Name according to W-9 form with d/b/a: [redacted]y Hospital District No. 1
Federal Tax Identification Number: 9[redacted]

Name according to W-9 form with d/b/a[redacted]l District 3 of P[redacted]
Federal Tax Identification Number: 9[redacted]

Name according to W-9 form with d/b/a: [redacted]District #4, Ki[redacted]A
Federal Tax Identification Number: 9[redacted]

[redacted]UP Washington, Inc.
PARTICIPATING PROVIDER AGREEMENT
For Physician, [redacted] and Facility Providers

THIS PARTICIPATING PROVIDER AGREEMENT (this "Agreement") is made by and between [redacted]UP Washington, Inc. ("[redacted]") an[redacted]y Hospital District No. 1, federal tax identification number 91-[redacted]hich does business in its own name and under the names (and at the locations) set forth on Exhibit A ("[redacted] District 3 of Pa[redacted]deral tax identification number 91-6[redacted]ich does business in its own name and under the names (and at the locations) set forth on Exhibit A ("[redacted]), and[redacted]l District #4, K[redacted] WA, federal tax identification number [redacted]9 which does business in its own name and under the names (and at the locations) set forth on Exhibit A ("S[redacted](collectively, Mo[redacted]and [redacted]ie are hereinafter referred to as "Provider")("Provider"), effective A[redacted](the "Effective Date").

RECITALS:

A. [redacted]OUP is authorized to arrange for the provision of managed health care services to Covered Persons in the State of Washington.

B. Provider is authorized in the State of Washington to provide Covered Services to Covered Persons.

C. [redacted]UP desires that Provider provides the Covered Services contemplated herein to Covered Persons pursuant to the terms and conditions set forth in this Agreement, consistent with the provisions of 42 CFR 434.6 and Provider desires to provide such services.

AGREEMENT:

NOW, THEREFORE, in consideration of the mutual covenants and agreements contained herein and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, A[redacted]UP and Provider agree as follows:

ARTICLE I
DEFINITIONS

The following terms shall have the meanings set forth below with respect to services furnished under the Medicaid Program, and as specifically set forth, the Medicare Program.

1.1 Agency. "Agency" means a federal, state or local agency, administration, board or other governing body responsible for the governance or administration of a Program. With respect to the State of Washington, as used herein, Agency also means the Washington Health Care Authority ("HCA").

1.2 Behavioral Health Care Services. "Behavioral Health Care Services" means services rendered for the treatment of mental health or drug and alcohol conditions.

1.3 CMS. "CMS" means the Center for Medicare & Medicaid Services, an administrative agency within the United States Department of Health & Human Services ("HHS").

1.4 Clean Claim. "Clean Claim" means a claim that can be processed without obtaining additional information from the provider of the service or from a third party and 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.

1.5 Covered Person. "Covered Person" means a person who is an eligible Program beneficiary and who is enrolled as an AM[redacted] member in accordance with applicable Program enrollment requirements.

1.6 Covered Services. "Covered Services" means (a) health care services that HCA determines are covered for enrollees, (b) those health care services (including Behavioral Health Care Services) that a Covered Person is entitled to receive through AMER[redacted] pursuant to Regulatory Requirements, and (c) for which an **Attachment A** is attached hereto setting forth the Providers' reimbursement under one or more Programs including Medicare.

1.7 Eligible Charges. "Eligible Charges" are charges for Covered Services as submitted by Provider, subject to program eligibility, benefit design, coordination of benefits and applicable authorizations. Eligible charges are those charges billed by the provider subject to conditions and requirements which make the service eligible for reimbursement. Eligibility for reimbursement of the service is dependent upon application of the following conditions and requirements: member program eligibility, provider program eligibility, benefit coverage, authorization requirements, provider manual guidelines, AM[redacted]JP administrative, clinical, and reimbursement policies, and code editing logic. The allowed amount reimbursed for the eligible charge is based on the applicable fee schedule or contracted/negotiated rate after application of coinsurance, co-payments, deductibles, and coordination of benefits.

[redacted]ROUP will not reimburse providers for items the provider receives free of charge and items the provider provides to the member free of charge.

1.8 Emergency Medical Condition. "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairments of bodily functions, or serious dysfunction of any bodily organ or part. An Emergency Medical Condition shall not be defined on the basis of lists of diagnoses or symptoms.

1.9 Emergency Services. "Emergency Services" means inpatient and outpatient contracted services furnished by a provider qualified to furnish the services needed to evaluate or stabilize an emergency medical condition (42 CFR 438.114(a)).

1.10 HIPAA Regulations. "HIPAA Regulations" shall mean those regulations adopted pursuant to the Health Insurance Portability and Accountability Act of 1996 and codified at Title 45 of the Code of Federal Regulations ("C.F.R.") relating to the privacy and security of protected health information, and including, without limitation, any amendments or successor laws, rules or regulations thereto.

1.11 Medically Necessary.

(a) Definition. "Medically Necessary" means services that are "medically necessary" as is defined in WAC [redacted] Those services, based upon generally accepted medical practices in light of the Covered Person's condition at the time of treatment, that are:

(i) Appropriate and consistent with the diagnosis of the treating provider and the omission of which could adversely affect the Covered Person's medical condition;

(ii) Compatible with the standards of acceptable medical practice in the community;

(iii) Provided in a safe, appropriate, and cost-effective setting given the nature of the diagnosis and the severity of the symptoms;

(iv) Not provided solely for the convenience of the Covered Person or the convenience of the provider or hospital;

(v) Not primarily custodial care unless custodial care is a Covered Service; and

(vi) There are no other effective and more conservative or substantially less costly treatment, service and setting available.

(vii) related to the enrollee's ability to achieve age-appropriate growth and development.

(b) Medicare Considerations. Under the Medicare program, "Medically Necessary" services are health care services that are:

(i) Reasonable and necessary to prevent illnesses or medical conditions, or provide early screening, interventions, and/or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a handicap, cause illness or infirmity of a Covered Person, or endanger life;

(ii) Provided at appropriate facilities and at the appropriate levels of care for the treatment of a Covered Person's health conditions;

(iii) Consistent with health care practice guidelines and standards that are endorsed by professionally recognized health care organizations or governmental agencies;

(iv) Consistent with the diagnoses of the presenting symptoms and conditions; and

(v) No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency.

1.12 Participating Provider. "Participating Provider" means a person, health care provider, practitioner, or entity, acting within their scope of practice and licensure, with a written agreement with A[redacted]UP to provide Covered Services to Covered Persons or any other person or entity that (a) is licensed to provide the health care services such person or entity is providing under the laws of Washington; (b) is party to a participation agreement with [redacted]UP to provide Covered Services to Covered Persons, or is an employee or subcontractor of a Participating Provider and will be furnishing Covered Services hereunder; and (c) is, if applicable, duly credentialed by AMERI[redacted]accordance with AME[redacted] credentialing requirements for the services the Participating Provider provides. The definition of "Participating Provider" includes, but is not limited to, Provider.

1.13 Primary Care Provider. "Primary Care Provider" or "PCP" means a participating provider who has the responsibility for supervising, coordinating, and providing primary health care to enrollees, initiating referrals for specialist care, and maintaining the continuity of enrollee care. PCPs include, but are not limited to Pediatricians, Family Practitioners, General Practitioners, Internists, Physician Assistants (under the supervision of a physician), or Advanced Registered Nurse Practitioners (ARNP), as designated by AM[redacted] The definition of PCP is inclusive of primary care physician as it is used in 42 CFR 438. All federal requirements applicable to primary care physicians will also be applicable to primary care providers as the term is used herein. PCPs shall be credentialed in accordance with AM[redacted] credentialing requirements for Primary Care Providers.

1.14 Primary Care Services. "Primary Care Services" means (a) those Covered Services provided to a Covered Person involving initial and basic primary medical care, including, but not limited to, the Covered Services specifically identified as primary care services in an applicable Program Contract, and (b) the supervision and coordination of the delivery of these Covered Services to a Covered Person.

1.15 Program. "Program" means a Washington Medicaid managed care program ("Medicaid"), a state or local Child Health Insurance Program ("CHIP"), a Medicare Advantage program ("Medicare"), or any successor programs thereto, and such other federal, state or local program related to, or administered in conjunction with, Medicare, Medicaid, or CHIP including, without limitation, any program providing coverage for eligible family members of CHIP beneficiaries or persons eligible for coverage under both the Medicare and Medicaid Programs, and for which an **Attachment A** is incorporated into this Agreement setting forth the Providers' reimbursement for a respective Program.

1.16 Program Contract. "Contract" means the entire written agreement between HCA and [redacted]OUP, including any exhibits, documents, and materials incorporated by reference or any applicable Agency of a jurisdiction, which governs the delivery of managed health care services to Program beneficiaries.

1.17 Regulatory Requirements. "Regulatory Requirements" means any requirements imposed by applicable federal, state or local laws, rules, regulations, a Program Contract, or otherwise imposed by an Agency in connection with the operation of a Program or the performance required by either party under this Agreement

ARTICLE II
[redacted]P OBLIGATIONS

2.1 Identification Cards. [redacted]UP shall issue each Covered Person an identification card reflecting the Covered Person's name, the Covered Person's selected Primary Care Provider, the Covered Person's A[redacted]UP identification number, and such other information as required by an Agency. A sample identification card will be provided upon request of Provider.

2.2 Provider Manual. [redacted]OUP shall furnish Provider with a "Provider Manual" referencing the policies and procedures established by AM[redacted]P including, without limitation, eligibility verification, utilization review, drug utilization, quality assurance, member grievances, provider grievances, appeals and such other policies and procedures applicable to A[redacted]UP and Provider as required by Regulatory Requirements, and to otherwise effect the delivery of managed health care services to Covered Persons hereunder. [redacted]UP shall provide electronic access to its Provider Manual through [redacted]UP's websit[redacted]GROUP shall provide Provider with at least sixty (60) days prior notice of any material modifications to such Provider Manual thereafter.

2.3 Policies and Procedures. A[redacted]UP shall reference material policies and procedures applicable to Provider in the Provider Manual. Notwithstanding the above, [redacted]UP's failure to include a specific policy or procedure in the Provider Manual shall not limit the applicability of such policy and procedure to Provider; provided that [redacted]OUP uses its commercially reasonable efforts to notify Provider of such policy. [redacted]ROUP shall furnish Provider with written notice of any material modifications to such policies and procedures during the term of this Agreement, and shall respond to Provider inquiries related to such policies and procedures in a timely manner. Provider shall comply with all A[redacted]UP policies and procedures communicated to Provider by AME[redacted]

2.4 Reports. [redacted]OUP shall provide to Provider such utilization profiles or other reports, if any, which A[redacted]UP is required to provide to Provider under Regulatory Requirements.

2.5 Provider Listing; Marketing/Advertising. For the purposes of enrolling and referring Covered Persons, marketing, complying with Program Contract requirements, reporting to Agencies, and otherwise carrying out the terms and conditions of this Agreement, [redacted]OUP shall be entitled to use the name(s), business address(es), and phone number(s) of Provider including any individual Participating Provider employed by or under contract with Provider to provide services hereunder. A[redacted]UP shall, and shall be entitled to, use information related to any such individual Participating Provider's education, specialty, subspecialty, licensure, certification and hospital affiliation for the purposes described above.

2.6 Credentialing. Except as mutually agreed by the parties and as evidenced in writing by an addendum to this Agreement, A[redacted]UP shall credential Provider and all Participating Providers providing services hereunder on behalf of Provider pursuant to [redacted]OUP credentialing criteria applicable to Provider and any such Participating Providers.

2.7 Schedule of Benefits and Determination of Covered Services. AME[redacted] shall provide Provider with schedules of Covered Services for applicable Programs and will notify Provider in a timely manner of any material amendments or modifications to such schedules.

2.8 Affiliate Services.

(a) Covered Services furnished to members of certain out-of-state entities affiliated with A[redacted]P, including, without limitation, other AME[redacted] corporations ("Affiliates"), shall be paid in accordance with the rates set forth in this Agreement or such other rates established by the Affiliate's state Program governing care to out-of-state members. Such services will be furnished in accordance with the terms and conditions of the Provider Manual. Notwithstanding the above, for purposes of this Section, "Affiliate Services" shall mean those services required to be furnished to an Affiliate's members pursuant to the applicable Program in the state in which the Affiliate is responsible for furnishing services.

(b) [redacted]OUP shall be responsible for coordinating between Provider and the applicable Affiliate for any member of an Affiliate that receives services at Provider. [redacted]OUP shall ensure that the Affiliate adjudicates and pays for services furnished hereunder in accordance with this Agreement.

(c) Nothing in this Agreement shall be construed to make Provider a participating provider of any Affiliate, and Provider shall not be identified as such in any Affiliate directory of participating providers.

(d) Affiliates shall be deemed third party beneficiaries of this Section.

ARTICLE III
PROVIDER OBLIGATIONS

3.1 Provider Services. Provider shall provide to Covered Persons those Covered Services within the scope of Provider's licensure, expertise, and usual and customary range of services pursuant to the terms and conditions of this Agreement, and shall be responsible to [redacted]OUP for its performance hereunder. Provider shall provide to Covered Persons access to 24 hours a day, 7 days per week urgent and emergency services as required by Regulatory Requirements. Provider shall release to AM[redacted]P any information necessary for [redacted]OUP to perform any of its obligations under this Agreement or under the Program Contract.

3.2 Licensure and Accreditation. At all times during the term of this Agreement, Provider shall (a) maintain in good standing all applicable licenses, certifications and registrations required for Provider to furnish services hereunder; (b) be a certified Medicare and certified Medicaid Provider, to the extent required under the Programs; (c) obtain and maintain accreditation at all times during the term of this Agreement from the applicable nationally recognized accrediting body, and (d) not be subject to any determination or action that would adversely impact Provider's license or status as a certified Medicare and Medicaid provider. Provider shall ensure that each of Provider's employees is duly licensed, certified or registered as required under a Program and applicable standards of professional ethics and practice. Provider shall notify A[redacted]UP within three (3) business days following Provider's receipt of any notice of any restrictions upon, or any suspension or loss of, any licensure, certification or registration, or receipt of any notice of any restrictions, suspension or revocation of such accreditation required hereunder. Provider shall submit to AME[redacted]evidence of Provider's satisfaction of the requirements set forth in this section upon AME[redacted] reasonable request. Subject to Regulatory Requirements, AME[redacted] has the right to immediately terminate this Agreement upon the expiration, surrender, revocation, restriction, or suspension of such accreditation. Provider shall obtain and maintain a National Provider Identification number ("NPI") as required by applicable law.

3.3 Covered Person Verification. Provider shall establish a Covered Person's eligibility for services prior to rendering services, except in the case of an Emergency Medical Condition where such verification may be impractical. In the case of an Emergency Medical

Condition, Provider shall establish a Covered Person's eligibility as soon as reasonably practical. [redacted]OUP shall provide a system for Providers to contact A[redacted]P to verify Covered Person eligibility 24 hours a day, 7 days per week. Nothing contained in this Agreement shall, or shall be construed to, require advance notice, coverage verification, or pre-authorization for emergency room services provided in accordance with the federal Emergency Medical Treatment and Active Labor Act ("EMTALA") prior to Provider's rendering such services. Nothing contained in a participating provider agreement may have the effect of modifying benefits, terms, or conditions contained in the Program Contract. In the event of any conflict between the participating provider agreement and the Program Contract, the benefits, terms, and conditions of the Program Contract shall govern with respect to Covered Services provided to Covered Persons.

3.4 Provider Responsibility. A[redacted]UP shall not be liable for, nor will it exercise control or direction over, the manner or method by which Provider provides services to Covered Persons. Provider shall be solely responsible for all medical advice and services provided by Provider to Covered Persons. Provider acknowledges and agrees that [redacted]OUP may deny payment for provider services rendered to a Covered Person which it determines are not Medically Necessary, are not Covered Services pursuant to an applicable Program Contract, or are not otherwise provided in accordance with this Agreement. Neither such a denial nor any action taken by A[redacted]DUP pursuant to a utilization review, referral, or discharge planning program shall operate to modify Provider's obligation to provide appropriate services to a Covered Person under applicable law and any code of professional responsibility. Provider may discuss treatment or non-treatment options with Covered Persons irrespective of whether such treatment options are Covered Services.

3.5 Coordinated and Managed Care. Provider shall participate in AMER[redacted] systems designed to facilitate the coordination of health care services. Subject to medical judgment, patient care interests, and a patient's express instructions, and recognizing that the level of Covered Services provided by Provider may be affected by the Provider's scope of services, Provider shall use best efforts to cooperate and provide clinical encounter data as required by such systems, and shall obtain all required Covered Person consents or authorizations necessary for Provider to report such clinical encounter data to AMERI[redacted]

3.6 Concurrent Review. Provider agrees to provide access to AME[redacted] employees to review Covered Persons' medical records and perform on-site concurrent review, in accordance with WAC 284-43-324, during normal business hours. AME[redacted] employees will cooperate with the requirements of the Provider while on Provider's premises. During any such on-site concurrent review, Provider shall provide AME[redacted] with access to a telephone and appropriate work space to conduct the review.

3.7 Compliance with Credentialing, Utilization Management, Quality Assurance, Grievance, Coordination of Benefits, Third Party Liability and other Rules, Regulations, Policies and Procedures. Provider shall comply and cooperate with all AM[redacted] and Regulatory Requirements related to credentialing, utilization management, quality assurance, grievances, coordination of benefits, third party liability, and any applicable performance improvement

projects. Provider shall comply with the terms of the Provider Manual. Provider shall comply with ancillary surety bond requirement (Section 4708(d) of the Balanced Budget Act of 1997).

3.8 Insurance Coverage.

(a) Professional Liability. At all times during the term of this Agreement, Provider shall maintain professional liability insurance, including maintaining such tail or prior acts coverage necessary to avoid any gap in coverage for claims arising from incidents occurring during the term of this Agreement. Such insurance shall (i) be obtained from a carrier authorized to conduct business in the jurisdiction in which Provider operates; (ii) maintain minimum policy limits equal to $1,000,000.00 per occurrence and $3,000,000.00 in the aggregate for acute care hospitals and $1,000,000.00 per occurrence and $3,000,000.00 in the aggregate for other providers; and (iii) include coverage for the professional acts and omissions of Provider and any employee, agent or other person for whose acts or omissions Provider is responsible.

