To request translation or disability-related accommodations, please contact us at **bcc@clackamas.us** | **503-655-8581**.

Si quiere solicitar servicios de traducción o adaptaciones para la discapacidad, contáctenos en/al **bcc@clackamas.us** | **503-655-8581**.

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Щоб попросити переклад або спеціальні послуги для осіб з особливими потребами, зверніться до нас, скориставшись такими контактними даними: **bcc@clackamas.us** | **503-655-8581**.

如需翻译服务或残障相关的协助，请与我们联系：**bcc@clackamas.us** | **503-655-8581**。

Để yêu cầu dịch vụ dịch thuật hoặc điều chỉnh liên quan đến tình trạng khuyết tật, vui lòng liên hệ với chúng tôi qua **bcc@clackamas.us** | **503-655-8581.**

Clackamas County
www.clackamas.us

Health, Housing & Human Services
CLACKAMAS COUNTY

Mary Rumbaugh
Director

March 19, 2026 BCC Agenda Date/Item: _____

Board of County Commissioners
Clackamas County

Approval of a Provider Agreement with Providence Health Plans for reimbursement of services provided to Providence members. Agreement Value is approximately $1,500,000 for 10 years. Funding is through Providence Health Plans. No County General Funds are involved.

Previous Board Action/Review	Previous Agreement April 22, 2010, Agenda Item A3		
Performance Clackamas	Healthy People		
Counsel Review	Yes - Ryan Hammond	**Procurement Review**	No
Contact Person	Sarah Jacobson	**Contact Phone**	503-742-5303

EXECUTIVE SUMMARY: The Health Centers Division of Health, Housing, and Human Services Department requests approval of a Provider Agreement with Providence Health Plans. The purpose of this agreement is for the Health Centers Division to bill Providence for reimbursement of services provided to their members at the health centers. This agreement is estimated to generate $150,000 in annual revenue for HCD. In fiscal year 24-25, the Health Centers Division's clinics served 146 Providence members. The services provided to Providence members encompass behavioral health and primary care.

RECOMMENDATION: The staff respectfully requests that the Board of County Commissioners approve agreement (12297) with Providence Health Plans and authorize Chair Roberts or his designee to sign on behalf of Clackamas County.

Respectfully submitted,

Mary Rumbaugh

Mary Rumbaugh
Director of Health, Housing & Human Services

For Filing Use Only

PROVIDENCE HEALTH PLAN, PROVIDENCE HEALTH ASSURANCE AND PROVIDENCE PLAN PARTNERS PROVIDER AGREEMENT

THIS AGREEMENT ("Agreement") is between **PROVIDENCE HEALTH PLAN** (PHP), an Oregon non-profit corporation, **PROVIDENCE HEALTH ASSURANCE** (PHA), an Oregon non-profit corporation and **PROVIDENCE PLAN PARTNERS (**PPP**),** a Washington non-profit corporation, and their wholly-owned subsidiaries (hereinafter referred to collectively as "Health Plan") and **CLACKAMAS COUNTY, A POLITICAL SUBDIVISION OF THE STATE OF OREGON, ON BEHALF OF THE HEALTH CENTERS DIVISION OF ITS DEPARTMENT OF HEALTH, HOUSING, AND HUMAN SERVICES** (hereinafter referred to as "Network Provider"), and together with any attachment(s) or exhibit(s) describes the terms and conditions under which Network Provider shall participate in Health Plan's provider network(s).

RECITALS

WHEREAS, Health Plan operates as a health care service contractor under the laws of Oregon and Washington; and

WHEREAS, Health Plan operates as a Management Services Organization (MSO), Third-Party Administrator (TPA), and Administrative Services Only (ASO) provider for self-funded employer health benefit plans and other health care financing arrangements; and

WHEREAS, Health Plan offers or administers one or more health benefit plans and desires to enter into a written agreement to arrange for the provision of certain Covered Services to Members of such products or plans; and

WHEREAS, Network Provider is lawfully qualified to provide health care services and is willing to provide such services to Members of Health Plan; and

WHEREAS, Health Plan and Network Provider mutually desire to preserve and enhance patient dignity; and

WHEREAS, Health Plan and Network Provider desire to create a culture of health care safety; and

WHEREAS, Health Plan desires to advance the healing ministry of Jesus in the communities it serves;

NOW, THEREFORE, in consideration of the promises and mutual covenants herein stated, it is agreed by and between the parties as follows:

1. DEFINITIONS

As used in this Agreement and its Exhibits, Attachments or Addendums each of the following terms (and the plural thereof, when appropriate) shall have the meaning set forth herein, except where the context makes clear that such meaning is not intended.

1.1 Care Management shall mean a program of care coordination and case management developed to manage high cost and at-risk members with complex healthcare needs.

1.2 Chief Medical Officer (CMO) shall mean the physician so designated by Health Plan to supervise utilization and quality management activities and to be responsible for such other programs and activities as may be designated by Health Plan. Medical Directors may be utilized by the CMO to assist in these functions.

1.3 Clean Claim shall mean a claim that has no defect, impropriety, lack of any required substantiating documentation or particular circumstance requiring special treatment that prevents timely payment.

1.4 Clinical Quality Improvement Studies are studies regarding the measurable outcome or end result of care.

1.5 CMS is the Centers for Medicare and Medicaid Services, the federal government agency that regulates the Medicare program.

1.6 Coinsurance is the percentage or portion of the cost of care that a Member may be obligated to pay for a Covered Service.

1.7 Copayment or Copay is the fixed dollar amount that a Member may be obligated to pay for a Covered Service at the

time the care is provided.

1.8 Covered Services are Medically Indicated health care services and supplies rendered or furnished to Member by Network Provider or by another Network Provider for which benefits are available under a Member's health care contract or plan.

1.9 Credentialing is the initial process by which Health Plan, or its designee, verifies practitioner or facility qualifications for panel membership in accordance with criteria adopted by Health Plan.

1.10 Deductible is the amount of out-of-pocket expense that Member is responsible to pay for Covered Services prior to being eligible to receive Health Plan benefits.

1.11 Emergency shall mean the sudden and unexpected onset of a condition requiring medical or surgical care for which Member secures care immediately after the onset of the condition, or as soon thereafter as care can be available, but in any case no later than twenty-four (24) hours after the onset. An Emergency situation shall include, but not be limited to, suspected heart attack or stroke, poisoning, loss of consciousness, severe respiratory distress, hemorrhaging or convulsion. The State of Oregon defines an "Emergency medical condition" as a medical condition that manifests itself by symptoms of sufficient severity that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of a person, or a fetus in the case of a pregnant woman, in serious jeopardy. Health Plan may determine that other similarly acute conditions are Emergencies. The final determination of whether a condition is an Emergency rests with Health Plan and may be subject to the procedures for post treatment utilization review.

1.12 Exhibit(s), Attachment(s) or Addendum(s) shall mean the documents that accompany this Agreement, each of which is incorporated herein by reference. Such Exhibit(s), Attachment(s) or Addendum(s) may contain proprietary compensation and reimbursement information, fee schedules, and such other matters that may be unique to the features of Health Plan.

1.13 Health Plan shall mean either PHP, PHA, PPP or a wholly-owned subsidiary, or PHP, PHA, PPP and their wholly-owned subsidiaries, collectively, as designated in the Exhibits, Attachments or Addendums hereto.

1.14 HIPAA is the Health Insurance Portability and Accountability Act of 1996 that contains federal regulations addressing standards for electronic transactions and other administrative issues for the health care and health insurance industries.

1.15 Individual Contract or Employer Group Agreement shall mean the agreement between Health Plan and Member, or between Health Plan and Member's employer group, which defines terms and conditions of Health Plan's obligation to provide, arrange for, and/or reimburse for medical care provided to Member.

1.16 Medical Home shall mean primary care physician(s) who specialize in family practice, general practice, internal medicine or pediatrics; a nurse practitioner; or a physician assistant, when providing services under the supervision of a physician, who agree(s) to be responsible for the continuing medical care by serving as case manager. Medical Homes provide preventive care and health screenings, medical management of many chronic conditions, allergy shots, treatment of some breaks and sprains, and care for many major illnesses and nearly all minor illnesses and conditions. Many Medical Homes offer maternity care and minor outpatient surgery as well.

1.17 Medical Directors shall mean physicians who are designated by the CMO and are responsible for quality management and utilization management review, including concurrent hospital review.

1.18 Medically Indicated shall mean a service or supply provided or ordered by a practitioner that is clinically appropriate, as commonly and customarily recognized by the practitioner’s profession, to prevent, treat or care for symptoms of an illness or injury, or to diagnose an illness or condition that is harmful to life or health. The decision whether a service or supply ordered by the practitioner was Medically Indicated for the purposes of qualifying for payment by Health Plan rests with Health Plan, subject to the procedures for reconsideration.

1.19 Medical Neighborhood/Medical Home Network Provider shall mean an Outpatient Surgical Facility, Home Health Provider, Hospital, Network Practitioner, Treatment Facility, or Skilled Nursing Facility that has a written agreement with Health Plan to participate as a Network Provider for a Providence Medical Neighborhood/Medical Home Plan.

1.20 Member shall mean any person entitled to receive benefits for Covered Services underwritten or administered by Health Plan.

1.21 Network Facility shall mean a hospital or other health care facility that is contracted to provide Covered Services to Members of Health Plan. “In-Network” status with respect to any particular type of coverage, reflected on an Exhibit, shall be contingent upon Health Plan’s designation of a facility as such.

