First Choice Health™
Healthy Employees. Healthy Companies.™

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The First Choice Health PPO Network

Preferred Provider/Group Agreement

This is an agreement entered into between First Choice Health Network, Inc., a Washington corporation, and Healthcare Direct, Inc., a wholly owned subsidiary, (hereinafter "FCHN") and_____ (hereinafter "Provider"). The effective date of this agreement is the 1st day of _____ 200____

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

1. DEFINITIONS

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

1.2 Benefit Plan means a program offered by or administered by a Payor for the payment of Covered Services provided to an eligible Participant. Benefit Plans may be insured or self-insured, and shall not include discount card 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 required substantiating documentation including, but not limited to coordination of benefits information, 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 for which a Participant is eligible to receive under the Participant's Benefit Plan. Covered Services is further defined as services for which a Provider is entitled to receive payment pursuant to the terms this Agreement and for which benefits have not been exhausted

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

1.8 Emergency Medical Condition means the emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to

believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the Participant's health in serious jeopardy.

1.9 Emergency Services means covered inpatient or outpatient health care services that are (1) furnished by a provider qualified to furnish emergency services; and (2) needed to evaluate or stabilize an emergency medical condition.

1.10 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.

1.11 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.

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

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

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

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

1.15 Payor means employers, insurance companies, associations, trusts, third-party administrators (TPA) and any other legal entity which has an obligation to administer and pay for Covered Services provided to a Participant under a Benefit Plan.

1.16 Primary Care Provider ("PCP") means an allopathic or osteopathic physician or ARNP, 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.

1.17 Provider Group means a clinic or group of health care professionals, which are licensed and/or certified under applicable federal and/or state laws, which bill as one entity, and which has contracted with FCHN to provide Covered Services to Participants.

1.18 Provider Manual means a document prepared by FCHN which sets forth the FCHN's and Payor's policies and procedures including, but not limited to, billing and claims payment, provider credentialing, participant grievances, utilization review, and quality management.

1.19 Specialist Provider means an allopathic or osteopathic physician or ARNP, whose practice is limited to a particular specialty and is either board certified or board eligible and 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.

1.20 Urgent Services mean Covered Services provided when a Participant not residing in FCHN's Service Area is temporarily absent from his/her area of residence and such services are medically necessary and immediately required: (a) as a result of unforeseen illness, injury, or condition; and (b) 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.

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 policies and procedures set forth in FCHN's Provider Manual. Except in the case of emergency, Provider agrees to verify each Participant's eligibility prior to providing Covered Services.

Provider agrees to furnish Covered Services to Participant on the same basis as such services are made available to individuals who are not Participants, and without regard to the Participant's enrollment in FCHN as a private purchaser or as a participant in publicly financed programs of health care services. In providing services under this Agreement, Provider shall exercise the degree of care, skill and knowledge expected of a prudent health care provider. Provider 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. Emergency Services shall be available and accessible within the referral network on a twenty-four (24) hour, seven-day a week basis. Provider shall ensure that Provider arranges for appropriate call schedules in the event Participants are unable to contact their Participating Provider.

2.3 Primary Care Providers (PCP's)

For Participant's enrolled in gatekeeper products, PCP's are intended to be the patient's first source of care. Primary care providers are required to comply with any applicable Utilization Management and Quality Improvement programs as outlines in Section 2.9. Some Participant benefit contracts require the PCP to facilitate medically necessary specialist referrals via an approved process.

2.4 Specialist Providers

Specialist Providers shall adhere to the degree of responsibility requested by the referring FCHN PCP. For Participants enrolled in gatekeeper products, the Specialist shall also communicate to the referring PCP regarding Participant's evaluation and treatment plan. Specialists are required to comply with any applicable Utilization Management and Quality Improvement programs as described in Section 2.9. The primary care provider, in conjunction with the specialist, shall decide whether follow-up care shall be provided by himself/herself or through continued specialty referral.

2.5 Emergency Services

Provider shall provide Participant access to Emergency Services without a referral or prior approval from FCHN. Provider shall notify FCHN or Payor of the provision of Emergency Services to a Member within twenty-four (24) hours immediately following the provision of such services.

