

HOSPITAL SERVICE AGREEMENT

THIS AGREEMENT is made and entered into by and between Qual-Med Washington Health Plan, Inc. (hereinafter called "QM"), a corporation organized under the laws of the State of Washington and a licensed health maintenance organization, and University of Washington Medical Center a licensed Hospital under the laws of the State of Washington (hereinafter called "Hospital").

WHEREAS, QM is principally engaged in the business of providing, arranging, managing and administering Health Care Services; and

WHEREAS, Hospital operates one or more hospitals and may in the future operate other hospital and desires to provide hospital services in such facilities in conjunction with Health Plans, as defined herein, under the terms and conditions hereinafter set forth; and

WHEREAS, QM has entered into contracts with one or more physician corporations or physicians to arrange for the delivery by participating physicians of certain Health Care Services to Members, and such contractual services will interface with the delivery of hospital services by Hospital hereunder; and

WHEREAS, the parties desire to enter into a long-term relationship in order to facilitate financial planning and appropriate utilization of facilities;

NOW, THEREFORE, in consideration of the foregoing and of the mutual covenants, promises and undertakings hereinafter set forth, the parties hereto agree as follows:

ARTICLE 1 DEFINITIONS

The following terms as used in this Agreement shall be construed and interpreted as follows unless the context otherwise expressly requires a different construction and interpretation:

1.1 "Certified Length of Stay" means the number of inpatient day(s) authorized by a Written Referral or an additional number of inpatient day(s) for such admission when authorized by the Medical Director prior to the expiration of the previously authorized inpatient days for that admission.

1.2 "Charges" or "Billed Charges" means the lesser of: the amount billed by Hospital; the amounts set forth on Attachment A and incorporated herein by this reference; for a Member enrolled in Medicare, the amount that would be received by accepting Medicare assignment, which for inpatients is DRG plus capital and

teaching pass through components. Charges do not include any amounts disallowed under any paragraph of this Agreement.

1.3 "Copayment" means the payments (not covered by premiums), as specified in a Member's Health Plan in "Copayment Schedules", "Deductibles" or similar provisions, which are made by Members directly to providers for certain specific services upon delivery, pursuant to the terms of the Member's Health Plan. By this reference, all of such Copayment provisions and any amendments thereto, are incorporated herein.

1.4 "Emergency Medical Care" means services rendered in the diagnosis and treatment of a Medical Emergency. "Medical Emergency" means circumstances which a reasonably prudent person would regard as the unexpected onset of sudden or acute illness or injury, or, in the case of a pregnant woman, the imminent delivery of a baby, requiring immediate medical care such that the Member's life or health would have been jeopardized had the care been delayed. All claims for Emergency Medical Care must be accompanied by sufficient documentation to establish the medical necessity and emergency nature of the services. The existence and duration of a Medical Emergency shall be determined solely by QM, in consultation with the attending physician, in the exercise of its reasonable judgment.

1.5 "Health Care Services" means all of those services to which a Member is entitled pursuant to the terms of the Member's current Health Plan. These services may include, but are not limited to, medical, surgical, diagnostic, therapeutic and preventive services, hospital services, optometric, pharmaceutical, dental, extended care, and other medical ancillary services.

1.6 "Health Plan" means medical and hospital service agreements, group health plans, membership agreements, benefit plans, administrative service agreements and similar agreements by which QM agrees to provide, arrange for, manage or administer Health Care Services for any person(s).

1.7 "Hospital Services" means those medically necessary Health Care Services which are generally and customarily provided by Hospital, which are prescribed, directed or authorized by a physician. Hospital Services include inpatient services and all services rendered in the emergency room or outpatient departments of Hospital and all services of Hospital's subcontractors.

Hospital Services are limited to those services that are included as benefits in a paid-up Member's Health Plan and as limited by any exclusions, or scope, time and dollar amount limitations in such Health Plan. Health Plans may be amended from time to time and such agreements and such amendments are incorporated herein by this reference.

1.8 "Inpatient day" means each day a Member is formally admitted by Hospital and is provided with room, board and continuous nursing service. An admission and discharge or death occurring on the same day will be counted as one inpatient day. A Member and her newborn(s) will be deemed to be one patient, per inpatient day, so long as both are in the Hospital, provided that neither is suffering from any condition requiring treatment beyond that rendered in normal delivery or C-Sections.

1.9 "Medical Director" means the person serving as Medical Director on behalf of QM or his or her designee(s).

1.10 "Medically Necessary" means any Health Care Services required to preserve and maintain the Member's health in accordance with acceptable standards of medical practice as determined by the Medical Director.

1.11 "Medicare" means the program of health insurance established pursuant to Title XVIII of the Social Security Act.

1.12 "Member" means a paid-up and otherwise fully eligible person enrolled in a Health Plan who, as a result of such membership, is contractually entitled to Health Care Services or compensation for such services under the terms of such Health Plan, or any other individual so designated specifically by QM. A Member shall include such persons and dependents as defined by such Health Plan and may be designated in such Health Plan by any descriptive word recognizing a contractual obligation to an individual and his or her dependents.

