and internal and external review process. Disputes between Provider and a Payor with a fully insured Benefit Plan not "grandfathered" under PPACA about an adverse benefit determination shall be handled in accordance with PPACA, applicable implementing regulations, and applicable state law and regulations, including an internal grievance procedure of the Payor and an external review process.

9.3 No Effect on Right of Termination

The provisions of this Section 9 shall not affect either party's right to terminate this Agreement as provided for under Section 8.2 of this Agreement.

10. GENERAL PROVISIONS

10.1 State Regulated Payors. With respect to any Payor that is subject to the state insurance laws and regulations, the provisions set forth in Schedule C, attached hereto and incorporated into this Agreement, are fully operative and applicable to FCHN, Provider, and the respective Payors. In the event of any conflict between the provisions set forth in Schedule C and the other terms of this Agreement, the applicable Schedule shall have priority. If Provider provides Covered Services to Participants enrolled in Benefit Plans offered or administered by Payors subject to state insurance laws and regulations of states other than as referenced in Schedule C, the corresponding specific state Schedules posted on the FCHN website or otherwise made available to Provider are added to the Agreement and apply to Provider with respect to such Payors, and Provider agrees to comply with the applicable Schedules.

10.2 Amendments to Comply with Law

In the event that either party to this Agreement in good faith and upon advice of legal counsel determines that this Agreement or any practices which are or could be employed in performing under this Agreement are inconsistent with or do not satisfy the requirements of any applicable state or federal laws or regulations, the parties in good faith shall undertake to amend this Agreement to comply with such laws and regulations. In the event the parties are not able to agree upon the revised terms in a timely manner, either party may terminate this Agreement immediately by giving written notice of termination to the other.

10.3 Independent Contractors

Each party to this Agreement shall be acting as an independent contractor. Provider shall not be construed to be an employee of FCHN and will at all times be acting and performing hereunder as an independent contractor practicing the profession of medicine or the providing other licensed healthcare services. None of the provisions of this Agreement are intended to create nor shall they be deemed or construed to create a partnership or joint venture, or any relationship between the parties hereto other than that of independent entities contracting with each other solely for the purpose of effecting the provisions of this Agreement. Neither party shall, by entering into this Agreement, authorize the other party to act as a general or special agent of such other party in any respect, except as expressly set forth in this Agreement, and neither party shall become liable for any of the

obligations or debts of the other. Provider is not entitled to any of FCHN's employment benefits, such as vacation, sick leave with pay, paid days off, health insurance, life insurance, accident insurance, or severance pay during or upon termination of this Agreement.

10.4 Notice

Any notice or other communication given pursuant to this Agreement shall be in writing and shall be deemed to have been duly given when delivered personally, by courier with delivery receipt, sent by facsimile (with confirmation of receipt), or when mailed by United States mail, postage prepaid, to FCHN, Inc. at 600 University Street, Suite 1400, Seattle, WA 98101, fax (206) 667-8062, and to Provider at Provider's then current address of record and fax number on file with FCHN, or to such other address as either party may specify by notice to the other party as set forth in this provision.

10.5 Amendment

This Agreement may be amended from time to time by FCHN, by providing Provider sixty (60) days advance written notice of the amendment. If Provider objects to the amendment, Provider must so advise FCHN in writing within thirty (30) days after receipt of the amendment. If FCHN receives no written objection from Provider to the amendment within the time described above, the amendment will become effective at the end of the sixty (60) day period. If FCHN does receive from Provider a written objection to the amendment within the time described above, FCHN may, at its sole option, withdraw the amendment, and FCHN will notify Provider in writing whether or not the amendment is withdrawn. If FCHN withdraws the amendment, this Agreement will continue in force without any effect of the amendment. If FCHN notifies Provider that the amendment is not withdrawn, then the amendment shall become effective at the end of the sixty (60) day period. If, following notice of non-withdrawal from FCHN, Provider continues to object to the amendment, Provider may terminate this Agreement as outlined in Section 8.2.3.

10.6 Severability/Conformity with Law

In the event any provision of this Agreement is rendered invalid or unenforceable by any State or Federal law or regulation, or declared null and void by any court of competent jurisdiction, the remaining provisions of this Agreement shall remain in full force and effect to the fullest extent possible consistent with the intent and purpose of this Agreement, unless the severance of any such provision substantially impairs the benefits of the remaining provisions of this Agreement. This Agreement shall be interpreted, and if necessary, amended, to conform to applicable federal and state law in effect on or after the Agreement's effective date.

10.7 Entire Agreement

This Agreement, including the attachments hereto and any documents incorporated herein by reference, constitutes the entire agreement between the parties with respect to the subject matter of this Agreement and supersedes all prior arrangements and negotiations between the parties, written or oral, express or implied.

10.8 Waiver

Neither the failure nor delay on the part of either party to exercise any right under this Agreement shall serve as a waiver of that right. A waiver of any provision of this Agreement must be in writing and signed by the party making such waiver. If either party should waive a breach of any provision of this Agreement, it shall not be deemed or construed as a waiver of any other breach of the same or different provision.

10.9 Applicable Law

This Agreement shall be interpreted, enforced, and governed in accordance with the laws of the State of Washington, notwithstanding any conflict of law doctrine to the contrary. Venue for any action or proceeding shall lie in King County, Washington.

10.10 Medical Care

It is hereby understood that Provider is solely responsible for all decisions and liability regarding Provider's medical care and treatment of Participants. It is also agreed that the traditional relationship between Provider and patient shall in no way be affected by or interfered with by any of the terms of this Agreement. Provider understands that any financial determinations made by FCHN or the Payors and any determinations made in connection with utilization review are solely for purposes of determining whether services are Covered Services under the terms of a Benefit Plan as defined in this Agreement and the extent to which payments may be made by

Payors for such services. Accordingly, such determinations shall in no way affect the responsibility of Provider to provide appropriate services to Participants.

10.11 Nondiscrimination
Provider agrees not to discriminate against Participants and to render services without regard to race, sex, marital status, sexual orientation, religion, national origin, color, age, physical or mental handicap, veteran status, or any other basis upon which discrimination is prohibited under applicable law or regulation.

10.12 Assignment
Neither FCHN nor Provider shall assign this Agreement without the express prior written consent of the other, except that FCHN may assign this Agreement to a successor entity, or to any entity succeeding to the rights and obligations of FCHN by operation of law, all without the prior consent of Provider.

10.13 Force Majeure
Neither party shall be considered in breach of this Agreement for any failure or delay in performance hereunder if the failure or delay is occasioned by an act of God, act of a governmental authority, or by any other emergency beyond the reasonable control of the party whose performance is affected, including but not limited to acts of terrorism, war, natural disaster, or the result of a strike, lockout, or other labor dispute.

10.14 Attorneys' Fees
Except as otherwise set forth in Section 9 of this Agreement, in any suit, action, or proceeding between the parties relating to or arising from this Agreement, the prevailing party shall be entitled to recover reasonable attorneys' fees, costs, and other expenses, including fees and expenses incurred on any appeal and in any bankruptcy proceeding, in addition to whatever other relief may be awarded .

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed by their authorized representatives as of the date first set forth above.