(b) General Liability. At all times during the term of this Agreement, Provider shall maintain general comprehensive liability insurance from a carrier authorized to conduct business in the jurisdiction in which Provider operates, in amounts required under Regulatory Requirements. Said insurance shall cover Provider's premises, insuring Provider against any claim of loss, liability, or damage caused by or arising out of the condition or alleged condition of said premises, or the furniture, fixtures, appliances, or equipment located therein, together with the standard liability protection against any loss, liability or damage resulting from the operation of a motor vehicle by Provider, Provider's employees or agents.

(c) Workers Compensation. Provider shall maintain workers' compensation insurance for Provider's employees. Said insurance shall be obtained from a carrier authorized to conduct business in the jurisdiction in which Provider operates and shall provide such limits of coverage as required by Regulatory Requirements.

(d) Evidence of Insurance. Provider shall provide AM[redacted] with evidence of Provider's compliance with the foregoing insurance requirements as reasonably requested by A[redacted]OUP from time to time during the term of this Agreement, but in no event less than annually. Provider shall provide AM[redacted]UP with at least thirty (30) days prior written notice of any cancellation or non-renewal of any required coverage or any reduction in the amount of Provider's coverage, and shall secure replacement coverage meeting the requirements hereunder so as to ensure no lapse in coverage. Provider shall furnish [redacted]OUP with a certificate of insurance evidencing such replacement coverage. Provider shall also furnish a certificate of insurance to a requesting Agency upon request. Provider may maintain coverage hereunder through a self-funded insurance plan, provided that Provider maintains actuarially sound reserves related to such self-funded plan and provides to [redacted]OUP on a semi-annual basis an opinion letter from an independent actuarial firm or other proof reasonably acceptable to A[redacted]UP attesting to the financial adequacy of such reserves.

3.9 Contracted Provider Requirements. Unless otherwise approved by A[redacted]UP, Provider and its employees shall perform all the services required hereunder directly and not pursuant to any subcontract between Provider and any other person or entity (a "Contracted Provider"). In the event that any portion of the services that Provider is responsible for hereunder are performed for or on behalf of Provider by a Contracted Provider, Provider shall be responsible for ensuring that such Contracted Provider furnishes such services in compliance with all of Provider's obligations under this Agreement, the Program Contract and in accordance with WAC 284-43-300 including, without limitation, maintaining required insurance, and holding Covered Persons harmless for the cost of any services or supplies provided by Contracted Providers to such Covered Persons. This section shall not preclude Provider from using contract nursing services or obtaining *locums tenens* coverage for Participating Physicians that are on temporary leave.

In accordance with 42 C.F.R. Section 455.105, Provider further agrees to furnish to [redacted]OUP or to the Secretary of Health and Human Services (the "Secretary") on request, information related to business transactions, within 35 days of the date on a request by the Secretary or an Agency, full and complete information about:

(a) The ownership of any Contracted Provider with whom Provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and

(b) Any significant business transactions between Provider and any wholly owned supplier, or between Provider and any Contracted Provider, during the 5-year period ending on the date of the request.

3.10 Proprietary Information; Confidentiality

(a) The parties acknowledge and agree that all the following information is proprietary: A[redacted]UP's quality assurance, utilization management, risk management and peer review programs; A[redacted]UP's credentialing procedures; this Agreement, including the rates of reimbursement payable under this Agreement; AM[redacted] Provider Manual; information related to A[redacted]UP programs, policies, protocols and procedures, and all information otherwise furnished to Provider by A[redacted]UP as a result of this Agreement. The parties agree not to use such proprietary information except for the purpose of carrying out their obligations under this Agreement. Neither party shall disclose any proprietary information to any person or entity without the other party's express written consent except to the extent such information is available in the public domain or was acquired by such party from a third party not bound to preserve the confidentiality of such information or unless required by law.

(b) Provider and [redacted]UP shall each treat all information which is obtained through its respective performance under the Agreement as confidential information to the extent that confidential treatment is required under applicable law and regulations, including without limitation 42 C.F.R. §422.118 and 45 C.F.R. Parts 160 and 164, as may be amended from time to time, and shall not use any information so obtained in any manner except as

necessary to the proper discharge of its obligations and securing of its rights hereunder. Provider and [redacted]OUP shall each have a system in effect to protect all records and all other documents deemed confidential by law which are maintained in connection with the respective activities of Provider or AM[redacted]P and performed in connection with this Agreement. Any disclosure or transfer of confidential information by Provider or AME[redacted] will be in accordance with applicable law.

3.11 Representations and Warranties.

(a) Provider Status. Provider hereby represents and warrants that Provider: (i) has the power and authority to enter into this Agreement; (ii) is legally organized and operated to provide the services contemplated hereunder; (iii) is not in violation of any licensure or accreditation requirement applicable to Provider under law, Program Contract or Agency rules; (iv) is in good standing with HCA; (v) has not been convicted of bribery or attempted bribery of any official or employee of the jurisdiction in which Provider operates, nor made an admission of guilt of such conduct which is a matter of record; (vi) is capable of providing all data related to the services provided hereunder in a timely manner as reasonably required by AMER[redacted]o satisfy Regulatory Requirements, including, without limitation, data required under the Health Employer Data and Information Set and National Committee for Quality Assurance requirements; and (vii) qualifies as a participating provider in all Programs in accordance with the applicable Regulatory Requirements.

(b) Provider Information and Documentation. Provider represents and warrants that all information provided by Provider to AM[redacted] including without limitation, information relating to insurance coverage, quality assurance, credentialing, change of ownership of Provider and availability of medical care by Provider to Covered Persons, is true and correct as of the date such information is furnished, and Provider is unaware of any undisclosed facts or circumstances that would make such information inaccurate or misleading. Provider shall provide A[redacted]UP with written notice of any changes to such information within five (5) business days of such change.

(c) [redacted]UP Status. [redacted]ROUP hereby represents and warrants that [redacted]DUP: (i) has the power and authority to enter into this Agreement; (ii) is not in violation of any licensure or accreditation requirement applicable to AME[redacted] under Regulatory Requirements; (iii) has not been convicted of bribery or attempted bribery of any official or employee of the jurisdiction in which AM[redacted] operates, nor made an admission of guilt of such conduct which is a matter of record; (iv) qualifies to participate in a Program as of the date on which Provider may furnish Covered Services hereunder for such Program; and (v) is not, to A[redacted]'s best knowledge, the subject of an inquiry or investigation that could foreseeably result in AM[redacted] failing to comply with the representations in subsections (i) – (iv) above.

3.12 Reporting Fraud and Abuse. Provider shall cooperate with AM[redacted] anti-fraud compliance program. If Provider identifies any actual or suspected fraud, abuse or misconduct in connection with the services rendered hereunder, in violation of state or federal

law, Provider immediately shall report such activity directly to AME[redacted] in accordance with the Provider Manual. Provider shall comply with HCA approved fraud and abuse policies and procedures.

3.13 Conformance with Law. Without limiting the applicability of, any other sanctions and penalties that may be applicable for Provider's failure to conform with such federal, state and local laws, rules and regulations, Provider acknowledges and agrees that, in connection with the Medicare Program, Provider's failure to report potential fraud or abuse to CMS may result in sanctions, cancellation of contract, or exclusion from participation in the Medicare Program. Provider agrees to comply with all state and federal laws, rules and regulations that apply to all persons receiving state and federal funds, including without limitation, all applicable Medicare laws, rules and regulations and all CMS instructions.

3.14 Provision of Non-Covered Services. Except in the case of an Emergency Medical Condition, prior to the provision of any services to a Covered Person that are not Covered Services, Provider (a) shall advise the Covered Person, in writing, (i) of the nature of the service; (ii) that the service is not a Covered Service for which compensation is payable hereunder; and (iii) that the Covered Person will be responsible for paying for the service; and (b) shall otherwise comply with all Regulatory Requirements related to the provision of non-covered services to Covered Persons.

3.15 Provider Disclosures.

(a) Disclosures of Ownership and Control. In accordance with Regulatory Requirements, Provider shall disclose its information on ownership and control to HCA in the following circumstances:

(1) upon contract execution, upon request during the re-validation of enrollment process, and within thirty-five (35) business days after any change in ownership of Provider;

(2) the name and address of any person (individual or corporation) with an ownership or control interest in Provider;

(3) if Provider is a corporate entity, the disclosure must include primary business address, every business location, and P.O. box address;

(4) if Provider has corporate ownership, the tax identification number of the corporate owner(s);

(5) if Provider is an individual, date of birth and Social Security Number;

(6) if Provider has a five percent (5%) ownership interest in any of its subcontractors, the tax identification number of the subcontractor(s);

(7) whether any person with an ownership or control interest in Provider is related by marriage or blood as a spouse, parent, child, or sibling to any other person with an ownership or control interest in Provider;

(8) if Provider has a five percent (5%) ownership interest in any of its subcontractors, whether any person with an ownership or control interest in such subcontractor is related by marriage or blood as a spouse, parent, child, or sibling to any other person with an ownership or control interest in Provider.

(9) whether any person with an ownership or control interest in Provider also has an ownership or control interest in any other Medicaid provider, in the state's fiscal provider or in any managed care entity.

(b) Disclosures of Information on Persons Convicted of Crimes. In accordance with Regulatory Requirements, Provider shall disclose investigate and disclose to HCA and [redacted]OUP, upon contract execution or renewal, and upon request of HCA or [redacted]OUP, the identity of any person who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs and who is:

(1) A person who has an ownership or control interest in the Provider.

(2) An agent or person who has been delegated the authority to obligate or act on behalf of Provider.

(3) An agent, managing employee, general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of, the Provider.

ARTICLE IV
REIMBURSEMENT

4.1 Claims Submission. Except to the extent Provider is compensated on a capitation basis under this Agreement, Provider shall submit claims on either a current CMS-1500 claim form for professional claims or a CMS-1450 claim form for institutional claims (or successor forms), or the electronic equivalent in the manner and to the location described in the Provider Manual. Provider is encouraged to submit claims information through electronic data interchange ("EDI") that allows for automated processing and adjudication of claims. As [redacted]ROUP continues to develop electronic interface systems for registration, eligibility and benefit verification and claims processing, Provider will use such electronic interface systems.

Provider must use HIPAA compliant billing codes when billing or submitting encounter data. This applies to both electronic and paper claims. When billing codes are updated, Provider is required to use appropriate replacement codes for submitted claims for Covered Services. In its discretion, AM[redacted]P may amend the Agreement as it deems necessary to clarify

changes to standard billing codes. Regardless of whether AM[redacted] so amends the Agreement, [redacted]OUP shall not pay any claims submitted using non-compliant billing codes.

Claims must be submitted within three hundred sixty five (365) days following the date service is rendered. Claims not received by AM[redacted]P from Provider within such period may be denied payment. [redacted]OUP will not deny Clean Claims for payment solely due to these claims being received after three hundred sixty five (365) days from the date services were rendered in the event that Provider was unable to determine that the patient was an [redacted]OUP Covered Person, and where Provider timely filed such claim with another payor. In such event, Provider shall have three hundred sixty five (365) days to resubmit such claim to [redacted]OUP from the date Provider receives a denial from the payor to which Provider originally submitted the claim. Such submission shall include proof of timely filing, and denial by, such other payor.

4.2 Reimbursement. As payment in full for Covered Services provided to Covered Persons hereunder, [redacted]OUP shall pay to Provider the reimbursement specifically set forth in each Attachment A applicable to M[redacted] and [redacted] The parties agree that each of [redacted], [redacted]ch a[redacted]nie, respectively, shall bill [redacted]OUP for the Covered Services it provides to Covered Persons and AM[redacted] shall reimburse each of M[redacted] and [redacted]e as appropriate in accordance with each Attachment A applicable to M[redacted] or S[redacted], provided, however, that only one of [redacted], [redacted]h an[redacted]nie shall be entitled to bill for each Covered Service provided to a Covered Person. Notwithstanding any provision contained in this Agreement, to the extent AM[redacted]P has paid one of M[redacted]r Sn[redacted] for a Covered Service, such payment shall satisfy in full AM[redacted]s obligation to each of [redacted], [redacted]h an[redacted]nie with regard to such Covered Service and in no event shall [redacted]OUP be liable in connection with such Covered Service for any additional amounts to any party. [redacted], [redacted]h an[redacted]ie shall jointly and severally indemnify and hold harmless [redacted]OUP from and against any claims, demands, obligations and liabilities, including reasonable attorneys' fees and costs, for or in connection with any such additional amounts. . Reimbursement for Clean Claims shall be made in accordance with all prompt pay requirements as established under applicable law. Ninety-five percent (95%) of the monthly volume of clean claims shall be paid within thirty (30) days of receipt by AMER[redacted]and ninety-five percent (95%) of the monthly volume of all claims shall be paid or denied within sixty (60) days of receipt and ninety-nine percent (99%) within (90) calendar days of receipt by [redacted]UP, except as agreed to in writing by the parties on a claim-by-claim basis. Provider agrees to accept payments or appropriate denials made in accordance with this Agreement as payment in full for all Covered Services provided to Covered Persons. Provider shall be responsible for collecting co-payments from Covered Persons to the extent required by Regulatory Requirements.

With respect to Medicaid Covered Services, A[redacted]JP shall pay Provider interest at the rate of one (1) percent per month, as set forth in WAC 284-43-321(2)(d), which section may be amended or recodified from time to time, on the unpaid portion of Medicaid Clean

Claims not adjudicated within such period as required under applicable prompt pay requirements. With respect to Medicare Covered Services, AM[redacted]P shall pay Provider interest at a rate equal to the CMS interest rate in effect at the time of such charge. [redacted]OUP will update the CMS interest rate applicable to this Agreement on a prospective basis within thirty (30) days following its publication in the Federal Register.

[redacted]OUP reserves the right to conduct chart review upon reasonable notice to Provider in order to determine the appropriateness of services and/or charges on a specific claim. In accordance with WAC 284-43-324(3), Provider shall be granted similar rights to review [redacted]OUP denials of specific claims. A[redacted]UP reserves the right to use a code-editing software to determine which services are considered part of, incidental to, or inclusive of the primary procedure.

4.3 Capitation of Contracted Providers; Encounter Data Requirements. If Provider is compensated for services provided hereunder on a capitated basis, Provider shall:

(a) Arrange and coordinate all capitated Covered Services for Covered Persons assigned to Provider or one of Provider's Participating Physicians for such capitated Covered Services;

(b) Accept the capitation payment payable hereunder as payment in full for all such capitated Covered Services provided to such Covered Persons; and

(c) Timely submit complete encounter data for capitated services rendered to Covered Persons, including, without limitation, statistical and descriptive medical, diagnostic and patient data for Covered Services rendered to Covered Persons, and reporting requirements included in applicable Program Contracts. Provider shall completely and accurately report encounter data to A[redacted]UP. Provider shall ensure that it has the capacity to submit all required data to enable A[redacted]UP to meet the reporting requirements in the Encounter Data Transaction Guide published by HCA.

(d) If Provider is not compensated on a capitation basis, the Provider shall be compensated as stated in Section 4.2 above.

4.4 Financial Incentives. No provision in this Agreement shall, or shall be construed to, create any incentive, financial or otherwise, for Provider to withhold Medically Necessary services.

4.5 Recoveries from Third Parties. Provider acknowledges and agrees that claims payments made by [redacted]OUP pursuant to Program requirements are subject to Program requirements regarding third party liability. Provider shall cooperate with AMER[redacted] policies and procedures related to third party liability recovery in the event claims for services rendered by Provider to a Covered Person are related to an illness or injury for which a third party may be liable, including, without limitation, claims that may be covered by automobile insurance, workers' compensation coverage, other health insurance, or otherwise give rise to a

claim for third party liability, coordination of benefits or subrogation (to the extent permitted by Regulatory Requirements). Provider shall take all reasonable actions required by [redacted]OUP to assis[redacted]ROUP in obtaining such recoveries, including executing any appropriate documents reasonably requested by AM[redacted]P to enforce such claims or to assign any payments to AM[redacted] However Provider and A[redacted]P shall not refuse or reduce services provided under this agreement solely due to the existence of similar benefits under any other health care contract. In addition AME[redacted] shall pay claims for prenatal care and preventive pediatric care and shall seek reimbursement from such third parties.

4.6 Right of Refund/Request for Additional Payments. AM[redacted] shall be entitled to request a refund in an amount equal to any overpayments made by AME[redacted] to Provider provided that any refund requests by AME[redacted] shall be made in conformance with RCW 48.43.600 timelines for notice and objection, as such section may be amended or recodified from time to time. Upon determination that an overpayment is due from Provider to [redacted]GROUP shall first give Provider notice of overpayment and request reimbursement via check for such an overpayment. If Provider fails to contest the request in writing within thirty (30) days following the date of Provider's receipt of such notice, the request is deemed accepted. Provider then must submit a check to AM[redacted] for such overpayment, or [redacted]DUP shall be entitled to offset such overpayment against other amounts due and payable by [redacted]DUP to Provider. Except in the case of fraud by the Provider, payments made by[redacted]up shall be considered final and not subject to adjustment twenty-four (24) months after such payment is received by Provider.

If Provider determines that AM[redacted]P has made an underpayment to Provider for Covered Services rendered to a Covered Person, Provider shall make a written request for additional payment from A[redacted]JP only in accordance with RCW 48.43.605, as such section may be amended or recodified from time to time. Such written request must specify the reasons for such underpayment request and must be submitted within twenty-four (24) months after the date that the claim was denied by AM[redacted]P or payment intended to satisfy the claim was made by AM[redacted]

4.7 Provider-Preventable Conditions. Provider understands and agrees that no payment will be made to Provider by A[redacted]UP for any provider-preventable conditions which have been identified by an applicable Agency/Program or pursuant to Regulatory Requirements. In addition, Provider shall identify provider-preventable conditions that are associated with claims for services provided under a Program hereunder or with courses of treatment furnished to Covered Persons for which payment under a Program would otherwise be available.