1.13 "Nonparticipating Provider" is a health care provider who does not have an effective Participating Provider contract with QM.

1.14 "Participating Provider" means any person or entity who has contracted to provide Health Care Services to Members with an expectation of receiving payment, other than Copayments, directly or indirectly from or through QM and such contract is in effect at the time that such services are rendered.

1.15 "Peer Review Committee" means the panel of Participating Physicians appointed by QM to establish and maintain a system of review to assure the quality and appropriateness of Health Care Services provided to Members.

1.16 "Subscriber Group" means the employer or other person identified in a Health Plan.

1.17 "Written Referral" or "Referral" means the form to authorize Health Care Services to be rendered, including appropriate authorizations, as may be revised from time to time

by QM, identified as "Referral Authorization for Medical Care Services" or "Hospital Service Purchase Order" or other form designated for such purpose. Except in the event of a Medical Emergency or for routine laboratory or x-ray tests performed outside of a hospital setting, all Referrals require the prior written authorization of QM. Subsequent confirmation shall be obtained through a Referral for Emergency Care. In unusual cases where treatment is urgently needed but which do not qualify as Medical Emergencies, prior approval by QM shall be obtained by telephone, with subsequent confirmation through a Referral. Prior approval by telephone shall not be required if the diagnosis that treatment is urgently needed occurs after normal QM business hours and telephone authorization cannot be obtained within a reasonable time, but subsequent confirmation through a Referral shall be obtained. QM will pay Hospital only for services rendered in accordance with a Referral.

ARTICLE 2 HOSPITAL SERVICES

2.1 Hospital agrees to provide Medically Necessary covered Hospital Services to eligible Members as follows:

2.1.1 Hospital shall provide non-emergency inpatient or outpatient Hospital Services in accordance with Written Referrals and certification of length of stay. Hospital shall assure the provision of prior Written Referral for all non-emergency hospital inpatient and outpatient Services.

2.1.2 Hospital shall provide emergency Hospital Services on an inpatient or outpatient basis without prior authorization provided that Hospital shall notify the Medical Director immediately within normal business hours or on the first working day following such admission. Hospital shall obtain subsequent confirmation through a Written Referral. The existence of a Medical Emergency shall be subject to review and final determination by the Medical Director.

2.1.3 Hospital agrees to accept for admission all Members who are admitted, in accordance with the authorization provisions of 2.1.1 and 2.1.2, by physicians with admitting privileges at Hospital. Except as otherwise provided in this Agreement, such admission shall be in accordance with the general admission policies of Hospital. Hospital shall provide Hospital Services for Members in a manner similar to those provided to all other patients.

2.2 Before providing Hospital Services to a Member, except when unable to do so in event of a Medical Emergency, Hospital will determine the following:

2.2.1 That the Member possesses a valid membership identification card and supporting identification, and membership is verified by QM; and

2.2.2 That the Member is in good standing as determined by a written list provided by QM or by telephone inquiry to QM. Such written list shall be provided to Hospital upon Hospital's request.

2.3 To the extent permitted by law and by the standards promulgated by the Joint Committee on Accreditation of Healthcare Organizations, Hospital will accept the written results of laboratory and radiological tests or procedures performed on a Member, in a facility certified pursuant to Medicare requirements, within two (2) weeks prior to admission and will not require that duplicate tests or procedures be performed or be charged for after the Member is admitted, except that (a) determination of blood type and cross-match is excluded from this provision and (b) surgical cases will require chest x-ray and complete blood count within seventy-two (72) hours prior to surgery, and (c) tests necessary to reflect changes in the patient's condition are not considered duplicate tests. The parties recognize that the attending physician may order additional tests or procedures if necessary to verify current patient condition.

2.4 Hospital agrees to conform with applicable law and regulations regarding informed consent forms as developed by Hospital, prior to any procedure or treatment. Hospital acknowledges that adherence to the then prevailing standards of medical ethics is paramount.

2.5 Hospital shall be duly licensed within its jurisdiction. Support staff shall be licensed and participate in continuing medical education as required by law. Evidence of such licensing shall be submitted to QM upon request. QM has relied upon state licensing and regulatory authorities and accordingly, Hospital shall give immediate notice to QM of the suspension or termination of such license.

2.6 Hospital agrees that it will provide such policies of malpractice insurance, or self-insurance, as shall be necessary to insure Hospital and all persons and entities performing services under or through Hospital against any claim or claims for damages arising by reason of personal injury or death occasioned directly or indirectly in connection with the performance of any Hospital or Health Care Services by Hospital. Such insurance, or self-insurance, coverage shall be subject to the review and approval of QM. QM has relied in part upon Hospital's ability to maintain malpractice insurance, or self-insurance, coverage and accordingly, Hospital shall give QM immediate notice of the lapse, termination or cancellation of such insurance, or self-insurance. Current malpractice coverage

maintained by Hospital shall be deemed adequate compliance with this paragraph upon the effective date hereof and throughout the term hereof.

