

PARTICIPATING PRACTITIONER AGREEMENT

THIS AGREEMENT is entered into on this ____ day of _____ by and between CENTRAL OREGON INDEPENDENT PRACTICE ASSOCIATION, a not-for-profit corporation organized under the laws of the State of Oregon (hereinafter called "COIPA"), and _____, a duly licensed provider in the State of Oregon who is associated with COIPA as a participating practitioner (hereinafter called "Practitioner").

RECITALS

- A. COIPA will enter into contracts with various Managed Care Plans.
- B. COIPA and its Participating Practitioners will be obligated to provide or arrange for the provision of comprehensive health care services to enrolled Members in Managed Care Plans.
- C. This is a non-exclusive Agreement. Both Practitioner and COIPA are free to contract with any other organization, insurer, employer, individual or Managed Care Plan whether or not the other party is a participant in such agreement.

NOW, THEREFORE, in consideration of the premises and mutual covenants herein contained, the parties hereto agree as follows:

I. DEFINITIONS

1.1 "Covered Services" shall mean those health services provided by Practitioner to Members for which Practitioner is qualified, which services qualify for payment by the Plan pursuant to the terms of its applicable Individual or Group Service Agreement and the Plan's Medical Service Agreement between the Plan and COIPA.

1.2 "Emergency" shall mean the sudden and unexpected onset of a condition requiring medical or surgical care, for which the Member secures such care immediately after the onset (or as soon thereafter as care can be available, but in any case no later than 24 hours after the onset). An Emergency shall include, but not be limited to, (1) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part; or (4) with respect to a pregnant woman who is having contractions: a) that there is inadequate time to effect a safe transfer to another hospital before delivery, or b) that the transfer may pose a threat to the health or safety of the woman or the unborn child. COIPA and/or Plans may determine that other similarly acute conditions are Emergencies. The decision of whether a condition is an Emergency rests with the Managed Care Plan and is subject to its procedures for post-treatment utilization review and grievance.

1.3 "Individual Service Agreement" or "Group Service Agreement" shall mean the agreement between a Plan and its Member or between the Plan and the Member's employer group, which defines terms

and conditions of the Plan's obligation to provide, arrange for, and/or reimburse for medical care provided to the Member.

1.4 "Medically Indicated" shall mean a service or supply ordered by a Practitioner which is necessary in order to treat or care for symptoms of an illness or injury, or to diagnose an illness or condition that is harmful to life or health, and which is commonly and customarily recognized throughout the Practitioner's profession as appropriate in the treatment. The decision whether a service or supply ordered by the Practitioner was Medically Indicated for the purposes of qualifying for payment by the Health Care Plan rests with the Plan.

1.5 "Member" shall mean any person who is enrolled in a Managed Care Plan with which COIPA has contracted.

1.6 "Participating Institution" shall mean a hospital or other health care institution, which contracts with COIPA for the purpose of providing Covered Services to Members. Participating status shall be contingent upon COIPA designation as such.

1.7 "Practitioner" shall mean a licensed doctor of medicine or osteopathy, nurse practitioner, physician assistant or podiatrist who has entered into an agreement with COIPA to provide Covered Services to Members.

1.9 "Plan" shall mean any arrangement between COIPA and another party, such as an insurer, consumer or consumer's employer, Health Maintenance Organization, government or other similar entities, whose obligation it is to arrange for the provision of, or provide reimbursement for, health care services.

1.10 "Rules and Regulations of COIPA" shall mean the Application, Credentialing Procedures, Office Procedure Manual and Reapplication Process, and such other matters as the COIPA Board of Directors shall approve.

II. SERVICES

2.1 Practitioner agrees to provide or arrange for Members those medical services which are Covered Services and are within Practitioner's medical specialty as designated to COIPA on the Credentialing Application.

2.2 Practitioner hereby agrees to accept and provide such Covered Services for a reasonable number of Members, provided however that upon prior approval of the Plan, Practitioner may limit their practice to existing patients who are or become Members. In doing so, Practitioner must close their practice to all new members without preference to a particular health plan. Practitioner may, following written notice to COIPA, the affected Member and the appropriate Plan, withdraw from the treatment of a Member when, in Practitioner's professional judgment, it would be in the Member's best interest to do so. Practitioner agrees that such notice of withdrawal from a Member's care shall allow sufficient time, under the circumstances, for the Member's care to be transferred in a proper manner to another Practitioner.

2.3 Practitioner agrees not to admit any Member to a hospital or other inpatient facility in a non-Emergency or elective situation without first obtaining the necessary authorization pursuant to the Plan's preadmission certification procedure, if any.

2.4 Practitioner agrees, except in accordance with the provisions, spirit and intent of this Agreement, and within the limits of their specialty, (A) not to discriminate in their provision of Covered Services to Members because of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, age, health, handicap or membership in a contracting Plan, and (B) to render Covered Services to Members in the same manner, in accordance with the same standards, and within the same time availability as offered to their non-Plan patients.

2.5 Practitioner further agrees that, should they arrange with a non-Participating Practitioner to treat their Member-patients in their absence, it will be Practitioner's responsibility to ensure that such non-Participating Practitioner will comply with Practitioner's obligations hereunder, including but not limited to (A) acceptance of the fee established by the Plan as full payment for Covered Services rendered to Practitioner's Member-patients; (B) acceptance of the COIPA and the Plan's peer and utilization review procedures; (C) agreement not to bill Members directly under any circumstances except for copayments and non-covered Services as defined in Individual and Group Service Agreements; and (D) obtaining authorization from the Plan prior to all non-emergency hospitalizations.