2.6 Benefit Plan Participation

Provider hereby authorizes Payors contracting with FCHN to offer Provider's services to groups of employees or individuals in accordance with the provisions of any Benefit Plans offered by such Payors.

2.7 Licensing Requirements

Provider shall remain in good standing all necessary licenses, certifications and/or registrations required by law permits or other approvals required by State and Federal law to provide or arrange for the provision of covered services to Participants. Provider shall submit evidence of such licenses, permits or other approvals to FCHN upon request.

Provider shall immediately notify FCHN, in writing, of any action against their license, certification, or registration; any change in business address; any legal, governmental, or Board action; any change in clinical privileges; any change in hospital staff privileges; any changes in practice scope; any sanctions or restrictions; any medical or mental health problems that could effect the care of patients; or any other problem or situation which may impair the provider's ability to carry out their responsibilities under this Agreement.

2.8 Insurance

Provider shall provide and maintain, at its sole cost and expense and for the duration of this Agreement, policies of general comprehensive liability and professional liability insurance, or self-insurance, in an amount 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, agents or employees pursuant to the terms of this Agreement. Provider shall notify FCHN immediately but no more than two (2) 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.

2.9 Medical Management and Quality Improvement

Provider agrees to comply with and participate in FCHN's or Payors' medical management/utilization management programs and requirements, whichever is applicable, which may include but are not limited to, pre-authorization, notification, concurrent review, retrospective review, case management, disease management programs, pharmacy and specialty pharmacy programs, referral management, quality assurance and improvement programs and medical necessity oversight.

FCHN SHALL BE RESPONSIBLE FOR ENFORCING PROVIDER CONTRACT PROVISIONS THAT PROHIBIT THE PROVIDER FROM BILLING THE PLAN OR PATIENT FOR NON-MEDICALLY NECESSARY SERVICES UNLESS THESE SERVICES HAVE BEEN SPECIFICALLY DISCLOSED AS POTENTIALLY NON-COVERED TO THE PATIENT AND SPECIFIC WRITTEN CONSENT HAS BEEN OBTAINED.

Provider further agrees to share Participant information as specifically related to these functions. 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 law, in a timely manner to facilitate the Medical Management program.

2.10 Compliance

Provider agrees to comply with all applicable federal and state laws and regulations. Where Payor is a Washington State licensed health care services contractor, HMO or disability carrier, Provider further agrees to comply with the following Washington State Participant hold harmless and continuance of care requirements:

2.10.1 Provider agrees that in no event, including, but not limited to, non-payment by Payor, insolvency, or breach of this contract shall Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against a Participant or person acting on their behalf, other than Payor, for services provided pursuant to this agreement. This provision shall not prohibit collection of deductibles, co-payments, coinsurance, and/or non-covered services, which have not otherwise been paid by a primary or secondary carrier in accordance with regulatory standards for coordination of benefits, from Participants in accordance with the Benefit Plan.

2.10.2 Provider agrees, in the event of Payors' insolvency, to continue to provide the services promised in this contract to Participant for the duration of the period for which premiums on behalf of the Participant were paid to Payor or until the Participant's discharge from in-patient facilities, whichever time is greater.

2.10.3 Providers may not bill the Participant for Covered Services (except for deductibles, co-payments, or coinsurance) where Payor denies payments because the provider has failed to comply with the terms or conditions of this Agreement.

2.10.4 Notwithstanding any other provision of this agreement, nothing in this Agreement shall be construed to modify the rights and benefits contained in the Benefit Plan.

2.10.5 Provider further agrees that these Hold Harmless and Continuation of Care provisions of this Section shall survive termination of this contract regardless of the

cause giving rise to termination and shall be construed to be for the benefit of the Participant, and that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Providers and Participants or persons acting on their behalf.

2.10.6 Provider acknowledges that willfully collecting or attempting to collect an amount from a covered person knowing that collection to be in violation of the participating provider or facility contract constitutes a Class C felony under RCW 48.80.030(5).

