First Choice Health Network
Preferred Provider/Group Agreement

This Agreement is entered into between First Choice Health Network, Inc., a Washington corporation, ("FCHN, Inc.") and First Choice Health Network of Oregon, Inc., an Oregon corporation, ("FCHN, Oregon") on one hand, and (hereinafter "Provider") on the other hand. The effective date of this Agreement is ("Effective Date").

FCHN, Inc. and FCHN, Oregon is collectively referred to herein as "FCHN".

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

1. DEFINITIONS

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

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

1.3 Clean Claim means a claim that has no defect or impropriety, including any lack of any required substantiating documentation or particular circumstances requiring special treatment that prevents timely payments from being made on the claim.

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

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

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

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

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

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

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

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

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

Medical Necessity alone does not determine coverage.

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

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

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

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

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

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

1.18 **Specialist Provider** means a Participating Provider who is an allopathic or osteopathic physician or other licensed healthcare provider who (i) practices in a particular specialty, (ii) is either Board certified or obtains Board certification within five (5) years after completing residency training, (iii) meets FCHN's credentialing standards, and (iv) under the terms of this Agreement, agrees to provide Covered Services to Participants within the scope of his or her license.
1.19 **Urgent Services** means Covered Services provided when a Participant not residing in FCHN’s Service Area is temporarily absent from his or her area of residence and (i) such services are Medically Necessary and immediately required as a result of unforeseen illness, injury, or condition, and (ii) it was not reasonable given the circumstances for the Participant to obtain the services through a provider network in the Participant’s area of residence.

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

2. **RESPONSIBILITIES OF PROVIDER**

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

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

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

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

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

2.5 **Benefit Plan**
Provider hereby authorizes Payors contracting with FCHN to offer Provider’s services to groups of employees or individuals in accordance with the provisions of any Benefit Plans offered by such Payors. Nothing in this Agreement
shall have the effect of modifying benefits, terms or conditions contained in a Benefit Plan. In the event of any conflict between this Agreement and a Benefit Plan, the benefits, terms and conditions of the Benefit Plan shall govern with respect to Covered Services provided to Participants in the Benefit Plan. Provider's services are not offered in connection with motor vehicle insurance, personal injury protection, workers compensation, or any other program for the payment of healthcare services that is excluded from the definition of a benefit plan under applicable law.

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

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

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

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

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

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

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

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

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

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

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

The provisions of this Section shall survive expiration or termination of this Agreement.
2.9 Medical Management, Utilization Review and Quality Improvement
Provider agrees to comply with and participate in FCHN’s or Payors’ Medical Management Program, Utilization Review, and quality improvement programs and requirements, credentialing, grievance, appeal and adverse benefit determination procedures, whichever is applicable, which may include but are not limited to, pre-authorization, notification, concurrent review, retrospective review, case management, disease management programs, pharmacy and specialty pharmacy programs, pharmacy benefit substitution process, referral management, quality assurance and improvement programs and Medical Necessity oversight.

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

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

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

2.12 FCHN Provider Policies and Procedures
Providers shall comply with all Provider Policies and Procedures which are electronically accessible to Provider, as updated with sixty (60) days advance notice to Provider, or if applicable, the notice described in Section 3.2 below, including, but not limited to, billing and claims payment, provider credentialing, Participant grievances, appeal and adverse benefit determination procedures, Utilization Review, quality management, data reporting requirements, pharmacy benefit substitution processes, confidentiality requirements and any applicable federal or state requirements. Subject to any continuation of care provisions of this Agreement, Provider may terminate this Agreement in accordance with Section 8.2.1 if Provider does not agree with such updates. In the event that any provision in the Provider Policies and Procedures or any amendment thereto is inconsistent with the terms of this Agreement, the terms of this Agreement shall control.

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

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

2.15 Compliance
Provider agrees to comply with all of the terms of this Agreement, all applicable federal and state laws and regulations, all applicable rules and standards of accrediting agencies having jurisdiction over and designated by FCHN, and as applicable, the ethical standards of the American Medical Association, all of the above as they may be adopted, amended, revised, or renumbered.
2.16 **Provider Group**
Where Provider is a Provider Group, Provider agrees to ensure that the licensed physicians and other healthcare providers comprising the Provider Group are informed of, and agree to comply with and be bound by, the terms of this Agreement.

