SCHEDULE C
PREFERRED PROVIDER/GROUP AGREEMENT
OREGON STATE LAW AND REGULATION PROVISIONS

With respect to any Payor that is an Insurer as defined in ORS 743.801, as it may be revised, renumbered, or replaced, the provisions set forth in this Schedule C are fully operative and applicable to FCHN, Provider, and the respective Payors under the Agreement to which this Schedule C is attached. For Payors meeting the definition described above, in the event of any conflict between the provisions set forth in this Schedule C and the other terms of the Agreement, the provisions of this Schedule C shall have priority. Except as modified by this Schedule C, all terms and conditions of the Agreement to which this Schedule C is attached remain in full force and effect.

With respect to any Payor that is an Insurer as defined in ORS 743.801, as it may be revised, renumbered, or replaced:

1. **Definitions.** Sections 1.9 and 1.21 of the Agreement are deleted in their entirety, and the following are substituted therefor. In addition, the following new Sections 1.22, 1.23, 1.24 and 1.25 are added to Section 1, immediately following Section 1.21.

1.9 **Emergency Medical Condition** means a medical condition (A) that manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would : (i) place the health of a Participant, or a fetus an unborn child in the case of a pregnant Participant, in serious jeopardy; (ii) result in serious impairment to bodily functions; or (iii) result in serious dysfunction of any bodily organ or part; or (B) with respect to a pregnant Participant who is having contractions, for which there is inadequate time to effect a safe transfer to another hospital before delivery or for which a transfer may pose a threat to the health or safety of the participant or the unborn child.

1.21 **Utilization Review** means a set of formal techniques designed to monitor the use of or evaluate the Medical Necessity, appropriateness, efficacy, or efficiency of health care services or procedures given or proposed to be given to a Participant or the setting in which such services or procedures are provided.

1.22 **Continuity of Care** means the feature of a Benefit Plan under which a Participant who is receiving care from a Provider is entitled to continue with care with the Provider for a limited period of time after this Agreement terminates.

1.23 **Emergency Medical Screening Exam** means the medical history, examination, ancillary tests, and medical determinations required to ascertain the nature and extent of an Emergency Medical Condition.

1.24 **Emergency Services** means, with respect to an Emergency Medical Condition: (A) an Emergency Medical Screening Exam that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and (B) such further medical examination and treatment as are required under 42 USC 1395dd to Stabilize a participant, to the extent the examination and treatment are within the capability of the staff and facilities available at a hospital.

1.25 **Stabilize** means to provide medical treatment as necessary to: (A) ensure that, within reasonable medical probability, no material deterioration of an Emergency Medical Condition is likely to occur during or to result from the transfer of a participant from a facility; and (B) with respect to a pregnant participant who is in active labor, to perform the delivery, including the delivery of the placenta.

2. **Responsibilities of Provider.** Sections 2.1, 2.5, the first paragraph of Section 2.9, and Section 2.15 of the Agreement are deleted in their entirety and the following are substituted therefor:

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. Provider agrees to verify each Participant's eligibility prior to providing Covered Services except in the case of Emergency Services. Provider will notify FCHN or the appropriate Payor of the provision of Medically Necessary services of either type described above Emergency Services that are provided to a Participant within the twenty-four (24) hour period 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 Payor's 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 or Payors, and shall remain solely responsible for the quality of services rendered. Provider may withdraw from the care of a Participant when, in the professional judgment of Provider, it is in the best interest of the Participant to do so; provided, however that Provider agrees to provide reasonable notice to FCHN and Payors of such withdrawal and to facilitate appropriate transfer of care.

2.5 Benefit Plan Participation

Provider hereby authorizes (i) FCHN and its Affiliates to contract with Payors that will administer and pay for Covered Services provided by Provider to Participants under Benefit Plans, and (ii) FCHN agrees that such contracts will obligate the Payors to comply with all applicable terms, limitations, and conditions of this Agreement. Provider further authorizes Payors contracting with FCHN or its affiliates to offer Provider's services to groups of employees or individuals in accordance with the provisions of any Benefit Plans offered by such Payors. 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.

2.9 Medical Management, Utilization Review and Quality Improvement

Provider agrees to comply with and participate in FCHN's or Payors' Medical Management, Utilization Review, and quality improvement 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. A doctor of medicine or osteopathy licensed under ORS chapter 677, as it may be revised, renumbered, or replaced, retained by either FCHN or Payors, shall be responsible for all final medical and mental health decisions related to coverage or payment made pursuant to this Agreement.