First Choice Health Network, Inc.
Address: 600 University Street, Suite 1400
Seattle, WA 98101

Signature: _____
By: Kenneth Hamm
Title: President & CEO

CENTRIA HEALTHCARE, LLC
Address: 41521 West 11 Mile Rd
Novi, MI 48375

Signature: _____
By: Alicia Decker
Title: VP of Autism Services

TIN: 27-1402749

First Choice Health Network of Oregon, Inc.
Address: 11000 SW Stratus Street, Suite 325
Beaverton, Oregon 97008

Signature: _____
By: Kenneth Hamm
Title: President & CEO

CENTRIA HEALTHCARE, LLC

Signature: _____
By: Alicia Decker
Title: VP of Autism Services

SCHEDULE A
Business Associate Agreement

This Business Associate Agreement ("Agreement") is made and entered into by and between CENTRIA HEALTHCARE, LLC, ("Covered Entity" or "CE"), and FCHN ("Business Associate" or "BA"). Covered Entity and Business Associate may be referred to individually as a "Party" and collectively as the "Parties".

Recitals

WHEREAS, CE and BA have entered into an agreement pursuant to which BA will provide certain services to or on behalf of CE, and BA may create, receive, maintain, transmit, or have access to Protected Health Information in order to provide those services ("Services Agreement");

WHEREAS, the Department of Health and Human Services ("HHS") has promulgated regulations at 45 Code of Federal Regulations ("C.F.R.") Parts 160 and 164 implementing the privacy requirements ("Privacy Rule") and regulations at 45 C.F.R. Parts 160, 162 and 164 implementing the security requirements ("Security Rule") set forth in the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA") as amended by regulations implementing Subtitle D of the Health Information Technology for Economic and Clinical Health Act which is Title XIII of the American Recovery and Reinvestment Act of 2009 (Public Law 111-5);

WHEREAS, the Privacy Rule and Security Rule require CE to enter into a written contract with BA in order to assure certain protections for the privacy and security of Protected Health Information, and the Privacy Rule and Security Rule prohibit the disclosure or use of Protected Health Information to or by BA if such a contract is not in place;

WHEREAS, both Parties mutually agree to satisfy the foregoing regulatory requirements and all federal, state and local confidentiality, privacy, and security laws through this Agreement;

NOW THEREFORE, in consideration of the foregoing and of the mutual promises contained herein, the receipt and sufficiency of which are hereby acknowledged, CE and BA agree as follows:

1. Definitions.
Terms used, but not otherwise defined in this Agreement shall have the same meaning as those terms in 45 C.F.R. Part 160, Part 162, and Part 164, then in effect or as amended, which are collectively referred to as the "HIPAA Rules".

1.1 **"Breach"** shall have the same meaning as the term "Breach" in 45 C.F.R. § 164.402.

1.2 **"Data Aggregation"** shall have the meaning given such term in 45 C.F.R. § 164.501.

1.3 **"Designated Record Set"** shall have the meaning given to such term in 45 C.F.R. § 164.501.

1.4 **"Disclose"** and **"Disclosure"** mean, with respect to Protected Health Information, the release, transfer, provision of, access to, or divulging in any other manner of Protected Health Information outside BA's internal operations or to persons or entities other than members of its workforce.

1.5 **"Electronic Protected Health Information" or "EPHI"** shall have the meaning found in the Security Rule, 45 C.F.R. § 160.103.

1.6 **"HITECH Act"** shall mean the Health Information Technology for Economic and Clinical Health Act, found in Title XIII of the American Recovery and Reinvestment Act of 2009, Public Law 111-005, and the regulations promulgated thereunder by the Secretary.

1.7 **"Individual"** shall have the same meaning found in 45 C.F.R. § 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R. § 164.502(g).

1.8 **"Protected Health Information" or "PHI"** shall have the same meaning as the term "protected health information" in 45 C.F.R. § 160.103, limited to the information created, received, maintained, or transmitted by BA from or on behalf of CE pursuant to this Agreement.

1.9 **"Required by Law"** shall have the same meaning found in 45 C.F.R. § 164.103.

1.10 **"Secretary"** shall mean the Secretary of the Department of Health and Human Services or his or her designee.

1.11 **"Unsecured PHI"** shall have the same meaning as the term "unsecured protected health information" in 45 C.F.R. § 164.402.

1.12 **"Use" or "Uses"** shall mean, with respect to Protected Health Information, the sharing, employment, application, utilization, examination, or analysis of such information within BA's internal operations.

2. *Authorized Uses and Disclosures by Business Associate.*

2.1 *General Use and Disclosure*
Except as otherwise limited in this Agreement, BA may Use or Disclose PHI on behalf of CE as necessary to provide services as set forth in the Services Agreement, if such Use or Disclosure of PHI would not violate the Privacy Rule if done by CE.

2.2 *Business Activities of Business Associate*

2.2.1 Unless otherwise limited herein, BA may Use PHI:

(a) As necessary for the proper management and administration of BA or to carry out the legal responsibilities of BA;

(b) To provide Data Aggregation services as permitted by 42 CFR § 164.504(e)(2)(i)(B);

(c) To De-identify any and all PHI created, received, maintained, or transmitted by BA on behalf of CE provided that the De-identification conforms to the requirements of the HIPAA Rules. Such resulting De-identified information is not PHI and is not subject to the terms of this Agreement; and

(d) As Required by Law.

2.2.2 Unless otherwise limited herein, BA may Disclose PHI for the proper management and administration of BA or to carry out the legal responsibilities of BA provided that:

(a) The Disclosure is Required by Law; or

(b) BA obtains reasonable assurances from the person to whom the PHI is Disclosed that it will be held confidentially and Used or further Disclosed only as Required by Law or for the purposes for which it was Disclosed to the person, and the person notifies BA of any instances of which it is aware in which the confidentiality of the PHI has been breached.

3. Business Associate Obligations.

3.1 *Use of PHI*
BA shall not Use or further Disclose PHI other than as permitted or required by the Services Agreement, this Agreement, or as Required by Law. In Using, Disclosing, or requesting PHI from CE, BA agrees to limit

PHI to the minimum necessary to accomplish the intended purpose of such Use, Disclosure, or request. "Minimum necessary" shall be interpreted in accordance with the HITECH Act and the HIPAA Rules, and implementing regulation or guidance on the definition.

3.2 *Appropriate Safeguards; Compliance with Security Rule*
BA shall use appropriate administrative, technical, and physical safeguards to prevent Use or Disclosure of PHI other than as provided for by this Agreement. BA shall comply with the Security Rule and shall implement administrative, physical, and technical safeguards (including written policies and procedures) that will reasonably and appropriately protect the confidentiality, integrity, and availability of the EPHI it creates, receives, maintains, or transmits on behalf of CE.

3.3 *Disclosure to Subcontractors*
BA agrees to ensure that any subcontractor that creates, receives, maintains, or transmits PHI on behalf of BA agrees to comply with the applicable HIPAA Rules and the same restrictions and conditions that apply through this Agreement to BA with respect to such PHI by entering into a Business Associate Agreement with the subcontractor consistent with 45 C.F.R. 164.502(e).