ARTICLE V
PROVISIONS APPLICABLE TO PHYSICIAN, [redacted]L AND FACILITY PROVIDERS

5.1 Primary Care Provider Services. If Provider is furnishing Primary Care Services under this Agreement, Provider shall, and shall cause the Primary Care Providers employed by or under contract with Provider to, accept as patients all Covered Persons who are eligible and have

chosen a Primary Care Physician with an open panel to receive their Primary Care Services from Provider or a Primary Care Provider employed by or under contract with Provider. Provider further agrees to provide, or to arrange for the provision of, appropriate Primary Care Services to such Covered Persons. Provider and any Primary Care Providers employed by or under contract with Provider, shall refer Covered Persons to Specialist Physicians only in accordance with procedures established by AM[redacted]

5.2 Specialist Physician Services. If Provider is furnishing Specialist Physician services under this Agreement, Provider, and the Specialist Physicians employed by or under contract with Provider, shall accept as patients all Covered Persons who are referred by Primary Care Providers to Provider. Provider shall provide, or arrange for the provision of, appropriate Specialist Physician Covered Services (as may be more specifically described in **Attachment A** to this Agreement). Provider and any Specialist Physicians employed by or under contract with Provider, shall refer Covered Persons to other Specialist Physicians only in accordance with procedures established by AM[redacted]

5.3 Hospital Affiliation and Privileges. Provider, in the case of a solo provider, or any providers employed by or under contract with Provider, in the case of a group provider, shall maintain in effect privileges to practice at one or more Participating Hospitals. Provider shall immediately notify A[redacted]UP in the event any such hospital privileges are revoked, limited, surrendered, or suspended at any hospital or health care facility.

5.4 Participating Provider Requirements. If Provider is a group provider, Provider shall cause all Participating Providers employed by or under contract with Provider to comply with all terms and conditions of this Agreement. Notwithstanding the foregoing, Provider acknowledges and agrees that A[redacted]UP is not obligated to accept as Participating Providers all providers employed by or under contract with Provider.

5.5 Federally Qualified Health Centers. If Provider is a federally qualified health center ("FQHC") or a rural health center ("R[redacted] as defined under applicable federal law, Provider shall comply with all requirements related to FQHCs and RHCs under Regulatory Requirements including, without limitation, compliance with the service quality standards required in connection with current and future clinical quality reporting methods that are applicable to FQHCs and administered by federal oversight agencies.

5.6 Post-Stabilization. Provider shall comply with all applicable law related to the post-stabilization care of a Covered Person after an Emergency Medical Condition has been stabilized.

5.7 Automatic Termination; Automatic Exclusion.

(a) Automatic Termination. If Provider is an individual Provider, in addition to the other termination provisions set forth in this Agreement, this Agreement shall automatically and immediately terminate upon the expiration, surrender, revocation or restriction

of Provider's medical staff privileges at any one or more Participating Hospitals or if Provider fails to maintain active staff privileges with respect to at least one (1) Participating Hospital.

If Provider is a group medical practice, in addition to the other termination provisions set forth in this Agreement, this Agreement shall automatically and immediately terminate only with regard to the individual Participating Provider who is subject to the expiration, surrender, revocation, restriction or suspension of the Provider's medical staff privileges at any one or more Participating Hospitals, or if Provider fails to maintain active staff privileges with respect to at least one Participating Hospital.

(b) Automatic Exclusion. If Provider is a group provider, then upon the occurrence of any of the actions described in subparagraph (a) above related to the medical staff privileges of an individual Participating Provider employed by or contracted with Provider, [redacted]ROUP shall be entitled to exclude such Participating Provider from participation under this Agreement.

5.8 Exclusion of Individual Participating Providers. Notwithstanding any other provision contained in this Agreement, A[redacted]JP shall be entitled to exclude from participation under this Agreement an individual Participating Provider employed by or contracted with Provider, for any of the reasons included in, and in accordance with the terms and conditions of, the termination provisions otherwise included in the Agreement. In the event of such exclusion, this Agreement shall continue in full force and effect as to all other Participating Providers employed by or contracted with Provider who are not so excluded.

5.9 Effect of Termination or Exclusion of Specialist Physicians. In the event any Specialist Physicians employed by or under contract with Provider are excluded from participation under this Agreement, or in the event that Provider is a Specialist Physician, if this Agreement is terminated for any reason, A[redacted]JP shall notify all affected Covered Persons under treatment by such Specialist Physician of such termination prior to the effective date of such termination.

5.10 Provider's Obligations in Case of Emergency Medical Condition Affecting Covered Person.

(a) Provider shall render timely and appropriate Medically Necessary services to treat an Emergency Medical Condition affecting a Covered Person, and shall comply with all applicable law related to the post-stabilization care of a Covered Person after an Emergency Medical Condition has been stabilized. Provider shall use its best efforts to notify [redacted]ROUP at the time of eligibility verification or by the end of the next business day after admission and identification of a Covered Person as an inpatient, or after rendition of emergency outpatient Covered Services to a Covered Person. Notwithstanding any provision contained in this Agreement, no notification to, or coverage verification or pre-authorization from, [redacted]OUP is required prior to Provider rendering Emergency Services to a Covered Person.

(b) If Emergency Services are required for an Emergency Medical Condition affecting a Covered Person and such Covered Person's condition cannot be treated at Provider's facilities, or if no Participating Specialist Physician with hospital privileges at Provider's facility is available to treat the Covered Person at Provider's facility, Provider shall arrange for the services of an alternate Participating Hospital, or, as applicable, the services of an alternate Participating Specialist Physician; provided, however, that in the event obtaining the services of an alternate Participating Hospital or an alternate Participating Specialist Physician is impractical, Provider shall arrange for the services by an appropriate non-participating hospital or, as applicable, an appropriate non-participating specialist physician.

5.11 Claim Submission for Facilities. In addition to the other requirements described in this Agreement related to Provider's claim submission, for inpatient lengths of stay in excess of thirty (30) days, Provider, at its discretion, may provide AME[redacted] with interim claims within ten (10) days after the end of the initial thirty (30) day period or any successive thirty (30) day period thereafter.

5.12 Physician Privileges. Subject to Provider's medical staff approval for privileges, Provider shall grant admitting and attending privileges to AME[redacted] Participating Physicians who satisfy Provider's credentialing criteria.

ARTICLE VI
COMPLIANCE WITH REGULATORY REQUIREMENTS

6.1 Compliance with Regulatory Requirements. A[redacted]P and Provider shall each comply with all applicable Regulatory Requirements related to this Agreement. The failure of this Agreement to expressly reference a Regulatory Requirement applicable to either party in connection with their duties and responsibilities hereunder shall in no way limit such party's obligation to comply with such Regulatory Requirement.

6.2 Hold Harmless. Provider agrees to abide by the provisions of WAC 182-502-160, and agrees that in no event, including, but not limited to non-payment by AME[redacted]OUP 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 Covered Person, any person acting on behalf of a Covered Person, or HCA for services provided pursuant to this Agreement and Provider shall accept payment from AMER[redacted]s payment in full. This provision shall not prohibit collection of nominal cost-sharing or supplemental charges made in accordance with the terms of applicable Program Contracts or Agency requirements. Provider further agrees that this section shall survive the termination of this Agreement regardless of the cause giving rise to such termination and shall be construed to be for the benefit of Covered Person, and that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and a Covered Person or persons acting on such Covered Person's behalf. Provider agrees and understands that willfully collecting or attempting to collect an amount from a covered person knowing that collection to be in violation of the participating provider or facility contract constitutes a class C felony under RCW 48.80.030(5). Provider agrees, in the event of AME[redacted]nsolvency,

to continue to provide the services promised in this Agreement to Covered Persons of [redacted]OUP for the duration of the period for which premiums on behalf of the Covered Person were paid to provider or until the Covered Person's discharge from inpatient facilities, whichever time is greater. Notwithstanding any other provision of this Agreement, nothing in this Agreement shall be construed to modify the rights and benefits contained in the Covered Person's health plan. Provider may not bill the Covered Person for Covered Services (except for deductibles, copayments, or coinsurance) where AM[redacted] denies payments because the provider has failed to comply with the terms or conditions of this Agreement. Provider further agrees (i) that the provisions of WAC 284-43-320(a), (b), (c), and (d) shall survive termination of this contract regardless of the cause giving rise to termination and shall be construed to be for the benefit of provider's Covered Persons, and (ii) that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between provider and Covered Persons or persons acting on their behalf. If provider agreements with other providers who agree to provide Covered Services to Covered Persons of A[redacted]P with the expectation of receiving payment directly or indirectly from AM[redacted], such providers must agree to abide by the provisions of WAC 284-43-320 (a), (b), (c), (d), and (e).

Documents, procedures, and other administrative policies and programs referenced in the Program Contract must be available for review by the Provider prior to contracting. Providers must be given reasonable notice of not less than sixty (60) days of changes that affect provider compensation and that affect health care service delivery unless changes to federal or state law or regulations make such advance notice impossible, in which case notice shall be provided as soon as possible.

Pursuant to 42 C.F.R. §422.504(i)(3)(g)(1), Provider agrees to hold harmless all Medicare-eligible Covered Persons and look solely to AM[redacted]P for the payment of any compensation due from [redacted]OUP to Provider. In accordance with 422.504(g)(1)(i) and 422.504(i)(3)(i), Provider shall not hold any enrollee liable for payment of any fees that are the legal obligation of AM[redacted]

6.3 Compliance with Program Contract. Nothing in this Agreement shall be construed to terminate or reduce the legal responsibility of AME[redacted]o state Agency to ensure that all activities under Program Contract are carried out. AME[redacted] shall afford Provider access to all necessary training and information to enable Provider to carry out its responsibilities under the Program Contract.

6.4 Medicare Co-payments and Deductibles; Limitations of Billing.

(a) In connection with the Medicare Program, applicable co-payments and deductibles as permitted under the Medicare Program and set forth in the AM[redacted] Provider Manual or in the schedule of benefits for the Medicare Program are the only amounts that Provider may collect from a Medicare-eligible Covered Person in connection with Covered Services. Provider acknowledges that Medicaid cost-sharing requirements may preclude Provider's collection of co-payments or deductibles from dual eligible Medicare and Medicaid Covered Persons.

(b) Provider shall be responsible for collecting any known and applicable Medicare Program co-payments or deductibles in accordance with the policies and procedures set forth in the AM[redacted]P Provider Manual.

(c) Provider understands that if Provider initiates any actions to collect payment from any Medicare-eligible Covered Person over and above allowable co-payments, excluding payment for services not covered under the Medicare Program, AM[redacted] will initiate and maintain such necessary action to stop Provider or Provider's employee, agent, assign, trustee, or successor in interest from maintaining such action against such Medicare-eligible Covered Person.

(d) Covered Persons eligible for both Medicare and Medicaid will not be held liable for Medicare Part A and B cost sharing when the State of Washington is responsible for paying such amounts. [redacted]OUP will not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the member under title XIX if the member were not enrolled in such a plan. The provider will accept AM[redacted] payment as payment in full or bill the appropriate State source, as appropriate.

6.5 Appointment Waiting Times. Provider shall offer hours of operation that are no less than the hours of operation offered to patients with other insurance coverage, including but not limited to commercial health plans. If Provider is a primary care physician, Provider is encouraged to offer after-hours office care to Covered Persons on evenings and weekends. Provider agrees that it will provide for regular monitoring of timely access and corrective action by [redacted]OUP if Provider fails to comply with the appointment wait time standards as stated in 42 CFR 438.206(c)(1). Provider shall comply with 42 CFR §438.206(c)(1). Provider shall comply with appointment standards that are no longer than the following: (a) Transitional healthcare services by a primary care provider shall be available for clinical assessment and care planning within seven (7) calendar days of discharge from inpatient or institutional care for physical or behavioral health disorders or discharge from a substance use disorder treatment program; (b) Transitional healthcare services by a home care nurse or home care registered counselor within seven (7) calendar days of discharge from inpatient or institutional care for physical or behavioral health disorders or discharge from a substance use disorder treatment program, if ordered by the enrollee's primary care provider or as part of the discharge plan; (c) Non-symptomatic (i.e., preventive care) office visits shall be available from the Covered Person's PCP or another provider within thirty (30) calendar days. A non-symptomatic office visit may include, but is not limited to, well/preventive care such as physical examinations, annual gynecological examinations, or child and adult immunizations; (d) Non-urgent, symptomatic (i.e., routine care) office visits shall be available from the Covered Person's PCP or another provider within ten (10) calendar days. A non-urgent, symptomatic office visit is associated with the presentation of medical signs not requiring immediate attention; (e) Urgent, symptomatic office visits shall be available from the Covered Person's PCP or another provider within twenty-four (24) hours. An urgent, symptomatic visit is associated with the presentation of medical signs that require immediate attention, but are not life threatening; and (f) Emergency medical care shall be available twenty-four (24) hours per day, seven (7) days per week.

6.6 Non-Discrimination. Provider shall abide by the federal Civil Rights Act of 1964, the Federal Rehabilitation Act of 1973, and all other applicable statutes, regulations and orders (including, without limitation, Executive Orders 11246 and 11375, "Equal Employment Opportunities") as amended, and any and all successor statutes, regulations and related orders. Provider shall not exclude any Covered Person from participation in any aid, care, service or other benefit, or deny any Covered Person such services on the grounds of race, color, national origin, sex, age, disability, political beliefs or religion. Provider shall not subject any Covered Person to discrimination due to such Covered Person's status as a Program Contract beneficiary. [redacted]OUP is responsible for ensuring that providers furnish Covered Services to Covered Persons without regard to the Covered Person's enrollment in the plan as a private purchaser of the plan or as a participant in publicly financed programs of health care services. This requirement does not apply to circumstances when the provider should not render services due to limitations arising from lack of training, experience, skill, or licensing restrictions.

6.7 Transfers of Covered Persons. Without otherwise limiting AM[redacted] rights pursuant to this Agreement, upon AM[redacted]'s determination made in good faith and with reasonable belief that a Covered Person's health or safety is in jeopardy, AMER[redacted] may require that such Covered Person be transferred immediately for care to another provider at [redacted]UP's direction, and Provider shall fully cooperate with any such transfer requirement.

6.8 Prohibited Practices. Nothing in this Agreement shall be construed as prohibiting any Participating Provider from:

(a) Discussing treatment or non-treatment options with Covered Persons irrespective of A[redacted]P's position on such treatment or non-treatment options or whether such treatment options are Covered Services;

(b) Acting within the lawful scope of such provider's practice, advising or advocating on behalf of a Covered Person for such Covered Person's health status, medical care, or treatment or non-treatment options, including any alternative treatments that might be self-administered by the Covered Person;

(c) Advocating on behalf of a Covered Person within the utilization review or grievance processes established by A[redacted]DUP or individual authorization process to obtain Medically Necessary Covered Services; or

(d) Discouraging Covered Persons 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 a carrier.

6.9 Authorizations. Provider shall comply with AM[redacted]s preauthorization and authorization processes and procedures applicable to Provider as more fully set forth in the Provider Manual.

6.10 Non-Discrimination Against Participating Providers. Neither AM[redacted] nor Provider shall discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of such provider's license or certification under applicable State law, solely on the basis of such license or certification. This requirement shall not be construed as an "any willing provider" law, and AM[redacted] may limit provider participation to the extent necessary to meet the needs of Covered Persons or to establish any measures designed to maintain quality and control costs. Neither AME[redacted] nor Provider shall discriminate against providers serving high-risk populations or those that specialize in conditions requiring costly treatments.

6.11 Cultural Competency Plan. Provider shall participate with the State's efforts to promote the delivery of services in a culturally competent manner to all Covered Persons, including those with limited English proficiency and diverse cultural ethnic backgrounds. To that end, Provider shall use best efforts to comply with all known AME[redacted] policies and procedures designed to ensure that culturally competent services, including but not limited to effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs, are provided by [redacted]OUP both directly and through its health care providers and subcontractors.

6.12 Marketing. Provider shall not engage in any marketing activities to Covered Persons, for or on behalf of A[redacted]P, except in accordance with Regulatory Requirements. Specifically, Provider shall not distribute any marketing materials to Covered Persons or in connection with A[redacted]OUP services unless such materials are first submitted by Provider to A[redacted] and [redacted]UP submits such materials to HCA for approval.

6.13 Compliance with Federal Regulations. [redacted]P and Provider acknowledge and agree that the services provided hereunder are subject to federal regulations governing operation of a Medicaid managed care program. In connection therewith, the parties agree to comply with all applicable requirements of 42 C.F.R. Part 434 and 42 C.F.R. Section 438.6 as they pertain to the subject matter of this Agreement.

6.14 Employed or Contracted Individuals. In no event shall Provider employ or subcontract any responsibilities hereunder to any individual who has been excluded from participation under any federal or state health benefits program, including without limitation the Medicaid or Medicare programs.

6.15 Prohibited Referrals. In accordance with federal and state law, Provider is prohibited from referring any Covered Persons for designated health services to any entity in which Provider, or a member of Provider's immediate family, has a financial relationship.

6.16 Cooperation upon Transfers of Members. Provider agrees to fully cooperate with [redacted]OUP and with providers of other health plans in connection with any transition of

care of a Covered Person to another provider so as to assure maximum health outcomes for any such Covered Person.

6.17 Reporting Requirements.

(a) In accordance with 42 C.F.R. §422.504(i); AM[redacted]P and Provider expressly agree in each case as permitted by law:

(i) HHS, the Comptroller General of HHS (the "Comptroller General") or their designees, may audit, evaluate, or inspect any books, contracts, medical records, patient care documentation, and all other records of AME[redacted] and Provider, as well as their related entities, contractors, subcontractors or transferees, that pertain to any aspect of the services performed under this Agreement, reconciliation of benefit liabilities, and determination of amounts payable under this Agreement, or as the Secretary of HHS (the "Secretary") may deem necessary to enforce this Agreement.

(ii) [redacted]OUP and Provider each agree to make available, for the purposes specified in 42 C.F.R. §422.504(d), (e), their respective premises, physical facilities and equipment, records relating to Covered Persons and any additional relevant information that CMS may require.

(iii) HHS, the Comptroller General, or their designees' right to inspect, evaluate and audit shall extend through ten (10) years from the final date of the Medicare Program contract or the completion of a final audit by CMS related to same, whichever is later, unless CMS determines there is a special need to retain a particular record or group of records for a longer period and so notifies A[redacted]UP at least thirty (30) days prior to the normal disposition date, or CMS determines there is a reasonable possibility of fraud.

(b) In accordance with 42 C.F.R. §422.504(a)(8), Provider shall comply with reporting requirements in 42 C.F.R. §422.516 and the requirements in 42 C.F.R. §422.310 for submitting data to CMS.

