MIKE KREIDLER
STATE INSURANCE COMMISSIONER

STATE OF WASHINGTON

OFFICE OF
INSURANCE COMMISSIONER

Phone: (360) 725-7000
www.insurance.wa.gov

FILED

JAN 15 2014

Hearings Unit, OIC
Patricia D. Petersen
Chief Hearing Officer

In the Matter of	)	
	)	NO. 13-0293
SEATTLE CHILDREN'S HOSPITAL,	)	
	)	DECLARATION OF
	)	MOLLY NOLLETTE IN
	)	SUPPORT OF MOTION TO
	)	DISMISS ADJUDICATIVE
	)	PROCEEDING

I, Molly Nollette, declare as follows:

1. I am over the age of 18 and make this declaration based on my personal knowledge.

2. I am employed by the Washington State Office of Insurance Commissioner ("OIC") as the Deputy Commissioner in charge of the Rates and Forms Division. This is the division that is responsible for reviewing and approving or disapproving health plans that must be filed with, and approved by, the Commissioner prior to being offered in Washington. I am familiar with the Washington Health Benefit Exchange plans that were filed by BridgeSpan Health Company, Coordinated Care Corporation, and Premera Blue Cross and with additional documents filed with the Rates and Forms Division in connection with those filings.

3. Attached hereto as Exhibit "A" is a true and correct copy of a contract between Premera Blue Cross and Seattle Children's Hospital that was submitted to the Rates and Forms Division by Premera in response to an inquiry from me to Premera.

4. Attached hereto as Exhibit "B" is a true and correct copy of a letter to me from Waltraut Lehmann, Premera's Regulatory Affairs Manager, dated September 19, 2013, discussing Premera's contract with Seattle Children's Hospital and setting forth Premera's position that the contract will legally preclude the Hospital from balance billing enrollees under Premera's Health Benefit Exchange plan which is known as its "Heritage Signature" product.

5. Attached hereto as Exhibit "C" is a true and correct copy of a letter to me from Kelly Wallace, Chief Financial Officer of Seattle Children's Hospital, dated November 1, 2013, disputing Premera's interpretation of the parties' contract.

6. Attached hereto as Exhibit "D" is a true and correct copy of the Chief Hearing Officer's "Findings of Fact, Conclusions of Law, and Final Order" in OIC matter number 13-0232, the adjudicative proceeding in which Coordinated Care Corporation successfully appealed the OIC's initial disapproval of its proposed 2014 Washington Health Benefit Exchange plan.

7. Attached hereto as Exhibit "E" is a true and correct copy of the Chief Hearing Officer's letter dated October 31, 2013 to counsel for Seattle Children's Hospital denying the Hospital's Motion to Intervene in the Coordinated Care proceeding as untimely.

8. Attached hereto as Exhibit "F" is a true and correct copy a Letter to Issuers dated April 5, 2013, issued by the United States Department of Health and Human Services Centers for Medicare and Medicaid Services providing guidance to issuers who

offer products through both state and federally operated health benefit exchanges. Page 7 of this letter addresses "essential community providers" and the minimum expectations that apply to plans for including such providers.

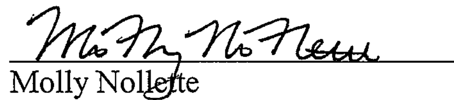
9. Attached hereto as Exhibit "G" is a true and correct copy of a document entitled "Instructions for the Essential Community Providers Application Section" also published by the United States Department of Health and Human Services Centers for Medicare and Medicaid Services. As noted in note one, page 7-1, and in the table 7-2 on page 7-5, the essential community provider categories specified by CMS include "hospitals," but not pediatric specialty hospitals or even children's hospitals, as a category of essential community provider that filers must identify in their filing. As set forth on page 7-10, paragraph 3, only if an applicant does not agree to offer a contract to at least one ECP in each available ECP category in each county in the applicant's service area must the applicant submit a supplemental response describing how the applicant's provider networks provide access to a broad range of ECP types.

10. Attached hereto as Exhibits "H, "I," and "J" are the essential community provider score results for the plans submitted by BridgeSpan Health Company, Coordinated Care Corporation, and Premera Blue Cross that are the subject of this proceeding. All of the plans exeeded the federal essential community provider requirements and passed.

11. The three Washington Health Benefit Exchange plans which are the subject of this proceeding have been certified as qualified health plans by the Washington Health Benefit Exchange.

12. I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

Dated this 15th day of January, 2014.



Molly Nollette

CERTIFICATE OF MAILING

The undersigned certifies under the penalty of perjury under the laws of the State of Washington that I am now and at all times herein mentioned, a citizen of the United States, a resident of the State of Washington, over the age of eighteen years, not a party to or interested in the above-entitled action, and competent to be a witness herein.

On the date given below I caused to be served the foregoing DECLARATION OF MOLLY NOLLETTE IN SUPPORT OF MOTION TO DISMISS ADJUDICATIVE PROCEEDING on the following individuals via Hand Delivery, US Mail and e-mail at the below indicated addresses:

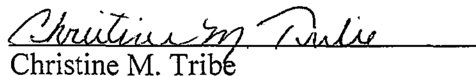
VIA HAND DELIVERY TO:
OIC Hearings Unit
Attn: Patricia Petersen, Chief Hearings Officer
5000 Capitol Blvd
Tumwater, WA 98501

VIA US MAIL AND EMAIL TO:
Seattle Children's Hospital, care of
Michael Madden, Attorney at Law
Bennett Bigelow & Leedom, P.S.
601 Union Street, Suite 3500
Seattle, WA 98101-1363
mmadden@bbllaw.com

Gwendolyn C. Payton
Lane Powell PC
1420 Fifth Avenue, Suite 4200
Seattle, WA 98101-2375
paytong@lanepowell.com

Maren Norton. Esq.
Stoel Rives LLP
600 University St Ste 3600
Seattle, WA 98101-4109
MRNORTON@stoel.com

SIGNED this 15th day of January, 2014, at Tumwater, Washington.



Christine M. Tribe

DECLARATION OF MOLLY NOLLETTE IN SUPPORT OF MOTION TO DISMISS ADJUDICATIVE PROCEEDING

OIC CASE NO. 13-0293

EXHIBIT A

State:	*Washington*	***Filing Company:***	*Premera Blue Cross*
TOI/Sub-TOI:	*H21 Health - Other/H21.000 Health - Other*		
Product Name:	*PBC Seattle Children's Agreement*		
Project Name/Number:	*Custom Contract Submission/*		

Filing at a Glance

Company:	Premera Blue Cross
Product Name:	PBC Seattle Children's Agreement
State:	Washington
TOI:	H21 Health - Other
Sub-TOI:	H21.000 Health - Other
Filing Type:	Form
Date Submitted:	03/03/2011
SERFF Tr Num:	PBCC-127063778
SERFF Status:	Closed-Approved
State Tr Num:	226759
State Status:	Approved
Co Tr Num:	PCWFAM SEACHILD (5/11)
Implementation Date Requested:	05/01/2011
Author(s):	Wendy Stiles, Tricia Green, Cindy Wilkins
Reviewer(s):	Jennifer Kreitler (primary)
Disposition Date:	03/23/2011
Disposition Status:	Approved
Implementation Date:	05/01/2011

State Filing Description:

State:	*Washington*	***Filing Company:***	*Premera Blue Cross*
TOI/Sub-TOI:	*H21 Health - Other/H21.000 Health - Other*		
Product Name:	*PBC Seattle Children's Agreement*		
Project Name/Number:	*Custom Contract Submission/*		

General Information

Project Name: Custom Contract Submission
Project Number:
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Filing Status Changed: 03/23/2011
State Status Changed: 03/23/2011
Created By: Wendy Stiles
Corresponding Filing Tracking Number:

Status of Filing in Domicile:
Date Approved in Domicile:
Domicile Status Comments:
Market Type:
Overall Rate Impact:

Deemer Date:
Submitted By: Wendy Stiles

Filing Description:
March 3, 2011

Ms. Jennifer Kreitler
Office of the Insurance Commissioner
Rates and Forms Division
5000 Capitol Blvd.
Tumwater, WA 98501

Re: CONTRACT FILINGS – Seattle Children's
PremeraFirst Facility Agreement PF98FAC4 (04/00) rev. 2/01)
Amendment to PremeraFirst Facility Agreement PCWFAM SeaChild (5/11)
Proposed Effective Date: May 1, 2011

Dear Ms. Kreitler:

Enclosed for filing is a custom agreement for Seattle Children's. This filing includes the core contract, custom amendment, compensation exhibits and Attachment A. Proprietary rate information has been redacted. We are currently seeking approval for the custom amendment to the core agreement. As discussed with your office, we will amend the core agreement with our proposed regulatory amendment at a later date.

A redline version of the core contract is included.

Please feel free to contact me at (425) 918-5545 or via email at wendy.stiles@premera.com should you have any questions.

Sincerely,

Wendy L. Stiles
Sr. Compliance Analyst/Paralegal

Enclosures

State:	*Washington*	***Filing Company:***	*Premera Blue Cross*
TOI/Sub-TOI:	*H21 Health - Other/H21.000 Health - Other*		
Product Name:	*PBC Seattle Children's Agreement*		
Project Name/Number:	*Custom Contract Submission/*		

Company and Contact

Filing Contact Information

Wendy Stiles, Compliance Analyst
7001 220ths St SW
mail stop 352
Mountlake Terrace, WA 98043

wendy.stiles@premera.com
425-918-5545 [Phone]

Filing Company Information

Premera Blue Cross
PO Box 327
MS 390
Seattle, WA 98111-0327
(425) 918-5834 ext. [Phone]

CoCode: 47570
Group Code: 962
Group Name:
FEIN Number: 91-0499247

State of Domicile: Washington
Company Type: Hospital Medical Service Corporation
State ID Number: 204

Filing Fees

Fee Required? No
Retaliatory? No
Fee Explanation:

State Specific

If you are filing a Healthcare or Disability filing, is the Co Tracking # field populated on the General Information Tab? If no, your filing will be rejected. (yes/no): yes
Form Tab Only - Are the Form # and Form Description fields populated corresponding to the attached form? (yes/no): yes
If your are submitting a File and Use product, have you populated the Implementation Date field? (yes/no): yes

State:	Washington	**Filing Company:**	Premera Blue Cross
TOI/Sub-TOI:	H21 Health - Other/H21.000 Health - Other		
Product Name:	PBC Seattle Children's Agreement		
Project Name/Number:	Custom Contract Submission/		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Jennifer Kreitler	03/23/2011	03/23/2011

State:	Washington	**Filing Company:**	Premera Blue Cross
TOI/Sub-TOI:	H21 Health - Other/H21.000 Health - Other		
Product Name:	PBC Seattle Children's Agreement		
Project Name/Number:	Custom Contract Submission/		

Disposition

Disposition Date: 03/23/2011

Implementation Date: 05/01/2011

Status: Approved

Comment:

You have been selected to take part in our online customer survey. Please take a minute or two to give us your feedback so we can better serve you. The survey is completely voluntary and confidential.

Take the survey at: http://www.sesrc.wsu.edu/PugetSound/RatesandForms

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Filing Instructions		Yes
Supporting Document	PPACA Uniform Compliance Summary		Yes
Supporting Document	Cover Letter		Yes
Supporting Document	PF Facility Agreement (Redline)		Yes
Form	Amendment to PF Facility Agreement	Approved	Yes
Form	PF Facility Agreement	Approved	Yes
Form	2008 Regulatory Amendment	Approved	Yes
Form	PF Compensation Exhibit A	Approved	Yes
Form	Attachment A to Compensation Exhibit A	Approved	Yes
Form	PF Compensation Exhibit B	Approved	Yes

State:	Washington	Filing Company:	Premera Blue Cross
TOI/Sub-TOI:	H21 Health - Other/H21.000 Health - Other		
Product Name:	PBC Seattle Children's Agreement		
Project Name/Number:	Custom Contract Submission/		

Form Schedule

Lead Form Number: PCWFAM SeaChild (5/11)

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1	Approved 03/23/2011	Amendment to PF Facility Agreement	PCWFAM SeaChild (5/11)	OTH	Initial			PCWFAM Seattle Children's.pdf
2	Approved 03/23/2011	PF Facility Agreement	PF98FAC4 (04/00) rev. 2/01	OTH	Initial			PF98FAC4 Seattle Children's.pdf
3	Approved 03/23/2011	2008 Regulatory Amendment	PCWREG08AM (1/08)	OTH	Initial			2008 Reg Amd.pdf
4	Approved 03/23/2011	PF Compensation Exhibit A	PCWFHSP EXD (9/10)	OTH	Initial			PCWFHSPEXD Ex A Seattle Children's.pdf
5	Approved 03/23/2011	Attachment A to Compensation Exhibit A	PCWFATTAD (1/10)	OTH	Initial			PCWFATTAD Seattle Children's.pdf
6	Approved 03/23/2011	PF Compensation Exhibit B	PCWFHSP EX (9/10)	OTH	Initial			PCWFHSPEX Ex B Seattle Children's.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage

State:	Washington	**Filing Company:**	Premera Blue Cross
TOI/Sub-TOI:	H21 Health - Other/H21.000 Health - Other		
Product Name:	PBC Seattle Children's Agreement		
Project Name/Number:	Custom Contract Submission/		

OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

AMENDMENT TO
PREMERAFirst FACILITY AGREEMENT

SEATTLE CHILDREN'S

The Agreement entered into by and between PREMERAFirst, Inc. ("Intermediary") and Seattle Children's ("Facility") is hereby-amended effective May 1, 2011, as follows:

1. **PART 6, Section 6.01, ("Term"):** this section is deleted in its entirety and replaced with the following:

   "The revisions to this Agreement will take effect on the date specified above and will automatically renew from year to year thereafter, unless terminated in accordance with this Part 6, provided, however, that Compensation Exhibits A pertaining to facility rates will remain in effect through February 2013 and will continue in effect thereafter unless and until (i) the parties agree upon revised terms, or (ii) either party elects to terminate the entire Agreement as set forth below; and Compensation Exhibit B; pertaining to Home Care Services rates, will remain in effect through February 28, 2013."

2. **PART 6, Section 6.02, ("Voluntary Termination"):** this section is deleted in its entirety, renamed "Termination", and replaced with the following:

   "If either party fails to comply with or perform when due any material term or condition of this Agreement, the other party shall notify the defaulting party in writing, and the defaulting party shall have 30 days to cure the default. If the defaulting party fails to cure the default within 30 days, the other party may declare, that this Agreement shall be terminated subject to 60 days written notice. For the purposes of this Section 6.02, notice shall comply with the terms of Section 7.10 and shall also specify in reasonable detail the specific nature of the default and shall also state that failure to cure a default will result in termination of this Agreement as set forth in this section. Default hereunder shall include any changes by Intermediary or Facility's Tier assignment during the term of this Agreement.

   Other than as set forth in Section 6.03, and subject to the terms of Section 6.04, this Agreement may be terminated at any time without cause by either party following issuance of 90 days written notice, provided that neither Party may issue such notice prior to March 1, 2013.

   Should either party wish to revise the terms of the Compensation Exhibit A, such revisions to be effective after February 28, 2013, said party shall issue a renewal proposal that sets forth proposed revisions in detail in accordance with the notice provisions of Part 7.10 of the Agreement. The receiving party agrees to begin good faith negotiations within five (5) working days of its receipt of the renewal proposal. Should the parties fail to reach agreement on revised terms within thirty (30) days of the date of the renewal proposal, either party may terminate this Agreement without cause in accordance with Part 6.02 (as amended) of this Agreement."

The effective date of this amendment is May 1, 2011. All other terms and conditions of the Agreement remain unchanged, except as specified in this or any other amendment to the Agreement.

SEATTLE CHILDREN'S	PREMERAFirst, INC.
BY:	BY:
Signature	Signature
	Rich Maturi
Print or Typed Name	Print or Typed Name
	SVP, Health Care Delivery Systems
Title	Title
Date Signed	Date Signed
Tax ID #:	

PREMERAFirst FACILITY AGREEMENT

CHILDRENS HOSPITAL AND
REGIONAL MEDICAL CENTER

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APPLICABLE PRODUCT AND COMPENSATION ADDENDA

PREMERAFirst
FACILITY AGREEMENT

This Agreement is a contract between PREMERAFirst, Inc. (hereinafter referred to as "Intermediary") and Childrens Hospital and Regional Medical Center (hereinafter referred to as "Facility"). The effective date of this Agreement is January 1, 2001.

WHEREAS, Intermediary is a duly licensed corporation, domiciled in the State of Washington and organized and operating under applicable state law, and has been appointed for purposes of state and federal law by Plans to act solely as a contracting agent and not as principal;

WHEREAS, Facility is a duly licensed Health Care Facility which holds all required licenses, certificates and/or accreditations as required by law;

NOW, THEREFORE, in consideration of mutual promises, covenants and agreements contained in this Agreement, the parties agree as follows:

PART 1 DEFINITIONS

When capitalized in this Agreement, any word or term listed below has the meaning listed after it in this Definitions Section.

1.01 Agreement includes, when used herein, this Facility Agreement and Product and Compensation Addenda related hereto, as both may be amended from time to time.

1.02 Allowed Amount means a Plan determined amount that is based on a specific payment methodology or negotiated rates. The Allowed Amount is the maximum amount Facility shall receive from the Plan for Covered Services furnished to Enrollees and is the sum of the Plan Payment and any Enrollee responsibility, such as Deductible, Copayment, Coinsurance or coordination of benefits.

1.03 Claim means a charge submitted by Facility to Plan, which contains Complete and Accurate Information that allows a Plan to determine an Enrollee's available benefits for Covered Services.

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

1.05 Coinsurance means the percentage of eligible medical expenses payable by an Enrollee to Facility for Covered Services as defined by the applicable Subscriber Agreement.

1.06 Compensation, as used herein, includes, but is not limited to, the terms, components, structure, formula and/or amount of payment made to the Facility for Covered Services provided hereunder including, without limitation, and as appropriate, the Capitation Payment, the Plan Payment, the Plan Fee Schedule, and Risk Pool Allocations.

1.07 Complete and Accurate Information includes:

- Complete and accurate description of the services performed and charges made using appropriate industry diagnosis codes (e.g., ICD-9-CM) and appropriate revenue codes (e.g., UB-92);

- Other known insurance coverage, third party resources, or health care benefits available to Enrollee. This includes workers' compensation, motor vehicle medical coverage, homeowners medical coverage, subrogation cases; and
- Any other information required and requested by Intermediary or a Plan to perform its obligations under this Agreement and/or the Subscriber Agreements.

