[redacted] WASHINGTON, INC.
PROVIDER AGREEMENT

This Provider Agreement (hereinafter "Agreement") is made and entered into by and between [redacted] Washington, Inc. (hereinafter "[redacted] and the undersigned Provider (hereinafter "Provider"), and shall be effective as of the date set forth immediately above [redacted] signature (the "Effective Date"). In consideration of the mutual promises and covenants herein contained, the sufficiency of which is acknowledged by the parties, the parties agree as follows:

ARTICLE I
DEFINITIONS

"Affiliate" means any entity that is: (i) owned or controlled, either directly or through a parent or subsidiary entity, by [redacted] or any entity which controls or is under common control with [redacted] and/or (ii) that is identified as an Affiliate on a designated web site as referenced in the provider manual(s). Unless otherwise set forth in this Agreement, an Affiliate may access the rates, terms and conditions of this Agreement.

"Agency" means a federal, state or local agency, administration, board or other governing body with jurisdiction over the governance or administration of a Health Benefit Plan.

"Audit" means a post-payment review of the Claim(s) and supporting clinical information reviewed by [redacted] to ensure payment accuracy. The review ensures Claim(s) comply with all pertinent aspects of submission and payment including, but not limited to, contractual terms, Regulatory Requirements, Coded Service Identifiers (as defined in the PCS) guidelines and instructions, [redacted] medical policies and clinical utilization management guidelines, reimbursement policies, and generally accepted medical practices. Audit does not include medical record review for quality and risk adjustment initiatives, or activities conducted by [redacted] Special Investigation Unit ("SIU").

"Claim" means either the uniform bill claim form or electronic claim form in the format prescribed by Plan submitted by a provider for payment by a Plan for Health Services rendered to a Member.

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

"Cost Share" means, with respect to Covered Services, an amount which a Member is required to pay under the terms of the applicable Health Benefit Plan. Such payment may be referred to as an allowance, coinsurance, copayment, deductible, penalty or other Member payment responsibility, and may be a fixed amount or a percentage of applicable payment for Covered Services rendered to the Member.

"Covered Services" means Medically Necessary Health Services, as determined by Plan and described in the applicable Health Benefit Plan, for which a Member is eligible for coverage.

"Government Contract" means the contract between [redacted] and an applicable party, such as an Agency, which governs the delivery of Health Services by [redacted] to Member(s) pursuant to a Government Program.

"Government Program" means any federal or state funded program under the Social Security Act, and any other federal, or state, county or other municipally funded program or product in which [redacted] maintains a contract to furnish services as designated by [redacted] For purposes of this Agreement, Government Program does not include the Federal Employees Health Benefits Program ("FEHBP"), or any state or local government employer program.

"Health Benefit Plan" means the document(s) that set forth Covered Services, rules, exclusions, terms and conditions of coverage. Such document(s) may include but are not limited to a Member handbook, a health certificate of coverage, or evidence of coverage.

"Health Service" means those services, supplies or items that a health care provider is licensed, equipped and staffed to provide and which he/she/it customarily provides to or arranges for individuals.

"Medically Necessary" or "Medical Necessity" means the definition as set forth in the applicable Participation Attachment(s).

"Member" means any individual who is eligible, as determined by Plan, to receive Covered Services under a Health Benefit Plan. For all purposes related to this Agreement, including all schedules, attachments, exhibits, provider manual(s), notices and communications related to this Agreement, the term "Member" may be used interchangeably with the terms Insured, Covered Person, Covered Individual, Enrollee, Subscriber, Dependent Spouse/Domestic Partner, Child, Beneficiary or Contract Holder, and the meaning of each is synonymous with any such other.

"Network" means a group of providers that support, through a direct or indirect contractual relationship, one or more product(s) and/or program(s) in which Members are enrolled.

Provision intentionally left blank.

"Participating Provider" means a person, including but not limited to, a physician or other health care professional or entity, including but not limited to a hospital, health care facility, a partnership of such professionals, or a professional corporation, or an employee or subcontractor of such person or entity, that is party to an agreement to provide Covered Services to Members that has met all applicable required Plan credentialing requirements, standards of participation and accreditation requirements for the services the Participating Provider provides, and that is designated by Plan to participate in one or more Network(s). Unless otherwise specifically delineated, all references herein to "Provider" may also mean and refer to "Participating Provider".

"Participation Attachment(s)" means the document(s) attached hereto and incorporated herein by reference, and which identifies the additional duties and/or obligations related to Network(s), Government Program(s), Health Benefit Plan(s), and/or Plan programs such as quality and/or incentive programs.

"Plan" means [redacted] and or an Affiliate. For purposes of this Agreement, when the term "Plan" applies to an entity other than [redacted] "Plan" shall be construed to only mean such entity (i.e., the financially responsible Affiliate or Other Payor under the Member's Health Benefit Plan).

"Plan Compensation Schedule" and "Plan Compensation Schedule Attachment" (collectively "PCS") means the document(s) attached hereto and incorporated herein by reference, and which set forth the [redacted] Rate(s) and compensation related terms for the Network(s) in which Provider participates. The PCS may include provider type, additional Provider obligations and specific [redacted] compensation related terms and requirements.

"Regulatory Requirements" means any requirements, as amended from time to time, imposed by applicable federal, state or local laws, rules, regulations, guidelines, instructions, Government Contract, or otherwise imposed by an Agency or government regulator in connection with the procurement, development or operation of a Health Benefit Plan, or the performance required by either party under this Agreement. The omission from this Agreement of an express reference to a Regulatory Requirement applicable to either party in connection with their duties and responsibilities shall in no way limit such party's obligation to comply with such Regulatory Requirement.

'[redacted] Rate" means the reimbursement amount that Provider and [redacted] have agreed upon as set forth in the Plan Compensation Schedule ("PCS"). The [redacted] Rate includes applicable Cost Shares, and shall represent payment in full to Provider for Covered Services.

ARTICLE II
SERVICES/OBLIGATIONS

2.1 Member Identification. [redacted] shall ensure that Plan provides a means of identifying Member either by issuing a paper, plastic, electronic, or other identification document to Member or by a telephonic, paper or electronic communication to Provider. This identification need not include all information necessary to determine Member's eligibility at the time a Health Service is rendered, but shall include information necessary to contact Plan to determine Member's participation in the applicable Health Benefit Plan. Provider acknowledges and agrees that possession of such identification document or ability to access eligibility information telephonically or electronically, in and of itself, does not qualify the holder thereof as a Member, nor does the lack thereof mean that the person is not a Member. [redacted] shall ensure that Provider furnish Health Services to each Medicaid Member without regard to the Medicaid Member's enrollment in the plan as a private purchaser of the plan or as a participant in publicly financed programs of health care services. This requirement does not apply to circumstances when the provider should not render services due to limitations arising from lack of training, experience, skill, or licensing restrictions." ." In the event Member fails to provide a valid identification card at the time of service and, as a result, precertification, preauthorization, preadmission, and utilization management procedures of Plan are not met, then Plan shall review such services for Medical Necessity and coverage and shall pay Provider for such Medically Necessary Covered Services

2.2 Provider Non-discrimination. Provider shall provide Health Services to Members in a manner similar to and within the same time availability in which Provider provides Health Services to any other individual. Provider will not differentiate, or discriminate against any Member as a result of his/her enrollment in a Health Benefit Plan, or because of race, color, creed, national origin, ancestry, religion, sex, marital status, age, disability, payment source, state of health, need for Health Services, status as a litigant, status as a Medicare or Medicaid beneficiary, sexual orientation, gender identity, or any other basis prohibited by law. Provider shall not be required to provide any type, or kind of Health Service to Members that he/she/it does not customarily provide to others. Additional requirements may be set forth in the applicable Participation Attachment(s).

2.3 Publication and Use of Provider Information. Provider agrees that [redacted] Plans or their designees may use, publish, disclose, and display, for commercially reasonable general business purposes, either directly or through a third party, information related to Provider, including but not limited to demographic information, information regarding credentialing, affiliations, performance data, [redacted] Rates, and information related to Provider for transparency initiatives.

2.4 Use of Symbols and Marks. Neither party to this Agreement shall publish, copy, reproduce, or use in any way the other party's symbols, service mark(s) or trademark(s) without the prior written consent of such other party. Notwithstanding the foregoing, the parties agree that they may identify Provider as a participant in the Network(s) in which he/she/it participates.

2.5 Submission and Adjudication of Claims. Provider shall submit, and Plan shall adjudicate, Claims in accordance with the applicable Participation Attachment(s), the PCS, the provider manual(s) and Regulatory Requirements. If Provider submits Claims prior to receiving notice of [redacted] approval pursuant to section 2.13, then such Claims must be submitted in accordance with prior authorization requirements, and shall be processed as out of network. [redacted] shall not make retroactive adjustments with respect to such Claims.

2.6 Payment in Full and Hold Harmless.

2.6.1 Provider agrees to accept as payment in full, in all circumstances, the applicable [redacted] Rate whether such payment is in the form of a Cost Share, a payment by Plan, or a payment by another source, such as through coordination of benefits or subrogation. Provider shall bill, collect, and accept compensation for Cost Shares. Provider agrees to make reasonable efforts to verify Cost Shares prior to billing for such Cost Shares. In no event shall Plan be obligated to pay Provider or any person acting on behalf of Provider for services that are not Covered Services, or any amounts in excess of the [redacted] Rate less Cost Shares or payment by another source, as set forth above. Consistent with the foregoing, Provider agrees to accept the [redacted] Rate as payment in full if the Member has not yet satisfied his/her deductible.

2.6.2 Except as expressly permitted under Regulatory Requirements, Provider agrees that in no event, including, but not limited to non-payment by [redacted] 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 Member, any person acting on behalf of a Member, or HCA for services provided pursuant to this Agreement. This provision shall not prohibit collection of deductibles, copayments, coinsurance and/or payment for noncovered services, which have not otherwise been paid by a primary or secondary issuer in accordance with the terms of regulatory standards for coordination of benefits, from a Member in accordance with applicable Government Contracts or Agency requirements. This provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and a Member or persons acting on such Member's behalf. Provider agrees, in the event of [redacted] insolvency, to continue to provide the services promised in this Agreement to Members of [redacted] for the duration of the period for which premiums on behalf of the Member were paid to provider or until the Member's discharge from inpatient facilities, whichever time is greater. Provider shall not hold Member liable for payment of any fees that are the legal obligation of [redacted] Notwithstanding any other provision of this Agreement, nothing in this Agreement shall be construed to modify the rights and benefits contained in the Member's health plan. Provider may not bill the Member for Covered Services (except for deductibles, copayments, or coinsurance) where [redacted] denies payments because the provider has failed to comply with the terms or conditions of this Agreement. Provider further agrees that the provisions of WAC 284-170-421 (3)(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 Members. If Provider enters into agreements with other

providers who agree to provide Covered Services to Members of [redacted] with the expectation of receiving payment directly or indirectly from [redacted] then such providers must agree to abide by the provisions of WAC 284-170-421(3) (a), (b), (c), (d), and (e). Provider agrees and understands that willfully collecting or attempting to collect an amount from a Member 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).

2.7 Recoupment/Offset/Adjustment for Overpayments. Except as expressly permitted under Regulatory Requirements, [redacted] shall be entitled to request a refund in an amount equal to any overpayments made by [redacted] to Provider provided that any refund requests by [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] 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 [redacted] for such overpayment, or [redacted] shall be entitled to offset such overpayment against other amounts due and payable by [redacted] to Provider. If an offset occurs, such recoupment shall occur on a single remittance (when financially doable) and will clearly identify the specific accounts the offset is applicable to.

2.7.1 Pursuant to RCW 48.43.605, except in the case of fraud, or coordination of benefits as provided below in Section 2.7.2, Provider may not: (a) request additional payment from [redacted] to satisfy a Claim unless Provider does so in writing to [redacted] within twenty-four (24) months after the date that the Claim was denied or payment intended to satisfy the Claim was made. If [redacted] fails to contest the request in writing within thirty (30) days following the date of [redacted] receipt of such notice, the request is deemed accepted. [redacted] then must remit the additional payment to Provider within thirty (30) days. Any such request must specify why the Provider believes [redacted] owes the additional payment.

2.7.2 Provider may not, if doing so for reasons related to coordination of benefits with another carrier or entity responsible for payment of a Claim: (a) request additional payment from [redacted] to satisfy a Claim unless Provider does so in writing to [redacted] within thirty (30) months after the date the Claim was denied or payment intended to satisfy the Claim was made. If [redacted] fails to contest the request in writing within thirty (30) days following the date of [redacted] receipt of such notice, the request is deemed accepted. [redacted] then must remit the additional payment to Provider within thirty (30) days. Any such request must specify why the Provider believes [redacted] owes the additional payment, and include the name and mailing address of any entity that has disclaimed responsibility for payment of the Claim.

2.7.3 Pursuant to RCW 48.43.600, except in the case of fraud, or as provided below in Sections 2.7.4 and 2.7.5, [redacted] may not: (a) request a refund from a Provider of a payment previously made to satisfy a Claim unless it does so in writing to the Provider within twenty-four (24) months after the date that the payment was made; or (b) request that a contested refund be paid any sooner than six (6) months after receipt of the request. Any such request must specify why [redacted] believes Provider owes the refund. If Provider fails to contest the request in writing to [redacted] within thirty (30) days of its receipt, the request is deemed accepted and the refund must be paid.

2.7.4 [redacted] may not, if doing so for reasons related to coordination of benefits with another carrier or entity responsible for payment of a Claim: (a) request a refund from Provider of a payment previously made to satisfy a Claim unless it does so in writing to Provider within thirty (30) months after the date that the payment was made; or (b) request that a contested refund be paid any sooner than six (6) months after receipt of the request. Any such request must specify why [redacted] believes Provider owes the refund, and include the name and mailing address of the entity that has primary responsibility for payment of the Claim. If Provider fails to contest the request in writing to [redacted] within thirty (30) days of its receipt, the request is deemed accepted and the refund must be paid.

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

2.7.6 If any provision in this Agreement conflicts with this section, this section shall prevail. However, nothing in this section prohibits [redacted] from choosing at any time to make additional payments to a Provider to satisfy a Claim.

2.7.7 For purposes of this section, "refund" means the return, either directly or through an offset to a future Claim, of some or all of a payment already received by Provider.

2.7.8 This section neither permits nor precludes [redacted] from recovering from a Member any amounts paid to Provider for benefits to which the Member was not entitled under the terms and conditions of the Health Benefit Plan.

2.8 Use of Subcontractors. Provider and Plan may fulfill some of their duties under this Agreement through subcontractors. For purposes of this provision, subcontractors shall include, but are not limited to, vendors and non-Participating Providers that provide supplies, equipment, staffing, and other services to Members at the request of, under the supervision of, and/or at the place of business of Provider or plan. Provider shall provide [redacted] with thirty (30) days prior notice of any Health Services subcontractors with which Provider may contract to perform Provider's duties and obligations under this Agreement, and Provider shall remain responsible to Plan for the compliance of his/her/its subcontractors with the terms and conditions of this Agreement as applicable, including, but not limited to, the Payment in Full and Hold Harmless provisions herein. Plan shall provide Provider with thirty (30) days prior notice of any Plan subcontractors with which Plan may contract to perform Plan's duties and obligations under this agreement. Additionally, Plan shall not engage in third-party audits for Provider claims where the third party PR subcontractor is contingency based, or otherwise financially motivated to deny or reduce payment to Provider

2.9 Compliance with Provider Manual(s) and Policies, Programs and Procedures. Provider agrees to cooperate and comply with, [redacted] provider manual(s), and all other policies, programs and procedures (collectively "Policies") established and implemented by Plan applicable to the Network(s) in which Provider participates. [redacted] or its designees may modify the provider manual(s) and its Policies by making a good faith effort to provide notice to Provider at least sixty (60) days in advance of the effective date of material modifications thereto.

2.10 Referral Incentives/Kickbacks. Provider represents and warrants that Provider does not give, provide, condone or receive any incentives or kickbacks, monetary or otherwise, in exchange for the referral of a Member, and if a Claim for payment is attributable to an instance in which Provider provided or received an incentive or kickback in exchange for the referral, such Claim shall not be payable and, if paid in error, shall be refunded to [redacted]

2.11 Networks and Provider Panels. Provider shall be eligible to participate only in those Networks designated on the Provider Networks Attachment of this Agreement. Provider shall not be recognized as a Participating Provider in such Networks until the later of: 1) the Effective Date of this Agreement or; 2) as determined by Plan in its sole discretion, the date Provider has met Plan's applicable credentialing requirements, standards of participation and accreditation requirements. Provider acknowledges that Plan may develop, discontinue, or modify new or existing Networks, products and/or programs. In addition to those Networks designated on the Provider Networks Attachment, [redacted] may also identify Provider as a Participating Provider in additional Networks, products and/or programs designated in writing from time to time by [redacted] The terms and conditions of Provider's participation as a Participating Provider in such additional Networks, products and/or programs shall be on the terms and conditions as set forth in this Agreement unless otherwise agreed to in writing by Provider and [redacted]

In addition to and separate from Networks that support some or all of Plan's products and/or programs (e.g., HMO, PPO and Indemnity products), Provider further acknowledges that certain Health Services, including by way of example only, laboratory or behavioral health services, may be provided exclusively by designated Participating Providers (a "Health Services Designated Network"), as determined by Plan. If Provider provides such designated Health Services, they shall be specifically identified in this agreement. Upon identification and exclusion from this Agreement, Provider agrees to refer Members to such designated Participating Providers in a Health Services Designated Network for the provision of certain Health Services, even if Provider performs such services. Notwithstanding any other provision in this Agreement, if Provider provides a non-emergency Health Service to a Member for which Provider is not a designated Participating Provider in a Health Services Designated Network, then Provider agrees that he/she/it shall not be reimbursed for such services by [redacted] Plan or the Member, unless Provider was authorized to provide such Health Service by Plan.

2.12 Change in Provider Information. Provider shall immediately send written notice, in accordance with the Notice section of this Agreement, to [redacted] of:

2.12.1 Any legal, governmental, or other action or investigation involving Provider which could affect Provider's credentialing status with Plan, or materially impair the ability of Provider to carry out his/her/its duties and obligations under this Agreement, except for temporary emergency diversion situations; or

2.12.2 Any change in Provider accreditation, affiliation, hospital privileges (if applicable), insurance, licensure, certification or eligibility status, or other relevant information regarding Provider's practice or status in the medical community.

2.13 Provider Credentialing, Standards of Participation and Accreditation. Provider warrants that he/she/it meets all applicable Plan credentialing requirements, standards of participation, and accreditation requirements for the Networks in which Provider participates. A description of the applicable credentialing requirements, standards of participation, and accreditation requirements, are set forth in the provider manual(s) and/or in the PCS. Provider acknowledges that until such time as Provider has been determined to have fully met Plan's credentialing requirements, standards of participation, and accreditation requirements, as applicable, Provider shall not be entitled to the benefits of participation under this Agreement, including without limitation the [redacted] Rates set forth in the PCS attached hereto.