6.18 Delegation. In accordance with 42 C.F.R. §422.504(i)(3)(iii), any services or other activity performed by a related entity, contractor, subcontractor, or first-tier or downstream entity of Provider in accordance with a contract or written agreement shall be consistent and comply with [redacted]UP's contractual obligations with CMS. Provider shall comply with the requirements of 42 C.F.R. §422.504(i)(4) if any of A[redacted]'s activities or responsibilities under its contract with CMS are delegated to other parties. Delegated activities shall be documented and agreed upon between AM[redacted]P and Provider.

6.19 Accountability. In accordance with 42 C.F.R. §422.504(i)(3)(ii), Provider may only delegate activities or functions to a provider, related entity, contractor, or subcontractor in a manner consistent with the requirements set forth in 42 C.F.R. §422.504(i)(4). In accordance with 42 C.F.R. 422.504(i), A[redacted]UP shall oversee and be ultimately responsible to CMS for all responsibilities described in this Agreement.

6.20 Laboratory Compliance. Provider shall comply with all requirements of the Clinical Laboratory Improvement Act ("CLIA"), regulations promulgated thereunder and any amendments and successor statutes and regulations thereto. Upon execution of this Agreement, Provider shall furnish written verification to AM[redacted]P that Provider's laboratory facilities, if any, and those with which it conducts business related to Covered Persons, have appropriate CLIA certification of registration or waiver and a CLIA identification number. Provider shall notify [redacted]OUP in writing of any changes in Provider's CLIA certification status or the certification status of any laboratory facilities with which Provider conducts business related to Covered Persons within five (5) business days of any such changes.

6.21 Right to Review Records/Availability of Records.

(a) In addition to and without limiting any audit rights otherwise set forth in the Agreement and immediate access for Medicaid fraud investigators, Provider agrees that agents and employees of HCA and HHS shall have the right to inspect, evaluate and audit any pertinent books, financial records, documents, papers, and records of Provider involving financial transactions related to a Program Contract. HCA representatives and authorized federal and state personnel including, but not limited to the Office of the Inspector General (OIG), the Medicaid Fraud Control Unit (MFCU), HHS, the Department of Justice (DOJ), the Comptroller of the Treasury and any other duly authorized state or federal agency, shall have immediate and complete access to all records pertaining to services provided to Covered Persons.

(b) Provider shall make all records, including, but not limited to, financial, administrative and medical records available at Provider's expense, including computerized data stored by Provider, to any duly authorized government agency, including, but not limited to, HCA, CMS, OIG, MFCU, HHS, DOJ and the Office of the Comptroller of the Treasury, upon any authorized government agency's request for administrative, civil and/or criminal review, audit, evaluation, inspection, investigation and/or prosecution . HCA, CMS, OIG, MFCU, HHS , DOJ and the Office of the Comptroller of the Treasury, as well as any authorized state or federal agency or entity shall have the right to evaluate through inspection, evaluation, review or request, whether announced or unannounced, or other means, any record pertinent to this Agreement, including but not limited to medical records, billing records, financial records, and/or any records related to services rendered, quality, appropriateness and timeliness of services and/or any records relevant to an administrative, civil and/or criminal investigation and/or prosecution, and such evaluation, inspection, review or request, when performed or requested, shall be performed with the immediate cooperation of the Provider. Requested records shall be provided at no expense to Agency personnel, including representatives from HCA, OIG, the MFCU, DOJ and the HHS, or any duly authorized state or federal agency. Upon request, the Provider shall assist in such reviews, and provide complete copies of medical records. Any authorized government agency, including but not limited to, HCA, CMS, OIG, MFCU, HHS, DOJ and the Office of the Comptroller of the Treasury, may use these records to carry out their authorized duties, reviews, audits, administrative, civil and/or criminal investigations and/or prosecutions. Provider shall cooperate fully in any audit, investigation or review by [redacted]UP, Agency, MPI, MFCU, or other state or federal entity and in any subsequent legal action that may result from such an audit, investigation or review involving this

Agreement, including promptly supplying all data and information requested for such investigation; provided that nothing in this section shall be construed to limit a Provider's right to defend its actions in any legal proceeding in accordance with its rights under the law.

6.22 Provider to Monitor Quality. Provider shall maintain a quality assurance system to monitor the quality of services delivered under this Agreement and initiate corrective action where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which the Provider practices and/or the standards established by the Program or its designee.

6.23 Availability of Records. A[redacted]UP and Provider recognize that in the event of termination of the Medicaid Program between A[redacted]UP and the Program for any of the reasons described in the Medicaid Program Contract, AME[redacted] shall immediately make available, to the Program, or its designated representative, in a usable form, any and all records, whether medical or financial, related to AM[redacted]s and Provider's activities undertaken pursuant to this Agreement. The provision of such records shall be at no expense to the Program.

6.24 FQH[redacted]C. If Provider is an FQHC/[redacted], [redacted]UP shall adhere to federal requirements for reimbursement for FQHC/RH[redacted]services. The agreed upon payment from [redacted]UP to the FQ[redacted]/RHC is set forth in Attachment A to this Agreement. Any bonus or incentive arrangements made to the FQHCs/RHCs associated with Program Covered Persons shall also be specified to the Program. AME[redacted] shall submit the name of Provider and the number of Medicaid encounters paid to Provider by month of service to the Program for reasonable cost based reconciliation purposes.

6.25 Lobbying. By signing this Agreement, Provider certifies to the best of its knowledge and belief that federal funds have not been used for lobbying in accordance with 45 CFR Part 93 and 31 USC 1352. Provider shall disclose any lobbying activities using non-federal funds in accordance with and to the extent required by 45 CFR Part 93.

6.26 Covered Person Rights. Notwithstanding anything to the contrary in this Agreement, Provider agrees to observe, protect and promote all rights of Covered Persons as patients in accordance with all applicable laws, Program Contract and Agency requirements. Provider shall provide any information that a Covered person needs in order to decide among all relevant treatment options.

6.27 Survival. Upon expiration or termination of this Agreement for any reason, with or without cause, Provider expressly agrees that Sections 9.4,6.2 and 9.5 of this Agreement shall survive such termination or expiration.

6.28 Monitoring. Provider agrees to A[redacted]P monitoring Provider's performance on an ongoing basis and subject to formal review, which review shall be accordance with a periodic schedule established by HCA consistent with industry standards and Regulatory Requirements. Formal review must be completed no less than once every three years and must

identify deficiencies or areas for improvement and provide for corrective action in accordance with 42 CFR 438.230(b).

6.29 Performance Within the U.S. Provider agrees that all services to be performed herein shall be performed in the United States of America. Breach, or anticipated breach, of the foregoing shall be a material breach of this Agreement and, without limitation of remedies, shall be cause for immediate termination of this Agreement.

6.30 Americans with Disabilities Act Compliance. Provider shall make reasonable accommodation for Covered Persons with disabilities, in accord with the Americans with Disabilities Act, for all services and shall assure physical and communication barriers shall not inhibit Covered Persons with disabilities from obtaining such services.

6.31 Interpreter Services. In compliance with 42 CFR 438.10(c)(4), Provider shall assure that interpreter services are provided for Covered Persons with a primary language other than English, free of charge. Provider shall also provide interpreter services for all interactions between such Covered Persons and Provider including, but not limited to: all appointments, emergency services, and all steps necessary to file grievances and appeals.

6.32 Read Ability. Provider shall ensure that all written information provided to Covered Persons is accurate, is not misleading, is comprehensible to its intended audience, is designed to provide the greatest degree of understanding, and is written at the sixth grade reading level. All such written materials must have the written approval of AME[redacted] prior to use.

6.33 Coordination of Benefits. Provider understands and agrees that when a Covered Person is covered by two or more plans, the primary plan must pay or provide its benefits as if the Program did not exist.

6.34 Program Integrity Requirements. Provider shall comply with AME[redacted] HCA approved Program Integrity policies and procedures and the Program Integrity requirements of the Program Contract, including but not limited to compliance with Section 1902(a)(68) of the Social Security Act, 42 C.F.R. § 438.610, 42 C.F.R. §455, 42 C.F.R. §1000 through 1008 and Chapter 182-502A WAC.

If Provider is defined as a subcontractor under the Program Contract, Provider shall verify that services billed by Provider were actually provided to Covered Persons and shall conduct ongoing analysis of utilization, claims, billing and/or encounter data to detect overpayments and including audits and investigations of Provider's Contracted Providers and downstream entities.

6.35 Enrollee Self Determination. Provider shall obtain informed consent prior to treatment from Covered Persons, or persons authorized to consent on behalf of a Covered Person, and shall comply with the provisions of the Natural Death Act (RCW 70.122) and state and federal Medicaid rules concerning advance directives, and, when appropriate, inform Covered Persons of their right to make anatomical gifts.

6.36 Coordination of Care. If Provider is a PCP, then Provider shall, in consultation with other appropriate health care professionals such as care coordinators or care managers, be responsible for the provision, coordination, and supervision of health care to meet the needs of each Covered Person, including initiation and coordination of referrals for medically necessary specialty care, and shall assess and develop individualized clinical treatment plans for children with special health care needs, which ensure integration of clinical and non-clinical disciplines and services in the overall plan of care.

6.37 Special Health Care Needs. Provider shall identify child or adult Covered Persons with special health care needs in the course of any contact or Covered Person initiated health care visit and report such identification to AMER[redacted]

6.38 Sterilization and Hysterectomies. Provider shall assure that all sterilizations and hysterectomies performed for Covered Persons are in compliance with 42 CFR 441 Subpart F, and that the HCA Sterilization Consent Form (HCA 13-364)) or its equivalent is used.

6.39 Enrollee Self-Referral. Provider understands and agrees that Covered Persons have the right to self-refer for certain services to participating or non-participating local health departments and participating or non-participating family planning clinics, paid through separate arrangements with the State of Washington. The services to which a Covered Person may self-refer include: (a) family planning services and sexually-transmitted disease screening and treatment services provided at participating or nonparticipating providers, including but not limited to family planning agencies, such as Planned Parenthood; (b) immunizations, sexually-transmitted disease screening and follow-up, immunodeficiency virus (HIV) screening, tuberculosis screening and follow-up, and family planning services through and if provided by a local health department; (c) immunizations, sexually transmitted disease screening, family planning and mental health services through and if provided by a school-based health center; and (d) all services received by American Indian or Alaska Native enrollees under the Special Provisions for American Indians and Alaska Natives subsection as set forth in the Program Contract.

6.40 Solvency Requirements. If Provider is at financial risk, as defined in the Program Contract, A[redacted]DUP shall establish, enforce and monitor solvency requirements that provide assurance of Provider's ability to meet its obligations. Furthermore, Provider acknowledges that A[redacted]UP shall annually conduct surveys of Covered Persons' satisfaction with Provider in accordance with Program Contract requirements, which surveys shall to be provided to HCA or Covered Persons upon request.

6.41 Subrogation. Provider acknowledges and agrees that it shall subrogate to the State of Washington for all criminal, civil and administrative action recoveries undertaken by any government entity, including, but not limited to, all claims AMER[redacted]or Provider have or may have against any entity that directly or indirectly receives funds under the Program Contract including, but not limited to, any health care provider, manufacturer, wholesale or retail supplier, sales representative, laboratory, or other provider in the design, manufacture,

marketing, pricing, or quality of drugs, pharmaceuticals, medical supplies, medical devices, durable medical equipment, or other health care related products or services.

6.42 Additional Medicare Program Provisions.

(a) Executive Order 13496. This provision is applicable to Providers who participate in AM[redacted]'s Medicare program under Medicare Parts C and D and receive at least $10,000 or more in payments from such AM[redacted]P Medicare program. Provider shall comply with the requirements of Executive Order 13496, 29 CFR 471, Appendix A to Subpart A.

(b) Risk Adjustment Data Validation Audits. In connection with the Medicare Program:

(1) [redacted]OUP and Provider are required in accordance with 42 CFR § 422.310(e) to submit a sample of medical records for Covered Persons for the purpose of validation of risk adjustment data. Accordingly, AN[redacted]P, or its designee, shall have the right to obtain copies of such documentation on at least an annual basis. Provider agrees to provide the requested medical records to AM[redacted]P, or its designee, within fourteen (14) calendar days from AMERIGROUP's, or its designee's, written request. Such records shall be provided to [redacted]OUP, or its designee, at no additional cost.

(2) Data Reporting Submissions. Provider agrees to provide to [redacted]OUP all information necessary for [redacted]UP to meet its data reporting and submission obligations to CMS, including but not limited to, data necessary to characterize the context and purpose of each encounter between a Covered Person and the Provider ("Risk Adjustment Data"), and data necessary for A[redacted]UP to meet its reporting obligations under 42 CFR §§ 422.516 and 422.310. In accordance with the CMS requirements, [redacted]ROUP reserves the right to assess Provider for any penalties resulting from Provider's submission of false data.

(3) Risk Adjustment Data. Provider's Risk Adjustment Data shall include all information necessary for AM[redacted]UP to submit such data to CMS as set forth in 42 CFR § 422.310 or any subsequent or additional regulatory provisions. If Provider fails to submit his/her/its Risk Adjustment Data accurately, completely and truthfully, in the format described in the 42 CFR § 422.310 or any subsequent or additional regulatory provisions, then this will result in denials and/or delays in payment of Provider's claims.

(4) Accuracy of Risk Adjustment Data. Provider further agrees to certify the accuracy, completeness, and truthfulness of Provider generated Risk Adjustment Data that [redacted]OUP is obligated to submit to CMS. Within thirty (30) days after the beginning of every fiscal year or as required by CMS while Provider participates in the AMER[redacted] Medicare program pursuant to the Agreement, Provider agrees to provide AME[redacted] with Risk Adjustment Data that is true, complete and correct, in a format that AME[redacted] specifies.

(c) Medicare Non-Covered Services. Notwithstanding any other provision in this Agreement applicable to non-Covered Services, Provider is not prohibited from the collection of amounts due for Medicare services that have been correctly identified in advance as a non-Covered Service, subject to medical coverage criteria, with appropriate disclosure to the Covered Person of his/her financial obligation. This advance notice must be provided in accordance with the CMS regulations for Medicare Advantage organizations. CMS regulations require that a coverage determination be made with a standard denial notice (Notice of Denial of Medical Coverage (or Payment)/CMS-10003) for a non-Covered Service or item when such service or item is typically not covered, but could be covered under specific conditions. If prior to rendering the service or item, Provider obtains, or instructs the Covered Person to obtain, a coverage determination of a non-Covered Service or item, the Covered Person can be held financially responsible for such non-Covered Services or items. However, if a service or item is never covered by [redacted]UP, such as a statutory exclusion, and the Covered Person's Evidence of Coverage (EOC) clearly specifies that the service or item is never covered, Provider does not have to seek a coverage determination from AM[redacted] in order to hold the Covered Person responsible for the full cost of the service or item. Additional information, related requirements and the process to request a coverage determination can be found in the Provider Manual. Both parties agree that failure to follow the CMS regulations can result in Provider's financial liability.

6.43 Pharmacy Preauthorization and Emergency Fill Requirements. Provider and [redacted] shall each comply with all applicable pharmacy preauthorization and emergency requirements of the Program Contract and WAC 284-170-470, including but not limited to compliance with the following:

(a) Disclose if the provider or pharmacy has the right to make a prior authorization request; and

(b) Provide that if A[redacted]UP or Provider requires the authorization number to be transmitted on a pharmaceutical claim, the issuing party will provide the authorization number to the billing pharmacy. The authorization number will be communicated to the billing pharmacy after approval of a prior authorization request and upon receipt of a claim for that authorized medication.

(c) The prior authorization determination must be transmitted to the requesting party and must include the information about whether a request was approved and if the request was made by the pharmacy, notification will additionally be made to the prescriber.

(d) [redacted]P and Provider acknowledge and agree that [redacted]OUP shall authorize an emergency fill by the dispensing pharmacist and approve the claim payment. An emergency fill is only applicable when:

(1) The dispensing pharmacy cannot reach AM[redacted] prior authorization department by phone as it is outside of that department's business hours; or

(2) [redacted]OUP is available to respond to phone calls from a dispensing pharmacy regarding a covered benefit, but AME[redacted] cannot reach the prescriber for full consultation.

6.44 Potentially Preventable Readmissions. To facilitate care transitions for Covered Persons, Provider and A[redacted] shall comply with all Potentially Preventable Readmission ("PPR") requirements, as set forth in the Program Contract and WAC 1[redacted] Consistent with the PPR provisions of the Program Contract, AM[redacted] and Provider shall work together to facilitate care transitions for Covered Persons and Provider shall be responsible for ensuring completion of the following: (a) discharge screenings, (b) discharge/care plans, (c) discharge education, and (d) follow up care after discharge, including for mental health services, as applicable. In addition, for high risk members, Provider will allow AME[redacted] or [redacted]UP's designee to assist with the coordination of planning, including visiting the Covered Person.

ARTICLE VII
RECORDS

7.1 Records. Provider shall ensure that information about Covered Persons, including their medical records, shall be kept confidential in a manner consistent with state and federal laws and regulations. Provider shall maintain medical, financial and administrative records concerning services provided to Covered Persons in accordance with industry standards and Regulatory Requirements, including without limitation applicable law regarding confidentiality of Covered Person information. Such records shall be retained by Provider for the period of time required under Regulatory Requirements applicable to the Program involved. Provider shall provide state and federal agencies access to review records related to services provided hereunder in accordance with Regulatory Requirements. Provider shall permit AME[redacted] or its designated agent to review records directly related to services provided to Covered Persons, either by providing such records to A[redacted]UP for off-site review, or on-site at Provider's facility, upon reasonable notice from AM[redacted] and during regular business hours. Provider shall obtain all necessary releases, consents and authorizations from Covered Persons with respect to their medical records to permit AME[redacted] access to such records. Provider shall supply the records described above at no charge upon request. The rights and obligations of the parties under this section shall survive the termination of this Agreement. Provider will have the right to audit AM[redacted]P records relating to Covered Services rendered by Provider to Covered Person's.

7.2 Record Transfer. Provider shall cooperate in the transfer of Covered Persons' medical records to other Participating Providers when required, subject to Regulatory Requirements, and shall assume the cost associated therewith. Following a Covered Person's request for record transfer, Provider shall use best efforts to transfer such Covered Person's medical records in Provider's custody within ten (10) days following the request, or such other time period required under applicable Regulatory Requirements.