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 Oregon Medical Association and the American Medical Association, all of the above as they may be adopted, amended, revised, or renumbered. Provider agrees to comply with the following hold harmless requirements:

2.15.1 Provider hereby agrees that in no event, including, but not limited to, non-payment by a Payor, a Payor's insolvency, or breach of this Agreement shall Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against a Participant or person acting on a Participant's behalf, other than a Payor, for Covered Services provided pursuant to this Agreement, nor shall Provider charge to or collect from any Participant or person acting on Participant's behalf, any amount in excess of that amount of compensation allowed for a particular Covered Service in Schedule B to this Agreement. Participants shall have no liability to Provider for any sums owed by Payors. This provision shall not prohibit collection of

Deductibles, Co-payments, Coinsurance, or charges for non-covered services, which have not otherwise been paid by a primary or secondary Payor in accordance with applicable standards for coordination of benefits, from a Participant in accordance with the terms of the Participant's Benefit Plan.

2.15.2 If Provider contracts with other providers or facilities who agree to provide Covered Services to Participants with the expectation of receiving payment directly or indirectly from a Payor, such providers or facilities must agree to abide by the provisions of paragraph 2.15.1.

3. Responsibilities of FCHN. Sections 3.5, 3.6, 3.10, and 3.11 of the Agreement are deleted in their entirety and the following are substituted therefor:

3.5 Eligibility

FCHN shall require all Payors contracting with it to provide timely information on a Participant's eligibility for Covered Services upon request by Provider. FCHN shall require that during ordinary business hours, Payors shall assure reasonable access, using electronic transactions as required by applicable law, for confirmation that services are Covered Services and a Participant is eligible under a Benefit Plan. For services other than those required to treat an Emergency Medical Condition, FCHN will require that Payors answer Provider's requests for prior determination of eligibility and whether the services proposed to be provided are Covered Services within two (2) business days after the Payor's receipt of the request and that Payors have qualified health care personnel available for same day telephone responses to inquiries concerning certification of continued length of stay. FCHN will require that the Payors inform Provider with one of the following answers, or as otherwise required by applicable law: (i) the requested service is authorized, (ii) the requested service is not authorized, (iii) the entire requested service is not authorized, but a specified portion of the requested service or a specified alternative service is authorized, or (iv) the requested service is not authorized because the Payor needs additional specified information in order to make a decision on the request.

3.6 Provider's Right to Inform Patients

FCHN may not, and shall require that Payors shall not, preclude or discourage Provider, financially penalize Provider, and FCHN shall not terminate this Agreement, all of the foregoing due to Provider:

a Providing information to or communicating with a Participant in a manner that is not slanderous, defamatory or intentionally inaccurate concerning:
   1 any aspect of the Participant's medical condition;
   2 any proposed treatment or treatment alternatives, whether covered by the Payor's Benefit Plan or not; or
   3 the Provider's general financial arrangement with a Payor.

b Referring a Participant to another provider, whether or not that provider is a Provider as defined in this Agreement. If Provider refers a Participant to another provider, Provider shall (i) comply with the Benefit Plan's and/or Payors' written policies and procedures with respect to any such referrals, and (ii) inform the Participant that the referral services may not be Covered Services under the Participant's Benefit Plan.

c Advocating a decision, policy, or practice, so long as Provider is practicing in conformity with ORS 677.095, as it may be revised, renumbered, or replaced.

Nothing in this Agreement shall be construed to require Provider to deny care to a Participant because of a determination that services are not Covered Services or are experimental, or to deny referral of a Participant to another provider for the provision of such care, if, as described in Section 2.11 of this Agreement, the Participant is informed that the Participant will be responsible for the payment for such services and care and the Participant nonetheless desires to obtain such services, care, or referral.

Nothing in this Agreement shall be construed to authorize Provider to bind FCHN or its Payors to pay for any services.

3.10 List of Payors

FCHN shall provide Provider in writing or electronically, on or before the Effective Date of this Agreement, a list of all Payors known by FCHN at that time. This list shall be updated at least every 90 days and will be readily available to Provider by posting on the FCHN website, toll-free telephone number, or other readily available mechanism. FCHN will provide each Payor with information necessary to enable the Payor to comply with all relevant terms, limitations, and conditions of this Agreement.
In addition, FCHN agrees to make available to Provider for review, or to cause Payors to make available to Provider for review, a written copy of or electronic access to the documents and instruments referred to in this Agreement.

3.11 Explanation of Payment/Remittance Advice

FCHN shall ensure that Payors 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, including the source of any reduction from the billed charges to the allowed amount; 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. Sections 4.1 and 4.2 of the Agreement are deleted in their entirety and the following are substituted therefor, and the following new Section 4.4 is added to the Agreement:

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 shall be under no obligation 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 thirty (30) 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 shall have no obligation 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 thirty (30) calendar days after Provider first receives notice that Payor is a secondary payor under applicable coordination of benefits procedures, whichever shall be later. Adjustments to claims that have been paid or denied, where the claim submittal failed to include a particular item or service, must be requested in accordance with Section 4.4 below.