3.4 *Delegation of Covered Entity's Duties*
To the extent BA is to carry out one or more of CE's obligations under the Privacy Rule, BA shall comply with the requirements of the Privacy Rule that apply to CE in the performance of such obligations.

3.5 *Disclosure Accounting*
BA agrees to document all Disclosures of PHI and information related to such Disclosures as would be required for CE to respond to a request by an Individual for an accounting of Disclosures in accordance with 45 C.F.R. § 164.528 ("Disclosure Information") and to retain such documentation for six (6) years from the date of Disclosure.

Within thirty (30) calendar days after receipt of a written notice from CE of a request by an Individual for an accounting of Disclosures of PHI, BA shall provide to CE the Disclosure Information to enable CE to meet the Disclosure accounting obligations under 45 C.F.R. § 164.528. In the event a request for an accounting regarding PHI is delivered directly to BA or it subcontractors, BA shall within ten (10) calendar days after receipt forward such request to CE. Within twenty (20) calendar days after forwarding the request to CE, BA shall provide its Disclosure Information to CE. It shall be CE's responsibility to prepare and deliver any accounting of disclosures to the Individual. BA will include, in any Disclosure Information, the information listed in 45 C.F.R. § 164.528(b).

3.6 *Access to PHI*
Within fifteen (15) calendar days following CE's request, BA shall make available to CE or, at the written direction of CE, to an Individual, for inspection and copying PHI about the Individual that is in a Designated Record Set maintained by the BA, so that CE may meet its access obligations under 45 C.F.R. §164.524. If CE requests an electronic copy of PHI that is maintained by BA electronically in a Designated Record Set, BA will provide an electronic copy in the form and format specified by CE in accordance with 45 C.F.R. § 164.524(c)(2). Any denial of access to the PHI requested shall be the responsibility of the CE.

3.7 *Amendment of PHI*
Upon receipt of a request from CE, BA shall promptly amend or make available to CE for amendment, an Individual's PHI maintained by BA in a Designated Record Set to enable CE to meet its obligations under 45 C.F.R. § 164.526. Any denial of a request by an Individual for amendment of PHI maintained by BA pursuant to the Agreement shall be the responsibility of CE.

3.8 *Government Access to Books and Records*
BA shall make its internal practices, books, and records relating to the Use and Disclosure of PHI received from, or created or received by BA on behalf of CE, available to the Secretary for purposes of determining CE's compliance with the HIPAA Rules. Unless prohibited by law or court or order, BA shall provide to

CE, (i) prompt written notice of BA's receipt of any such request from the Secretary, and (ii) a copy of any documentation, books, and records provided by BA to the Secretary pursuant to the Secretary's request.

3.9 Reporting and Mitigation of Unauthorized Use and Disclosure of PHI or Breach of Unsecured PHI

3.9.1 Reporting of Unauthorized Use and Disclosure of PHI. BA shall provide a written report to CE of any Uses or Disclosures of PHI not authorized by the Services Agreement or this Agreement of which it becomes aware not more than thirty (30) calendar days after the unauthorized Use or Disclosure is discovered.

3.9.2 Reporting of Breach of Unsecured PHI. BA shall notify CE within thirty (30) calendar days following the discovery of a suspected or actual Breach of Unsecured PHI. A suspected or actual Breach shall be treated as discovered by BA as of the first day on which the Breach is known, or, by exercising reasonable diligence would have been known, to the BA. If a delay is requested by a law enforcement official in accordance with 45 C.F.R. § 164.412, BA may delay notifying CE for the applicable period of time.

3.9.3 Content of Notice. The notice of unauthorized Use or Disclosure, or of Breach of Unsecured PHI, shall include:

(a) To the extent possible, the identification of each Individual whose Unsecured PHI has been, or is reasonably believed by BA to have been improperly accessed, acquired, Used or Disclosed;

(b) Information related to the unauthorized person or persons who impermissibly Used the PHI or to whom the improper Disclosure was made, and whether the PHI was actually acquired or viewed;

(c) The nature of the Breach or other non-permitted Use or Disclosure, including a brief description of what happened, the date of the non-permitted Use or Disclosure or Breach and the date of discovery;

(d) A description of the types of Unsecured PHI that were involved in the non-permitted Use or Disclosure or Breach, including the nature of services, types of identifiers, and the likelihood of re-identification, including whether full name, social security number, credit card number, date of birth, home address, account number, diagnosis, medication, treatment plan, or other information were involved;

(e) The corrective or investigative action BA took or will take to prevent further non-permitted Uses or Disclosures, to protect against future Breaches, and the extent to which the risk to the PHI has been mitigated;

(f) Any details necessary for CE to conduct a risk assessment to determine the probability that the PHI believed to have been improperly accessed, acquired, Used or Disclosed has been compromised and the steps the affected Individuals should take to protect themselves; and

(g) Such other information, including a written report, as CE may reasonably request.

3.9.4 Costs of Breach Notification and Mitigation. BA shall, at its own cost and expense, mitigate to the extent practicable, any harmful effects known to BA of any Use or Disclosure of PHI in violation of the requirements of this Agreement. To the extent that CE determines that the Breach notification requirements of the HIPAA Rules are triggered by a Breach of Unsecured PHI, as described in Section 4.3 below, BA shall reimburse CE for all reasonable and necessary costs related to such notifications.

3.9.5 Security Incidents. BA will report to CE any attempted or successful unauthorized access, Use, Disclosure, modification, or destruction of Electronic Protected Health Information provided by CE or interference with BA's system operations in BA's information system of which BA becomes aware. The Parties acknowledge that probes and reconnaissance scans are commonplace in the industry and, as such, the Parties acknowledge and agree that, to the extent such probes and reconnaissance scans constitute

Security Incidents, this Section 3.9.5 constitutes notice by BA to CE of the ongoing existence and occurrence of such Security Incidents for which no additional notice to CE shall be required, as long as such probes and reconnaissance scans do not result in unauthorized access, Use, or Disclosure of PHI. Probes and reconnaissance scans include, without limitation, pings and other broadcast attacks on BA's firewall, port scans, and unsuccessful log-on attempts that do not result in unauthorized access, Use or Disclosure of PHI.

3.9.6 State Law Requirements. In the event BA has an independent notification obligation related to impermissible Use or Disclosure of PHI in connection with this Agreement or the Services Agreement, BA shall promptly notify CE of such obligation and, at least five (5) business days before giving any such notice, BA shall notify CE of its intent to provide the required notifications, including any related information required by applicable state law.

3.10 *Retention of PHI*
BA shall retain all PHI throughout the term of this Agreement and shall continue to maintain such information not otherwise returned or destroyed pursuant to Section 5.4 of this Agreement for a period of seven (7) years after the termination of this Agreement.

3.11 *Restrictions on Disclosures*
BA will comply with written notice from CE to provide for confidential communications of PHI, or to restrict the Use or Disclosure of PHI, pursuant to 45 C.F.R. § 164.522, including any request by an Individual to restrict the Disclosure of the Individual's PHI to a health plan if the Disclosure is (1) for the purpose of carrying out payment or health care operations, is not for purposes of carrying out treatment, and it not otherwise Required by Law, and (2) the PHI pertains solely to a health care item or service for which the Individual, or person other than the health plan on behalf of the Individual, has paid the CE in full.