1.08 **Copayment** means the fixed amount an Enrollee must pay Facility each time the Enrollee receives a specified Covered Service, as defined by the applicable Subscriber Agreement.

1.09 **Covered Services** means those Medically Necessary medical and hospital services, supplies and accommodations for which an Enrollee is eligible under the terms of the applicable Subscriber Agreement and as are customarily provided by the Facility.

1.10 **Deductible** means the fixed amount an Enrollee must pay Facility for Covered Services before a Plan commences payment for Covered Services, as defined by the applicable Subscriber Agreement.

1.11 **Enrollee** means either a Subscriber or a dependent of a Subscriber who is properly enrolled under a Plan Subscriber Agreement, including individuals who are also Medicare beneficiaries. Enrollee also means an individual covered under another plan that has a reciprocal agreement with the plan and an individual enrolled with Plan subsidiaries, affiliates and nonaffiliated entities as designated by a Plan.

1.12 **HCFA** means the Health Care Financing Administration. HCFA is the federal agency responsible for administering Medicare and overseeing administration of Medicaid by the states.

1.13 **Health Care Facility** means an institution or other health care delivery organization that provides services to Plan Enrollees. A Health Care Facility includes, but is not limited to, a hospital, a hospice, a skilled nursing facility, or an ambulatory surgical center. A Health Care Facility may also be referred to as a "Provider."

1.14 **Inpatient** means an Enrollee who has been formally admitted to a Health Care Facility or who stays in a Health Care Facility for more than 24 hours.

1.15 **Inpatient Services** means medical and surgical services and supplies furnished to an Enrollee who has been formally admitted to a Health Care Facility as an Inpatient.

1.16 **Intermediary** means an independent corporation appointed by Plans to secure contracts, on Plans' behalf, with Health Care Facilities and Practitioners to furnish health care services to Enrollees.

1.17 **Medicaid** means the federal program administered by the state, which provides medical benefits to eligible low income persons, and is administered and operated individually by participating states.

1.18 **Medical Emergency** means the emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention; or that failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the Enrollee's health in serious jeopardy. In determining Medical Emergency, a Plan will take into consideration the specific circumstances affecting the Enrollee's decision to obtain Medical Emergency services.

1.19 **Medically Necessary/Medical Necessity** means those Covered Services and supplies which, in the judgment of the Plan, meet all of the following requirements:

They must be: .

- Essential to the diagnosis or the treatment of an illness, accidental injury or condition harmful or threatening to the Enrollee's life or health, unless otherwise provided as preventive services;
- Appropriate for the medical condition as specified in accordance with authoritative medical or scientific literature;
- Not primarily or solely for the convenience of the Enrollee, the Enrollee's family or legal guardian, the Enrollee's Practitioner or another provider;
- Medically effective treatment of the diagnosis as demonstrated by:
  - Sufficient evidence to draw conclusions about the effect of the health intervention on the health outcome;
  - Evidence that the health intervention can be expected to produce its intended effects on health outcomes; and
  - Expected beneficial effects of the health intervention on health outcomes that outweigh its expected harmful effects;
- Cost-effective as determined by being among the least costly of the alternative supplies or levels of service which are medically effective, readily available, and can safely be provided to the Enrollee. A health intervention is cost-effective if there is no other available health intervention that offers a clinically appropriate benefit at a materially lower cost. When an Enrollee is receiving Inpatient Services, it further means that the services and/or supplies cannot be safely provided on an outpatient basis or in an alternative setting without adversely affecting the Enrollee's condition or the quality of care rendered; and
- Not primarily for research or data accumulation.

The fact that health care services were furnished, prescribed or approved by a Practitioner or other qualified Provider does not in and of itself mean that those services were Medically Necessary.

1.20 Medicare means the federally administered health insurance program which covers costs of hospitalization, medical care, and some related services for eligible persons.

1.21 Noncovered Services means services not covered by an Enrollee's Subscriber Agreement, and for which the Plan does not provide benefits. Noncovered services are identified as such on Facility's payment voucher and the Enrollee's explanation of benefits.

1.22 Outpatient Services means health care services rendered to an Enrollee who is not an Inpatient, whether or not the Enrollee occupies a bed.

1.23 Participant means a Practitioner, Provider, Health Care Facility or other entity who or which agrees to accept from and to look solely to a Plan for payment according to the terms of the Subscriber Agreement for Covered Services rendered to Enrollees, and also includes any Practitioner with whom Participant has entered into an approved subcontract pursuant to Section 7.04 hereof to render Covered Services to Enrollees.

1.24 Plan means a health care services contractor, health maintenance organization, insurer, trust, self-funded health program or other entity responsible for the payment of Covered Services rendered to Enrollees, which is listed in the attached Exhibits 1A through 1B and has appointed Intermediary to act as a contracting agent.

1.25 **Plan Fee Schedule** means a Plan-determined schedule of allowable payments for services defined by diagnosis code, procedural code, or other service coding system. A Plan Fee Schedule may be based on any industry standard method, including, but not limited to, the Resource Based Relative Value Schedule (RBRVS), and St. Anthony's, with a Plan-determined conversion factor.

1.26 **Plan Payment**, as used herein, means the amount to be paid by Plan to Facility for Covered Services pursuant to this Agreement as set forth in the attached Compensation Exhibit. The Plan Payment is the Allowed Amount less any Enrollee responsibility such as Deductible, Copayment or Coinsurance.

1.27 **Practitioner** means an individual who provides professional health care services and is licensed, certified, or registered by the state in which the services are performed.

1.28 **Product and Compensation Addendum**, as used herein, means the attached addendum designating: (1) the Plan program under which Covered Services provided by Facility pursuant to this Agreement and (2) the related Compensation. The Product and Compensation Addendum is incorporated into, and made part of, this, Agreement.

1.29 **Provider** means an organization which provides health care services such as hospitals, home health agencies, skilled nursing facilities, nursing homes, and surgical centers.

1.30 **Subscriber** means the individual in whose name the coverage under a Subscriber Agreement is established.

1.31 **Subscriber Agreement** means any contract entered into by a Plan, with or for the benefit of an Enrollee, entitling the Enrollee to receive benefits for Covered Services.

PART 2 OBLIGATIONS OF INTERMEDIARY AND/OR PLANS

2.01 **Payment**. Plan will pay Facility Plan Payment directly for Covered Services that Facility renders to Enrollees, in accordance with the terms of this Agreement and the attached Product and Compensation Addenda.

2.02 **Marketing**. Plans shall develop and actively market their Participant panels.

2.03 **Identification Cards**. Intermediary shall issue or arrange with Plans for the issuance of identification cards to Enrollees. Enrollees will be instructed to present identification cards to Facility at the time services are requested. Such identification cards are not a verification of eligibility as an Enrollee or a guarantee of payment, but a means of providing information that Facility can easily use to verify eligibility with a Plan.

2.04 **Promotion**. Intermediary will arrange with Plans to design Subscriber benefit packages and/or use other means to encourage Enrollees to use Facility's services. Intermediary and Plans will have the right to use Facility's name for such promotional purposes, for marketing, for informing the public of Facility's identity and to otherwise carry out the terms of this Agreement. This provision for promotion of Facility is nonexclusive.

2.05 **Information to be Provided**. Intermediary will arrange for Plans to make available to Facility a telephone number or other means for checking an Enrollee's benefits and eligibility for benefits, including any limitations or conditions on services or benefits. A Plan's verification of eligibility and description of Covered Services under the Subscriber Agreement is not a guarantee of payment.

2.06 **Directories**. Plan will list Facility in provider directories and other marketing materials.

2.07 **Network Adequacy**. Plan desires to offer reasonable access to and a reasonable choice of providers for existing and potential Enrollees. Selection of providers for network adequacy is the sole discretion of Plan. Plan shall contract with such Providers as required.

2.08 **Benefit and Eligibility Determinations**. Plan shall have the sole authority to determine the eligibility of Enrollees for benefits and whether services are included under the terms of the Plan Subscriber Agreements. Facility shall not take any action or make any representations regarding eligibility or benefits without the prior authorization of Plan. Facility may appeal benefit and eligibility determinations in accordance with Section 7.02 of the Agreement.

PART 3 OBLIGATIONS OF FACILITY

3.01 **Services Provided to Enrollees**. Facility will provide Covered Services to Enrollees in compliance with the terms of this Agreement. When providing such services, Facility will exercise the degree of care, skill and learning expected of a prudent Health Care Facility. Facility will observe, protect and promote the rights of Enrollees as patients.

Facility must contract for all commercial products agreed-to by Facility and Plan as of the effective date of this Agreement for the entire term of this Agreement. Additional commercial products may be added to this Agreement during the term of this Agreement as set forth in Section 7.01C hereof.

Unless agreed otherwise by Plan, termination of any commercial Product and Compensation Addendum by Facility shall terminate all commercial Product and Compensation Addenda. The terms under which Facility may terminate public products are set forth in the applicable public Product and Compensation Addendum.

3.02 **Nondiscrimination**. Facility will provide Covered Services to Enrollees on the same basis as such services are made available to patients who are not Enrollees, and without regard to the Enrollee's participation in a Plan as a private purchaser of health care coverage or as a participant in publicly financed programs of health care services, with respect to the availability and quality of Facility services.

Facility further agrees to comply with applicable state or federal regulatory laws and not to discriminate in the treatment of patients or in the quality of services delivered to Enrollees on the basis of race, color, sex, age, religion, national origin, place of residence, health status, handicap, source of payment, or Enrollee's Plan.

3.03 **Licenses**. Facility will maintain in good standing all licenses, permits, governmental or board authorizations or approvals required by law for Facility's operation and Plan's credentialing standards. Facility will submit evidence of such licenses, permits, governmental or board authorizations or approvals to Intermediary upon request.

3.04 **Responsibility for Services**. Facility will be solely responsible for the quality of services provided to Enrollees. Nothing contained in this Agreement shall be construed to alter Facility's responsibility to provide acceptable services per current medical standards, or to change the nature of the Facility-Enrollee relationship. Facility should discuss all medical options with the Enrollee regardless if such options are a Covered Service. The final decision to provide or receive services, regardless of whether such services are Medically Necessary, not Medically Necessary or Noncovered Services, is between Facility, the Enrollee and the Enrollee's Practitioner. Nothing in this provision shall be construed to authorize Facility to bind a Plan to pay for any service.

Facility may appeal Plan's payment decisions in accordance with Section 7.02.

3.05 **Credentialing**. Facility warrants, currently and for the duration of this Agreement, that it meets Plans' credentialing standards, and that Facility has all licenses, permits, and/or governmental or board authorizations or approvals necessary to provide Covered Services in accordance with the applicable requirements in the state(s) in which Facility operates. Facility further warrants that it will cooperate with Plan's credentialing and recredentialing processes. Facility will provide immediate written notice to Intermediary of any changes in the licenses, permits, and/or governmental or board authorizations or approvals referenced above, including, but not limited to, ownership, business address, Tax Identification Number, new Practitioner proposed to be included as a Participant pursuant to this Agreement and any factors that may materially impact Facility's ability to provide Covered Services to Enrollees hereunder. Facility's credentialing application shall be incorporated by reference into this Agreement.

Facility agrees not to render Covered Services to Plan's Enrollees prior to written notification from Plan to Facility that the Facility has been fully credentialed and approved for participation by Plan.

3.06 **Care Management and Quality Improvement**. Facility agrees to cooperate with and participate in Plans' quality improvement, Enrollee grievances, and care management programs. For utilization management programs, this includes, but is not limited to, notification of admissions, applicable referral procedures, and reporting of clinical encounter data.

Facility further agrees to cooperate with Plans' concurrent review and discharge planning procedures, by providing medical records and other necessary information regarding Enrollees' care in progress, length of stay and discharge status upon Plans' reasonable request. Facility agrees that such access and information provision will take place at no charge to Plans or Intermediary.

Facility acknowledges that care management services and functions may be performed by a Plan, an affiliate or an outside utilization management entity designated by a Plan.

3.07 **Authorization**. Plan will make reasonable efforts to notify Facility of those classes of Enrollees whose Subscriber Agreements require authorization of Facility's services.

3.08 **Retrospective Review**. A Plan may conduct a retrospective review to determine whether all services provided to an Enrollee are covered and/or Medically Necessary. Facility will abide by a Plan's decisions made through retrospective review subject to the dispute resolution procedures stated in Section 7.02. Facility will not seek payment from a Plan or the Enrollee for Covered Services which the Plan determines were not Medically Necessary as a result of its retrospective review other than in compliance with Section 4.01 hereof.

3.09 **Onsite Clinical Quality and Health Improvement Review**. Facility will allow and fully cooperate with onsite quality review conducted by a Plan and/or its agents. Such reviews will be scheduled at appropriate times during regular business hours and with reasonable prior notice to Facility.

3.10 **Reporting to Plan**. Facility shall cooperate with Plans' data collection and reporting efforts, in compliance with requirements of the National Committee for Quality Assurance (NCQA) and HEDIS®, or any other accreditation program(s) designated by Plan. (NCQA's Health Plan Employer Data Information Set; HEDIS® is a registered trademark of NCQA.)

Facility shall provide immediate written notice to Plan of any legal, regulatory, or governmental action which Facility reasonably believes could materially impact the ability of the Facility to carry out the duties and obligations of this Agreement, including, without limitation, litigation initiated by a patient against Facility.

3.11 **Insurance**. Facility will provide and maintain, at its sole expense, policies of general comprehensive liability and professional liability insurance, or self insurance, in an amount acceptable to Intermediary as set forth in Intermediary's or Plans' credentialing standards. Such policies shall insure against any claim or claims for damage arising by reason of personal injury or death occasioned directly or

indirectly in connection with the acts or omissions of Facility, its agents or employees pursuant to this Agreement. Facility shall notify Intermediary no less than ten days before any reduction in coverage or revocation, suspension or other termination of any such policy.

Upon request, Facility will provide Intermediary with evidence of compliance with this Section 3.11, in the form of a certificate of insurance or evidence of self insurance or evidence in some other form as Intermediary will deem satisfactory.

3.12 **Transfer.** Facility will transfer Enrollees to other Health Care Facilities only in a manner consistent with Facility's contracted status. Exceptions to this requirement are Medical Emergency cases when the appropriate contracted Provider is not available, or when, in the judgment of the treating Practitioner, transfer to another facility is medically appropriate. All other transfers must be authorized by Enrollee's Plan.

3.13 **Specialty Services.** Facility will cooperate with Intermediary and Plan efforts to assure the availability of specialty services Practitioners whose contracted status is consistent with Facility's contracted status according to this Agreement. Such specialty services include, but are not limited to, anesthesiology, radiology, pathology and emergency room physicians.

3.14 **Administrative Rules and Procedures.** Facility will abide by administrative rules and procedures issued by Intermediary and/or a Plan with respect to, but not limited to, authorizations, Enrollee rights, responsibilities and grievances, billing procedures and standards, and other matters that relate to Facility's provision of Covered Services to Enrollees and compliance with this Agreement. Intermediary and/or Plan will provide written information to Facility, as well as any necessary revisions, regarding such administrative rules and procedures. Changes to documents, procedures and other administrative policies and programs that affect Facility Compensation and that affect health care service delivery shall be made pursuant to the provisions of Section 7.01A.

3.15 **Accuracy of Information.** Facility warrants and represents that, to the best of Facility's knowledge, all information given to Intermediary and/or Intermediary's designees in applying for and maintaining this Agreement is true, accurate, and complete in all material respects.

3.16 **Remuneration for Services from other Providers.** Facility agrees not to solicit or receive any remuneration or "kickbacks" prohibited by federal law, whether directly or indirectly, overtly or covertly, in cash or in kind, in return for referrals to other agencies or Providers, or to purchase, lease, order to arrange goods, facilities, services or items in return for referrals to other agencies or Providers.

3.17 **Inpatient Admission.** Within one business day after Inpatient admission, Facility agrees to notify Plan of any emergency hospital admission of an Enrollee. Facility also agrees to notify Plan of any non-emergency hospital admission of an Enrollee as soon as possible after the decision to admit has been made or within one business day of actual admit.

PART 4 PAYMENT AND BILLING

4.01 **Payment.** Plan will pay Facility in accordance with the terms of this Agreement. Facility will seek payment solely from the Enrollee's Plan for Covered Services rendered to that Plan's Enrollees and shall accept as full payment the Allowed Amount(s) set forth in the applicable Product and Compensation Addenda attached to this Agreement.

Facility will collect payment directly from the Enrollee for Deductibles, Coinsurance and Copayment amounts, or for Noncovered Services, in accordance with the terms of the applicable Subscriber Agreement. Facility's charge to the Enrollee for Deductibles, Copayments or Coinsurance as set forth in the Subscriber Agreement, in combination with the Plan's payment, will not exceed the Allowed Amount for Covered Services. In addition to Section 4.02, under no circumstances including, but not limited to, nonpayment by the Enrollee's Plan, Plan insolvency or breach of this Agreement, shall

Facility bill any amount in addition to those listed above, or have recourse against the Enrollee, Intermediary or any other Plan contracted with Intermediary for services provided pursuant to this Agreement. This provision shall survive termination of this Agreement.

Facility will not knowingly seek payment from a Plan for any Covered Services rendered to a person who misrepresents his or her status as an Enrollee or who previously obtained coverage from a Plan as an Enrollee through fraud or misrepresentation.

During any appeal or mediation process, Facility shall not bill or otherwise seek collection from Enrollee for any payment amounts in dispute.

Except as provided in this Agreement, Facility will not seek payment from Enrollees or a Plan for services determined not to be Medically Necessary by the Plan unless the Enrollee has agreed in writing to be financially responsible for those services before those services are provided.

The benefits to which an Enrollee is entitled shall be limited to those specified in the Subscriber Agreement in effect at the time services are performed, and are subject to the Enrollee's continued eligibility.