1.22 Network Practitioner shall mean a physician or other health care professional who is contracted to provide Covered Services to Members of Health Plan with respect to a type of coverage, through Network Provider or otherwise. “In-Network” status with respect to a type of coverage, reflected on an Exhibit, shall be contingent upon Health Plan's designation of a practitioner as such.

1.23 Network Provider shall mean a Network Facility or a Network Practitioner.

1.24 Out of Network Benefit means the amount payable to a Network Provider with respect to a Member covered by a Product not described in an Exhibit to this Agreement.

1.25 Personal Physician/Primary Care Physician (PCP) shall mean a Network Practitioner specializing in Internal Medicine, Family Practice, General Practice, Pediatrics or Obstetrics/Gynecology who has contracted with Health Plan and is (A) the case manager who acts as a Member’s point of entry to the delivery system, and (B) manages/oversees all services for the Member including office care, preventive health maintenance, and referral management. A Personal Physician/PCP may not be a Personal Physician/PCP for immediate family members under this Agreement.

1.26 Physician Advisor shall mean a physician who has entered into a separate agreement to advise Health Plan with respect to medical appropriateness.

1.27 Preventive and Clinical Practice Guidelines shall mean the statements systematically developed from time to time by Health Plan, which assist Network Practitioners and their Member patients in deciding upon appropriate health care for specific clinical circumstances.

1.28 Prior Authorization shall mean Health Plan approval, in advance of treatment, of payment for Covered Services. Prior Authorization determinations relating to benefit coverage and medical necessity shall be binding on Health Plan for no more than 30 days following receipt of Prior Authorization.

1.29 Product is a policy or specified health benefit plan structure which defines coverage of health care benefits for Members.

1.30 Providence Commercial Network (PCN) is the network of Network Providers contracted to provide services on a fee-for-service basis with no risk borne by Network Providers. The network is available to Health Plan Members enrolled in an PCN product. PCN products include Providence Administrative Services Only (ASO) products where Member’s employer or another health care service contractor bears risk. Employers who select a Providence ASO product may at their discretion elect to exclude one or more Network Practitioners or Network Facilities from their designated network.

1.31 Medical Home/Neighborhood Member shall mean a Member who is enrolled in a Medical Home/Neighborhood Plan underwritten or administered by Health Plan.

1.32 Provider shall include Network Providers and out-of-Network Providers with respect to a type of coverage.

1.33 Recredentialing is the process by which continued eligibility to participate in Health Plan contracts is determined. Health Plan, or its designee, verifies practitioner or facility qualifications in accordance with criteria adopted by Health Plan. This process is completed at least every three years.

1.34 Referral Provider shall mean a Network Practitioner who is contracted with Health Plan to provide Covered Services to Members upon a referral from a Medical Home/Neighborhood or other Primary Care Provider made responsible for managing the care of a Member under a Network described in an Exhibit. Referral Providers shall cooperate with the referral system to facilitate appropriate referral services to Members.

1.35 Rules and Regulations of Health Plan shall mean the criteria and procedures pertaining to credentialing and re-credentialing, participation, compensation, payment rules, processing guidelines, medical policy, utilization management, quality improvement, Health Plan standards, and such other matters determined from time to time by Health Plan. The Rules and Regulations of Health Plan may be viewed on Health Plan's website.

1.36 Scope of Service shall mean those services which fall within the geographic and CPT code limits established in the Exhibits. If no geographic or CPT code limits are established in the Exhibits, Scope of Service shall refer to those services

which Network Provider is professionally qualified to render.

1.37 Standards of Care and Service shall mean standards which have been developed by Health Plan incorporating concepts from CMS, from medical group practice accreditation programs, and from community standards. These standards include, but are not limited to, access, accommodations, panel size and medical record documentation.

1.38 Urgent shall mean services that are needed right away but are not life threatening. These include, but are not limited to, high fevers, minor sprains, cuts and burns, and ear, nose and throat infections. Routine care that can be delayed until Member can be seen by Member's physician is not Urgent care. The final determination of whether a condition is Urgent rests with Health Plan and may be subject to the procedures for post-treatment utilization review.

2. OBLIGATIONS OF HEALTH PLAN

2.1 Services. Health Plan agrees to provide the following services necessary to fulfill the terms of this Agreement including, but not limited to:

Claims processing services;
Member services;
Medical and quality management services;
Credentialing services;
Claims review process linked to peer review;
Marketing, sales and public relations.

2.2 Support. Health Plan may provide statistical support and assistance to Network Provider for quality assurance, peer review, and medical management review functions, through the development and operation of a medical management information system.

2.3 Orientation and Training. Health Plan agrees to provide orientation and training for Network Provider in the use of the administrative services described herein, and the Rules and Regulations of Health Plan.

2.4 Eligibility Verification. Health Plan agrees to provide eligibility verification and benefit information through its customer service department.

2.5 Documents Provided. Copies of any Health Plan documents referenced in this Agreement will be provided to, or made available for examination by, Network Provider.

2.6 Relationship. Health Plan will not intervene in any manner in the provision of Network Facility services, it being understood and agreed that the traditional relationship between Network Facility and patient, as well as physician and patient, will be maintained.

3. OBLIGATIONS OF NETWORK PROVIDER

3.1 Scope of Service. Health Plan retains Network Provider to render Covered Services to Health Plan Members through Network Providers within such Network Providers' Scope of Service. All services shall be rendered subject to the terms and conditions of this Agreement and in accordance with the Rules and Regulations of Health Plan.

3.2 Accepting Members. If Network Provider includes Network Practitioners who are Personal Physicians, Network Provider agrees that such Network Practitioners will accept newly enrolled Members and Members who transfer from another Personal Physician. A Personal Physician shall provide Covered Services for a reasonable number of Members. Upon prior approval of Health Plan, which will not be unreasonably withheld, a Personal Physician may limit his or her practice to existing patients who are or become Members. A Personal Physician with an open practice may not refuse to be a Personal Physician for a Member who chooses that Personal Physician.

3.3 Provider/Patient Relationship. Network Practitioners may not terminate a relationship with a Member solely for inconvenience reasons. However, a Network Practitioner may withdraw from the care of a Member when, in the professional judgment of the Network Practitioner, it is in the best interest of the Member to do so. In terminating any patient relationship, the Network Practitioner should give due regard to ethical considerations. This action may only occur after following the procedural steps identified in the Rules and Regulations of Health Plan.

3.4 Authorization. Network Provider agrees not to admit any Member to a hospital or other inpatient facility in a non-Emergency or elective situation without first receiving the necessary Prior Authorizations pursuant to the Rules and Regulations of Health Plan and Health Plan's Prior Authorization Program.

3.5 Prompt Service. Services rendered will be instituted as promptly as practicable, consistent with sound medical practice and in accordance with accepted community professional standards.

3.6 Sufficient Practitioners. Network Provider agrees at all times to maintain prompt and adequate access to Health Plan Members.

3.7 Utilization Management. Network Provider understands that the purpose of the utilization management program is to determine which services are Medically Indicated. Cooperation shall extend to provision of or access to medical records, on-site review and telephone review, at no additional cost to Health Plan. Health Plan will make every reasonable effort to meet Network Provider's needs when scheduling an on-site review.

3.8 Non-Discrimination. Network Provider agrees that in accordance with the provisions, spirit and intent of this Agreement, and within the limits of its Network Practitioners' specialties, Network Provider will (A) not discriminate in the provision of medical services to Members on the basis of membership in Health Plan, source of payment, race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, age, health status or handicap, or any other category protected under State or Federal law, and (B) to render medical services to Members in the same manner, in accordance with the same standards, and within the same time availability as offered to other patients.

3.9 Services To Practitioner's Family. Network Provider agrees not to seek compensation for Covered Services rendered by a Network Practitioner to that Network Practitioner's immediate family member, i.e., spouse, daughter, son, stepdaughter, stepson, grandchild.

3.10 Call/Non-Par Coverage. Network Provider agrees that its Network Practitioners will make prior arrangements to provide coverage for Members on a 24-hour a day, 7-day a week basis with a Network Practitioner of same or similar specialty. When a Network Practitioner is unable to make prior arrangements to provide coverage with a Network Practitioner of same or similar specialty due to the unavailability of Network Practitioners in the geographic area, Network Provider agrees to provide such coverage through non-Network Practitioners; such arrangements shall be determined by Network Provider, with notice to Health Plan, which has the right to disapprove. Notification of any permanent on-call changes are to be in writing thirty (30) days prior to the scheduled change. The same terms and conditions as agreed to by Network Provider shall be in effect and primary coverage may not be through a hospital emergency room or urgent care center.

3.11 Non-Par Coverage Compliance. Network Provider agrees that if arrangements are made with a non-Network Practitioner to treat Members in the absence of Network Practitioners, Network Provider agrees to ensure that such non-Network Practitioner will comply with the obligations of this Agreement, including but not limited to (A) acceptance of the fee established by Health Plan as full payment for Covered Services rendered to Member; (B) acceptance of the peer and medical management procedures of Health Plan; (C) agreement not to bill Members directly under any circumstances except for Copayments, Coinsurance, Deductibles and non-Covered Services as defined in Individual and Group Service Agreements; and (D) obtaining required authorization from Health Plan prior to hospitalizations.

3.12 Refer To Network Providers. Network Provider agrees that its Network Practitioners will, whenever possible, provide or arrange for care of Members with Network Practitioners and/or Network Facilities.