3.12 *Prohibition on Sale of PHI*
Except as otherwise expressly permitted by the HIPAA Rules, BA shall not directly or indirectly receive remuneration, including financial or non-financial remuneration, in exchange for an Individual's PHI unless CE or BA obtains a valid authorization that meets the requirements of 45 C.F.R § 164.508 and states that the disclosure will result in remuneration to the BA.

3.13 *Standard Transactions.*
BA shall comply with the HIPAA Rules' Standards for Electronic Transactions when conducting any Standard Transactions on behalf of CE.

4. Covered Entity Obligations.

4.1 With regard to the Use and/or Disclosure of Protected Health Information by BA, CE agrees to:

4.1.1 Notice of Privacy Practices
Provide BA in a timely manner a written or electronic copy of the notice of privacy practices (the "Notice") that CE provides to Individuals in accordance with 45 C.F.R. § 164.520, including any limitation(s) in such Notices to the extent that such limitation may affect BA's Use or Disclosure of PHI.

4.1.2 Restrictions
Notify BA in writing of any restrictions to the Use or Disclosure of PHI that CE has agreed to in accordance with 45 C.F.R. § 164.522 to the extent that such restriction may affect BA's Use or Disclosure of PHI. CE will promptly notify BA in writing of the termination of any such restriction requirement and inform BA whether any of the PHI will remain subject to the terms of the restriction agreement.

4.1.3 Authorizations

Inform BA, in writing and in a timely manner, of any changes in, or revocation of an authorization provided to a CE by an Individual to Use or Disclose PHI to the extent that such changes may affect BA's Use or Disclosure of PHI.

4.1.4 Confidential Communications
Notify BA in writing and in a timely manner, of any confidential communications requests related to an Individual's PHI that CE has agreed to in accordance with 45 C.F.R. § 164.522, to the extent that such request may affect BA's Use or Disclosure of PHI. CE will promptly notify BA in writing of the termination of any such confidential communications requirement.

4.2 CE shall not request BA to Use or Disclose PHI in any manner that would not be permissible under the Privacy Rule if done by a CE.

4.3 *Determination of Breach and Notification Obligations*
CE will be solely responsible to determine whether a non-permitted Use or Disclosure constitutes a Breach and will be responsible to provide, to the extent and within the time required by the HIPAA Rules, notice to the affected Individuals, the media, and the Secretary of any Breach of Unsecured PHI. If CE determines the non-permitted Use or Disclosure is a Breach that triggers the HIPAA Rules' breach notification requirements, then BA will reimburse CE for all reasonable and necessary costs related to the notifications of a Breach of Unsecured PHI created, received, maintained or transmitted by BA.

5. Term and Termination.

5.1 *Term and Effective Date*
This Agreement shall be effective on the effective date of the Services Agreement and shall continue in effect until all obligations of the Parties have been met, unless terminated as provided herein or by the mutual agreement of the Parties.

5.2 *Termination for Material Breach*
Upon CE's determination, in its sole discretion, that BA has violated a material term of this Agreement, CE will provide BA with written notice of the violation and either (i) an opportunity to cure the breach or end the violation within thirty (30) calendar days after BA's receipt of the notice or such other period determined reasonable and appropriate by CE, or (ii) terminate this Agreement if BA does not cure the breach or end the violation within such period, or (3) immediately terminate this Agreement if eliminating the violation or cure of the breach is not possible.

5.3 *Termination of Agreement*
This Agreement shall automatically terminate without any further action of the Parties upon the termination or expiration of the Services Agreement.

5.4 *Effect of Termination*

5.4.1 Upon termination of this Agreement, BA shall return all PHI received from, or created or received by BA on behalf of CE that is then maintained in any form by BA or its subcontractors, or if expressly requested to do so by CE, BA shall destroy such PHI and provide CE documentation evidencing such destruction. BA shall retain no copies of such PHI except as follows. If BA determines that return or destruction of PHI is not feasible, BA shall provide notice to CE of the conditions that make return or destruction infeasible, and shall extend the protections of this Agreement to such PHI and limit further Uses and Disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as BA maintains such PHI.

5.4.2 In the event this Agreement is terminated for any reason, the Services Agreement will also terminate as of the effective date of termination of this Agreement.

5.5 *Survival*
The obligations of BA under this Section 5 shall survive the termination of this Agreement.

6. Miscellaneous.

6.1 *Indemnification.* Each Party shall indemnify, defend and hold harmless the other Party (including without limitation the other Party's employees, officers, directors, agents, successors and assigns) from and against any and all claims, causes of action, liabilities, damages, costs or expenses (including without limitation attorneys' fees, court costs, costs of administrative or other proceedings, and costs of investigation) arising out of or related to any breach of any of the terms and provisions of this Agreement by the indemnifying Party or any party acting by or through the indemnifying Party (including without limitation its employees, agents, representatives or Subcontractors). The obligations of the Parties under this Section 6.1 shall survive the termination of this Agreement.

6.2 *Compliance with Law*
BA and CE agree to comply with all federal, state, and local laws applicable to the privacy and security of health information, including but not limited to the HIPAA Rules and the HITECH Act. Upon the compliance date or other effective date of any law or final regulation or amendment to final regulation adopted by the Secretary that affects the obligations of either Party to this Agreement, this Agreement will automatically amend such that the obligations of each Party under this Agreement remain in compliance with such law or regulation. The Parties agree to take such action as is necessary to document any such amendment to this Agreement as is necessary for compliance with the requirements of the HIPAA Rules and the HITECH Act, and any other applicable law or regulation.

6.3 *No Third Party Beneficiaries*
Nothing in this Agreement shall confer any rights, remedies, obligations, or liabilities upon any person or other third party other than the Parties to this Agreement.

6.4 *Disputes*
If any controversy, dispute, or claim arises between the Parties with respect to this Agreement, the Parties shall make good faith efforts to resolve such matters informally and in accordance with the dispute resolution process specified in the Services Agreement.

6.5 *Interpretation*
Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits CE and BA to comply with applicable HIPAA Rules and the HITECH Act. In the event of any inconsistency or conflict between this Agreement and any other agreement between the Parties, the terms and conditions of this Agreement shall have priority.

6.6 *Notice*
Any notice to be given hereunder shall be given in writing and in accordance with the applicable terms of the Services Agreement.

6.7 *Governing Law*
This Agreement shall be interpreted, enforced, and governed in accordance with the laws of the State of Oregon, notwithstanding any conflict of law doctrine to the contrary.

6.8 *Amendments; Waiver*
This Agreement may not be modified or amended, nor shall any provision hereof be waived, except in a writing duly signed by authorized representatives of the Parties. A waiver with respect to one event shall not be construed as continuing, or as a bar to or waiver of any right or remedy as to subsequent events. A failure or delay in enforcing compliance with any term or condition of this Agreement does not constitute a waiver of such term or condition unless it is expressly waived in writing.

6.9 *Survival*
BA's obligations to protect the privacy and safeguard the security of PHI as set forth in this Agreement shall survive the termination of this Agreement.

6.10 *Severability*
The invalidity of unenforceability of any provision of this Agreement shall not affect the validity or enforceability of any other provision of this Agreement, which shall remain in full force and effect.