ARTICLE VIII
COMPLAINT/DISPUTE RESOLUTION

8.1 Complaints of Covered Persons. [redacted]UP shall notify the Provider concerning any complaint by a Covered Person involving that Provider or a Participating Provider of that Provider in accordance with procedures set forth in the Provider Manual. The provisions of this Article shall only apply to disputes that have complied fully with all grievance and appeal procedures set forth in the Provider Manual.

8.2 Negotiation of Disputes.

(a) In the event of a dispute arising out of this Agreement that is not resolved by, or is not within the scope of relationship management set forth in the Agreement, or that is not resolved by informal discussions among the parties, the parties shall negotiate the dispute. Any party may initiate negotiation by sending a written description of the dispute to the other parties by certified or registered mail or personal delivery. The description shall explain the nature of the dispute in detail and set forth a proposed resolution, including a specific time frame within which the parties must act. The party receiving the letter must respond in writing within thirty (30) days with a detailed explanation of its position and a response to the proposed resolution. Within thirty (30) days of the initiating party receiving this response, principals of the party who have authority to settle the dispute will meet to discuss the resolution of the dispute. The initiating party shall initiate the scheduling of this negotiating session.

(b) In the event the parties are unable to resolve the dispute following the negotiation, a party shall have the right to pursue all available remedies at law or equity, including injunctive relief.

8.3 Dispute Resolution. Except as otherwise required by a specific federal or state statute or regulation governing dispute resolution, no process for the resolution of disputes arising out of a participating provider contract shall be considered fair under RCW 48.43.055 unless the process meets all the provisions of WAC 284-43-322.

(1) A dispute resolution process may include an initial informal process but must include a formal process for resolution of all contract disputes.

(2) [redacted]UP may have different types of dispute resolution processes as necessary for specialized concerns such as provider credentialing or as otherwise required by law. For example, disputes over Program coverage of Covered Services are subject to the grievance procedures established for Covered Persons.

(3) [redacted]UP must allow not less than thirty (30) days after the action giving rise to a dispute for providers to complain and initiate the dispute resolution process.

(4) [redacted]UP may not require alternative dispute resolution to the

exclusion of judicial remedies; however, AM[redacted]P may require alternative dispute resolution prior to judicial remedies.

(5) [redacted]UP must render a decision on provider complaints within a reasonable time for the type of dispute. In the case of billing disputes, AMER[redacted]must render a decision within sixty (60) days of the complaint.

ARTICLE IX
TERM; TERMINATION

9.1 Initial Term and Renewal. Subject to the terms and conditions otherwise set forth in this Agreement, this Agreement shall have an initial term of two (2) years, commencing as of the Effective Date, and shall renew automatically thereafter for successive terms of one (1) year, unless either party notifies the other of its intent not to renew at least one hundred and twenty (120) days prior to the end of the term.

9.2 Termination Without Cause. Notwithstanding any other provision included in this Agreement, Provider and A[redacted]UP shall each be entitled to terminate this Agreement at any time during its term by providing ninety (90) days prior written notice to the other party.

9.3 Termination by Either Party for Cause. Either party may terminate this Agreement for cause, defined as a material breach of this Agreement by the other party hereto, upon ninety (90) days prior written notice to the other party. The notice shall set forth the reasons for termination and provide the breaching party ninety (90) days to cure such material breach or the termination becomes effective.

9.4 Immediate Termination; Automatic Termination.

(a) Immediate Termination. [redacted]OUP shall be entitled to terminate this Agreement immediately upon A[redacted]P's determination made in good faith and with reasonable belief that (A) a Covered Person's health is subject to imminent danger or a physician's ability to practice medicine is effectively impaired by an action of the Board of Medicine or other governmental agency or (B) Provider continues a practice or pattern of (1) substantial disregard for the rules and regulations of AM[redacted]P with respect to patient care, or (2) material deviation from the practice and quality assurance standards, or (C) Provider's continued participation could adversely affect the care of Covered Persons. In addition, [redacted]OUP may immediately terminate this Agreement upon the filing of a petition in bankruptcy for liquidation or reorganization by or against Provider, if Provider becomes insolvent, or if a receiver is appointed for Provider or its property. In the case of termination under this subsection, the effective date of such termination shall be the date set forth in [redacted]UP's written notice to Provider notifying Provider of such termination.

(b) Automatic Termination. This Agreement shall automatically and immediately terminate upon the expiration, surrender, revocation, restriction or suspension of any professional license required for Provider to perform the services contemplated hereunder or

Provider's participation in any applicable Program. In addition, if Provider is terminated, barred, suspended or otherwise excluded from participation in, or has voluntarily withdrawn as the result of a settlement agreement related to, any program under Titles XVIII, XIX or XX of the Social Security Act, this Agreement shall automatically and immediately terminate.

(c) Appeal of Termination. In the event that Provider objects to termination of the Agreement for any reason, Provider shall utilize AM[redacted] Complaint/Dispute Resolution process as more fully set forth in Article VIII of this Agreement.

9.5 Partial Termination. A[redacted]P shall be entitled to terminate this Agreement, pursuant to its terms, as it applies to one of Mo[redacted]d S[redacted] without terminating the Agreement in its entirety, and in such case, the Agreement shall continue in full force and effect in connection with the entity or entities as to which the Agreement has not been terminated. [redacted] and [redacted]ie shall be entitled to terminate this Agreement as it applies to itself without terminating the Agreement in its entirety, in which case, the Agreement shall continue in full force and effect as to the remaining entity.

9.6 Continuation of Care.

(a) In the event of the termination of this Agreement for any reason except termination of this Agreement for cause by A[redacted]P pursuant to subsection (c) below, any Covered Person who is suffering from and receiving active health care services or who is an inpatient shall have the right to continue to receive health care services from Provider for a period of up to sixty (60) days from the date of the termination of this Agreement or until the Covered Person's discharge from inpatient facilities up to ninety (90) days, whichever time is greater. Any Covered Person who is pregnant and receiving treatment in connection with that pregnancy at the time of termination of this Agreement may continue to receive health care services from Provider for the remainder of her pregnancy and six (6) weeks post-partum.

(b) During the continuity of care provision described in subsection (a) above, Provider shall continue to provide services in accordance with the terms of this Agreement applicable immediately prior to the termination of this Agreement, and AME[redacted] shall continue to meet all of the obligations of this Agreement.

(c) A Covered Person shall not have the right to continuation of care if the termination of this Agreement is for loss of Provider license, or if the termination of this Agreement is due to reasons related to quality of health care services rendered, health, safety or welfare of Covered Persons.

(d) In connection with the Medicare Program, Provider agrees that, upon termination of this Agreement for any reason (other than termination of Provider for reasons of medical competence or professional behavior), Provider shall continue to furnish Covered Services to all Medicare Covered Persons hospitalized as of the date of such termination up through the discharge of such Covered Persons. AM[redacted]P shall pay Provider for such Covered Services in accordance with the terms of Attachment A - Medicare. In addition,

Provider agrees that in the event of AM[redacted]s insolvency, termination of the CMS contract or other cessation of operations, Covered Services to Covered Persons will continue through the period for which the premium has been paid to AM[redacted] and services to Covered Persons confined in an inpatient hospital on the date of termination of the CMS contract or on the date of insolvency or other cessation of operations will continue until their discharge.

ARTICLE X
MISCELLANEOUS

10.1 Amendment.

(a) This Agreement may be amended by the mutual agreement of the parties as evidenced in a writing signed by the parties.

(b) In addition, A[redacted]UP shall be entitled to amend this Agreement as follows without the written agreement of Provider:

(i) Upon thirty (30) days prior written notice to Provider, if the amendment is being effected by A[redacted]UP to comply with a Regulatory Requirement, such amendment shall be effective as of the effective date set forth in the amendment. Notwithstanding the above, A[redacted]UP shall be entitled to amend the Agreement upon less than thirty (30) days prior written notice if a shorter notice period is required in order to comply with such Regulatory Requirement.

(ii) Upon sixty (60) days prior written notice to Provider, to the extent the amendment is being effected by AM[redacted]UP for a purpose other than compliance with a Regulatory Requirement. Provider shall be entitled to object to the amendment, by written notice provided to A[redacted]OUP within sixty (60) days following Provider's receipt of such amendment. If a timely objection is received by AM[redacted] then the amendment shall not take effect until the parties mutually agree on a resolution to the objection or this Agreement is terminated in accordance with the terms hereof.

(iii) An amendment to the Agreement may not be made retroactive without the consent of the Provider.

(c) Addition or Deletion of d/b/a Entities by Provider. The parties acknowledge and agree that Provider shall be entitled by written notification to AMERI[redacted] to add or delete a d/b/a name (or operating location), as initially set forth on Exhibit A to the Agreement. The parties shall not be required to execute an amendment by mutual consent to evidence such an addition or deletion; it being agreed that written notice by Provider to [redacted]ROUP shall be sufficient. To the extent that Provider desires to operate under a new d/b/a name (or operating location), any addition of a d/b/a name (or operating location) shall not be effective until such entity is credentialed in accordance with AMER[redacted]equirements.

10.2 Non-Exclusivity; Volume. This Agreement shall not, nor shall it be construed to, limit or restrict AM[redacted]P in any manner from entering into any other agreements of any nature whatsoever with other persons or entities for the provision of the same or similar services contemplated hereunder. Neither this Agreement, nor anything contained herein, shall guarantee or obligate A[redacted]UP or any other party to provide any minimum number of referrals to Provider hereunder.

10.3 Assignment.

(a) This Agreement may not be assigned by Provider without the prior written consent of A[redacted]OUP and may not be assigned by either party without the consent of HCA.

(b) In the event of a partial assignment of this Agreement by AMER[redacted] the obligations of the Provider shall be performed for AM[redacted]P with respect to the part retained and shall be performed for A[redacted]UP assignee with respect to the part assigned, and such assignee shall be solely responsible to perform all obligations of AME[redacted] with respect to the part assigned.

(c) The rights and obligations of the parties hereunder shall inure to the benefit of, and shall be binding upon, any permitted successors and assigns of the parties hereto.

10.4 Indemnification.

(a) Provider agrees to indemnify, defend, and hold harmless AME[redacted] and its officers, employees and agents from and against any and all liability, loss, claim, damage or expense, including defense costs and legal fees, incurred in connection with (i) Provider's breach of any representation and warranty made by Provider in this Agreement, and (ii) claims for damages of any nature whatsoever, including, but not limited to, bodily injury, death, personal injury or property damage arising from Provider's delivery of health care services or Provider's performance or failure to perform Provider's obligations hereunder.

(b) [redacted]OUP agrees to indemnify, defend, and hold harmless Provider and, if Provider is an entity, its officers, employees and agents from and against any and all liability, loss, claim, damage or expense, including defense costs and legal fees, incurred in connection with (i) A[redacted]'s breach of any representation and warranty made by [redacted]OUP in this Agreement, and (ii) claims for damages of any nature whatsoever, arising from A[redacted]UP's performance or failure to perform its obligations hereunder.

(c) Notwithstanding the foregoing subsections (a) and (b), this Section shall be null and void to the extent that it is interpreted to reduce insurance coverage to which either party is otherwise entitled, by way of any exclusion for contractually assumed liability or otherwise.

(d) Provider agrees to indemnify and hold harmless HCA and its employees against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against HCA or its employees through the intentional

misconduct, negligence, or omission of the Provider, its agents, officers, employees or contractors.

10.5 Waiver. Either party's waiver of any breach or violation of this Agreement by the other party shall not, nor shall it be construed to, constitute a waiver of any subsequent breach or violation of this Agreement by the other party.

10.6 Severability. The invalidity or unenforceability of any provision contained herein shall not affect the validity of any other provisions of this Agreement, and this Agreement shall be construed in all respects as if such invalid or unenforceable provision were omitted, or, to the extent permitted by applicable law, such invalid or unenforceable paragraph shall be replaced with another paragraph as similar in terms as may be possible and as may be legal, valid and enforceable.

10.7 Construction. This Agreement shall be construed without regard to any presumption or other rule requiring construction against the party causing this Agreement to be drafted.

10.8 Notice. Any notice required to be given under this Agreement shall be sent by certified mail, return receipt requested, postage prepaid; hand delivery; overnight prepaid delivery; or confirmed facsimile to the addresses set forth below, or to such other address designated by a party hereto by notice to the other party pursuant to the terms of this Agreement:

If to A[redacted]UP, at the address set forth in the Provider Manual.

If to Provider, to the address set forth in Provider's AM[redacted] participation application.

10.9 Independent Contractor Status. Nothing contained herein shall, or shall be construed to, create a partnership, joint venture or any other relationship between the parties hereto other than that of independent contractors.

10.10 Entire Agreement. This Agreement, and any exhibits, attachments and amendments hereto, constitute the entire Agreement ("Entire Agreement") and understanding between the parties with respect to the subject matter hereof, and supersede any prior understandings and agreements between the parties, whether written or oral, with respect to the subject matter hereof; provided however; the parties acknowledge and agree that the Provider Manual is not incorporated by reference into this Agreement and is not deemed part of the Entire Agreement.

10.11 Captions. The section headings in this Agreement are for convenience of reference only, shall not define or limit the provisions hereof, and shall have no legal effect whatsoever.

10.12 Coordination of Defense of Claims. The parties hereto shall make all reasonable efforts, consistent with advice of counsel and their requirements of their respective insurance policies and carriers, to coordinate the defense of claims in which either party is named a defendant, or has a substantial possibility of being named a defendant.

10.13 Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the State of Washington, excluding and without application of any conflicts of law principles.

10.14 Counterparts. This Agreement and any amendment hereto may be executed in two or more counterparts, each of which shall be deemed to be an original and all of which taken together shall constitute one and the same agreement.

10.15 Non-Performance. Neither party shall be liable, nor deemed to be in default hereunder, for any delay in performance or failure to perform under this Agreement which results directly or indirectly from acts of God, civil or military authority, acts of public enemy, war, accidents, fires, explosions, employee strikes or other work interruptions, earthquakes, floods, failure of transportation, or any cause beyond the reasonable control of such party. Provider acknowledges and agrees that this Agreement and the arrangement contemplated herein is subject to regulation by state and federal governmental authorities. In the event that any action of any such governmental authority impairs, limits, or delays either party's performance of any obligation hereunder, that party shall be excused from such performance, and party's failure to perform such obligation for such reason shall not constitute a breach of this Agreement.

Name According to W-9 Form, with d/b/a:	Federal Tax Identification Number:
[redacted] District 3 of Pa[redacted]	[redacted]
[redacted]District #4, Kin[redacted]A	[redacted]
[redacted]y Hospital District No.1	[redacted]

ATTACHMENT A

[redacted]UP Washington, Inc.

[redacted] ([redacted] SERVICES

MEDICAID Reimbursement

[redacted]p shall compensate Provider for Covered Services provided to Covered Persons, subject to all terms and conditions of this Agreement, benefit design, coordination of benefits (COB), applicable authorization requirements, applicable coinsurance, program eligibility and [redacted] Provider Manual in an amount equal to the lesser of Eligible Charges or the amounts shown below unless otherwise specified.

Section I: Inpatient Facility Services

Service Description	Billing Code	Rate	Method
Inpatient Facility Services	Applicable Inpatient Revenue Codes	106% of the Washington Medicaid [redacted] Rates	Per Service

Section II: Outpatient Facility Services

Service Description	Billing Code	Rate	Method
Outpatient Facility Services	Applicable Revenue Codes with CPT/HCPCS Code	106% of the Washington Medicaid [redacted] Rates	Per Service

1. Inpatient Facility Services and Outpatient Facility Services are payable based on the Washington Medicaid[redacted]("C[redacted] rates applicable to Provider as published by Washington Department of Social and Health Services ("DSHS"). [redacted]p shall update the[redacted] rates no more than sixty (60) days from the date of receipt of notice of final changes to Provider's rates or on the effective date of such changes, whichever is later. Such changes will be applied on a prospective basis. A[redacted] will not be responsible for interest payments that are the result of late notification to A[redacted] of [redacted]hanges.

2. Provider shall give notice to A[redacted] in writing regarding changes in Provider's Charge Master within 30 (thirty) days of any adjustments to the charge amounts set

Name According to W-9 Form, with d/b/a:	Federal Tax Identification Number:
[redacted] District 3 of Pa[redacted]	[redacted]
[redacted]District #4, Kin[redacted]A	[redacted]
[redacted]y Hospital District No.1	[redacted]

forth in the Provider's Charge Master for a Covered Service set forth above for which Provider's reimbursement hereunder is based on a percentage of Eligible Charges.

Section III: Notes

1. All services billed by Provider will be submitted on CMS – 1450 (or its successor) forms or corresponding electronic format.

2. Eligible Charges are those charges billed by the Provider subject to conditions and requirements which make the service eligible for reimbursement. Eligibility for reimbursement of the service is dependent upon application of the following conditions and requirements: Covered Person program eligibility, provider program eligibility, benefit coverage, authorization requirements, provider manual guidelines, A[redacted] administrative, clinical and reimbursement policies, and code editing logic. The allowed amount reimbursed for the eligible charge is based on the applicable fee schedule or contracted/negotiated rate after application of coinsurance, co-payments, deductibles, and coordination of benefits. [redacted]p will not reimburse provider for services or items the provider receives and/or provides free of charge.

Section IV: Exclusions

1. Payments are for facility services only; professional services are excluded.

2. Any services not specified in this Attachment A or in the referenced Fee Schedule(s) according to the reimbursement table above are not reimbursable. In the event a Covered Service for a payable code does not have a published dollar amount on the then current applicable State Rate/Fee Schedule, has a zero dollar amount listed, or requires manual pricing, such code shall be reimbursed at a rate established by [redacted]p for such Covered Service.

Name According to W-9 Form, with d/b/a:	Federal Tax Identification Number:
[redacted] District 3 of Pa[redacted]	[redacted]
[redacted]District #4, Kin[redacted]A	[redacted]
[redacted]y Hospital District No.1	[redacted]

ATTACHMENT A

[redacted]UP Washington, Inc.

Specialist and A[redacted]Services

MEDICAID REIMBURSEMENT

[redacted]p shall compensate Provider for Covered Services provided to Covered Persons, subject to all terms and conditions of this Agreement, benefit design, coordination of benefits (COB), applicable authorization requirements, applicable coinsurance, program eligibility and [redacted]s Provider Manual, in an amount equal to the lesser of Eligible Charges or the amounts shown below unless otherwise specified.