2.6 In the event of illness or injury for which a third party has accepted financial responsibility or has been judged to be liable, the amount available for collection by Practitioner from the third party shall be applied to charges for medical care of a Member prior to accessing the resources of the Plan. If such third party liability eliminates any financial obligation of the Plan on a Member's behalf, the provisions of this Agreement do not apply to the situation. In the event the third party is not liable for the illness or injury of a Member or if recovery from the third party is less than the Plan's obligation to Member in the absence of payment by a third party, Practitioner must comply with the Plan's rules governing the provision of Covered Services and the terms of this Agreement in order for the Plan to accept financial responsibility.

2.7 Practitioner shall pay all dues and assessments levied by the Board of COIPA when due. Failure to pay is grounds for termination.

III. COMPENSATION

3.1 Practitioner's compensation for Covered Services rendered shall be at the rates set forth and according to the appropriate Plan contract.

3.2 Practitioner hereby agrees that in no event, including but not limited to non-payment by the Plan; insolvency of the Plan; or breach of this Agreement, shall Practitioner bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Member, enrollee, or other persons acting on their behalf other than the Plan, for Medically Indicated Covered Services provided pursuant to the Plan's Group Service Agreement. Practitioner acknowledges that payment is not likely in these circumstances. This provision shall not prohibit collection of supplemental charges or copayments from a Member made in accordance with the terms of the Group Service Agreement under which the Member is enrolled.

3.2.1 This provision applies to Covered Services provided during a time period for which a Member's premiums have been paid.

3.2.2 This provision shall be understood to be for the benefit of the Member.

3.3 The appropriate Plan may require its Members to pay a nominal fee or copayment for certain Covered Services as set forth in the Member's Individual or Group Service Agreement with the Plan. Practitioner shall be responsible for the collection and Members shall be responsible for payment of such copayments at the time the Covered Services are rendered. Such copayments may be modified at any time by the Plan. Members may also be responsible for co-insurance amounts.

3.4 A Plan shall have no obligation to pay any amounts that together with all other payments to and contractual adjustments made by Practitioner exceed the amount payable by a Plan for Covered Services rendered.

3.5 COIPA hereby is given the authority to enter into agreements with various Plans, among which one or more may require withholds. In such an event, COIPA has the authority to authorize the withholding of a percentage of each payment due to Practitioner to be set aside by the Plan(s) in risk pools or reserve funds, and Practitioner will be compensated at a set rate as specified by the Plan. COIPA shall require the Plans to agree that reserve funds will be used for utilization in excess of projected amounts or returned to Practitioner, if projections are met.

IV. BILLING PROCEDURES

4.1 Practitioner shall bill the Plan for all Covered Services rendered to Members. Practitioner shall receive compensation for Covered Services rendered according to the Plan, less any applicable copayments regardless of whether such copayments were actually collected.

4.2 Practitioner shall submit a HCFA 1500 claim form or electronic claim to the appropriate Plan for all Covered Services rendered to Members, which claim form shall show whether the applicable copayment has been collected. Such claim form shall include statistical and descriptive medical, including all CPT, HCPC, ICD-10 coding, and patient data in a form specified by the Plan. Billings will be consistent with ethical and community standard billing practices. Such claim form shall be submitted to the Plan within 120 days of the date the practitioner provides such service for which he/she seeks reimbursement. Appeals of payment or denial decisions must be made according to guidelines, if any, in the Plan. Practitioner shall submit all claims within one year of the date the practitioner provides such service regardless of whether the claims will be reimbursed.

V. MEDICAL SERVICE AGREEMENTS PLAN(S)

5.1 COIPA intends to contract for the delivery of health care services through contracts with health maintenance organizations (HMO). Practitioner shall be required to participate in "risk-sharing" agreements COIPA enters into, to the extent Practitioner's services are contemplated thereunder.

5.2 Practitioner shall individually elect whether to participate in any nonrisk PPO contract offered to Practitioners. Practitioner or Practitioner's representative shall be individually responsible for negotiating all fees and reimbursement(s) to be received under such nonrisk-sharing agreements. COIPA will only negotiate the non-reimbursement issues associated with nonrisk-sharing agreements. To the extent a nonrisk-sharing agreement is offered to Practitioners, Practitioners shall not discuss the reimbursement rates, fees or service pricing of such nonrisk agreement(s) with any other Practitioner, including whether or not such Practitioners have accepted or rejected the same or similar agreement(s).

5.3 Practitioner agrees to maintain the confidentiality of documents, terms and conditions relating to reimbursement or payment rates and methods and other proprietary information of contracting Plans. Practitioner agrees to return all copies of documents containing any Plan's proprietary information upon termination of this Agreement. This provision shall continue in effect notwithstanding termination of this Agreement.

VI. PRACTITIONER WARRANTIES/COMPLIANCE WITH RULES AND REGULATIONS

6.1 Practitioner states as a material term of this Agreement that they are now and will remain as long as this Agreement remains in effect, (A) the holder of a currently valid Oregon license to provide the applicable services for their practice listed in the definition of Practitioner in this agreement, and (B) an active, associate or provisional active member in good standing on the medical or other applicable staff of a Participating Institution, if appropriate to their practice.