4.02 **Enrollee Billings and Continuation of Services**

A. **No Recourse Against Enrollee**

1. Facility hereby agrees that in no event, including but not limited to nonpayment by Plan, Plan insolvency, or breach of this Agreement shall Facility bill, charge, collect a deposit from, seek compensation, remuneration from, or have any recourse against an Enrollee or person acting on an Enrollee's behalf, other than a Plan, for services provided pursuant to this Agreement. This provision shall not prohibit collection of Deductible, Copayments, Coinsurance, and/or Noncovered Services which have not otherwise been paid by a primary or secondary carrier in accordance with regulatory standards for coordination of benefits, from Enrollees in accordance with the terms of the Enrollee's Subscriber Agreement.
2. Facility agrees, in the event of a Plan's insolvency, to continue to provide the services promised in this Agreement to Enrollees of that Plan for the duration of the period for which premiums on behalf of the Enrollee were paid to Plan or until the Enrollee's discharge from inpatient facilities, whichever time is greater.
3. Notwithstanding any other provision of this Agreement, nothing in this Agreement shall be construed to modify the rights and benefits contained in the Enrollee's Subscriber Agreement.
4. Facility may not bill Enrollee for Covered Services (except for Deductibles, Copayments, or Coinsurance), where a Plan denies payment because Facility has failed to comply with the terms or conditions of this Agreement.
5. Facility further agrees that: (i) the provisions of 1, 2, 3 and 4 of this Section shall survive termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of Plan's Enrollees, and (ii) that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Facility and Enrollees or persons acting on Enrollees' behalf.
6. If Facility contracts with other Providers that agree to provide Covered Services to Enrollees of a Plan with the expectation of receiving payment directly or indirectly from Plan, such Providers must agree to abide by the provisions of 1, 2, 3, 4 and 5 of this Section.

B. Facility acknowledges that willfully collecting or attempting to collect an amount from an Enrollee, knowing that collection to be in violation of this Section 4.02, constitutes a class C felony under RCW 48.80.030(5).

C. No changes shall be made to this Section 4.02 without prior approval of Washington State's Office of Insurance Commissioner, in accordance with WAC 284-43-320.

4.03 **Claims Submission.** Facility will submit Claims to a Plan in a manner and on forms acceptable to the Plan. Facility should submit Claims within 60 days after Covered Services are rendered, but Plan will be under no obligation to pay a Claim if Plan receives it more than 365 days after the date Covered Services were provided, or 60 calendar days after Facility first receives notice that Plan is a secondary payor under applicable coordination of benefits procedures, whichever shall be later. Facility may not seek payment from Enrollee or any Plan for Covered Services submitted after that time.

Facility will be reimbursed for only Covered Services which were ordered by a physician or other qualified Practitioner, delivered to the Enrollee and documented in the medical record. The coding convention used on submitted Claims will accurately reflect services provided and the reasons for the procedure, service, supply or encounter. Upon request, Facility will furnish all information reasonably required by a Plan to substantiate the provision of, and charges for, Covered Services, at no charge to the Plan or Intermediary.

For Covered Services provided to Enrollees, Plan shall pay Facility as soon as practical but subject to the following minimum standards:

A. Ninety-five percent (95%) of the monthly volume of Clean Claims shall be paid within 30 days of receipt by Plan; and
B. Ninety-five percent (95%) of the monthly volume of all Claims shall be paid or denied within 60 days of receipt by Plan, except as agreed to in writing by the parties on a Claim-by-Claim basis.

The receipt date of a Claim shall be the date the Plan receives either written or electronic notice of the Claim.

Plan shall pay Facility interest on undenied and unpaid Clean Claims more than 61 days old. Interest shall be assessed at the rate of one percent per month, and shall be calculated monthly as simple interest prorated for any portion of a month. Plan shall add the interest payable to the amount of unpaid Claims without the necessity of the Facility submitting an additional Claim. Plan shall not apply any interest paid to an Enrollee's Deductible, Copayment, Coinsurance or any similar obligation of the Enrollee.

When Plan issues payment in the Facility and Enrollee names, Plan shall make Claim checks payable in the name of Facility first and the Enrollee second.

Claim denials shall include the specific reason why the Claim was denied. If the denial is based upon Medical Necessity or similar grounds, Plan, upon request from Facility, shall promptly disclose the supporting basis for the decision.

These standards do not apply to Claims about which there is substantial evidence of fraud or misrepresentation by Facility or Enrollee, or instances where Plan has not been granted reasonable access to information under Facility's control.

4.04 **Cancellation of Coverage.** Neither Intermediary nor Plan will be liable to Facility for any health care services provided to an Enrollee whose coverage under the applicable Subscriber Agreement is canceled retroactively by the Enrollee's Plan. Reasons for such cancellation may include, but are not limited to, misrepresentation and nonpayment of premiums.

4.05 **Refunds.** Claim approval and/or payments made by a Plan are contingent upon receipt of Complete and Accurate Information from Facility. Facility will promptly refund amounts paid by a Plan if it is determined that a Plan has accepted responsibility for payment based upon erroneous or incomplete

In addition, Facility shall make such data and other records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of Enrollees, subject to applicable state and federal laws related to the confidentiality of medical records.

Facility and its representatives may audit, examine and inspect Plan's and/or Intermediary's books and records of account relating to transactions between Plan and Facility during normal business hours upon giving reasonable notice to Plan.

5.03 **Confidentiality of Medical Records.** Facility and Plans will keep confidential, and take all reasonable precautions to prevent the unauthorized disclosure of, any and all records, both paper and electronic, required to be prepared and/or maintained by this Agreement in accordance with state and federal law.

PART 6 TERM AND TERMINATION

6.01 **Term.** This Agreement will take effect on the date specified on page one, and will remain in force for an initial term of 12 months. Product and Compensation Addenda shall have the effective date set forth therein and shall have a term concluding on the day upon which the term of this Agreement concludes. This Agreement will automatically renew from year to year thereafter, unless terminated as provided below.

6.02 **Voluntary Termination.** Other than as set forth in Section 6.03, and subject to the terms of Section 6.04, this Agreement may be terminated at any time without cause by either party upon 60 days prior written notice. If either party fails to comply with or perform when due any material term or condition of this Agreement, the other party shall notify the defaulting party in writing, and the defaulting party shall have 30 days to cure the default. If the defaulting party fails to cure the default within 30 days, the other party may declare, that this Agreement shall be terminated subject to the 60 day notice period set forth above. For the purposes of this section 6.02, notice shall comply with the terms of Section 7.10 and shall also specify in reasonable detail the specific nature of the default and shall also state that failure to cure a default will result in termination of this Agreement as set forth in this section.

6.03 **Termination by Intermediary.** In addition, the Intermediary may terminate this Agreement at any time as follows:

A. This Agreement shall terminate immediately upon receipt by the Facility of written notice:

1. in the event Facility's license(s), permit(s), or any governmental or board authorizations or approvals related to its business operations and/or the provision of Covered Services are canceled, denied, lost, suspended, or voluntarily forfeited. Facility shall provide Intermediary immediate written notice of any such actions;
2. in the event Facility fails to satisfy Plan credentialing or recredentialing standards;
3. in the event Facility makes any material misstatements or omissions on any material submitted to Intermediary or its designees;
4. in the event Facility's insurance coverage required by this Agreement lapses for any reason. Facility shall provide Intermediary immediate written notice of any such lapse.

B. This Agreement shall terminate automatically and immediately in the event Intermediary determines, in its sole discretion, that Facility's action or inaction and/or continuation of this Agreement may have a significant adverse effect on Enrollees care.

6.04 **Services After Termination.** In addition to other provisions of this Agreement, the following provisions will survive termination of this Agreement:

A. All provisions of Part 4 shall apply to health care services performed prior to termination.

B. Inpatient Services to Enrollees who are Inpatients as of the termination date shall continue until such time as those Enrollees are discharged or for the duration of the period for which premiums were paid to Plan on Enrollee's behalf, whichever time is greater.

6.05 **Continued Record Access.** Facility will maintain records of Enrollees as required by law. Facility will allow each Plan continued access to Facility's retained records for the longer of seven years or as required by law after the date this Agreement terminates.

6.06 **Removal from Directories.** If this Agreement terminates, Intermediary and/or Plan(s) will remove Facility from all future directories that list Intermediary's contracted Health Care Facilities. Upon the termination date, Facility will inform any Enrollees that seek services at Facility that this Agreement has been terminated.

6.07 **Notification of Enrollees.** Plan shall provide Enrollees with timely notification of the termination of this Agreement. Facility shall provide Plan with a contemporaneous copy of communications with Enrollees regarding termination or continuation of Facility's contractual relationship with Plan. In order to ensure the continuity and appropriateness of medical care to Enrollees, Plan may immediately inform Enrollees of the effective date of the Termination of this Agreement and request that Enrollees select another Facility prior to the effective date of the Termination of this Agreement.

PART 7 GENERAL PROVISIONS

7.01 **Amendments.**

A. Intermediary and/or Plan may amend this Agreement, Compensation, any Product and Compensation Addenda relating hereto, and any manual, policy, or administrative procedure pertaining to this Agreement at any point during the term of this Agreement by providing Facility 60 days prior written notice consistent with the terms of Section 7.10. The proposed amendments shall become effective 60 days after the receipt of written notice by the Facility, unless the parties can agree otherwise at an earlier date. Any such amendment shall be in writing, shall include an effective date and shall be signed by Intermediary.

B. In addition, this Agreement may be amended at any time during its terms by mutual consent of the Intermediary and Facility. Any such amendment shall be in writing, shall include an effective date, and shall be signed by Intermediary and Facility.

C. Plan may establish new products from time to time and shall make such reasonable amendments to this Agreement as are required to implement them. Facility shall receive notice from Plan not less than 45 business days prior to implementation of new products. With Facility approval, a new Product and Compensation Addendum will be incorporated into this Agreement. Plan agrees not to advertise Facility as a provider of services for any new product until agreed to by Facility.

Changes to this Agreement may be subject to prior regulatory approval.

7.02 **Provider Dispute Resolution.** In the event there is a dispute under this Agreement that is subject to dispute resolution, Facility and Plan shall first attempt to resolve the matter through informal good faith discussions. Such discussions may include a meeting or meetings between the parties. In the event the parties determine that the matter cannot be resolved informally, the following procedures shall apply.

A. Facility must submit to Plan a written Request for Internal Appeal within 90 days of the Plan's action from which the Facility wishes to appeal. The Request for Internal Appeal must include a detailed description of the issues in dispute, the Facility's position with respect to the disputed issues, all evidence offered by Facility in support of the Request, and a description of the relief

sought. Plan is under no obligation to consider a Request for Internal Appeal received by Plan later than 90 days after Plan's action from which the Facility wishes to appeal.

1. **Billing Disputes.**

   In the event the matter subject to dispute is a Billing Dispute, the following process and schedule shall apply.

   The Plan will consider the issues raised in the Request and notify the Facility of its determination as quickly as possible, but no later than 30 days following receipt of the Facility's Request.

   If Facility is not satisfied with Plan's determination, the Facility shall, within 15 days after Facility's receipt of the Plan's response, send Plan a response setting forth the specific grounds upon which Facility disagrees with the Plan determination. Plan shall consider the issues raised in Facility's response and shall notify Facility of Plan's Final Determination as quickly as possible, but no later than 15 days following Plan's receipt of Facility's objections.

   If Facility is not satisfied with Plan's determination, (or Plan does not respond timely) Facility may initiate non-binding mediation pursuant to Section 7.02B by notifying Plan within 30 days of receipt (or due date) of the Plan's decision.

2. **Other Disputes.**

   In the event the matter in dispute is not a Billing Dispute, the following process and schedule shall apply.

   The Plan will consider the issues raised in the request and notify the Facility of its determination as quickly as possible, but no later than 60 days following receipt of the Facility's Request, unless Plan reasonably believes that the complexity of the matter in dispute requires a greater period of time. In any such case, Plan shall notify Facility prior to the end of the 60 day period that it reasonably believes that a greater period of time is required, and the basis for that belief. Upon such written notice to Facility, Plan shall be entitled to extend the period for response for a reasonable period of time, not to exceed an additional 60 days, unless a longer period is agreed to by both parties in writing. During this period of time, Plan and Facility may continue to exchange information and meet, as they deem appropriate, to ensure that information material to the dispute may be considered by Plan.

   If Facility is not satisfied with Plan's determination, Facility may initiate non-binding mediation pursuant to Section 7.02B and by notifying Plan within 30 days of receipt (or due date) of the Plan's decision.

B. Upon timely initiation of mediation, the Parties shall agree upon a mediator. The mediator's fees shall be borne in equal shares by the Parties. Unless agreed otherwise, all other related costs incurred by the Parties shall be the sole responsibility of the party incurring the cost. The mediator shall, in consultation with the Parties, determine a process and schedule for the mediation. In the event the Parties cannot resolve the matter through non-binding mediation, either Party may institute an action in any Superior Court of competent jurisdiction. By mutual consent, the parties may forego non-binding mediation and proceed directly to a Superior Court action.

C. All notices and correspondence pursuant to this Section 7.02 shall comply with the terms of Section 7.10.

D. This Agreement will be construed in accordance with the procedural and substantive laws of the State of Washington.

E. Modifications to this Agreement, Compensation, manuals, policies, administrative procedures, and other matters subject to Section 3.14 shall not be subject to dispute resolution under this Section

7.02. However, whether such modifications have been proposed and made in compliance with the terms of this Agreement and with applicable law is subject to dispute resolution hereunder.

During any appeal or mediation process, Facility shall not bill or otherwise seek collection from Enrollee for any payment amounts in dispute.

7.03 **Assignment**. No assignment of the rights, duties or obligations of this Agreement, including assignment by operation of law, will be made by Facility without the written consent of Intermediary. If Intermediary or any Plan merges, consolidates with another entity or does business under another or with another entity or name, this Agreement will continue in full force and effect.

7.04 **Subcontracts and Affiliation Agreements**. If Facility wishes to establish an agreement with a subcontractor or an affiliate to provide Covered Services to Enrollees hereunder, the contract proposed to be used must be submitted to Plan for prior approval 30 days prior to the agreement's effective date, along with all necessary information required to administer the agreement.

Such agreements shall be in place and approved by Plan prior to providing Covered Services to Enrollees. All such agreements shall conform to regulatory requirements of WAC 284-43-320. In addition, each such subcontract shall have a copy of this Agreement appended thereto and shall provide that:

A. the party with whom Facility so contracts must satisfy and comply with the terms of this Agreement; and

B. the subcontract and/or affiliation agreement to the extent it relates to a Plan, shall be terminable at the request of Intermediary consistent with the terms of Section 6.03 hereof.

All Providers who provide Covered Services under such an agreement must be credentialed as required by the Plan and the credentialing approved by Plan prior to providing Covered Services to Enrollees.

7.05 **Entire Agreement**. This Agreement, including all exhibits, addenda, attachments and amendments, constitutes the entire agreement between Intermediary and Facility. No implied covenants will be read into this Agreement. This Agreement supersedes all prior agreements between the parties.

7.06 **Severability/Conformity with Law**. If any part of this Agreement shall be found to be invalid, void or unenforceable, the remainder of the Agreement shall remain in full force and effect. Both parties will comply with all applicable state and federal laws and regulations, including but not limited to those related to Medicare, Medicaid and/or other state or federal health care delivery programs. This Agreement shall be interpreted, and if necessary amended, to conform with applicable state and federal law in effect on or after its effective date.

7.07 **Headings**. The headings of sections and paragraphs contained in this Agreement are for reference purposes only and will not in any way affect the meaning or interpretation of this Agreement.

7.08 **Relationship of Parties**. Neither Facility nor Intermediary nor any of their respective employees, will be construed to be the agent, employee or representative of the other, or liable for any acts of omission or commission on the part of the other.

Facility understands and agrees that Intermediary is merely acting as an agent for and on behalf of Plans for the sole purpose of engaging Facility to provide the services set forth in this Agreement. Facility further understands and agrees that Intermediary is not in the business of providing insurance coverages or health care benefits to others.

7.09 **Nonrestrictive Participation**. Nothing contained in this Agreement or any related document will be construed to restrict the participation of Facility in any other health care delivery system or payment plan.

7.10 **Notices**. Other than as set forth below, notices required by this Agreement will be in writing and mailed, postage prepaid, to the other party at the principal address shown in this Agreement or to such other address as may be provided by one party to the other. Notice is considered effective on the date it is received, or three days following the postmark date, whichever is earlier. Notices of Termination and Requests, Notices, and correspondence required under the terms of Section 7.02A shall be sent certified mail, return receipt requested.

7.11 **Waiver of Breach**. Neither the failure nor delay on the part of either party to exercise any right under this Agreement will serve as a waiver of that right. If either party should waive any breach of any provision of this Agreement, it will not be deemed or construed as a waiver of any other breach of the same or a different provision.

7.12 **Changes to Subscriber Agreements**. Plans may change, revise, modify or alter the form and/or content of any Subscriber Agreement without prior notice to Facility.

7.13 **Trademarks**. The parties and Plans reserve the right to control the use of their respective names, symbols, trademarks and service marks presently existing or later established. In addition, neither party will use the other party's name, symbols, trademarks or service marks, nor shall Facility use the name, symbol or service mark of any Plan in advertising or promotional material or otherwise, without prior written consent of that party or Plan, as appropriate, and will cease any such usage immediately upon written notice of that party or upon termination of this Agreement, whichever is sooner, except as provided at Section 2.04.

If Facility utilizes its own Enrollee education materials inclusive of Plan's name and information, then such materials must be submitted to Plan at least 60 days prior to its intended use. Such materials must receive the prior approval of Plan and of any regulatory body to ensure conformity with applicable regulatory requirements.

7.14 **Proprietary and Confidential Information**. The existence of this Agreement is not considered confidential information. However, neither party will disclose the terms or contents of this Agreement and/or any of the attachments, addenda, amendments and exhibits without prior written consent of the other party. In addition, neither Party shall disclose the course or substance of any ongoing contractual negotiations other than to counsel for that party or to any regulatory body regarding matters within the jurisdiction of that body, without the prior written consent of the other Party. Intermediary and Plan(s) consider the rates, formulas and pricing methodologies used in establishing various payment and risk-sharing provisions, including information supplied by Participant in any bid documents, to be proprietary and confidential information.

This provision shall survive termination of this Agreement.

7.15 **Indemnification.**

A. **Indemnification of Facility**. Plan agrees to indemnify Facility and to hold harmless Facility against any claims, actions, liabilities, damages, and losses (collectively "Damages"), including reasonable attorneys' fees and costs, to the extent such Damages are caused by Plan's negligence in discharge of duties or obligations which are solely the responsibility of Plan, its agents or employees during the term of this Agreement. Notwithstanding the foregoing, such Indemnity shall not include any claim arising from an allegation of medical malpractice against the Facility, its agents or employees.