2.7 Hospital shall cooperate with all QM administrative policies and procedures relating to the delivery of Hospital Services and with all applicable state and federal laws, rules and regulations relating to HMOs. A copy of such policies has been provided to Hospital. QM agrees to notify Hospital of any new or revised standards or policies which may materially effect this Agreement.

2.8 Hospital has in the past and will, throughout the term of this Agreement, deliver Hospital Services to and will not discriminate against QM Members and will provide care which is consistent with the community standard.

2.9 In accordance with Article 10 hereof, QM shall not intervene in any undue manner with nor be vicariously responsible for the rendition of Hospital Services hereunder, it being agreed that Hospital is responsible for the provision of such services under this Agreement.

2.10 Hospital agrees that it shall not discriminate against any Member on the basis of age, race, creed, color, religion, sex, national origin, sexual orientation, marital status, physical, sensory or mental handicap, place of residence, socioeconomic status or status as a recipient of medicare under Title XVIII of the Social Security Act.

ARTICLE 3 MEMBER IDENTIFICATION AND ELIGIBILITY

3.1 In most instances, QM shall furnish Member an identification card which is to be presented upon admission to Hospital upon each instance of provision of Hospital Services. With respect to Members who have not received identification cards, Hospital shall verify eligibility, covered services and prior authorization under paragraph 3.2 hereof.

3.2 QM shall maintain adequate personnel and facilities to provide telephone and written response to inquiries regarding eligibility, covered services, and prior authorization for Hospital Services at the time of inquiry or on the next working day.

3.3 Upon request, QM will provide a current list as well as timely updates of all administrative personnel to whom any inquiries should be directed.

3.4 QM shall perform those administrative, accounting, marketing, enrollment and other functions necessary, convenient or appropriate for the administration of Health Plan(s).

3.5 QM shall collect all dues, premiums and other items of income to which QM shall be entitled except for all Copayments which the parties mutually agree shall be more conveniently collected by Hospital.

3.6 QM shall prepare and make available to Members a list or lists, updated from time to time, of Participating Providers.

ARTICLE 4 RECORDS AND INFORMATION

4.1 Hospital and QM agree that the medical records of all Members shall be treated as confidential, in compliance with state and federal laws governing the confidentiality of patients' medical records.

4.2 Notwithstanding the confidentiality accorded medical records under Paragraph 4.1 of this Article, QM, through its Medical Director, shall have the right, upon twenty-four (24) hours advance notice during regular business hours and at such reasonable locations within Hospital as Hospital may designate, to review in person the following records and information, both concurrent with treatment and after discharge. Such reviews shall be conducted in accordance with Hospital's policies and procedures and shall pertain to QM Members only.

4.2.1 Complete information relating to the Hospital Services rendered to a Member whether or not such services are included as benefits in a Member's Health Plan;

4.2.2 Utilization of Hospital Services by Members and their attending physicians; and

4.2.3 Any medical records or charts of a Member.

4.3 Hospital shall, at the time of the admission of any Member, have said Member execute a standard admission form containing an authorization that permits Hospital to release medical records to QM.

4.4 Hospital agrees to make copies or permit QM to make copies of Members' records at a fee of five (5) cents per page.

4.5 QM agrees to obtain the authorization of a Member for release of medical records in the event authorization is not otherwise obtained.

4.6 Upon the specific request of the Medical Director, Hospital agrees to provide to QM information and copies of the results of any utilization review studies conducted at Hospital. Hospital's utilization review information shall be released in accordance with Hospital policies and procedures and shall pertain to QM Members only.

4.7 Hospital agrees to permit QM to audit business records relating to Members, for the purpose of verification of billing information, provided that QM submits a written list of those Members' names, account numbers, dates of service and service codes, at least seven working days prior to such examination. QM will pay Hospital reasonable and necessary expenses resulting from such audit.

4.8 The parties agree to cooperate and comply with audits and inspections of records or facilities required under state or federal laws.

4.9 Upon request, QM will provide Hospital with current copies of documents incorporated herein by reference.

ARTICLE 5 QUALITY ASSURANCE AND UTILIZATION REVIEW

5.1 The parties recognize the necessity for quality assurance and utilization review programs and agree to cooperate to achieve effective programs. Such cooperation will include, without limitation, permitting QM nurses to review Members' charts concurrent with treatment and after discharge, permitting QM nurses to attend discharge planning conferences, and submitting periodic reports as requested by QM. QM shall give Hospital twenty-four (24) hour notice and will coordinate site visits with Hospital staff. Site visits will occur during normal business hours.

5.2 Hospital agrees to provide the Medical Director access to medical and other records of Members in accordance with Hospital policies and state and federal laws for the purpose of conducting quality assurance and utilization review programs. In the event that QM requests Hospital to conduct a quality assurance study or utilization review program for Members, then QM will pay Hospital for such activity based upon a mutually agreed fee. Hospital agrees to respond promptly to telephone inquiries from the Medical Director regarding information from a Member's medical charts concerning the Member's medical condition for the purpose of assessing the Member's status and conducting an ongoing certification of length of stay. Any such telephone inquiries by the Medical Director shall be made to Hospital's Utilization Review Coordinator and the information requested shall be limited to the Member's status as it relates to the certification of length of stay. Hospital shall not charge for response to such telephone inquiries.