6.11 *Counterparts; Electronic Copies*
This Agreement may be executed in any number of counterparts, each of which shall be deemed an original and all of which taken together shall constitute one and the same instrument. Electronic copies of this fully executed Agreement shall be deemed to be originals.

IN WITNESS WHEREOF, the Parties have duly executed this Agreement as of the effective date of the Services Agreement.

Business Associate
FCHN

Signature: _____
Kenneth Hamm, President & CEO

Covered Entity
CENTRIA HEALTHCARE, LLC

Signature: _____
Name: Alicia Decker
Title: VP of Autism Services

SCHEDULE B

First Choice Health

Fee Schedule

CONFIDENTIAL AND PROPRIETARY

Board Certified Applied Behavior Therapist

Fee Schedule
(BCBA and BCBA-D Services)

1. **Reimbursement Rate**

First Choice Health Network Payors shall reimburse Covered Services at the following rate for Applied Behavioral Analysis services billed using Category III CPT Codes or CPT Codes listed below*:

Code	Service	FCH Reimbursement Rate	Provider Type
0359T	Behavior identification assessment, by the physician or other qualified health care professional, face-to-face with patient and caregiver(s), includes administration of standardized and non-standardized test, detailed behavior history, patient observation and caregiver interview, interpretation of test results, discussions of findings and recommendation with the primary guardian(s)/caregiver(s), and preparation of report	$480.00	BCBA, not a therapy assistant
0360T	Observational behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by one technician; first 30 minutes of technician time, face-to- face with the patient	$26.50	Therapy Assistant
0361T	Each additional 30 minutes of technician time, face-to-face with the patient (List separately in addition to code for primary service)	$26.50	Therapy Assistant

0362T	Exposure follow up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by physician or other qualified health care professional with the assistance of one or more technicians; first thirty minutes of technician(s) time, face-to-face with the patient	$62.50	Therapy Assistant
0363T	Each additional 30 minutes of technician(s) time, face to face with the patient.	$62.50	Therapy Assistant
0364T	Adaptive behavior treatment by protocol, administered by technician, face-to-face with one patient; first 30 minutes of technician time	$26.50	Therapy Assistant
0365T	Each additional 30 minutes of technician time (List separately in addition to code for primary service)	$26.50	Therapy Assistant
0366T	Group adaptive behavior treatment by protocol, administered by technician, face-to-face with two or more patients; first 30 minutes of technician time	$50.00	Therapy Assistant
0367T	Each additional 30 minutes of technician time (List separately in addition to code for primary service)	$50.00	Therapy Assistant
0368T	Adaptive behavior treatment with protocol modification, administered by physician or qualified health care professional, face-to-face with one patient; first 30 minutes of patient face-to-face time	$62.50	BCBA, not a therapy assistant
0369T	Each additional 30 minutes of patient face-to-face time(List separately in addition to code for primary procedure	$62.50	BCBA, not a therapy assistant
0370T	Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without patient present)	$78.00	MD, PhD. Or BCBA
0371T	Multiple-family group adaptive behavior treatment guidance, administered by physician o other qualified health care professional (without patient present)	$150.00	MD , PhD.or BCBA
0372T	Adaptive behavior treatment social skills group, administered by physician or other qualified health care professional face to face with multiple patients.	$150.00	BCBA, not a therapy assistant
0373T	Exposure adaptive behavior treatment with protocol modification requiring two or more technicians for severe maladaptive behavior(s); first 60 minutes of technician's time, face-to-face with patient	$45.00	Therapy Assistant

0374T	Each additional 30 minutes of technicians' time, face-to-face with patient (List separately in addition to code for primary service)	$26.50	Therapy Assistant
All other services will be reimbursed at seventy percent (70%) of providers billed charges			

CPT	Service	FCH Reimbursement Rate	Provider Type
96150	Health and behavior assessment, each 15 minutes face-to-face with the patient; initial assessment	$31.25 per unit	BCBA, not a therapy assistant
96151	Re-assessment	$31.25 per unit	BCBA, not a therapy assistant
96152	Health and behavior intervention, each 15 minutes, face-to-face; individual	$31.25 per unit	BCBA, not therapy assistant
96154	Health and behavior intervention, each 15 minutes, face-to-face; family	$11.25 per unit	For Therapy assistant
All other services will be reimbursed at seventy percent (70%) of providers billed charges			

*Not all First Choice Health Network Payors will accept Category III CPT Codes. When a FCH Payor does not accept Category III CPT Codes, First Choice Health Network Payor may require provider to bill with CPT Codes 96150-96154.

2. ABA Guidelines

Provider agrees to the following guidelines:

- BCBA are Masters Prepared and BCBA-D are Doctoral level
- All claims submitted will be billed on CMS-1500 forms using the codes listed above
- BCBA needs to bill for all therapy assistant services
- BCBA must bill for BCaBA and Behavioral Technician services
- When distinct direct services performed by a BCBA and a therapy assistant are billed together on the same date of service, modifier 59 should be added to the BCBA billed code, when appropriate.

ABA1

SCHEDULE C
PREFERRED PROVIDER/GROUP AGREEMENT
OREGON STATE LAW AND REGULATION PROVISIONS

With respect to any Payor that is an Insurer as defined in ORS 743.801, as it may be revised, renumbered, or replaced, the provisions set forth in this Schedule C are fully operative and applicable to FCHN, Provider, and the respective Payors under the Agreement to which this Schedule C is attached. For Payors meeting the definition described above, in the event of any conflict between the provisions set forth in this Schedule C and the other terms of the Agreement, the provisions of this Schedule C shall have priority. Except as modified by this Schedule C, all terms and conditions of the Agreement to which this Schedule C is attached remain in full force and effect.

With respect to any Payor that is an Insurer as defined in ORS 743.801, as it may be revised, renumbered, or replaced:

1. **Definitions.** Sections 1.8 and 1.20 of the Agreement are deleted in their entirety, and the following are substituted therefor. In addition, the following new Sections 1.21, 1.22, 1.23 and 1.24 are added to Section 1, immediately following Section 1.20.

1.8 Emergency Medical Condition means a medical condition (A) that manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would : (i) place the health of a Participant, or a fetus an unborn child in the case of a pregnant Participant, in serious jeopardy; (ii) result in serious impairment to bodily functions; or (iii) result in serious dysfunction of any bodily organ or part; or (B) with respect to a pregnant Participant who is having contractions, for which there is inadequate time to effect a safe transfer to another hospital before delivery or for which a transfer may pose a threat to the health or safety of the participant or the unborn child.

1.20 Utilization Review means a set of formal techniques designed to monitor the use of or evaluate the Medical Necessity, appropriateness, efficacy, or efficiency of health care services or procedures given or proposed to be given to a Participant or the setting in which such services or procedures are provided.

1.21 Continuity of Care means the feature of a Benefit Plan under which a Participant who is receiving care from a Provider is entitled to continue with care with the Provider for a limited period of time after this Agreement terminates.

1.22 Emergency Medical Screening Exam means the medical history, examination, ancillary tests, and medical determinations required to ascertain the nature and extent of an Emergency Medical Condition.