B. **Indemnification of Intermediary and Plan**. Facility agrees to indemnify Intermediary and/or Plan and to hold harmless Intermediary and/or Plan against any Damages (as defined in 7.15A), including reasonable attorneys' fees and costs, to the extent such Damages arise or are related to (i) claims of malpractice or negligence for which Facility, its employees, agents or representatives are responsible, or (ii) the use or maintenance of any property, facility or equipment by or under the

direction of Facility or (iii) the performance of any activity by or under the direction or control of Facility during the term of this Agreement.

This provision shall survive termination of this Agreement.

7.16 Compliance. Plan and Facility shall comply with all requirements under state and federal law relative to their obligations under this Agreement. Plan and Facility agree to work jointly to satisfy regulatory reporting and disclosure requirements in a timely manner. This provision also applies to any provider subcontracts and affiliation agreements Facility may have for Covered Services rendered to Enrollees under Plan.

PART 8 AGREEMENT

8.01 **Replacement Agreements**. From time to time, Intermediary may issue a replacementagreement which represents this Agreement, together with any attachments, appendices, exhibits and amendments which have been agreed to in writing by Intermediary and Facility as of the date the replacement agreement is issued. Facility agrees to execute the replacement agreement without further negotiation.

IN WITNESS WHEREOF, the parties hereto have executed and delivered this Agreement in duplicate original.

CHILDRENS HOSPITAL AND REGIONAL MEDICAL CENTER

BY: Kelly Wallace
Signature

Kelly Wallace
Print or Typed Name

6-15-01
Date Signed

Tax ID #: 91-0564748

Whose mailing address is:

P.O. Box 5371

Seattle, WA 98105-0371

PREMERAFirst, Inc.

BY: Teresa Marro
Signature

Teresa Marro
~~Deborah R. Varner~~
Print or Typed Name

Director
~~Vice President~~, Health Care Delivery Systems
Date Signed

Whose mailing address is:

PO Box 327

Seattle, WA 98111-0327

EFFECTIVE DATE: January 1, 2001

EXHIBIT 1A
TO
PREMERAFirst
FACILITY AGREEMENT

In accordance with Section 1.24 of the Agreement, the following companies shall be considered a Plan for the purposes of administering the Agreement:

Premera Blue Cross
P.O. Box 327
Seattle, Washington 98111-0327

Facility hereby expressly acknowledges its understanding that this Agreement constitutes a contract between Facility and the Plans, that Premera Blue Cross ("PBC") is an independent corporation operating under licenses from the Blue Cross and Blue Shield Association (the "Association"), an Association of Independent Blue Cross and Blue Shield Plans, permitting PBC to use the Blue Cross Service Marks in the States of Washington and Alaska and that PBC is not contracting as an agent of the Association. Facility further acknowledges and agrees that it has not entered into this Agreement based upon representations by any person other than PBC and that the Association, affiliates of PBC, and/or any other person, entity or organization other than PBC shall not be held accountable or liable to Facility for any of the obligations of PBC to Facility created under this Agreement. This paragraph shall not create any additional obligations whatsoever on the part of PBC other than those obligations created under other provisions of this Agreement.

Premera Blue Cross is an Independent Licensee of the Blue Cross and Blue Shield Association.

**As of June 30, 1998, Medical Service Corporation of Eastern Washington and Blue Cross of Washington and Alaska merged into a single company known as Premera Blue Cross. In Eastern Washington, the company will be referred to as MSC Incorporated as Premera Blue Cross.

EXHIBIT 1B
TO
PREMERAFirst
FACILITY AGREEMENT

In accordance with Section 1.24 of the Agreement, the following company shall be considered a Plan for the purposes of administering the Agreement:

Blue Cross Blue Shield of Alaska
P.O. Box 327
Seattle, Washington 98111-0327

Facility hereby expressly acknowledges its understanding that this Agreement constitutes a contract between Facility and the Plan, that Blue Cross Blue Shield of Alaska ("BCBS of Alaska") is an independent corporation operating under licenses from the Blue Cross and Blue Shield Association (the "Association"), an Association of Independent Blue Cross and Blue Shield Plans, permitting BCBS of Alaska to use the Blue Cross Service Marks in the States of Washington and Alaska and the Blue Shield Service Marks in the State of Alaska and in the following Eastern Washington counties: Adams, Benton, Chelan, Douglas, Ferry, Franklin, Garfield, Grant, Kittitas, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens and Whitman, and that BCBS of Alaska is not contracting as an agent of the Association. Facility further acknowledges and agrees that it has not entered into this Agreement based upon representations by any person other than BCBS of Alaska and that the Association, affiliates of BCBS of Alaska, and/or an other person, entity or organization other than BCBS of Alaska shall not be held accountable or liable to Facility for any of the obligations of BCBS of Alaska to Facility created under this Agreement. This paragraph shall not create any additional obligations whatsoever on the part of Intermediary or BCBS of Alaska other than those obligations created under other provisions of this Agreement.

Blue Cross Blue Shield of Alaska is an Independent Licensee of the Blue Cross and Blue Shield Association.

AMENDMENT TO PREMERAFirst FACILITY AGREEMENT

CHILDRENS HOSPITAL AND REGIONAL MEDICAL CENTER

The Agreement entered into by and between PREMERAFirst, Inc. ("Intermediary") and Childrens Hospital and Regional Medical Center ("Facility") is hereby-amended effective January 1, 2001, as follows:

1. **PART 1, Section 1.02, ("Allowed Amount"):** this section is deleted in its entirety and replaced with the following:

   "**Allowed Amount** means a Plan determined amount that is based on a specific payment methodology or negotiated rates as set forth in the attached Compensation Addendum. The Allowed Amount is the maximum amount Facility shall receive from the Plan for Covered Services furnished to Enrollees and is the sum of the Plan Payment and any Enrollee responsibility, such as Deductible, Copayment, Coinsurance or coordination of benefits."

2. **PART 1, Section 1.03, ("Claim"):** this section is deleted in its entirety and replaced with the following:

   "**Claim** means a charge submitted by Facility to Plan, on a HCFA 1500 or UB-92 claims form or its successors, which contains Complete and Accurate Information that allows a Plan to determine the payment for Covered Services rendered to Enrollees."

3. **PART 1, Section 1.07, ("Complete and Accurate Information"):** the first bullet item in this section is deleted in its entirety and replaced with the following:

   "Complete and accurate description of the services performed and charges made using appropriate industry diagnosis codes (e.g., ICD-9-CM) and appropriate revenue codes (e.g., UB-92) in accordance with published state and federal guidelines for HCFA 1500's and UB-92 Claims submission and Plan Minimum Billing Guidelines;"

4. **PART 1, Section 1.07, ("Complete and Accurate Information"):** the third bullet item in this section is deleted in its entirety and replaced with the following:

   "Any other information required and requested by Plan to determine whether a Claim is a Clean Claim ."

5. **PART 1, Section 1.11, ("Enrollee"):** this section is deleted in its entirety and replaced with the following:

   "**Enrollee** means either a Subscriber or a dependent of a Subscriber who is properly enrolled under a Plan Subscriber Agreement, including individuals who are also Medicare beneficiaries. Enrollee also means an individual covered under any plan sponsored by a licensee of the Blue Cross Blue Shield Association and an individual enrolled with Plan subsidiaries, affiliates and nonaffiliated entities as designated by a Plan. Facility will be provided written notice of any subsidiaries,

affiliates or non-affiliated entities with whom Plan affiliates after the effective date of this Agreement."

6. **PART 1, Section 1.24, ("Plan"):** this section is deleted in its entirety and replaced with the following:

"**Plan** means a health care services contractor, health maintenance organization, insurer, trust, self-funded health program or other entity responsible for discharging Plan duties hereunder, which is listed in the attached Exhibits 1(A through C) and has appointed Intermediary to act as a contracting agent."

7. **PART 2, Section 2.03, ("Identification Cards"):** this section is deleted in its entirety and replaced with the following:

"Intermediary shall issue or arrange with Plans for the issuance of identification cards to Enrollees. The identification card shall bear the name of the Plan, the name of the Enrollee, the Enrollee's selected Primary Care Practitioner (as appropriate) and the Enrollee identification number. Enrollees will be instructed to present identification cards to Facility at the time services are requested. Such identification cards are not a verification of eligibility as an Enrollee or a guarantee of payment, but a means of providing information that Facility can easily use to verify eligibility with a Plan."

8. **PART 2, Section 2.05, ("Information to be Provided"):** this section is deleted in its entirety and replaced with the following:

"Intermediary will arrange for Plans to make available to Facility a telephone number or other means by which Facility can obtain timely information of patient eligibility for health care services and benefits, including any limitations or conditions on services or benefits. Plan will not retroactively deny payment to Facility based upon a lack of eligibility in excess of 90 days following Plan verification of eligibility. A Plan's verification of eligibility and description of Covered Services under the Subscriber Agreement is not a guarantee of payment. Notwithstanding the above, Plan will be financially responsible in the event Plan misquotes benefits and/or Enrollee eligibility based upon information in Plan's custody at the time of the authorization."
"

9. **PART 2, Section 2.06, ("Directories"):** this section is deleted in its entirety and replaced with the following:

"The Plan agrees to list Facility as a Preferred Provider in all directories and other similar Preferred Provider listings. The Plan agrees to print and distribute these directories to its covered Enrollees, and make best efforts to update these directories at least annually. Copies of directories will be distributed to Facility upon request."

10. **PART 2, Section 2.09, ("Licenses and Authorizations"):** a new section 2.09 is added to the Agreement as follows:

"Plan warrants, currently and for the duration of this Agreement, that it has all licenses, permits, and/or governmental or board authorizations or approvals necessary to meet the obligations set forth in this Agreement in accordance with the applicable requirements in the state(s) in which Plan operates. Plan will provide immediate written notice to Facility of any changes in the licenses, permits, and/or governmental or board authorizations or approvals referenced above, including, but not limited to, ownership, business address, Tax Identification Number, and any factors that may materially impact Plan's ability to carry out the terms of this Agreement."

11. **PART 2, Section 2.10, ("Insurance"):** a new section 2.10 is added to the Agreement as follows:

"Plan will provide and maintain, at its sole expense, policies of general comprehensive liability and professional liability insurance, or self insurance, in an amount generally accepted for industry standards."

12. **PART 2, Section 2.11, ("No Recourse Against Facility"):** a new section 2.11 is added to the Agreement as follows:

"Plan shall not penalize Facility because Facility, in good faith, reports to state or federal authorities any act or practice by Plan that jeopardizes patient health or welfare or that may violate state or federal law."

13. **PART 3, Section 3.01, ("Services Provided to Enrollees"):** this section is deleted in its entirety and replaced with the following:

"Facility will provide Covered Services to Enrollees in compliance with the terms of this Agreement. When providing such services, Facility will exercise the degree of care, skill and learning expected of a prudent health care Facility. Facility will observe, protect and promote the rights of Enrollees as patients.

Facility must contract for all commercial products agreed to by Facility and Plan as of the effective date of this Agreement for the entire term of this Agreement. Additional commercial products may be added to this Agreement during the term of this Agreement as set forth in Section 7.01 hereof.

Unless agreed otherwise by Plan, termination of any commercial Product and Compensation Addendum by Facility shall terminate all commercial Product and Compensation Addenda."

14. **PART 3, Section 3.02, ("Nondiscrimination"):** this section is deleted in its entirety and replaced with the following:

"The Parties acknowledge that Plan utilization review and care management policies may differ from those employed by other carriers. Subject to any such distinction, Facility will provide Covered Services to Enrollees on the same basis as such services are made available to patients who are not Enrollees, and without regard to the Enrollee's participation in a Plan as a private purchaser of health care coverage or as a participant in publicly financed programs of health care services, with respect to the availability and quality of Facility services.

Facility further agrees to comply with applicable state or federal regulatory laws and not to discriminate in the treatment of patients or in the quality of services delivered to Enrollees on the basis of race, color, sex, age, religion, national origin, place of residence, health status, or handicap."

15. **PART 3, Section 3.05, ("Credentialing"):** the first paragraph of this section is deleted in its entirety and replaced with the following:

"Facility warrants, currently and for the duration of this Agreement, that it meets Plans' credentialing standards of which Facility has received prior written notice, and that Facility has all licenses, permits, and/or governmental or board authorizations or approvals necessary to provide Covered Services in accordance with the applicable requirements in the state(s) in which Facility operates. Facility further warrants that it will cooperate with Plan's credentialing and recredentialing processes. Facility will provide immediate written notice to Intermediary of any changes in the licenses, permits, and/or governmental or board authorizations or approvals referenced above, including, but not limited to, ownership, business address, Tax Identification Number, new

Practitioner proposed to be included as a Participant pursuant to this Agreement and any factors that may materially impact Facility's ability to provide Covered Services to Enrollees hereunder. Facility's credentialing application shall be incorporated by reference into this Agreement."

16. **PART 3, Section 3.08, ("Retrospective Review"):** this section is deleted in its entirety and replaced with the following:

"A Plan may conduct a retrospective review to determine whether all services provided to an Enrollee are covered and/or Medically Necessary. Facility will abide by a Plan's decisions made through retrospective review subject to the dispute resolution procedures stated in Section 7.02. Plan will not reverse any prior authorization of Covered Services as Medically Necessary unless Plan medical review determines that the Plan authorized the services based upon materially incomplete or inaccurate information provided to Plan by, or on behalf of, Facility. Facility will not seek payment from a Plan or the Enrollee for Covered Services which the Plan determines were not Medically Necessary as a result of its retrospective review other than in compliance with Section 4.01 hereof."

17. **PART 3, Section 3.09, ("Onsite Clinical Quality and Health Improvement Review"):** this section is deleted in its entirety and replaced with the following:

"Facility will allow and fully cooperate with onsite quality review conducted by a Plan and/or its agents. Such reviews will be scheduled at appropriate times during regular business hours and with reasonable prior notice to Facility, and will be conducted pursuant to administrative rules, procedures and standards furnished to Facility as described in Section 3.14."

18. **PART 3, Section 3.10, ("Reporting to Plan"):** the first paragraph in this section is deleted in its entirety and replaced with the following:

"Facility shall cooperate with Plans' data collection and reporting efforts, in compliance with requirements of the National Committee for Quality Assurance (NCQA) and HEDIS®, or any other accreditation program(s) designated by Plan. (NCQA's Health Plan Employer Data Information Set; HEDIS® is a registered trademark of NCQA.) Such reviews will be scheduled at appropriate times during regular business hours and with reasonable prior notice to Facility.

Facility shall provide immediate written notice to Plan of any legal, regulatory, or governmental action of which Facility is aware which Facility reasonably believes could materially impact the ability of the Facility to carry out the duties and obligations of this Agreement, including, without limitation, litigation initiated by a patient against Facility."

19. **PART 3, Section 3.13, ("Specialty Services"):** this section is deleted in its entirety and replaced with the following:

"Facility will make best efforts to cooperate with Intermediary and Plan efforts to assure the availability of specialty services Practitioners whose contracted status is consistent with Facility's contracted status according to this Agreement. Such specialty services include, but are not limited to, anesthesiology, radiology, pathology and emergency room physicians."

20. **PART 3, Section 3.14, ("Administrative Rules and Procedures"):** this section is deleted in its entirety and replaced with the following:

"Facility will abide by administrative rules and procedures issued by Intermediary and/or a Plan with respect to, but not limited to, authorizations, utilization management, quality management, Enrollee rights, responsibilities and grievances, billing procedures and standards, and other matters that relate

to Facility's provision of Covered Services to Enrollees and compliance with this Agreement. Intermediary and/or Plan will provide written information to Facility prior to execution of this Agreement as well as any necessary revisions, regarding such administrative rules and procedures. Changes to documents, procedures and other administrative policies and programs that affect Facility Compensation and that affect health care service delivery shall be made pursuant to the provisions of Section 7.01A. Any administrative rule or procedure established by way of the prior course of dealing between the parties shall not be modified without prior written notice to Facilitypurusant to Section 7.01A."

21. **PART 3, Section 3.15, ("Accuracy of Information")**: this section is deleted in its entirety and replaced with the following:

"Facility represents that, to the best of Facility's knowledge, all information given to Intermediary and/or Intermediary's designees in applying for and maintaining this Agreement is true, accurate, and complete in all material respects."

22. **PART 3, Section 3.17, ("Inpatient Admission")**: this section is deleted in its entirety and replaced with the following:

"Within one business day after Inpatient admission, Facility agrees to notify Plan of any emergency hospital admission of an Enrollee. A business day means Monday through Friday, 8:00 a.m. to 5:00 p.m. excluding holidays. Facility also agrees to notify Plan of any non-emergency hospital admission of an Enrollee as soon as possible after the decision to admit has been made or within one business day of actual admit."

23. **PART 4, Section 4.01, ("Payment")**: the first and fifth paragraphs of this section are deleted in their entirety and replaced with the following:

"Plan will pay Facility for Covered Services rendered to Enrollees in accordance with the applicable Product and Compensation Addenda incorporated by reference herein. Facility will seek payment solely from the Enrollee's Plan for Covered Services rendered to that Plan's Enrollees and shall accept as full payment the Allowed Amount(s) set forth in the applicable Product and Compensation Addenda attached to this Agreement.

Except as provided in this Agreement, Facility will not seek payment from Enrollees or a Plan for services determined not to be Medically Necessary by the Plan unless the Enrollee has agreed in writing to be financially responsible for those services before those services are provided. Retrospective determinations of Medical Necessity are governed by Section 3.08."

24. **PART 4, Section 4.03, ("Claims Submission")**: the first paragraph of this section is deleted in its entirety and replaced with the following:

"Facility will submit Claims to a Plan on a HCFA 1500 or UB-92 in a manner acceptable to the Plan and consistent with Section 1.07 hereof. Facility should submit Claims within 60 days after Covered Services are rendered, but Plan will be under no obligation to pay a Claim if Plan receives it more than 365 days after the date Covered Services were provided, or 60 calendar days after Facility first receives notice that Plan is a secondary payor under applicable coordination of benefits procedures, whichever shall be later. Facility may not seek payment from Enrollee or any Plan for Covered Services submitted after that time."