5.3 QM agrees that Hospital may conduct its customary and usual programs for quality assurance and utilization review upon Members and Hospital shall make available the results of such programs to QM, without charge. QM agrees to make the results of such programs available to Hospital, for Hospital's patients only, without charge to Hospital.

5.4 The parties agree to cooperate in a program of discharge planning which may be conducted by either party.

5.5 Hospital will make a reasonable effort to make available to the Medical Director a telephone and an appropriate workplace for the purpose of carrying out the utilization review and quality assurance programs.

ARTICLE 6 COMPENSATION AND PAYMENT

6.1 QM will pay Hospital Billed Charges for covered Hospital Services rendered to eligible Members in accordance with the terms and conditions of this Agreement. Rates to be used in determining Billed Charges are set forth on Attachment A.

6.2 Hospital agrees to accept Billed Charges as payment in full for services or supplies covered under a Member's Health Plan, whether that amount is paid in whole or in part by the Member, QM, or by any combination of insurers or health plans that pay before QM in the order of benefit determination.

6.3 Hospital agrees that in the event it renders any services to a Member without obtaining any prior authorization required by QM, or provides any services to a Member beyond the Certified Length of Stay, it will not charge, bill or attempt to collect from QM, a Member, a subscriber, or Subscriber Group for charges incurred in connection with such admission or such uncertified length of stay unless Hospital has obtained the explicit agreement of such Member, subscriber, or Subscriber Group for such services. Standard hospital admission forms will not satisfy this requirement. The Agreement of a Member, subscriber, or Subscriber Group shall not bind QM.

6.4 QM verification of eligibility is made based upon records at hand. If QM discovers subsequent to such verification that a patient was in fact not enrolled, QM will promptly notify Hospital and payment (if any) will be determined based on the effective date of termination of enrollment. If Hospital fails to make a reasonable attempt to verify an individual's eligibility for service, or if the admitting information provided by Hospital is inaccurate, and QM should later determine either that the individual or the services rendered were in fact ineligible for coverage at the time they were rendered, QM shall not be liable for payment for such services.

6.5 The parties agree to abide by the provisions set out in Attachment B. Provided however, that with regard to Members who are covered under a Health Plan for which QM acts as a third party administrator and who are not covered under any other QM

Health Plan, Hospital agrees to look solely to the third party payor for payment for services provided to such Members.

6.6 Each Member is personally responsible for Copayments or deductibles. Hospital agrees to exercise its best efforts to collect Copayments at the time of admission or within a reasonable time after services are rendered. The amount of such Copayments, whether or not collected by Hospital, shall be deducted from any amount due from QM under this Agreement, except when proper coordination of benefits procedures prohibit application of Copayments.

6.7 QM agrees to make a good faith effort to aid in the collection of Copayments or deductibles owed by Members to Hospital.

6.8 Hospital will submit itemized statements with usual and customary charges for Hospital Services, for each episode of Hospital Service for Members in a mutually agreeable standardized format, such as UB-92. Such claims and itemized statements will be submitted within ninety (90) days following the date of discharge.

6.9 No payments for Hospital Services rendered to Members hereunder will be made to Hospital if the delivered Hospital Services do not comply with the quality of care or utilization standards adopted in a QM quality assurance, peer and utilization review program. Hospital further agrees that Hospital will not seek payment from Members or Subscriber Groups for any such Services. A copy of such QM policies has been provided to Hospital.

6.10 The applicable charges will compensate Hospital for all Hospital Services provided to Members except for services and items which are not covered benefits including television and telephone. The excluded items are or may be the responsibility of the Member, and Hospital may bill and collect separately for those which are the responsibility of the Member.

ARTICLE 7 COORDINATION OF BENEFITS

QM is a secondary payor in any situation where there is another payor as primary carrier. Hospital will make reasonable inquiry of each Member to whom it provides services to learn whether that Member has health insurance or health benefits other than Member's Health Plan or is entitled to payment by a third party under any other insurance or plan of any type. If so, Hospital will promptly inform QM. QM reserves the right to coordinate benefits with other health plans, insurance carriers and HMOs. Hospital consents to QM's release of medical information to such other parties as necessary to accomplish the coordination of benefits. In the event that coordination of

benefits occurs, QM will provide supplemental reimbursement to Hospital, up to the allowable expense, from funds saved through coordination for services rendered to the Member during the claim determination period. If no funds have been saved through coordination, QM agrees to reimburse Hospital in an amount equal to the allowable expense less the amount paid by other health plans, insurance carriers and HMOs, not to exceed the amount provided in Article 6.

ARTICLE 8 TERM AND TERMINATION

8.1 The initial term of this Agreement shall be one (1) years, commencing and effective on September 1, 1994, and terminating August 31, 1995. This Agreement shall continue for additional terms of one (1) year each thereafter, unless terminated by notice not less than ninety (90) days prior to the expiration of the initial term or any additional term. The parties agree to meet annually no less than ninety (90) days prior to the end of each successive term to discuss billed charges for successive term(s). In the absence of such notice, this Agreement shall be automatically renewed. Any party may terminate this Agreement without cause by giving ninety (90) days prior written notice of its intention to terminate.