2.14 Provider Staffing and Staff Privileges. Provider agrees to maintain professional staffing levels to meet community access standards and where applicable, agrees to facilitate and to expeditiously grant admitting privileges to Participating Providers who meet Provider's credentialing standards.

2.15 Adjustment Requests. If Provider believes a Claim has been improperly adjudicated for a Covered Service for which Provider timely submitted a Claim to Plan, Provider must submit a request for an adjustment to Plan in accordance with the provider manual(s). However, a Plan's system error resulting in multiple improper claim adjudications shall be immediately escalated and shall not require Provider to submit multiple adjustment requests or claim appeals.

2.16 Provision and Supervision of Services. In no way shall [redacted] or Plan be construed to be providers of Health Services or responsible for, exercise control, or have direction over the provision of such Health Services. Provider shall be solely responsible to the Member for treatment, medical care, and advice with respect to the provision of Health Services. Provider agrees that all Health Services provided to Members under this Agreement shall be provided by Provider or by a qualified person under Provider's direction. Provider warrants that any nurses or other health professionals employed by or providing services for Provider shall be duly licensed or certified under applicable law. In addition, nothing herein shall be construed as authorizing or permitting Provider to abandon any Member.

2.17 Coordination of Benefits/Subrogation. Subject to Regulatory Requirements, Provider agrees to cooperate with Plan regarding subrogation and coordination of benefits, as set forth in Policies and the provider manual(s), and to notify Plan promptly after receipt of information regarding any Member who may have a Claim involving subrogation or coordination of benefits.

2.18 Cost Effective Care. Provider shall provide Covered Services in the most cost effective, clinically appropriate setting and manner. In addition, in accordance with the provider manual(s) and Policies, Provider shall utilize Participating Providers, and when Medically Necessary or appropriate, refer and transfer Members to Participating Providers for all Covered Services, including but not limited to specialty, laboratory, ancillary and supplemental services. . For such referrals, Plan shall maintain an adequate network of Participating Providers . If such adequate network is not available, Provider shall have no obligation under this provision of in-network referrals and/or transfers.

2.19 Facility-Based Providers. Provider agrees to request its contracted facility-based providers or those with exclusive privileges with Provider to obtain and maintain Participating Provider status with [redacted] Until such time as facility-based providers enter into agreements with [redacted] Provider agrees to use best efforts to cooperate with [redacted] to help prevent Members from being billed amounts in excess of the applicable [redacted] non-participating reimbursement for such Covered Services. Facility-based providers may include, but are not limited to, anesthesiologists, radiologists, pathologists, neonatologists, hospitalists and emergency room physicians.

2.20 This provision intentionally left blank.

ARTICLE III
CONFIDENTIALITY/RECORDS

3.1 Proprietary and Confidential Information. Except as otherwise provided herein, all information and material provided by either party in contemplation of or in connection with this Agreement remains proprietary and confidential to the disclosing party. This Agreement, including but not limited to the [redacted] Rates, is [redacted] proprietary and confidential information. Neither party shall disclose any information proprietary or confidential to the other, or use such information or material except: (1) as otherwise set forth in this Agreement; (2) as may be required to perform obligations hereunder; (3) as required to deliver Health Services or administer a Health Benefit Plan; (4) to Plan or its designees; (5) upon the express written consent of the parties; or (6) as required by Regulatory Requirements, such as Federal Pricing Transparency regulations. This provision, however, shall not be construed to prohibit Provider from disclosing information to other Providers that have entered into an "Interlocal Agreement" as described and authorized under RCW 70.44.240 and RCW 70.44.450. Notwithstanding the foregoing, either party may disclose such information to its legal advisors, lenders and business advisors, provided that such legal advisors, lenders and business advisors agree to maintain confidentiality of such information. Provider and [redacted] shall each have a system in place that meets all applicable Regulatory Requirements to protect all records and all other documents relating to this Agreement which are deemed confidential by law. Any disclosure or transfer of proprietary or confidential information by Provider or [redacted] will be in accordance with applicable Regulatory Requirements. Provider shall immediately notify [redacted] if Provider is required to disclose any proprietary or confidential information at the request of an Agency or pursuant to any federal or state freedom of information act request.

3.2 Confidentiality of Member Information. Both parties agree to comply with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act ("HITECH Act"), and as both may be amended, as well as any other applicable Regulatory Requirements regarding confidentiality, use, disclosure, security and access of the Member's personally identifiable information ("PII") and protected health information ("PHI"), (collectively "Member Information"). Provider shall review all Member Information received from [redacted] to ensure no misrouted Member Information is included. Misrouted Member Information includes but is not limited to, information about a Member that Provider is not currently treating. Provider shall immediately destroy any misrouted Member Information or safeguard the Member Information for as long as it is retained. In no event shall Provider be permitted to misuse or re-disclose misrouted Member Information. If Provider cannot destroy or safeguard misrouted Member Information, Provider must contact [redacted] to report receipt of misrouted Member Information.

3.3 Network Provider/Patient Discussions. Notwithstanding any other provision in this Agreement and regardless of any benefit or coverage exclusions or limitations associated with a Health Benefit Plan, Provider shall not be prohibited from discussing fully with a Member any issues related to the Member's health including recommended treatments, treatment alternatives, treatment risks and the consequences of any benefit coverage or payment decisions made by Plan or any other party. In addition, nothing in this Agreement shall be construed to, create any financial incentive for Provider to withhold Covered Services, or prohibit Provider from disclosing to the Member the general methodology by which Provider is compensated under this Agreement, such as for example, whether Provider is paid on a fee for service, capitation or Percentage Rate basis. Plan shall not refuse to allow or to continue the participation of any otherwise eligible provider, or refuse to compensate Provider in connection with services rendered, solely because Provider has in good faith communicated with one or more of his/her/its current, former or prospective patients regarding the provisions, terms or requirements of a Health Benefit Plan as they relate to the health needs of such patient. Nothing in this section shall be construed to permit Provider to disclose [redacted] Rates or specific terms of the compensation arrangement under this Agreement.

3.4 Plan Access to and Requests for Provider Records. Provider and its designees shall comply with all applicable state and federal record keeping and retention requirements, and, as set forth in the provider manual(s) and/or Participation Attachment(s), shall permit Plan or its designees to have, with appropriate working space and without charge, on-site access to and the right to perform an Audit, examine, copy, excerpt and transcribe any books, documents, papers, and records related to Member's medical and billing information within the possession of Provider and inspect Provider's operations, which involve transactions relating to Members and as may be reasonably required by Plan in carrying out its responsibilities and programs including, but not limited to, assessing quality of care, complying with quality initiatives/measures, Medical Necessity, concurrent review, appropriateness of care, accuracy of Claims coding and payment, risk adjustment assessment as described in the provider manual(s), including but not limited to completion of the

Encounter Facilitation Form (also called the "SOAP" note), compliance with this Agreement, and for research. In lieu of on-site access, at Plan's request, Provider or its designees shall submit records to Plan, or its designees via photocopy or electronic transmittal, within thirty (30) days, at no charge to Plan from either Provider or its designee. Provider shall make such records available to the state and federal authorities involved in assessing quality of care or investigating Member grievances or complaints in compliance with Regulatory Requirements. Provider acknowledges that failure to submit records to Plan in accordance with this provision and/or the provider manual(s), and/or Participation Attachment(s) may result in a denial of a Claim under review, whether on pre-payment or post-payment review, or a payment retraction on a paid Claim, and Provider is prohibited from balance billing the Member in any of the foregoing circumstances.

3.5 Transfer of Medical Records. Following a request, Provider shall transfer a Member's medical records in a timely manner, or within such other time period required under applicable Regulatory Requirements, to other health care providers treating a Member at no cost to [redacted] Plan, the Member, or other treating health care providers.

3.6 Clinical Data Sharing. [redacted] and Provider desire to collaborate by sharing data, including Member Information, to enhance certain health care operations activities, primarily to help improve quality and efficiency of health care. Each party's access to better clinical and administrative data is critical to the mutual goal of [redacted] and Provider improving health care quality as it relates to their respective Members and patients. Therefore and upon request, Provider agrees to provide data to [redacted] for treatment purposes, for payment purposes, for health care operations purposes consistent with those enumerated in the first two paragraphs of the health care operations definition in HIPAA (45 CFR 164.501), or for purposes of health care fraud and abuse detection or compliance. Provider shall provide data as set forth in Policies or the provider manual(s), as applicable.

ARTICLE IV
INSURANCE

4.1 [redacted] Insurance. [redacted] shall self-insure or maintain insurance as required under applicable Regulatory Requirements to insure [redacted] and its employees, acting within the scope of their duties.

4.2 Provider Insurance. Provider shall self-insure or maintain insurance in types and amounts reasonably determined by Provider, or as required under applicable Regulatory Requirements.

ARTICLE V
RELATIONSHIP OF THE PARTIES

5.1 Relationship of the Parties. For purposes of this Agreement, [redacted] and Provider are and will act at all times as independent contractors. Nothing in this Agreement shall be construed, or be deemed to create, a relationship of employer or employee or principal and agent, partnership, joint venture, or any relationship other than that of independent entities contracting with each other for the purposes of effectuating this Agreement.

5.2 Provider Representations and Warranties. Provider represents and warrants that it has the corporate power and authority to execute and deliver this Agreement on its own behalf, and on behalf of any other individuals or entities that are owned, or employed or subcontracted with or by Provider to provide services under this Agreement. Provider further certifies that individuals or entities that are owned, employed or subcontracted with Provider agree to comply with the terms and conditions of this Agreement.

ARTICLE VI
INDEMNIFICATION AND LIMITATION OF LIABILITY

6.1 Indemnification. [redacted] and Provider shall each indemnify, defend and hold harmless the other party, and his/her/its directors, officers, employees, agents, Affiliates and subsidiaries ("Representatives"), from and against any and all losses, claims, damages, liabilities, costs and expenses (including without limitation, reasonable attorneys' fees and costs) arising from third party claims resulting from the indemnifying party's or his/her/its Representative's failure to perform the indemnifying party's obligations under this Agreement, and/or the indemnifying party's or his/her/its Representative's violation of any law, statute, ordinance, order, standard of care, rule or regulation. The obligation to provide indemnification under this Agreement shall be contingent upon the party seeking indemnification providing the indemnifying party with prompt written notice of any claim for which indemnification is sought, allowing the indemnifying party to control the defense and

settlement of such claim, provided however that the indemnifying party agrees not to enter into any settlement or compromise of any claim or action in a manner that admits fault or imposes any restrictions or obligations on an indemnified party without that indemnified party's prior written consent which will not be unreasonably withheld, and cooperating fully with the indemnifying party in connection with such defense and settlement.

6.2 This provision intentionally left blank.

ARTICLE VII
DISPUTE RESOLUTION

7.1 Complaints of Members. [redacted] shall notify the Provider concerning any complaint by a Member 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.

7.2 Negotiation of Disputes. 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.

7.2.1 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.

7.3 Dispute Resolution. Except as expressly permitted under Regulatory Requirements or regulations 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 284-170-440.

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

7.3.2 [redacted] 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 Government Program coverage of Covered Services are subject to the grievance procedures established for Members.

7.3.3 [redacted] 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. If [redacted] fails to grant or reject a request within thirty (30) days after it is made, the complaining Provider may proceed as if the complaint had been rejected.

7.3.4 [redacted] may not require alternative dispute resolution to the exclusion of judicial remedies; however, [redacted] may require alternative dispute resolution prior to judicial remedies.

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

7.4 Period of Limitations. Unless otherwise provided for in this Agreement or a Participation Attachment(s), neither party shall commence any action at law or equity against the other to recover on any legal or equitable claim arising out of this Agreement ("Action") more than six (6) years after the events which gave rise to such Action; provided, however, this six (6) year limitation shall not apply to Actions by [redacted] against Provider related to fraud, waste or abuse which shall be subject to the period of limitations set forth in applicable Regulatory Requirements. In the situation where Provider believes that [redacted] underpaid a Claim, the Action arises on the date when [redacted] first denies the Claim or first pays the Claim in an

amount less than expected by Provider. In the situation where [redacted] believes that it overpaid a Claim, the Action arises when Provider first contests in writing [redacted] notice to it that the overpayment was made. The deadline for initiating an Action shall not be tolled by the appeal process, provider dispute resolution process or any other administrative process. To the extent an Action is timely commenced, it will be administered in accordance with Article VII of this Agreement.

ARTICLE VIII
TERM AND TERMINATION

8.1 Term of Agreement. This Agreement shall commence at 12:01 AM on the Effective Date for a term of one (1) year, and shall continue automatically in effect thereafter for consecutive one (1) year terms unless otherwise terminated as provided herein.

8.2 Termination Without Cause. Either party may terminate this Agreement without cause at any time by giving at least one hundred eighty (180) days prior written notice of termination to the other party. Notwithstanding the foregoing, should a Participation Attachment(s) contain a longer without cause termination period, the Agreement shall continue in effect only for such applicable Participation Attachment(s) until the termination without cause notice period in the applicable Participation Attachment(s) ends. Either party may also terminate participation or inclusion in one or more specific Networks without terminating all Networks.

8.3 Breach of Agreement. Except for circumstances giving rise to the Immediate Termination section, if either party fails to comply with or perform when due any material term or condition of this Agreement, the other party shall notify the breaching party of its breach in writing stating the specific nature of the material breach, and the breaching party shall have thirty (30) days to cure the breach. If the breach is not cured to the reasonable satisfaction of the non-breaching party within said thirty (30) day period, the non-breaching party may terminate this Agreement by providing written notice of such termination to the other party. The effective date of such termination shall be no sooner than sixty (60) days after such notice of termination.

8.4 Immediate Termination.

8.4.1 This Agreement or any Participation Attachment(s) may be terminated immediately by [redacted] if:

8.4.1.1 Provider commits any act or conduct for which his/her/its license(s), permit(s), or any governmental or board authorization(s) or approval(s) necessary for business operations or to provide Health Services are lost or voluntarily surrendered in whole or in part; or

8.4.1.2 Provider commits fraud or makes any material misstatements or omissions on any documents related to this Agreement which Provider submits to [redacted] or to a third party; or

8.4.1.3 Provider files a petition in bankruptcy for liquidation or reorganization by or against Provider, if Provider becomes insolvent, or makes an assignment for the benefit of its creditors without [redacted] written consent, or if a receiver is appointed for Provider or its property; or

8.4.1.4 Provider's insurance coverage as required by this Agreement lapses for any reason; or

8.4.1.5 Provider fails to maintain compliance with Plan's applicable credentialing requirements, accreditation requirements or standards of participation; or

8.4.1.6 [redacted] reasonably believes based on Provider's conduct or inaction, or allegations of such conduct or inaction, that the well-being of patients may be jeopardized; or

8.4.1.7 Provider has been abusive to a Member, a [redacted] employee or representative; or

8.4.1.8 Provider and/or his/her/its employees, contractors, subcontractors, or agents are ineligible, excluded, suspended, terminated or debarred from participating in a Government Program, and in the case of an employee, contractor, subcontractor or agent, Provider fails to remove such individual from responsibility for, or involvement with, the Provider's business operations related to this Agreement, or if Provider has

voluntarily withdrawn his/her/its participation in any Government Program as the result of a settlement agreement; or

8.4.1.9 Provider is convicted or has been finally adjudicated to have committed a felony or misdemeanor, other than a non-DUI related traffic violation.

8.4.2 This Agreement may be terminated immediately by Provider if:

8.4.2.1 [redacted] commits any act or conduct for which its license(s), permit(s), or any governmental or board authorization(s) or approval(s) necessary for business operations are lost or voluntarily surrendered in whole or in part; or

8.4.2.2 [redacted] files for bankruptcy, or if a receiver is appointed.

8.4.2.3 [redacted] commits fraud or makes any material misstatements or omissions on any documents related to this Agreement which it submits to Provider or to a third party.

8.5 Partial Termination of Participating Providers. [redacted] shall be entitled to terminate this Agreement as it applies to one or a number of Participating Providers under the terms of this Article VIII, without terminating the Agreement in its entirety, and in such case, the Agreement shall continue in full force and effect in connection with Provider and/or any and all Participating Providers as to which the Agreement has not been terminated. Notwithstanding the foregoing, [redacted] reserves the right to terminate Participating Provider(s) from any or all Network(s) under the terms of this Article VIII while continuing the Agreement for the remaining Participating Provider(s).

8.6 Transactions Prior to Termination. Except as otherwise set forth in this Agreement, termination shall have no effect on the rights and obligations of the parties arising out of any transaction under this Agreement occurring prior to the date of such termination.

8.7 Continuation of Care Upon Termination. If this Agreement or any Participation Attachment terminates for any reasons other than one of the grounds set forth in the "Immediate Termination" section, then Provider shall, at [redacted] discretion, continue to provide Covered Services to all designated Members under this Agreement or any terminating Participation Attachment, as applicable, in accordance with Regulatory Requirements. During such continuation period, Provider agrees to: (i) accept reimbursement from [redacted] for all Covered Services furnished hereunder in accordance with this Agreement and at the rates set forth in the PCS attached hereto; and (ii) adhere to [redacted] Policies, including but not limited to, Policies regarding quality assurance requirements, referrals, pre-authorization and treatment planning.

8.8 Survival. The provisions of this Agreement set forth below shall survive termination or expiration of this Agreement or any Participation Attachment(s):

8.8.1 Publication and Use of Provider Information;

8.8.2 Payment in Full and Hold Harmless;

8.8.3 Recoupment/Offset/Adjustment for Overpayments;

8.8.4 Confidentiality/Records;

8.8.5 Indemnification and Limitation of Liability;

8.8.6 Dispute Resolution;

8.8.7 Continuation of Care Upon Termination; and

8.8.8 Any other provisions required in order to comply with Regulatory Requirements.

ARTICLE IX
GENERAL PROVISIONS

9.1 Amendment. Except as otherwise expressly permitted under Regulatory Requirements, upon sixty (60) days prior written notice to Provider, this Agreement may be amended by the mutual agreement of the parties as

evidenced in writing and signed by the parties. In addition, [redacted] shall be entitled to amend this Agreement as follows without the written agreement of Provider:

9.1.1 Upon thirty (30) days prior written notice to Provider, if the amendment is being effected by [redacted] to comply with a Regulatory Requirement, such amendment shall be effective as of the effective date set forth in the amendment. Notwithstanding the above, [redacted] 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.

9.1.2 Provision intentionally left blank.

9.1.3 An amendment to the Agreement may not be made retroactive without the consent of the Provider.

9.2 Assignment. This Agreement may not be assigned by Provider or [redacted] without the prior written consent of the other party. Any assignment by either party without such prior consent shall be voidable at the sole discretion of [redacted] may assign this Agreement in whole or in part. In the event of a partial assignment of this Agreement by [redacted] the obligations of the Provider shall be performed for [redacted] with respect to the part retained and shall be performed for [redacted] assignee with respect to the part assigned, and such assignee is solely responsible to perform all obligations of [redacted] with respect to the part assigned. 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.