6.2 Practitioner shall cooperate with such programs of initial and periodic credentialing and appraisal as may be established by COIPA. Practitioner hereby consents and authorizes the release to COIPA or COIPA's designated agents, any utilization, peer review, NCQA or other information regarding Practitioner's practice of medicine (hereinafter "Credentialing Information"). To the extent ORS 41.675 applies to any Credentialing Information, and to the extent the privilege conferred thereunder extends to Practitioner, Practitioner hereby waives said privilege. To the extent a privilege conferred by ORS 41.675 is claimed by, or applies to any other individual(s) or entity with regard to any Credentialing Information, COIPA and its designated agents shall first obtain consent to the release of the Credentialing Information by the holder(s) of the privilege before obtaining the Credentialing Information. Practitioner releases from liability COIPA and its designated agents, Plans and their employees and agents, Practitioners, and any other person(s) or entities which furnish Credentialing Information to COIPA or its designated agents, for acts made in good faith and without malice in connection with this provision.

6.3 Practitioner shall be bound by the Bylaws of COIPA and its Rules and Regulations as they may be amended from time to time. If Practitioner violates any of the provisions of the Bylaws or Rules and Regulations, or any of the principles of professional conduct, or acts contrary to or in violation of any Plan's agreement, all contractual rights under this Agreement which pertain to Practitioner may terminate and all fees for Covered Services rendered to Members by Practitioner which accrue prior to such termination shall be paid within 10 days of the date of termination. Copies of the Bylaws and Rules and Regulations will be provided to or be available for examination by Practitioner upon request.

6.4 Whether implemented by COIPA and/or any Plan(s), Practitioner agrees to cooperate and participate in the following, as designated from time to time by COIPA and/or the appropriate Plan(s), and/or as required by state or federal regulations:

- a. Internal utilization review/management, quality improvement and customer service activities, systems and rules and regulations;
- b. External audit systems;
- c. Grievance system rules and regulations;

- d. Development of evaluation criteria for new medical technologies or new applications of established technologies (including medical procedures, drugs and devices);
- e. Credentialing processes including on-site visitation of Practitioner's place of practice by COIPA and/or Plan designee;
- f. Medical record organization and retention systems; and
- g. Such other systems, activities and procedures relating to Plan accreditation by the National Committee for Quality Assurance and any other accreditation organizations, as may be determined from time to time by COIPA and the Plans with which it contracts.
- h. Standards of Participation from each health plan which include such items as; payment rules, provider manual; and code of conduct.

Practitioner further agrees to comply with any final determinations made pursuant to any of the review processes noted above, as such determination(s) relate to his or her responsibilities under this Agreement.

VII. REFERRALS

7.1 Practitioner shall refer Members to other Practitioners who have contracted with the Member's Plan; provided that such referrals are consistent with sound medical practice. Practitioner shall inform a Member that they may be responsible for payment of health care services provided by a health care provider who is not a Practitioner to the extent such a referral is requested by the Member or deemed necessary by Practitioner. Prior documented authorization, except in an Emergency, from the Medical Director of the Plan must be obtained for referral to health care providers who are not Practitioners if such referral is for the purpose of receiving Covered Services.

7.2 In cooperation with utilization/quality management, Practitioner shall participate in referral systems established by Plan(s) and reviewed by the COIPA Board, to facilitate appropriate referrals for Covered Services. The purpose of the referral system is to evaluate provider criteria to facilitate appropriate referrals to meet patient needs. Practitioner retains the right to exercise their medical judgment when making patient referrals. The procedures Practitioners shall follow when utilizing the referral system shall be set forth in the Rules and Regulations of COIPA.

VIII. RECORDS SHARING AND CONFIDENTIALITY

8.1 Practitioner shall participate in any system established by COIPA or an appropriate Plan which will facilitate, to the extent feasible, the maximum sharing of records, subject to compliance by the Plan with state and/or federal law regarding confidentiality. Practitioner agrees to retain records in accordance with the minimum requirements of state and federal law (no less than 6 years). Such obligations continue despite the termination of this Agreement, whether by rescission or otherwise. COIPA shall have access at reasonable times upon demand to the books, records, and papers of Practitioner relating to Covered Services provided to Members, the cost thereof, and any payments received by Practitioner from Members.

8.2 In the event oftennination of this Agreement, Practitioner shall nonetheless make Member medical records available upon request of the appropriate Plan or Member for copying by the Plan or another Practitioner.

8.3 Practitioner shall treat all medical records of Members as confidential, in compliance with all federal and state laws and regulations regarding the confidentiality of patient records.

8.4 Practitioner shall cooperate with COJPA and the Plans in maintaining and providing medical histories, financial, administrative and other records of Members as shall be requested. COIPA shall require Plans with which it contracts to obtain medical records releases from such Plans' Members. The parties agree that such records shall maintain the confidential nature they had while in the possession of Practitioner.

8.5 Practitioner shall, upon reasonable request by a Plan, and subject to proof of compliance with Section 6.2 hereof, provide the Plan access to and/or copies of records necessary to process claims and to comply with the provisions of COIPA and/or Plan utilization and quality management programs and records requests from state and federal regulatory agencies and review organizations. Plans will allow Practitioner a reasonable length of time within which to provide the requested documents. Whenever possible and convenient, the Plan will review records on-site to avoid the need for duplication of records by Practitioner. The parties agree that such records shall maintain the same confidential nature they had while in the possession of Practitioner.

8.6 Practitioner agrees to maintain the confidentiality of documents, terms, and conditions relating to reimbursement rates and methods and other proprietary information of each Plan with which COIPA contracts. Practitioner agrees to return all copies of documents containing any of the Plan's proprietary information upon termination of this Agreement. This provision shall continue in effect notwithstanding the tennination of this Agreement.

IX. ACCESSIBILITY AND CONTINUITY OF CARE

9.1 Practitioner agrees to make prior arrangements for other Participating Practitioner(s) to provide coverage for Members on a 24-hour a day, 7-day a week basis when Practitioner is unavailable to Members. The same tenns and conditions as agreed to by Practitioner shall be in effect and primary coverage may not be through a hospital emergency room or urgent care center.