Section I: Fee Schedule Reimbursement

Service Description	Billing Code	Rate	Method
Evaluation and Management	Applicable CPT/HCPCS Code	106 % of Washington State Medicaid Fee Schedule	Per Service
Professional Services	Applicable CPT/HCPCS Code	106 % of Washington State Medicaid Fee Schedule	Per Service

1. Payments specified as Washington State Medicaid Fee Schedule refer to the applicable Washington State Medicaid Fee Schedule in effect as of the date of service for the market(s) and program(s) covered by the Agreement at the time the Covered Service is initiated to the Covered Persons. An[redacted]will update the Fee Schedule no more than sixty (60) days from the date of receipt of notice of final changes or on the effective date of such changes, whichever is later. Fee Schedule changes will be applied on a prospective basis. A[redacted]p will not be responsible for interest payments that are the result of late notification to Am[redacted]f Fee Schedule changes.

2. All appropriate modifiers must be used in accordance with standard billing guidelines, if applicable.

3. Allied Health professionals are reimbursed in accordance with the applicable methodology for the above referenced fee schedule. If fee schedule is A[redacted] proprietary fee schedule, the applicable state methodology on which such fee schedule is based on shall be used to determine the appropriate level of reimbursement.

Name According to W-9 Form, with d/b/a:	Federal Tax Identification Number:
[redacted] District 3 of P[redacted]	[redacted]
[redacted]District #4, Kin[redacted]A	[redacted]
[redacted]y Hospital District No.1	[redacted]

Section II: Notes

1. All services billed by Provider will be submitted on CMS-1500 (or its successor) forms or corresponding electronic format.

2. Eligible Charges are those charges billed by the Provider subject to conditions and requirements which make the service eligible for reimbursement. Eligibility for reimbursement of the service is dependent upon application of the following conditions and requirements: Covered Person program eligibility, provider program eligibility, benefit coverage, authorization requirements, provider manual guidelines, [redacted] administrative, clinical and reimbursement policies, and code editing logic. The allowed amount reimbursed for the eligible charge is based on the applicable fee schedule or contracted/negotiated rate after application of coinsurance, co-payments, deductibles, and coordination of benefits. A[redacted] will not reimburse provider for services or items the provider receives and/or provides free of charge.

Section III: Exclusions

1. Any services not specified in this Attachment A or in the referenced Fee Schedule(s) according to the reimbursement table above are not reimbursable. In the event a Covered Service for a payable code does not have a published dollar amount on the then current applicable State Fee Schedule, has a zero dollar amount listed, or requires manual pricing, such code shall be reimbursed at a rate established by Ar[redacted]or such Covered Service.

Name According to W-9 Form, with d/b/a:	Federal Tax Identification Number:
[redacted]District #4, Kir[redacted]A	[redacted]

ATTACHMENT A – Medicare Advantage

[redacted]UP Washington, Inc.

[redacted]

MEDICARE ADVANTAGE Reimbursement

[redacted]p shall compensate Provider for Covered Services provided to Covered Persons, subject to all terms and conditions of this Agreement, benefit design, Coordination of Benefits (COB), applicable authorization requirements, applicable coinsurance, program eligibility and [redacted]s Provider Manual, in an amount equal to the lesser of Eligible Charges or the amounts shown below unless otherwise specified.

Section I: Inpatient Facility Services

Service Description	Billing Code	Rate	Method
Eligible Inpatient Facility Services	Applicable Revenue Codes	100 % CMS Critical Access Hospital Rates	Per Service

1. Inpatient Facility Services are based on the applicable CMS [redacted]Rates as defined by the Provider's Fiscal Intermediary Rate Letter in effect as of the date of discharge.

2. Payments specified as CMS Fee Schedule(s), Rates and/or CMS methodologies refer to the applicable Medicare allowable amount otherwise payable by CMS for the market(s), program(s) and related items and services covered by the Agreement net of applicable member cost sharing. In the event CMS reduces compensation to A[redacted] as a result of a CMS directive or a change in Federal law, the amount payable to Provider hereunder will be reduced in the amount specified by CMS as a result of such directive or change in law, or in the absence of such specification, in the same percentage amount as payment is reduced by CMS to A[redacted] will update the CMS Fee Schedule(s), CMS Rates and/or CMS methodologies no more than sixty (60) days from the date of receipt of notice of final changes or on the effective date of such changes, whichever is later. CMS Fee Schedule(s), Rates and/or CMS methodology changes will be applied on a prospective basis. A[redacted] will not be responsible for interest payments that are the result of late notification to Ame[redacted] CMS Fee Schedule(s), Rates and/or CMS methodology changes.

3. Provider must submit a copy of their most current Fiscal Intermediary Rate Letter within sixty (60) days upon of receipt, or the above percentage shall be reduced by no more than five percent (5%).

Name According to W-9 Form, with d/b/a:	Federal Tax Identification Number:
[redacted] District #4, Ki[redacted]A	[redacted]

Section II: Outpatient Facility Services

Service Description	Billing Code	Rate	Method
Eligible Outpatient Facility Services	Applicable Revenue Codes with applicable CPT/HCPCS Codes	100 % CMS Critical Access Hospital Rates	Per Service

1. Outpatient Facility Services are based on the applicable CMS [redacted] Rates as defined by the Provider's Fiscal Intermediary Rate Letter in effect as of the date of discharge.

2. Payments specified as CMS Fee Schedule(s), Rates and/or CMS methodologies refer to the applicable Medicare allowable amount otherwise payable by CMS for the market(s), program(s) and related items and services covered by the Agreement net of applicable member cost sharing. In the event CMS reduces compensation to [redacted]up as a result of a CMS directive or a change in Federal law, the amount payable to Provider hereunder will be reduced in the amount specified by CMS as a result of such directive or change in law, or in the absence of such specification, in the same percentage amount as payment is reduced by CMS to [redacted] will update the CMS Fee Schedule(s), CMS Rates and/or CMS methodologies no more than sixty (60) days from the date of receipt of notice of final changes or on the effective date of such changes, whichever is later. CMS Fee Schedule(s), Rates and/or CMS methodology changes will be applied on a prospective basis. A[redacted] will not be responsible for interest payments that are the result of late notification to Am[redacted] CMS Fee Schedule(s), Rates and/or CMS methodology changes.

3. Provider must submit a copy of their most current Fiscal Intermediary Rate Letter within sixty (60) days upon of receipt, or the above percentage shall be reduced by no more than five percent (5%).

Section III: Notes

1. All services billed by Provider will be submitted on CMS - 1450(or its successor) forms or corresponding electronic format.

2. Eligible Charges are those charges billed by the Provider subject to conditions and requirements which make the service eligible for reimbursement. Eligibility for reimbursement of the service is dependent upon application of the following conditions and requirements: Covered Person program eligibility, provider program eligibility, benefit coverage, authorization requirements, provider manual guidelines, A[redacted] administrative, clinical and reimbursement policies, and code editing logic. The allowed amount reimbursed for the eligible charge is based on the applicable fee schedule or

contracted/negotiated rate after application of coinsurance, co-payments, deductibles, and coordination of benefits. [redacted]p will not reimburse provider for services or items the provider receives and/or provides free of charge.

Section IV: Exclusions

1. Payments are for facility services only; professional services of physicians are excluded.

2. Any services not specified in this Attachment A or in the referenced Fee Schedule(s) according to the reimbursement table above are not reimbursable. In the event a Covered Service for a payable code does not have a published dollar amount on the then current applicable CMS Rate/Fee Schedule, has a zero dollar amount listed, or requires manual pricing, such code shall be reimbursed at a rate established by [redacted]p for such Covered Service.

Name According to W-9 Form, with d/b/a:	Federal Tax Identification Number:
[redacted] District #4, Kir[redacted]/A	[redacted]

ATTACHMENT A – Medicare Advantage

[redacted]UP Washington, Inc.

PRIMARY CARE PHYSICIAN & ALLIED HEALTH PROFESSIONALS SERVICES

MEDICARE ADVANTAGE REIMBURSEMENT

[redacted]p shall compensate Provider for Covered Services provided to Covered Persons, subject to all terms and conditions of this Agreement, benefit design, Coordination of Benefits (COB), applicable authorization requirements, applicable coinsurance, program eligibility and [redacted]p 's Provider Manual, in an amount equal to the lesser of Eligible Charges or the amounts shown below unless otherwise specified.

Section I: Reimbursement

Service Description	Billing Code	Rate	Method
Professional Services	Applicable CPT/HCPCS code	100 % of CMS Physician Fee Schedule	Per Service
Clinical Laboratory Services	Applicable CPT/HCPCS code	45 % of CMS Clinical Laboratory Fee Schedule	Per Service
Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)	Applicable CPT/HCPCS code	65 % of CMS DMEPOS Fee Schedule	Per Service
Drugs & Biologicals	Applicable CPT/HCPCS/NDC code	100 % of Medicare Part B Drug Average Sales Price ("ASP") Fee Schedule	Per Service

1. Payments specified as CMS Fee Schedule(s), Rates and/or CMS methodologies refer to the applicable Medicare allowable amount otherwise payable by CMS for the market(s), program(s) and related items and services covered by the Agreement net of applicable member cost sharing. In the event CMS reduces compensation to [redacted]p as a result of a CMS directive or a change in Federal law, the amount payable to Provider hereunder will be reduced in the amount specified by CMS as a result of such directive or change in law, or in the absence of such specification, in the same percentage amount as payment is reduced by CMS to A[redacted] will update the CMS Fee Schedule(s), CMS Rates and/or CMS methodologies no more than sixty (60) days from the date of receipt of notice of final changes or on the effective date of such changes, whichever is later. CMS Fee Schedule(s), Rates and/or CMS methodology changes will be applied on a prospective basis. A[redacted] will not be responsible for

interest payments that are the result of late notification to Ame[redacted] CMS Fee Schedule(s), Rates and/or CMS methodology changes.

2. Each drug/product must be billed using the standard CPT/HCPCS code, National Drug Code (NDC) number of the covered medication, description of product, dosage and units administered. Drugs are priced using CPT/HCPCS codes and reimbursed from the contracted fee schedule.

3. All appropriate modifiers must be used in accordance with standard billing guidelines, if applicable.

Section II: Notes

1. All services billed by Provider will be submitted on a CMS 1500 (or its successor) form or corresponding electronic format.

2. Eligible Charges are those charges billed by the Provider subject to conditions and requirements which make the service eligible for reimbursement. Eligibility for reimbursement of the service is dependent upon application of the following conditions and requirements: Covered Person program eligibility, provider program eligibility, benefit coverage, authorization requirements, provider manual guidelines, A[redacted] administrative, clinical and reimbursement policies, and code editing logic. The allowed amount reimbursed for the eligible charge is based on the applicable fee schedule or contracted/negotiated rate after application of coinsurance, co-payments, deductibles, and coordination of benefits. [redacted]p will not reimburse provider for services or items the provider receives and/or provides free of charge.

Section III: Exclusions

1. Any services not specified in this Attachment A or in the referenced Fee Schedule(s) according to the reimbursement table above are not reimbursable. In the event a Covered Service for a payable code does not have a published dollar amount on the then current applicable CMS Fee Schedule, has a zero dollar amount listed, or requires manual pricing, such code shall be reimbursed at a rate established by A[redacted] for such Covered Service.

Name According to W-9 Form, with d/b/a:	Federal Tax Identification Number:
[redacted] District #4, Kin[redacted]A	[redacted]

ATTACHMENT A – Medicare Advantage

[redacted]UP Washington, Inc.

[redacted] ("R[redacted]

MEDICARE ADVANTAGE REIMBURSEMENT

[redacted]p shall compensate Provider for Covered Services provided to Covered Persons, subject to all terms and conditions of this Agreement, benefit design, Coordination of Benefits (COB), applicable authorization requirements, applicable coinsurance, program eligibility and [redacted]s Provider Manual, in an amount equal to the lesser of Eligible Charges or the amounts shown below unless otherwise specified.

Section I: Fee Reimbursement

Service Description	Billing Code	Rate	Method
All Outpatient Covered Services	Applicable Revenue Code with applicable CPT/HCPCS Code	100 % of National Encounter R[redacted] Rate	Per Visit

1. Payments specified as "National Encounter R[redacted]Rate" refer to the CMS National Per Visit Limit rate for RHC's, in effect as of the date of service for the market(s) and program(s), covered by the Agreement at the time the Covered Service is initiated to the Covered Person. This rate is all inclusive of professional, technical and facility charges including evaluation and management, routine surgical and therapeutic procedures, and diagnostic testing (including laboratory and radiology) capable of being performed on site.

2. Payments specified as CMS Fee Schedule(s), Rates and/or CMS methodologies refer to the applicable Medicare allowable amount otherwise payable by CMS for the market(s), program(s) and related items and services covered by the Agreement net of applicable member cost sharing. In the event CMS reduces compensation to [redacted]p as a result of a CMS directive or a change in Federal law, the amount payable to Provider hereunder will be reduced in the amount specified by CMS as a result of such directive or change in law, or in the absence of such specification, in the same percentage amount as payment is reduced by CMS to A[redacted] will update the CMS Fee Schedule(s), CMS Rates and/or CMS methodologies no more than sixty (60) days from the date of receipt of notice of final changes or on the effective date of such changes, whichever is later. CMS Fee Schedule(s), Rates and/or CMS methodology changes will be applied on a prospective basis. A[redacted] will not be responsible for

interest payments that are the result of late notification to Ame[redacted] CMS Fee Schedule(s), Rates and/or CMS methodology changes.

3. Provider must specify all services rendered during encounter, and all services rendered will be reimbursed under the all-inclusive Per Visit rate.

4. Laboratory, radiology and medications administered are not reimbursed separately. To the extent that the provider has the capabilities to provide these services and has historically provided these services, the RH[redacted]shall continue to provide such services. The bundling of therapeutic and diagnostic testing ("ancillary") services into the per visit rate is not meant to imply that the [redacted]C shall vend or refer out such ancillary services to other [redacted] network providers merely for the purpose of maximizing reimbursement.[redacted]up reserves the right to audit historical charging patterns to ensure that this is observed.

5. All appropriate modifiers must be used in accordance with standard billing guidelines, if applicable.

Section II: Notes

1. All services billed by Provider will be submitted on a CMS – 1450 (or its successor) form or corresponding electronic format

2. Eligible Charges are those charges billed by the Provider subject to conditions and requirements which make the service eligible for reimbursement. Eligibility for reimbursement of the service is dependent upon application of the following conditions and requirements: Covered Person program eligibility, provider program eligibility, benefit coverage, authorization requirements, provider manual guidelines, A[redacted] administrative, clinical and reimbursement policies, and code editing logic. The allowed amount reimbursed for the eligible charge is based on the applicable fee schedule or contracted/negotiated rate after application of coinsurance, co-payments, deductibles, and coordination of benefits. [redacted]p will not reimburse provider for services or items the provider receives and/or provides free of charge.

Section III: Exclusions

1. Any services not specified in this Attachment A or in the referenced Fee Schedule(s) according to the reimbursement table above are not reimbursable. In the event a Covered Service for a payable code does not have a published dollar amount on the then current applicable CMS Fee Schedule, has a zero dollar amount listed, or requires manual pricing, such code shall be reimbursed at a rate established by A[redacted]for such Covered Service.

Name According to W-9 Form, with d/b/a:	Federal Tax Identification Number:
[redacted]District #4, Kin[redacted]A	[redacted]

ATTACHMENT A – Medicare Advantage

[redacted]UP Washington, Inc.

Specialist and A[redacted]Services

MEDICARE ADVANTAGE REIMBURSEMENT

[redacted]p shall compensate Provider for Covered Services provided to Covered Persons, subject to all terms and conditions of this Agreement, benefit design, Coordination of Benefits (COB), applicable authorization requirements, applicable coinsurance, program eligibility and [redacted]up 's Provider Manual, in an amount equal to the lesser of Eligible Charges or the amounts shown below unless otherwise specified.

Section I: Reimbursement

Service Description	Billing Code	Rate	Method
Professional Services	Applicable CPT/HCPCS code	100 % of CMS Physician Fee Schedule	Per Service
Clinical Laboratory Services	Applicable CPT/HCPCS code	45 % of CMS Clinical Laboratory Fee Schedule	Per Service
Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)	Applicable CPT/HCPCS code	65 % of CMS DMEPOS Fee Schedule	Per Service
Drugs & Biologicals	Applicable CPT/HCPCS/NDC code	100 % of Medicare Part B Drug Average Sales Price ("ASP") Fee Schedule	Per Service

1. Payments specified as CMS Fee Schedule(s), Rates and/or CMS methodologies refer to the applicable Medicare allowable amount otherwise payable by CMS for the market(s), program(s) and related items and services covered by the Agreement net of applicable member cost sharing. In the event CMS reduces compensation to[redacted]up as a result of a CMS directive or a change in Federal law, the amount payable to Provider hereunder will be reduced in the amount specified by CMS as a result of such directive or change in law, or in the absence of such specification, in the same percentage amount as payment is reduced by CMS to A[redacted]will update the CMS Fee Schedule(s), CMS Rates and/or CMS methodologies no more than sixty (60) days from the date of receipt of notice of final changes or on the effective date of such changes, whichever is later. CMS Fee Schedule(s), Rates and/or CMS methodology changes will be applied on a prospective basis. A[redacted] will not be responsible for

interest payments that are the result of late notification to Am[redacted] CMS Fee Schedule(s), Rates and/or CMS methodology changes.

2. Each drug/product must be billed using the standard CPT/HCPCS code, National Drug Code (NDC) number of the covered medication, description of product, dosage and units administered. Drugs are priced using CPT/HCPCS codes and reimbursed from the contracted fee schedule.

3. All appropriate modifiers must be used in accordance with standard billing guidelines, if applicable.

Section II: Notes

1. All services billed by Provider will be submitted on a CMS 1500 (or its successor) form or corresponding electronic format.