4.2 Payment or Denial 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 Payors shall be required to pay a clean claim or deny the claim not later than thirty (30) days after the date on which the Payor receives the claim; and

4.2.2 If a Payor requires additional information before payment of a claim, not later than thirty (30) days after the date on which the Payor receives the claim, the Payor shall be required to notify the Provider and the Participant in writing and give them an explanation of the additional information needed to process the claim. The Payor shall be required to pay the clean claim or deny the claim not later than thirty (30) days after the date on which the Payor receives the additional information.

4.2.3 A Payor is considered to have received a claim when the claim is received by the Payor itself or when the claim is received by a representative of the Payor that performs claims handling on the sole behalf of the Payor, whichever receipt date is earlier. A representative may include but is not limited to a third party administrator, a claims service, or a pricing service. When a Payor uses such a representative, then the date on which the Payor receives the claim includes the days in which a claim is in the control of the representative, including the date on which the representative received 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.

To the extent required by applicable law or regulation, FCHN shall require that any Payor failing to pay claims within the above stated timelines, or any other timeline or standard established by applicable law or regulation, shall pay simple interest of twelve (12) percent per annum on the unpaid amount of the claim that is due and owing, accruing from the date after the payment was due until the claim is paid. Interest on any overdue payment for a claim will begin to accrue on the 31st day after:

a. the date on which the Payor received the claim; or
b. the date the Payor receives the requested additional information.

Interest will be payable with the payment of the claim without the necessity of Provider submitting an additional claim. A Payor will not be required to pay interest that is in the amount of two dollars ($2.00) or less on any claim, or such revised amount as may be established under applicable law or regulation.

Interest shall be assessed at the rate of one percent (1%) per month, and shall be calculated monthly as simple interest prorated for any portion of a month. Any interest paid under this Section shall not be applied by the Payor to a Participant's Deductible, Co-payment, Coinsurance, or any similar obligation of the Participant.

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 review claims status of FCHN Payors and to assist Provider in collecting payments due and owing from any such Payor as determined by FCHN to be appropriate.

FCHN shall require that Payors provide to Provider, upon request, an annual accounting accurately summarizing the financial transactions between Payors and Provider for that year.

4.4 Overpayment and Underpayment Recoveries

As required by applicable law, adjustments to claims that have been denied or paid, where the claim submittal failed to include a particular item or service, or was otherwise in error, must be requested and accomplished as follows, and refunds of incorrect claims payments must be requested and accomplished as follows:

4.4.1 Except as provided in paragraphs 4.4.2 and 4.4.3, a Payor may request a refund from Provider for overpayment of a previously paid claim provided the request is received by the Provider within eighteen (18) months after the date the initial payment was made. Such a request must be in writing and specify why Provider owes the refund. 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 A Payor's request for refund related to coordination of benefits with another entity responsible for payment of a claim must be received in writing by the Provider within thirty (30) months after the date that payment was made. The request must specify why Provider owes the refund and include the name and mailing address of the other entity that has primary responsibility for payment of the claim. 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.

4.4.3 A Payor may at any time request a refund from a Provider of payment previously made to satisfy a claim if a third party, including a government entity, is found responsible for satisfaction of the claim as a consequence of liability imposed by law and the Payor is unable to recover directly from the third party because the third party has or will pay Provider for the services covered by the claim.

4.4.4 Provider may contest a refund request described in paragraph 4.4.1 or 4.4.2 in writing to the Payor within thirty (30) days after receipt in accordance with Section 9, Dispute Resolution, of this Agreement. If Provider fails to contest a request within this thirty (30) day period, the request shall be deemed accepted by Provider as due and owing, and Provider shall pay the refund within thirty (30) days after the request is deemed accepted. If Provider has not paid the refund within thirty (30) days after the request is deemed accepted, the Payor may recover the amount through an offset to a future claim.

4.4.5 Except as provided in paragraph 4.4.7, Provider may request an additional payment from a Payor to satisfy a claim provided the request is received by the Payor within eighteen (18) months from the date the claim was denied or payment intended to satisfy the claim was made by the Payor. Such a request must be in writing, specify why Provider believes the Payor owes the additional payment, and may not require that the additional payment be made any sooner than six (6) months from the date of Payor's 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.

4.4.6 Payors may not consider Provider's claim untimely if the claim is received no later than twelve (12) months after a different payor (i) denied the claim in whole or in part; or (ii) requested a refund of an erroneous payment made on the claim.