2.11 Subcontracts

If Provider subcontracts with any other Provider to provide Covered Services to Participants hereunder, such subcontract must be approved by FCHN prior to its effective date. In addition, any such subcontract must comply with all terms of this Agreement and applicable state law.

2.12 Non-Covered Services/Exclusions

Provider shall provide notice to Participant of their personal financial obligations for non-covered services. Provider may bill a Participant for non-covered services if Provider has, prior to the provision of non-covered services, obtained a written acknowledgment and acceptance of financial responsibility from the Participant after full disclosure of (i) Provider's intent to bill Participant for non-covered services, and (ii) the non-liability of FCHN or Payor for such non-covered services.

2.13 FCHN Provider Manual

Providers shall comply with all policies and procedures set forth in the FCHN Provider Manual, as updated with sixty (60) days advance notice, and including, but not limited to, billing and claims payment, provider credentialing, participant grievances, utilization review, and quality management. Subject to any termination and continuation of care provisions of this Agreement, Provider may terminate this Agreement without penalty if Provider does not agree with such changes. In the event that any provision in these manuals or any amendment thereto, is inconsistent with the terms of this Agreement, the terms of this Agreement shall control.

2.14 Claims Payment

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

2.15 Acceptance of Payment

Provider shall accept payment as outlined in Schedule B. 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 for any service for which benefits are not payable. 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.

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, Claim Submission and Payment, of this Agreement.

3.2 Provider Relations

FCHN shall provide Provider with certain administrative support including, but not limited to Provider orientation and ongoing education. FCHN agrees to furnish Provider with a copy of the FCHN Provider Manual setting forth its policies on billing and claims payment, provider credentialing, participant grievances, utilization review, and quality management. FCHN shall notify Provider at least sixty (60) days prior to the effective date of changes to policies or procedures contained in the Provider Manual that affect Providers compensation or health care service delivery. Subject to any termination and continuation of care provisions of this Agreement, Provider may terminate this Agreement 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 correct such errors when a new directory is published.

Provider shall not advertise or otherwise market their status as Participating Providers without FCHN's prior written approval of the form and content of such advertising or marketing.

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. 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 confirm a Participant's eligiblity for Covered Services upon request by Provider. During ordinary business hours, FCHN Payors, shall assure reasonable access, through standard means of communication, for the confirmation that services are covered and a Participant is eligible under a Benefit Plan. The FCHN Payor may require that an eligibility or coverage confirmation code number is included with any billing.

3.6 Provider's Right to Inform Patients

FCHN shall not in any way preclude or discourage Provider from informing Participants of the care they require, including various treatment options, and whether in their 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 patient with a health carrier. Nothing in this Agreement shall be construed to authorize Provider to bind FCHN or its Payors to pay for any services.

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

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

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

3.8 Participant's Contracting for Services Outside of Benefit Plan

FCHN may not prohibit directly or indirectly its Participants from freely contracting at any time to obtain any health care services outside FCHN on any terms or conditions the Participants choose. Such additional direct contracts shall be documented and make clear that FCHN or its Payors are not liable for the payment of those health care services. Members shall be financially responsible for all additional services resulting from services obtained outside of the Participant's Benefit Plan. Nothing in this provision shall be construed to bind FCHN Payors for any services delivered outside of Participant's Benefit Plan.

3.9 ID Cards

FCHN shall require its Payors to provide each Participant with a membership identification card displaying the First Choice Health or Healthcare Direct name or logo, the Participant's name and identifier, group name and/or number, telephone number to confirm eligibility and benefit verification, any applicable co-pay 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 FCHN Participant:

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

b) where Payor is identified as accessing FCHN PPO Network in the FCHN tools, 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 or Healthcare Direct logo.

3.10 List of Payors

FCHN shall provide Provider with a list of Payors and employer groups at the time of entering into this Agreement. These lists shall be updated quarterly and posted on the FCHN web site.