8.2 When this Agreement is terminated, either at the end of any term or in accordance with this Article, eligible Members who are inpatients in Hospital may continue as inpatients until the Members' normal discharge dates, and Hospital shall be eligible for reimbursement by QM under the terms of this Agreement. Hospital agrees to accept the rates in effect immediately prior to termination as full reimbursement for such Members' care.

8.3 Upon the happening of any of the following events of default, this Agreement may be terminated by the non-defaulting party if the default is not corrected within thirty (30) days following delivery of written notice to the defaulting party of the specific description of the default. Such events are the following:

8.3.1 The failure of QM to make any payment required under this Agreement after it is past due.

8.3.2 The default of either party in the substantial performance of substantive and nonmonetary terms, conditions, covenants or obligations contained in this Agreement.

8.3.3 The loss, by either party, of any license, certificate or qualification required by law to be maintained in order for such party to discharge its obligations under this Agreement.

8.4 In the event of any substantial changes, the termination, or non-renewal of this Agreement, QM will notify, in a timely manner, all affected Members and appropriate regulatory agencies.

8.5 At the sole option of the other party and notwithstanding any other section of this Agreement, this Agreement will terminate immediately upon written notification in the event of the filing of a petition under the U.S. Bankruptcy Code, whether voluntarily by either party or involuntarily by a creditor of either party; the appointment of a receiver for either party; the declaration of insolvency of either party, by a court of competent jurisdiction; or an announcement by either party of plans to terminate its business operations in King County, Washington.

ARTICLE 9 ARBITRATION

9.1 The parties agree to establish an informal procedure to resolve disputes arising under this Agreement prior to submitting such disputes to formal arbitration. As needed, each party shall designate three representatives from upper-level management or medical staff to review such disputes and attempt to resolve them. In the event the committee is unable to satisfactorily resolve a dispute within ninety (90) days, then it may be submitted to formal arbitration.

9.2 It is agreed between Hospital and QM that in the event of any dispute under this Agreement concerning any of the covenants, terms or conditions thereof, the parties, as a condition precedent to the commencement of any civil action in any court of competent jurisdiction, shall submit the dispute to binding arbitration. Said arbitration shall be conducted in King County, Washington. The arbitration shall proceed in accordance with the rules and regulations of the American Arbitration Association then in effect. The panel of arbitrators shall be selected as follows: One member of the panel shall be designated by Hospital; one member shall be designated by QM; and the third member shall be selected by the members designated by Hospital and QM. Each party shall pay its own cost of arbitration.

ARTICLE 10 RELATIONSHIP OF THE PARTIES

10.1 The relationship between QM and Hospital is an independent contractor relationship and none of the provisions of this Agreement are intended to create nor shall be construed to create an agency, partnership, employer/employee, master/servant or joint venture relationship between the parties. Neither party hereto is and neither party hereto shall hold himself, herself, or itself out to a Member or any third party as being an actual,

apparent or ostensible agent of, a partner, employee or servant of, or a joint venturer with, the other party.

10.2 Neither QM nor Hospital nor any of their respective officers, directors, agents, representatives or employees shall be deemed to be an officer, director, agent, representative or employee of the other party and neither this Agreement nor the manner of its implementation shall be deemed to create a direct or substantial relationship between the acts or omissions of any such officer, director, agent, representative or employee and the other party.

10.3 QM shall be liable for any and all losses, damages, costs, expenses and attorney fees arising from any claim or demand of any kind or character of any Member or third party, to the extent that the alleged injury to any such Member or third party was caused directly or substantially by the willful or negligent acts or omissions of QM or any of its officers, directors, agents, representatives or employees.

10.4 Hospital shall be liable for any and all losses, damages, costs, expenses and attorney fees arising from any claim or demand of any kind or character of any Member or third party, to the extent that the alleged injury to any such Member or third party was caused directly or substantially by the negligent acts or omissions of Hospital or any of its officers, directors, agents, representatives or employees.

10.5 No party hereto shall be liable for injuries or damages to a Member or third party in the absence of a direct or substantial relationship between the injury or damage and the acts or omissions of a party. Consequently, neither party hereto shall be liable for injuries or damages arising from the acts or omissions of other independent contractors performing other services included in a Benefit Schedule, in the absence of direct or substantial control.

ARTICLE 11 USE OF NAME

11.1 Hospital agrees that during the term of this Agreement, QM shall have the right to designate and make public reference to Hospital as a QM participating Hospital. All uses of Hospital name must be preapproved by Hospital administration prior to use. Hospital hereby grants permission for QM to use Hospital's name in participating provider directories.

11.2 QM agrees that, during the term of this Agreement, Hospital shall have the right to designate and make public reference to its status as a QM participating Hospital.