3.13 Prior Authorization. Except in cases requiring Emergency treatment, Network Provider and its Network Practitioners will not be compensated for Covered Services rendered to Members which were not provided in compliance with the Rules and Regulations of Health Plan and/or which were not authorized by Health Plan, nor will such services be billable to Member. Network Practitioners will follow Health Plan’s Prior Authorization Requirements.

3.14 Change In Status. Network Provider agrees to provide Health Plan with an updated schedule of Network Practitioners categorized by name, board status, facility status, hospital affiliation, and relationship to Network Provider, at Health Plan's request or when there is a change in Network Practitioner status. Network Provider agrees that Health Plan may use Network Practitioners’ name, office address, office telephone number, type of practice and an indication of willingness to accept new patients, in Health Plan directories.

3.15 Appeals and Grievances. Network Provider and its Network Practitioners agree to cooperate with Health Plan in resolving any Member appeals or grievances related to the provision of Covered Services.

3.16 Subcontracting. Prior to services being provided, Health Plan must authorize the use of a subcontractor to perform services covered under the Agreement.

3.17 Discharge Planning. Network Provider will provide for the discharge planning of Member, in coordination with Health Plan and Network Providers.

3.18 Peer Review. Network Provider will perform peer review upon written delegation by Health Plan. Network Provider will provide Health Plan with a written report regarding the results of the delegated peer review process. Health Plan will not disclose the written report to any person, except in a proceeding where a physician participant contests the denial, restriction or termination of clinical privileges by a Network Facility. Health Plan will use peer review report for purposes of training, supervision, or discipline of physician participants.

3.19 Referrals. If the Product requires referrals, then the Member's designated Medical Home/Medical Neighborhood/PCP shall only refer Member (A) to participating Referral Providers, or (B) with Health Plan's prior approval, to consulting physicians or other health care providers who are not participating Referral Providers provided that such referrals are consistent with sound medical practice. Except in an Emergency, notification of prior approval for out of network referrals must be obtained from the Member's designated Medical Home/Medical Neighborhood/PCP or the Health Plan in advance of services.

3.20 Referral Systems. If the Product requires referrals, then Network Provider agrees to participate in referral systems established by Health Plan to facilitate appropriate referral services. Network Provider retains the right to exercise Network Provider's medical judgment when making patient referrals. The procedures Network Provider shall follow when utilizing the referral system shall be set forth in the Rules and Regulations of Health Plan.

3.21 Plan Of Treatment. If the Product requires referrals, then the Member's designated Medical Home/Medical Neighborhood/PCP and Network Providers shall agree on the proposed plan of treatment prior to implementation of such treatment by Referral Practitioner. Should the Referral Practitioner desire to refer Member to another Referral Practitioner, such referral must be obtained from Member's designated Medical Home/Medical Neighborhood/PCP in advance. Referral Practitioner will send a copy of the Member record to Member's designated Medical Home/Medical Neighborhood/PCP after all approved visits or after any urgent or emergent care visits.

3.22 Referral Required. If the Product requires referrals, Referral Provider hereby agrees that they will not be compensated by Health Plan or by Member for Covered Services rendered to Members who have not been referred in advance by the Member's designated Medical Home/Medical Neighborhood/PCP unless such Member requires Emergency treatment.

3.23 Referrals and Out of Network. If the commercial Product requires Referrals and has an opt-out benefit for no referral, then Network Providers who see a Member without a referral from the Member's designated Medical Home/Medical Neighborhood/PCP will be reimbursed in accordance with the terms of this Agreement and the Member's Out Of Network Benefit.

4. NETWORK PROVIDER WARRANTIES / COMPLIANCE WITH RULES AND REGULATIONS

4.1 Initial and Periodic Appraisal. Network Provider agrees to cooperate with such programs of initial and periodic appraisal as may be established by Health Plan. Network Provider agrees to require its Network Practitioners to permit Health Plan to obtain any utilization, peer review or other information regarding Network Practitioner practice of medicine from any participating institution at which Network Practitioner has practiced, provided that Network Provider is not prohibited from disclosing such information under state or federal law. Network Provider and its Network Practitioners release Health Plan and its employees or agents or any person furnishing information to Health Plan from liability for acts made in good faith and without malice in connection with this provision.

4.2 Conditional Credentialing. Initial and periodic appraisal may result in conditional credentialing. Whether to grant conditional credentialing is determined solely by Health Plan.

4.3 Rules and Regulations of Health Plan. Network Provider and its Network Practitioners agree to be bound by the Rules and Regulations of Health Plan as they may be amended from time to time. If Network Provider or any Network Practitioner violates any of the provisions of the Rules and Regulations of Health Plan, or any of the principles of professional conduct adopted by Health Plan, or acts contrary to or in violation of any Health Plan agreements, all contractual rights under this Agreement which pertain to Network Provider or to such Network Practitioner may be terminated in accordance with the Term and Termination section of this Agreement. The Rules and Regulations of Health Plan are available for examination by Network Provider and by Network Practitioners on Health Plan's website.

4.4 Physician Practitioner Requirements. Network Practitioners who are physicians and covered by this Agreement each agree that he or she is now, and will remain as long as this Agreement remains in effect, (A) the holder of (i) a currently valid license to practice medicine or osteopathy in the state of Oregon and/or Washington within his or her scope of practice, and (ii) a valid DEA or CDS certificate, as applicable, a copy of which shall be submitted to Health Plan, (B) certified as recognized by the Board of Medical Specialists or the American Osteopathic Association (unless Network Practitioner graduated prior to 1980), and (C) a medical staff member, as appropriate, in good standing on the medical staff of a Network Facility licensed as a hospital. ***Network Provider agrees to notify Health Plan immediately of any change in licensure or hospital privileges status (whether or not the hospital which has taken such action is a Network Facility).***

4.5 Non-Physician Practitioner Requirements. Network Providers who are not physicians each state as a material term of this Agreement that Network Provider and all professional employees of Network Provider are now and will remain, as long as this Agreement remains in effect, the holders of all currently required licenses, certificates and/or registrations by appropriate federal, state and local governmental agencies to provide health care services that Network Provider and professional employees of Network Provider undertake to provide to Health Plan Members under this Agreement. ***Network Provider agrees to notify Health Plan immediately upon a change in status of such licensure, certification, or registration of any Network Provider.***

4.6 Specialty Education. Network Provider agrees to require all Network Practitioners covered by this Agreement to have education and/or training and experience in the field in which they practice and to be Board Certified (unless the Network Practitioner graduated prior to 1980), or have completed an approved specialty education and/or training program.

4.7 Patient Advocate. Network Provider may act as a patient advocate regarding a decision, policy, or practice without being subject to termination or penalty for the sole reason of such advocacy. Network Provider can freely communicate with patients regarding the treatment options available to them, including medication treatment options, regardless of benefit coverage limitations.

4.8 Fraud and Abuse. Network Provider and its Network Practitioners agree to comply with Health Plan's Fraud and Abuse program and with Health Plan's questionable billing practices policies and procedures.

4.9 Network Facility Certification. Network Facility warrants that its facilities are currently certified under Title XVIII (Medicare) of the Social Security Act, when applicable, and have appropriate state licensure. Network Facility warrants that should it provide services in exempt units (skilled nursing, psychiatric, swing, rehabilitation, etc.), the units will be certified under Title XVIII (Medicare) and Title XIX (Medicaid) of the Social Security Act and have appropriate state licensure. Network Facility further warrants that it is currently accredited by a recognized accrediting organization, such as JCAHO, AAAHC or CARF, as applicable. State and/or CMS site surveys may satisfy Health Plan criteria, provided information is current. Each Network Facility agrees to maintain such licensure and certification during the term of this Agreement.

4.10 Liability Insurance. Network Provider agrees to ensure that Network Provider and its Network Practitioners, Network Facilities, and all persons and entities performing services under this Agreement, maintain such policies of general liability and professional liability insurance, self-insurance under applicable law, or such other program of liability coverage as may be customary and acceptable to Health Plan to insure Network Provider, its Network Practitioners, its Network Facilities, its employees, and agents against any claim or claims for damages arising by reason of personal injuries or death occasioned directly or indirectly in connection with the performance of, or failure to perform, any health care service provided under this Agreement, the use of any property and facilities provided by Network Provider, and activities performed by Network Provider in connection with this Agreement. The amounts and extent of such insurance coverage shall be subject to the approval of Health Plan, which approval shall not be unreasonably withheld. Certificates of Insurance for the above insurance policies shall be provided to Health Plan upon request and shall provide that Health Plan be given at least thirty (30) days prior written notice of reduction or cancellation of such coverage. Any declaration sheets, exclusions, endorsements, or information on any incident which might reasonably result or has resulted in a lawsuit or legal action may be requested by Health Plan as deemed necessary.

4.11 Program Cooperation and Participation. Network Provider and its Network Practitioners agree to cooperate and to participate in the following, as designated from time to time by Health Plan and/or as required by state or federal regulations:

Internal medical and quality management, quality improvement, and customer service activities;
Disease management programs;
External audit systems;
Rules and Regulations of Health Plan;
Development of evaluation criteria for new medical technologies or new applications of established technologies (including medical procedures, drugs and devices);
Such other systems, activities and procedures relating to Health Plan accreditation by external accrediting bodies as may be determined from time to time by Health Plan;

Clinical Quality Improvement and Outcome studies; and
Standards of Care and Service, all of which are set forth in Rules and Regulations of Health Plan and/or other Health Plan documents and communications.