9.3 Scope/Change in Status.

9.3.1 [redacted] and Provider agree that this Agreement applies to Health Services rendered by Provider at the Provider's location(s) on file with [redacted] [redacted] may, in its discretion, limit this Agreement to Provider's locations, operations, business or corporate form, status or structure in existence on the Effective Date of this Agreement and prior to the occurrence of any of the events set forth in subsections 9.3.1.1 – 9.3.1.5. Unless otherwise required by Regulatory Requirements, Provider shall provide at least ninety (90) days prior written notice of any such event.

9.3.1.1 Provider (a) sells, transfers or conveys his/her/its business or any substantial portion of his/her/its business assets to another entity through any manner including but not limited to a stock, real estate or asset transaction or other type of transfer; (b) is otherwise acquired or controlled by any other entity through any manner, including but not limited to purchase, merger, consolidation, alliance, joint venture, partnership, association, or expansion; or

9.3.1.2 Provider transfers control of his/her/its management or operations to any third party, including Provider entering into a management contract with a physician practice management company or with another entity which does not manage Provider as of the Effective Date of this Agreement, or there is a subsequent change in control of Provider's current management company; or

9.3.1.3 Provider acquires or controls any other medical practice, facility, service, beds or entity; or

9.3.1.4 Provider changes his/her/its locations, business or operations, corporate form or status, tax identification number, or similar demographic information; or

9.3.1.5 Provider creates or otherwise operates a licensed health maintenance organization or commercial health plan (whether such creation or operation is direct or through a Provider affiliate).

9.3.2 Notwithstanding the termination provisions of Article VIII, and without limiting any of [redacted] rights as set forth elsewhere in this Agreement, [redacted] shall have the right to terminate this Agreement by giving at least sixty (60) days written notice to Provider if [redacted] determines, that as a result of any of the transactions listed in subsection 9.3.1, Provider cannot satisfactorily perform the obligations hereunder, or cannot comply with one or more of the terms and conditions of this Agreement, including but not limited to the confidentiality provisions herein; or [redacted] elects in its reasonable business discretion not to do business with Provider, the successor entity or

new management company, as a result of one or more of the events as set forth in subsection 9.3.1.

9.3.3 Provider shall provide [redacted] with thirty (30) days prior written notice of:

9.3.3.1 Addition or removal of individual provider(s) who are employed or subcontracted with Provider, if applicable. Any new individual providers must meet Plan's credentialing requirements or other applicable standards of participation prior to being designated as a Participating Provider; or

9.3.3.2 A change in mailing address.

9.3.4 If Provider is acquired by, acquires or merges with another entity, and such entity already has an agreement with [redacted] will determine in its sole discretion which Agreement will prevail.

9.4 Definitions. Unless otherwise specifically noted, the definitions as set forth in Article I of this Agreement will have the same meaning when used in any attachment, the provider manual(s) and Policies.

9.5 Entire Agreement. This Agreement, exhibits, attachments, appendices, and amendments hereto, together with any items incorporated herein by reference, constitute the entire understanding between the parties and supersedes all prior oral or written agreements between them with respect to the matters provided for herein. If there is an inconsistency between any of the provisions of this Agreement and the provider manual(s) then this Agreement shall govern. In addition, if there is an inconsistency between the terms of this Agreement and the terms provided in any attachment to this Agreement, then the terms provided in that attachment shall govern.

9.6 Force Majeure. Neither party shall be deemed to be in violation of this Agreement if such party is prevented from performing any of his/her/its obligations hereunder due to natural or man-made disasters, including fire, flood, earthquake, terrorism, cyber security incidents, or any similar unforeseeable act beyond its reasonable control, acts of any public enemy, statutory or other laws, regulations, rules, orders, or actions of the federal, state, or local government or any agency thereof.

9.7 Compliance with Regulatory Requirements. [redacted] and Provider agree to comply with all applicable Regulatory Requirements, as amended from time to time, relating to their obligations under this Agreement, and maintain in effect all permits, licenses and governmental and board authorizations and approvals as necessary for business operations. Provider warrants that as of the Effective Date, he/she/it is and shall remain licensed and certified for the term of this Agreement in accordance with all Regulatory Requirements (including those applicable to utilization review and Claims payment) relating to the provision of Health Services to Members. Provider shall supply evidence of such licensure, compliance and certifications to [redacted] upon request. If there is a conflict between this section and any other provision in this Agreement, then this section shall control.

9.7.1 In addition to the foregoing, Provider warrants and represents that at the time of entering into this Agreement, neither he/she/it nor any of his/her/its employees, contractors, subcontractors, principals or agents are ineligible, excluded, suspended, terminated or debarred from participating in a Government Program ("Ineligible Person"). Provider shall remain continuously responsible for ensuring that his/her/its employees, contractors, subcontractors, principals or agents are not Ineligible Persons. If Provider or any employees, subcontractors, principals or agents thereof becomes an Ineligible Person after entering into this Agreement or otherwise fails to disclose his/her/its Ineligible Person status, Provider shall have an obligation to (1) immediately notify [redacted] of such Ineligible Person status and (2) within ten (10) days of such notice, remove such individual from responsibility for, or involvement with, Provider's business operations related to this Agreement.

9.8 Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the State of Washington, unless such state laws are otherwise preempted by federal law. However, coverage issues specific to a Health Benefit Plan are governed by the state laws where the Health Benefit Plan is issued, unless such state laws are otherwise preempted by federal law.

9.9 Intent of the Parties. It is the intent of the parties that this Agreement is to be effective only in regards to their rights and obligations with respect to each other; it is expressly not the intent of the parties to create any

independent rights in any third party or to make any third party a third party beneficiary of this Agreement, except to the extent specified in the Payment in Full and Hold Harmless section of this Agreement, or in a Participation Attachment(s).

9.10 Non-Exclusive Participation. None of the provisions of this Agreement shall prevent Provider or Plan from participating in or contracting with any provider, preferred provider organization, health maintenance organization/health insuring corporation, or any other health delivery or insurance program. Provider acknowledges that Plan does not warrant or guarantee that Provider will be utilized by any particular number of Members.

9.11 Notice. Any notice required to be given pursuant to the terms and provisions of this Agreement shall be in writing and shall be delivered by hand, facsimile, electronic mail, or mail. Notice shall be deemed to be effective: (a) when delivered by hand, (b) upon transmittal when transmitted by facsimile transmission or by electronic mail, (c) upon receipt by registered or certified mail, postage prepaid, (d) on the next business day if transmitted by national overnight courier, or (e) if sent by regular mail, five (5) days from the date set forth on the correspondence. Unless specified otherwise in writing by a party, [redacted] shall send Provider notice to an address that [redacted] has on file for Provider, and Provider shall send [redacted] notice to [redacted] address as set forth in the provider manual(s). Notwithstanding the foregoing, and unless otherwise required by Regulatory Requirements, [redacted] may post updates to its provider manual(s) and Policies on its web site.

9.12 Severability. In case any one or more of the provisions of this Agreement shall be invalid, illegal, or unenforceable in any respect, the remaining provisions shall be construed liberally in order to effectuate the purposes hereof, and the validity, legality and enforceability of the remaining provisions shall not in any way be affected or impaired thereby. If one or more provisions of the Agreement are invalid, illegal or unenforceable and an amendment to the Agreement is necessary to maintain its integrity, the parties shall make commercially reasonable efforts to negotiate an amendment to this Agreement and any attachments or addenda to this Agreement which could reasonably be construed not to contravene such statute, regulation, or interpretation. In addition, if such invalid, unenforceable or materially affected provision(s) may be severed from this Agreement and/or attachments or addenda to this Agreement without materially affecting the parties' intent when this Agreement was executed, then such provision(s) shall be severed rather than terminating the Agreement or any attachments or addenda to this Agreement.

9.13 Waiver. Neither the waiver by either of the parties of a breach of any of the provisions of this Agreement, nor the failure of either of the parties, on one or more occasion, to enforce any of the provisions of this Agreement, shall thereafter be construed as a waiver of any subsequent breach of any of the provisions of this Agreement.

9.14 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.

9.15 Counterparts and Electronic Signatures.

9.15.1 This Agreement and any amendment hereto may be executed in two (2) 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.

9.15.2 Either party may execute this Agreement or any amendments by valid electronic signature, and such signature shall have the same legal effect of a signed original.

PROVIDER NETWORKS ATTACHMENT

Provider shall be designated as a Participating Provider in the following Networks on the later of: 1) the Effective Date of this Agreement or; 2) as determined by Plan in its sole discretion, the date Provider has met applicable credentialing requirements, standards of participation and accreditation requirements:

Government Programs:

Health Benefit Plans issued pursuant to an agreement between Plan and Agency in which Members have access to a network of providers and receive an enhanced level of benefits when they obtain Covered Services from Participating Providers regardless of product licensure status. Provider participates in one or more of the following Networks which support such Health Benefit Plans:

- [redacted] Medicaid Network
- Medicare Advantage

MEDICAID
PARTICIPATION ATTACHMENT TO THE
[redacted] WASHINGTON, INC.
PROVIDER AGREEMENT

This is a Medicaid Participation Attachment ("Attachment") to the [redacted] Provider Agreement ("Agreement"), entered into by and between [redacted] and Provider and is incorporated into the Agreement.

ARTICLE I
DEFINITIONS

The following definitions shall apply to this Attachment. Terms not otherwise defined in this Attachment shall carry the meaning set forth in the Agreement.

"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.

"Medicaid Program(s)" means, for purposes of this Attachment, a medical assistance program provided under a Health Benefit Plan approved under Title XVI, (Supplemental Security Income), Title XIX (Medicaid) and/or Title XXI (Children's Health Insurance Program "CHIP Program(s)") of the Social Security Act or any other federal or state funded program or product as designated by [redacted]

"Medicaid Covered Services" means, for purposes of this Attachment, only those Covered Services provided under Plan's Medicaid Program(s); health care services that HCA determines are covered for enrollees, those health care services (including Behavioral Health Care Services) that a Medicaid Member is entitled to receive through [redacted] pursuant to Regulatory Requirements, and for which a PCS is attached hereto setting forth the Providers' reimbursement under one or more Programs. Medicaid Covered Services do not include the preventable adverse events as set forth in the provider manual(s).

"Medicaid Member" means, for purposes of this Attachment, a Member who is enrolled in Plan's Medicaid Program(s).

"Medically Necessary/Medical Necessity" means services that are "medically necessary" as is defined in WAC 182-500-0070, a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent worsening of conditions in the Medicaid Member that endanger life, or cause suffering of pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity, or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the Medicaid Member requesting the service. For the purpose of this Attachment, "course of treatment" may include mere observation or, where appropriate, no medical treatment at all.

"State Agency" means the Washington Health Care Authority ("HCA") or other duly authorized state agency.

ARTICLE II
SERVICES/OBLIGATIONS

2.1 Participation-Medicaid Network. As a participant in [redacted] Medicaid Network, Provider will render Medicaid Covered Services to Medicaid Members in accordance with the terms and conditions of the Agreement and this Attachment consistent with the provisions of 42 CFR 434.6. Such Medicaid Covered Services provided shall be within the scope of Provider's licensure, expertise, and usual and customary range of services pursuant to the terms and conditions of the Agreement and this Attachment, and Provider shall be responsible to [redacted] for his/her/its performance hereunder. Provider shall release to [redacted] any information necessary for [redacted] to perform any of its obligations under the Agreement or under the Government Contract. Except as set forth in this Attachment or the Plan Compensation Schedule ("PCS"), all terms and conditions of the Agreement will apply to Provider's participation in [redacted] Medicaid Network. The terms and conditions set forth in this Attachment are limited to the provision of and payment for Health Services provided to Medicaid Members. [redacted] shall ensure that Provider furnishes Health Services to each Medicaid Member without regard to the Medicaid Member's enrollment in the plan as a private purchaser of the plan or as a participant in publicly financed programs of health care services. This requirement does not apply to circumstances when the Provider should not render services due to limitations arising from lack of training, experience, skill, or licensing restrictions."

2.2 Provider's Duties and Obligations to Medicaid Members. All of Provider's duties and obligations to Members set forth in the Agreement shall also apply to Medicaid Members unless otherwise specifically set forth in this Attachment. Provider shall not discriminate in the acceptance of Medicaid Members for treatment, and shall provide to Medicaid Members the same access to services, including but not limited to, hours of operation, as Provider gives to all other patients. Provider shall furnish [redacted] with at least ninety (90) days prior written notice if Provider plans to close its practice to new patients or ceases to continue in Provider's current practice.

2.2.1 To the extent mandated by Regulatory Requirements, Provider shall ensure that Medicaid Members have access to twenty-four (24) hour-per-day, seven (7) day-per-week urgent and Emergency Services, as defined in the PCS.

2.2.2 Unless otherwise required under Regulatory Requirements, a PCP, as defined in the PCS, shall provide Medicaid Covered Services or make arrangements for the provision of Medicaid Covered Services to Medicaid Members on a twenty-four (24) hour-per-day, seven (7) day-per-week basis to assure availability, adequacy, and continuity of care to Medicaid Members. If Provider is unable to provide Medicaid Covered Services, Provider shall arrange for another Participating Provider to cover Provider's patients in accordance with [redacted] Policies. Provider and any PCPs employed by or under contract with Provider may arrange for Medicaid Covered Services to Medicaid Members to be performed by a Specialist Physician only in accordance with [redacted] Policies.

2.2.3 If Provider is furnishing Specialist Physician services under this Attachment, Provider and the Specialist Physician(s) employed by or under contract with Provider, shall accept as patients all Medicaid Members and may arrange for Medicaid Covered Services to Medicaid Members to be performed by Specialist Physician only in accordance with [redacted] Policies.

2.2.4 If Provider is a mental health care practitioner and providers Health Services to a Medicaid Member during an appeal or adverse certification process, the Provider must provide to the Medicaid Member written notification that the Medicaid Member is responsible for the payment of these Health Services, unless the health carrier elects to pay for the Health Services provided.

2.3 Provider Responsibility. [redacted] shall not be liable for, nor will it exercise control or direction over, the manner or method by which Provider provides Health Services to Medicaid Members. Provider shall be solely responsible for all medical advice and services provided by Provider to Medicaid Members. Provider acknowledges and agrees that [redacted] may deny payment for services rendered to a Medicaid Member which it determines are not Medically Necessary, are not Medicaid Covered Services under the applicable Medicaid Program(s), or are not otherwise provided or billed in accordance with the Agreement and/or this Attachment. A denial of payment or any action taken by [redacted] pursuant to a utilization review, referral, discharge planning program or claims adjudication shall not be construed as a waiver of Provider's obligation to provide appropriate Health Services to a Medicaid Member under applicable Regulatory Requirements and any code of professional responsibility. Provider may discuss treatment or non-treatment options with Medicaid Member irrespective of whether such treatment options are Medicaid Covered Services. However, this provision does not require Provider to provide Health Services if Provider objects to such service on moral or religious grounds.

2.3.1 No health carrier subject to the jurisdiction of the state of Washington may in any way preclude or discourage their providers from informing patients of the care they require, including various treatment options, and whether in their view such care is consistent with Medical Necessity, medical appropriateness, or otherwise covered by the patient's service agreement with the health carrier. No health carrier may prohibit, discourage, or penalize a provider otherwise practicing in compliance with the law from advocating on behalf of a patient with a health carrier. Nothing in this section shall be construed to authorize Provider to bind health carriers to pay for any service.

2.3.2 No health carrier may preclude or discourage Members 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.

2.4 Reporting Fraud and Abuse. Provider shall cooperate with [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 Regulatory Requirements, Provider shall promptly report such activity directly to the compliance officer of [redacted] or through the compliance hotline in accordance with the provider manual(s). In addition, Provider is not limited in any respect in reporting other actual or suspected fraud, abuse, or misconduct to [redacted] Provider shall also refer all potential allegations of fraud to HCA and the Medicaid Fraud Control Division (MFCD) as described in 42 C.F.R § 455.23.

2.5 Plan Marketing/Information Requirements. Provider agrees to abide by Plan's marketing/information requirements. Provider shall forward to Plan for prior approval all flyers, brochures, letters and pamphlets Provider intends to distribute to [redacted] Medicaid Members concerning its payor affiliations, or changes in affiliation or relating directly to the Medicaid population. Provider will not distribute any marketing or recipient informing materials without the consent of Plan or the applicable State Agency.

2.6 Schedule of Benefits and Determination of Medicaid Covered Services. [redacted] shall make available upon Provider's request schedules of Medicaid Covered Services for applicable Medicaid Program(s), and will notify Provider in a timely manner of any material amendments or modifications to such schedules.

2.7 Medicaid Member Verification. Provider shall establish a Medicaid Member's eligibility for Medicaid Covered Services prior to rendering services, except in the case of an Emergency Condition, as defined in the PCS, where such verification may not be possible. In the case of an Emergency Condition, Provider shall establish a Medicaid Member's eligibility as soon as reasonably practical. Plan shall provide a system for Providers to contact Plan to verify a Medicaid Member's eligibility twenty-four (24) hours a day, seven (7) days per week. Nothing contained in this Attachment or the Agreement shall, or shall be construed to, require advance notice, coverage verification, or pre-authorization for Emergency Services, as defined in the PCS, provided in accordance with the federal Emergency Medical Treatment and Labor Act ("EMTALA") prior to Provider's rendering such Emergency Services.

2.8 Hospital Affiliation and Privileges. To the extent required under Plan's credentialing requirements, Provider or any Participating Providers employed by or under contract or subcontract with Provider shall maintain privileges to practice at one or more of [redacted] participating hospitals or furnish documentation to [redacted] that referral arrangements have been made with another [redacted] contracted provider to assume the Participating Provider admission responsibilities of Provider. In addition, in accordance with the Change in Provider Information Section of the Agreement, Provider shall immediately notify [redacted] in the event any such hospital privileges are revoked, limited, surrendered, or suspended at any hospital or health care facility.

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

2.10 Coordinated and Managed Care. Provider shall participate in utilization management and care management programs designed to facilitate the coordination of services as referenced in the applicable provider manual(s). As part of such programs, [redacted] shall use best efforts to transition Members to appropriate care settings . Non-responsiveness by [redacted] or the inability of [redacted] to appropriately transfer Members shall not result in Provider non-payment for services.

2.11 Representations and Warranties. Provider represents and warrants that all information provided to [redacted] is true and correct as of the date such information is furnished, and that Provider is unaware of any undisclosed facts or circumstances that would make such information inaccurate or misleading. Provider further represents and warrants that Provider: (i) is legally authorized to provide the services contemplated hereunder; (ii) is qualified to participate in all applicable Medicaid Program(s); (iii) is not in violation of any licensure or accreditation requirement applicable to Provider under Regulatory Requirements; (iv) 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; (v) is capable of providing all data related to the services provided hereunder in a timely manner as reasonably required by [redacted] to satisfy its internal requirements and Regulatory Requirements, including, without limitation, data required under the Healthcare Effectiveness Data and Information Set ("HEDIS") and National Committee for Quality Assurance ("NCQA") requirements; and (vi) is not, to Provider's best knowledge, the subject of an inquiry or investigation that could foreseeably result in Provider failing to comply with the representations set forth herein. In accordance with the Change in Provider Information Section of the Agreement, Provider shall immediately provide [redacted] with written notice of any material changes to such information.