1.23 Emergency Services means, with respect to an Emergency Medical Condition: (A) an Emergency Medical Screening Exam that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and (B) such further medical examination and treatment as are required under 42 USC 1395dd to Stabilize a participant, to the extent the examination and treatment are within the capability of the staff and facilities available at a hospital.

1.24 Stabilize means to provide medical treatment as necessary to: (A) ensure that, within reasonable medical probability, no material deterioration of an Emergency Medical Condition is likely to occur during or to result from the transfer of a participant from a facility; and (B) with respect to a pregnant participant who is in active labor, to perform the delivery, including the delivery of the placenta.

2. **Responsibilities of Provider.** Sections 2.1, 2.5, the first paragraph of Section 2.9, and Section 2.15 of the Agreement are deleted in their entirety and the following are substituted therefor:

2.1 Provide or Arrange for Covered Services
For each Participant, Provider shall provide, or arrange for the provision of Covered Services on a timely basis, without regard to health status or medical condition, and in accordance with generally accepted medical practice guidelines and standards pursuant to the terms of this Agreement, and in accordance with applicable FCHN Provider Policies and Procedures. Provider agrees to verify each Participant's eligibility prior to providing Covered Services except in the case of Emergency Services. Provider will notify FCHN or the appropriate Payor of the provision of Medically

Necessary services of either type described above Emergency Services that are provided to a Participant within the twenty-four (24) hour period immediately following the provision of such services.

Provider agrees to furnish Covered Services to each Participant on the same basis as such services are made available to individuals who are not Participants, and without regard to the Participant's enrollment in a Payor's Benefit Plan as a private purchaser or as a participant in publicly financed programs of health care services. In providing services under this Agreement, Provider shall exercise the degree of care, skill, and knowledge expected of a reasonably prudent health care provider and in a manner consistent with currently approved methods and practices in Provider's medical specialty. Provider shall exercise his or her own professional medical judgment, free of any direction or control by FCHN or Payors, and shall remain solely responsible for the quality of services rendered. Provider may withdraw from the care of a Participant when, in the professional judgment of Provider, it is in the best interest of the Participant to do so; provided, however that Provider agrees to provide reasonable notice to FCHN and Payors of such withdrawal and to facilitate appropriate transfer of care.

2.5 Benefit Plan Participation

Provider hereby authorizes (i) FCHN to contract with Payors that will administer and pay for Covered Services provided by Provider to Participants under Benefit Plans, and (ii) FCHN agrees that such contracts will obligate the Payors to comply with all applicable terms, limitations, and conditions of this Agreement. Provider further authorizes Payors contracting with FCHN to offer Provider's services to groups of employees or individuals in accordance with the provisions of any Benefit Plans offered by such Payors. Provider's services are not offered in connection with motor vehicle insurance, personal injury protection, workers compensation, or any other program for the payment of healthcare services that is excluded from the definition of a benefit plan under applicable law.

2.9 Medical Management, Utilization Review and Quality Improvement

Provider agrees to comply with and participate in FCHN's or Payors' Medical Management, Utilization Review, and quality improvement programs and requirements, whichever is applicable, which may include but are not limited to, pre-authorization, notification, concurrent review, retrospective review, case management, disease management programs, pharmacy and specialty pharmacy programs, referral management, quality assurance and improvement programs and Medical Necessity oversight. A doctor of medicine or osteopathy licensed under ORS chapter 677, as it may be revised, renumbered, or replaced, retained by either FCHN or Payors, shall be responsible for all final medical and mental health decisions related to coverage or payment made pursuant to this Agreement.

2.15 Compliance

Provider agrees to comply with all of the terms of this Agreement, all applicable federal and state laws and regulations, all applicable rules and standards of accrediting agencies having jurisdiction over and designated by FCHN, and, as applicable, the ethical standards of the Oregon Medical Association and the American Medical Association, all of the above as they may be adopted, amended, revised, or renumbered. Provider agrees to comply with the following hold harmless requirements:

2.15.1 Provider hereby agrees that in no event, including, but not limited to, non-payment by a Payor, a Payor's insolvency, or breach of this Agreement shall Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against a Participant or person acting on a Participant's behalf, other than a Payor, for Covered Services provided pursuant to this Agreement, nor shall Provider charge to or collect from any Participant or person acting on Participant's behalf, any amount in excess of that amount of compensation allowed for a particular Covered Service in Schedule B to this Agreement. Participants shall have no liability to Provider for any sums owed by Payors. This provision shall not prohibit collection of Deductibles, Co-payments, Coinsurance, or charges for non-covered services, which have not otherwise been paid by a primary or secondary Payor in accordance with applicable standards for coordination of benefits, from a Participant in accordance with the terms of the Participant's Benefit Plan.

2.15.2 If Provider contracts with other providers or facilities who agree to provide Covered Services to Participants with the expectation of receiving payment directly or indirectly from a Payor, such providers or facilities must agree to abide by the provisions of paragraph 2.15.1.

3. **Responsibilities of FCHN.** Sections 3.5, 3.6, 3.10, and 3.11 of the Agreement are deleted in their entirety and the following are substituted therefor:

3.5 Eligibility

FCHN shall require all Payors contracting with it to provide timely information on a Participant's eligibility for Covered Services upon request by Provider. FCHN shall require that during ordinary business hours, Payors shall assure reasonable access, using electronic transactions as required by applicable law, for confirmation that services are Covered Services and a Participant is eligible under a Benefit Plan. For services other than those required to treat an Emergency Medical Condition, FCHN will require that Payors answer Provider's requests for prior determination of eligibility and whether the services proposed to be provided are Covered Services within two (2) business days after the Payor's receipt of the request and that Payors have qualified health care personnel available for same day telephone responses to inquiries concerning certification of continued length of stay. FCHN will require that the Payors inform Provider with one of the following answers, or as otherwise required by applicable law: (i) the requested service is authorized, (ii) the requested service is not authorized, (iii) the entire requested service is not authorized, but a specified portion of the requested service or a specified alternative service is authorized, or (iv) the requested service is not authorized because the Payor needs additional specified information in order to make a decision on the request.

3.6 Provider's Right to Inform Patients

FCHN may not, and shall require that Payors shall not, preclude or discourage Provider, financially penalize Provider, and FCHN shall not terminate this Agreement, all of the foregoing due to Provider:

a Providing information to or communicating with a Participant in a manner that is not slanderous, defamatory or intentionally inaccurate concerning:
   1 any aspect of the Participant's medical condition;
   2 any proposed treatment or treatment alternatives, whether covered by the Payor's Benefit Plan or not; or
   3 the Provider's general financial arrangement with a Payor.

b Referring a Participant to another provider, whether or not that provider is a Provider as defined in this Agreement. If Provider refers a Participant to another provider, Provider shall (i) comply with the Benefit Plan's and/or Payors' written policies and procedures with respect to any such referrals, and (ii) inform the Participant that the referral services may not be Covered Services under the Participant's Benefit Plan.

c Advocating a decision, policy, or practice, so long as Provider is practicing in conformity with ORS 677.095, as it may be revised, renumbered, or replaced.