3.11 Explanation of Benefits

FCHN shall ensure that Payors produce an Explanation of Benefits (EOB) during the claim adjudication process which must, at a minimum, identify: FCHN, total billed charges, allowed amount in accordance with FCHN fee schedules, amount Payor responsible to pay, amount Participant responsible to pay, and explanation for non-payment of a particular code or service must be noted. FCHN Providers may refuse to give the Payor the benefit of FCHN's fee schedule if the EOB does not display minimum data elements and at least one of the following names and/or logos: FCHN, Healthcare Direct, or Beech Street.

4. CLAIMS SUBMISSION AND PAYMENT

4.1 Claims Submission

Provider agrees to submit clean claims for Covered Services rendered to Participants on standard UB-92 and CMS-1500 forms. Completed UB-92 and CMS-1500 forms shall be submitted to the address set forth on the Participant's Benefit Plan identification card. Claims shall be submitted within at least thirty (30) days of the date of the Covered Service rendered. Payor shall be under no obligation to pay a claim if FCHN or any of its Payors receives it more than three-hundred-sixty-five (365) calendar days after the date a Covered Service was rendered, or sixty (60) calendar days after Provider first receives notice that FCHN's Payor is a secondary payor under applicable coordination of benefits procedures, whichever shall be later. Payors shall not be responsible for adjusting claim payments due to under payments or other errors more than three Hundred and sixty five (365) days after initial claim payment was made. Provider is not obligated to refund incorrect payments more than thre-hundred-sixty-five (365) days after initial claims payment was received. Provider further agrees to bill their usual fee for the service rendered and to complete all required patient and procedure information on the claim form. In submitting claims pursuant to this Section, Provider shall certify that all data submitted is accurate and truthful.

4.2 Payment of Claims

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

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

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

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

4.2.4 Claims may be subject to standard claims editing software to detect bundling and unbundling, as well as incorrect billing. Upon request Payor shall inform FCHN of unbundling software and most frequent rebundling issues for FCHN for provider education and training.

Where Payor is a Washington State licensed health care services contractor, HMO, disability carrier, any Payor failing to pay claims within the above stated standards and any standard established by applicable state law or regulation shall pay interest on undenied and unpaid clean claims more than sixty-one days old until the carrier meets these defined standards. Interest shall be assessed at the rate of one percent per month, and shall be calculated monthly as simple interest prorated for any portion of a month. The carrier shall add the interest payable to the amount of the unpaid claim without the necessity of the provider submitting an additional claim. Any interest paid under this section shall not be applied by the

carrier to a Participant's deductible, copayment, coinsurance, or any similar obligation of the Participant.

FCHN is not the guarantor, or in any way responsible to Providers, for any claim payments, including charges and interest due if applicable. FCHN shall meet with Provider as needed to review FCHN Payors and to assist Provider in collecting payments due and owning 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 carrier has not been granted reasonble access to information under the Provider's control.

4.3 Coordination of Benefits and Third Party Liability

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

When Payor is primary, Provider shall accept their FCHN payment rate under 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 is secondary, Provider shall first look to and promptly bill and take reasonable steps to collect payment from the primary carrier. Provider shall look to Payor only for any additional payment, which is in accordance with this Agreement and applicable laws regarding COB.

When self-insured Benefit Plans are secondary, they may only be required to pay up to the primary's allowable depending on the group's Benefit Plan. The provider has the right to request a copy of the Payor's documented COB and third party liability policies and programs.

Under no circumstances shall Payor reimburse Provider any amount greater than as provided for under this Agreement. If Provider has received payment from another carrier or entity 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.

4.4 Overpayment and Underpayment Recoveries

Where Payor is a Washington State licensed health care services contractor, HMO, disability carrier or Self-funded Multiple Employer Welfare Arrangement, Provider further agrees to comply with the following requirements:

4.4.1 Payor may request a refund from Provider for overpayment of a previously paid claim within 24 months after the initial payment was made. Such a request must be in writing and specify why Provider owes the refund. Provider may contest the request in writing to Payor within thirty (30) days of receipt in accordance with Section 9. Dispute Resolution, of this Agreement. Failure by Provider to contest a request within this thirty (30) day period shall result in the request being deemed to have been accepted by Provider as due and owing. Where a request for refund is contested by Provider, Payor may not request that the refund be paid any sooner than six (6) months from the date of Provider's receipt of the request.