3. **RESPONSIBILITIES OF FCHN**

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

3.2 **Provider Relations**
FCHN shall provide Provider with certain administrative support including, but not limited to Provider orientation and ongoing education. FCHN agrees to furnish Provider electronic access to the FCHN Provider Policies and Procedures setting forth its policies on billing and claims payment, provider credentialing, Participant grievances, appeal and adverse benefit determination procedures, data reporting requirements, pharmacy benefit substitution processes, confidentiality requirements, Utilization Review, quality management, and any applicable federal and state requirements. FCHN shall notify Provider at least sixty (60) days prior to the effective date of changes to policies or procedures that affect Provider compensation or health care service delivery unless changes to federal or state law or regulations make such advance notice impossible, in which case notice shall be provided as soon as possible. Provider may terminate this Agreement pursuant to Section 8.2.1 and subject to continuation of care provisions in Section 8.3 without penalty if Provider does not agree with such changes. FCHN shall review and give consideration to any Provider comments received prior to the effective date of any change.

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

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

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

3.5 **Eligibility**
FCHN shall require all Payors contracting with it to provide timely information on a Participant’s eligibility for Covered Services, including any limitations or conditions on services or benefits, upon request by Provider. FCHN shall require that during ordinary business hours, FCHN Payors shall assure reasonable access, through standard means of communication, or with respect to Payors doing business in Oregon, using electronic transactions as required by applicable law, for the confirmation that services are Covered Services and a Participant is eligible under a Benefit Plan.
3.6 Provider's Right to Inform Patients
FCHN may not and FCHN shall require all Payors contracting with it to not in any way preclude or discourage Provider from informing Participants of the care they require, including various treatment options, and whether in Provider's view such care is consistent with Medical Necessity, medical appropriateness, or otherwise covered by the Participant's Benefit Plan, nor prohibit, discourage, or penalize a Provider otherwise practicing in compliance with the law from advocating on behalf of a Participant with FCHN or a Payor. Nothing in this Agreement shall be construed to authorize Provider to bind FCHN or its Payors to pay for any services.

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

3.7 Provider's Right to Report to Federal or State Authorities
FCHN shall not and FCHN shall require all Payors contracting with it to not penalize a Participating Provider because the Provider, in good faith, reports to State or Federal authorities any act or practice by FCHN or its Payors that jeopardizes patient health or welfare, or that may violate State or Federal law.

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

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

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

Provider is obligated to accept any individual as a Participant:

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

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

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

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

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

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

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

4.1.2 Payors are not required by FCHN to pay a claim if FCHN or the Payor receives the claim more than three-hundred-sixty-five (365) calendar days after the date the Covered Service was rendered, or sixty (60) calendar days after Provider first receives notice that Payor is a secondary payor under applicable coordination of benefits procedures, whichever shall be later.

4.1.3 Provider may submit, within the timely filing period described in Section 4.1.2 above, corrections to claims that were submitted with incomplete or invalid information. Incomplete means that information was missing from the claim, and invalid means that the information submitted was illogical, incorrect, or did not conform to the required claim format. Payors are not required by FCHN to pay corrected claims received by FCHN or any Payor more than three hundred sixty-five (365) calendar days after the date the Covered Service was rendered, or sixty (60) calendar days after Provider first receives notice that Payor is a secondary payor under applicable coordination of benefits procedures, whichever shall be later.

4.1.4 Provider agrees that requests for adjustments to claims that have been paid or denied, where the claim submittal failed to include a particular item or service or was otherwise in error, must be received by Payors within three hundred sixty-five (365) calendar days after the date the claim was denied or an initial payment was made for the claim. Payors are not required by FCHN to make payments for claims adjustment requests received after such time. Provider shall be under no obligation to refund incorrect claims payments requested by Payors or FCHN more than three hundred sixty-five (365) calendar days after the date an initial payment was made for the claim.

4.2 Payment of Claims
FCHN shall require all Payors to pay Provider pursuant to Schedule B of this Agreement in accordance with the applicable Benefit Plan, as soon as practical, subject to the following minimum standards:

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

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

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

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

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

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

4.3 Coordination of Benefits and Third Party Liability
Provider agrees to cooperate with Payors’ coordination of benefits (COB) and third party liability policies and programs.