X. INSURANCE

10.1 Practitioner shall provide and maintain such policies of general and professional liability insurance or such other program of professional liability coverage, as may be customary and acceptable to COIPA to insure Practitioner against any claim or claims for damages arising by reason of personal injuries or death occasioned directly or in connection with the performance of, or the failure to perform, any service provided by Practitioner or their employees or agents. The amounts and extent of such insurance coverage shall be subject to the approval of COIPA, which approval shall not be unreasonably withheld. Upon request by COIPA, Practitioner will provide COIPA with evidence of such coverage, including name of carrier, policy number, limits and expiration date. As a minimum, Practitioner shall have professional liability coverage of \$1,000,000. per occurrence and \$3,000,000. aggregate. Practitioner shall provide COIPA with at least ten (10) days advance written notice of any modification to or tennination of such insurance coverage.

XI. ADMINISTRATION

11.1 Practitioner agrees that COIPA and each Plan with which COIPA contracts may use their name, address, phone number, type of practice and an indication of willingness to accept new patients through COIPA and/or a Plan on a roster of Practitioners. This roster may be inspected by and is intended for the use of enrolled Members, prospective Members, Practitioners, non- Practitioners and prospective Practitioners.

11.2 Practitioner agrees to cooperate in providing for effective implementation of the provisions of Members' Individual or Group Service Agreements relating to covered benefits or coordination of benefits and other third party claims.

11.3 Practitioner understands and agrees that any additional fees charged to Members are prohibited except for copayments or for non-Covered Services. An "additional fee" shall mean any charge which is not previously approved by the appropriate Plan or COIPA.

XII. TERM AND TERMINATION

12.1 The term of this Agreement shall commence on the date of execution. This Agreement shall continue in effect until December 31 of the year of execution, and thereafter to December 31 of each following year unless terminated pursuant to the terms of this Agreement or by the Bylaws of COIPA.

12.2 This Agreement may be terminated by COIPA as follows:

- a. Automatically without further action required by the Board of Directors of COIPA if Practitioner retires from the practice of their health care profession, is adjudicated legally incompetent, dies or has their professional license not renewed, revoked, restricted or suspended without reinstatement.
- b. At the Board's discretion if Practitioner fails to meet any of the criteria set forth within Section 3.11 of COIPA Bylaws; or
- c. Pursuant to the criteria and procedures set forth in Articles V and VI of COIPA Bylaws (collectively the "Fair Hearing Plan").

12.3 At any time during the term hereof, this Agreement may be terminated by Practitioner by giving written notice at least 60 days in advance of such termination. Upon such termination, the rights of Practitioner shall terminate with respect to Members of groups enrolled by any Plan after COIPA receives such Practitioner's notice of termination provided, however, this Agreement shall continue in effect with respect to Members of groups enrolled prior to COIPA's receipt of such notice for a maximum period of 60 days from the date such notice is mailed. Subject to the conditions set forth in Article III of this Agreement, during said 60-day period, Practitioner shall be regularly paid for Covered Services rendered to enrolled Members per the then existing compensation schedule of the appropriate Plan(s).

12.4 Nothing herein shall be construed as limiting the right of COIPA to terminate this Agreement immediately where COIPA determines that the health, safety or welfare of one or more Members is jeopardized by continuation of the Agreement, or if Practitioner suffers limitation, revocation, termination or suspension of their license or medical staff privileges.

12.5 Practitioner shall provide sixty (60) days advance notice of termination when leaving the COIPA service area.

XIII. GENERAL PROVISIONS

13.1 **Amendments.** This Agreement may be amended by COIPA upon giving thirty (30) days' prior written notice to Practitioner, personally delivered or by first class, registered or certified mail of such proposed amendment. The continued participation in the program by Practitioner without objection within the thirty (30) day period shall constitute Practitioner's approval of such amendment. In the event Practitioner objects to such amendment, COIPA may, at its option, continue the Agreement unamended or terminate the Agreement sixty (60) days from the date of receipt of written objection from Practitioner. During said sixty (60) day period, the terms and conditions of the Agreement as it existed the day prior to the date of the written notice of objection, including all terms and conditions of compensation, shall continue to be in effect. Termination of the Agreement under this provision of the contract shall be treated as a "voluntary termination" by Practitioner without right to hearing.

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

13.3 **Governing Law.** This Agreement shall be governed in all respects by the applicable laws of Oregon and applicable federal law. In the event any term, condition or provision hereof becomes void as a matter of law or is deemed invalid by a court of competent jurisdiction, any and all other terms and provisions hereof shall remain valid and in force.

13.4 **Non-assignability.** This Agreement, being intended to secure the services of Practitioner shall not be assigned, delegated, or transferred in any manner inconsistent with this Agreement without the written consent of COIPA.

13.5 **Notices.** Any notice required to be given pursuant to the terms and provisions hereof shall be in writing and shall be personally delivered or sent, postage prepaid, to COIPA or Practitioner at their respective places of business as designated on the signature page hereof and thereafter as designated from time to time by the parties.

13.6 **Gender Neutrality.** All terms and conditions of this Agreement shall be understood to be gender neutral.

13.7 **Independent Parties.** None of the provisions of this Agreement are intended to create nor shall be deemed or construed to create any relationship between the parties hereto other than that of independent contractors, solely for the purpose of effecting the provisions of the Agreement. Neither of the parties hereto, nor any of their respective officers, directors, or employees, shall act as nor be construed to be the agent, the employee or the representative of the other party.