ARTICLE 12 MISCELLANEOUS

12.1 This Agreement is intended as the complete integration of all understandings regarding the subject matter hereof between the parties hereto. No prior or contemporaneous addition, deletion, or other amendment hereto shall have any force or effect whatsoever, unless embodied herein in writing. No subsequent novation, addition, deletion or other amendment hereto shall have any force or effect unless embodied in a written contract executed and approved pursuant to all policies and procedures of QM and Hospital. Any amendment to this Agreement must be approved by the Washington Insurance Commission prior to use.

12.2 This Agreement shall in no way be construed to provide any rights hereunder directly to Members or to increase the duties or responsibilities of the parties hereto beyond the requirements established by this Agreement. The sole purpose of this Agreement is to establish the respective rights and duties of the parties hereto, each to the other, and the rights of Members are derived solely from their Health Plans. However, if appropriate, a Member may assert the provisions of paragraph 6.5 hereof, as a defense.

12.3 The parties agree to execute the provisions of this Agreement in a manner designed to preserve human dignity.

12.4 The parties agree to cooperate in the identification and resolution of complaints or grievances by Members arising in connection with this Agreement. In the event any complaint or grievance by Members arises as a result of any service or treatment by Hospital, QM agrees to assist the Hospital's Patient Representative in resolving such complaint or grievance according to the established procedure for such matters at Hospital.

ARTICLE 13 NOTICES

Except for notices required by Articles 2 and 4, any notice required to be given pursuant to the terms and provisions hereof shall be in writing and shall be sent by Certified Mail, Return Receipt Requested, to Hospital at: 1959 NE Pacific St, RC-34 Seattle, WA 98195; and to QM at: 2331 130th Avenue, N.E., Suite 200, Bellevue, WA, 98009-3387; or elsewhere as either party may designate in writing.

ARTICLE 14 ENFORCEABILITY

If any provision of this Agreement shall be rendered invalid or unenforceable by a court of competent jurisdiction,

for any reason to any extent, the remainder of this Agreement shall not be affected thereby, but shall be enforced to the greatest extent permitted by law. Any state action at law or in equity filed by either party hereto with respect to this Agreement shall be filed in King County, Washington and the parties hereby stipulate to such venue and to the jurisdiction of such court.

ARTICLE 15 ASSIGNABILITY

This Agreement may not be assigned by either party without the prior written consent of the other party and such consent shall not be unreasonably withheld. In the event of merger, consolidation, or acquisition of either party, this Agreement shall be binding upon the parties and any successor of the parties. A corporate name change shall not constitute an assignment.

ARTICLE 16 APPLICABLE LAW

This Agreement shall be governed by the laws of the State of Washington.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement.

Hospital

By R. Hinckley

Its Executive Director

Date: 10/24/94

Qual-Med Washington Health Plan, Inc.

By D. B. Miller, MD

Its MEDICAL DIRECTOR

Date: 11-1-94

Approved as to form

Lisa Vincie
Assistant Attorney General
State of Washington
University of Washington Division

HOSPITAL SERVICE AGREEMENT

ATTACHMENT A

Billed Charges, as defined in Paragraph 1.2 of the Agreement, are as follows:

INPATIENT SERVICES: ALL PATIENT DIAGNOSTIC RELATED GROUPS (APDRG)

QM will reimburse Hospital for inpatient services provided under this Agreement under the APDRG methodology, by applying the Health Care Authority weights, version 9, to a base rate of \$4,578 per inpatient discharge.

For those APDRG's with a relative weight of zero (0), QM will reimburse Hospital eighty-five percent (85%) of billed charges.

On January 1 of each successive renewal year, QM will add the new APDRG numbers added by the Health Care Authority, or upgrade the version of weights, if applicable.

HIGH CHARGE OUTLIER

The APDRG outlier threshold is calculated at the APDRG payment times 1.75.

If the outlier threshold is LESS than billed charges, then the difference between billed charges and the outlier threshold will be reimbursed at eighty-five percent (85%) of charges and added to the APDRG payment.

The above methodology does not apply to specific specialty services. For Cardiac Surgery, Neonatal Intensive Care, and Transplant Services, see attached sheets for specific high charge outlier reimbursement.

For Psychiatric and Rehabilitation Services, there is no high charge outlier.

LOW CHARGE OUTLIER

On a case by case basis, QM may reimburse Hospital the lesser of the APDRG payment or eighty-seven percent (87%) of billed charges.

For Neonatal Intensive Care, Psychiatry and Rehabilitation Services, this low charge outlier methodology will not apply.

For Transplant Services, see attached sheets for low charge outlier reimbursement.

The following services shall be reimbursed under methods other than APDRG methodology:

Cardiac Surgery Case Rates

The following cardiac surgery services will be reimbursed as follows:

<u>APDRG</u>	<u>Hospital Case Price</u>
104 - Valve Procedure with Cardiac Cath	\$23,885
105 - Valve Procedure W/O Cardiac Cath	\$21,553
106 - Coronary Bypass with Cardiac Cath	\$18,306
107 - Coronary Bypass W/O Cardiac Cath	\$15,974
112 - Percutaneous Cardiovascular Procedures (PTCA)	\$ 6,238
545 - Cardiac Valve Procedure with major cc	\$35,963
546 - Coronary bypass with major cc	\$28,650
Cardiac Cath	\$ 2,320

The cardiac outlier threshold will be \$70,000. Charges exceeding the outlier threshold will be reimbursed at eighty percent (80%) of charges and added to the case rates outlined above. AICD/PCD implantable defibrillators will be passed through at cost and added to the above case prices.