ARTICLE III
COMPENSATION AND AUDIT

3.1 Submission and Adjudication of Medicaid Claims. Unless otherwise instructed, or required by Regulatory Requirements, Provider shall submit Claims to Plan, using appropriate and current Coded Service Identifier(s), within three hundred sixty-five (365) days from the date the Health Services are rendered or Plan may refuse payment. If Plan is the secondary payor, or in situations of retroactive eligibility changes, the three hundred sixty-five (365) day period will not begin until Provider receives notification of primary payor's responsibility.

3.1.1 Provider agrees to submit Claims in a format consistent with industry standards and acceptable to Plan either (a) electronically through electronic data interchange ("EDI"), or (b) if electronic submission is not available, utilizing paper forms as defined by the National Uniform Claim Committee ("NUCC").

3.1.2 Provider agrees to provide to [redacted] unless otherwise instructed, at no cost to [redacted] Plan or the Medicaid Member, all information necessary for Plan to determine its payment liability. Such information includes, without limitation, accurate and Clean Claims for Medicaid Covered Services. If [redacted] or Plan asks for additional information so that Plan may process the Claim, Provider must provide that information within sixty (60) days, or before the expiration of the three hundred sixty-five (365) day period referenced in section 3.1 above, whichever is longer.

3.1.3 Once [redacted] determines Plan has any payment liability, all Clean Claims will be adjudicated in accordance with the terms and conditions of a Medicaid Member's Health Benefit Plan, the PCS, the provider manual(s), and the Regulatory Requirements applicable to Plan's Medicaid Program(s). However, [redacted] and/or Plan shall not revise, bundle or adjust any HCPCS and/or CPT codes which have been appropriately coded and submitted by Provider using industry standard practices.

3.1.4 [redacted] shall meet the timeliness of payment standards specified for Medicaid fee-for-service in Section 1902(a)(37)(A) of the Social Security Act, 42 C.F.R. § 447.46 and specified for health carriers in WAC 284-170-431. To be compliant with both payment standards, [redacted] shall pay ninety-five percent (95%) of the monthly volume of Clean Claims within thirty (30) calendar days of receipt and shall pay or deny ninety-five percent (95%) of the monthly volume of all Claims within sixty (60) days of receipt. Notwithstanding the foregoing, [redacted] and Provider may agree to a different payment requirement in writing on a claim by claim basis.

3.1.5 [redacted] shall pay Provider interest at the rate of one percent (1%) per month, as set forth in WAC 284-170-431(2)(d) which section may be amended or recodified from time to time, on the unpaid or undenied portion of Clean Claims not adjudicated within the time periods discussed above, as required under applicable prompt pay requirements.

3.1.6 Provider agrees to accept payments or appropriate denials made in accordance with this Agreement as payment in full for all Medicaid Covered Services provided to Medicaid Members. Provider shall be responsible for collecting co-payments from Medicaid Members to the extent required by Regulatory Requirements.

3.2 This provision intentionally left blank.

3.3 Audit for Compliance with CMS Guidelines. Notwithstanding any other terms and conditions of the Agreement, this Attachment, or the PCS, Plan has the same rights as CMS, to review and/or Audit and, to the extent necessary recover payments on any claim for Medicaid Covered Services rendered pursuant to this Attachment and the Agreement to ensure compliance with CMS Regulatory Requirements.

3.4 Records Retention. In addition to the Plan Access to and Requests for Provider Records provision of the Agreement, Provider shall maintain an adequate record system for recording services, charges, dates and all other commonly accepted information elements for Medicaid Covered Services in a manner that is current, detailed and organized, and that permits effective and confidential patient care and quality review, administrative, civil and/or criminal investigations and/or prosecutions. Provider shall maintain all medical records for Medicaid Members in accordance with applicable Regulatory Requirements.

3.4.1 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 Government 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 Medicaid Members.

3.4.2 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 Attachment, 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] State 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 Attachment, 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.

3.4.3 The right for the parties named above to audit, access and inspect under this section exists for ten (10) years from the final date of the Attachment period or from the date of completion of any audit, whichever is later, or any other timeframe authorized by law

3.4.4 Provider will have the right to audit [redacted] records relating to Medicaid Covered Services rendered by Provider to Medicaid Members.

3.5 Encounter Data. If Provider is paid on a capitated basis, Provider shall timely submit complete and accurate encounter data for capitated services rendered to Medicaid Members, including, without limitation, statistical and descriptive medical, diagnostic and patient data for Medicaid Covered Services rendered to Medicaid Members, to meet the encounter data reporting requirements set forth in the Government Contract.

ARTICLE IV
COMPLIANCE WITH FEDERAL REGULATORY REQUIREMENTS

4.1 Federal Funds. Provider acknowledges that payments Provider receives from Plan to provide Medicaid Covered Services to Medicaid Members are, in whole or part, from federal funds. Therefore, Provider and any of his/her/its subcontractors are subject to certain laws that are applicable to individuals and entities receiving federal funds, which may include but are not limited to, Title VI of the Civil Rights Act of 1964 as implemented by 45 CFR Part 80; the Age Discrimination Act of 1975 as implemented by 45 CFR Part 91; the Americans with Disabilities Act as implemented by 28 CFR Part 35; the Rehabilitation Act of 1973 as implemented by 45 CFR Part 84, lobbying restrictions as implemented by 45 CFR Part 93 and 31 USC 1352, Title IX of the Education Amendments of 1972, as amended (20 U.S.C. sections 1681, 1685-1686, and 1783) and any other regulations applicable to recipients of federal funds.

4.2 Surety Bond Requirement. If Provider provides home health services or durable medical equipment, Provider shall comply with all applicable provisions of Section 4724(b) of the Balanced Budget Act of 1997, including, without limitation, any applicable requirements related to the posting of a surety bond.

4.3 Laboratory Compliance. If Provider renders lab services in the office, it must maintain a valid Clinical Laboratory Improvement Amendments ("CLIA") certificate for all laboratory testing sites and comply with CLIA regulations at 42 CFR Part 493 for all laboratory testing sites performing Health Services pursuant to this Attachment.

ARTICLE V
COMPLIANCE WITH STATE REGULATORY REQUIREMENTS

5.1 Indemnification of State. In addition to the Indemnification provision of the Agreement, Provider shall indemnify and hold harmless the State, its agencies, officers, and employees from all claims and suits, including court costs, attorney's fees, and other expenses, brought because of injuries or damages received or sustained by any person, persons, or property that is caused by any act or omission of Provider.

5.2 This provision intentionally left blank.

5.3 State Agency Government Contract. Provider shall comply with the terms applicable to providers set forth in the Government Contract, including incorporated documents, between Plan and the applicable State Agency, which applicable terms are incorporated herein by reference. Nothing in this Attachment shall be construed to terminate or reduce the legal responsibility of [redacted] to State Agency to ensure that all activities under the Government Contract are carried out. [redacted] shall afford Provider access to all necessary training and information to enable Provider to carry out its responsibilities under the Government Contract. Documents, procedures, and other administrative policies and programs referenced in the Government Contract must be available for review by the Provider prior to contracting.

5.4 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 Attachment and, without limitation of remedies, shall be cause for immediate termination of the Agreement and this Attachment.

5.5 No Payment Outside the United States. Provider agrees that [redacted] shall not provide any payments for items or services provided under the Agreement to any financial institution or entity located outside the United States of America.

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

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

5.8 Readability. Provider shall ensure that all written information provided to Medicaid Members 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 [redacted] prior to use.

5.9 Coordination of Benefits/Third Party Liability. In addition to the Coordination of Benefits/Subrogation provision of the Agreement, Provider understands and agrees that when a Medicaid Member is covered by two or more plans, the primary plan must pay or provide its benefits as if the Medicaid Program did not exist. Provider acknowledges and agrees that claims payments made by [redacted] pursuant to Medicaid Program requirements are subject to Medicaid Program requirements regarding third party liability. Provider shall cooperate with [redacted] policies and procedures related to third party liability recovery in the event claims for services rendered by Provider to a Medicaid Member 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] to assist [redacted] in obtaining such recoveries, including executing any appropriate documents reasonably requested by [redacted] to enforce such claims or to assign any payments to [redacted]. However Provider and [redacted] 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 [redacted] shall pay claims for prenatal care and preventive pediatric care and shall seek reimbursement from such third parties.

5.10 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 Medicaid Members on evenings and weekends. Provider agrees that it will provide for regular monitoring of timely access and corrective action by [redacted] 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 Medicaid Member'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 Medicaid Member'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 Medicaid Member'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.

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

5.11.1 Discussing treatment or non-treatment options with Medicaid Members irrespective of [redacted] position on such treatment or non-treatment options or whether such treatment options are Medicaid Covered Services;

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

5.11.3 Advocating on behalf of a Medicaid Member within the utilization review or grievance processes established by [redacted] or individual authorization process to obtain Medically Necessary Medicaid Covered Services; or

5.11.4 Discouraging Medicaid Members 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.

5.12 Cultural Competency Plan. Provider shall participate with the State of Washington's efforts to promote the delivery of services in a culturally competent manner to all Medicaid Members, including those with limited English proficiency and diverse cultural ethnic backgrounds. To that end, Provider agrees to comply with all [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] both directly and through its health care providers and subcontractors.

5.13 Authorizations. Provider shall comply with [redacted] preauthorization and authorization processes and procedures applicable to Provider as more fully set forth in the provider manual(s).

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

5.15 Transfers of Members. Without otherwise limiting [redacted] rights pursuant to this Agreement, upon [redacted] determination made in good faith and with reasonable belief that a Medicaid Member's health or safety is in jeopardy, [redacted] may require that such Medicaid Member be transferred immediately for care to another provider at [redacted] direction, and Provider shall fully cooperate with any such transfer requirement. Additionally, Provider shall cooperate in all respects with provider of other health plans to assure maximum health outcomes with regard to transitioning Medicaid Members.

5.16 Monitoring. Provider agrees to [redacted] 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).

5.17 Provider to Monitor Quality. Provider shall maintain a quality assurance system to monitor the quality of services delivered under this Attachment 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 Medicaid Program or its designee.

5.18 Medicaid Member Rights. Notwithstanding anything to the contrary in this Agreement, Provider agrees to observe, protect and promote all rights of Medicaid Members as patients in accordance with all applicable laws, Government Contract and Agency requirements. Provider shall provide any information that a Medicaid Member needs in order to decide among all relevant treatment options.

5.19 Program Integrity Requirements. Provider shall comply with [redacted] HCA approved program integrity policies and procedures and the program integrity requirements of the Government 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 Government Contract, Provider shall verify that services billed by Provider were actually provided to Medicaid Members and shall conduct ongoing analysis of utilization, claims, billing and/or encounter data to detect overpayments and including audits and investigations of Provider's subcontractors and downstream entities.

5.20 Enrollee Self Determination. Provider shall obtain informed consent prior to treatment from Medicaid Members, or persons authorized to consent on behalf of a Medicaid Member, 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 Medicaid Members of their right to make anatomical gifts.

5.21 Enrollee Self-Referral. Provider understands and agrees that Medicaid Members 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 Medicaid Member may self refer include: (i) including 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; (ii) 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; (iii) immunizations, sexually transmitted disease screening, family planning and mental health services through and if provided by a school-based health center; and (iv) 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 Government Contract.

5.22 Solvency Requirements. If Provider is at financial risk, as defined in the Government Contract, [redacted] shall establish, enforce and monitor solvency requirements that provide assurance of Provider's ability to meet its obligations. Furthermore, Provider acknowledges that [redacted] shall annually conduct surveys of

Medicaid Members' satisfaction with Provider in accordance with Government Contract requirements, which surveys shall to be provided to HCA or Medicaid Members upon request.

5.23 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 [redacted] or Provider have or may have against any entity that directly or indirectly receives funds under the Government 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.

5.24 Assignment. Notwithstanding Section 9.2 of the Agreement, this Agreement may not be assigned by either party without the consent of HCA.

5.25 Pharmacy Preauthorization and Emergency Fill Requirements. Provider and [redacted] shall each comply with all applicable pharmacy preauthorization and emergency requirements of the Government 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 [redacted] 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] and Provider acknowledge and agree that [redacted] 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 [redacted] prior authorization department by phone as it is outside of that department's business hours; or

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

(e) Drug Utilization Review Process. Provider agrees to comply with [redacted] drug utilization review process, including but not limited to, the exception rule (ETR) process as outlined in the provider manual and on [redacted] website.

5.26 Potentially Preventable Readmissions. If applicable, to facilitate care transitions for Medicaid Members, Provider and [redacted] shall comply with all Potentially Preventable Readmission ("PPR") requirements, as set forth in the Government Contract and WAC 182-550-2900 and 182-550-3000. Consistent with the PPR provisions of the Government Contract, [redacted] and Provider shall work together to facilitate care transitions for Medicaid Members 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 [redacted] or [redacted] designee to assist with the coordination of planning, including visiting the Medicaid Member.

5.27 Reporting. Provider shall submit to [redacted] all reports and clinical information required by Regulatory Requirements or otherwise reasonably requested by [redacted]

5.27.1 If Provider is a Certified Behavioral Health Agency (BHA), Provider must comply with behavioral health reporting requirements, including Service Encounter Reporting Instructions ("SERI"). Provider must report behavioral health supplemental transactions to [redacted] as set forth in the provider manual(s), or as required under applicable Regulatory Requirements.

5.28 Provider Insurance Coverage. In addition to the Provider Insurance provision in the Agreement, Provider, at all times during the term of this Agreement, shall:

5.28.1 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 $5,000,000.00 per occurrence and $10,000,000.00 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.

5.28.2 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.

5.28.3 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.

5.28.4 Provide [redacted] with evidence of Provider's compliance with the foregoing insurance requirements as reasonably requested by [redacted] from time to time during the term of this Agreement, but in no event less than annually. Provider shall provide [redacted] 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] 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] on a semi-annual basis an opinion letter from an independent actuarial firm or other proof reasonably acceptable to [redacted] attesting to the financial adequacy of such reserves.

5.29 Discharge Planning. In a twenty-four (24) hour setting, Provider shall provide discharge planning services that meet the standard set forth below:

Provider shall coordinate, as needed with HCA and/or Division of Behavioral Health and Recovery (DBHR) prevention services, vocational services, housing services and supports, and other community resources and services that may be appropriate, including, but not limited to Department of Children, Youth, and Families (DCYF) services for children and families, including but not limited to, DCYF-contracted home visiting, Early Support for Infants and Toddlers (ESIT), Early Childhood Intervention and Prevention Services (ECLIPSE), Early Childhood Education and Assistance Program (ECEAP) and Head Start programs using the information letter template jointly developed by the DCYF and HCA.

5.30 Supervision by Behavioral Health Provider. As applicable, Provider will receive payment for the supervision of behavioral health providers whose license or certification restricts them to work under supervision.

5.31 Data Use, Security and Confidentiality. Provider shall comply with all data use, security, and confidentiality terms and conditions applicable to the provider, as referenced in the applicable provider manual(s) or as required by Regulatory Requirements.

5.32 Telemedicine. If Provider is a telemedicine provider, in accordance with Regulatory Requirements:

5.32.1 Provider must obtain the Medicaid Member's consent for billing in advance of the service being delivered, if Provider intends to bill the Medicaid Member or Plan for audio-only telemedicine services, and;

5.32.2 As of January 1, 2023, for audio-only telemedicine services, Provider must have an established relationship with the Medicaid Member, as defined by Washington law.

As defined in RCW 48.43.735(9)(d), "Established relationship" means the provider providing audio-only telemedicine has access to sufficient health records to ensure safe, effective, and appropriate care services and: (i) The covered person has had, within the past three years, at least one in-person appointment, or at least one real-time interactive appointment using both audio and video technology, with the provider providing audio-only telemedicine or with a provider employed at the same medical group, at the same clinic, or by the same integrated delivery system operated by a carrier licensed under chapter 48.44 or 48.46 RCW as the provider providing audio-only telemedicine; or (ii) The covered person was referred to the provider providing audio-only telemedicine by another provider who has had, within the past three years, at least one in-person appointment, or at least one real-time interactive appointment using both audio and video technology, with the covered person and has provided relevant medical information to the provider providing audio-only telemedicine.

5.32.3 [redacted] will reimburse Provider for a Medicaid Covered Service provided to a Medicaid Member through telemedicine or store and forward technology if:

(a) The Health Service is a Medicaid Covered Service when provided in person by Provider;

(b) The Medicaid Covered Service is Medically Necessary;

(c) The Medicaid Covered Service is a service recognized as an essential health benefit under section 1302(b) of the federal Patient Protection and Affordable Care Act in effect on January 1, 2015, RCW 48.43.005 and 48.43.715;

(d) The Medicaid Covered Service is determined to be safely and effectively provided through telemedicine or store and forward technology according to generally accepted health care practices and standards, and the technology used to provide the Medicaid Covered Service meets the standards required by state and federal laws governing the privacy and security of protected health information; and

5.32.4 In accordance with subsection 5.32.3 above, [redacted] will reimburse Provider for a Medicaid Covered Service provided to a Medicaid Member through telemedicine as provided by Washington law, the same amount of compensation [redacted] would pay Provider under this Agreement, if the Medicaid Covered Service was provided in person by Provider.

5.32.5 An originating site for a telemedicine Health Service subject to subsection 5.32.3 above includes a:

(a) Hospital;

(b) [redacted]

(c) Federally Qualified Health Center;

(d) Physician's or other provider's office;

(e) Licensed or Certified Behavioral Health Agency;

(f) Skilled Nursing Facility;

(g) Home or any location determined by the individual receiving the service including, but not limited to, a pharmacy licensed under Chapter 18.64 RCW or a school-based health center as defined in RCW 43.70.825. If the site chosen by the individual receiving service is in a state other than the state of Washington, a provider's ability to conduct a telemedicine encounter in that state is determined by the licensure status of the provider and the provider licensure laws of the other state; or

(h) Renal dialysis center, except an independent renal dialysis center.

5.32.6 Provider shall ensure that access to telemedicine Health Services is inclusive for Medicaid Members who may have disabilities or limited English proficiency and for whom the use of telemedicine technology may be more challenging, in accordance with Regulatory Requirements.

ARTICLE VI
TERMINATION

6.1 Termination of Medicaid Participation Attachment. Either party may terminate this Attachment without cause by giving at least one hundred eighty (180) days prior written notice of termination to the other party.

6.2 Termination of Government Contract. If a Government Contract between the applicable State Agency and [redacted] terminates, expires or ends for any reason or is modified to eliminate a Medicaid Program, this Attachment shall have no further force or effect with respect to the applicable Medicaid Program. In the event of termination of the Government Contract between [redacted] and State Agency, Provider shall immediately make available to State Agency, or its designated representative, in a usable form, any or all records, whether medical or financial, related to Provider's activities undertaken pursuant to this Agreement. The provision of such records shall be at no expense to [redacted] or State Agency.

6.3 Effect of Termination. Following termination of this Attachment, the remainder of the Agreement shall continue in full force and effect, if applicable. In addition, upon termination of this Attachment but subject to the Continuation of Care provision(s) and applicable Regulatory Requirements, any references to services, reimbursement, or participation in Networks related to the Medicaid Program are hereby terminated in full and shall have no further force and effect.