4.4.2 Provider may request an additional payment from a Payor on a claim within twenty four (24) months from the date the claim was denied, or payment intended to satisfy

the claim was made by Payor. Such a request must be in writing, specify why Provider believes Payor owes the additional payment, and require that the additional payment not be made any sooner than six (6) months following receipt of the request. Any dispute arising out of such a request shall be handled in accordance with Section 9. Dispute Resolution, of this Agreement.

4.4.3 A request for refund by a Payor, or a request for additional payment by Provider pursuant to this Subsection 4.3 must be made within thirty (30) months after the claim was paid or submitted where coordination of benefits is involved.

4.4.4 "Refund" means the return, either directly or through offset to a future claim, of some or all of a payment already received by the Provider.

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 Payor to perform its obligations under this Agreement. Where documents are requested by FCHN or Payor for audit, accreditation and/or oversight review purposes, FCHN or Payor shall reimburse Provider for reasonable costs incurred in providing copies of requested documents, not to exceed a rate of ten cents ($.10) per page. FCHN or Payor shall not reimburse Provider for copies of documents requested for purposes of payment of claims, resolution of quality of care or service concerns, complaints and/or grievances, or medical management review and coverage determinations.

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

5.2 Record Retention

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

5.3 External Audits

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

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, both parties agree that all information, including Payor information, reimbursement rates and fee schedules, as well as other information identified by either party as confidential or

proprietary, shall not be disclosed without the express prior written consent of the other party. This provision shall not preclude access to such records in order to allow billing and quality assurance review with respect to Covered Services delivered pursuant to this Agreement or access by Payors pursuant to this Agreement. The parties agree that this section shall survive termination of this Agreement. Upon termination of this Agreement, any documents identified by either party, as proprietary shall be returned to the respective party.

6.2 Participant Health Information

6.2.1 The parties acknowledge that as a result of this Agreement, that either party and Payor 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, Section 1171 of Public Law 104-191 ("HIPAA"), and Chapter 70.02 RCW, the Washington State Health Care Information Access and Disclosure of 1991. The parties and Payor agree to maintain the confidentiality of such Health Information, and to not disclose Health Information other than as necessary to carry out the terms and conditions of this Agreement, or as permitted or required by federal or state laws or regulations.

6.2.2 The parties shall implement a documented information and privacy security program that includes administrative, technical and physical safe guards designed to prevent the accidental or otherwise unauthorized use or disclosure of health Information. Such information privacy and security program shall, at a minimum, comply with applicable HIPAA regulations regarding the privacy and security of Health Information by the compliance date for such regulations of April 14, 2003.

6.2.3 To the extent either party, in carrying out its responsibilities under this Agreement, conducts Standard Transaction(s) as that term is defined under HIPAA, that party shall, without limitation, comply with the HIPAA regulations, "Administrative Requirements for Transactions," 45 CFR 162.200 et seq., by the compliance date of October 16, 2003.

6.2.4 Upon termination of this Agreement, at the request of the party that owns Health Information, the other party shall promptly return to the requesting party all Health Information which has been provided to it, or dispose of such Health Information in a manner mutually agreed upon by the parties.

6.3 Effect of Termination

The parties understand that the requirements of this Section 6, shall survive the termination of this Agreement.

7. INDEMNIFICATION

FCHN and Provider shall indemnify and hold the other party harmless from loss, damage, or defense costs (including, but not limited to reasonable attorney's fees) arising from actual or alleged wrongful acts or omissions of the other party, its officers, employees, subcontractors, or other agents in performing services contemplated under this Agreement which are solely the responsibility of either FCHN or Provider. Neither party shall be liable for any liability of the other party, its agents, officers or

employees, whether resulting from judgment, settlement, award fine or otherwise, which arises out of such other party's actions or omissions under this Agreement.