Network Provider and its Network Practitioners further agree to comply with any final determinations made pursuant to any of the review processes noted above, as such determination(s) relates to Network Provider's rights and responsibilities under this Agreement. Failure to comply with such final determinations may constitute grounds for termination in accordance with the Term and Termination section of the Agreement.

4.12 Facility Inpatient Admission. If Network Provider operates a hospital Network Facility, it agrees to notify Health Plan within twenty four (24) hours after any Emergency-related inpatient hospital admission of a Member, or by the end of the next working day if the admission occurs on a weekend or holiday, and will permit review of the admission by a Health Plan physician reviewer or designated representative. The purpose of the review is to provide certification of the medical indications for the admission under Health Plan's utilization management program, which certification shall, for approved admissions, in no event be for a period shorter than the period between date of admission and receipt by Network Provider of notice of certification. Failure by such Network Facility to notify Health Plan of Member's admission and to substantiate the medical indication for the admission within the time period set forth above may result in forfeiture of Network Provider's right to compensation from either Health Plan or Member for services rendered to such Member during his or her stay.

5. QUALITY AND MEDICAL MANAGEMENT PROGRAM

5.1 Health Plan oversees the quality, cost and utilization of services rendered to Members through its Quality and Medical Management Program, in accordance with state and federal rules and regulations, and with Health Plan standards. Network Provider, Network Practitioners and Network Facilities agree to support the administration of the Quality and Medical Management Program.

A description of the Quality and Medical Management Program may be viewed on Health Plan's website.

Key features:

Quality and Medical Management Program Committees that review and monitor medical management and quality management activities;
Continuous quality of care and service improvements;
Program oversight by Medical Directors and experienced Quality and Medical Management Program staff;
Medical Policy and Payment Rule development process;
Technology Assessment Program;
Formal appeal and complaint resolution process;
Ethics Committee participation.

Medical Management Activities:

Preauthorization of selected inpatient admissions, day surgery, selected outpatient services and drugs. A complete list of these procedures is available on Health Plan's website. This list is subject to periodic modification.;
Second opinions;
Concurrent review of inpatient admissions, continued stays, and discharge planning;
Identification of patients needing individualized care management, case management, and exceptional needs care coordination (ENCC);
Review of urgent and emergent claims for appropriateness of level of care. Specialized maternity management program, Providence Beginnings. Mental Health/Chemical Dependency Program;
Organ Transplant Program. Pharmacy Management Program.

Prior Authorization. Prior Authorization is required for certain health care services. A list of inpatient, outpatient, and short- stay services that require Prior Authorization is available on Health Plan's website. The list of services requiring Prior Authorization is subject to periodic modification by Health Plan.

No Benefit Guarantee. Network Provider agrees that Prior Authorization does not guarantee benefits or payment. Benefits are based on eligibility at the time the service is rendered and are subject to any applicable contract terms.

Questions. Questions regarding materials posted on the Health Plan website should be directed to the appropriate Health Plan Provider Relations Representative.

Denied Services. Network Provider or its Network Practitioners may request a re-review of a service denied for lack of medical indications within one hundred and eighty (180) days of the initial denial. The request must be in writing and must include additional information that was not available at the time of the original determination.

Review. Professional medical staff will review all of the available information submitted with the request for re-review. At the discretion of the Chief Medical Officer or designated medical Director, a review by a physician advisor or independent third party may be requested.

Time to Complete Review. Health Plan will complete the review within twenty (20) business days of receipt of all information necessary to process the request. If Health Plan cannot make a determination within twenty (20) business days, Member and/or Provider will be notified of the reason for the delay. Health Plan will make a decision and notify Member and/or Provider within ten (10) additional business days.

Quality Initiatives. Health Plan strongly encourages Network Facilities to actively participate in Medicare Quality Initiatives, and all of the public reporting initiatives of The Leapfrog Group.

6. BILLING AND COMPENSATION

6.1 Payment for Covered Services. Health Plan agrees to pay Network Provider or its Network Practitioners for Covered Services rendered by Network Provider to Members, within Network Provider's Scope of Service.

6.2 Compensation Terms. Network Provider or its Network Practitioners will be compensated for Covered Services rendered in accord with the terms set forth in the Exhibits.

6.3 Implementation of Member Benefits. Network Provider agrees to comply with all Health Plan Rules and Regulations relating to the delivery of Covered Services. Health Plan may consult with Network Provider regarding significant changes to existing Health Plan administrative policies and procedures prior to implementation. Network Provider agrees to cooperate with Health Plan in monitoring Member Coinsurance, Copayment and/or Deductible in order to ensure that payment limitations imposed by federal law are not exceeded.

6.4 Member Responsibility. Health Plan may require Members to pay a Coinsurance, Copayment, and/or Deductible for certain Covered Services as set forth in the Member's Individual Contract or Employer Group Agreement with Health Plan. Network Provider agrees to be responsible for the collection of such Coinsurance, Copayment, and/or Deductibles. Network Provider may not waive Member’s responsibility as set forth in the Member’s Individual or Group Service Agreement with Health Plan. Members will be responsible for the payment of such Coinsurance, Copayment, and/or Deductibles.

6.5 Coordination of Benefits. Coordination of benefits (COB) refers to the rules for the order of benefit determination under which health benefit plans pay claims when a person is covered under more than one plan. Such coordination of benefits is intended to provide the covered person with the most allowable benefits available under the plans and to preclude the Network Provider from receiving an aggregate of more than one hundred percent (100%) of covered charges from all coverage. When the primary and secondary plan benefits are coordinated, determination of liability will be in accordance with the administrative rules adopted by Oregon Department of Consumer and Business Services and applicable state and federal regulation. For Network Providers residing outside the State of Oregon, applicable state laws will apply.

6.6 Contract Allowable. Health Plan will have no obligation to pay any amount that, together with all other Health Plan payments to and contractual adjustments made by the Network Provider, exceeds the amount allowable by Health Plan for the service as set forth in the Exhibits.

6.7 Additional Fees Prohibited. Network Provider understands and agrees that any additional fees or surcharges for Covered Services charged to Members are prohibited. An additional fee shall mean any charge that is not previously approved by Health Plan. A surcharge is an additional fee which is charged to a Member for Covered Services but which is not provided for under the applicable enrollment agreement or disclosed in the evidence of the Member's coverage.

6.8 Claim Submission. Network Provider agrees to submit claims whether primary, secondary or other payor to Health Plan on industry accepted claim forms for all Covered Services rendered to Members. Such claim form shall include statistical and descriptive medical and patient data (including present-on-admission (POA) for hospitals) in a form specified by Health Plan. Diagnosis codes listed will note the highest level of specificity. Billings will be consistent with ethical and community standard billing practices, and shall include such "CMS compliant" encounter data or other information as may be required of Health Plan by CMS or by state agencies. Under usual circumstances, such claim form shall be submitted to Health Plan within sixty (60) days of the date of service, and in no case later than twelve (12) months from the date of service. Neither Member nor Health Plan shall be responsible for the payment of bills submitted after the twelve (12) month period,

except in cases where Network Provider submits the claim no later than 12 months after a different insurer (a) denied the claim in whole or in part; or (b) requested a refund of an erroneous payment made on the claim.

6.9 Accepting Partial Member Payment. Network Provider may accept a partial or estimated payment on coinsurance and/or deductible obligations before Health Plan has adjudicated the amount of such obligations, but only if the following conditions have been met: (1) Network Provider has verified Member's eligibility and benefits, and (2) Network Provider has a reliable process in place for timely reconciliation and timely repayment to Member of any overpayments by Member. Network Provider is expected to make extended payment options available to the patient when necessary. Network Provider may not redirect Member to another provider solely for the purpose of shifting financial risk to the other provider.

6.10 Third Party. In the event of a Member's illness or injury for which a third party other than Health Plan has accepted financial responsibility or has been judged to be liable by an entity empowered to assess liability (such as a court or similar adjudicative body), Network Provider will bill the third party for payment prior to billing Health Plan. Any remaining unpaid balance due after forty five (45) days from billing may be billed to Health Plan for payment consideration. The amount available for collection by Network Provider from the third party shall be applied to charges for medical care of a Member at Health Plan's contracted rates prior to accessing the resources of Health Plan. If such third party liability eliminates any financial obligation of Health Plan on a Member's behalf, Health Plan will have no liability under this Agreement with respect to such illness or injury. In the event the third party is not liable for the illness or injury of a Member or if recovery from the third party is less than Health Plan's obligation to Member in the absence of payment by a third party, Network Provider must comply with Health Plan's rules governing the provision of Covered Services and the terms of this Agreement in order for Health Plan to be financially responsible.

6.11 Electronic Claims. The parties agree to cooperate in electronic submission of claims whenever possible.

6.12 Pay Clean Claim. Health Plan agrees to pay a Clean Claim within the time period mandated by applicable state and federal law.

6.13 Refund Request by Health Plan. Except in cases of coordination of benefits, fraud or abuse of billing, Health Plan may not request refunds from Network Provider unless it is within eighteen (18) months of initial payment. The request must be in writing and must specify why the refund is being requested. Health Plan may not request that a contested refund be paid earlier than six (6) months after the Network Provider receives the request. In the case of coordination of benefits, Health Plan may not request a refund unless it is within thirty (30) months after the date of payment. The request must be in writing and must specify why the refund is being requested and include the name of the primary payor or entity. If Network Provider fails to contest the refund request within thirty (30) days, the request is deemed accepted and Network Provider must pay within thirty (30) days (60 days total). If Network Provider does not pay, Health Plan can recover through offset of a future claim. Health Plan may at any time request a refund if the third party or government entity is found responsible by law, or if the Health Plan is unable to recover directly from the third party because the third party already paid or will pay the Network Provider for the health care services covered by the claim.