6.4 Continuation of Care. In addition to the Continuation of Care Upon Termination provision of the Agreement, in the event of the termination of this Attachment for any reason except termination of this Attachment for cause by [redacted] any Medicaid Member 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 Attachment or until the Medicaid Member's discharge from inpatient facilities up to ninety (90) days, whichever time is greater. Any Medicaid Member 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.

6.4.1 During the continuity of care provision described in this section above, Provider shall continue to provide services in accordance with the terms of this Attachment applicable immediately prior to the termination of this Attachment, and [redacted] shall continue to meet all of the obligations of this Attachment. Provider will maintain and share, as appropriate, records for Medicaid Members in accordance with professional standards. Provider shall comply with 42 CFR §438.208(b)(5).

6.4.2 A Medicaid Member shall not have the right to continuation of care if the termination of this Attachment 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 Medicaid Members.

ARTICLE VII
GENERAL PROVISIONS

7.1 Inconsistencies. In the event of an inconsistency between terms and conditions of this Attachment and the terms and conditions as set forth in the Agreement, the terms and conditions of this Attachment shall govern. Except as set otherwise forth herein, all other terms and conditions of the Agreement remain in full force and effect. Notwithstanding the Entire Agreement provision of the Agreement, the parties acknowledge and agree that the provider manual is not incorporated by reference into this Attachment as it relates Provider's participation in [redacted] Medicaid Network and it not deemed part of the entire Attachment. In the event of a) a conflict between the provisions of this Attachment and the Agreement, or b) any inconsistency or ambiguity in this Attachment, such conflict, inconsistency or ambiguity shall be resolved by giving precedence in the following order: i) state or federal law, rule, regulation or ordinance (Regulatory Requirement); ii) this Attachment; and iii) the Agreement.

7.2 Disclosure Requirements. In accordance with Regulatory Requirements, and State Agency requirements, if applicable, Provider agrees to disclose to [redacted] complete ownership, control and relationship information ("Disclosures") in accordance with 42 CFR 455.100 through 455.106. Provider shall provide required Disclosures to [redacted] at the time of initial contract, upon contract renewal, and/or upon request by

[redacted] Provider further agrees to notify [redacted] within fourteen (14) days of any changes to the Disclosures. Failure to provide Disclosures as required under Regulatory Requirements shall be deemed a material breach of this Attachment and the Agreement.

7.3 Survival of Attachment. Provider further agrees that: (1) the hold harmless and continuation of care sections shall survive the termination of this Attachment or disenrollment of the Medicaid Member; and (2) these provisions supersede any oral or written contrary agreement now existing or hereafter entered into between Provider and a Medicaid Member or persons acting on their behalf that relates to liability for payment for, or continuation of, Medicaid Covered Services provided under the terms and conditions of these provisions.

7.4 Provider Education

7.4.1 Provider shall participate in training when requested by HCA. Provider's requests for HCA to allow an exception to participation in required training must be in writing and include a plan for how the required information will be provided to Provider's targeted staff.

7.4.2 If Provider has community behavioral health employees who work directly with Medicaid Members, Provider shall provide such employees with annual training on safety and violence prevention topics described in RCW 49.19.030.

7.5 Mental Health Advance Directive. In accordance with 71.32 RCW, Provider shall inform all Medicaid Members who present for mental health services of their right to a Mental Health Advance Directive, and shall provide technical assistance to those Medicaid Members who express an interest in developing and maintaining a Mental Health Advance Directive. A "Mental Health Advance Directive" means a written document in which the Medicaid Member makes a declaration of instructions, or preferences, or appoints an agent to make decisions on behalf of the Medicaid Member regarding the Medicaid Member's mental health treatment. Provider shall also maintain current copies of any Medicaid Member's Mental Health Advance Directive in the Medicaid Member's record and shall inform Medicaid Members that complaints concerning noncompliance with a Mental Health Advance Directive should be referred to the Department of Health.

7.6 Compliance with 42 CFR Part 2. To the extent that in performing its services under this Attachment, Provider uses, discloses, maintains, or transmits protected health information that is protected by 42 CFR Part 2, Provider acknowledges and agrees that in receiving, storing, processing or otherwise dealing with any such records for Medicaid Members, Provider is fully bound by 42 CFR Part 2; and, if necessary will resist any efforts to obtain access to such records except as permitted under 42 CFR Part 2. Notwithstanding any other language in this Attachment, Provider acknowledges and agrees that any Medicaid Member information Provider receives that is protected by 42 CFR Part 2 is subject to protections that prohibit Provider from disclosing such information to agents or subcontractors without the specific written consent of the Medicaid Member.

7.7 Provider Subcontractors. In addition to the Provider Subcontractors provision in the Agreement, if Provider delegates or subcontracts any functions of [redacted] delegated by [redacted] to Provider, [redacted] consent to such action is required and the agreement governing such subcontract or delegation shall include all applicable requirements of the Government Contract (or any successor sections thereto).

MEDICARE ADVANTAGE
PARTICIPATION ATTACHMENT TO THE
[redacted] WASHINGTON, INC.
PROVIDER AGREEMENT

This is a Medicare Advantage Participation Attachment ("Attachment") to the [redacted] Provider Agreement ("Agreement"), entered into by and between [redacted] and Provider and is incorporated into the Agreement.

ARTICLE I
DEFINITIONS

The following definitions shall apply to this Attachment. Terms not otherwise defined in this Attachment shall carry the meaning set forth in the Agreement.

"Clean Claim" means a Claim that has no defect or impropriety, including a lack of required substantiating documentation, or particular circumstances requiring special treatment that prevents timely payment from being made on the Claim. A Claim is clean even though Plan refers it to a medical specialist within Plan for examination. If additional documentation (e.g., a medical record) involves a source outside Plan, then the Claim is not considered clean.

"CMS" is defined as set forth in Article I of the Agreement.

"Downstream Entity(ies)" means any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the Medicare Advantage benefit, below the level of the arrangement between [redacted] and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

"Emergency Condition" is defined as set forth in the PCS.

"Emergency Services" is defined as set forth in the PCS.

"First Tier Entity(ies)" means any party that enters into a written agreement, acceptable to CMS, with [redacted] to provide administrative services or health care services for a Medicare eligible Member under the Medicare Advantage Program.

"Medically Necessary" or "Medical Necessity" means care for which CMS determines is reasonable and necessary under Medicare for services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of MA Member's medical condition and meet accepted standards of medical practice.

"Medicare" means the Health Insurance for the Aged Act, Title XVIII of the Social Security Act, as then constituted or later amended.

"Medicare Advantage Covered Services ("MA Covered Services")" means, for purposes of this Attachment, only those Covered Services provided under Plan's Medicare Advantage Program.

"Medicare Advantage Member ("MA Member")" means, for purposes of this Attachment, a Member who is covered under a Medicare agreement between CMS and Plan under Part C of Title XVIII of the Social Security Act ("Medicare Advantage Program") and for Plan's DSNP Medicare Program, the beneficiary is also entitled to Medicaid under Title XIX of the Social Security Act, see 42 USC §1396 et seq..

"Medicare Advantage Network" means Network of Providers that provides MA Covered Services to MA Members.

"Related Entity(ies)" means any entity that is related to [redacted] by common ownership or control and (1) performs some of [redacted] management functions under contract or delegation; (2) furnishes services to MA Member under an oral or written agreement; or (3) leases real property or sells materials to [redacted] at a cost of more than twenty-five hundred dollars ($2,500) during a contract period.

"Urgently Needed Care" means MA Covered Services provided when a MA Member is either: (1) temporarily absent from Plan's Medicare Advantage service area and such MA Covered Services are Medically Necessary and immediately required: (a) as a result of an unforeseen illness, injury, or condition; and (b) it was not reasonable, given the circumstances, to obtain the services through Plan's Medicare

Advantage Network; or (2) under unusual and extraordinary circumstances, the MA Member is in the service area but Plan's Network is temporarily unavailable or inaccessible and such MA Covered Services are Medically Necessary and immediately required: (a) as a result of an unforeseen illness, injury, or condition; and (b) it was not reasonable, given the circumstances, to obtain the services through Plan's Medicare Advantage Network.

ARTICLE II
SERVICES/OBLIGATIONS

2.1 Participation-Medicare Advantage. As a participant in Plan's Medicare Advantage Network, Provider will render MA Covered Services to MA Members enrolled in Plan's Medicare Advantage Program in accordance with the terms and conditions of the Agreement and this Attachment. Except as set forth in this Attachment, or in the PCS, all terms and conditions of the Agreement will apply to Provider's participation in Plan's Medicare Advantage Program(s). The terms and conditions set forth in this Attachment are limited to the provision of and payment for Health Services provided to MA Members. This Agreement does not apply to any of Plan's Medicare Advantage Private Fee for Service or Medical Savings Account Programs. If Plan contracts with a third party to manage all or any portion of its Medicare Advantage Network, then upon 60 days notice Provider shall use best efforts to contract separately with such third party to maintain its status as a Participating Provider for such Network(s).

2.1.1 New Programs. Provider acknowledges that Plan has or may develop Medicare Advantage Networks that support certain products, programs or plans with specific participation criteria that may include but are not limited to, quality and/or cost of care metrics. Pursuant to this Agreement, Provider shall be a Participating Provider in any such Network unless [redacted] notifies Provider in writing to the contrary. Plan shall notify Provider sixty (60) days in advance of any specific Network participation criteria. Any notice of non-inclusion in any of Plan's Medicare Advantage Network(s) shall be provided in writing sixty (60) days in advance.

2.2 This provision intentionally left blank.

2.3 Accountability/Oversight. Plan delegates to Provider its responsibility under its Medicare Advantage contract with CMS to provide the services as set forth in this Attachment to MA Members. Plan may revoke this delegation, including, if applicable, the delegated responsibility to meet CMS reporting requirements, and thereby terminate this Attachment if CMS or Plan determine that Provider has not performed satisfactorily. Such revocation shall be consistent with the termination provisions of the Agreement and this Attachment. Performance of Provider shall be monitored by Plan on an ongoing basis as provided for in this Attachment. Provider further acknowledges that Plan shall oversee and is accountable to CMS for the functions and responsibilities described in the Medicare Advantage Regulatory Requirements and ultimately responsible to CMS for the performance of all services. Further, Provider acknowledges that Plan may only delegate such functions and responsibilities in a manner consistent with the standards as set forth in 42 CFR § 422.504(i)(4).

2.4 Accountability/Credentialing. Both parties acknowledge that accountability shall be in a manner consistent with the requirements as set forth in 42 CFR § 422.504(i)(4). Therefore the following are acceptable for purposes of meeting these requirements:

2.4.1 The credentials of medical professionals affiliated with Plan or Provider will be either reviewed by Plan, if applicable; or

2.4.2 The credentialing process will be reviewed and approved by Plan and Plan must audit Provider's credentialing process and/or delegate's credentialing process on an ongoing basis.

2.5 Medicare Provider. Provider must have a provider and/or supplier agreement, whichever is applicable, with CMS that permits Provider to provide services under original Medicare.

ARTICLE III
ACCESS: RECORDS/FACILITIES

3.1 Inspection of Books/Records. Provider acknowledges that Plan, Health and Human Services Department ("HHS"), the Comptroller General, or their designees have the right to timely access to inspect, evaluate and audit any books, contracts, medical records, patient care documentation, and other records of Provider, or his/her/its First Tier, Downstream and Related Entities, including but not limited to subcontractors or

transferees involving transactions related to Plan's Medicare Advantage contract through ten (10) years from the final date of the contract period or from the date of the completion of any audit, or for such longer period provided for in 42 CFR § 422.504(e)(4) or other Regulatory Requirements, whichever is later. For the purposes specified in this section, Provider agrees to make available Provider's premises, physical facilities and equipment, records relating to Plan's MA Member, including access to Provider's computer and electronic systems and any additional relevant information that CMS may require. Provider acknowledges that failure to allow HHS, the Comptroller General or their designees the right to timely access under this section can subject Provider to a fifteen thousand dollar ($15,000) penalty for each day of failure to comply.

3.2 Confidentiality. In addition to the confidentiality requirements under the Agreement, each party agrees to abide by all Regulatory Requirements applicable to that party regarding confidentiality and disclosure for mental health records, medical records, other health information, and MA Member information. Provider agrees to maintain records and other information with respect to MA Member in an accurate and timely manner; to ensure timely access by MA Member to the records and information that pertain to him/her; and to safeguard the privacy of any information that identifies a particular MA Member. Information from, or copies of, records may be released only to authorized individual. Provider must ensure that unauthorized individuals cannot gain access to or alter patient records. Original medical records must be released only in accordance with Regulatory Requirements, court orders or subpoenas. Both parties acknowledge that Plan, HHS, the Comptroller General or its designee have the right, pursuant to section 3.1 above, to audit and/or inspect Provider's premises to monitor and ensure compliance with the CMS requirements for maintaining the privacy and security of protected health information ("PHI") and other personally identifiable information ("PII") of MA Member.

ARTICLE IV
ACCESS: BENEFITS AND COVERAGE

4.1 Non-Discrimination. Provider shall not deny, limit, or condition the furnishing of Health Services to MA Member of Plan on the basis of any factor that is related to health status, including, but not limited to medical condition; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of acts of domestic violence; or disability.

4.2 Direct Access. Provider acknowledges that MA Member may obtain covered mammography screening services and influenza vaccinations from a participating provider without a referral and that MA Member who are women may obtain women's routine and preventive Health Services from a participating women's health specialist without a referral.

4.3 No Cost Sharing. Provider acknowledges that covered influenza vaccines and pneumococcal vaccines are not subject to MA Member Cost Share obligations.

4.4 Timely Access to Care. Provider agrees to provide MA Covered Services consistent with Plan's: (1) standards for timely access to care and member services; (2) policies and procedures that allow for MA Member Medical Necessity determinations; and (3) policies and procedures for Provider's consideration of MA Member input in the establishment of treatment plans.

4.5 Accessibility to Care. A Provider who is a primary care provider, or a gynecologist or obstetrician, shall provide Health Services or make arrangements for the provision of Health Services to MA Member on a twenty-four (24) hour per day, seven (7) day a week basis to assure availability, adequacy and continuity of care to MA Member. In the event Provider is not one of the foregoing described providers, then Provider shall provide Health Services to MA Member on a twenty-four (24) hour per day, seven (7) day a week basis or at such times as Health Services are typically provided by similar providers to assure availability, adequacy, and continuity of care to MA Member. If Provider is unable to provide Health Services as described in the previous sentence, Provider will arrange for another Participating Provider to cover Provider's patients in Provider's absence.

ARTICLE V
BENEFICIARY PROTECTIONS

5.1 Cultural Competency. Provider shall ensure that MA Covered Services rendered to MA Members, both clinical and non-clinical, are accessible to all MA Members, including those with limited English proficiency or reading skills, with diverse cultural and ethnic backgrounds, the homeless, and MA Members with physical and mental disabilities. Provider must provide information regarding treatment options in a cultural-competent manner, including the option of no treatment. Provider must ensure that MA Members with

disabilities have effective communications with participants throughout the health system in making decisions regarding treatment options.

5.2 Health Assessment. Provider acknowledges that Plan has procedures approved by CMS to conduct a health assessment of all new MA Members within ninety (90) days of the effective date of their enrollment. Provider agrees to cooperate with Plan as necessary in performing this initial health assessment.

5.3 Identifying Complex and Serious Medical Condition. Provider acknowledges that Plan has procedures to identify MA Members with complex or serious medical conditions for chronic care improvement initiatives; and to assess those conditions, including medical procedures to diagnose and monitor them on an ongoing basis; and establish and implement a treatment plan appropriate to those conditions, with an adequate number of direct access visits to specialists to accommodate the treatment plan. To the extent applicable, Provider agrees to assist in the development and implementation of the treatment plans and/or chronic care improvement initiatives.

5.4 Advance Directives. Provider shall establish and maintain written policies and procedures to implement MA Members' rights to make decisions concerning their health care, including the provision of written information to all adult MA Members regarding their rights under Regulatory Requirements to make decisions regarding their right to accept or refuse medical treatment and the right to execute an advance medical directive. Provider further agrees to document or oversee the documentation in the MA Members' medical records whether or not the MA Member has an advance directive, that Provider will follow state and federal requirements for advance directives and that Provider will provide for education of his/her/its staff and the community on advance directives.

5.5 Standards of Care. Provider agrees to provide MA Covered Services in a manner consistent with professionally recognized standards of health care.

5.6 Hold Harmless. In addition to the hold harmless provision in the Agreement, Provider agrees that in no event, including but not limited to non-payment by Plan, insolvency of Plan or breach of the Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a MA Member or persons other than Plan acting on their behalf for MA Covered Services provided pursuant to this Attachment. This section does not prohibit the collection of supplemental charges or Cost Shares on Plan's behalf made in accordance with the terms of the MA Member's Health Benefit Plan or amounts due for services that have been correctly identified in advance as a non-MA Covered Service, subject to medical coverage criteria, with appropriate disclosure to the MA Member of their 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 when such Health Service is typically not covered, but could be covered under specific conditions. If prior to rendering the non-Covered Service, Provider obtains, or instructs the MA Member to obtain, a coverage determination of a non-Covered Service(s), the MA Member can be held financially responsible for non-Covered Services. However, if a service or item is never covered by the Plan, such as a statutory exclusion, and the MA Member's Evidence of Coverage ("EOC") clearly specifies that the service or item is never covered, the Provider does not have to seek a coverage determination from [redacted] in order to hold the MA Member 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 Guidebook. Both Parties agree that failure to follow the CMS regulations can result in Provider's financial liability.

5.6.1 Dual Eligibles. Provider further agrees that for MA Members who are dual eligible beneficiaries for Medicare and Medicaid, that Provider will ensure he/she/it will not bill the MA Member for Cost Sharing that is not the MA Member's responsibility and such MA Members will not be held liable for Medicare Parts A and B Cost Sharing when the State is liable for the Cost Sharing. In addition, Provider agrees to accept Plan payment as payment in full or Provider should bill the appropriate state source.

5.7 Continuation of Care-Insolvency. Provider agrees that in the event of Plan's insolvency, termination of the CMS contract or other cessation of operations, MA Covered Services to MA Members will continue through the period for which the premium has been paid to Plan, and services to MA Members 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.

5.8 Out of Network Referrals and Transfers. In addition to the Cost Effective Care provision in the Agreement, Provider shall seek authorization from Plan prior to referring or transferring an MA Member to a non-Participating Provider. For Plan's HMO Medicare Advantage Network, if a Participating Provider is not accessible or available for a referral or transfer, then Provider shall call Plan for an authorization, which shall be responded to by Plan in compliance with Regulatory Requirements If, however, a Participating Provider is accessible and available for a referral or transfer, then Provider shall transfer or refer the MA Member to such Participating Provider. For Plan's PPO MA Members, Provider shall advise the MA Member that an out of network referral is being made, and shall ensure that the MA Member understands and agrees to be financially responsible for any additional costs related to such out of network service.