8. TERM AND TERMINATION

8.1 Term of Agreement

This Agreement shall take effect on the date specified on page one (1) and end on December 31 of that year and each successive year shall automatically renew for successive one-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, upon 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 occurrence of any of the events identified in FCHN's Credentialing and Recredentialing Policies and Procedures. Written notice of such action shall be given to Provider by FCHN as provided for in such policies and procedures.

8.2.3 Termination for Cause

Either party may terminate this Agreement for cause by giving the other party thirty (30) days prior written notice. Such notice shall specify the reasons for the termination and shall provide the other party thirty (30) days from the date of receipt of the notice of termination to correct the cause to the satisfaction of the complaining party. Should the cause not be cured within this thirty (30) day period, termination shall occur thirty (30) days from the end of that 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 Any payments accrued to Provider for Covered Services shall be duly paid by Payor.

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 termination date, except for any applicable Deductible, Co-payment or Coinsurance amounts, as specified in Section 2.13.1 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 Payors Medical Director determines that the care of the Participant can be safely transferred to another facility, or (iii) FCHN makes arrangements to transfer the Participant's care to another Participating Provider.

8.4 Notice to Participants

If the Agreement is terminated, FCHN shall require Payor to make a good faith effort to provide written notice of termination to all Participants within fifteen (15) working days of receipt of the notice of termination.

9. DISPUTE RESOLUTION

9.1 Disputes Between Provider and FCHN

9.1.1 Informal Process.

Disputes between Provider and FCHN with regard to performance by either party under this Agreement shall be resolved, to the extent possible, by informal meetings and discussions between the parties. Both Provider and First Choice Health shall communicate directly in an effort to mutually resolve differences regarding payment and medical appropriateness.

9.1.2 Formal Process.

Where Provider or FCHN desire to pursue resolution of a dispute beyond such informal meetings and discussion, either party may provide the other with written notice of the dispute, and requesting a response within thirty (30) of receipt of the notice, or if the dispute involves a billing dispute, within sixty (60) days of receipt of the request. Where the party in receipt of a dispute fails to grant or deny the dispute within thirty (30) days of receipt (or sixty (60) days in the case of a billing dispute), the party requesting such review may proceed as if the dispute has been rejected.

9.1.3 Nonbinding Mediation.

A request for review which has been rejected by either party pursuant to Section 9.1.2 may be submitted by the other to nonbinding mediation. Mediation shall be conducted by a mediator mutually agreed to by the parties, and shall be conducted pursuant to rules similar to those of the Judicial Arbitration and Mediation Service (JAMS), Chapter 7.07 of the Revised Code of Washington, or any other rules of mediation agreed to by the parties. The mediator's fees shall be born in equal shares by the parties. Unless otherwise agreed, all other related costs incurred by the parties shall be the sole responsibility of the party incurring the cost. The mediation shall take place in Seattle, Washington, or such other place as mutually agreed to by the parties.

9.1.4 Other Remedies.

In the event the parties cannot resolve the matter through nonbinding mediation, either party may pursue judicial remedy in a court of competent jurisdiction. By mutual consent the parties may agree to forego non-binding mediation and proceed directly to a judicial remedy.

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.

9.2 Disputes Between Provider and Payor

9.2.1 Informal Process.

Provider shall promptly notify FCHN of any failure by a Payor to pay Provider in accordance with the requirements of Section 4.2 of this Agreement, to provide information regarding Participant eligibility and benefit confirmation, or provide any other information required under the terms of this Agreement. Disputes between Provider and Payor regarding performance under this Agreement shall be resolved, to the extent possible, by informal meetings and discussions between the both parties.

9.2.2 Formal Process.
Where Provider desires to pursue resolution of a dispute beyond such informal meetings and discussion, Provider may provide Payor with written notice of the dispute, and requesting a response within thirty (30) of receipt of the notice, or if the dispute involves a billing dispute, within sixty (60) days of receipt of the request. Where the Payor fails to grant or deny the dispute within thirty (30) days of receipt of the request, or sixty (60) days in the case of a billing dispute, Provider may proceed as if the dispute has been rejected.