6.14 Additional Payment Request by Network Provider. Except in cases of coordination of benefits, fraud or abuse of billing, Network Provider may not request additional payment unless the request is in writing and within eighteen (18) months of the date of a denial or partial payment. The request must be in writing and must specify why the additional payment is being requested. The Network Provider may not request that an additional payment be paid earlier than six (6) months after Health Plan receives the request. In the case of coordination of benefits, Network Provider may not request additional payment unless it is within thirty (30) months after the date the claim was denied or payment intended to satisfy the claim was made. The request must be in writing and must specify the reason for the request and must include the name and address of the primary payor or entity.

6.15 Once Per Case. A request for re-review will be performed by Health Plan only once per case.

6.16 Never Events. Neither Network Provider nor Network Practitioners nor Network Facilities shall seek payment from Health Plan or from Member for costs associated with “never events.” Health Plan will not provide payment for identified “never events.” Health Plan will be guided by the recommendations of the National Quality Forum, the American Hospital Association, CMS, and other relevant sources as to what constitute such events.

7. RECORDS AND CONFIDENTIALITY

7.1 Record Sharing. Network Provider agrees to participate in any system established by Health Plan that will facilitate, to the extent feasible, the maximum sharing of records, subject to compliance by Health Plan with state and/or federal law regarding confidentiality. Network Provider agrees to retain records in accordance with other minimum requirements of state law. Such obligations continue despite the termination of this Agreement. Health Plan shall have access at reasonable times upon demand to the records of Network Provider. Network Provider and Health Plan agree to treat all medical records of

Members as confidential so as to comply with all federal and/or state laws and regulations regarding the confidentiality of patient records. Network Provider agrees to cooperate with Health Plan in maintaining and providing financial records, and medical histories, administrative and other records of Members as shall be requested. Requests for copies shall be reasonable in nature.

7.2 Record Copying. Network Provider agrees, upon reasonable request by Health Plan, to provide access to and/or copies of all records necessary (A) for purposes of assessing quality of care, medical indications and/or appropriateness of care, (B) for claims adjudication, and (C) to comply with the provisions of the Rules and Regulations of Health Plan and/or the utilization and quality management program, the re-appraisal process, and records requests from state and federal regulatory agencies and review organizations. Health Plan will allow Network Provider a reasonable length of time within which to provide the requested documents. The parties agree that such records shall maintain the same confidential nature they had while in the possession of Network Provider. Network Provider is responsible for costs associated with record copying.

7.3 Record Retention. All clinical records shall be retained for ten (10) years, or as is required by law, after the date of service for which claims are made. If an audit, litigation, or research and evaluation, or other action involving the records is started before the end of the ten (10) year period, the records must be retained until all issues are resolved.

7.4 Audit of Records. Network Provider agrees, at all reasonable times, to provide Health Plan and any state or federal regulatory agency, and their duly authorized representatives, access to its facilities and to its medical records for the purpose of making audit or examination; upon request, Network Provider agrees to provide a suitable work area and copying capabilities to facilitate such a review or audit. This right to inspect, evaluate, and audit extends through ten (10) years from expiration or termination of this Agreement or completion of audit, whichever is later, unless the regulator extends this period or asserts a right to inspect, evaluate, or audit at any other time on account of a special need to retain particular records or a dispute or possibility of dispute related to such records, in which case the regulator's determination shall govern. This provision shall continue in effect notwithstanding the termination of this Agreement.

7.5 Proprietary Information. Network Provider agrees to maintain the confidentiality of documents, terms, and conditions relating to reimbursement rates and methods and other proprietary information of Health Plan. Upon request, Network Provider agrees to return all copies of documents containing any of Health Plan's proprietary information upon termination of this Agreement.

7.6 Medical Record Availability. Subject to applicable confidentiality requirements, Network Provider agrees to provide for a system, to the extent feasible, which permits sharing of records by Network Providers and other health care professionals providing service to Members. Medical records shall be made available to each Network Provider and other health care professional treating Member. In addition, medical records shall be made available upon request by any proper committee of Network Provider or Health Plan to determine that content and quality are acceptable, as well as for peer review or grievance review.

7.7 Compliance with Applicable Law. Notwithstanding anything to the contrary, Network Provider's obligations under this agreement are expressly subject to the Oregon Public Records Law, Oregon Revised Statutes ("ORS") Chapter 192 et. seq., and any other applicable state or federal law. Health Plan asserts that Confidential Information, defined above, submitted pursuant to this agreement is exempt from disclosure under one or more exceptions including, but not limited to: ORS 192.345(2) (trade secrets) and ORS 192.354(4) (confidential submissions). While Network Provider will make good faith efforts to perform under this agreement, Network Provider's disclosure of Confidential Information, in whole or in part, will not be a breach of the agreement if such disclosure was pursuant to a request under the Oregon Public Records Law, or any other state or federal law, or if such disclosure was compelled by deposition, interrogatory, request for documents, subpoena, civil investigative demand, or similar processes. If Network Provider is subject to such a disclosure order or receives from a third party any public records request for the disclosure of Confidential Information, Network Provider shall notify Health Plan within a reasonable period of time of the request. Health Plan is exclusively responsible for defending Health Plan's position concerning the confidentiality of the requested information. Network Provider is not required to assist Health Plan in opposing disclosure of Confidential Information, nor is Network Provider required to provide a legal opinion as to whether the Confidential Information is protected under ORS Chapter 192, et. seq., or other applicable state or federal law.

8. AMENDMENTS

8.1 Amendment. Health Plan may amend this Agreement by notifying Network Provider in writing of changes in compensation and language. If no written objection is received within thirty (30) days, Network Provider shall be deemed to approve such amendment.

8.2 Regulatory Amendment. If state or federal law, government agency regulations or accrediting agency requirements

change and affect any provisions of this Agreement, then this Agreement will be deemed amended to conform with such changes effective the date such changes become effective. Health Plan will give Network Provider written notice of such changes.

9. TERM AND TERMINATION

9.1 Effective Date. The term of this Agreement shall commence on March 1, 2026. This Agreement shall remain in effect until the tenth (10) anniversary of the effective date (the "Initial Term"), unless terminated pursuant to the terms of this Agreement.

9.2 Credentialing Required. Participating status for individual practitioners or facilities covered under this Agreement is contingent upon credentialing approval in advance by Health Plan. Network Provider will be notified by Health Plan of the effective date for each Network Practitioner or Network Facility.

9.3 Termination without Cause. This Agreement may be terminated without cause by Network Provider or Health Plan upon sixty (60) days prior written notice. Upon such termination, the rights of Network Provider shall terminate, provided, however, that such action shall not release Network Provider from obligations to persons then receiving treatment. Network Provider agrees to be paid in accordance with this Agreement for Covered Services provided prior to termination of this Agreement.

9.4 Termination Automatic with Cause.

The following provision applies to Network Facilities:

This Agreement will automatically terminate upon the revocation, non-renewal, limitation or suspension of a Network Facility's license for any or all parts of its facilities or services.

The following provisions apply to Network Practitioners:

This Agreement will automatically terminate upon the occurrence of any of the following events: if Network Practitioner (i) dies, (ii) retires, (iii) is adjudicated incompetent, (iv) has his or her professional license revoked, restricted, suspended, or not renewed, (v) loses his or her hospital privileges, or (vi) voluntarily leaves active practice in Health Plan service area for a period of six (6) months or more.

9.5 Termination with Cause.

The following provisions apply to Network Facilities and to Network Practitioners:

This Agreement may be terminated with cause by either party by giving written notice to the other party at least thirty (30) days in advance of the effective date of termination in the event that the other party (i) fails to pay valid, past due debts, (ii) lacks the financial resources to pay its financial obligations, (iii) fails to maintain required professional liability insurance coverage, (iv) makes any intentional misrepresentation to Member regarding the provision of medical services or the payment thereof, (v) fails to accept the results of and comply with the requirements of the utilization and quality management committees of Health Plan, (vi) fails to participate in and accept the Rules and Regulations of Health Plan, (vii) is determined by Health Plan to no longer meet Health Plan's standards for credentialing, (viii) suffers limitation of a required license, or(ix) is in breach of any material provision of this Agreement. Such notice shall set forth the facts underlying the alleged breach. Remedy of such breach within twenty (20) days of the receipt of such notice shall revive the Agreement in effect for its remaining term, subject to any other provision of this Agreement.

The following provision also applies to Network Practitioners:

At Health Plan's discretion, with thirty (30) days prior written notice, this Agreement may be terminated with cause if any Network Practitioner has his or her professional license revoked, restricted, suspended, or not renewed, or suffers limitation of hospital medical staff privileges. A Network Practitioner's license shall be deemed to have been "restricted" if any requirement is imposed on the Network Practitioner by a licensing agency that does not apply to all licensees of the same category of license held by Network Practitioner. If Network Provider is terminated under this provision, payment for Covered Services provided prior to termination shall be made in accordance with this Agreement and the notice of termination shall set forth the facts underlying the alleged breach.

9.6 Termination with Cause of Less Than Entire Agreement. Health Plan may, at its sole discretion, choose to terminate an individual practitioner or individual facility providing Covered Services under this Agreement whose conduct

would otherwise give Health Plan cause to terminate this Agreement in its entirety. Upon such individual termination, the Agreement shall remain in effect as to all other practitioners or facilities covered by it.