2. Eligible Charges are those charges billed by the Provider subject to conditions and requirements which make the service eligible for reimbursement. Eligibility for reimbursement of the service is dependent upon application of the following conditions and requirements: Covered Person program eligibility, provider program eligibility, benefit coverage, authorization requirements, provider manual guidelines, A[redacted] administrative, clinical and reimbursement policies, and code editing logic. The allowed amount reimbursed for the eligible charge is based on the applicable fee schedule or contracted/negotiated rate after application of coinsurance, co-payments, deductibles, and coordination of benefits. [redacted]p will not reimburse provider for services or items the provider receives and/or provides free of charge.

Section III: Exclusions

1. Any services not specified in this Attachment A or in the referenced Fee Schedule(s) according to the reimbursement table above are not reimbursable. In the event a Covered Service for a payable code does not have a published dollar amount on the then current applicable CMS Fee Schedule, has a zero dollar amount listed, or requires manual pricing, such code shall be reimbursed at a rate established by A[redacted] for such Covered Service.

Name According to W-9 Form, with d/b/a:	Federal Tax Identification Number:
[redacted] District 3 of P[redacted]	[redacted]
[redacted] District #4, Kin[redacted]A	[redacted]
[redacted]y Hospital District No.1	[redacted]

ATTACHMENT A-1

[redacted]UP Washington, Inc.

PRIMARY CARE PHYSICIAN AND [redacted] SERVICES WITH MEDICAL CARE MANAGEMENT

MEDICAID REIMBURSEMENT

[redacted]p shall compensate Provider for Covered Services provided to Covered Persons, subject to all terms and conditions of this Agreement, benefit design, coordination of benefits (COB), applicable authorization requirements, applicable coinsurance, program eligibility and [redacted]s Provider Manual, in an amount equal to the lesser of Eligible Charges or the amounts shown below unless otherwise specified.

Section I: Fee Schedule Reimbursement

Service Description	Billing Code	Rate	Method
Evaluation and Management	Applicable CPT/HCPCS Code	106 % of Washington State Medicaid Fee Schedule	Per Service
Professional Services	Applicable CPT/HCPCS Code	106 % of Washington State Medicaid Fee Schedule	Per Service

1. Payments specified as Washington State Medicaid Fee Schedule refer to the applicable Washington State Medicaid Fee Schedule in effect as of the date of service for the market(s) and program(s) covered by the Agreement at the time the Covered Service is initiated to the Covered Persons. An[redacted]will update the Fee Schedule no more than sixty (60) days from the date of receipt of notice of final changes or on the effective date of such changes, whichever is later. Fee Schedule changes will be applied on a prospective basis. A[redacted]p will not be responsible for interest payments that are the result of late notification to Am[redacted]f Fee Schedule changes.

2. All appropriate modifiers must be used in accordance with standard billing guidelines, if applicable.

3. Allied Health professionals are reimbursed in accordance with the applicable methodology for the above referenced fee schedule. If fee schedule is A[redacted] proprietary fee schedule, the applicable state methodology on which such fee schedule is based on shall be used to determine the appropriate level of reimbursement.

Name According to W-9 Form, with d/b/a:	Federal Tax Identification Number:
[redacted] District 3 of Pa[redacted]	[redacted]
[redacted]District #4, Kin[redacted]A	[redacted]
[redacted]y Hospital District No.1	[redacted]

Section II: Medical Care Management Reimbursement effective upon the Arrangement Effective Date set forth in the Attachment A-2 to the Agreement through De[redacted]

Included under this Agreement is eligibility for Medical Care Management Reimbursement. Provider shall be paid Per Member, Per Month ("PM/PM") specified below, in addition to reimbursement stated in above.

MEDICAL CARE MANAGEMENT	
Product	Rate PM/PM
Medicaid	$3.00 PMPM

1. Such payment shall be made monthly on or before the 20th of the month following the calculation of membership. [redacted]p shall provide a listing of all members which the monthly medical care management reimbursement is based upon.

Section III: Notes

1. All services billed by Provider will be submitted on CMS-1500 (or its successor) forms or corresponding electronic format.

2. Eligible Charges are those charges billed by the Provider subject to conditions and requirements which make the service eligible for reimbursement. Eligibility for reimbursement of the service is dependent upon application of the following conditions and requirements: Covered Person program eligibility, provider program eligibility, benefit coverage, authorization requirements, provider manual guidelines, [redacted] administrative, clinical and reimbursement policies, and code editing logic. The allowed amount reimbursed for the eligible charge is based on the applicable fee schedule or contracted/negotiated rate after application of coinsurance, co-payments, deductibles, and coordination of benefits. A[redacted] will not reimburse provider for services or items the provider receives and/or provides free of charge.

Section IV: Exclusions

1. Any services not specified in this Attachment A or in the referenced Fee Schedule(s) according to the reimbursement table above are not reimbursable. In the event a Covered Service for a payable code does not have a published dollar amount on the then current applicable State Fee Schedule, has a zero dollar amount listed, or requires manual pricing, such code shall be reimbursed at a rate established by Ar[redacted]or such Covered Service.

Name According to W-9 Form, with d/b/a:	Federal Tax Identification Number:
[redacted] District 3 of P[redacted]	[redacted]
[redacted] District #4, Kl[redacted]A	[redacted]
[redacted]y Hospital District No.1	[redacted]

ATTACHMENT A - 1

[redacted]UP Washington, Inc.

[redacted] ("[redacted]

MEDICAID REIMBURSEMENT

[redacted]p shall compensate Provider for Covered Services provided to Covered Persons, subject to all terms and conditions of this Agreement, benefit design, coordination of benefits (COB), applicable authorization requirements, applicable coinsurance, program eligibility and [redacted]s Provider Manual, in an amount equal to the lesser of Eligible Charges or the amounts shown below unless otherwise specified.

Section I: Fee Reimbursement

Service Description	Billing Code	Rate	Method
Professional Services	Applicable CPT/HCPCS Codes	106 % of the Washington State Medicaid Fee Schedule	Per Service

1. Payments specified as "Washington State Medicaid Fee Schedule" refer to the applicable Washington State Medicaid Fee Schedule in effect as of the date of service for the market(s) and program(s) covered by the Agreement at the time the Covered Service is initiated to the Covered Persons. A[redacted] will update the Fee Schedule no more than sixty (60) days from the date of receipt of notice of final changes or on the effective date of such changes, whichever is later. Fee Schedule changes will be applied on a prospective basis. A[redacted]p will not be responsible for interest payments that are the result of late notification to Am[redacted]f Fee Schedule changes.

2. All appropriate modifiers must be used in accordance with standard billing guidelines, if applicable.

Section II: Medical Care Management Reimbursement effective upon the Arrangement Effective Date set forth in the Attachment A-2 to the Agreement through De[redacted]

Included under this Agreement is eligibility for Medical Care Management Reimbursement. Provider shall be paid Per Member, Per Month ("PM/PM") specified below, in addition to reimbursement stated in above.

Name According to W-9 Form, with d/b/a:	Federal Tax Identification Number:
[redacted] District 3 of P[redacted]	[redacted]
[redacted]District #4, Ki[redacted]A	[redacted]
[redacted]y Hospital District No.1	[redacted]

MEDICAL CARE MANAGEMENT	
Product	Rate PM/PM
Medicaid	$3.00 PMPM

1. Such payment shall be made monthly on or before the 20th of the month following the calculation of membership. [redacted]p shall provide a listing of all members which the monthly medical care management reimbursement is based upon.

Section III: Notes

1. All services billed by Provider will be submitted on a CMS 1500 (or its successor) form or corresponding electronic format.

2. Eligible Charges are those charges billed by the Provider subject to conditions and requirements which make the service eligible for reimbursement. Eligibility for reimbursement of the service is dependent upon application of the following conditions and requirements: Covered Person program eligibility, provider program eligibility, benefit coverage, authorization requirements, provider manual guidelines, A[redacted] administrative, clinical and reimbursement policies, and code editing logic. The allowed amount reimbursed for the eligible charge is based on the applicable fee schedule or contracted/negotiated rate after application of coinsurance, co-payments, deductibles, and coordination of benefits. A[redacted] will not reimburse provider for services or items the provider receives and/or provides free of charge.

Section IV: Exclusions

1. Any services not specified in this Attachment A or in the referenced Fee Schedule(s) according to the reimbursement table above are not reimbursable. In the event a Covered Service for a payable code does not have a published dollar amount on the then current applicable State Fee Schedule, has a zero dollar amount listed, or requires manual pricing, such code shall be reimbursed at a rate established by A[redacted] for such Covered Service.

PROVIDER NAME:	FEDERAL TAX ID NUMBER:
[redacted]y Hospital District No. 1	[redacted]
[redacted]l District 3 of P[redacted]	[redacted]
[redacted] District #4, Ki[redacted]VA	[redacted]

ATTACHMENT A - 2

[redacted]UP Washington, Inc.

Primary Care Physician Shared Savings Arrangement Reimbursement

Medicaid

Introduction

The parties agree to enter into a Shared Savings Arrangement (the "Arrangement") as defined in this Attachment A-2.

Section 1: Definitions:

Unless otherwise defined in this Attachment A-2, all defined terms shall have the meanings set forth in Article I of the Agreement.

Arrangement Effective Date: The effective date as set forth in Section 2 below.

Arrangement Year: The measurement period for the Arrangement. In the first year of the Arrangement, the Arrangement Year is defined as the time period commencing on the Arrangement Effective Date and ending on [redacted] of that same year. The Arrangement Year for all subsequent periods will be the applicable calendar year.

Arrangement Year MLR: The MLR for the Arrangement Year, calculated as the result of the Total Medical Expenses for the Arrangement Year divided by the Total Premium for the Arrangement Year.

Incurred But Not Reported (IBNR): When calculating the Total Medical Expenses for the Arrangement, a reasonable factor will be applied to the paid medical expenses for the period to adjust for any claims that have been incurred but not yet reported. The IBNR factors will be based on [redacted]p historical paid claims experience, and will be developed by Am[redacted]n an actuarially sound basis.

Kick Premium Adjustment: An adjustment to the calculation of Total Premium applicable to any state OB/NICU kick premium for a Member that exceeds the Stop-Loss Deductible amount. Such OB/NICU kick premium will be adjusted to the Stop-Loss Deductible amount for purposes of inclusion in the calculation of Total Premium.

Member: A Covered Person, as defined in the Agreement, that is assigned to Provider or Provider's PCPs for purposes of the Arrangement.

PROVIDER NAME:	FEDERAL TAX ID NUMBER:
[redacted]y Hospital District No. 1	[redacted]
[redacted] District 3 of P[redacted]	[redacted]
[redacted]District #4, Ki[redacted]A	[redacted]

Membership Threshold: The number [redacted]oup Members that the Provider is required to have in a panel prior to A[redacted] consideration and implementation of the Arrangement provisions. The Membership Threshold is specified in Exhibit 2.

Medical Loss Ratio (MLR): The result of the Total Medical Expenses divided by the Total Premium.

Stop-Loss: A methodology that will be incorporated into the Total Medical Expenses calculation designed to afford protection to the Provider against the impact under this Agreement of certain high-dollar claims. . For any Arrangement for which Provider is at Substantial Financial Risk, as such term is defined in 42 CFR 422.208(a), such Stop-Loss methodology shall meet all requirements set forth in 42 CFR 422.208(f). Should the Provider experience a decrease in their attributed membership level throughout the term of this Agreement, the Provider shall remain compliant with the stop-loss deductible levels set forth in 42 CFR 422.208.

Stop-Loss Deductible: The Stop-Loss Deductible is the amount of claim amount that must be reached, either on a per Member per Arrangement Year basis, or on a per claim basis, before a Stop-Loss Credit is applied to the calculation of Total Medical Expenses. The Stop-Loss Deductible amount is specified in Exhibit 2.

Stop-Loss Expense: The Stop-Loss Expense, included as part of the Total Medical Expenses calculation, will be the per member per month amount specified in Exhibit 2.

Stop-Loss Credit: The claims amounts in excess of the Stop Loss Deductible specified in Exhibit 2, multiplied by the Stop-Loss Credit Percentage specified in Exhibit 2.

Stop-Loss Credit Percentage: The percentage of Stop-Loss Credits deducted from paid claims as part of the Total Medical Expenses calculation, as specified in Exhibit 2.

Target MLR: The Target MLR is defined in Exhibit 2.

Target MLR Floor: The Target MLR Floor amount is specified in Exhibit 2 and represents the MLR percentage below which no further surplus can be earned by the Provider.

Total Medical Expenses: The costs incurred by [redacted] for payment for all Covered Services (including hospital, medical, pharmacy and nonhospital) provided to each Member by all providers (participating and non-participating, and including Provider and its PCPs) furnishing such services to Members, adjusted by the Stop-Loss Expense and Stop-Loss Credits. Total Medical Expenses include:

- Claims and capitation paid through the defined claims run-out period
- Plus a reasonable amount for IBNR
- Plus the Stop-Loss Expense
- Minus the Stop-Loss Credits

PROVIDER NAME:	FEDERAL TAX ID NUMBER:
[redacted]y Hospital District No. 1	[redacted]
[redacted] District 3 of P[redacted]	[redacted]
[redacted]District #4, Ki[redacted]A	[redacted]

No expenses will be included in Total Medical Expenses for the An[redacted]alue-Added Member Benefits (where applicable). For purposes of MLR calculations, inpatient claims will be assigned to the time period in which the inpatient date of admission occurred.

Total Premium: The premium and other revenue amounts received from the state by [redacted]p for each Member (adjusted to reflect any membership adjustments made by the state for previous months) net of any premium taxes including any Kick Premium Adjustment as defined herein.

Value-Added Member Benefits: Benefits provided to Members for which the state does not provide premium or other revenue to [redacted] and which [redacted]p has identified as a value-added benefit in its disclosures to the state.

Section 2: Conditions and Arrangement Effective Date

The provisions of this Attachment A-2 shall apply solely with respect to Provider and those Primary Care Physicians employed by or under contract with Provider and credentialed in accordance with [redacted] requirements to furnish services under this Agreement ("Participating Providers"). As a condition of participation in the Arrangement as set forth in this **Attachment A-2 and Exhibits 1 and 2** hereto, Provider and its Participating Providers must:

(a) be approved by [redacted]p as meeting [redacted]s quality, access and utilization requirements as described in Section 6 below;
(b) maintain membership at or above the Membership Threshold as specified in Exhibit 2 for two (2) consecutive months; and
(c) execute and submit to [redacted]p the Notice and Certification Form attached as Exhibit 4 and made a part hereof.

This Attachment A-2 shall become effective following written notice from [redacted] of Provider's satisfaction of all of the requirements set forth in subsections (a) – (c) above, and shall be made effective as of the date specified in such written notice, which shall be the later of: the 1st day of the calendar quarter following satisfaction of all of the requirements set forth in subsections (a) – (c) above, or, if this Agreement requires approval by an applicable Agency, the 1st day of the calendar quarter following receipt of such approval by A[redacted], whichever is later. Provider acknowledges that the requirements referenced in subsections (a) and (b) above are ongoing requirements, and that [redacted]p retains the right to monitor and enforce Provider's compliance with such requirements throughout the term of this Agreement, and to terminate this Arrangement if Provider fails to maintain compliance with such requirements.

Prior to the Arrangement Effective Date, Provider's sole compensation under the Agreement shall be in accordance with the Attachment A-1.

PROVIDER NAME:	FEDERAL TAX ID NUMBER:
[redacted]y Hospital District No. 1	[redacted]
[redacted] District 3 of P[redacted]	[redacted]
[redacted] District #4, Ki[redacted]/A	[redacted]

Any contracts in place between Provider and a Participating Provider to furnish services to Members under this Agreement must meet all requirements imposed under federal and state law or regulations applicable to the Programs to which this Agreement applies, including without limitation the applicable requirements of 42 C.F.R. 422.208 and 42 C.F.R. 417.122. In addition, such contracts must specify that Participating Provider is not entitled to direct compensation from [redacted]up pursuant to this Attachment A-2. Without limiting the foregoing, the parties agree that this Attachment A-2, including all Exhibits and Attachments hereto, may not be amended for a minimum of 12 months from the date of any prior amendment to this Attachment A-2, except as required to comply with applicable laws, rules or regulations.

Section 3: Professional Services Reimbursement

[redacted]p shall pay Provider for Covered Services furnished by Provider to applicable Covered Persons in accordance with the terms set forth in Attachment A-1. As set forth in the Agreement, Provider is solely responsible for collecting all applicable copayments, deductibles and coinsurance, subject to state cost-sharing obligations with respect to Members dually eligible under the Medicare and Medicaid programs. [redacted]up reserves the right to review and audit, at reasonable times and upon demand, any and all Provider records and reports relating to Covered Services provided to Members.

Section 4: Arrangement Calculation

Provider will be eligible to receive compensation under the Arrangement in accordance with and as calculated in Exhibit 1.

Provider acknowledges and agrees that the Arrangement will be administered as a single arrangement applied to the aggregated membership of the three (3) entities, and all surpluses and deficits under this Arrangement shall be determined on the basis of such aggregated membership. [redacted]p shall make any payments due under the Arrangement solely and directly to P[redacted] District 3 of P[redacted]p shall not direct [redacted]District 3 of [redacted] regarding the distribution of any amounts paid under the Arrangement to any of the three (3) entities. P[redacted]District 3 of Pa[redacted]hall manage the participation of [redacted]y Hospital District No. 1, [redacted]District 3 of Pa[redacted]nd Pu[redacted] District #4, K[redacted]WA under a single Arrangement and [redacted]District 3 of [redacted]y will be solely responsible for the distribution of any shared savings surplus funds between [redacted]ty Hospital District No. 1, [redacted]l District 3 of [redacted] and [redacted] District #4, Ki[redacted]VA in accordance with a separate agreement betwee[redacted]nty Hospital District No. 1, [redacted] District 3 of P[redacted]y and [redacted] District #4, K[redacted]WA; provided that any such distribution shall comply with all applicable state and federal law, including without limitation the requirements of 42 CFR 42 C.F.R. 422.208 and 42 C.F.R. 417.122. [redacted] District 3 of [redacted] agrees to defend, indemnify and hold A[redacted] harmless for claims related to

PROVIDER NAME:	FEDERAL TAX ID NUMBER:
[redacted]y Hospital District No. 1	[redacted]
[redacted] District 3 of P[redacted]	[redacted]
[redacted]District #4, Ki[redacted]/A	[redacted]

[redacted] District 3 of Pacific County's distribution of funds pursuant to this Attachment A-2.