When Payor’s Benefit Plan is primary, Provider shall accept payment of the amount for the Covered Services on the FCHN fee schedule set forth in Schedule B to this Agreement as payment in full from Payor, subject to Provider’s right to collect Co-payments, Deductibles, Coinsurance and payments for non-covered services from the Participant. When Payor’s Benefit Plan is secondary, Provider shall first look to and promptly bill and take reasonable steps to collect payment from the primary plan. Provider may seek additional payment from a Payor whose Benefit Plan is secondary in accordance with this Agreement and applicable laws regarding COB; provided however that in no event shall a Payor be obligated to pay more than 100 percent of the amount on FCHN fee schedule set forth in Schedule B to this Agreement and in no event shall Provider be entitled to total compensation exceeding 100 percent of its billed charges.

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

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

5. MAINTENANCE OF RECORDS, INSPECTION AND AUDIT

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

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

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

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

5.3 External Audits
Both parties agree to cooperate with any external audits mandated by state or federal law, and shall make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating
complaints, grievances, appeals, or review of any adverse benefit determinations of Participants, subject to applicable state and federal laws related to the confidentiality of medical records. Both parties shall cooperate with review of encounter data in relation to the administration of Payor risk adjustment and reinsurance programs if applicable.

5.4 Claims Audit
Provider agrees that Payor will have the right to audit Provider's claims for Medical Necessity and/or review of Covered Services billed, including documentation and coding of such services. FCHN will require that Payor's access to medical records for audit purposes must be limited to only that necessary to perform the audit. Provider shall have claims audit rights that are reciprocal to Payor's claims audit rights. FCHN will require that the auditing Payor agree to be responsible for reimbursing Provider for any reasonable expenses incurred for an on-site audit. In all cases, FCHN will make commercially reasonable best efforts to facilitate the timely resolution of Payor audits as described in sections 5.4.1 through 5.4.3.

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

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

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

6. CONFIDENTIAL AND PROPRIETARY INFORMATION

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

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

6.2 Participant Health Information
FCHN and Provider acknowledge that as a result of this Agreement, each party may have access to and receive from one another, individually identifiable health information ("Health Information") as that term is defined under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and applicable state law. Each party to this Agreement shall ensure that it and its personnel maintain confidentiality of all patient records, charts and other patient identifying information in accordance with HIPAA and applicable state law, and that it and its personnel implement and use appropriate safeguards to prevent any unauthorized use or unlawful disclosure of Protected Health Information ("PHI"), take appropriate action to ensure that other persons appropriately safeguard and use
6.3 Effect of Termination
FCHN and Provider understand and agree that the requirements of this Section 6 shall survive the expiration or termination of this Agreement.

7. INDEMNIFICATION

To the extent consistent with applicable state law, FCHN and Provider (each an “Indemnifying Party”) shall defend, indemnify, and hold the other party and its officers, directors, shareholders, members, employees, and agents (the “Indemnified Party”) harmless from and against any and all liabilities and losses, together with any costs and expenses, including, but not limited to reasonable attorney’s fees and costs (collectively, “Damages”) arising from claims asserted by a third party as a result of the Indemnifying Party’s, or its officers’, directors’, shareholders’, members’, employees’, or agents’ actual or alleged (i) negligent acts or omissions, (ii) intentional or wrongful acts or omissions, or (iii) breach or failure of performance under this Agreement. To the extent consistent with applicable state law, Damages shall not include any amount resulting from the Indemnified Party’s (i) negligent acts or omissions, (ii) intentional or wrongful acts or omissions, or (iii) breach or failure of performance under this Agreement. The indemnification obligations set forth in this Section 7 shall survive the expiration or termination of this Agreement.

8. TERM AND TERMINATION

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

8.2 Termination

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

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

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

8.3 Effect of Termination – Continuation of Care
This Agreement shall be of no further force or effect as of the effective date of termination except that:
8.3.1 FCHN shall require that Payors pay to Provider any payments accrued to Provider for Covered Services rendered prior to the effective date of termination and properly billed to Payors within the time required under this Agreement.