Nothing in this Agreement shall be construed to require Provider to deny care to a Participant because of a determination that services are not Covered Services or are experimental, or to deny referral of a Participant to another provider for the provision of such care, if, as described in Section 2.11 of this Agreement, the Participant is informed that the Participant will be responsible for the payment for such services and care and the Participant nonetheless desires to obtain such services, care, or referral.

Nothing in this Agreement shall be construed to authorize Provider to bind FCHN or its Payors to pay for any services.

3.10 List of Payors

FCHN shall provide Provider in writing or electronically, on or before the Effective Date of this Agreement, a list of all Payors known by FCHN at that time. This list shall be updated at least every 90 days and will be readily available to Provider by posting on the FCHN website, toll-free telephone number, or other readily available mechanism. FCHN will provide each Payor with information necessary to enable the Payor to comply with all relevant terms, limitations, and conditions of this Agreement.

In addition, FCHN agrees to make available to Provider for review, or to cause Payors to make available to Provider for review, a written copy of or electronic access to the documents and instruments referred to in this Agreement.

3.11 Explanation of Payment/Remittance Advice

FCHN shall ensure that Payors produce an Explanation of Payment (EOP) or Remittance Advice (RA) during the claim adjudication process which must, at a minimum, identify: FCHN; total billed charges; allowed amount in accordance with FCHN fee schedules, including the source of any reduction from the billed charges to the allowed amount; the

amount the Payor is responsible to pay; the amount the Participant is responsible to pay; and an explanation for non-payment of a particular code or service. Provider may refuse to give the Payor the benefit of FCHN's fee schedule if the EOP/RA does not display minimum data elements and the FCHN names and/or logo.

4. **Claims Submission and Payment.** Sections 4.1 and 4.2 of the Agreement are deleted in their entirety and the following are substituted therefor, and the following new Section 4.4 is added to the Agreement:

4.1 Claims Submission

Provider agrees to submit Clean Claims for Covered Services rendered to Participants on standard UB-04 and CMS-1500 forms, or successors to such forms. Completed UB-04 and CMS-1500 forms shall be submitted electronically or to the address set forth on the Participant's Benefit Plan identification card. Provider agrees to bill its usual and customary charges for the services rendered, to properly and accurately complete all required Provider, Participant, service, and procedure information on the claim form, and to accept payment in full as described in Section 2.14 of this Agreement. In submitting claims pursuant to this Section, Provider shall certify that all data submitted is accurate and truthful.

4.1.1 Claims shall be submitted at the earliest possible date after the date Covered Services are rendered.

4.1.2 Payors shall be under no obligation to pay a claim if FCHN or the Payor receives the claim more than three-hundred-sixty-five (365) calendar days after the date the Covered Service was rendered, or thirty (30) calendar days after Provider first receives notice that Payor is a secondary payor under applicable coordination of benefits procedures, whichever shall be later.

4.1.3 Provider may submit, within the timely filing period described in Section 4.1.2 above, corrections to claims that were submitted with incomplete or invalid information. Incomplete means that information was missing from the claim, and invalid means that the information submitted was illogical, incorrect, or did not conform to the required claim format. Payors shall have no obligation to pay corrected claims received by FCHN or any Payor more than three hundred sixty-five (365) calendar days after the date the Covered Service was rendered, or thirty (30) calendar days after Provider first receives notice that Payor is a secondary payor under applicable coordination of benefits procedures, whichever shall be later. Adjustments to claims that have been paid or denied, where the claim submittal failed to include a particular item or service, must be requested in accordance with Section 4.4 below.

4.2 Payment or Denial of Claims

FCHN shall require all Payors to pay Provider pursuant to Schedule B of this Agreement, as soon as practical, subject to the following minimum standards:

4.2.1 Payors shall be required to pay a clean claim or deny the claim not later than thirty (30) days after the date on which the Payor receives the claim; and

4.2.2 If a Payor requires additional information before payment of a claim, not later than thirty (30) days after the date on which the Payor receives the claim, the Payor shall be required to notify the Provider and the Participant in writing and give them an explanation of the additional information needed to process the claim. The Payor shall be required to pay the clean claim or deny the claim not later than thirty (30) days after the date on which the Payor receives the additional information.

4.2.3 A Payor is considered to have received a claim when the claim is received by the Payor itself or when the claim is received by a representative of the Payor that performs claims handling on the sole behalf of the Payor, whichever receipt date is earlier. A representative may include but is not limited to a third party administrator, a claims service, or a pricing service. When a Payor uses such a representative, then the date on which the Payor receives the claim includes the days in which a claim is in the control of the representative, including the date on which the representative received the claim.

4.2.4 Claims may be subject to code review software or correct coding edits. FCHN will request that Payors inform FCHN of code review or correct coding software and most frequent claims editing issues for FCHN as needed to facilitate Provider education and training.

To the extent required by applicable law or regulation, FCHN shall require that any Payor failing to pay claims within the above stated timelines, or any other timeline or standard established by applicable law or regulation, shall pay simple interest of twelve (12) percent per annum on the unpaid amount of the claim that is due and owing, accruing from the date after the payment was due until the claim is paid. Interest on any overdue payment for a claim will begin to accrue on the 31st day after:

a. the date on which the Payor received the claim; or

b. the date the Payor receives the requested additional information.

Interest will be payable with the payment of the claim without the necessity of Provider submitting an additional claim. A Payor will not be required to pay interest that is in the amount of two dollars ($2.00) or less on any claim, or such revised amount as may be established under applicable law or regulation.

Interest shall be assessed at the rate of one percent (1%) per month, and shall be calculated monthly as simple interest prorated for any portion of a month. Any interest paid under this Section shall not be applied by the Payor to a Participant's Deductible, Co-payment, Coinsurance, or any similar obligation of the Participant.

FCHN is not the guarantor of, or in any way responsible to Providers for, any claims payments, including charges and interest due if applicable. FCHN shall meet with Provider as needed to review claims status of FCHN Payors and to assist Provider in collecting payments due and owing from any such Payor as determined by FCHN to be appropriate.

FCHN shall require that Payors provide to Provider, upon request, an annual accounting accurately summarizing the financial transactions between Payors and Provider for that year.

4.4 Overpayment and Underpayment Recoveries

As required by applicable law, adjustments to claims that have been denied or paid, where the claim submittal failed to include a particular item or service, or was otherwise in error, must be requested and accomplished as follows, and refunds of incorrect claims payments must be requested and accomplished as follows:

4.4.1 Except as provided in paragraphs 4.4.2 and 4.4.3, a Payor may request a refund from Provider for overpayment of a previously paid claim provided the request is received by the Provider within eighteen (18) months after the date the initial payment was made. Such a request must be in writing and specify why Provider owes the refund. Where a request for refund is contested by Provider, Payor may not request that the refund be paid any sooner than six (6) months from the date of Provider's receipt of the request.

4.4.2 A Payor's request for refund related to coordination of benefits with another entity responsible for payment of a claim must be received in writing by the Provider within thirty (30) months after the date that payment was made. The request must specify why Provider owes the refund and include the name and mailing address of the other entity that has primary responsibility for payment of the claim. Where a request for refund is contested by Provider, Payor may not request that the refund be paid any sooner than six (6) months from the date of Provider's receipt of the request.