ARTICLE VI
COMPENSATION AND AUDIT

6.1 Submission and Adjudication of Medicare Advantage Claims. Unless required by Regulatory Requirements, Provider shall submit Claims to Plan, using appropriate and current Coded Service Identifier(s), within three-hundred sixty five (365) days from the date the Health Services are rendered or Plan will refuse payment. If Plan is the secondary payor or in situation of retroactive eligibility changes, the three-hundred sixty five (365) day period will not begin until Provider receives notification of primary payor's responsibility.

6.1.1 Provider agrees to provide to [redacted] unless otherwise instructed, at no cost to [redacted] Plan or the MA Member, all information necessary for Plan to determine its payment liability. Such information includes, without limitation, accurate and Clean Claims for MA Covered Services. Once [redacted] determines Plan has any payment liability, all Clean Claims will be paid in accordance with the terms and conditions of a MA Member's Health Benefit Plan, the PCS, and the provider manual(s).

6.1.2 Provider agrees to submit Claims in a format consistent with industry standards and acceptable to Plan either (a) electronically through electronic data interchange ("EDI"), or (b) if electronic submission is not available, utilizing paper forms as defined by the National Uniform Claim Committee ("NUCC").

6.1.3 If [redacted] or Plan asks for additional information so that Plan may process the Claim, Provider must provide that information within sixty (60) days, or before the expiration of the three hundred sixty-five (365) day period referenced in section 6.1 above, whichever is longer.

6.2 Prompt Payment. [redacted] shall pay ninety-five percent (95%) of the monthly volume of Clean Claims within thirty (30) calendar days of receipt and shall pay or deny ninety-five percent (95%) of the monthly volume of all Claims within sixty (60) days of receipt. Notwithstanding the foregoing, [redacted] and Provider may agree to a different payment requirement in writing on a claim by claim basis.

6.3 Audit for Compliance with CMS Guidelines. Notwithstanding any other terms and conditions of the Agreement, Plan has the same rights as CMS, to review and/or Audit and, to the extent necessary recover payments on any claim for MA Covered Services rendered pursuant to this Agreement to ensure compliance with CMS Regulatory Requirements.

ARTICLE VII
REPORTING AND DISCLOSURE REQUIREMENTS

7.1 Risk Adjustment Documentation and Coding Reviews and Audits. Provider is required in accordance with 42 CFR § 422.310(e) to submit medical records for MA Members for the purpose of validation of Risk Adjustment Data (as defined below in section 7.2) as requested by Plan. Provider is also required to comply with all other medical record requests from Plan for other governmental (e.g., CMS, Office of Inspector General (OIG)) and/or Plan documentation and coding review and audit activities. Accordingly, Plan, or its designee, shall have the right, as set forth in section 3.4 of the Agreement to obtain copies of such documentation on at least an annual basis or otherwise as Plan may reasonably require. Provider agrees to provide copies of the requested medical records to Plan, or its designee, within fourteen (14) calendar days from Plan's, or its designee's, and/or any Agency's written request, unless sooner required by CMS or such other Agency. Such records shall be provided to Plan, or its designee, or a governmental agency, at no additional cost to Plan, its designee or such Agency. Provider also agrees to participate in education and/or remediation, as required by Plan, based on the outcome of any documentation and coding reviews and/or audits.

7.2 Data Reporting Requirements. Provider shall provide to Plan all information necessary for or requested by Plan to enable Plan 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 MA Member and the Provider ("Risk Adjustment Data"), and data necessary for or requested by Plan to enable Plan to meet its reporting obligations under 42 CFR §§ 422.516 and 422.310 or under any subsequent or additional regulatory provisions or CMS guidance. In accordance with CMS Regulatory Requirements, Plan reserves the right to assess Provider for any penalties resulting from Provider's submission of false data.

7.3 Risk Adjustment Data Submission. Provider shall submit all diagnosis data generated in connection with this Agreement by way of filing a Claim with Plan. Where Provider identifies supplemental diagnosis data through retrospective medical chart review or other processes, Provider shall file an amended Claim containing the supplemental diagnosis data. If an amended Claim cannot be filed and Provider wants to submit supplemental diagnosis data, then Provider shall ensure that a Claim (i.e., the associated encounter data record) has already been submitted for the original MA Member/Provider encounter. This Claim must be (i) from the same date of service, (ii) having the same Provider identification number, (iii) with the same MA Member information, and (iv) containing the same procedural information as the supplemental data identified through the retrospective medical chart review or other processes. Plan requires submission of the original Claim prior to the submission of supplemental data to ensure the two (2) can be linked.

Supplemental diagnosis data shall be submitted in a format specified by Plan. If Provider reasonably determines that a Provider is unable to meet these requirements, then Provider must inform Plan within a reasonable time, but no later than thirty (30) days after receiving knowledge, actual or constructive of such inability, and Plan shall have the right to validate the data by auditing medical records and/or data generation processes, or by requesting additional data and/or documentation from Provider to confirm the acceptability of the data. For purposes of clarity, Provider shall cooperate with any such requests by Plan or on Plan's behalf, as set forth in this Agreement. If Provider identifies data corrections (e.g., prior data submissions not supported in the medical record), then Provider shall promptly inform Plan and submit data corrections to Plan in a format specified by Plan as soon as reasonably possible, but in no event later than thirty (30) days after identifying.

7.4 Risk Adjustment Data. Provider's Risk Adjustment Data shall include all information necessary for or requested by Plan to enable Plan to submit such data to CMS as set forth in 42 CFR § 422.310 or any subsequent or additional regulatory provisions or CMS guidance. If Provider fails to submit accurate, complete, and truthful Risk Adjustment Data in the format described in 42 CFR § 422.310 or any subsequent or additional regulatory provisions or CMS guidance, then this may result in denials and/or delays in payment of Provider's Claims. Plan will make best efforts to work with Provider to resolve Risk Adjustment Data format and/or processing issues.

7.5 Accuracy of Risk Adjustment Data. Risk Adjustment Data submitted by Provider must be accurate, complete, and truthful. By submitting Risk Adjustment Data to Plan, Provider is certifying and attesting to the accuracy, completeness, and truthfulness of such Risk Adjustment Data. If requested by Plan, Provider shall execute such further certifications or attestations as to the accuracy, completeness, and truthfulness of such Risk Adjustment Data as Plan may require.

ARTICLE VIII
QUALITY ASSURANCE/QUALITY IMPROVEMENT REQUIREMENTS

8.1 Independent Quality Review Organization. Provider agrees to comply and cooperate with an independent quality review and improvement organization's activities pertaining to the provision of MA Covered Services for MA Member.

8.2 Compliance with Plan Medical Management Programs. Provider agrees to comply with Plan's medical policies, quality improvement and performance improvement programs, and medical management programs to the extent provided to or otherwise made available to Provider in advance.

8.3 Consulting with Participating Providers. Plan agrees to consult with Participating Providers regarding its medical policies, quality improvement program and medical management programs and ensure that practice guidelines and utilization management guidelines: (1) are based on reasonable medical evidence or a consensus of health care professionals in the particular field; (2) consider the needs of the enrolled population; (3) are developed in consultation with participating physicians; (4) are reviewed and updated periodically; and (5) are communicated to providers and, as appropriate, to MA Member. Plan also agrees to

ensure that decisions with respect to utilization management, MA Member education, coverage of Health Services, and other areas in which the guidelines apply are consistent with the guidelines.

ARTICLE IX
COMPLIANCE

9.1 Compliance: Medicare Laws/Regulations. Provider agrees to comply, and to require any of his/her/its subcontractors to comply, with all applicable Medicare Regulatory Requirements and CMS instructions. Further, Provider agrees that any MA Covered Services provided by Provider or his/her/its subcontractors to or on the behalf of Plan's MA Member will be consistent with and will comply with Plan's Medicare Advantage contractual obligations.

9.2 Compliance: Exclusion from Federal Health Care Program. Provider may not employ, or subcontract with an individual, or have persons with ownership or control interests, who have been convicted of criminal offenses related to their involvement in Medicaid, Medicare, or social services programs under Title XX of the Social Security Act, and thus have been excluded from participation in any federal health care program under §§1128 or 1128A of the Act (or with an entity that employs or contracts with such an individual) for the provision of any of the following: healthcare, utilization review, medical social work, or administrative services.

9.3 Compliance: Appeals/Grievances. Provider agrees to comply with Plan's policies and procedures in performing his/her/its responsibilities under the Agreement. Provider specifically agrees to comply with Medicare Regulatory Requirements regarding MA Member appeals and grievances and to cooperate with Plan in meeting its obligations regarding MA Member appeals, grievances and expedited appeals, including the gathering and forwarding of information in a timely manner and compliance with appeals decisions.

9.4 Compliance: Policy and Procedures. Provider agrees to comply with Plan's policy and procedures in performing his/her/its responsibilities under the Agreement and this Attachment including any supplementary documents that pertain to Plan's Medicare Advantage Program such as the provider manual(s).

9.5 Illegal Remunerations. Both parties specifically represent and warrant that activities to be performed under this Agreement are not considered illegal remunerations (including kickbacks, bribes or rebates) as defined in 42 USCA § 1320(a)-7b.

9.6 Compliance: Training, Education and Communications. In accordance with CMS requirements, Provider agrees and certifies that it, as well as its employees, subcontractors, Downstream Entities, Related Entities and agents who provide services to or for Plan's Medicare Advantage and/or Part D MA Members or to or for Plan itself shall conduct general compliance and fraud, waste and abuse training, education and/or communications annually or as otherwise required by Regulatory Requirements, and must be made a part of the orientation for a new employee, new First Tier Entities, Downstream Entities, or Related Entities, and for all new appointments of a chief executive, manager, or governing body member who performs leadership and/or oversight over the service provided under the Agreement. Provider or its subcontractors or Downstream Entities shall ensure that their general compliance and fraud, waste and abuse training and education is comparable to the elements, set forth in [redacted] Standards of Ethical Business Conduct and shall provide documentation to demonstrate compliance prior to execution of the Agreement and annually thereafter. In addition, Provider is responsible for documenting applicable employee's, subcontractor's, Downstream Entity's, Related Entity's and/or agent's attendance and completion of such training on an annual basis. Provider shall provide such documentation to Plan and as required to support a Plan or CMS audit. If necessary and upon request, Plan or its designee can make such compliance training, education and lines of communication available to Provider in either electronic, paper or other reasonable medium.

9.7 Federal Funds. Provider acknowledges that payments Provider receives from Plan to provide MA Covered Services to MA Members are, in whole or part, from federal funds. Therefore, Provider and any of his/her/its subcontractors are subject to certain Regulatory Requirements that are applicable to Members and entities receiving federal funds, which may include but is not limited to, Title VI of the Civil Rights Act of 1964 as implemented by 45 CFR Part 80; the Age Discrimination Act of 1975 as implemented by 45 CFR Part 91; the Americans with Disabilities Act; the Rehabilitation Act of 1973 as implemented by 45 CFR Part 84, lobbying restrictions as implemented by 45 CFR Part 93 and 31 USC 1352 and any other regulations applicable to recipients of federal funds.

ARTICLE X
MARKETING

10.1 Approval of Materials. Both parties agree to comply, and to require any of his/her/its subcontractors to comply, with all applicable Regulatory Requirements, CMS instructions, and marketing activities under this Agreement, including but not limited to, the Medicare Marketing Guidelines for Medicare Managed Care Plans and any requirements for CMS prior approval of materials. Any printed materials, including but not limited to letters to Plan MA Members, brochures, advertisements, telemarketing scripts, packaging prepared or produced by Provider or any of his/her/its subcontractors pursuant to this Agreement must be submitted to Plan for review and approval at each planning stage (i.e., creative, copy, mechanicals, blue lines, etc.) to assure compliance with Regulatory Requirements. Plan agrees its approval will not be unreasonably withheld or delayed.

ARTICLE XI
TERMINATION

11.1 Notice Upon Termination. If Plan decides to terminate this Attachment, Plan shall give Provider written notice, to the extent required under CMS regulations, of the reasons for the action, including, if relevant, the standards and the profiling data the organization used to evaluate Provider and the numbers and mix of Participating Providers Plan needs. Such written notice shall also set forth Provider's right to appeal the action and the process and timing for requesting a hearing.

11.2 Effect of Termination. Following termination of this Attachment, the remainder of the Agreement shall continue in full force and effect, if applicable. In addition, upon termination of this Attachment but subject to the Continuation of Care provision(s) and applicable Regulatory Requirements, any references to services, reimbursement, or participation in Networks related to the Medicare Advantage Program are hereby terminated in full and shall have no further force and effect.

11.3 Termination Without Cause. Either party may terminate this Attachment without cause by giving at least one hundred twenty (120) days prior written notice of termination to the other party.

ARTICLE XII
GENERAL PROVISIONS

12.1 Inconsistencies. In the event of an inconsistency between terms of this Attachment and the terms and conditions as set forth in the Agreement, the terms and conditions of this Attachment shall govern. Except as set forth herein, all other terms and conditions of the Agreement remain in full force and effect.

12.2 Interpret According to Medicare Laws. Provider and Plan intend that the terms of the Agreement and this Attachment as they relate to the provision of MA Covered Services under the Medicare Advantage Program shall be interpreted in a manner consistent with applicable requirements under Medicare Regulatory Requirements.

12.3 Subcontractors. In addition to the Use of Subcontractors provision of the Agreement, Provider agrees that if Provider enters into subcontracts to perform services under the terms of this Attachment, Provider's subcontracts shall include: (1) an agreement by the subcontractor to comply with all of Provider's obligations in the Agreement and this Attachment; (2) a prompt payment provision as negotiated by Provider and the subcontractor; (3) a provision setting forth the term of the subcontract (preferably one (1) year or longer); and (4) dated signatures of all the parties to the subcontract.

12.4 Delegated Activities. If Plan has delegated activities to Provider, then Plan will provide the following information to Provider and Provider shall provide such information to any of its subcontracted entities:

12.4.1 A list of delegated activities and reporting responsibilities;

12.4.2 Arrangements for the revocation of delegated activities;

12.4.3 Notification that the performance of the contracted and subcontracted entities will be monitored by Plan;

12.4.4 Notification that the credentialing process must be approved and monitored by Plan; and

12.4.5 Notification that all contracted and subcontracted entities must comply with all applicable Medicare Regulatory Requirements and CMS instructions.

12.5 Delegation of Provider Selection. In addition to the responsibilities for delegated activities as set forth herein, to the extent that Plan has delegated selection of providers, contractors, or subcontractor to Provider, Plan retains the right to approve, suspend, or terminate any such arrangement.

12.6 Survival of Attachment. Provider further agrees that: (1) the hold harmless and continuation of care sections shall survive the termination of this Attachment or disenrollment of the MA Member; and (2) these provisions supersede any oral or written contrary agreement now existing or hereafter entered into between Provider and an MA Member or persons acting on their behalf that relates to liability for payment for, or continuation of, MA Covered Services provided under the terms and conditions of these clauses.

12.7 Attachment Amendment. Notwithstanding the Amendment provision in the Agreement, this Attachment shall be automatically modified to conform to required changes to Regulatory Requirements related to Medicare Advantage Programs without the necessity of executing written amendments. For amendments not required by Regulatory Requirements related to Medicare Advantage Programs, [redacted] shall make a good faith effort to provide notice to Provider at least thirty (30) days in advance of the effective date of the amendment.

12.8 References to Regulatory Requirements. All references in this Attachment to any Regulatory Requirement shall mean and refer to the existing law, regulation or guidance as of the Effective Date of the Agreement and any subsequent, successor or additional Regulatory Requirements related to the same subject matter.

PLAN COMPENSATION SCHEDULE ("PCS")

ARTICLE I
DEFINITIONS

The definitions set forth below shall apply with respect to all of the terms outlined in this PCS. Terms not otherwise defined in this PCS and defined elsewhere in the Agreement shall carry the meanings set forth in the Agreement.

"Capitation" means the amount paid by [redacted] to a provider or management services organization on a per member per month basis for either specific services or the total cost of care for Covered Services.

"Case Rate" means the all-inclusive [redacted] Rate for an entire admission or one outpatient encounter for Covered Services.

"Chargemaster" or "Charge Master" means facility's listing of facility charges for products, services and supplies.

"Coded Service Identifier(s)" means a listing of descriptive terms and identifying codes, updated from time to time by CMS or other industry source, for reporting Health Services on the CMS 1500 or CMS 1450/UB-04 claim form or its successor as applicable based on the services provided. The codes include but are not limited to, American Medical Association Current Procedural Terminology ("CPT®-4"), CMS Healthcare Common Procedure Coding System ("HCPCS"), International Classification of Diseases, 10th Revision ("ICD-10"), National Uniform Billing Committee ("Revenue Code") and National Drug Code ("NDC") or their successors.

"Cost to Charge Ratio" ("CCR") means the quotient of cost (total operating expenses minus other operating revenue) divided by charges (gross patient revenue) expressed as a decimal, as defined by Regulatory Requirements.

"Diagnosis-Related Group" ("DRG") means Diagnosis Related Group or its successor as established by CMS or other grouper, including but not limited to, a state mandated grouper or other industry standard grouper.

"DRG Rate" means the all-inclusive dollar amount which is multiplied by the appropriate DRG Weight to determine the [redacted] Rate for Covered Services.

"DRG Weight" means the weight applicable to the specific DRG methodology set forth in this PCS, including but not limited to, CMS DRG weights as published in the Federal Register, state agency weights, or other industry standard weights.

"Eligible Charges" means those Provider Charges that meet [redacted] conditions and requirements for a Health Service to be eligible for reimbursement. These conditions and requirements include but are not limited to: Member program eligibility, Provider program eligibility, benefit coverage, authorization requirements, provider manual specifications, [redacted] administrative, clinical and reimbursement policies and methodologies, code editing logic, coordination of benefits, Regulatory Requirements, and this Agreement. Eligible Charges do not include Provider Charges for any items or services that Provider receives and/or provides free of charge.

"Emergency Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the health of the individual, or in the case of a pregnant woman, the health of the woman or her unborn child; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

"Emergency Services" means those Covered Services furnished by a provider qualified to furnish emergency services, and which are needed to evaluate or treat an Emergency Condition.

"Encounter Data" means Claim information and any additional information submitted by a provider under capitated or risk-sharing arrangements for Health Services rendered to Members.

"Encounter Rate" means the [redacted] Rate that is all-inclusive of professional, technical and facility charges including evaluation and management, pharmaceuticals, routine surgical and therapeutic procedures, and diagnostic testing (including laboratory and radiology) capable of being performed on site.

"Fee Schedule(s)" means the complete listing of [redacted] Rate(s) for specific services that is payment for each unit of service allowed based on applicable Coded Service Identifier(s) for Covered Services.

"Global Case Rate" means the all-inclusive [redacted] Rate which includes facility, professional and physician services for specific Coded Service Identifier(s) for Covered Services.

"Inpatient Services" means Covered Services provided by a facility to a Member who is admitted and treated as a registered inpatient, is assigned a licensed bed within the facility, remains assigned to such bed and for whom a room and board charge is made.

"Observation" means the services furnished on the facility's premises, including use of a bed and periodic monitoring by nursing or other staff, which are Medically Necessary to evaluate a Member's condition and determine if the Member requires an inpatient admission to the facility. Such determination shall be in compliance with Policies or Regulatory Requirements.