25. **PART 4, Section 4.03, ("Claims Submission")**: the second paragraph of this section is deleted in its entirety and replaced with the following:

"Facility will be reimbursed for only Covered Services which were ordered by a physician or other qualified Practitioner, delivered to the Enrollee and documented in the medical record. The coding convention used on submitted Claims will accurately reflect services provided and the reasons for the procedure, service, supply or encounter. Upon request, Facility will furnish all information reasonably required by a Plan to substantiate the provision of, and charges for, Covered Services, subject to the following provisions:

1. Plan Access. Upon 30 days prior written notice to Facility, Plan shall have the right to inspect or receive copies of the medical, administrative and accounting records maintained by Facility pertaining to the billing and rendering of Covered Services to Enrollees, subject to confidentiality and to the limitations of state and federal law, and the confidentiality terms of Section 5.03.

2. Time of Inspections. Plan shall conduct inspections pursuant to paragraph 1 above only at a mutually convenient time during Facility's normal business hours.

3. Releases. Plan shall be responsible for obtaining written releases by Enrollees to the extent required by law authorizing the release of medical information by Facility and hold Facility harmless for any liability in connection with the requested release.

4. Reimbursement. Plan shall pay Facility a $10.00 pulling fee and $.30 per page for duplication of records when required in conjunction with inspection and audit as described in this Section 4.03."

26. **PART 4, Section 4.03, ("Claims Submission"):** the third paragraph of this section is deleted in its entirety and replaced with the following:

"For Covered Services provided to Enrollees, Plan or the responsible agent shall pay Facility as soon as practical but subject to the following minimum standards:"

27. **PART 4, Section 4.04, ("Cancellation of Coverage"):** this section is deleted in its entirety and replaced with the following:

"Neither Intermediary nor Plan will be liable to Facility for any health care services provided to an Enrollee whose coverage under the applicable Subscriber Agreement is canceled retroactively by the Enrollee's Plan. Plan will not retroactively deny payment to Facility in excess of 90 days following Plan verification of eligibility. Reasons for such cancellation may include, but are not limited to, misrepresentation and nonpayment of premiums."

28. **PART 4, Section 4.05, ("Refunds"):** this section is deleted in its entirety and replaced with the following:

"Claim approval and/or payments made by a Plan are contingent upon receipt of Complete and Accurate Information from Facility. Facility will promptly refund amounts paid by a Plan if it is determined that a Plan has accepted responsibility for payment based upon erroneous or incomplete information, if benefits are misapplied by the Plan and an Enrollee is not entitled to those benefits, or any other reason for an erroneous payment. In the event prompt refund is not made by Facility within 60 days of written notice by Plan, the amount to be refunded may instead be offset against any future amounts due Facility. Nothing in this section shall affect Facility's ability to dispute Plan's actions pursuant to Section 7.02 or any other available legal means."

29. **PART 4, Section 4.07, ("Other Enrollee Coverage and Other Party Liability"):** the second paragraph of this section is deleted in its entirety and replaced with the following:

"Facility will provide complete information, to the extent known by Facility, to the Enrollee's Plan regarding benefits available to an Enrollee from other sources, subject to other party liability, or due to work-related injuries or illnesses. Facility will promptly refund any excess payments from Plan if, after payment is made, an Enrollee is found to be covered by another program, plan, or health care agreement that is determined to be the primary coverage; or that another party is liable for payment. At the Plan's discretion, the amount to be refunded may instead be offset against any future amounts due Facility after written notice pursuant to Section 4.05."

30. **PART 5, Section 5.01, ("Records"):** this section is deleted in its entirety and replaced with the following:

"Facility will prepare and maintain all appropriate records including, but not limited to, medical, medical abstract, financial and administrative records for each Enrollee who receives services at Facility. The records will be maintained in accordance with prudent record-keeping procedures and as required by law.

Upon request, Facility will furnish all information reasonably required by a Plan to substantiate the provision of, and charges for, Covered Services, subject to the following provisions:

1. **Plan Access.** Upon 30 days prior written notice to Facility, Plan shall have the right to inspect or receive copies of the medical, administrative and accounting records maintained by Facility pertaining to the billing and rendering of Covered Services to Enrollees, subject to confidentiality and to the limitations of state and federal law, and the confidentiality terms of Section 5.03.

2. **Time of Inspections.** Plan shall conduct inspections pursuant to paragraph 1 above only at a mutually convenient time during Facility's normal business hours.

3. **Releases.** Plan shall be responsible for obtaining written releases by Enrollees to the extent required by law authorizing the release of medical information by Facility and hold Facility harmless for any liability in connection with the requested release.

4. **Reimbursement.** Plan shall pay Facility a $10.00 pulling fee and $.30 per page for duplication of records when required in conjunction with inspection and audit as described in this Section 5.01."

31. **PART 5, Section 5.02, ("Inspection and Audit"):** the first paragraph of this section is deleted in its entirety and replaced with the following:

"Except as provided by law, Intermediary and Plans will allow and fully cooperate with inspection, audit and duplication by Facility or its representatives of any and all data and other records which relate to this Agreement to the extent necessary to perform the audit or inspection. Such data and other records include, but are not limited to, claims processing, premium levels, revenues collected, utilization, payment amounts, claim denials and any other information appropriate in light of the compensation methodology under the Plan. Such inspection, audit verification and duplication will be allowed upon reasonable notice during regular business hours. Facility shall pay Plan or Intermediary a reasonable amount for duplication of records when required in conjunction with inspection and audit, as described in this Section 5.02."

32. **PART 6, Section 6.04, ("Services After Termination"):** a new paragraph "C" is added to this section as follows:

"In the event this Agreement is terminated and an Enrollee remains hospitalized on and after the effective date of such termination, Plan is obligated to pay for such services in the amounts established by this Agreement, regardless of the cause giving rise to termination."

33. **PART 7, Section 7.01, ("Amendments"):** this section is deleted in its entirety and replaced with the following:

A. Plan may amend this Agreement, any manual, policy, or administrative procedure pertaining to this Agreement to incorporate a modification generally applicable to contracted Facilities at any point during the term of this Agreement by providing Facility 60 days prior written notice consistent with the terms of Section 7.10. The proposed amendments shall become effective 60 days after the receipt of written notice by the Facility, unless the parties can agree otherwise at an earlier date. Any such amendment shall be in writing, shall include an effective date and shall be signed by Intermediary. Nothwithstanding the above, Plan must amend any Compensation Exhibit pursuant to Subsection 7.01B.

In the event Facility believes that a modification to any Compensation Exhibit relating hereto, or to any manual, policy, or administrative procedure pertaining to this Agreement will have a material impact on Facility's reasonable economic assumptions hereunder, Plan and Facility shall meet in an attempt to address Facility's concerns. In the event Plan and Facility cannot agree upon whether such an impact will occur or upon an alternative to the proposed modification, the proposed modification shall be effective at the conclusion of the notice period set forth above.

B. Plan may make Amendments applicable exclusively to this Agreement at any time during its term with the written consent of Facility. Any such amendment shall be in writing,shall be signed by Intermediary and Facility and shall be effective upon the date agreed to by the Parties. Amendments to any Compensation Exhibit must be made hereunder.

C. Plan may establish new products, or Facility may develop or initiate new healthservices which are not currently available to Enrollees. Upon such an event, a written notification will be sent to the other party no less than 60 days prior to the proposed implementation date. Subject to a Plan determination that any such services/products are Covered Services, the parties agree to negotiate in good faith an acceptable level of reimbursement for such services/products, andthe product amendments will be updated in writing, with required signatures by both parties.

D. Plan can amend this Agreement as required by regulatory changes by providing Facility 60 days prior written notice consistent with the terms of Section 7.10. The proposed amendments shall become effective 60 days after the receipt of written notice unless the parties can agree otherwise at an earlier date or to alternate language. Any such amendment shall be in writingand shall include an effective date.

E. No such changes will be retroactive unless expressly agreed to by Facility or required by law.

Changes to this Agreement may be subject to prior regulatory approval."

34. **PART 7, Section 7.02(A)(2), ("Provider Dispute Resolution – Other Disputes"):** the second paragraph of this section is deleted in its entirety and replaced with the following:

"The Plan will consider the issues raised in the request and notify the Facility of its determination as quickly as possible, but no later than 60 days following receipt of the Facility's Request, unless Plan reasonably believes that the complexity of the matter in dispute requires a greater period of time. In

any such case, Plan shall notify Facility prior to the end of the 60 day period that it reasonably believes that a greater period of time is required, and the basis for that belief. Upon such written notice to Facility, Plan shall be entitled to extend the period for response for a reasonable period of time, not to exceed an additional 60 days, unless a longer period is agreed to by both parties in writing. During this period of time, Plan and Facility may continue to exchange information and meet, as they deem appropriate, to ensure that information material to the dispute may be considered by Plan. Notwithstanding the above, Plan and Facility may jointly agree to an extended period of time for resolution of the dispute."

35. **PART 7, Section 7.03, ("Assignment"):** this section is deleted in its entirety and replaced with the following:

"No assignment of the rights, duties or obligations of this Agreement, including assignment by operation of law, will be made by Facility without the written consent of Intermediary. If Intermediary or any Plan merges, consolidates with another entity or does business under another or with another entity or name, this Agreement will continue in full force and effect and Plan will provide Facility written notice of the assignment and its impact on Facility and Plan Enrollees."

36. **PART 7, Section 7.06, ("Severability/Conformity with Law"):** this section is deleted in its entirety and replaced with the following:

"If any part of this Agreement shall be found to be invalid, void or unenforceable, the remainder of the Agreement shall remain in full force and effect. Both parties will comply to the best of their abilities with all applicable state and federal laws and regulations, including but not limited to those related to Medicare, Medicaid and/or other state or federal health care delivery programs. This Agreement shall be interpreted, and if necessary amended in writing subject to Section 7.10, to conform with applicable state and federal law in effect on or after its effective date."

37. **PART 7, Section 7.14, ("Proprietary and Confidential Information"):** this section is deleted in its entirety and replaced with the following:

"The existence of this Agreement is not considered confidential information. However, neither party will disclose the terms or contents of this Agreement and/or any of the attachments, addenda, amendments and exhibits without prior written consent of the other party. In addition, neither Party shall disclose the course or substance of any ongoing contractual negotiations other than to counsel for that party or to any regulatory body regarding matters within the jurisdiction of that body, without the prior written consent of the other Party. The Parties consider the rates, formulas and pricing methodologies used in establishing various payment and risk-sharing provisions, including information supplied by Participant in any bid documents, to be proprietary and confidential information.

This provision shall survive termination of this Agreement."

38. **PART 7, Section 7.15, ("Indemnification"):** this section is deleted in its entirety and replaced with the following:

A. **Indemnification of Facility**. To the fullest extent permitted by law, Plan agrees to indemnify Facility and to hold harmless Facility against any claims, actions, liabilities, damages, and losses (collectively "Damages"), including reasonable attorneys' fees and costs, to the extent such Damages are caused by Plan's breach of this Agreement, or negligence in discharge of duties or obligations which are solely the responsibility of Plan, its agents or employees during the term of this Agreement. Notwithstanding the foregoing, such Indemnity shall not include any claim arising from an allegation of medical malpractice against the Facility, its agents or employees.

B. **Indemnification of Intermediary and Plan**. To the fullest extent permitted by law, Facility agrees to indemnify Intermediary and/or Plan and to hold harmless Intermediary and/or Plan against any claims, actions, liabilities, damages, and losses (collectively "Damages"), including reasonable attorneys' fees and costs, to the extent such Damages are caused by Facility's breach of this Agreement, or negligence in discharge of duties or obligations which are solely the responsibility of Facility, its agents or employees during the term of this Agreement. Notwithstanding the foregoing, such Indemnity shall not include any claim arising from an allegation of medical malpractice against Intermediary and/or Plan, its agents or employees.

This provision shall survive termination of this Agreement."

The effective date of this amendment is January 1, 2001. All other terms and conditions of the Agreement remain unchanged, except as specified in this or any other amendment to the Agreement.

CHILDRENS HOSPITAL AND REGIONAL MEDICAL CENTER	PREMERAFirst, Inc.
BY: Kelly Wallace Signature	BY: Teresa Marro Signature
Kelly Wallace Print or Typed Name	Teresa Marro ~~Deborah R. Varner~~ Print or Typed Name
V.P AND CFO Title	Director ~~Vice President~~, Health Care Delivery Systems Title
6-15-01 Date Signed	7/25/01 Date Signed
Tax ID #: 91-0564748	

AMENDMENT TO
PREMERAFirst PROVIDER
AND
FACILITY AGREEMENTS

The Agreement entered into by and between PremeraFirst, Inc. ("Intermediary") and Provider is hereby amended effective January 1, 2008. This Amendment applies to all Plan agreements and ensures compliance with applicable statutory requirements. This Amendment also applies to all subcontracts entered into by Provider for the provision of Covered Services under the Agreement. Provider must ensure that all such subcontractors receive a copy of this Amendment.

This Amendment is in addition to the Agreement and does not replace or supersede the Agreement. The Agreement, except as specifically modified herein, shall remain in effect.

The Agreement is amended as follows:

1. Any provision regarding "Coordination of Benefits" is deleted and replaced as required by WAC. 284-51 with the following provision:

"Provider agrees to cooperate in the administration of coordination of benefits between Plan and other payers. When Plan is the secondary payer, Plan will have no financial responsibility to Provider once Provider has received payment equivalent to the Plan Allowed Amount or other amount when required by law, from all sources of payment."

2. Any provision defining "Medically Necessary/Medical Necessity" is deleted and replaced with the following definition:

"**Medically Necessary/Medical Necessity** shall mean health care services that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

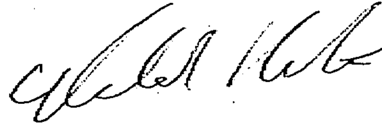
A. in accordance with generally accepted standards of medical practice;

B. clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and

C. not primarily for the convenience of the patient, physician, or other health car e provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease."

The effective date of this amendment is January 1, 2008. All other terms and conditions of the Agreement remain unchanged, except as specified in this or any other amendment to the Agreement.

PREMERAFirst, INC.
BY:



Signature

Rich Maturi
Print or Typed Name

SVP, Health Care Delivery Systems
Title

PREMERAFirst
FACILITY AGREEMENT
COMPENSATION EXHIBIT A

SEATTLE CHILDREN'S
DBA: Seattle Children's Hospital

EFFECTIVE: May 1, 2011

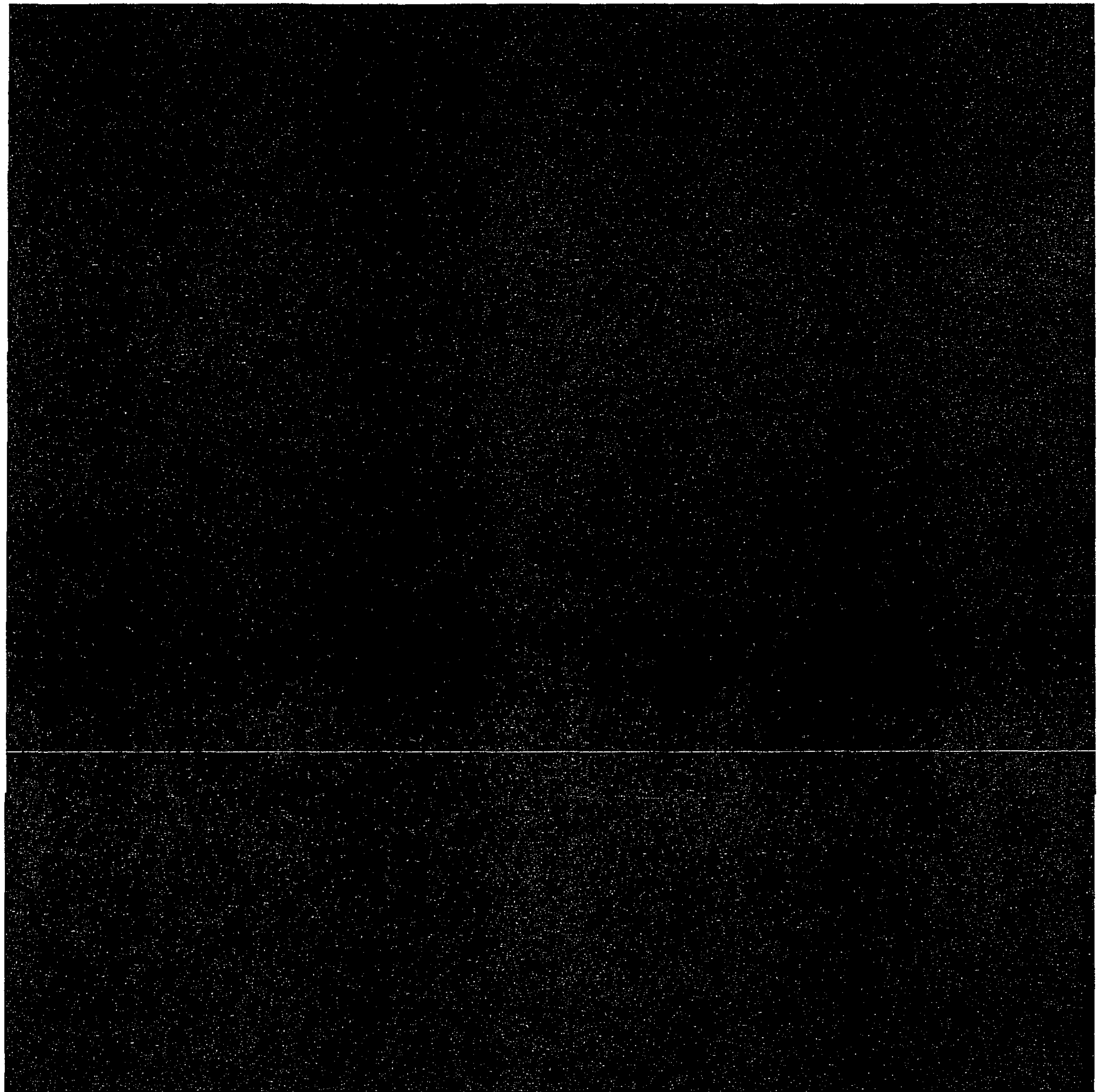
This Compensation Exhibit Applies to the Following Plans and Products:

Premera Blue Cross	Preferred
	Participating
	Dimensions
Premera Blue Cross Blue Shield of Alaska	Participating
	Preferred
LifeWise Health Plan of Washington	
LifeWise Health Plan of Oregon	

INPATIENT CARE

OUTPATIENT CARE

ADDITIONAL PROVISIONS



DIMENSIONS PRODUCT STRUCTURE

1. **Tiering**. Benefit designs that Plan offers within the Dimensions product will employ different levels of Enrollee Copayment and Coinsurance for Covered Services depending upon the Dimensions Benefit Tier with which a particular Dimensions Facility is associated. Dimensions Facilities will be associated with a Dimensions Benefit Tier based upon the standards set forth in Attachment A.