Neonatal/Rehabilitation/Psychiatric Services Per Diem Rates

These services will be reimbursed at the following per diem rates:

Level I - Nursery (APDRG 620 & 629)	\$ 410 per day
NICU Services	See attached sheet for preferred rates
Inpatient Rehabilitation Services (APDRG 462)	\$ 768 per day
Rehabilitation Service with Ventilator Dependence (APDRG 462)	\$ 927 per day

Per Diem Rates

Psychiatric Services: (APDRG 424-432)	
Inpatient Acute	\$ 650 per day
Med Psych	\$ 850 per day

Partial Hospitalization Program \$ 350 per day

High Dose Chemotherapy Treatments

During the first four months of this Agreement, UWMC and QM shall discuss mutually acceptable reimbursement for high dose chemotherapy treatments without transplant. The following interim rates have been developed for this four month period:

For the period of September 1 through December 31, 1994, High Dose Chemotherapy Services without Bone Marrow Transplant and Leukemia Induction Therapy Services shall be reimbursed at the lesser of eighty-five percent (85%) of charges or the case rate of \$98,000 (\$80,000 UWMC, \$18,000 UWP).

For the entire term of this Agreement, High Dose Chemotherapy Services with Autologous Bone Marrow Transplant shall be reimbursed at the per case rates listed in this Attachment. Additionally all other chemotherapy treatments shall be reimbursed under the APDRG methodology of the term of this Agreement.

OUTPATIENT SERVICES

QM will reimburse Hospital eighty-five percent (85%) of billed charges for outpatient services.

NEONATAL SERVICES

APDRG Number	APDRG Description	Rate Per Day	Percent of Charges
<u>Neonates Extreme Immaturity</u>			
602 <750 gms, discharged alive		\$1,325	
603 <750, died		\$1,325	
604 750-999, discharged alive		\$1,325	
605 750-999, died		\$1,325	

Neonates Immaturity

607 1000-1499 w/o sig OR pr, disch alive	\$1,200
611 1500-1999 w/o sig OR pr w m maj prob	\$1,200
612 1500-1999 w/o sig OR pr w maj prob	\$1,100
613 1500-1999 w/o sig OR pr w min prob	\$1,100
614 1500-1999 w/o sig OR w other prob	\$ 975
617 2000-2999 w/o sig OR pr w m maj prob	\$1,200
618 2000-2999 w/o sig OR pr w maj prob	\$ 975
619 2000-2999 w/o sig OR pr w min prob	\$ 975
621 2000-2999 w/o sig OR pr w other prob	\$ 975
626 >2499 w/sig OR or w mult maj prob	\$1,100
627 >2499 w/sig OR pr w maj prob	\$ 850
628 >2499 w/sig OR pr w min prob	\$ 850
630 >2499 w/sig OR pr w other prob	\$ 850

631 BPD & other chronic resp dis perinatal \$ 850

Neonates Died or Transferred

608 1000-1499 died	85%
637 Neonate died w/in 1 day, born here	85%
638 Neonate died w/in 1 day, not born here	85%
639 Neonate trans<5 days old, born here	85%
640 Neonate trans<5 days old, not born here	85%

Notes: Per diem rates are inclusive of all patient services (e.g. labs, diagnostics, therapies, pharmacy, supplies, etc.) and apply regardless of unit location.

NICU Outlier: The per diem outlier threshold will be two times the total per diem payment. Billed charges exceeding the outlier threshold will be reimbursed at eighty percent (80%) of charges and added to the total per diem payment.

UWMC/UWP Exclusive Solid Organ Transplant Rates

For the term of this Agreement, University of Washington Medical Center will be the exclusive provider of Kidney/Pancreas, Liver, and Pancreas transplantation in the State of Washington, and the exclusive provider of Heart and lung transplantation in Western Washington for QM Members. This Agreement is non-exclusive for Kidney transplantation.

I. Pre-Transplant Work-Up:

UWMC:	85% of charges
UWP:	85% of charges

II. Inpatient Transplant Admission:

For the inpatient transplant admission, reimbursement shall be the lesser of total billed charges or the following case rates:

A. Case Rates

	<u>UWMC</u>	<u>UWP</u>	<u>Total</u>	<u>UWMC Outlier</u>
Heart	\$ 82,000	\$31,000	\$113,000	\$147,000
Lung	\$135,000	\$27,000	\$162,000	\$200,000
Kidney	\$ 35,000	\$ 7,500	\$ 42,500	\$ 85,000
Kidney/Pancreas	\$ 95,000	\$15,000	\$110,000	\$160,000
Liver	\$105,000	\$37,000	\$142,000	\$170,000
Pancreas	\$ 65,000	*	*	\$115,000