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

13.9 Attorneys' Fees. In the event suit or legal action is instituted by any party hereto seeking interpretation of the terms hereof or alleging a breach of this Agreement, the prevailing party shall be entitled to all costs and attorneys' fees incurred at trial or upon any appeal therefrom.

13.10 Retroactive Reimbursement. To the extent ORS 743.803 applies to this Agreement, Provider agrees to waive the right to seek retroactive reimbursement for any treatment or services rendered to an Enrollee by Provider prior to their credentialing and membership approval by IPA. In the event Provider is prevented by law from waiving such right, they shall accept the amount of one dollar (\$1.00) as full and complete consideration for all treatment or services rendered before Provider was credentialed and approved for membership by IPA.

IN WITNESS WHEREOF, the undersigned have executed this Agreement as of the date and year first above written.

PRACTITIONER

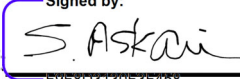
BY: _____
(Signature)

(Print Name)

(Address)

(Area of Practice/Specialty)

CENTRAL OREGON INDEPENDENT
PRACTICE ASSOCIATION

Signed by:

BY: _____
(Signature)

Sani Askari, DO

(Print Name)

1230 NE 3RD ST STE A-200

Bend Oregon 97701
(Address)

Amendment to Participating Provider Agreement

Member Business Associate Agreement

This Member Business Associate Agreement ("Agreement") is adopted by Central Oregon Independent Practice Association, Inc. ("COIPA") and Participating Provider of COIPA ("Member"), as an addendum to the Participating Provider Agreement between COIPA and Member, and is enforceable and effective as of September 22, 2014 for an existing Member or on the date a Member becomes a Participating Provider of COIPA.

Recitals

A. COIPA has entered into and may in the future enter into written agreements that require COIPA to be provided with, to have access to, or to create Protected Health Information ("Underlying Agreements"), that are subject to federal regulations issued pursuant to the Health Insurance Portability and Accountability Act ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act ("HITECH") and accompanying codified regulations at 45 C.F.R. parts 160 and 164 ("HIPAA Regulations").

B. The primary purpose of this Agreement is to permit COIPA, as a business associate, to engage in and assist Member with conducting quality assessment and improvement activities, population-based activities relating to improving health or reducing health care costs, protocol development, case management, and care coordination as permitted by the HIPAA Regulations.

C. This Agreement will supplement each Underlying Agreement only with respect to COIPA's use, disclosure, or creation of Protected Health Information under an Underlying Agreement to allow Member, as a covered entity, to comply with the HIPAA Regulations.

The parties agree:

SECTION 1. Definitions Used By HIPAA

Unless otherwise defined in this Agreement, all capitalized terms used in this Agreement have the meanings ascribed in the HIPAA Regulations, provided, however, that "PHI" and "ePHI" shall mean Protected Health Information and Electronic Protected Health Information, respectively, as defined in the HIPAA Regulations, limited to the information COIPA received from or created or received on behalf of Member as Member's business associate. "Administrative Safeguards" shall have the same meaning as the term "administrative safeguards" in the HIPAA Regulations, with the exception that it shall apply to the management of the conduct of COIPA's workforce, not Member's workforce, in relation to the protection of that information.

SECTION 2. OBLIGATIONS OF COIPA AND MEMBER REGARDING PROTECTED HEALTH INFORMATION

2.1. Obligations of COIPA. With regard to its Use and/or Disclosure of PHI, COIPA agrees to:

- 2.1.1 not Use or Disclose PHI other than as permitted or required by this Agreement or as Required By Law. COIPA may Use and Disclose Protected Health Information only if its Use or Disclosure is in compliance with each applicable requirement of the Business Associate provisions of the HIPAA Regulations.
- 2.1.2 use appropriate safeguards to prevent Use or Disclosure of PHI other than as provided for by this Agreement.
- 2.1.3 report to Member any Use or Disclosure of PHI not provided for by this Agreement of which COIPA becomes aware.
- 2.1.4 ensure that any agents and subcontractors to whom it provides PHI received from, or created or received by COIPA on behalf of Member agree to the same restrictions and conditions set forth in the Business Associate provisions of the HIPAA Regulations that apply through this Agreement to COIPA with respect to such information.
- 2.1.5 within twenty (20) days of receiving a written request from Member, make available to Member the PHI necessary for Member to respond to requests from Individuals for access to PHI about them in the event that the PHI in COIPA's possession constitutes a Designated Record Set. In the event any Individual requests access to PHI directly from COIPA, COIPA shall within five (5) business days forward such request to Member. Any denials of access to the PHI requested shall be the responsibility of Member.
- 2.1.6 within thirty (30) days of receiving a written request from Member, make available to Member the PHI for amendment and incorporate any amendments to the PHI in accordance with the HIPAA Regulations in the event that the PHI in COIPA's possession constitutes a Designated Record Set.
- 2.1.7 within thirty (30) days of receiving a written request from Member, make available to Member the information required for Member to provide an accounting of disclosures of PHI as required by the Privacy Rule. COIPA shall provide Member with the following information: (i) the date of the disclosure, (ii) the name of the entity or person who received the PHI, and if known, the address of such entity or person, (iii) a brief description of the PHI disclosed, and (iv) one of the following, as applicable: (a) a brief statement of the purpose of such disclosure which includes an explanation that reasonably informs the individual of the basis for such disclosure or in lieu of such

statement, (b) a copy of a written request from the Secretary of Health and Human Services to investigate or determine compliance with HIPAA; or (c) a copy of the individual's request for an accounting. In the event the request for an accounting is delivered directly to COIPA, COIPA shall within seven (7) business days forward such request to Member.