2. **Modifications to Tiering Standards**. Plan may (a) modify the Dimensions Tiering standards; (b) create additional Dimensions Tiering Standards it deems of importance to Dimensions Enrollees; and/or (c) create additional Dimensions Benefit Tiers during the term of this Addendum. Notice of any such modifications or additions hereunder will be provided in compliance with Section 3.14 of the Agreement.

3. **Plan Option Tiering Standards**. In addition to the standards issued and employed pursuant to Sections 1 and 2, Plan may associate a particular Dimensions Facility with a higher Benefit Tier in order to satisfy Dimensions Enrollee needs. Notices hereunder shall be provided to the affected Facilities in compliance with Section 3.14 of the Agreement.

4. **Change in Facility Tier**. Plan will notify Facility of any change in its assigned tier pursuant to Section 3.14 of the Agreement.

5. **Directories**. Plan will include Dimensions Facilities in its directories as set forth in Section 2.06 of the Agreement.

TERM

This Exhibit will remain in force through February 28, 2013 (Initial Term) and will continue after this Initial Term unless terminated by either party pursuant to Section 6 of the Agreement.

This Compensation Exhibit A supersedes any previous terms that set forth Facility payment for Covered Services provided to Enrollees. The PremeraFirst Facility Agreement shall remain unmodified and in full force and effect, except as specified in this Exhibit or any other amendment to the Agreement.

IN WITNESS WHEREOF, the parties hereto have executed and delivered this Compensation Exhibit in duplicate original.

SEATTLE CHILDREN'S **DBA: Seattle Children's Hospital**	**PREMERAFirst, INC.**
BY: ______ Signature	**BY:** ______ Signature
______ Print or Typed Name	Rich Maturi Print or Typed Name
______ Title	SVP, Health Care Delivery Systems Title
______ Date Signed	______ Date Signed
Tax ID #: ______	

PREMERAFirst FACILITY AGREEMENT
ATTACHMENT A
TO
COMPENSATION EXHIBIT A
NETWORK TIERING STANDARDS

EFFECTIVE: **May 1, 2011**

SEATTLE CHILDREN'S
DBA: Seattle Children's Hospital

Plan and Facility have entered into an agreement under which Facility will provide Covered Services to Plan Enrollees enrolled in Plan's commercial products. Pursuant to Section 1 (Dimensions Product Structure) of the Exhibit, following are the Network Tiering Standards for dates of service commencing on or after June 1, 2002. Plan may also employ Plan Option Tiering Standards as set forth in Section 3 (Dimensions Product Structure) of the Exhibit.

PART 1 CRITERIA FOR NETWORK TIER DESIGNATION

NETWORK TIER 1 – Any Facility who does not have an agreement with Plan will be assigned to Network Tier 1. Facilities assigned to Network Tier 1 are out-of-network for all Plan products.

NETWORK TIER 2 – Any Facility who has an agreement with Plan and does not meet the criteria for Network Tier 3 will be assigned to Network Tier 2. Facilities assigned to Network Tier 2 are in the following Networks: Global, Heritage, LifeWise Preferred.

NETWORK TIER 3 – Any Facility who has an agreement with Plan, and whose severity adjusted cost-per-case is competitive with that of other local facilities, according to a methodology developed by Plan, will be assigned to Network Tier 3. Facilities assigned to Network Tier 3 are in the following Networks: Global, Heritage, Foundation, LifeWise Preferred.

PREMERAFirst
FACILITY AGREEMENT
COMPENSATION EXHIBIT B

SEATTLE CHILDREN'S
DBA: Seattle Children's Home Care

EFFECTIVE: May 1, 2011 – February 28, 2013

This Compensation Exhibit applies to the following Plans and Products:

PLAN	PRODUCT
Premera Blue Cross	Participating
	Preferred
	Dimensions
Premera Blue Cross Blue Shield of Alaska	Participating
	Preferred
LifeWise Health Plan of Washington	
LifeWise Health Plan of Oregon	

The following pages (2-11) were redacted.

TERM
Effective May 1, 2011 – February 28, 2013

This Compensation Exhibit B supersedes any previous terms that set forth Facility payment for Covered Services provided to Enrollees. The PremeraFirst Facility Agreement shall remain unmodified and in full force and effect, except as specified in this Exhibit or any other amendment to the Agreement.

IN WITNESS WHEREOF, the parties hereto have executed and delivered this Compensation Exhibit in duplicate original.

SEATTLE CHILDREN'S **DBA: Seattle Children's Home Care**	**PREMERAFirst, INC.**
BY: ____________________ Signature	BY: ____________________ Signature
____________________ Print or Typed Name	Rich Maturi Print or Typed Name
____________________ Title	SVP, Health Care Delivery Systems Title
____________________ Date Signed	____________________ Date Signed
Tax ID #: ____________________	

Supporting Document Schedules

Satisfied - Item:	Cover Letter
Comments:	see attached cover letter
Attachment(s):	PBC Seattle Children's Cover Ltr.pdf
Item Status:	
Status Date:	

Satisfied - Item:	PF Facility Agreement (Redline)
Comments:	Please see attached redline version of the PF Facility Agreement.
Attachment(s):	pf98fac4 Seattle Children's Redline.pdf
Item Status:	
Status Date:	

March 3, 2011

Ms. Jennifer Kreitler
Office of the Insurance Commissioner
Rates and Forms Division
5000 Capitol Blvd.
Tumwater, WA 98501

Re: CONTRACT FILINGS – Seattle Children's

PremeraFirst Facility Agreement	PF98FAC4 (04/00) rev. 2/01)
Amendment to PremeraFirst Facility Agreement	PCWFAM SeaChild (5/11)
Proposed Effective Date:	May 1, 2011

Dear Ms. Kreitler:

Enclosed for filing is a custom agreement for Seattle Children's. This filing includes the core contract, custom amendment, compensation exhibits and Attachment A. Proprietary rate information has been redacted. We are currently seeking approval for the custom amendment to the core agreement. As discussed with your office, we will amend the core agreement with our proposed regulatory amendment at a later date.

A redline version of the core contract is included.

Please feel free to contact me at (425) 918-5545 or via email at wendy.stiles@premera.com should you have any questions.

Sincerely,

Wendy L. Stiles

Wendy L. Stiles
Sr. Compliance Analyst/Paralegal

Enclosures

PREMERAFirst FACILITY AGREEMENT

CHILDRENS HOSPITAL AND REGIONAL MEDICAL CENTER

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APPLICABLE PRODUCT AND COMPENSATION ADDENDA

PREMERAFirst
FACILITY AGREEMENT

This Agreement is a contract between PREMERAFirst, Inc. (hereinafter referred to as "Intermediary") and Childrens Hospital and Regional Medical Center (hereinafter referred to as "Facility"). The effective date of this Agreement is January 1, 2001.

WHEREAS, Intermediary is a duly licensed corporation, domiciled in the State of Washington and organized and operating under applicable state law, and has been appointed for purposes of state and federal law by Plans to act solely as a contracting agent and not as principal;

WHEREAS, Facility is a duly licensed Health Care Facility which holds all required licenses, certificates and/or accreditations as required by law;

NOW, THEREFORE, in consideration of mutual promises, covenants and agreements contained in this Agreement, the parties agree as follows:

PART 1 DEFINITIONS

When capitalized in this Agreement, any word or term listed below has the meaning listed after it in this Definitions Section.

1.01 **Agreement** includes, when used herein, this Facility Agreement and Product and Compensation Addenda related hereto, as both may be amended from time to time.

1.02 **Allowed Amount** means a Plan determined amount that is based on a specific payment methodology or negotiated rates. The Allowed Amount is the maximum amount Facility shall receive from the Plan for Covered Services furnished to Enrollees and is the sum of the Plan Payment and any Enrollee responsibility, such as Deductible, Copayment, Coinsurance or coordination of benefits.

1.03 **Claim** means a charge submitted by Facility to Plan, which contains Complete and Accurate Information that allows a Plan to determine an Enrollee's available benefits for Covered Services.

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

1.05 **Coinsurance** means the percentage of eligible medical expenses payable by an Enrollee to Facility for Covered Services as defined by the applicable Subscriber Agreement.

1.06 **Compensation**, as used herein, includes, but is not limited to, the terms, components, structure, formula and/or amount of payment made to the Facility for Covered Services provided hereunder including, without limitation, and as appropriate, the Capitation Payment, the Plan Payment, the Plan Fee Schedule, and Risk Pool Allocations.

1.07 **Complete and Accurate Information** includes:

- Complete and accurate description of the services performed and charges made using appropriate industry diagnosis codes (e.g., ICD-9-CM) and appropriate revenue codes (e.g., UB-92);

- Other known insurance coverage, third party resources, or health care benefits available to Enrollee. This includes workers' compensation, motor vehicle medical coverage, homeowners medical coverage, subrogation cases; and
- Any other information required and requested by Intermediary or a Plan to perform its obligations under this Agreement and/or the Subscriber Agreements.

1.08. **Copayment** means the fixed amount an Enrollee must pay Facility each time the Enrollee receives a specified Covered Service, as defined by the applicable Subscriber Agreement.

1.09 **Covered Services** means those Medically Necessary medical and hospital services, supplies and accommodations for which an Enrollee is eligible under the terms of the applicable Subscriber Agreement and as are customarily provided by the Facility.

1.10 **Deductible** means the fixed amount an Enrollee must pay Facility for Covered Services before a Plan commences payment for Covered Services, as defined by the applicable Subscriber Agreement.

1.11 **Enrollee** means either a Subscriber or a dependent of a Subscriber who is properly enrolled under a Plan Subscriber Agreement, including individuals who are also Medicare beneficiaries. Enrollee also means an individual covered under another plan that has a reciprocal agreement with the plan and an individual enrolled with Plan subsidiaries, affiliates and nonaffiliated entities as designated by a Plan.

1.12 **HCFA** means the Health Care Financing Administration. HCFA is the federal agency responsible for administering Medicare and overseeing administration of Medicaid by the states.

1.13 **Health Care Facility** means an institution or other health care delivery organization that provides services to Plan Enrollees. A Health Care Facility includes, but is not limited to, a hospital, a hospice, a skilled nursing facility, or an ambulatory surgical center. A Health Care Facility may also be referred to as a "Provider."

1.14 **Inpatient** means an Enrollee who has been formally admitted to a Health Care Facility or who stays in a Health Care Facility for more than 24 hours.

1.15 **Inpatient Services** means medical and surgical services and supplies furnished to an Enrollee who has been formally admitted to a Health Care Facility as an Inpatient.

1.16 **Intermediary** means an independent corporation appointed by Plans to secure contracts, on Plans' behalf, with Health Care Facilities and Practitioners to furnish health care services to Enrollees.

1.17 **Medicaid** means the federal program administered by the state, which provides medical benefits to eligible low income persons, and is administered and operated individually by participating states.

1.18 **Medical Emergency** means the emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention; or that failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the Enrollee's health in serious jeopardy. In determining Medical Emergency, a Plan will take into consideration the specific circumstances affecting the Enrollee's decision to obtain Medical Emergency services.

1.19 **Medically Necessary/Medical Necessity** means those Covered Services and supplies which, in the judgment of the Plan, meet all of the following requirements:

They must be:

- Essential to the diagnosis or the treatment of an illness, accidental injury or condition harmful or threatening to the Enrollee's life or health, unless otherwise provided as preventive services;
- Appropriate for the medical condition as specified in accordance with authoritative medical or scientific literature;
- Not primarily or solely for the convenience of the Enrollee, the Enrollee's family or legal guardian, the Enrollee's Practitioner or another provider;
- Medically effective treatment of the diagnosis as demonstrated by:
  - Sufficient evidence to draw conclusions about the effect of the health intervention on the health outcome;
  - Evidence that the health intervention can be expected to produce its intended effects on health outcomes; and
  - Expected beneficial effects of the health intervention on health outcomes that outweigh its expected harmful effects;
- Cost-effective as determined by being among the least costly of the alternative supplies or levels of service which are medically effective, readily available, and can safely be provided to the Enrollee. A health intervention is cost-effective if there is no other available health intervention that offers a clinically appropriate benefit at a materially lower cost. When an Enrollee is receiving Inpatient Services, it further means that the services and/or supplies cannot be safely provided on an outpatient basis or in an alternative setting without adversely affecting the Enrollee's condition or the quality of care rendered; and
- Not primarily for research or data accumulation.

The fact that health care services were furnished, prescribed or approved by a Practitioner or other qualified Provider does not in and of itself mean that those services were Medically Necessary.

1.20 **Medicare** means the federally administered health insurance program which covers costs of hospitalization, medical care, and some related services for eligible persons.

1.21 **Noncovered Services** means services not covered by an Enrollee's Subscriber Agreement, and for which the Plan does not provide benefits. Noncovered services are identified as such on Facility's payment voucher and the Enrollee's explanation of benefits.

1.22 **Outpatient Services** means health care services rendered to an Enrollee who is not an Inpatient, whether or not the Enrollee occupies a bed.

1.23 **Participant** means a Practitioner, Provider, Health Care Facility or other entity who or which agrees to accept from and to look solely to a Plan for payment according to the terms of the Subscriber Agreement for Covered Services rendered to Enrollees, and also includes any Practitioner with whom Participant has entered into an approved subcontract pursuant to Section 7.04 hereof to render Covered Services to Enrollees.

1.24 **Plan** means a health care services contractor, health maintenance organization, insurer, trust, self-funded health program or other entity responsible for the payment of Covered Services rendered to Enrollees, which is listed in the attached Exhibits 1A through 1B and has appointed Intermediary to act as a contracting agent.

1.25 **Plan Fee Schedule** means a Plan-determined schedule of allowable payments for services defined by diagnosis code, procedural code, or other service coding system. A Plan Fee Schedule may be based on any industry standard method, including, but not limited to, the Resource Based Relative Value Schedule (RBRVS), and St. Anthony's, with a Plan-determined conversion factor.

1.26 **Plan Payment**, as used herein, means the amount to be paid by Plan to Facility for Covered Services pursuant to this Agreement as set forth in the attached Compensation Exhibit. The Plan Payment is the Allowed Amount less any Enrollee responsibility such as Deductible, Copayment or Coinsurance.

1.27 **Practitioner** means an individual who provides professional health care services and is licensed, certified, or registered by the state in which the services are performed.

1.28 **Product and Compensation Addendum**, as used herein, means the attached addendum designating: (1) the Plan program under which Covered Services provided by Facility pursuant to this Agreement and (2) the related Compensation. The Product and Compensation Addendum is incorporated into, and made part of, this, Agreement.

1.29 **Provider** means an organization which provides health care services such as hospitals, home health agencies, skilled nursing facilities, nursing homes, and surgical centers.

1.30 **Subscriber** means the individual in whose name the coverage under a Subscriber Agreement is established.

1.31 **Subscriber Agreement** means any contract entered into by a Plan, with or for the benefit of an Enrollee, entitling the Enrollee to receive benefits for Covered Services.

PART 2 OBLIGATIONS OF INTERMEDIARY AND/OR PLANS

2.01 **Payment**. Plan will pay Facility Plan Payment directly for Covered Services that Facility renders to Enrollees, in accordance with the terms of this Agreement and the attached Product and Compensation Addenda.

2.02 **Marketing**. Plans shall develop and actively market their Participant panels.

2.03 **Identification Cards**. Intermediary shall issue or arrange with Plans for the issuance of identification cards to Enrollees. Enrollees will be instructed to present identification cards to Facility at the time services are requested. Such identification cards are not a verification of eligibility as an Enrollee or a guarantee of payment, but a means of providing information that Facility can easily use to verify eligibility with a Plan.

2.04 **Promotion**. Intermediary will arrange with Plans to design Subscriber benefit packages and/or use other means to encourage Enrollees to use Facility's services. Intermediary and Plans will have the right to use Facility's name for such promotional purposes, for marketing, for informing the public of Facility's identity and to otherwise carry out the terms of this Agreement. This provision for promotion of Facility is nonexclusive.

2.05 **Information to be Provided**. Intermediary will arrange for Plans to make available to Facility a telephone number or other means for checking an Enrollee's benefits and eligibility for benefits, including any limitations or conditions on services or benefits. A Plan's verification of eligibility and description of Covered Services under the Subscriber Agreement is not a guarantee of payment.

2.06 **Directories**. Plan will list Facility in provider directories and other marketing materials.

2.07 **Network Adequacy**. Plan desires to offer reasonable access to and a reasonable choice of providers for existing and potential Enrollees. Selection of providers for network adequacy is the sole discretion of Plan. Plan shall contract with such Providers as required.

2.08 **Benefit and Eligibility Determinations**. Plan shall have the sole authority to determine the eligibility of Enrollees for benefits and whether services are included under the terms of the Plan Subscriber Agreements. Facility shall not take any action or make any representations regarding eligibility or benefits without the prior authorization of Plan. Facility may appeal benefit and eligibility determinations in accordance with Section 7.02 of the Agreement.

PART 3 OBLIGATIONS OF FACILITY

3.01 **Services Provided to Enrollees**. Facility will provide Covered Services to Enrollees in compliance with the terms of this Agreement. When providing such services, Facility will exercise the degree of care, skill and learning expected of a prudent Health Care Facility. Facility will observe, protect and promote the rights of Enrollees as patients.

Facility must contract for all commercial products agreed-to by Facility and Plan as of the effective date of this Agreement for the entire term of this Agreement. Additional commercial products may be added to this Agreement during the term of this Agreement as set forth in Section 7.01C hereof.

Unless agreed otherwise by Plan, termination of any commercial Product and Compensation Addendum by Facility shall terminate all commercial Product and Compensation Addenda. The terms under which Facility may terminate public products are set forth in the applicable public Product and Compensation Addendum.

3.02 **Nondiscrimination**. Facility will provide Covered Services to Enrollees on the same basis as such services are made available to patients who are not Enrollees, and without regard to the Enrollee's participation in a Plan as a private purchaser of health care coverage or as a participant in publicly financed programs of health care services, with respect to the availability and quality of Facility services.

Facility further agrees to comply with applicable state or federal regulatory laws and not to discriminate in the treatment of patients or in the quality of services delivered to Enrollees on the basis of race, color, sex, age, religion, national origin, place of residence, health status, handicap, source of payment, or Enrollee's Plan.