9.7 Immediate Termination. Nothing herein shall be construed as limiting the right of Health Plan to terminate this Agreement, or an individual practitioner or facility providing Covered Services under this Agreement, immediately where Health Plan determines that the health, safety or welfare of any Member is jeopardized by failing to do so. If Network Provider is terminated under this provision, payment for Covered Services provided prior to termination shall be made in accordance with this Agreement.

9.8 Transitional Plan for Member. The parties recognize and agree that Member must not suffer or be exposed to avoidable risks to life and welfare due to circumstances related to termination of this Agreement. Therefore, upon receipt of termination notice by either party and under the supervision of the Chief Medical Officer, the parties agree to establish a written plan for transitional services for any affected Member. Such plan shall be completed within seven (7) working days of issuance of a termination notice. If Network Provider is a hospital, reimbursement for Covered Services provided after termination for any Member who is an inpatient of hospital as of the effective date of termination will continue to be governed by this Agreement until discharged from inpatient stay.

9.9 Continuity of Care. If Network Provider is a primary care provider and Health Plan terminates this Agreement without cause, this Agreement will continue in force for at least sixty (60) days following notice of termination to Members.

9.10 Coordination of Member Communication. Health Plan and Network Provider agree to coordinate any communications to be made by Health Plan or Network Provider to other parties of the reasons for and circumstances surrounding any termination of this Agreement.

9.11 Obligations after Termination. The following obligations of the parties shall continue after any termination of this Agreement:

9.11.1 To indemnify and hold each other harmless as otherwise described in this Agreement;

9.11.2 To cooperate with each other in the event any action or other proceeding based on or related to the facts having to do with this Agreement is brought by any third party against either of them;

9.11.3 To maintain medical records and allow access to information as provided in this Agreement.

9.11.4 To maintain the confidentiality of records.

9.11.5 To resolve disputes under this Agreement in accord with its terms.

9.11.6 To hold members harmless with respect to billings for Covered Services provided during the term of this Agreement.

9.11.7 To accept payment under this Agreement for members hospitalized at the time of termination.

9.11.8 To coordinate member communications.

9.12 Network Practitioner Rights upon Termination or Other Disciplinary Action. The Rules and Regulations of Health Plan (Credentialing Policies and Procedures) are incorporated by reference into this Agreement, including but not limited to those related to:

9.12.1 The process by which improvements and corrections may be required with respect to a Network Practitioner's performance.

9.12.2 The processes for identifying any need to take action with regard to limiting or terminating a Network Practitioner’s credentialing occurs.

9.12.3 The Network Practitioner’s rights to notice and opportunity to be heard when the Health Plan acts to remove or to limit participation in the Health Plan.

9.13 Rights and Obligations of Parties. Termination shall have no effect on the rights and obligations of the parties arising out of any transactions occurring prior to the effective date of such termination. Reimbursement for Covered

Services provided after termination for any Member who is an inpatient of Network Facility as of the effective date of termination will continue to be governed by this Agreement.

10. DISPUTE RESOLUTION

10.1 Health Plan Disciplinary Action. In the event that Health Plan imposes disciplinary action with respect to any Network Practitioner, including termination of this Agreement with respect to such Network Practitioner, the Network Practitioner shall have the right to a hearing before a Hearings Panel under the procedures set forth in Health Plan's Disciplinary Action Hearings Process Policy, which is incorporated by reference into this Agreement. In short, Network Practitioner has thirty (30) days from notice of discipline to request a hearing, and has the rights to select one of the three panel members, to be represented by counsel, to have a record made of the proceedings, to call and question witnesses, to present oral and written evidence. Any appeal from the decision of the Hearings Panel in such cases shall be handled as a dispute under the procedure set forth below.

10.2 Dispute/Litigation. In the event of any dispute arising out of or relating to this Agreement, the parties shall first attempt in good faith to mutually resolve the dispute. If the parties are unable to resolve the dispute within ninety (90) days of the grieving party's written notice of the dispute to the non-grieving party, or in accordance with the applicable timeframes and procedures otherwise described within this Section 10, the grieving party may bring legal action against the non-grieving party, which shall be filed in a Superior Court for the State of Oregon or in the Multnomah County Circuit Court.

10.3 Legal Fees. In the event suit or legal action is instituted by any party seeking interpretation of the terms hereof seeking redress for a breach of Paragraph 10.2 of this Agreement, the prevailing party shall be entitled to all costs and attorneys' fees incurred at trial or on any appeal.

11. HOLD HARMLESS

11.1 Hold Harmless. Network Provider may bill Member for non-Covered Services that Network Provider provides. Network Provider agrees that in no event, including but not limited to nonpayment by Health Plan, insolvency of Health Plan, or breach of this Agreement, shall Network Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a subscriber, an enrollee or persons (other than Health Plan) acting on a Member's behalf for Covered Services provided pursuant to this Agreement. This provision does not prohibit Network Provider from collecting Copayments, Coinsurance, Deductibles or fees for non-Covered Services delivered to Health Plan Members (subscribers/enrollees).

Network Provider agrees that this provision shall survive the termination of this Agreement, for Covered Services rendered prior to the termination of this Agreement, regardless of the cause giving rise to termination, and shall be construed to be for the benefit of Members. This provision is not intended to apply to services provided after this Agreement has been terminated.

Network Provider agrees that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between the Network Provider and Member, or persons acting on their behalf insofar as such contrary agreement relates to liability for payment for services provided under the terms and conditions of this Agreement.

Any modification, addition, or deletion to this provision shall become effective on a date no earlier than fifteen (15) days after the appropriate regulating entity has received written notification of proposed changes.

12. GOVERNING LAW & REGULATORY REQUIREMENT

12.1 Governing Law. This Agreement shall be governed by the applicable laws of Oregon and by applicable federal law. In the event any term or condition hereof shall be deemed invalid by an arbitrator or a court of competent jurisdiction, any and all other terms or provisions hereof shall remain valid and in force.

12.2 Agree to Comply. The Parties agree to comply with all applicable state and/or federal laws and regulations, including HIPAA.

13. TRANSPARENCY

13.1 Data Sharing. Health Plan intends to collect objective measurements relating to Network Provider's practice and to make such measurements available to other Network Providers, to patients, and/or to the public, in detail or in summary format, subject only to protecting patients' state and/or federal confidentiality rights. Network Provider will have the opportunity to meet with Health Plan to discuss the methodology of data collection and will have the opportunity to review

and correct Health Plan's source data prior to publishing. Network Provider hereby waives any claim that such measurements are privileged or confidential, under ORS 41.675 or otherwise, and consents to Health Plan's use and disclosure of such practice measurements.

14. GENERAL PROVISIONS

14.1 Assignment. Network Provider may not assign rights, duties or obligations under this Agreement without the prior written consent of Health Plan. This Agreement shall survive the sale, merger or asset transfer of Health Plan, and bind any successor of Health Plan to its terms and conditions.

14.2 Behavioral Health Services. Covered mental health and chemical dependency benefits administered by Health Plan's behavior health contractor are not covered under this contract. Covered mental health and chemical dependency benefits administered by Health Plan are covered under this contract.

14.3 Entire Agreement. This Agreement, including its Attachments, Addendums or Exhibits, contains all of the terms and conditions agreed upon by the parties regarding the subject matter of this Agreement. Any prior agreements, promises, negotiations or representations of or between the parties, either oral or written, relating to the subject matter of this Agreement, which are not expressly set forth in this Agreement and the Attachments, Addendums or Exhibits hereto, are null and void and of no further force or effect.

14.4 Headings. The headings of the various sections of this Agreement are inserted merely for the purpose of convenience and do not expressly or by implication limit or define or extend the specific terms of the section so designated.

14.5 Order of Precedence. The specific terms of an Attachment, Addendum or Exhibit shall take precedence, if in conflict with a general term of this Agreement. This Agreement may not modify the benefits, terms, or conditions of any Individual Contract or Employer Group Agreement with respect to what constitute Covered Services.

14.6 Indemnification. Within the limits of its insurance policies and to the extent not otherwise inconsistent with the laws of the State of Oregon and/or Washington, the Oregon Constitution, and the Oregon Tort Claims Act,the parties mutually agree to indemnify and to hold each other (including their officers, agents and employees) harmless against any and all claims, demands, damages, liabilities and costs incurred by the other party, arising out of or in connection with, either directly or indirectly, the breach of this Agreement by or willful misconduct of the indemnifying party or its employees or agents. The fact that a physician or other provider is a Network Practitioner does not make such person an agent of Health Plan unless the person's agreement with Health Plan explicitly so provides. The principles of comparative fault shall govern the interpretation and enforcement of this indemnity provision.

14.7 Independent Parties. None of the provisions of this Agreement is intended to create, nor shall any be deemed or construed to create, any relationship between the parties other than that of independent entities contracting with each other under this Agreement solely for the purpose of effecting the provisions of this Agreement. Neither of the parties hereto, nor any of their respective employees, shall be deemed to be the agent, employer, partner, joint venture, or representative of the other, except as specifically provided herein.

14.8 Invalid Provisions. The invalidity or unenforceability of any terms or conditions hereof shall in no way affect the validity or enforceability of any other term or provision.

14.9 Liaison. The parties agree to maintain an effective liaison and close cooperation with each other to provide maximum benefits to each Member at the most reasonable cost consistent with quality standards of medical practice.