- 2.1.8 make its internal practices, books and records relating to the Use and Disclosure of PHI available to the Secretary of HHS for purposes of determining Member's compliance with the Privacy Rule.
- 2.1.9 upon the expiration or termination of an Underlying Agreement, return to Member or destroy all PHI, including such information in possession of COIPA's subcontractors, as a result of the Underlying Agreement at issue and retain no copies, if it is feasible to do so. If return or destruction is infeasible, COIPA agrees to extend all protections, limitations and restrictions contained in this Agreement to COIPA's Use and/or Disclosure of any retained PHI, and to limit further Uses and/or Disclosures to the purposes that make the return or destruction of the PHI infeasible. This provision shall survive the termination or expiration of this Agreement and/or any Underlying Agreement.
- 2.1.10 use reasonable commercial efforts to mitigate any harmful effect that is known to COIPA of a Use or Disclosure of PHI by COIPA in violation of the requirements of this Agreement.
- 2.1.11 implement Administrative Safeguards, Physical Safeguards, and Technical Safeguards ("Safeguards") that reasonably and appropriately protect the Confidentiality, Integrity, and Availability of ePHI as required by the "Security Rule."
- 2.1.12 ensure that any agent and subcontractor to whom COIPA provides ePHI agrees to implement reasonable and appropriate safeguards to protect ePHI.
- 2.1.13 report promptly to Member any successful Security Incident of which COIPA becomes aware; provided, however, that with respect to attempted unauthorized access, Use, Disclosure, modification, or destruction of information or interference with system operations in an information system affecting ePHI, such report to Member will be made available upon written request.
- 2.1.14 make its policies, procedures and documentation required by the Security Rule relating to the Safeguards available to the Secretary of HHS for purposes of determining Member's compliance with the Security Rule.
- 2.1.15 if COIPA accesses, maintains, retains, modifies, records, stores, destroys, or otherwise holds, uses, or discloses Unsecured Protected Health Information as

defined by HITECH and the HIPM Regulations, it shall, following the discovery of a breach of such information, notify Member of such breach. Such notice shall include the identification of each individual whose unsecured protected health information has been, or is reasonably believed by COIPA to have been accessed, acquired, or disclosed during such breach.

2.1.16 to the extent COIPA is to carry out one or more of Member's obligations under the Privacy Rule, if any, COIPA will comply with the requirements of the Rule that apply to Member in the performance of such obligations.

2.2 Permitted Uses and Disclosures of PHI. Except as otherwise specified in this Agreement, COIPA may make any and all Uses and Disclosures of PHI necessary to perform its obligations under the Underlying Agreements. Unless otherwise limited herein, COIPA may:

- 2.2.1 Use the PHI in its possession for its proper management and administration and to carry out the legal responsibilities of COIPA;
- 2.2.2 Use or Disclose PHI to engage in, and assist Member with, conducting quality assessment and improvement activities, population-based activities relating to improving health or reducing health care costs, protocol development, case management, and care coordination as permitted by the HIPAA Regulations;
- 2.2.3 Disclose the PHI in its possession to a third party for the purpose of COIPA's proper management and administration or to carry out the legal responsibilities of COIPA, provided that the Disclosures are Required By Law or COIPA obtains reasonable assurances from the third party regarding the confidential handling of such PHI as required under the Privacy Rule;
- 2.2.4 provide Data Aggregation services relating to the Health Care Operations of the Member;
- 2.2.5 de-identify any and all PHI obtained by COIPA under this Agreement, and use such de-identified data, all in accordance with the de-identification requirements of the Privacy Rule;
- 2.2.6 make uses and disclosures and requests for PHI consistent with Member's and/or the Privacy Rule's minimum necessary standard and specifications; and
- 2.2.7 not use or disclose PHI in a manner that would violate the Privacy Rule, if done by Member, except for the specific uses and disclosures in this section above.

2.3 Obligations of Member. Member agrees to timely notify COIPA, in writing, of any arrangements between Member, as a Covered Entity and the Individual that is the

subject of PHI that may impact in any manner the Use and/or Disclosure of that PHI by COIPA under this Agreement. Member agrees that this Agreement authorizes COIPA, as a Business Associate of Member, to engage in and assist Member with the activities permitted by this Agreement and to contract with third parties for the purpose of accessing PHI pursuant to the Underlying Agreements.

2.4 Use of Subcontractors. Member agrees that COIPA may engage the services of other parties ("Subcontractors") to perform COIPA's obligations that are consistent with this Agreement and the Underlying Agreements. COIPA will ensure that any Subcontractor that creates, receives, maintains, or transmits PHI on behalf of COIPA agrees to the same restrictions and conditions that apply to COIPA under this Agreement.

SECTION 3. TERMINATION PROCEDURES

Should Member become aware of a pattern of activity or practice that constitutes a material breach of a material term of this Agreement by COIPA, Member shall provide COIPA with written notice of such breach in sufficient detail to enable COIPA to understand the specific nature of the breach. Member shall be entitled to terminate its participation in the Underlying Agreement associated with such breach if, after Member provides the notice to COIPA, COIPA fails to cure the breach within a reasonable time period not less than thirty (30) days specified by Member in such notice; provided, however, that such time period specified by Member shall be based on the nature of the breach involved.

SECTION 4. GENERAL PROVISIONS

4.1 Interpretation. The terms of this Agreement shall prevail in the case of any conflict with the terms of any Underlying Agreement to the extent necessary to allow Member, as a Covered Entity, to comply with the HIPAA Regulations.

4.2 No Third Party Beneficiaries. Nothing in this Agreement shall confer upon any person other than the parties and their respective successors or assigns, any rights, remedies, obligations, or liabilities whatsoever.