3.03 **Licenses**. Facility will maintain in good standing all licenses, permits, governmental or board authorizations or approvals required by law for Facility's operation and Plan's credentialing standards. Facility will submit evidence of such licenses, permits, governmental or board authorizations or approvals to Intermediary upon request.

3.04 **Responsibility for Services**. Facility will be solely responsible for the quality of services provided to Enrollees. Nothing contained in this Agreement shall be construed to alter Facility's responsibility to provide acceptable services per current medical standards, or to change the nature of the Facility-Enrollee relationship. Facility should discuss all medical options with the Enrollee regardless if such options are a Covered Service. The final decision to provide or receive services, regardless of whether such services are Medically Necessary, not Medically Necessary or Noncovered Services, is between Facility, the Enrollee and the Enrollee's Practitioner. Nothing in this provision shall be construed to authorize Facility to bind a Plan to pay for any service.

Facility may appeal Plan's payment decisions in accordance with Section 7.02.

3.05 **Credentialing**. Facility warrants, currently and for the duration of this Agreement, that it meets Plans' credentialing standards, and that Facility has all licenses, permits, and/or governmental or board authorizations or approvals necessary to provide Covered Services in accordance with the applicable requirements in the state(s) in which Facility operates. Facility further warrants that it will cooperate with Plan's credentialing and recredentialing processes. Facility will provide immediate written notice to Intermediary of any changes in the licenses, permits, and/or governmental or board authorizations or approvals referenced above, including, but not limited to, ownership, business address, Tax Identification Number, new Practitioner proposed to be included as a Participant pursuant to this Agreement and any factors that may materially impact Facility's ability to provide Covered Services to Enrollees hereunder. Facility's credentialing application shall be incorporated by reference into this Agreement.

Facility agrees not to render Covered Services to Plan's Enrollees prior to written notification from Plan to Facility that the Facility has been fully credentialed and approved for participation by Plan.

3.06 **Care Management and Quality Improvement**. Facility agrees to cooperate with and participate in Plans' quality improvement, Enrollee grievances, and care management programs. For utilization management programs, this includes, but is not limited to, notification of admissions, applicable referral procedures, and reporting of clinical encounter data.

Facility further agrees to cooperate with Plans' concurrent review and discharge planning procedures, by providing medical records and other necessary information regarding Enrollees' care in progress, length of stay and discharge status upon Plans' reasonable request. Facility agrees that such access and information provision will take place at no charge to Plans or Intermediary.

Facility acknowledges that care management services and functions may be performed by a Plan, an affiliate or an outside utilization management entity designated by a Plan.

3.07 **Authorization**. Plan will make reasonable efforts to notify Facility of those classes of Enrollees whose Subscriber Agreements require authorization of Facility's services.

3.08 **Retrospective Review**. A Plan may conduct a retrospective review to determine whether all services provided to an Enrollee are covered and/or Medically Necessary. Facility will abide by a Plan's decisions made through retrospective review subject to the dispute resolution procedures stated in Section 7.02. Facility will not seek payment from a Plan or the Enrollee for Covered Services which the Plan determines were not Medically Necessary as a result of its retrospective review other than in compliance with Section 4.01 hereof.

3.09 **Onsite Clinical Quality and Health Improvement Review**. Facility will allow and fully cooperate with onsite quality review conducted by a Plan and/or its agents. Such reviews will be scheduled at appropriate times during regular business hours and with reasonable prior notice to Facility.

3.10 **Reporting to Plan**. Facility shall cooperate with Plans' data collection and reporting efforts, in compliance with requirements of the National Committee for Quality Assurance (NCQA) and HEDIS®, or any other accreditation program(s) designated by Plan. (NCQA's Health Plan Employer Data Information Set; HEDIS® is a registered trademark of NCQA.)

Facility shall provide immediate written notice to Plan of any legal, regulatory, or governmental action which Facility reasonably believes could materially impact the ability of the Facility to carry out the duties and obligations of this Agreement, including, without limitation, litigation initiated by a patient against Facility.

3.11 **Insurance**. Facility will provide and maintain, at its sole expense, policies of general comprehensive liability and professional liability insurance, or self insurance, in an amount acceptable to Intermediary as set forth in Intermediary's or Plans' credentialing standards. Such policies shall insure against any claim or claims for damage arising by reason of personal injury or death occasioned directly or indirectly in connection with the acts or omissions of Facility, its agents or employees pursuant to this

Agreement. Facility shall notify Intermediary no less than ten days before any reduction in coverage or revocation, suspension or other termination of any such policy.

Upon request, Facility will provide Intermediary with evidence of compliance with this Section 3.11, in the form of a certificate of insurance or evidence of self insurance or evidence in some other form as Intermediary will deem satisfactory.

3.12 **Transfer**. Facility will transfer Enrollees to other Health Care Facilities only in a manner consistent with Facility's contracted status. Exceptions to this requirement are Medical Emergency cases when the appropriate contracted Provider is not available, or when, in the judgment of the treating Practitioner, transfer to another facility is medically appropriate. All other transfers must be authorized by Enrollee's Plan.

3.13 **Specialty Services**. Facility will cooperate with Intermediary and Plan efforts to assure the availability of specialty services Practitioners whose contracted status is consistent with Facility's contracted status according to this Agreement. Such specialty services include, but are not limited to, anesthesiology, radiology, pathology and emergency room physicians.

3.14 **Administrative Rules and Procedures**. Facility will abide by administrative rules and procedures issued by Intermediary and/or a Plan with respect to, but not limited to, authorizations, Enrollee rights, responsibilities and grievances, billing procedures and standards, and other matters that relate to Facility's provision of Covered Services to Enrollees and compliance with this Agreement. Intermediary and/or Plan will provide written information to Facility, as well as any necessary revisions, regarding such administrative rules and procedures. Changes to documents, procedures and other administrative policies and programs that affect Facility Compensation and that affect health care service delivery shall be made pursuant to the provisions of Section 7.01A.

3.15 **Accuracy of Information**. Facility warrants and represents that, to the best of Facility's knowledge, all information given to Intermediary and/or Intermediary's designees in applying for and maintaining this Agreement is true, accurate, and complete in all material respects.

3.16 **Remuneration for Services from other Providers**. Facility agrees not to solicit or receive any remuneration or "kickbacks" prohibited by federal law, whether directly or indirectly, overtly or covertly, in cash or in kind, in return for referrals to other agencies or Providers, or to purchase, lease, order to arrange goods, facilities, services or items in return for referrals to other agencies or Providers.

3.17 **Inpatient Admission**. Within one business day after Inpatient admission, Facility agrees to notify Plan of any emergency hospital admission of an Enrollee. Facility also agrees to notify Plan of any non-emergency hospital admission of an Enrollee as soon as possible after the decision to admit has been made or within one business day of actual admit.

PART 4 PAYMENT AND BILLING

4.01 **Payment**. Plan will pay Facility in accordance with the terms of this Agreement. Facility will seek payment solely from the Enrollee's Plan for Covered Services rendered to that Plan's Enrollees and shall accept as full payment the Allowed Amount(s) set forth in the applicable Product and Compensation Addenda attached to this Agreement.

Facility will collect payment directly from the Enrollee for Deductibles, Coinsurance and Copayment amounts, or for Noncovered Services, in accordance with the terms of the applicable Subscriber Agreement. Facility's charge to the Enrollee for Deductibles, Copayments or Coinsurance as set forth in the Subscriber Agreement, in combination with the Plan's payment, will not exceed the Allowed Amount for Covered Services. In addition to Section 4.02, under no circumstances including, but not limited to, nonpayment by the Enrollee's Plan, Plan insolvency or breach of this Agreement, shall Facility bill any amount in addition to those listed above, or have recourse against the Enrollee,

Intermediary or any other Plan contracted with Intermediary for services provided pursuant to this Agreement. This provision shall survive termination of this Agreement.

Facility will not knowingly seek payment from a Plan for any Covered Services rendered to a person who misrepresents his or her status as an Enrollee or who previously obtained coverage from a Plan as an Enrollee through fraud or misrepresentation.

During any appeal or mediation process, Facility shall not bill or otherwise seek collection from Enrollee for any payment amounts in dispute.

Except as provided in this Agreement, Facility will not seek payment from Enrollees or a Plan for services determined not to be Medically Necessary by the Plan unless the Enrollee has agreed in writing to be financially responsible for those services before those services are provided.

The benefits to which an Enrollee is entitled shall be limited to those specified in the Subscriber Agreement in effect at the time services are performed, and are subject to the Enrollee's continued eligibility.

4.02 Enrollee Billings and Continuation of Services

A. No Recourse Against Enrollee

1. Facility hereby agrees that in no event, including but not limited to nonpayment by Plan, Plan insolvency, or breach of this Agreement shall Facility bill, charge, collect a deposit from, seek compensation, remuneration from, or have any recourse against an Enrollee or person acting on an Enrollee's behalf, other than a Plan, for services provided pursuant to this Agreement. This provision shall not prohibit collection of Deductible, Copayments, Coinsurance, and/or Noncovered Services which have not otherwise been paid by a primary or secondary carrier in accordance with regulatory standards for coordination of benefits, from Enrollees in accordance with the terms of the Enrollee's Subscriber Agreement.
2. Facility agrees, in the event of a Plan's insolvency, to continue to provide the services promised in this Agreement to Enrollees of that Plan for the duration of the period for which premiums on behalf of the Enrollee were paid to Plan or until the Enrollee's discharge from inpatient facilities, whichever time is greater.
3. Notwithstanding any other provision of this Agreement, nothing in this Agreement shall be construed to modify the rights and benefits contained in the Enrollee's Subscriber Agreement.
4. Facility may not bill Enrollee for Covered Services (except for Deductibles, Copayments, or Coinsurance), where a Plan denies payment because Facility has failed to comply with the terms or conditions of this Agreement.
5. Facility further agrees that: (i) the provisions of 1, 2, 3 and 4 of this Section shall survive termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of Plan's Enrollees, and (ii) that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Facility and Enrollees or persons acting on Enrollees' behalf.
6. If Facility contracts with other Providers that agree to provide Covered Services to Enrollees of a Plan with the expectation of receiving payment directly or indirectly from Plan, such Providers must agree to abide by the provisions of 1, 2, 3, 4 and 5 of this Section.

B. Facility acknowledges that willfully collecting or attempting to collect an amount from an Enrollee, knowing that collection to be in violation of this Section 4.02, constitutes a class C felony under RCW 48.80.030(5).

C. No changes shall be made to this Section 4.02 without prior approval of Washington State's Office of Insurance Commissioner, in accordance with WAC 284-43-320.

4.03 **Claims Submission**. Facility will submit Claims to a Plan in a manner and on forms acceptable to the Plan. Facility should submit Claims within 60 days after Covered Services are rendered, but Plan will be under no obligation to pay a Claim if Plan receives it more than 365 days after the date Covered Services were provided, or 60 calendar days after Facility first receives notice that Plan is a secondary payor under applicable coordination of benefits procedures, whichever shall be later. Facility may not seek payment from Enrollee or any Plan for Covered Services submitted after that time.

Facility will be reimbursed for only Covered Services which were ordered by a physician or other qualified Practitioner, delivered to the Enrollee and documented in the medical record. The coding convention used on submitted Claims will accurately reflect services provided and the reasons for the procedure, service, supply or encounter. Upon request, Facility will furnish all information reasonably required by a Plan to substantiate the provision of, and charges for, Covered Services, at no charge to the Plan or Intermediary.

For Covered Services provided to Enrollees, Plan shall pay Facility as soon as practical but subject to the following minimum standards:

A. Ninety-five percent (95%) of the monthly volume of Clean Claims shall be paid within 30 days of receipt by Plan; and
B. Ninety-five percent (95%) of the monthly volume of all Claims shall be paid or denied within 60 days of receipt by Plan, except as agreed to in writing by the parties on a Claim-by-Claim basis.

The receipt date of a Claim shall be the date the Plan receives either written or electronic notice of the Claim.

Plan shall pay Facility interest on undenied and unpaid Clean Claims more than 61 days old. Interest shall be assessed at the rate of one percent per month, and shall be calculated monthly as simple interest prorated for any portion of a month. Plan shall add the interest payable to the amount of unpaid Claims without the necessity of the Facility submitting an additional Claim. Plan shall not apply any interest paid to an Enrollee's Deductible, Copayment, Coinsurance or any similar obligation of the Enrollee.

When Plan issues payment in the Facility and Enrollee names, Plan shall make Claim checks payable in the name of Facility first and the Enrollee second.

Claim denials shall include the specific reason why the Claim was denied. If the denial is based upon Medical Necessity or similar grounds, Plan, upon request from Facility, shall promptly disclose the supporting basis for the decision.

These standards do not apply to Claims about which there is substantial evidence of fraud or misrepresentation by Facility or Enrollee, or instances where Plan has not been granted reasonable access to information under Facility's control.

4.04 **Cancellation of Coverage**. Neither Intermediary nor Plan will be liable to Facility for any health care services provided to an Enrollee whose coverage under the applicable Subscriber Agreement is canceled retroactively by the Enrollee's Plan. Reasons for such cancellation may include, but are not limited to, misrepresentation and nonpayment of premiums.

4.05 **Refunds**. Claim approval and/or payments made by a Plan are contingent upon receipt of Complete and Accurate Information from Facility. Facility will promptly refund amounts paid by a Plan if it is determined that a Plan has accepted responsibility for payment based upon erroneous or incomplete information, if benefits are misapplied by the Plan and an Enrollee is not entitled to those benefits, or any other reason for an erroneous payment. In the event prompt refund is not made by Facility, at the Plan's discretion, the amount to be refunded may instead be offset against any future amounts due Facility.

4.06 **Limits on Refunds and Appeals of Denials**. Neither Plan nor Facility shall seek a refund or an appeal of a denial of a Claim more than 365 days after final adjudication of the Claim, except in the case of concealment, fraud or misrepresentation or as otherwise provided in an attached Product and Compensation Addendum. This time limit shall not apply to Plan's right to a prompt refund of a third party liability payment in accordance with Section 4.07.

4.07 **Other Enrollee Coverage and Other Party Liability**. Facility agrees to cooperate with Plans' coordination of benefits and duplicate coverage policies.

Facility will provide complete information to the Enrollee's Plan regarding benefits available to an Enrollee from other sources, subject to other party liability, or due to work-related injuries or illnesses. Facility will promptly refund any excess payments from Plan if, after payment is made, an Enrollee is found to be covered by another program, plan, or health care agreement that is determined to be the primary coverage; or that another party is liable for payment. At the Plan's discretion, the amount to be refunded may instead be offset against any future amounts due Facility.

If Facility has received payment from another coverage plan or entity which pays before Plan in the coordination of benefits order of benefit determination, and that payment is equal to or greater than the contracted rates set forth in this Agreement, Facility agrees to not seek additional reimbursement from Plan or to promptly refund any amounts already paid to Facility by Plan.

PART 5 RECORDS MAINTENANCE, AVAILABILITY, INSPECTION AND AUDIT

5.01 **Records**. Facility will prepare and maintain all appropriate records including, but not limited to, medical, medical abstract, financial and administrative records for each Enrollee who receives services at Facility. The records will be maintained in accordance with prudent record-keeping procedures and as required by law.

Plan will reimburse Facility for documents requested by Plan where multiple documents are being requested for audit, accreditation and/or oversight review purposes. Facility will be reimbursed at the rate of $.05 per page for all requested documents or selected portions of documents as indicated on the written medical records document request. Plan will not reimburse Facility for copies of documents or portions of documents when requested for the purposes of payment of claims, resolution of quality of care or service concerns, complaints and/or grievances, or medical management review and coverage determinations.

5.02 **Inspection and Audit**. Except as provided by law, Facility will allow and fully cooperate with inspection, audit and duplication by each Plan of any and all data and other records maintained on that Plan's Enrollees which relate to this Agreement to the extent necessary to perform the audit or inspection. Such data and other records include, but are not limited to, billing, payment, assignment, utilization review, medical and medical abstract records maintained on Enrollees pursuant to this Agreement, and charge and reimbursement data maintained by Facility related to charges made and payments received by Facility from other payers on behalf of Enrollees. Such inspection, audit verification and duplication will be allowed upon reasonable notice during regular business hours. Plan shall pay Facility a reasonable amount for duplication of records when required in conjunction with inspection and audit, as described in this Section 5.02.

In addition, Facility shall make such data and other records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of Enrollees, subject to applicable state and federal laws related to the confidentiality of medical records.

Facility and its representatives may audit, examine and inspect Plan's and/or Intermediary's books and records of account relating to transactions between Plan and Facility during normal business hours upon giving reasonable notice to Plan.

5.03 **Confidentiality of Medical Records**. Facility and Plans will keep confidential, and take all reasonable precautions to prevent the unauthorized disclosure of, any and all records, both paper and electronic, required to be prepared and/or maintained by this Agreement in accordance with state and federal law.

PART 6 TERM AND TERMINATION

6.01 **Term**. ~~This Agreement will take effect on the date specified on page one, and will remain in force for an initial term of 12 months. Product and Compensation Addenda shall have the effective date set forth therein and shall have a term concluding on the day upon which the term of this Agreement concludes. This Agreement will automatically renew from year to year thereafter, unless terminated as provided below.~~

The revisions to this Agreement will take effect on the date specified above and will automatically renew from year to year thereafter, unless terminated in accordance with this Part 6, provided, however, that Compensation Exhibits A pertaining to facility rates will remain in effect through February 2013 and will continue in effect thereafter unless and until (i) the parties agree upon revised terms, or (ii) either party elects to terminate the entire Agreement as set forth below; and Compensation Exhibit B; pertaining to Home Care Services rates, will remain in effect through February 28, 2013.