"Outlier Rate" means the payment applied to an admission which exceeds the outlier threshold as set forth in the PCS or in compliance with Policies or Regulatory Requirements.

"Outpatient Services" means Covered Services provided by a facility to a Member who is admitted and treated as a registered outpatient within the facility.

"Patient Day" means each approved calendar day of care that a Member receives in the facility, to the extent such day of care is a Covered Service under the terms of the Member's Health Benefit Plan, but excluding the day of discharge.

"Percentage Rate" means the [redacted] Rate that is a percentage of Eligible Charges billed by a provider for Covered Services.

"Per Diem Rate" means the [redacted] Rate that is the all-inclusive fixed payment for Covered Services rendered on a single date of service.

"Per Hour Rate" means the [redacted] Rate that is payment based on an increment of time for Covered Services.

"Per Relative Value Unit" ("RVU") means the [redacted] Rate for each unit of service based on the CMS, State Agency or other (e.g., American Society of Anesthesiologists (ASA)) defined Relative Value Unit (RVU).

"Per Service Rate" means the [redacted] Rate that is payment for each service allowed based on applicable Coded Service Identifier(s) for Covered Services.

"Per Unit Rate" means the [redacted] Rate that is payment for each unit of service allowed based on applicable Coded Service Identifier(s) for Covered Services.

"Per Visit Rate" means the [redacted] Rate that is the all-inclusive fixed payment for one encounter for Covered Services.

"Provider Charges" means the regular, uniform rate or price Provider determines and submits to [redacted] as charges for Health Services provided to Members. Such Provider Charges shall be no greater than the rate or price Provider submits to any person or other health care benefit payor for the same Health Services provided, regardless of whether Provider agrees with such person or other payor to accept a different rate or price as payment in full for such services.

"Short Stay" means an inpatient hospital stay that is less than a specified number of calendar days in compliance with Policies and/or Regulatory Requirements.

ARTICLE II
GENERAL PROVISIONS

Billing Form and Claims Reporting Requirements. Provider shall submit all Claims on a CMS 1500 or CMS 1450/UB-04 claim form or its successor form(s) as applicable based on the Health Services provided in accordance with Policies or applicable Regulatory Requirements for [redacted] hospitals, acute care hospital and/or rural health clinics. Provider shall report all Health Services in accordance with the Coded Service Identifier(s) reporting guidelines and instructions using HIPAA compliant billing codes. In addition, Plan shall not pay any Claim(s) nor accept any Encounter Data submitted using non-compliant codes. Plan audits that result in identification of Health Services that are not reported in accordance with the Coded Service Identifier(s) guidelines and instructions, will be

subject to recovery through remittance adjustment or other recovery action as may be set forth in the provider manual(s).

Claim Submissions for Pharmaceuticals. Each Claim submitted for a pharmaceutical product must include standard Coded Service Identifier(s), a National Drug Code ("NDC") number of the covered medication, a description of the product, and dosage and units administered.

Coding Updates. Coded Service Identifier(s) used to define specific rates are updated from time to time to reflect new, deleted or replacement codes. [redacted] shall use commercially reasonable efforts to update all applicable Coded Service Identifiers within sixty (60) days of release by CMS or other applicable authority. When billing codes are updated, Provider is required to use appropriate replacement codes for Claims for Covered Services, regardless of whether this Agreement has been amended to reflect changes to standard billing codes. If Provider bills a revised code prior to the effective date of the revised code, the Claim will be rejected or denied and Provider shall resubmit Claim with correct code. In addition, Claims with codes which have been deleted will be rejected or denied.

Coding Software. Updates to [redacted] Claims processing filters, code editing software, pricers, and any edits related thereto, as a result of changes in Coded Service Identifier(s) reporting guidelines and instructions, shall take place automatically and do not require any notice, disclosure or amendment to Provider. [redacted] reserves the right to use a code editing software as reasonably required by [redacted] to ensure Claims adjudication in accordance with industry standards, including, but not limited to, determining which services are considered part of, incidental to, or inclusive of the primary procedure and ensuring medically appropriate age, gender, diagnosis, frequency, and units billed.

Modifiers. All appropriate modifiers must be submitted in accordance with Regulatory Requirements specific to [redacted] hospitals, acute care hospitals and/or rural health clinics, industry standard billing guidelines and Policies. If appropriate modifiers are not submitted, Claims may be rejected or denied.

New/Expanded Service or New/Expanded Technology. In accordance with the Scope/Change in Status section of the Agreement, as of the Effective Date of this Agreement, any New/Expanded Service or New/Expanded Technology (defined below) is not reimbursable under this Agreement. Notwithstanding the foregoing, Provider may submit the following documentation to [redacted] at least sixty (60) days prior to the implementation of any New/Expanded Service or New/Expanded Technology for consideration as a reimbursable service: (1) a description of the New/Expanded Service or New/Expanded Technology; (2) Provider's proposed charge for the New/Expanded Service or New/Expanded Technology; (3) such other reasonable data and information required by [redacted] to evaluate the New/Expanded Service or New/Expanded Technology. In addition, [redacted] may also need to obtain approval from applicable Agency prior to [redacted] making determination that New/Expanded Service or New/Expanded Technology can be considered a reimbursable service. If [redacted] agrees that the New/Expanded Service or New/Expanded Technology may be reimbursable under this Agreement, then [redacted] shall notify Provider, and both parties agree to negotiate in good faith, a new [redacted] Rate for the New/Expanded Service or New/Expanded Technology within sixty (60) days of [redacted] notice to Provider. If the parties are unable to reach an agreement on a new [redacted] Rate for the New/Expanded Service or New/Expanded Technology before the end of the sixty (60) day period, then such New/Expanded Service or New/Expanded Technology shall not be reimbursed by [redacted] and the Payment in Full and Hold Harmless provision of this Agreement shall apply.

a. "New/Expanded Service" shall be defined as a Health Service: (a) that Provider was not providing to Members as of the Effective Date of this Agreement and; (b) for which there is not a specific [redacted] Rate as set forth in this PCS.

b. "New/Expanded Technology" shall be defined as a technological advancement in the delivery of a Covered Service which results in a material increase to the cost of such service. New/Expanded Technology shall not include a new device, or implant that merely represents a new model or an improved model of a device or implant used in connection with a service provided by Provider as of the Effective Date of this Agreement.

Non-Priced Codes for Covered Services. [redacted] reserves the right to establish a rate for codes that are not priced in this PCS or in the Fee Schedule(s), including but not limited to, Not Otherwise Classified Codes ("NOC"), Not Otherwise Specified ("NOS"), Miscellaneous, Individual Consideration Codes ("IC"), and By Report ("BR") (collectively "Non-Priced Codes"). [redacted] shall only reimburse Non-Priced Codes for Covered Services in the following situations: (i) the Non-Priced Code does not have a published dollar amount on the then current applicable Plan, State or CMS Fee Schedule, (ii) the Non-Priced Code has a zero dollar amount listed, or (iii) the Non-Priced Code requires manual pricing. In such situations, such Non-Priced Code shall be reimbursed at a rate established by [redacted] for such Covered Service. Notwithstanding the foregoing, [redacted] shall not price Non-Priced Codes that

are not Covered Services under the Members Health Benefit Plan. [redacted] may require the submission of medical records, invoices, or other documentation for Claims payment consideration.

Reimbursement for [redacted] Rate Based on Eligible Charges. Notwithstanding any reimbursement amount set forth herein, Provider shall only be allowed to receive such reimbursement if such reimbursement is for an Eligible Charge. In addition, if Provider reimbursement is under one or more of the following methodologies: Capitation, Case Rate, DRG Rate, Encounter Rate, Global Case Rate, Per Diem Rate, Per Relative Value Unit (RVU), and Per Visit Rate, then individual services billed shall not be reimbursed separately, unless otherwise specified in the PCS Attachment(s).

Reimbursement for Subcontractors. Plan shall not be liable for any reimbursement in addition to the applicable [redacted] Rate as a result of Provider's use of a subcontractor. Provider shall be solely responsible to pay subcontractors for any Health Services, and shall via written contract, contractually prohibit such subcontractors from billing, collecting or attempting to collect from [redacted] Plan or Members. Notwithstanding the foregoing, if [redacted] has a direct contract with the subcontractor, the direct contract shall prevail over this Agreement and the subcontractor shall bill [redacted] under the direct contract for any subcontracted services, with the exception of nursing services provided for Home Infusion Therapy, or unless otherwise agreed to by the parties.

Tax Assessment and Penalties. The [redacted] Rates in this Agreement include all sales and use taxes and other taxes on Provider revenue, gross earnings, profits, income and other taxes, charges or assessments of any nature whatsoever (together with any related interest or penalties) now or hereafter imposed against or collectible by Provider with respect to Covered Services, unless otherwise required by Agency pursuant to Regulatory Requirements. Neither Provider nor Plan shall add any amount to or deduct any amount from the [redacted] Rates, whether on account of taxes, assessments, tax penalties or tax exemptions.

Updates to [redacted] Rate(s) Based on External Sources. Unless otherwise required by Regulatory Requirements, and notwithstanding any proprietary fee schedule(s)/rate(s)/methodologies, [redacted] shall use commercially reasonable efforts to update the [redacted] Rate(s) based on External Sources, which include but are not limited to, i) CMS Medicare fee schedule(s)/rate(s)/methodologies; ii) Medicaid or State Agency fee schedule(s)/rate(s)/methodologies; iii) vendor fee schedule(s)/rate(s)/methodologies; or iv) any other entity's published fee schedule(s)/rate(s)/methodologies (collectively "External Sources") no later than sixty (60) days after [redacted] receipt of the final fee schedule(s)/rate(s)/methodologies change from such External Sources, or on the effective date of such final fee schedule(s)/rate(s)/methodologies change, whichever is later. The effective date of such final fee schedule(s)/rate(s)/methodologies change shall be the effective date of the change as published by External Sources. Fee schedule(s)/rate(s)/methodologies will be applied on a prospective basis. Claims processed prior to the implementation of the new [redacted] Rate(s) in [redacted] payment system shall not be reprocessed, however, if reprocessing is required by Regulatory Requirements, and such reprocessing could result in a potential under and/or over payment to a Provider, then Plan may reconcile the Claim adjustments to determine the remaining amount Provider owes Plan, or that Plan owes to Provider. Any resultant overpayment recoveries (i.e. Provider owes Plan) shall occur automatically without advance notification to Provider. Unless otherwise required by Regulatory Requirements, [redacted] shall not be responsible for interest payments that may be the result of a late notification by External Sources to [redacted] of fee schedule(s)/rate(s)/methodologies change.

PLAN COMPENSATION SCHEDULE ("PCS") ATTACHMENT

MEDICAID

For purposes of determining the [redacted] Rate, the total reimbursement amount that Provider and [redacted] have agreed upon for the applicable provider type(s) for Covered Services provided under this Agreement in effect on the date of service shall be as set forth below.

Program: [redacted] Medicaid Network [redacted] Hospital ([redacted])			
Service Description	**Billing Code**	**Rate/ Methodology**	**Rate Description**
Inpatient Facility Services	Applicable Inpatient Revenue Codes	108% of the Washington State Medicaid [redacted] Hospital Rates	Per Service
Outpatient Facility Services	Applicable Revenue Codes with CPT/HCPCS Code	108% of the Washington State Medicaid [redacted] Hospital Rates	Per Service

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

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

Medicaid Affiliate Services. Provider acknowledges that [redacted] is affiliated with health plans that offer similar benefits under similar programs as the programs covered hereunder ("Medicaid Affiliates"). The parties acknowledge that Provider is not a Participating Provider in Medicaid Affiliate's Network for purposes of rendering services to Medicaid Members. However, in the event Provider treats a Medicaid Member of a Medicaid Affiliate, subject to Regulatory Requirements, Provider shall accept as payment in full the rates established by the Medicaid Affiliate's state program governing care to Medicaid Members. Such services must be Medicaid Covered Services under the Medicaid Affiliate's state program, and shall require prior authorization, except for Emergency Services and services for which a Medicaid Member is entitled to self-refer. Upon request, [redacted] shall coordinate and provide information as necessary between Provider and Medicaid Affiliate for services rendered to Medicaid Member.

Reimbursement Specific to Provider Type

The following will be reimbursed for facility services only: Acute Care Hospital, ASC, Behavioral Health Facility, Free Standing Birthing Center, Rehabilitation Facility and SNF. Professional services are excluded.

Ambulance Provider Air and/or Ground shall be reimbursed in accordance with Regulatory Requirements for the applicable methodology based on the referenced fee schedule. If such reimbursement is based on an [redacted] Rate, the applicable state methodology on which such fee schedule is based, shall be used to determine the appropriate level of reimbursement.

Hospice reimbursement is inclusive of skilled nursing, home health aide, medical social worker services, dietary, pastoral, bereavement counseling, DME, medical supplies and administration of medication.

Specialty Provider Individual and/or group (Non-MD or DO) shall be reimbursed in accordance with Regulatory Requirements for the applicable methodology based on the referenced fee schedule.

Specialty Provider Individual and/or group (including Non-MD or DO) shall be reimbursed for anesthesiology services in accordance with the accumulation of base, modifier and time units multiplied by the Washington State Medicaid Anesthesia Conversion Factor. The services should be billed in minute increments. One time unit will be allowed for each fifteen (15) minute interval, or fraction thereof, starting from the time Provider begins to prepare the Member for induction and ending when the Member may safely be placed under post-operative supervision and Provider is no longer in personal attendance.

"Ambulatory Patient Group" ("APG") means the [redacted] Rate that is a fixed reimbursement to a facility for Outpatient Services and which incorporates data regarding the reason for the visit and patient data.

"Ambulatory Payment Classification" ("APC") or its successor shall have the meaning set forth in the Medicare law and CMS regulations and guidance.

"[redacted] Reference Laboratory Fee Schedule" means the [redacted] Rate that is the [redacted] Reference Laboratory Fee Schedule that is based on the Medicare Fee Schedule and may contain additional CPT/HCPCS codes. [redacted] Reference Laboratory Fee Schedule and/or rate changes will be applied on a prospective basis.

"[redacted] Medicaid Rate(s)/Fee Schedule(s)/Methodologies" means the [redacted] Medicaid Rate(s)/Fee Schedule(s)/ in effect on the date of service for the provider type(s)/service(s) identified herein for the applicable Medicaid Program(s).

"CMS Outpatient Prospective Payment System" ("OPPS") shall have the meaning set forth in Medicare law and CMS regulations and guidance.

"Medical Care Management Rate" means the amount paid by [redacted] to Provider on a per member per month basis for facilitation of collaborative programs meant to manage medical/social/mental health conditions more effectively.

"Medicare Fee Schedule" means the applicable Medicare Fee Schedule for the provider type(s) identified herein, including payment conversion factor, where applicable, and in effect on the date of the service is initiated to Members. Medicare Fee Schedule and/or rate changes will be applied on a prospective basis.

"Medicare LUPA National Base Rate" means the Medicare LUPA ("Low Utilization Payment Adjustment") National Base rate in effect as of the date of service for the market(s) and program(s) covered by the Agreement at the time the Covered Services are initiated to the Member. Medicare LUPA National Base Rate changes will be applied on a prospective basis.

"Medicare Part B Drug Average Sales Price ("ASP") Fee Schedule" means the Medicare Part B Drug Average Sales Price ("ASP") Fee Schedule (or successor) in effect as of the date of service for the market(s) and programs covered by the Agreement at the time the Covered Services is initiated to the Member. Medicare Part B Drug Average Sales Price ("ASP") Fee Schedule and/or rate changes will be applied on a prospective basis.

"Washington State Medicaid Rate(s)/Fee Schedule(s)/Methodologies" means the Washington State Medicaid Rate(s)/Fee Schedule(s)/ in effect on the date of service for the provider type(s)/service(s) identified herein for the applicable Medicaid Program(s).

PLAN COMPENSATION SCHEDULE ("PCS") ATTACHMENT

MEDICAID

For purposes of determining the [redacted] Rate, the total reimbursement amount that Provider and [redacted] have agreed upon for the applicable provider type(s) for Covered Services provided under this Agreement in effect on the date of service shall be as set forth below.

Program: [redacted] Medicaid Network [redacted]			
Service Description	**Billing Code**	**Rate/ Methodology**	**Rate Description**
All Outpatient Covered Services	Applicable CPT/HCPCS Codes	100% of Washington State Medicaid [redacted] Encounter Rate	Per Visit
[redacted] Separately Billable Codes	Applicable CPT/HCPCS NDC Code	108% of the Washington State Medicaid Fee Schedule	Per Service

Medicaid Affiliate Services. Provider acknowledges that [redacted] is affiliated with health plans that offer similar benefits under similar programs as the programs covered hereunder ("Medicaid Affiliates"). The parties acknowledge that Provider is not a Participating Provider in Medicaid Affiliate's Network for purposes of rendering services to Medicaid Members. However, in the event Provider treats a Medicaid Member of a Medicaid Affiliate, subject to Regulatory Requirements, Provider shall accept as payment in full the rates established by the Medicaid Affiliate's state program governing care to Medicaid Members. Such services must be Medicaid Covered Services under the Medicaid Affiliate's state program, and shall require prior authorization, except for Emergency Services and services for which a Medicaid Member is entitled to self-refer. Upon request, [redacted] shall coordinate and provide information as necessary between Provider and Medicaid Affiliate for services rendered to Medicaid Member.

Reimbursement Specific to Provider Type

The following will be reimbursed for facility services only: Acute Care Hospital, ASC, Behavioral Health Facility, Free Standing Birthing Center, Rehabilitation Facility and SNF. Professional services are excluded.

Ambulance Provider Air and/or Ground shall be reimbursed in accordance with Regulatory Requirements for the applicable methodology based on the referenced fee schedule. If such reimbursement is based on an [redacted] Rate, the applicable state methodology on which such fee schedule is based, shall be used to determine the appropriate level of reimbursement.

Hospice reimbursement is inclusive of skilled nursing, home health aide, medical social worker services, dietary, pastoral, bereavement counseling, DME, medical supplies and administration of medication.

Specialty Provider Individual and/or group (Non-MD or DO) shall be reimbursed in accordance with Regulatory Requirements for the applicable methodology based on the referenced fee schedule.

Specialty Provider Individual and/or group (including Non-MD or DO) shall be reimbursed for anesthesiology services in accordance with the accumulation of base, modifier and time units multiplied by the Washington State Medicaid Anesthesia Conversion Factor. The services should be billed in minute increments. One time unit will be allowed for each fifteen (15) minute interval, or fraction thereof, starting from the time Provider begins to prepare the Member for induction and ending when the Member may safely be placed under post-operative supervision and Provider is no longer in personal attendance.

"Ambulatory Patient Group" ("APG") means the [redacted] Rate that is a fixed reimbursement to a facility for Outpatient Services and which incorporates data regarding the reason for the visit and patient data.

"Ambulatory Payment Classification" ("APC") or its successor shall have the meaning set forth in the Medicare law and CMS regulations and guidance.