14.10 Notices. Notices required to be given pursuant to the terms and provisions hereof shall be in writing and shall be sent to Health Plan or Network Provider at their respective places of business.

14.11 Waiver. The waiver by either party of a breach or violation of any provision of this Agreement shall not operate as or be construed to be a waiver of any subsequent breach.

PROVIDENCE HEALTH PLAN, PROVIDENCE HEALTH ASSURANCE AND PROVIDENCE PLAN PARTNERS PROVIDER AGREEMENT

SIGNATURE PAGE

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed in their names by the undersigned officers, the same being duly authorized to do so.

CLACKAMAS COUNTY, A POLITICAL SUBDIVISION OF THE STATE OF OREGON, ON BEHALF OF THE HEALTH CENTERS DIVISION OF ITS DEPARTMENT OF HEALTH, HOUSING, AND HUMAN SERVICES

Signature

Print Name

Title

Date

PROVIDENCE HEALTH PLAN, PROVIDENCE HEALTH ASSURANCE AND PROVIDENCE PLAN PARTNERS

Signature

Don Antonucci
Print Name

Chief Executive Officer
Title

Date

CLACKAMAS COUNTY COUNSEL

Approved Via Email by Ryan Hammond on January 8, 2026

Signature

Print Name

Title

Date

PROVIDENCE HEALTH PLAN, PROVIDENCE HEALTH ASSURANCE AND PROVIDENCE PLAN PARTNERS
COMMERCIAL AND MEDICARE LINES OF BUSINESS
PROVIDENCE SIGNATURE NETWORK, PROVIDENCE CHOICE NETWORK, PROVIDENCE EXTEND PPO NETWORK, PROVIDENCE INTEL-CONNECTED CARE NETWORK, PROVIDENCE CONNECT (PROVCONNECT) NETWORK AND PROVIDENCE MEDICARE NETWORK
EXHIBIT

This Providence Signature, Providence Choice, Providence Extend PPO, Providence Intel-Connected Care, Providence Connect (ProvConnect) and Providence Medicare Network Exhibit sets forth terms and conditions which are applicable to the Networks. Network Provider agrees to participate in the Networks as listed below:

COMMERCIAL NETWORKS

Providence Signature Network (Signature Network) is a Providence Health Plan provider network for Individual Members, large and small employer groups and Employer Sponsored Accounts (ASO) who have selected to purchase a Product offered by or administered by Providence Health Plan for themselves or for their employees. Signature Network is a network of Network Practitioners and Network Facilities contracted to provide services to Members that have chosen Providence Health Plan's Signature provider network.

Providence Choice Network (Choice Network) is a Providence Health Plan provider network for Individual Members, large and small employer groups and Employer Sponsored Accounts (ASO) who have selected to purchase a Product offered by or administered by Providence Health Plan for themselves or for their employees. Providence Choice Network is a network of Network Practitioners and Network Facilities contracted to provide services to Members that have chosen Providence Health Plan's Providence Choice provider network.

Providence Extend PPO Network (Extend PPO Network) is a Providence Health Plan provider network for Individual Members, large and small employer groups and Employer Sponsored Accounts (ASO) who have selected to purchase a Product offered by or administered by Providence Health Plan for themselves or for their employees. Providence Extend PPO Network is a network of Network Practitioners and Network Facilities contracted to provide services to Members that have chosen Providence Health Plan's Providence Extend PPO provider network.

Providence-Intel Connected Care Network (Connected Care Network) is a Providence Health Plan provider network specific for Intel Corporation and is offered by or administered by Providence Health Plan. Providence-Intel Connected Care (Connected Care) Network is a network of Network Practitioners and Network Facilities contracted to provide services to Intel Members that have chosen Providence Health Plan's Providence-Intel Connected Care (Connected Care) provider network. Connected Care is a patient centered medical home plan that utilizes the Connected Care Network.

Providence Connect Network (ProvConnect Network) is a Providence Health Plan provider network for Individual Members, large and small employer groups and Employer Sponsored Accounts (ASO) who have selected to purchase a Product offered by or administered by Providence Health Plan for themselves or for their employees. ProvConnect Network is a network of Network Practitioners and Network Facilities contracted to provide services to Members that have chosen Providence Health Plan's ProvConnect provider network**.** ProvConnect Care is a patient centered medical home plan that utilizes the ProvConnect Network.

Providence Choice, Intel-Connected Care and ProvConnect Network Providers (Network Provider) will provide coordinated Covered Services based upon the Member's proposed plan of treatment as directed by the designated patient centered medical home.

MEDICARE NETWORK

Providence Medicare Network (Medicare Network) is a Providence Health Assurance provider network for Medicare Members who have selected to purchase a Product offered by or administered by Providence Health Assurance. Medicare Network is a network of Network Practitioners and Network Facilities contracted to provide services to Members that have chosen Providence Health Assurance's Medicare provider network.

Providence Medicare Network Communications and Marketing. Network Provider shall remain neutral when assisting beneficiaries with enrollment decisions. Network Provider may distribute and/or make available Health Plan marketing materials as long as Network Provider distributes or makes available marketing materials for all health plans with which the Network Provider participates, if requested by other health plans.

SCOPE OF SERVICES

Network Provider is engaged to provide Covered Services to Members.

Network Provider is engaged only to provide Covered Services which Network Provider is professionally qualified to render.

The rates in this Exhibit are premised on services offered by Network Provider as of the inception of this Agreement. In the event Network Provider adds new services, Network Provider agrees to notify Health Plan within a reasonable time, 1) in order for Health Plan to determine whether such new services will be incorporated into current Agreement, and 2) to negotiate in good-faith the rates applicable to such new services.

PAYMENT FOR COVERED SERVICES

Health Plan will pay Network Provider for Covered Services at 100% of the allowed compensation, less any applicable Copayment, Coinsurance and Deductibles, in accordance with the fee schedule in this Exhibit. Member coinsurance and deductibles are calculated using the allowed compensation, not billed charges.

PROVIDENCE HEALTH PLAN, PROVIDENCE HEALTH ASSURANCE AND PROVIDENCE PLAN PARTNERS
COMMERCIAL LINE OF BUSINESS
PROVIDENCE SIGNATURE NETWORK, PROVIDENCE CHOICE NETWORK, PROVIDENCE EXTEND PPO NETWORK, PROVIDENCE INTEL-CONNECTED CARE NETWORK AND PROVIDENCE CONNECT (PROVCONNECT) NETWORK EXHIBIT

BEHAVIORAL HEALTH FEE SCHEDULE

EFFECTIVE DATE: MARCH 1, 2026

Service Type	Codes	Payment Source	Rate
Professional Services **Provider Type: MD/DO/NP**	10000-99999 (CPT), applicable HCPCS	2023 CMS RBRVS RVUs (available as of 12/31/2022)	$49.35
Professional Services **Provider Type: LP**	10000-99999 (CPT), applicable HCPCS	2023 CMS RBRVS RVUs (available as of 12/31/2022)	$0.00
Professional Services **Provider Type: MA**	10000-99999 (CPT), applicable HCPCS	2023 CMS RBRVS RVUs (available as of 12/31/2022)	$37.00
Lab/Pathology	80000-89999 (CPT), applicable HCPCS	2023 CMS Laboratory (available as of 12/31/2022), codes with RBRVS RVUs will be priced at the RBRVS Rate.	100%
Drugs	A - S (HCPCS), applicable 9xxxx (CPT)	Drug codes will use the most current CMS Average Sales Price (ASP), if no ASP will be priced at Wholesale Acquisition Cost (WAC) or Average Wholesale Price (AWP).	100%
Immunizations	9xxxx (CPT), applicable (HCPCS)	Immunizations priced using Wholesale Acquisition Cost (WAC), if no WAC priced at CMS Average Sales Price (ASP) or Average Wholesale Price (AWP).	100%
Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)	HCPCS	2023 Medicare DMEPOS Fee Schedule (available December 31, 2022).	100%
Default		Services without an RVU, CLAB, CMS ASP, WAC, AWP, or established allowable.	60% of covered charges

TERMS AND CONDITIONS:

- Reimbursement will be at the allowed amount or billed charges, whichever is less.
- CMS Resource Based Relative Value Scale (RBRVS) Relative Value Unit (RVU). The RVU will be based on place of service and will not be geographically adjusted.
- New codes not included in the existing fee schedules may be evaluated and priced by Health Plan applying the most current published fee schedule rates, weights or RVUs. Service codes not encompassed by fee schedules may be priced at Health Plan's discretion by applying a most comparable rate. The most current code sets will be recognized by Health Plan in accordance with HIPAA regulations.
- Physical Therapists, Occupational Therapists, Speech Therapists, and Registered Dieticians will not be covered under this Fee Schedule.
- Audiologists and Certified Registered Nurse Anesthetists will not be covered under this Fee Schedule.
- Anesthesia services will not be covered under this Fee Schedule.

- Specific services within the code ranges listed above may be excluded from this Agreement. For example, Network Provider may not be contracted to provide the technical component for MRI, CT or other high tech services.
- This Agreement does not cover sleep study services unless Health Plan has approved Network Provider to perform those specific services.
- Providence Home Services is the designated provider for home health, hospice, prosthetics, supplies and durable medical equipment (including machines for the treatment of sleep apnea related conditions), unless a) otherwise approved by Health Plan, or b) area is not serviced by Providence Home Services.
- For any other commercial network, if there is no separate Fee Schedule, Network Provider will be reimbursed in accordance with the terms of this Fee Schedule and the Member's benefits.