4.4.3 A Payor may at any time request a refund from a Provider of payment previously made to satisfy a claim if a third party, including a government entity, is found responsible for satisfaction of the claim as a consequence of liability imposed by law and the Payor is unable to recover directly from the third party because the third party has or will pay Provider for the services covered by the claim.

4.4.4 Provider may contest a refund request described in paragraph 4.4.1 or 4.4.2 in writing to the Payor within thirty (30) days after receipt in accordance with Section 9, Dispute Resolution, of this Agreement. If Provider fails to contest a request within this thirty (30) day period, the request shall be deemed accepted by Provider as due and owing, and Provider shall pay the refund within thirty (30) days after the request is deemed accepted. If Provider has not paid the refund within thirty (30) days after the request is deemed accepted, the Payor may recover the amount through an offset to a future claim.

4.4.5 Except as provided in paragraph 4.4.7, Provider may request an additional payment from a Payor to satisfy a claim provided the request is received by the Payor within eighteen (18) months from the date the claim was denied or payment intended to satisfy the claim was made by the Payor. Such a request must be in writing, specify why Provider believes the Payor owes the additional payment, and may not require that the additional payment be made any sooner than six (6) months from the date of Payor's receipt of the request. Any dispute arising out of such a request shall be handled in accordance with Section 9, Dispute Resolution, of this Agreement.

4.4.6 Payors may not consider Provider's claim untimely if the claim is received no later than twelve (12) months after a different payor (i) denied the claim in whole or in part; or (ii) requested a refund of an erroneous payment made on the claim.

4.4.7 A Provider's request for additional payment related to coordination of benefits with another entity responsible for payment of a claim must be received in writing by the Payor within thirty (30) months after the date the claim was denied or payment intended to satisfy the claim was made. The request must specify why Provider believes the Payor owes the additional payment and must include the name and mailing address of the entity that has disclaimed responsibility for payment of the claim. The request for additional payment may not request that the additional payment be made any sooner than six (6) months after receipt of the request. Any dispute arising out of such a request shall be handled in accordance with Section 9, Dispute Resolution, of this Agreement.

4.4.8 As used in this Section, "refund" means the return, either directly or through an offset to a future claim, of some or all of a payment already received by the Provider.

4.4.9 This Section applies to claims for services provided through Benefit Plans to the extent required under applicable law and regulation.

5. Term and Termination. Sections 8.3 and 8.4 of the Agreement are deleted in their entirety and the following are substituted therefor, and the following new Section 8.5 is added to the Agreement:

8.3 Effect of Termination

This Agreement shall be of no further force or effect as of the effective date of termination except that:

8.3.1 FCHN shall require that Payors pay to Provider any payments accrued to Provider for Covered Services rendered prior to the effective date of termination and properly billed to Payors within the time required under this Agreement. Except as otherwise provided in this Section 8, claims for services provided by Provider after the effective date of termination of this Agreement are not eligible for processing and payment in accordance with the terms of this Agreement.

8.3.2 Provider shall not seek compensation from the Participant for any Covered Services provided under the terms of this Agreement prior to the effective date of termination, except for any applicable Deductible, Co-payment, or Coinsurance amounts, as specified in Section 2.15.1 of this Agreement.

8.3.3 FCHN will give notice to Payors of any termination of this Agreement within the time required by applicable law and regulation, and except as otherwise provided in this Section 8, FCHN will require Payors to cease claiming entitlement to (i) use of the FCHN fee schedule set forth in Schedule B for payment of claims, and (ii) the other rights set forth in this Agreement, effective as of the effective date of termination.

Nothing in this Agreement shall be construed to require Provider to agree, upon Provider's withdrawal from, or termination or nonrenewal of this Agreement, not to treat or solicit a Participant even at that Participant's request and expense. However, except as otherwise set forth in this Agreement, all such services shall be provided outside of the terms of this Agreement and Benefit Plans, and neither FCHN nor Payors shall be responsible to pay any fees for such services.

8.4 Continuity of Care

Upon termination of this Agreement, Provider agrees to provide continuing care to Participants consistent with the Continuity of Care benefits under the applicable Benefit Plan and applicable law and regulation, as follows:

8.4.1 Where the Participant is undergoing an active course of treatment that is Medically Necessary and by agreement of Provider and the Participant, it is desirable to maintain continuity of care, the Participant is entitled to continue receiving care from Provider as follows:

a. Except as provided in paragraph b of this Section, Provider shall provide care to a Participant who is entitled to Continuity of Care until the earlier of (i) the day following the date on which the active course of treatment entitling the Participant to continue receiving care from Provider is complete, or (ii) the 120th day after the date of notification by the Payor to the Participant of the termination of this Agreement.

b. A Participant who is undergoing care for a pregnancy and who becomes entitled to Continuity of Care after commencement of the second trimester of the pregnancy shall receive the care until the later of (i) the 45th day after the birth, or (ii) as long as the Participant continues under an active course of treatment, but not later than the 120th day after the date of notification by the Payor to the Participant of the termination of this Agreement.

8.4.2 The Provider's relationship with FCHN and/or Payor must be continued on the same terms and conditions as those of the agreement FCHN is terminating, except for any provision requiring that Payor assign new enrollees to the terminated Provider.

8.4.3 The date of notification given pursuant to this Section 8.4 is the earlier of the date on which the Participant receives the notice or the date on which the Payor receives or approves the request for continued care with Provider under the Continuity of Care benefits of the Participant's Benefit Plan.

8.5 Notice to Participants

8.5.1 If this Agreement is terminated, FCHN shall require Payors to give written notice of the termination and of the right to obtain Continuity of Care benefits to those Participants that the Payors know or reasonably should know are under the care of Provider. The notice may be given prior to the effective date of termination of this Agreement only if the Payors give notice in a good faith belief that the termination will take effect as stated in the notice. In any event, FCHN will require Payors to give notice to the Participants described above not later than the 10th day after the effective date of termination of this Agreement. If a Payor first learns the identity of an affected Participant after the effective date of termination of this Agreement or after the date on which the Payor gave notice to other affected Participants, then FCHN shall require the Payor to give notice of termination to the affected Participant not later than the 10th day after learning that Participant's identity.

8.5.2 If Provider is, or belongs to, a Provider Group, the Provider Group may deliver the notice of termination described in this Section 8.5 provided that (i) FCHN and the Payor give prior written consent to the Provider Group giving such notice and to the contents of the notice, and (ii) the notice is consistent with the requirements of this Section 8.5.

6. **General Provisions.** Section 10.9 of the Agreement is deleted in its entirety and the following is substituted therefor:

10.9 Applicable Law

This Agreement shall be interpreted, enforced, and governed in accordance with the laws of the State of Washington, notwithstanding any conflict of law doctrine to the contrary; provided, however that the substantive laws of the State of Oregon shall govern the interpretation and enforcement of the provisions of Schedule C attached to this Agreement. Venue for any action or proceeding shall lie in King County, Washington.

7. **Amendments to Comply with Law.** If amendments to the Agreement are needed to permit FCHN, Provider, and Payors to comply with applicable state law and regulation, FCHN and Provider agree to incorporate such revisions into the Agreement in a timely manner.