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

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

8.3.4 FCHN shall require Payor to cover Covered Services of a Primary Care Provider whose agreement with FCHN is terminated by FCHN without cause under the terms of this Agreement for at least sixty (60) days following notice of termination to the Participants or, in group coverage arrangements involving periods of open enrollment, only until the end of the next open enrollment period. The Provider's relationship with FCHN or Payor must be continued on the same terms and conditions as those of the agreement FCHN is terminating, except for any provision requiring that Payor assign new enrollees to the terminated Provider.

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

9. DISPUTE RESOLUTION

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

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

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

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

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

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

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

9.3 No Effect on Right of Termination
The provisions of this Section 9 shall not affect either party’s right to terminate this Agreement as provided for under Section 8.2 of this Agreement.

10. GENERAL PROVISIONS

10.1 State Regulated Payors. With respect to any Payor that is subject to the state insurance laws and regulations, the provisions set forth in Schedule C, attached hereto and incorporated into this Agreement, are fully operative and applicable to FCHN, Provider, and the respective Payors. In the event of any conflict between the provisions set forth in Schedule C and the other terms of this Agreement, Schedule C shall have priority. If Provider provides Covered Services to Participants enrolled in Benefit Plans offered or administered by Payors subject to state insurance laws and regulations of states other than as referenced in Schedule C, the corresponding specific state Schedules posted on the FCHN website or otherwise made available to Provider are added to the Agreement and apply to Provider with respect to such Payors, and Provider agrees to comply with the applicable Schedules.
10.2 Amendments to Comply with Law
In the event that either party to this Agreement in good faith and upon advice of legal counsel determines that this Agreement or any practices which are or could be employed in performing under this Agreement are inconsistent with or do not satisfy the requirements of any applicable state or federal laws or regulations, the parties in good faith shall undertake to amend this Agreement to comply with such laws and regulations. In the event the parties are not able to agree upon the revised terms in a timely manner, either party may terminate this Agreement immediately by giving written notice of termination to the other.

10.3 Independent Contractors
Each party to this Agreement shall be acting as an independent contractor. Provider shall not be construed to be an employee of FCHN and will at all times be acting and performing hereunder as an independent contractor practicing the profession of medicine or the providing other licensed healthcare services. None of the provisions of this Agreement are intended to create nor shall they be deemed or construed to create a partnership or joint venture, or any relationship between the parties hereto other than that of independent entities contracting with each other solely for the purpose of effecting the provisions of this Agreement. Neither party shall, by entering into this Agreement, authorize the other party to act as a general or special agent of such other party in any respect, except as expressly set forth in this Agreement, and neither party shall become liable for any of the obligations or debts of the other. Provider is not entitled to any of FCHN’s employment benefits, such as vacation, sick leave with pay, paid days off, health insurance, life insurance, accident insurance, or severance pay during or upon termination of this Agreement.

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

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

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

10.7 Entire Agreement
This Agreement, including the attachments hereto and any documents incorporated herein by reference, constitutes the entire agreement between the parties with respect to the subject matter of this Agreement and supersedes all prior arrangements and negotiations between the parties, written or oral, express or implied.
10.8 Waiver
Neither the failure nor delay on the part of either party to exercise any right under this Agreement shall serve as a waiver of that right. A waiver of any provision of this Agreement must be in writing and signed by the party making such waiver. If either party should waive a breach of any provision of this Agreement, it shall not be deemed or construed as a waiver of any other breach of the same or different provision.

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

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

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

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

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

10.14 Attorneys’ Fees
Except as otherwise set forth in Section 9 of this Agreement, in any suit, action, or proceeding between the parties relating to or arising from this Agreement, the prevailing party shall be entitled to recover reasonable attorneys’ fees, costs, and other expenses, including fees and expenses incurred on any appeal and in any bankruptcy proceeding, in addition to whatever other relief may be awarded.
IN WITNESS WHEREOF, the parties have caused this Agreement to be executed by their authorized representatives as of the date first set forth above.

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

Signature:                      Signature:
Title: President & CEO          Title:

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

Signature:                      Signature:
Title: President & CEO          Title:

BOARD OF COUNTY COMMISSIONERS
PACIFIC COUNTY, WASHINGTON

______________________________
Frank Wolfe, Chair

______________________________
Lisa Olsen, Commissioner

______________________________
Mike Runyon, Commissioner

ATTEST

______________________________
Marie Guernsey                      Date
Clerk of the Board