PROVIDENCE HEALTH PLAN, PROVIDENCE HEALTH ASSURANCE AND PROVIDENCE PLAN PARTNERS
MEDICARE LINE OF BUSINESS
PROVIDENCE MEDICARE NETWORK EXHIBIT

BEHAVIORAL HEALTH FEE SCHEDULE

EFFECTIVE DATE: MARCH 1, 2026

BEHAVIORAL HEALTH PROVIDER

Service Type	Codes	Payment Source	Rate
Professional Services	10000-99999 (CPT), applicable HCPCS	Most current Medicare Physician Fee Schedule (MPFS) with quarterly updates and will not include the bonuses or penalties associated with the Merit-based Incentive Payment System or the incentives associated with the Alternative Payment Models under the Medicare Quality Payment Program.	110%
Lab/Pathology	80000-89999 (CPT), applicable HCPCS	Most current Medicare Clinical Diagnostic Laboratory Fee Schedule, including updates. Lab services with an RBRVS weight will be reimbursed at the Professional Services rate.	100%
Drugs	A - S (HCPCS), applicable 9xxxx (CPT)	Most current Medicare Average Sales Price (ASP), if no ASP, priced at Wholesale Acquisition Cost (WAC) or Average Wholesale Price (AWP).	100%
Immunizations	9xxxx (CPT), applicable (HCPCS)	Most current Medicare Average Sales Price (ASP), if no ASP, priced at Wholesale Acquisition Cost (WAC) or Average Wholesale Price (AWP).	100%
Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)	HCPCS	Most current Medicare DMEPOS Fee Schedule, including updates.	100%
Parenteral and Enteral Nutrition (PEN)	HCPCS	Most current Medicare PEN Fee Schedule, including updates.	100%
Default		Services without an RVU, CLAB, CMS ASP, WAC, AWP, PEN or established allowable.	60% of covered charges

TERMS AND CONDITIONS:

- Allowed charges will be calculated according to the applicable fee schedule, or billed charges, whichever is less.
- Service codes not encompassed by fee schedules may be priced at Health Plan's discretion by applying a most comparable rate. The most current code sets will be recognized by Health Plan in accordance with HIPAA regulations.
- Revisions to fee schedules to accommodate CMS quarterly and off-cycle updates will occur regularly and in a reasonable timeframe, given revisions to claims adjudication software.
- Physical Therapists, Occupational Therapists and Speech Therapists will not be covered under this Fee Schedule.
- Anesthesia services will not be covered under this Fee Schedule.
- Specific services within the code ranges listed above may be excluded from this Agreement. For example, Network Provider may not be contracted to provide the technical component for MRI, CT or other high tech services.

- This Agreement does not cover sleep study services unless Health Plan has approved Network Provider to perform those specific services.
- Home Services: Providence Home Services is the designated provider for home health, hospice, prosthetics, supplies and durable medical equipment (including machines for the treatment of sleep apnea related conditions), unless a) otherwise approved by Health Plan, or b) area is not serviced by Providence Home Services.

PROVIDENCE HEALTH PLAN, PROVIDENCE HEALTH ASSURANCE AND PROVIDENCE PLAN PARTNERS
MEDICARE LINE OF BUSINESS
PROVIDENCE MEDICARE NETWORK EXHIBIT

PROVIDENCE HEALTH ASSURANCE
MEDICARE ADVANTAGE COMPLIANCE PROVISIONS

CMS requires that specific terms and conditions be incorporated into the Agreement between a Medicare Advantage Organization or First Tier Entity and a First Tier Entity or Downstream Entity to comply with the Medicare laws, regulations, and CMS instructions, including, but not limited to, the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 ("MMA"); and

Except as provided herein, all other provisions of the Agreement between Providence Health Assurance (a Medicare Advantage Health Plan, hereafter "PHA" or "MA organization") and Network Provider not inconsistent herein shall remain in full force and effect. This Exhibit shall supersede and replace any inconsistent provisions to such Agreement; to ensure compliance with required CMS provisions, and shall continue concurrently with the term of such Agreement.

NOW, THEREFORE, the parties agree as follows:

Definitions:

Centers for Medicare and Medicaid Services ("CMS"): the agency within the Department of Health and Human Services that administers the Medicare program.

Completion of Audit: completion of audit by the Department of Health and Human Services, the Government Accountability Office, or their designees of a Medicare Advantage Organization, Medicare Advantage Organization contractor or related entity.

Downstream Entity: any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit, below the level of the arrangement between an MA organization (or applicant) and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

Final Contract Period: the final term of the contract between CMS and the Medicare Advantage Organization.

First Tier Entity: any party that enters into a written arrangement, acceptable to CMS, with an MA organization or applicant to provide administrative services or health care services for a Medicare eligible individual under the MA program.

Medicare Advantage ("MA"): an alternative to the traditional Medicare program in which private plans run by health insurance companies provide health care benefits that eligible beneficiaries would otherwise receive directly from the Medicare program.

Medicare Advantage Organization ("MA organization"): a public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the MA contract requirements.

Member or Enrollee: a Medicare Advantage eligible individual who has enrolled in or elected coverage through a Medicare Advantage Organization.

Provider: (1) any individual who is engaged in the delivery of health care services in a State and is licensed or certified by the State to engage in that activity in the State; and (2) any entity that is engaged in the delivery of health care services in a State and is licensed or certified to deliver those services if such licensing or certification is required by State law or regulation.

Related entity: any entity that is related to the MA organization by common ownership or control and (1) performs some of the MA organization's management functions under contract or delegation; (2) furnishes services to Medicare enrollees under an oral or written agreement; or (3) leases real property or sells materials to the MA organization at a cost of more than $2,500 during a contract period.

Required Provisions:

First Tier or Downstream Entity agrees to the following:

1. HHS, the Comptroller General, or their designees have the right to audit, evaluate, collect, and inspect any pertinent information for any particular contract period, including, but not limited to, any books, contracts, computer or other electronic systems (including medical records and documentation of the first tier, downstream, and entities related to CMS' contract with [Entity Name], (hereinafter, "MA organization") through 10 years from the final date of the final contract period of the contract entered into between CMS and the MA organization or from the date of completion of any audit, whichever is later. [42 C.F.R. §§ 422.504(i)(2)(i) and (iv)]

2. HHS, the Comptroller General, or their designees have the right to audit, evaluate, collect, and inspect any records under paragraph 1 of this amendment directly from any first tier, downstream, or related entity. For records subject to review under paragraph 1, except in exceptional circumstances, CMS will provide notification to the MA organization that a direct request for information has been initiated. [42 C.F.R. §§ 422.504(i)(2)(ii) and (iii)]

3. First Tier or Downstream Entity will comply with the confidentiality and enrollee record accuracy requirements, including: (1) abiding by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information, (2) ensuring that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas, (3) maintaining the records and information in an accurate and timely manner, and (4) ensuring timely access by enrollees to the records and information that pertain to them. [42 C.F.R. §§ 422.504(a)(13) and 422.118]

4. Enrollees will not be held liable for payment of any fees that are the legal obligation of the MA organization. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]

5. For all enrollees eligible for both Medicare and Medicaid, enrollees will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Providers will be informed of Medicare and Medicaid benefits and rules for enrollees eligible for Medicare and Medicaid. First Tier or Downstream Entity may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under title XIX if the individual were not enrolled in such a plan. Providers will: (1) accept the MA plan payment as payment in full, or (2) bill the appropriate State source. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]

6. Any services or other activity performed in accordance with a contract or written agreement by First Tier or Downstream Entity are consistent and comply with the MA organization's contractual obligations. [42 C.F.R. § 422.504(i)(3)(iii)]

7. Contracts or other written agreements between the MA organization and providers or between first tier and downstream entities must contain a prompt payment provision, the terms of which are developed and agreed to by the contracting parties. The MA organization is obligated to pay contracted providers under the terms of the contract between Providence Health Assurance and the provider. [42 C.F.R. §§ 422.520(b)(1) and (2)]

   a) Health Plan shall pay ninety-five percent (95%) of Clean Claims within 30 days of receipt.
   b) Health Plan will investigate and seek resolution for any Clean Claim not paid within 30 days upon Network Provider request

8. Network Provider and any related entity, contractor or subcontractor will comply with all applicable Medicare laws, regulations, and CMS instructions. [42 C.F.R. §§ 422.504(i)(4)(v)]

9. If any of the MA organization's activities or responsibilities under its contract with CMS are delegated to any first tier, downstream and related entity:
   (i) The delegated activities and reporting responsibilities will be specified as follows:

   INTENTIONALLY LEFT BLANK. NETWORK PROVIDER HAS NO DELEGATED ACTIVITIES UNDER THIS AGREEMENT..

   (ii) CMS and the MA organization reserve the right to revoke the delegation activities and reporting requirements or to specify other remedies in instances where CMS or the MA organization determine that such parties have not performed satisfactorily.

(iii) The MA organization will monitor the performance of the parties on an ongoing basis.

(iv) The credentials of medical professionals affiliated with the party or parties will be either reviewed by the MA organization or the credentialing process will be reviewed and approved by the MA organization and the MA organization must audit the credentialing process on an ongoing basis.

(v) If the MA organization delegates the selection of providers, contractors, or subcontractor, the MA organization retains the right to approve, suspend, or terminate any such arrangement. [42 C.F.R. §§ 422.504(i)(4) and (5)]

In the event of a conflict between the terms and conditions above and the terms of a related agreement, the terms above control.