4.3 Amendment. To the extent that any relevant provision of the HIPAA Regulations is materially amended in a manner that changes the obligations of business associates or covered entities, the parties agree to negotiate in good faith appropriate amendments to this Agreement to give effect to these revised obligations.

4.4 Signatures. If Member is employed by a covered entity, COIPA and Member acknowledge that for purposes implementing any required documentation of a business associate agreement, Member hereby authorizes Member's employer to execute a business associate agreement on Member's behalf. Nothing in this provision is intended to interfere with any contractual rights COIPA or Member may have pursuant to any payer contract between COIPA and a third party payer.

IN WITNESS WHEREOF, the parties hereto have entered into this Amendment as of the date first set forth above.

PRACTITIONER

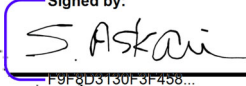
BY: _____
(Signature)

(Print Name)

(Address)

(Area of Practice/Specialty)

CENTRAL OREGON INDEPENDENT
PRACTICE ASSOCIATION

Signed by:
BY:  _____
(Signature) F9F8D3130F3F458...

Sani Askari, DO

(Print Name)

1230 NE 3RD ST STE A-200
Bend Oregon 97701
(Address)

**AMENDMENT TO
PARTICIPATING PRACTITIONER AGREEMENT**

MEDICARE COMPLIANCE PROVISIONS

WHEREAS, Practitioner has entered into a Participating Practitioner Agreement with Central Oregon Independent Practice Association ("COIPA"), as amended from time to time (the "Agreement");

AND WHEREAS, Practitioner and COIPA wish to amend the Agreement to ensure compliance with all the requirements of the Medicare Program;

NOW THEREFORE, for good and valuable consideration, the sufficiency and adequacy of which is hereby acknowledged, the parties hereby enter into this Amendment effective as of **May 1st 2021**.

1. **Definitions.** Any terms not otherwise defined herein shall have the meaning set forth in the Agreement. "Plan" shall refer to and expressly include PacificSource Health Plans.
2. **Precedence.** In the event of any conflict or inconsistency between this Amendment and the Agreement, such conflict or inconsistency shall be resolved by giving precedence first to this Amendment then the Agreement.
3. **Laws & Rules.** Practitioner agrees to comply with all applicable Medicare, Medicare Advantage, and Medicare Part D laws, rules, and regulations, reporting requirements, and the Centers for Medicare and Medicaid Services ("CMS") instructions to the extent applicable to Practitioner and to cooperate, assist, and provide information, as requested to CMS and/or its designee. (42 CFR §422.504(i)(4)(i)&(v) and 42 CFR §423.505(i)(4)(iv)).
4. **Records.** Practitioner agrees to comply with all applicable state and federal requirements regarding the privacy, confidentiality, accuracy, and retention of records of members of the Plan, including the requirements established by CMS which include, but are not limited to, the retention of all records for a period of ten years from the date this Agreement expires or terminates or the completion of any Medicare-related audit, whichever is later. (42 CFR §422.504(a)(13) and 42 CFR §422.118).
5. **Monitoring of Services.** Practitioner agrees that the Plan may monitor the performance of Practitioner on an ongoing basis regarding the provision of services to Plan members enrolled in Medicare Advantage or Medicare Part D. Monitoring may include auditing of records or requests for information related to the provision of such services. Any auditing activities shall be conducted in accordance with the terms of the medical services agreement between the Plan and COIPA. (42 CFR §422.504(i)(4)(iii) and 42 CFR §423.505(i)(4)(iii)).
6. **Right to Audit.** Practitioner agrees that CMS, Health and Human Services ("HHS"), and the Comptroller General or their designees shall have the right to audit, evaluate, or inspect any books, contracts, medical records, patient care documentation, or other records of Practitioner that pertain to or are related to any aspect of the services provided under the Agreement for a period of up to ten (10) years from the date the Agreement expires or

AMENDMENT TO PARTICIPATING PRACTITIONER AGREEMENT

terminates, or the completion of any Medicare-related audit, whichever is later, and such other periods in excess of ten (10) years or more as defined in Medicare, Medicare Advantage, and Medicare Part D laws, rules, and regulations and CMS instructions. This provision shall survive the termination of the Agreement for any reason. (42 CFR §422.504(e)(2) through (4), 42 CFR §422.504(i)(2)(i) and (ii) and 42 CFR §423.505(i)(2)(i) and (ii)).