6.02 **Voluntary Termination**. ~~Other than as set forth in Section 6.03, and subject to the terms of Section 6.04, this Agreement may be terminated at any time without cause by either party upon 60 days prior written notice. If either party fails to comply with or perform when due any material term or condition of this Agreement, the other party shall notify the defaulting party in writing, and the defaulting party shall have 30 days to cure the default. If the defaulting party fails to cure the default within 30 days, the other party may declare, that this Agreement shall be terminated subject to the 60 day notice period set forth above. For the purposes of this section 6.02, notice shall comply with the terms of Section 7.10 and shall also specify in reasonable detail the specific nature of the default and shall also state that failure to cure a default will result in termination of this Agreement as set forth in this section.~~

If either party fails to comply with or perform when due any material term or condition of this Agreement, the other party shall notify the defaulting party in writing, and the defaulting party shall have 30 days to cure the default. If the defaulting party fails to cure the default within 30 days, the other party may declare, that this Agreement shall be terminated subject to 60 days written notice. For the purposes of this Section 6.02, notice shall comply with the terms of Section 7.10 and shall also specify in reasonable detail the specific nature of the default and shall also state that failure to cure a default will result in termination of this Agreement as set forth in this section. Default hereunder shall include any changes by Intermediary or Facility's Tier assignment during the term of this Agreement.

Other than as set forth in Section 6.03, and subject to the terms of Section 6.04, this Agreement may be terminated at any time without cause by either party following issuance of 90 days written notice, provided that neither Party may issue such notice prior to March 1, 2013.

Should either party wish to revise the terms of the Compensation Exhibit A, such revisions to be effective after February 28, 2013, said party shall issue a renewal proposal that sets forth proposed revisions in detail in accordance with the notice provisions of Part 7.10 of the Agreement. The receiving party agrees to begin good faith negotiations within five (5) working days of its receipt of the renewal proposal. Should the parties fail to reach agreement on revised terms within thirty (30) days of the date of the renewal proposal, either party may terminate this Agreement without cause in accordance with Part 6.02 (as amended) of this Agreement.

6.03 **Termination by Intermediary**. In addition, the Intermediary may terminate this Agreement at any time as follows:

A. This Agreement shall terminate immediately upon receipt by the Facility of written notice:

1. in the event Facility's license(s), permit(s), or any governmental or board authorizations or approvals related to its business operations and/or the provision of Covered Services are canceled, denied, lost, suspended, or voluntarily forfeited. Facility shall provide Intermediary immediate written notice of any such actions;
2. in the event Facility fails to satisfy Plan credentialing or recredentialing standards;
3. in the event Facility makes any material misstatements or omissions on any material submitted to Intermediary or its designees;
4. in the event Facility's insurance coverage required by this Agreement lapses for any reason. Facility shall provide Intermediary immediate written notice of any such lapse.

B. This Agreement shall terminate automatically and immediately in the event Intermediary determines, in its sole discretion, that Facility's action or inaction and/or continuation of this Agreement may have a significant adverse effect on Enrollees care.

6.04 **Services After Termination**. In addition to other provisions of this Agreement, the following provisions will survive termination of this Agreement:

A. All provisions of Part 4 shall apply to health care services performed prior to termination.

B. Inpatient Services to Enrollees who are Inpatients as of the termination date shall continue until such time as those Enrollees are discharged or for the duration of the period for which premiums were paid to Plan on Enrollee's behalf, whichever time is greater.

6.05 **Continued Record Access**. Facility will maintain records of Enrollees as required by law. Facility will allow each Plan continued access to Facility's retained records for the longer of seven years or as required by law after the date this Agreement terminates.

6.06 **Removal from Directories**. If this Agreement terminates, Intermediary and/or Plan(s) will remove Facility from all future directories that list Intermediary's contracted Health Care Facilities. Upon the termination date, Facility will inform any Enrollees that seek services at Facility that this Agreement has been terminated.

6.07 **Notification of Enrollees**. Plan shall provide Enrollees with timely notification of the termination of this Agreement. Facility shall provide Plan with a contemporaneous copy of communications with Enrollees regarding termination or continuation of Facility's contractual relationship with Plan. In order to ensure the continuity and appropriateness of medical care to Enrollees, Plan may immediately inform Enrollees of the effective date of the Termination of this Agreement and request that Enrollees select another Facility prior to the effective date of the Termination of this Agreement.

PART 7 GENERAL PROVISIONS

7.01 **Amendments.**

A. Intermediary and/or Plan may amend this Agreement, Compensation, any Product and Compensation Addenda relating hereto, and any manual, policy, or administrative procedure pertaining to this Agreement at any point during the term of this Agreement by providing Facility 60 days prior written notice consistent with the terms of Section 7.10. The proposed amendments shall become effective 60 days after the receipt of written notice by the Facility, unless the parties can agree otherwise at an earlier date. Any such amendment shall be in writing, shall include an effective date and shall be signed by Intermediary.

B. In addition, this Agreement may be amended at any time during its terms by mutual consent of the Intermediary and Facility. Any such amendment shall be in writing, shall include an effective date, and shall be signed by Intermediary and Facility.

C. Plan may establish new products from time to time and shall make such reasonable amendments to this Agreement as are required to implement them. Facility shall receive notice from Plan not less than 45 business days prior to implementation of new products. With Facility approval, a new Product and Compensation Addendum will be incorporated into this Agreement. Plan agrees not to advertise Facility as a provider of services for any new product until agreed to by Facility.

Changes to this Agreement may be subject to prior regulatory approval.

7.02 **Provider Dispute Resolution**. In the event there is a dispute under this Agreement that is subject to dispute resolution, Facility and Plan shall first attempt to resolve the matter through informal good faith discussions. Such discussions may include a meeting or meetings between the parties. In the event the parties determine that the matter cannot be resolved informally, the following procedures shall apply.

A. Facility must submit to Plan a written Request for Internal Appeal within 90 days of the Plan's action from which the Facility wishes to appeal. The Request for Internal Appeal must include a detailed description of the issues in dispute, the Facility's position with respect to the disputed issues, all evidence offered by Facility in support of the Request, and a description of the relief sought. Plan is under no obligation to consider a Request for Internal Appeal received by Plan later than 90 days after Plan's action from which the Facility wishes to appeal.

1. **Billing Disputes**.

In the event the matter subject to dispute is a Billing Dispute, the following process and schedule shall apply.

The Plan will consider the issues raised in the Request and notify the Facility of its determination as quickly as possible, but no later than 30 days following receipt of the Facility's Request.

If Facility is not satisfied with Plan's determination, the Facility shall, within 15 days after Facility's receipt of the Plan's response, send Plan a response setting forth the specific grounds upon which Facility disagrees with the Plan determination. Plan shall consider the issues raised in Facility's response and shall notify Facility of Plan's Final Determination as quickly as possible, but no later than 15 days following Plan's receipt of Facility's objections.

If Facility is not satisfied with Plan's determination, (or Plan does not respond timely) Facility may initiate non-binding mediation pursuant to Section 7.02B by notifying Plan within 30 days of receipt (or due date) of the Plan's decision.

2. **Other Disputes**.

In the event the matter in dispute is not a Billing Dispute, the following process and schedule shall apply.

The Plan will consider the issues raised in the request and notify the Facility of its determination as quickly as possible, but no later than 60 days following receipt of the Facility's Request, unless Plan reasonably believes that the complexity of the matter in dispute requires a greater period of time. In any such case, Plan shall notify Facility prior to the end of the 60 day period that it reasonably believes that a greater period of time is required, and the basis for that belief. Upon such written notice to Facility, Plan shall be entitled to extend the period for response for a reasonable period of time, not to exceed an additional 60 days, unless a longer period is agreed to by both parties in writing. During this period of time, Plan and Facility may continue to exchange information and meet, as they deem appropriate, to ensure that information material to the dispute may be considered by Plan.

If Facility is not satisfied with Plan's determination, Facility may initiate non-binding mediation pursuant to Section 7.02B and by notifying Plan within 30 days of receipt (or due date) of the Plan's decision.

B. Upon timely initiation of mediation, the Parties shall agree upon a mediator. The mediator's fees shall be borne in equal shares by the Parties. Unless agreed otherwise, all other related costs incurred by the Parties shall be the sole responsibility of the party incurring the cost. The mediator shall, in consultation with the Parties, determine a process and schedule for the mediation. In the event the Parties cannot resolve the matter through non-binding mediation, either Party may institute an action in any Superior Court of competent jurisdiction. By mutual consent, the parties may forego non-binding mediation and proceed directly to a Superior Court action.

C. All notices and correspondence pursuant to this Section 7.02 shall comply with the terms of Section 7.10.

D. This Agreement will be construed in accordance with the procedural and substantive laws of the State of Washington.

E. Modifications to this Agreement, Compensation, manuals, policies, administrative procedures, and other matters subject to Section 3.14 shall not be subject to dispute resolution under this Section 7.02. However, whether such modifications have been proposed and made in compliance with the terms of this Agreement and with applicable law is subject to dispute resolution hereunder.

During any appeal or mediation process, Facility shall not bill or otherwise seek collection from Enrollee for any payment amounts in dispute.

7.03 **Assignment**. No assignment of the rights, duties or obligations of this Agreement, including assignment by operation of law, will be made by Facility without the written consent of Intermediary. If Intermediary or any Plan merges, consolidates with another entity or does business under another or with another entity or name, this Agreement will continue in full force and effect.

7.04 **Subcontracts and Affiliation Agreements**. If Facility wishes to establish an agreement with a subcontractor or an affiliate to provide Covered Services to Enrollees hereunder, the contract proposed to be used must be submitted to Plan for prior approval 30 days prior to the agreement's effective date, along with all necessary information required to administer the agreement.

Such agreements shall be in place and approved by Plan prior to providing Covered Services to Enrollees. All such agreements shall conform to regulatory requirements of WAC 284-43-320. In addition, each such subcontract shall have a copy of this Agreement appended thereto and shall provide that:

A. the party with whom Facility so contracts must satisfy and comply with the terms of this Agreement; and

B. the subcontract and/or affiliation agreement to the extent it relates to a Plan, shall be terminable at the request of Intermediary consistent with the terms of Section 6.03 hereof.

All Providers who provide Covered Services under such an agreement must be credentialed as required by the Plan and the credentialing approved by Plan prior to providing Covered Services to Enrollees.

7.05 **Entire Agreement**. This Agreement, including all exhibits, addenda, attachments and amendments, constitutes the entire agreement between Intermediary and Facility. No implied covenants will be read into this Agreement. This Agreement supersedes all prior agreements between the parties.

7.06 **Severability/Conformity with Law.** If any part of this Agreement shall be found to be invalid, void or unenforceable, the remainder of the Agreement shall remain in full force and effect. Both parties will comply with all applicable state and federal laws and regulations, including but not limited to those related to Medicare, Medicaid and/or other state or federal health care delivery programs. This Agreement shall be interpreted, and if necessary amended, to conform with applicable state and federal law in effect on or after its effective date.

7.07 **Headings**. The headings of sections and paragraphs contained in this Agreement are for reference purposes only and will not in any way affect the meaning or interpretation of this Agreement.

7.08 **Relationship of Parties**. Neither Facility nor Intermediary nor any of their respective employees, will be construed to be the agent, employee or representative of the other, or liable for any acts of omission or commission on the part of the other.

Facility understands and agrees that Intermediary is merely acting as an agent for and on behalf of Plans for the sole purpose of engaging Facility to provide the services set forth in this Agreement. Facility further understands and agrees that Intermediary is not in the business of providing insurance coverages or health care benefits to others.

7.09 **Nonrestrictive Participation**. Nothing contained in this Agreement or any related document will be construed to restrict the participation of Facility in any other health care delivery system or payment plan.

7.10 **Notices**. Other than as set forth below, notices required by this Agreement will be in writing and mailed, postage prepaid, to the other party at the principal address shown in this Agreement or to such other address as may be provided by one party to the other. Notice is considered effective on the date it is received, or three days following the postmark date, whichever is earlier. Notices of Termination and Requests, Notices, and correspondence required under the terms of Section 7.02A shall be sent certified mail, return receipt requested.

7.11 **Waiver of Breach**. Neither the failure nor delay on the part of either party to exercise any right under this Agreement will serve as a waiver of that right. If either party should waive any breach of any provision of this Agreement, it will not be deemed or construed as a waiver of any other breach of the same or a different provision.

7.12 **Changes to Subscriber Agreements**. Plans may change, revise, modify or alter the form and/or content of any Subscriber Agreement without prior notice to Facility.

7.13 **Trademarks**. The parties and Plans reserve the right to control the use of their respective names, symbols, trademarks and service marks presently existing or later established. In addition, neither party will use the other party's name, symbols, trademarks or service marks, nor shall Facility use the name, symbol or service mark of any Plan in advertising or promotional material or otherwise, without prior written consent of that party or Plan, as appropriate, and will cease any such usage immediately upon written notice of that party or upon termination of this Agreement, whichever is sooner, except as provided at Section 2.04.

If Facility utilizes its own Enrollee education materials inclusive of Plan's name and information, then such materials must be submitted to Plan at least 60 days prior to its intended use. Such materials must receive the prior approval of Plan and of any regulatory body to ensure conformity with applicable regulatory requirements.

7.14 **Proprietary and Confidential Information**. The existence of this Agreement is not considered confidential information. However, neither party will disclose the terms or contents of this Agreement and/or any of the attachments, addenda, amendments and exhibits without prior written consent of the other party. In addition, neither Party shall disclose the course or substance of any ongoing contractual negotiations other than to counsel for that party or to any regulatory body regarding matters within the jurisdiction of that body, without the prior written consent of the other Party. Intermediary and Plan(s) consider the rates, formulas and pricing methodologies used in establishing various payment and risk-sharing provisions, including information supplied by Participant in any bid documents, to be proprietary and confidential information.

This provision shall survive termination of this Agreement.

7.15 **Indemnification**.

A. **Indemnification of Facility**. Plan agrees to indemnify Facility and to hold harmless Facility against any claims, actions, liabilities, damages, and losses (collectively "Damages"), including reasonable attorneys' fees and costs, to the extent such Damages are caused by Plan's negligence in discharge of duties or obligations which are solely the responsibility of Plan, its agents or employees during the term of this Agreement. Notwithstanding the foregoing, such Indemnity shall not include any claim arising from an allegation of medical malpractice against the Facility, its agents or employees.

B. **Indemnification of Intermediary and Plan**. Facility agrees to indemnify Intermediary and/or Plan and to hold harmless Intermediary and/or Plan against any Damages (as defined in 7.15A), including reasonable attorneys' fees and costs, to the extent such Damages arise or are related to (i) claims of malpractice or negligence for which Facility, its employees, agents or representatives are responsible, or (ii) the use or maintenance of any property, facility or equipment by or under the

direction of Facility or (iii) the performance of any activity by or under the direction or control of Facility during the term of this Agreement.

This provision shall survive termination of this Agreement.

7.16 **Compliance**. Plan and Facility shall comply with all requirements under state and federal law relative to their obligations under this Agreement. Plan and Facility agree to work jointly to satisfy regulatory reporting and disclosure requirements in a timely manner. This provision also applies to any provider subcontracts and affiliation agreements Facility may have for Covered Services rendered to Enrollees under Plan.

PART 8 AGREEMENT

8.01 **Replacement Agreements**. From time to time, Intermediary may issue a replacement agreement which represents this Agreement, together with any attachments, appendices, exhibits and amendments which have been agreed to in writing by Intermediary and Facility as of the date the replacement agreement is issued. Facility agrees to execute the replacement agreement without further negotiation.

IN WITNESS WHEREOF, the parties hereto have executed and delivered this Agreement in duplicate original.

CHILDRENS HOSPITAL AND REGIONAL MEDICAL CENTER

BY: ______________________
Signature

____
Print or Typed Name

____
Date Signed

Tax ID #: ______________________

Whose mailing address is:

____

____

PREMERAFirst, Inc.

BY: ______________________
Signature

____
Print or Typed Name

____
Date Signed

Whose mailing address is:

____

____

EFFECTIVE DATE: January 1, 2001

EXHIBIT 1A
TO
PREMERAFirst
FACILITY AGREEMENT

In accordance with Section 1.24 of the Agreement, the following companies shall be considered a Plan for the purposes of administering the Agreement:

Premera Blue Cross
P.O. Box 327
Seattle, Washington 98111-0327

Facility hereby expressly acknowledges its understanding that this Agreement constitutes a contract between Facility and the Plans, that Premera Blue Cross ("PBC") is an independent corporation operating under licenses from the Blue Cross and Blue Shield Association (the "Association"), an Association of Independent Blue Cross and Blue Shield Plans, permitting PBC to use the Blue Cross Service Marks in the States of Washington and Alaska and that PBC is not contracting as an agent of the Association. Facility further acknowledges and agrees that it has not entered into this Agreement based upon representations by any person other than PBC and that the Association, affiliates of PBC, and/or any other person, entity or organization other than PBC shall not be held accountable or liable to Facility for any of the obligations of PBC to Facility created under this Agreement. This paragraph shall not create any additional obligations whatsoever on the part of PBC other than those obligations created under other provisions of this Agreement.

Premera Blue Cross is an Independent Licensee of the Blue Cross and Blue Shield Association.

**As of June 30, 1998, Medical Service Corporation of Eastern Washington and Blue Cross of Washington and Alaska merged into a single company known as Premera Blue Cross. In Eastern Washington, the company will be referred to as MSC Incorporated as Premera Blue Cross.

EXHIBIT 1B
TO
PREMERAFirst
FACILITY AGREEMENT

In accordance with Section 1.24 of the Agreement, the following company shall be considered a Plan for the purposes of administering the Agreement:

Blue Cross Blue Shield of Alaska
P.O. Box 327
Seattle, Washington 98111-0327

Facility hereby expressly acknowledges its understanding that this Agreement constitutes a contract between Facility and the Plan, that Blue Cross Blue Shield of Alaska ("BCBS of Alaska") is an independent corporation operating under licenses from the Blue Cross and Blue Shield Association (the "Association"), an Association of Independent Blue Cross and Blue Shield Plans, permitting BCBS of Alaska to use the Blue Cross Service Marks in the States of Washington and Alaska and the Blue Shield Service Marks in the State of Alaska and in the following Eastern Washington counties: Adams, Benton, Chelan, Douglas, Ferry, Franklin, Garfield, Grant, Kittitas, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens and Whitman, and that BCBS of Alaska is not contracting as an agent of the Association. Facility further acknowledges and agrees that it has not entered into this Agreement based upon representations by any person other than BCBS of Alaska and that the Association, affiliates of BCBS of Alaska, and/or an other person, entity or organization other than BCBS of Alaska shall not be held accountable or liable to Facility for any of the obligations of BCBS of Alaska to Facility created under this Agreement. This paragraph shall not create any additional obligations whatsoever on the part of Intermediary or BCBS of Alaska other than those obligations created under other provisions of this Agreement.

Blue Cross Blue Shield of Alaska is an Independent Licensee of the Blue Cross and Blue Shield Association.