'[redacted] Reference Laboratory Fee Schedule" means the [redacted] Rate that is the [redacted] Reference Laboratory Fee Schedule that is based on the Medicare Fee Schedule and may contain additional CPT/HCPCS codes. [redacted] Reference Laboratory Fee Schedule and/or rate changes will be applied on a prospective basis.

"[redacted] Medicaid Rate(s)/Fee Schedule(s)/Methodologies" means the [redacted] Medicaid Rate(s)/Fee Schedule(s)/ in effect on the date of service for the provider type(s)/service(s) identified herein for the applicable Medicaid Program(s).

"CMS Outpatient Prospective Payment System" ("OPPS") shall have the meaning set forth in Medicare law and CMS regulations and guidance.

"Medical Care Management Rate" means the amount paid by [redacted] to Provider on a per member per month basis for facilitation of collaborative programs meant to manage medical/social/mental health conditions more effectively.

"Medicare Fee Schedule" means the applicable Medicare Fee Schedule for the provider type(s) identified herein, including payment conversion factor, where applicable, and in effect on the date of the service is initiated to Members. Medicare Fee Schedule and/or rate changes will be applied on a prospective basis.

"Medicare LUPA National Base Rate" means the Medicare LUPA ("Low Utilization Payment Adjustment") National Base rate in effect as of the date of service for the market(s) and program(s) covered by the Agreement at the time the Covered Services are initiated to the Member. Medicare LUPA National Base Rate changes will be applied on a prospective basis.

"Medicare Part B Drug Average Sales Price ("ASP") Fee Schedule" means the Medicare Part B Drug Average Sales Price ("ASP") Fee Schedule (or successor) in effect as of the date of service for the market(s) and programs covered by the Agreement at the time the Covered Services is initiated to the Member. Medicare Part B Drug Average Sales Price ("ASP") Fee Schedule and/or rate changes will be applied on a prospective basis.

"Washington State Medicaid Rate(s)/Fee Schedule(s)/Methodologies" means the Washington State Medicaid Rate(s)/Fee Schedule(s)/ in effect on the date of service for the provider type(s)/service(s) identified herein for the applicable Medicaid Program(s).

PLAN COMPENSATION SCHEDULE ("PCS") ATTACHMENT

MEDICAID

For purposes of determining the [redacted] Rate, the total reimbursement amount that Provider and [redacted] have agreed upon for the applicable provider type(s) for Covered Services provided under this Agreement in effect on the date of service shall be as set forth below.

Program: [redacted] Medicaid Network			
Specialty Physician Group			
Service Description	**Billing Code**	**Rate/ Methodology**	**Rate Description**
Professional Services	Applicable CPT/HCPCS Code	108% of the Washington State Medicaid Fee Schedule	Per Service

[redacted] shall not compensate Provider for collection of specimens (including venipuncture), lab handling, or stat services, which [redacted] considers components of the laboratory test. In addition, [redacted] shall not compensate Provider for services not described by codes contained in the [redacted] Reference Laboratory Fee Schedule.

[redacted] shall update rates for codes from the Medicare schedules according to the provisions of the "Updates to Rates Based on External Sources" provision of the PCS.

[redacted] shall notify Provider in writing at least sixty (60) days before significant [redacted] initiated changes to the Reference Laboratory Fee Schedule. Provider shall notify [redacted] in writing within thirty (30) days of receiving the notice and if Provider objects to such changes both parties agree to discuss the objections. In any event, [redacted] may implement the changes sixty (60) days after notifying Provider. Notwithstanding the foregoing, all [redacted] Rate updates made pursuant to an External Source shall be governed by the "Updates to [redacted] Rate(s) Based on External Sources" provision of the PCS.

Medicaid Affiliate Services. Provider acknowledges that [redacted] is affiliated with health plans that offer similar benefits under similar programs as the programs covered hereunder ("Medicaid Affiliates"). The parties acknowledge that Provider is not a Participating Provider in Medicaid Affiliate's Network for purposes of rendering services to Medicaid Members. However, in the event Provider treats a Medicaid Member of a Medicaid Affiliate, subject to Regulatory Requirements, Provider shall accept as payment in full the rates established by the Medicaid Affiliate's state program governing care to Medicaid Members. Such services must be Medicaid Covered Services under the Medicaid Affiliate's state program, and shall require prior authorization, except for Emergency Services and services for which a Medicaid Member is entitled to self-refer. Upon request, [redacted] shall coordinate and provide information as necessary between Provider and Medicaid Affiliate for services rendered to Medicaid Member.

Reimbursement Specific to Provider Type

The following will be reimbursed for facility services only: Acute Care Hospital, ASC, Behavioral Health Facility, Free Standing Birthing Center, Rehabilitation Facility and SNF. Professional services are excluded.

Ambulance Provider Air and/or Ground shall be reimbursed in accordance with Regulatory Requirements for the applicable methodology based on the referenced fee schedule. If such reimbursement is based on an [redacted] Rate, the applicable state methodology on which such fee schedule is based, shall be used to determine the appropriate level of reimbursement.

Hospice reimbursement is inclusive of skilled nursing, home health aide, medical social worker services, dietary, pastoral, bereavement counseling, DME, medical supplies and administration of medication.

Specialty Provider Individual and/or group (Non-MD or DO) shall be reimbursed in accordance with Regulatory Requirements for the applicable methodology based on the referenced fee schedule.

Specialty Provider Individual and/or group (including Non-MD or DO) shall be reimbursed for anesthesiology services in accordance with the accumulation of base, modifier and time units multiplied by the Washington State Medicaid Anesthesia Conversion Factor. The services should be billed in minute increments. One time unit will be allowed for each fifteen (15) minute interval, or fraction thereof, starting from the time Provider begins to prepare the Member for induction and ending when the Member may safely be placed under post-operative supervision and Provider is no longer in personal attendance.

"Ambulatory Patient Group" ("APG") means the [redacted] Rate that is a fixed reimbursement to a facility for Outpatient Services and which incorporates data regarding the reason for the visit and patient data.

"Ambulatory Payment Classification" ("APC") or its successor shall have the meaning set forth in the Medicare law and CMS regulations and guidance.

'[redacted] DMEPOS and PEN Fee Schedule" means the applicable [redacted] DMEPOS and PEN Fee Schedule for the market(s) and program(s) covered by the Agreement. The parties acknowledge and agree that the [redacted] DMEPOS and PEN Fee Schedule is subject to modification by [redacted] at any time during the term of the Agreement. [redacted] DMEPOS and PEN Fee Schedule and/or rate changes will be applied on a prospective basis.

'[redacted] Reference Laboratory Fee Schedule" means the [redacted] Rate that is the [redacted] Reference Laboratory Fee Schedule that is based on the Medicare Fee Schedule and may contain additional CPT/HCPCS codes. [redacted] Reference Laboratory Fee Schedule and/or rate changes will be applied on a prospective basis. The [redacted] Reference Laboratory Fee Schedule contains all codes from the Medicare Clinical Laboratory Fee Schedule, pathology codes from the Medicare Physician Fee Schedule, and additional codes added by Plan.

'[redacted] Medicaid Rate(s)/Fee Schedule(s)/Methodologies" means the [redacted] Medicaid Rate(s)/Fee Schedule(s)/ in effect on the date of service for the provider type(s)/service(s) identified herein for the applicable Medicaid Program(s).

"CMS Outpatient Prospective Payment System" ("OPPS") shall have the meaning set forth in Medicare law and CMS regulations and guidance.

"Medical Care Management Rate" means the amount paid by [redacted] to Provider on a per member per month basis for facilitation of collaborative programs meant to manage medical/social/mental health conditions more effectively.

"Medicare Fee Schedule" means the applicable Medicare Fee Schedule for the provider type(s) identified herein, including payment conversion factor, where applicable, and in effect on the date of the service is initiated to Members. Medicare Fee Schedule and/or rate changes will be applied on a prospective basis.

"Medicare LUPA National Base Rate" means the Medicare LUPA ("Low Utilization Payment Adjustment") National Base rate in effect as of the date of service for the market(s) and program(s) covered by the Agreement at the time the Covered Services are initiated to the Member. Medicare LUPA National Base Rate changes will be applied on a prospective basis.

"Medicare Part B Drug Average Sales Price ("ASP") Fee Schedule" means the Medicare Part B Drug Average Sales Price ("ASP") Fee Schedule (or successor) in effect as of the date of service for the market(s) and programs covered by the Agreement at the time the Covered Services is initiated to the Member. Medicare Part B Drug Average Sales Price ("ASP") Fee Schedule and/or rate changes will be applied on a prospective basis.

"Washington State Medicaid Rate(s)/Fee Schedule(s)/Methodologies" means the Washington State Medicaid Rate(s)/Fee Schedule(s)/ in effect on the date of service for the provider type(s)/service(s) identified herein for the applicable Medicaid Program(s).

PLAN COMPENSATION SCHEDULE ("PCS") ATTACHMENT

MEDICARE ADVANTAGE

For Covered Services furnished by or on behalf of Provider for a Member enrolled in a Medicare Advantage Network, Provider agrees to accept an amount that is the [redacted] Medicare Advantage Rate, minus applicable Cost Shares, and modified before payment as described below. Provider agrees that this amount, plus applicable Cost Shares, is full compensation for Covered Services.

The "[redacted] Medicare Advantage Rate" is the amount calculated based on the rate or methodology stated below for each service, adjusted as described in the notes, and multiplied by the stated percentage.

Program: Medicare Advantage [redacted] Hospital ([redacted]			
Service Description	**Billing Code**	**Rate/ Methodology**	**Rate Description**
Inpatient Services	Applicable Revenue Codes	Rate from CMS Medicare Administrative Contractor letter multiplied by one hundred eight percent (108%)	Per Diem
Inpatient Skilled Nursing Services (Swing Bed)	Type of Bill 18x with Applicable Revenue Codes	Rate from CMS Medicare Administrative Contractor letter multiplied by one hundred percent (100%)	Per Diem
Outpatient Services	Applicable Revenue Codes with Applicable CPT/HCPCS Codes	Rate from CMS Medicare Administrative Contractor letter multiplied by one hundred eight percent (108%)	Per Service
Professional and Technical Services - Outpatient Method II	Rev Code: 96x, 97x, 98x	Medicare Drug Fee Schedule multiplied by one hundred fifteen percent (115%)	Per Service
Professional Services for Anesthesia - Outpatient Method II	Rev Code: 96x, 97x, 98x	Medicare anesthesia conversion factor, Medicare time units, and Medicare base units, multiplied by one hundred fifteen percent (115%)	Per Unit

Provider shall furnish Plan with a CMS Medicare Administrative Contractor letter at least once every twelve (12) months, within thirty (30) days of the date it receives the letter from its Medicare Administrative Contractor.

Plan shall apply new per diems, percent of charge, and per visit rates to dates of service no later than sixty (60) days after the date it receives the letter from the Provider or the Medicare effective date, whichever is later. Plan shall not adjust Provider's compensation retroactively.

When determining the amount payable to Provider, any reimbursement terms in this Agreement that are based, in whole or in part, on Medicare rates, pricing, fee schedules, or methodologies published or established by CMS, shall refer to the per claim payment amounts that CMS and a Medicare beneficiary would directly pay to Provider for the same items or services under original Medicare Part A or Part B. The amount payable to Provider shall not include any bonus payment or settlement amount paid to Provider by CMS outside of the Medicare per claim payment process, unless otherwise set forth in the Medicare Advantage reimbursement terms of this Agreement. Unless [redacted] notifies Provider otherwise, in the event CMS changes payment to Provider due to a CMS directive, Act of Congress, Executive Order, other governmental pronouncement, or Regulatory Requirement, the amount payable to Provider hereunder will automatically be changed as soon as reasonably practicable, as described herein, 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 changed by CMS to Provider.

Plan shall not compensate Provider for the bad debts of its Medicare Advantage members.

Plan and Provider shall consider Medicare interim amounts, including but not limited to, indirect medical education, disproportionate share, outliers, per diems, percent of charge, and all-inclusive rates, as final and Plan shall not adjust Provider's compensation through a settlement, even if Medicare adjusts its compensation to Provider based on a settlement.

Plan shall compensate Provider using the relevant payment system logic and data (for example: calculations, payment groupings, or federal and provider-specific factors) that are available in Plan's systems at the time Plan processes the Provider's Claim. Plan shall not retroactively adjust Provider's compensation for previously processed Claims to reconcile any difference with the payment system logic and data being used by Medicare on the same processing date for the same date of service. In addition, Plan shall not retroactively adjust Provider's compensation for previously processed claims to reflect Medicare's retroactive updates or changes to payment system logic and data. Provider shall not request adjustments solely based on these differences, updates, or changes. However, if incorrect rates are loaded and reimbursed by Plan to Provider, Plan shall then retroactively reprocess claims to reflect accurate payment.

PLAN COMPENSATION SCHEDULE ("PCS") ATTACHMENT

MEDICARE ADVANTAGE

For Covered Services furnished by or on behalf of Provider for a Member enrolled in a Medicare Advantage Network, Provider agrees to accept an amount that is the [redacted] Medicare Advantage Rate, minus applicable Cost Shares, and modified before payment as described below. Provider agrees that this amount, plus applicable Cost Shares, is full compensation for Covered Services.

The "[redacted] Medicare Advantage Rate" is the amount calculated based on the rate or methodology stated below for each service, adjusted as described in the notes, and multiplied by the stated percentage.

Program: Medicare Advantage			
[redacted]			
Service Description	**Billing Code**	**Rate/ Methodology**	**Rate Description**
All Services	Applicable CPT/HCPCS Codes	one hundred eight percent (108%) Rate from CMS Medicare Administrative Contractor letter multiplied by one hundred eight percent (108%)	Per Service

When determining the amount payable to Provider, any reimbursement terms in this Agreement that are based, in whole or in part, on Medicare rates, pricing, fee schedules, or methodologies published or established by CMS, shall refer to the per claim payment amounts that CMS and a Medicare beneficiary would directly pay to Provider for the same items or services under original Medicare Part A or Part B. The amount payable to Provider shall not include any bonus payment or settlement amount paid to Provider by CMS outside of the Medicare per claim payment process, unless otherwise set forth in the Medicare Advantage reimbursement terms of this Agreement. Unless [redacted] notifies Provider otherwise, in the event CMS changes payment to Provider due to a CMS directive, Act of Congress, Executive Order, other governmental pronouncement, or Regulatory Requirement, the amount payable to Provider hereunder will automatically be changed as soon as reasonably practicable, as described herein, 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 changed by CMS to Provider.

Plan shall not compensate Provider for the bad debts of its Medicare Advantage members.

Plan and Provider shall consider Medicare interim amounts, including but not limited to, indirect medical education, disproportionate share, outliers, per diems, percent of charge, and all-inclusive rates, as final and Plan shall not adjust Provider's compensation through a settlement, even if Medicare adjusts its compensation to Provider based on a settlement.

Plan shall compensate Provider using the relevant payment system logic and data (for example: calculations, payment groupings, or federal and provider-specific factors) that are available in Plan's systems at the time Plan processes the Provider's Claim. Plan shall not retroactively adjust Provider's compensation for previously processed Claims to reconcile any difference with the payment system logic and data being used by Medicare on the same processing date for the same date of service. In addition, Plan shall not retroactively adjust Provider's compensation for previously processed claims to reflect Medicare's retroactive updates or changes to payment system logic and data. Provider shall not request adjustments solely based on these differences, updates, or changes. However, if incorrect rates are loaded and reimbursed by Plan to Provider, Plan shall then retroactively reprocess claims to reflect accurate payment.

PLAN COMPENSATION SCHEDULE ("PCS") ATTACHMENT

MEDICARE ADVANTAGE

For Covered Services furnished by or on behalf of Provider for a Member enrolled in a Medicare Advantage Network, Provider agrees to accept an amount that is the [redacted] Medicare Advantage Rate, minus applicable Cost Shares, and modified before payment as described below. Provider agrees that this amount, plus applicable Cost Shares, is full compensation for Covered Services.

The '[redacted] Medicare Advantage Rate" is the amount calculated based on the rate or methodology stated below for each service, adjusted as described in the notes, and multiplied by the stated percentage.

Program: Medicare Advantage Specialty Physician Group			
Service Description	**Billing Code**	**Rate/ Methodology**	**Rate Description**
Professional and Technical Services	Applicable CPT/HCPCS Codes	Medicare Physician Fee Schedule multiplied by one hundred eight percent (108%)	Per Service
Part B Drugs and Biologicals	Applicable CPT/HCPCS Codes	Medicare Drug Fee Schedule multiplied by one hundred percent (100%)	Per Service
Laboratory Services	Applicable CPT/HCPCS Codes	Medicare Clinical Laboratory Fee Schedule multiplied by forty five percent (45%)	Per Service
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies	Applicable CPT/HCPCS Codes	Medicare Durable Medical Equipment, Prosthetics/Orthotics, and Supplies Fee Schedule multiplied by sixty five percent (65%)	Per Service
Professional Services for Anesthesia	Applicable CPT/HCPCS Codes	one hundred percent (100%) Medicare anesthesia conversion factor, Medicare time units, and Medicare base units, multiplied by one hundred percent (100%)	Per Unit

Plan shall compensate non-physician Primary Care Providers and Specialty Provider Individuals based on Medicare's percentage adjustments to the Medicare Physician Fee Schedule for each type of Provider.

When determining the amount payable to Provider, any reimbursement terms in this Agreement that are based, in whole or in part, on Medicare rates, pricing, fee schedules, or methodologies published or established by CMS, shall refer to the per claim payment amounts that CMS and a Medicare beneficiary would directly pay to Provider for the same items or services under original Medicare Part A or Part B. The amount payable to Provider shall not include any bonus payment or settlement amount paid to Provider by CMS outside of the Medicare per claim payment process, unless otherwise set forth in the Medicare Advantage reimbursement terms of this Agreement. Unless [redacted] notifies Provider otherwise, in the event CMS changes payment to Provider due to a CMS directive, Act of Congress, Executive Order, other governmental pronouncement, or Regulatory Requirement, the amount payable to Provider hereunder will automatically be changed as soon as reasonably practicable, as described herein, 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 changed by CMS to Provider.

Plan shall not compensate Provider for the bad debts of its Medicare Advantage members.

Plan and Provider shall consider Medicare interim amounts, including but not limited to, indirect medical education, disproportionate share, outliers, per diems, percent of charge, and all-inclusive rates, as final and Plan shall not adjust Provider's compensation through a settlement, even if Medicare adjusts its compensation to Provider based on a settlement.

Plan shall compensate Provider using the relevant payment system logic and data (for example: calculations, payment groupings, or federal and provider-specific factors) that are available in Plan's systems at the time Plan processes the Provider's Claim. Plan shall not retroactively adjust Provider's compensation for previously processed Claims to reconcile any difference with the payment system logic and data being used by Medicare on the same processing date for the same date of service. In addition, Plan shall not retroactively adjust Provider's compensation for previously processed claims to reflect Medicare's retroactive updates or changes to payment system logic and data. Provider shall not request adjustments solely based on these differences, updates, or changes. However, if incorrect rates are loaded and reimbursed by Plan to Provider, Plan shall then retroactively reprocess claims to reflect accurate payment.