9.2.3 A request for review which has been rejected by either party pursuant to Section 9.2.2 may be submitted by the other to nonbinding mediation. Mediation shall be conducted by a mediator mutually agreed to by the parties, and shall be conducted pursuant to rules similar to those of the Judicial Arbitration and Mediation Service (JAMS), Chapter 7.07 of the Revised Code of Washington, or any other rules of mediation agreed to by the parties. The mediator's fees shall be born in equal shares by the parties. Unless otherwise agreed, all other related costs incurred by the parties shall be the sole responsibility of the party incurring the cost. The mediation shall take place in such location as is mutually agreed to by the parties.

9.2.4 Other Remedies.
In the event the parties cannot resolve the matter through nonbinding mediation, either party may pursue judicial remedy in a court of competent jurisdiction. By mutual consent the parties may agree to forego non-binding mediation and proceed directly to a judicial remedy.

10. GENERAL PROVISIONS

10.1 Independent Contractors
Each Party to this Agreement shall be acting as an independent contractor. None of the provisions of this Agreement are intended to create nor shall be deemed or construed to create 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. Nothing contained in this Agreement shall be construed to create a partnership or joint venture or authorize FCHN or the Provider to act as a general or special agent of the other Party in any respect, except as expressly set forth in this Agreement.

10.2 Amendment
This Agreement may be amended from time to time by FCHN, by providing Provider sixty (60) days advance written notice of the amendment. If Provider objects to the amendment, he or

she must so advise FCHN in writing within thirty days after receipt of the amendment. When FCHN receives the objection it may, at its sole option, withdraw the amendment. If the amendment is not withdrawn, FCHN shall notify Provider that the amendment has not been withdrawn and the amendment shall become effective as outlined. If Provider does not withdraw the objection, Provider may terminate the agreement as outlined in Section 8.2.3.

10.3 Severability/Conformity with Law

In the event any provision of this Agreement is rendered invalid or unenforceable by any State or Federal 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.

10.4 Entire Agreement

This Agreement, its Attachments, and any documents incorporated herein by reference, constitute the entire Agreement between the parties. No implied covenants shall be read into this Agreement. This Agreement supersedes all prior agreements between the parties.

10.5 Waiver of Breach

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. 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.

10.6 Applicable Law

This Agreement shall be governed by and construed in accordance with the laws of the State of Washington and applicable Federal laws and regulations.

10.7 Medical Care

It is hereby understood that Provider is solely responsible for all decisions and liability regarding their 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 it's Payors and any determinations made in connection with utilization review are solely for purposes of determining whether services are covered services under the terms of a Benefit Plan or this Agreement and the extent to which payments may be made hereunder. Accordingly, such determinations shall in no way affect the responsibility of Provider to provide appropriate services to Participants.

10.8 Nondiscrimination

Provider agrees not to discriminate against person and to render services without regard to race, sex, marital status, sexual orientation, religion, national origin, color, age, physical or mental handicap, or veteran status.

10.9 Assignment

Neither First Choice Health nor Provider shall assign this agreement without the express written consent of the other, except that if First Choice Health is sold, merges or consolidates with another entity, this Agreement shall remain in full force and effect.

10.11 Force Majeure

Neither party shall be required to comply with the provisions of this Agreement if the failure to comply is occasioned by any act of God, bankruptcy, act of a governmental authority responding to an act of God or other emergency including but not limited to acts of terrorism, or the result of a strike, lockout, or other labor dispute.

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed by their authorized representatives as of the date written below.

FCHN		Provider	
Address:	First Choice Health Network 600 University Street, Suite 1400 Seattle, WA 98101	Address:	
Signature:	_____	Signature:	_____
By:	Kenneth Hamm	By:	_____
Its:	President & CEO	Its:	_____

Healthcare Direct		Provider	
Signature:	_____	Signature:	_____
By:	Kenneth Hamm	By:	_____
Its:	Board Chair	Its:	_____
Date:	_____	Date:	_____