* Currently being developed

For Eastern Washington QM Members utilizing lung transplantation services, due to non-exclusivity of services, rates shall be:

<u>UWMC</u>	<u>UWP</u>	<u>Total</u>
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\$145,800	\$29,160	\$174,960
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B. Case Rates Include:

- Up to one (1) day pre-transplant inpatient care
- Transplant work-up within twenty-four (24) hours of admission
- All physician services from day preceding surgery to discharge
- Organ acquisition
- Retransplant during admission
- Excludes Air Ambulance charges other than those associated with the organ harvest
- Forty-five (45) days outpatient surgeon follow-up from the date of surgery

Retransplants following discharge from initial inpatient transplant admission initiate a new case cycle. Authorization and payment for these transplants will follow terms of initial case rate.

C. Outliers - Facility Charges Only

Facility charges beyond the outlier limit will be reimbursed at seventy-five percent (75%) of charges.

III. Post Transplant Outpatient Follow-Up

(For visits related to the initial transplant - seven (7) month term)

UWMC: 85% of charges
UWP: 85% of charges

UWMC/UWP Exclusive Autologous Bone Marrow Transplant Rates

For the term of this Agreement, University of Washington Medical Center will be the exclusive provider of Autologous Bone Marrow Transplantation in the State of Washington for QM Members.

The rates below reflect all services related to work-up and corresponding transplant for patients needing several types of bone marrow transplants. The disease entities for which these transplants are available are: Acute Myeloid Leukemia, Acute Lymphoblastic Leukemia, Acute Myelogenous Leukemia, all types of non-Hodgkin's lymphomas and Hodgkin's disease.

I. Pre-Transplant Outpatient Work-Up:

UWMC: 85% of charges
UWP: 85% of charges

II. Transplant Admission:

For the inpatient transplant admission. reimbursement shall be the lesser of total billed charges or the following case rates:

A. Case Rates

	<u>UWMC</u>	<u>UWP</u>	<u>Total</u>	<u>UWMC Outlier</u>
High dose chemo with autologous bone marrow transplant (BMT)	\$80,000	\$18,000	\$98,000	\$160,000
Peripheral Blood Stem Cell (PBSC)	\$80,000	\$13,000	\$93,000	\$160,000
Radiolabeled Antibodies Therapy (RIT)**	\$77,000	\$13,000	\$90,000	\$154,000

**Not available for Hodgkin's disease

B. Case Rates Include:

- Pretransplant testing
- All physician services related to harvest and transplantation
- Up to one (1) day inpatient care for bone marrow harvest and storage for BMT and RIT
- TBI and chemotherapy for BMT and PBSC during transplant process
- Infusion of stored marrow or PBSC
- PBSC processing, reinfusion fee, and cost of high dose G-CSF for PBSC patients
- Two outpatient follow-up visits
- Excludes Air Ambulance charges other than those associated with the organ harvest

C. Outliers- Facility Charges Only

Facility charges beyond the outlier limit will be reimbursed at seventy-five percent (75%) of charges.

**III. Post-Transplant Outpatient Follow-Up
(for visits related to the initial transplant)**

UWMC: 85% of charges
UWP: 85% of charges

Notes:

- * All initial chemotherapy treatments and treatments required prior to admission (after the initial evaluation by UWMC physicians) will be performed by the Member's primary care physician.
- * After transplantation and two (2) outpatient follow-up visits, Members will be referred back to their primary care physician for any further treatment.

ATTACHMENT B
QUAL-MED WASHINGTON HEALTH PLAN, INC.
PARTICIPATING PROVIDER CONTRACT FORM

(a) Hospital hereby agrees that in no event, including, but not limited to nonpayment by Qual-Med, Qual-Med's insolvency or breach of this contract shall Hospital bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Member or other person, other than Qual-Med, acting on a Member's behalf, for services provided pursuant to this contract. This provision shall not prohibit collection of deductibles, Copayments, coinsurance, and/or non-covered services, which have not otherwise been paid by a primary or secondary carrier in accordance with regulatory standards for coordination of benefits, from Members in accordance with the terms of the Member's Health Plan.

(b) Hospital agrees, in the event of Qual-Med's insolvency, to continue to provide the services promised in this contract to Qual-Med Members for the duration of the period for which premiums on behalf of the Member were paid to Qual-Med or until the Member's discharge from inpatient facilities, whichever time is greater.

(c) Notwithstanding any other provision of this contract, nothing in this contract shall be construed to modify the rights and benefits contained in the Member's Health Plan.

(d) Hospital may not bill the Member for covered services (except for deductibles, Copayments or coinsurance) where Qual-Med denies payments because Hospital has failed to comply with the terms of this contract.

(e) Hospital further agrees (i) that the above provisions (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 Qual-Med's Members, and (ii) that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Hospital and Members or persons acting on their behalf.

(f) If Hospital contracts with other health care providers who agree to provider covered services to Members of Qual-Med with the expectation of receiving payment directly or indirectly from Qual-Med, such providers must agree to abide by the above provisions (a), (b), (c), (d) and (e).

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