Section 5: Termination of the Agreement

The provisions of this paragraph supplement, but do not otherwise limit or restrict, the termination provisions contained in the Participation Agreement. Upon the expiration or termination of the Agreement, [redacted]p shall continue to perform interim reconciliations in accordance with Exhibit 1, until such time as [redacted]p completes a final reconciliation pursuant to Exhibit 1 below with respect to the final Arrangement Year, or portion thereof, under the Agreement. Such final reconciliation will be performed within nine (9) months of termination of the Agreement. As provided in Exhibit 1, any amounts owed as a result of such final reconciliation, including if applicable, repayment of any interim shared savings payments made pursuant to Exhibit 1, shall be paid to the appropriate party within thirty (30) days following the final determination of such amount. Notwithstanding the foregoing, in the event that this Arrangement is terminated by [redacted]p for reasons set forth in Section 6, 7, 8 or 9 below, no additional surplus funds shall be due or payable to Provider by A[redacted]p as of the date of notice of termination.

Section 6: Quality, Access and Utilization Requirements

Provider or Provider's Primary Care Physician(s) shall ensure that Members receive Medically Necessary Covered Services in a timely and appropriate manner and that meet requirements for quality of care as reasonably established by Ar[redacted]based on industry standards. Provider must meet or exceed the Quality Threshold Target requirements set forth in Exhibit 3 attached thereto in order to qualify for any shared savings distribution as set forth in this Attachment A-2, and as calculated in Exhibit 1. A[redacted]p reserves the right to revise the Quality Threshold Target criteria set forth in Exhibit 3 annually in accordance with the terms of this Attachment A-2 as a prerequisite for continued participation in the Arrangement. Provider and its Participating Providers shall not discriminate in the acceptance or care of any Member based on health needs or status. Provider and its Participating Providers may not seek to transfer a Member to a different provider based on the degree of utilization of medical services needed by such Member or based on the Member's medical condition, except where required for the benefit of the Member; nor may Provider and its Participating Providers limit, delay, restrict or withhold access to Medically Necessary services by Members. Provider and its Participating Providers shall comply with [redacted]p quality assurance programs and shall cooperate with [redacted]'s efforts to review the appropriateness of care rendered to Members by Provider and its Participating Providers. In the event that Ar[redacted]reasonably believes that Members are not receiving appropriate quality or access to care by Provider or its Participating Providers, or that Provider or its Participating Providers are causing the inappropriate transfer of Members due to their health status, Am[redacted]shall have the right to suspend the compensation provisions of this Attachment A-2, and limit Provider's compensation to the reimbursement previously set forth on Attachment A-1 hereto, and/or to deem Provider in material breach of the Agreement.

PROVIDER NAME:	FEDERAL TAX ID NUMBER:
[redacted]y Hospital District No. 1	[redacted]
[redacted] District 3 of P[redacted]	[redacted]
[redacted]District #4, Ki[redacted]A	[redacted]

Section 7: Underutilization Monitoring

[redacted]p will monitor the rate of utilization of medical services by Members for potential underutilization of Covered Services. A set of the Provider's utilization measures will be compiled on a periodic basis and analyzed by A[redacted]p will conduct an internal review of any suspected underutilization. If A[redacted] determines that there are indications of underutilization, upon A[redacted] request, Provider will meet with A[redacted]o review the data. If there is sufficient indication of an underutilization issue, the Provider must submit a corrective action plan ("CAP") within 30 days of the in-person meeting. Failure to attend the required meeting or submit a timely CAP may result in the immediate removal of the Provider from the Arrangement. The CAP shall set forth targets for improvement and the time frame within which such targets must be achieved. If A[redacted]does not approve the CAP, the Provider will be given one opportunity to revise the CAP. The revised CAP must be resubmitted within 15 days of notice of disapproval from A[redacted]he Provider must implement the CAP immediately upon receipt of approval from A[redacted] may monitor the CAP on a quarterly basis, as well as future utilization of medical services by the Members assigned to the Provider. If, at any time, A[redacted]determines that the Provider has not complied with the CAP, or if the resubmitted CAP is deemed deficient by A[redacted] [redacted]p shall terminate the Arrangement.

Section 8: Member Turnover Monitoring

[redacted]p will monitor the rate of turnover of Members assigned to a Provider. If a Provider appears to have a disproportionate amount of Member turnover, A[redacted]may initiate an internal review. If the internal review indicates a turnover issue, Provider will meet with [redacted]p to review the data. If, after the meeting, A[redacted] determines that inappropriate Member turnover has occurred, [redacted]p shall terminate the Arrangement.

PROVIDER NAME:	FEDERAL TAX ID NUMBER:
[redacted]y Hospital District No. 1	[redacted]
[redacted]l District 3 of P[redacted]	[redacted]
[redacted] District #4, Ki[redacted]VA	[redacted]

Exhibit 1

[redacted]UP Washington, Inc.

Primary Care Physician Reimbursement

Medicaid
Shared Savings Arrangement Calculation

1. Shared Savings Arrangement Calculation
   A. If the Arrangement Year MLR is less than the Target MLR, the Provider is eligible to receive a shared savings payment.
      1) The calculation of the shared savings amount equals the Shared Savings Percentage set forth in Exhibit 2 times the difference between the Target MLR and the Arrangement Year MLR, times the Arrangement Year Total Premium. The shared savings amount is subject to the limitation described immediately below in Section 1.A.2. The calculation is: Shared Savings = {(Target MLR minus the Arrangement Year MLR) times the Shared Savings Percentage} times the Arrangement Year Total Premium}.

      2) The total incentive-based payments to the Provider from [redacted] inclusive of payments under this Arrangement, are limited to no more than the Overall Shared Savings Limit percentage (as specified in Exhibit 2) of the total reimbursement the Provider receives from [redacted] for direct services delivered to [redacted] Members during the Arrangement Year.

   B. If the Arrangement Year MLR is more than the Target MLR, no shared savings is earned. The Provider is not required to pay any deficit to [redacted]

2. Interim Quarterly Reconciliations and Payments
   Interim quarterly reconciliations will be completed by the Interim Quarterly Reconciliation Timeframe specified in Exhibit 2, using the Interim Quarterly Reconciliation Claims Run-out Period as specified in Exhibit 2 and subject to the Interim Quarterly Reconciliation Distribution Percentage specified in Exhibit 2. Any interim shared savings payments (subject to section 1.A.2. above) will be processed and mailed by [redacted] on or about the end of the Interim Quarterly Reconciliation Timeframe specified in Exhibit 2.

   Provider acknowledges that shared savings payments under the Arrangement are earned on an Arrangement Year basis, and any Arrangement Year interim distributions are considered an advance against the final Arrangement Year earned shared savings amount.

   Interim quarterly reconciliations will be performed on an Arrangement Year-to-date basis. If the Arrangement Year-to-date interim quarterly reconciliation results in an Arrangement

PROVIDER NAME:	FEDERAL TAX ID NUMBER:
[redacted]y Hospital District No. 1	[redacted]
[redacted] District 3 of P[redacted]	[redacted]
[redacted]District #4, Ki[redacted]A	[redacted]

Year-to-date earned shared savings payment, the amount of the Arrangement Year-to-date earned shared savings payment, subject to the Interim Quarterly Reconciliation Distribution Percentage specified in Exhibit 2, will be compared to the total of all previous Arrangement Year interim quarterly shared savings payments, and if there is a positive difference, the amount, will be remitted. If there is a negative difference, it will carry over to the next interim quarterly reconciliation, or the final Arrangement Year reconciliation if no further interim reconciliation periods remain.

3. Interim Final Arrangement Year Reconciliation and Payment

The interim final Arrangement Year reconciliation will be completed by the Interim Final Arrangement Year Reconciliation Timeframe specified in Exhibit 2, using the Interim Final Arrangement Year Reconciliation Claims Run-out Period as specified in Exhibit 2. Any interim final Arrangement Year shared savings payments (subject to section 1.A.2. above) will be processed and mailed by [redacted] on or about the end of the Interim Final Arrangement Year Reconciliation Timeframe specified in Exhibit 2.

The interim final Arrangement Year shared savings amount shall be net of all interim Arrangement Year distribution amounts, and will be determined in accordance with Sections 3.A and 3.B below.

A. If the interim final Arrangement Year reconciliation results in an earned shared savings payment, the amount of the earned shared savings payment (subject to section 1.A.2. above) will be compared to all previous Arrangement Year interim quarterly shared savings payments:

1) If there is a positive difference, the full amount of the difference will be remitted.

2) If there is a negative difference (shortfall), the Provider shall repay the total amount of the shortfall, within 60 days of notice by Ar[redacted] The Provider's obligation to repay A[redacted] will not exceed the amount of Arrangement Year-to-date interim payments made to the Provider.

B. If the interim final Arrangement Year reconciliation does not result in an earned shared savings payment, any Arrangement Year-to-date interim shared savings payments shall be paid back to A[redacted] by the Provider. The Provider's

PROVIDER NAME:	FEDERAL TAX ID NUMBER:
[redacted]y Hospital District No. 1	[redacted]
[redacted]l District 3 of P[redacted]	[redacted]
[redacted] District #4, Ki[redacted]VA	[redacted]

obligation to repay A[redacted] will not exceed the amount of Arrangement Year-to-date interim shared savings payments made to the Provider.

4. Final Arrangement Year Reconciliation and Payment

The final Arrangement Year reconciliation will be completed by the Final Arrangement Year Reconciliation Timeframe specified in Exhibit 2, using the Final Arrangement Year Reconciliation Claims Run-out Period as specified in Exhibit 2. Any final Arrangement Year shared savings payments (subject to section 1.A.2. above) will be processed and mailed by [redacted]p on or about the end of the Final Arrangement Year Reconciliation Timeframe specified in Exhibit 2.

Each Arrangement Year shall be subject to a separate final reconciliation without regard to the reconciliation of any other Arrangement Year that is subject to this Agreement.

Final settlement of the Arrangement Year shared savings amount shall be net of all Arrangement Year interim distribution amounts, including the interim final Arrangement Year reconciliation distribution.

A. If the final Arrangement Year reconciliation results in an earned shared savings payment, the amount of the earned shared savings payment (subject to Section 1.A.2. above) will be compared to all previous Arrangement Year interim quarterly and interim final shared savings payments for such Arrangement Year:

   1) If there is a positive difference, the full amount of the difference will be remitted.

   2) If there is a negative difference (shortfall), the Provider shall repay the total amount of the shortfall, within 60 days of notice by A[redacted] The Provider's obligation to repay [redacted]p will not exceed the amount of Arrangement Year-to-date interim payments made to the Provider.

B. If the final Arrangement Year reconciliation does not result in an earned shared savings payment, any Arrangement Year-to-date interim shared savings payments shall be paid back to [redacted]p by the Provider. The Provider's obligation to repay A[redacted] will not exceed the amount of Arrangement Year-to-date interim shared savings payments made to the Provider.

5. Dispute Resolution

If the Provider objects in writing to an interim or final reconciliation within 30 days following receipt of such reconciliation report, and if the parties cannot reach agreement on

such reconciliation or any payment due thereunder, then an independent third party CPA with a major accounting firm will be engaged by the parties to render an opinion. If the parties cannot agree on a CPA, then each party shall select a CPA with a major accounting firm, and such CPAs shall agree on a third, independent CPA to review Provider's objections and render an opinion. The cost of the CPA shall be shared equally by the parties. The CPA selected shall have thirty (30) days to issue his/her opinion. The opinion of the CPA shall be final, conclusive and binding on the parties, and the parties shall pay any surplus or overpayments amounts due in accordance with Exhibit 1 within thirty (30) days following issuance by the CPA of his/her opinion. If the Provider does not object in writing to an interim or final reconciliation within 30 days following receipt of such reconciliation report, the Provider shall be deemed to have accepted such reconciliation.

PROVIDER NAME:	FEDERAL TAX ID NUMBER:
[redacted]y Hospital District No. 1	[redacted]
[redacted] District 3 of P[redacted]	[redacted]
[redacted]District #4, Ki[redacted]/A	[redacted]

Exhibit 2

[redacted]UP Washington, Inc.

Primary Care Physician Summary of Shared Savings Arrangement Terms

Medicaid

Membership Threshold	500 Members
Target MLR	<table><tr><th>Previous Arrangement Year Actual MLR</th><th>Target MLR *</th></tr><tr><td>= or > 89%</td><td>Actual MLR *minus* 2% but not less than 89%</td></tr><tr><td>82% - 89%</td><td>Actual MLR</td></tr><tr><td>< 82%</td><td>Actual MLR *plus* 4% but not greater than 82%</td></tr></table> Claims incurred from [redacted] and paid through [redacted] will determine the target for the Arrangement year [redacted], plus an allowance for IBNR calculated consistent with A[redacted] annual statutory filings with the WA Office of the Insurance Commissioner for such prior calendar year. This methodology will roll forward by one calendar year and a 3 month claim run out for subsequent years. The target will be determined in early May of each year.
Target MLR Floor	5% Less than target MLR
Shared Savings Percentage	50%
Overall Shared Savings Limit	25%
Stop-Loss Deductible	$6,000.00 per Member per Year
Stop-Loss Expense	Actual total claim amounts in excess of the Stop-Loss Deductible (times the Stop-Loss Credit Percentage) for all Am[redacted]Members for the calendar year immediately preceding the Arrangement Year, divided

PROVIDER NAME:	FEDERAL TAX ID NUMBER:
[redacted]y Hospital District No. 1	[redacted]
[redacted] District 3 of P[redacted]	[redacted]
[redacted] District #4, Ki[redacted]A	[redacted]

	by the total member months for A[redacted] Medicaid members for the calendar year immediately preceding the Arrangement Year
Stop-Loss Credit Percentage	90%
Reconciliation Claims Run-out Period	Interim Quarterly: 3 months Interim Final: 3 months Final: 8 months
Reconciliation Timeframe	Interim Quarterly: 45-60 days after end of Interim Quarterly Reconciliation Claims Run-out Period Interim Final: 45-60 days after end of Interim Final Reconciliation Claims Run-out Period Final: 45-60 days after end of Final Reconciliation Claims Run-out Period
Reconciliation Distribution Percentage	Interim Quarterly: 50% Interim Final: 100% Final: 100%

PROVIDER NAME:	FEDERAL TAX ID NUMBER:
[redacted]y Hospital District No. 1	[redacted]
[redacted] District 3 of P[redacted]	[redacted]
[redacted]District #4, Ki[redacted]/A	[redacted]

Exhibit 3

[redacted]UP Washington, Inc.

Quality Threshold Targets

Medicaid

As a condition of participation in the Arrangement, Provider shall meet or exceed the Quality Threshold Target set forth in this **Exhibit 3**. A[redacted] shall review Provider's performance with respect to the Quality Threshold Target set forth in this **Exhibit 3** annually. This annual review will determine the Providers eligibility for participation in the Arrangement for that year.

1. Quality Threshold Target

The Quality Threshold Target, as defined below, must be met for any combination of the 5 measures specified below for the Arrangement Year:

HEDIS Measure Indicator	Quality Threshold Target	Shared Savings Value
Blood Sugar (HbA1C) poor control (CDC >9%)	Previous Year Score + 5 percentage points or NCQA 75th Percentile	20%
Kidneys Disease Screening (CDC – NEPH)	Previous Year Score + 5 percentage points or NCQA 75th Percentile	20%
Breast Cancer Screening (BCS)	Previous Year Score + 5 percentage points or NCQA 75th Percentile	20%
Controlling Blood Pressure (CBP)	Previous Year Score + 5 percentage points or NCQA 75th Percentile	20%
Weight Assessment Ages 18-74 (ABA)	Previous Year Score + 5 percentage points or NCQA 75th Percentile	20%

The HEDIS Measure Targets will be the rates listed above under the Quality Threshold Target column. The first Previous Year for the Quality Threshold Targets will be the calendar year 2016 levels and will roll forward by one calendar year for subsequent years (e.g. 2017). The Quality Threshold Target for any given year will be deemed to have been met if the Provider achieves any of the above 5 HEDIS Measures paid to the applicable 50% Shared Savings at the percentages listed above. If the Quality Threshold Target defined above is met, the Provider shall be deemed to meet the Quality Threshold Target condition set forth in Section 6 of this Attachment A-2.

PROVIDER NAME:	FEDERAL TAX ID NUMBER:
[redacted]y Hospital District No. 1	[redacted]
[redacted] District 3 of P[redacted]	[redacted]
[redacted]District #4, Ki[redacted]A	[redacted]

Exhibit 4

[redacted]UP Washington, Inc.

Primary Care Physician Reimbursement

Medicaid
Notice and Certification

Following the date that A[redacted] has approved Provider for compensation in accordance with the reimbursement provisions set forth in **Attachment A-2**, but prior to A[redacted] conversion of Provider's compensation to the terms of such **Attachment A-2**, a senior officer of Provider (President, CEO or CFO), with authority to issue a certification on behalf of Provider. shall execute and deliver to A[redacted]p the written notice and certification as set forth below:

I, _____, certify that **L[redacted] Hospital District No. 1, P[redacted] District 3 of Pa[redacted]nd Pu[redacted]istrict #4, King[redacted]** ("Provider") meet all of the requirements and qualifications set forth in **Attachment A-2** to the Agreement for reimbursement using the methodology set forth in such **Attachment A-2**. I further certify that Provider's performance under the Agreement is, and shall continue to be throughout the term thereof, in full compliance with all applicable federal and state laws, rules and regulations regarding the provision of services to Medicaid enrollees. I further certify that, in furnishing services hereunder, Provider will not limit, delay, restrict or withhold the provision, or arranging for the provision, of medically necessary Covered Services to Members except where required for the benefit of a Member, nor will Provider discriminate in accepting or retaining any Member as a patient, or in providing or arranging for the provision of medically necessary covered services to a Member, on the basis of a Member's health needs or status.

I acknowledge and agree that any effort by Provider to limit, delay, restrict or withhold the provision, or arranging for the provision, of medically necessary Covered Services or to discriminate on the basis of health status shall be grounds for immediate termination of the compensation program established under **Attachment A-2** and that [redacted]p shall have the right to suspend the compensation provisions of this **Attachment A-2**, and limit Provider's compensation to the reimbursement previously set forth on **Attachment A-1** hereto, and/or deem the Provider in material breach of the Agreement.

PROVIDER:
[redacted]y Hospital District No. 1

[redacted]