7. **Ultimate Responsibility.** Notwithstanding any term or provision of the Agreement, the Plan maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its Medicare Advantage and Medicare Part D contracts with CMS (42 CFR 422.504(1)(1) and 42 CFR §423.505(i)(1)). Practitioner acknowledges and agrees that the services it provides under this Agreement shall be consistent with and shall comply with the Plan's contractual obligations with CMS regarding benefit plans, which are subject to Medicare, Medicare Advantage, and/or Medicare Part D laws, rules, and regulations and CMS instructions. Practitioner agrees to cooperate with the Plan in meeting its responsibilities under Medicare Advantage and Medicare Part D. (42 CFR §422.504(i)(3)(iii) and 42 CFR §423.505(i)(3)(iii)).
8. **Member Hold Harmless.** Practitioner agrees that in no event, including, but not limited to, non-payment by the Plan, insolvency of the Plan or other financial difficulties of the Plan, shall Practitioner bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from or have any recourse against a Plan member for any fees that are the legal obligation of the Plan. Nothing in this section is intended to interfere with the Practitioner's ability to collect fees that are not a legal obligation of the Plan such as member copayments or charges related to services not covered under the member's benefit plan. This provision shall survive termination or expiration of this Agreement for any reason. (42 CFR §422.504(9)(1), 42 CFR §422.504(i)(3)(i) and 42 CFR §423.505(i)(3)(i)).
9. **Federal Funds/Non-Discrimination.** Practitioner acknowledges that the payments made hereunder are funded in whole or in part from federal funds thereby subjecting the parties to certain laws applicable to individuals and entities receiving federal funds, including but not limited to, Title VI of the Civil Rights Act of 1964, as implemented by regulations at 45 CFR part 80; the Age Discrimination Act of 1975, as implemented by regulations at 45 CFR part 91; and the Americans with Disabilities Act. This provision shall survive termination or expiration of this Agreement for any reason.
10. **Prompt Payment.** The Plan shall reimburse Practitioner within thirty (30) days of receipt of a Clean Claim for Medically Necessary Services provided to Members.
11. **Other CMS Matters.** The Plan shall oversee and is accountable to CMS for any functions or responsibilities that are described in 42 CFR §422.504(i)(3). Upon prior written consent of both parties, the parties agree to include in this Agreement such other terms and conditions as CMS may find necessary and appropriate in order to implement the Medicare Advantage or Medicare part D programs. (42 CFR §422.5040) and 42 CFR §423.505U)).
12. **Exclusion from Medicare.** Practitioner represents and warrants that Practitioner is not excluded from participation in the Medicare program. Further, Practitioner represents and warrants that Practitioner shall not employ or contract with any individual who is excluded from participation in the Medicare program to perform any services related to the provision or administration of any benefits under a federal health care program. Practitioner agrees to take reasonable precautions to review federal exclusion lists when hiring individuals and to

AMENDMENT TO PARTICIPATING PRACTITIONER AGREEMENT

take appropriate corrective action upon the discovery that an individual is excluded from participation in the Medicare program. (42 CFR §422.204(b)(4) and 42 CFR §422.752(a)(8)).

13. **Compliance with Policies and Procedures.** To the extent applicable, Practitioner agrees to comply with and abide by the rules, policies, and procedures the Plan has established as part of its Medicare Advantage and Medicare Part D Programs.
14. **Training Requirements.** Practitioner shall provide compliance training and education to its employees upon hire and thereafter at least annually in accordance with CMS requirements. Practitioner shall maintain accurate and complete records, including, but not limited to, educational records and proof of compliance by each employee, and shall provide such records to the Plan at least annually and upon request. If requested by Practitioner, the Plan shall provide Practitioner with access to training materials or sufficient information about training materials to comply with the CMS requirements for compliance training and education.
15. **Subcontracting Entities.** In the event Practitioner enters into contracts with other entities to perform its obligations hereunder, such subcontractors shall agree to comply with the terms of this Agreement, which include, but are not limited to, the following:
 - (a) The subcontractor must comply with all applicable federal and state laws, including but not limited to, Medicare laws, Medicare regulations, CMS instructions and the Plan's policies and procedures in the performance of his/her duties under the terms of any subcontract as it pertains to services performed on behalf on Members.
 - (b) Notwithstanding any term or provision of this Agreement, the Plan maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its Medicare Advantage and Medicare Part D contracts with CMS (42 CFR 422.504(i)(1) and 42 CFR §423.505(i)(1)). All services by a subcontracting entity provided in relation to satisfaction of the Plan's CMS contractual obligations shall be subject to oversight by the Plan and to revocation under the terms of this Agreement if the Plan determines that such obligations are not being performed to the satisfaction of CMS.
 - (c) The subcontractor shall maintain and provide to the Plan, the Oregon Department of Consumer and Business Services, and/or Insurance Division, all necessary records and information which may be required for compliance with state law including, without limitation, the Oregon insurance code and the regulations promulgated thereunder, and to the Department of Health and Human Services ("HHS") as may be required for compliance with applicable federal law, including, without limitation, 42U.S.C. 300e, et seq., Section 1876 of the Social Security Act, as amended, and 42 CFR Part 417. Specifically to the extent that the cost of such services is reimbursable by the Medicare program, Practitioner agrees to comply with the Access to Books, Documents and Records of Subcontractor provision of Section 952 of the Omnibus Budget Reconciliation Act of 1980 (PL-499) and 42 CFR Part 420, Subpart D, Section 420.300 et seq. In accordance with these provisions, Practitioner and any of its subcontractors will, upon proper written notice, allow the Comptroller General of the United States, the Secretary of Health and Human Services and their duly authorized representatives access to their subcontractor agreements, to their facilities and to their books, documents, and records necessary to certify the nature and extent of the costs of Medicare reimbursable services provided under this

**AMENDMENT TO
PARTICIPATING PRACTITIONER AGREEMENT**

Agreement as well as the right to inspect, evaluate, and audit any pertinent information for any particular contract period. Such access will be allowed, upon request, until the expiration of ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later. If the contract between Practitioner and the subcontractor to carry out any of the duties of the Agreement has a value of \$10,000 or more over a twelve (12) month period, such subcontract shall contain a clause which requires the subcontractor to comply with the above statues and regulations.

IN WITNESS WHEREOF, the parties hereto have entered into this Amendment as of the date first set forth above.

PRACTITIONER

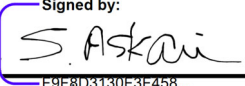
BY: _____
(Signature)

(Print Name)

(Address)

(Area of Practice/Specialty)

CENTRAL OREGON INDEPENDENT
PRACTICE ASSOCIATION

Signed by:
BY:  _____
(Signature) F9F8D3130F3F458...

Sani Askari, DO

(Print Name)

1230 NE 3RD ST STE A-200

Bend Oregon 97701
(Address)