4.4.7 A Provider's request for additional payment related to coordination of benefits with another entity responsible for payment of a claim must be received in writing by the Payor within thirty (30) months after the date the claim was denied or payment intended to satisfy the claim was made. The request must specify why Provider believes the Payor owes the additional payment and must include the name and mailing address of the entity that has disclaimed responsibility for payment of the claim. The request for additional payment may not request that the additional payment be made any sooner than six (6) months after 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.

4.4.8 As used in this Section, "refund" means the return, either directly or through an offset to a future claim, of some or all of a payment already received by the Provider.

4.4.9 This Section applies to claims for services provided through Benefit Plans to the extent required under applicable law and regulation.

5. **Term and Termination**. Sections 8.3 and 8.4 of the Agreement are deleted in their entirety and the following are substituted therefor, and the following new Section 8.5 is added to the Agreement:

8.3 Effect of Termination

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. Except as otherwise provided in this Section 8, claims for services provided by Provider after the effective date of termination of this Agreement are not eligible for processing and payment in accordance with the terms of 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 2.15.1 of this Agreement.

8.3.3 FCHN will give notice to Payors of any termination of this Agreement within the time required by applicable law and regulation, and except as otherwise provided in this Section 8, FCHN will require Payors to cease claiming entitlement to (i) use of the FCHN fee schedule set forth in Schedule B for payment of claims, and (ii) the other rights set forth in this Agreement, effective as of the effective date of termination.

Nothing in this Agreement shall be construed to require Provider to agree, upon Provider's withdrawal from, or termination or nonrenewal of this Agreement, not to treat or solicit a Participant even at that Participant's request and expense. However, except as otherwise set forth in this Agreement, all such services shall be provided outside of the terms of this Agreement and Benefit Plans, and neither FCHN nor Payors shall be responsible to pay any fees for such services.

8.4 Continuity of Care

Upon termination of this Agreement, Provider agrees to provide continuing care to Participants consistent with the Continuity of Care benefits under the applicable Benefit Plan and applicable law and regulation, as follows:

8.4.1 Where the Participant is undergoing an active course of treatment that is Medically Necessary and by agreement of Provider and the Participant, it is desirable to maintain continuity of care, the Participant is entitled to continue receiving care from Provider as follows:

a. Except as provided in paragraph b of this Section, Provider shall provide care to a Participant who is entitled to Continuity of Care until the earlier of (i) the day following the date on which the active course of treatment entitling the Participant to continue receiving care from Provider is complete, or (ii) the 120th day after the date of notification by the Payor to the Participant of the termination of this Agreement.

b. A Participant who is undergoing care for a pregnancy and who becomes entitled to Continuity of Care after commencement of the second trimester of the pregnancy shall receive the care until the later of (i) the 45th day after the birth, or (ii) as long as the Participant continues under an active course of treatment, but not later than the 120th day after the date of notification by the Payor to the Participant of the termination of this Agreement.

8.4.2 The Provider's relationship with FCHN and/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.

8.4.3 The date of notification given pursuant to this Section 8.4 is the earlier of the date on which the Participant receives the notice or the date on which the Payor receives or approves the request for continued care with Provider under the Continuity of Care benefits of the Participant's Benefit Plan.

8.5 Notice to Participants

8.5.1 If this Agreement is terminated, FCHN shall require Payors to give written notice of the termination and of the right to obtain Continuity of Care benefits to those Participants that the Payors know or reasonably should know are under the care of Provider. The notice may be given prior to the effective date of termination of this Agreement only if the Payors give notice in a good faith belief that the termination will take effect as stated in the notice. In any event, FCHN will require Payors to give notice to the Participants described above not later than the 10th day after the effective date of termination of this Agreement. If a Payor first learns the identity of an affected Participant after the effective date of termination of this Agreement or after the date on which the Payor gave notice to other affected Participants, then FCHN shall require the Payor to give notice of termination to the affected Participant not later than the 10th day after learning that Participant's identity.

8.5.2 If Provider is, or belongs to, a Provider Group, the Provider Group may deliver the notice of termination described in this Section 8.5 provided that (i) FCHN and the Payor give prior written consent to the Provider Group giving such notice and to the contents of the notice, and (ii) the notice is consistent with the requirements of this Section 8.5.

6. General Provisions. Section 10.9 of the Agreement is deleted in its entirety and the following is substituted therefor:

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; provided, however that the substantive laws of the State of Oregon shall govern the interpretation and enforcement of the provisions of Schedule C attached to this Agreement. Venue for any action or proceeding shall lie in King County, Washington.

7. Amendments to Comply with Law. If amendments to the Agreement are needed to permit FCHN, Provider, and Payors to comply with applicable state law and regulation, FCHN and Provider agree to incorporate such revisions into the Agreement in a timely manner.