POLK COUNTY BOARD OF COMMISSIONERS

DATE: December 11, 2024
TIME: 9:00 a.m.
PLACE: Polk County Courthouse, Dallas, Oregon

THE LOCATION OF THIS MEETING IS ADA ACCESSIBLE. PLEASE ADVISE THE BOARD OF COMMISSIONERS AT (503-623-8173), AT LEAST 24 HOURS IN ADVANCE, OF ANY SPECIAL ACCOMMODATIONS NEEDED TO ATTEND OR TO PARTICIPATE IN THE MEETING VIRTUALLY.

PAGE: **AGENDA ITEMS**

1. CALL TO ORDER AND NOTE OF ATTENDANCE

2. ANNOUNCEMENTS

   (a) Regular meetings of the Board of Commissioners are held on Tuesday and Wednesday each week. Each meeting is held in the Courthouse Conference Room, 850 Main Street, Dallas, Oregon. Each meeting begins at 9:00 a.m. and is conducted according to a prepared agenda that lists the principal subjects anticipated to be considered. Pursuant to ORS 192.640, the Board may consider and take action on subjects that are not listed on the agenda. The Board also holds a department staff meeting at 9:00am on every Monday in the Commissioners Conference Room at 850 Main Street, Dallas, Oregon.

   (b) The Grand Ronde Sanitary District Board is meeting on December 18, 2024 is being rescheduled at a later date.

3. COMMENTS (for items not on this agenda and limited to 3 minutes)
4. APPROVAL OF AGENDA
5. APPROVAL OF THE MINUTES FROM December 4, 2024
6. APPROVAL OF CONSENT CALENDAR
7. LENGTH OF SERVICE AWARDS – Matt Hawkins
   - Laura Willcoxen, 10 years of service
   - Kelvin Lowe, 10 years of service
8. POLK COUNTY FAIRGROUNDS OPERATING LEVY & RESOLUTION NO. 24-13

CONSENT CALENDAR

a) Polk County Contract No. 24-190, Regence BlueCross BlueShields
(Rosana Warren, Public Health)

b) Polk County Contract No. 24-191 (Amendment 1 to 24-190),
Regence BlueCross BlueShields
(Rosana Warren, Public Health)

c) Polk County Contract No. 24-192, A5 Interpreting dba Bridges Oregon, Inc
Rosana Warren, Health Services

d) Polk County Contract No. 24-193, A5 Interpreting dba Bridges Oregon, Inc
Rosana Warren, Health Services

e) Polk County Contract No. 24-195, Willamette Health Council
(Morgan Smith, County Counsel)

THE BOARD OF COMMISSIONERS WILL MEET IN EXECUTIVE SESSION PURSUANT TO ORS 192.660.

ADJOURNMENT

POLK COUNTY PUBLIC MEETINGS AND PUBLIC HEARINGS
GUIDELINE FOR CITIZENS

****

REGULAR MEETING AGENDA

Regular meetings of the Polk County Board of Commissioners convene at 9 a.m. each Wednesday morning. Any person wishing to bring a matter before the Board at one of these meetings may do so by mailing or delivering written notice, concisely describing the nature of the item, to the Board of Commissioners, Polk County Courthouse, Dallas, Oregon 97338, by noon on the preceding Thursday. Unless otherwise announced, meetings are held in the Main Conference Room of the Courthouse.

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APPEARANCE OF INTERESTED CITIZENS

The Board sets aside a time at each regular meeting for comment by the public on subjects not appearing on the Agenda. Individuals may come forward and make any statement they wish, but not to exceed three (3) minutes in length, except as is required to give concise answers to questions from Board members. If the subject will require a lengthier presentation, or merits inclusion as an item on the Agenda of a future meeting, the Board shall schedule it accordingly.

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PUBLIC HEARING FORMAT
Land Use

1. Chairman opens hearing.
   a. Reading of hearing request or appeal statement.
   b. Call for abstentions (ex parte contact or conflict of interest).
2. County staff presents background, summary and its recommendation (20-minute limit).
3. Applicant (Appellant) presents his/her case (15-minute limit).
4. Public testimony. Note that all testimony and evidence must be directed toward the applicable factual and legal criteria as identified in the record and/or during this hearing. Do not repeat previous testimony. Simply note for the record that you are in agreement with that earlier testimony. Your time to present testimony is limited. FAILURE TO RAISE AN ISSUE IN THIS HEARING, IN PERSON OR BY LETTER, OR FAILURE TO PROVIDE ADEQUATE SPECIFICITY TO AFFORD THE BOARD AN OPPORTUNITY TO RESPOND TO THE ISSUE MAY PRECLUDE LATER APPEAL TO LUBA ON THAT ISSUE.
   a. Individuals in favor of the application or appeal.
   b. Individuals against the application or appeal. At the discretion of the Chairman, an attorney, consultant, or other designated representative of two or more individuals may be allowed the combined time for each represented individual who does not speak, not to exceed 20 minutes. The Chairman may require proof of designation.
5. Rebuttal by Applicant (Appellant) (10-minute limit).
6. Questions from Board (discussion limited to individuals questioned by the Board).
   a. Staff.
   b. Applicant (Appellant).
   c. Individuals testifying.
7. Chairman closes hearing and announces closing of Record.
8. Chairman announces date for deliberation and decision.
9. The Board's decision is deemed the final decision of Polk County. It may be appealed to LUBA within 21 days of its issuance in written form. The address and phone number of LUBA may be obtained from the Polk County Community Development Department and will also appear on the Notice of Decision which will be mailed to all persons who testify, submit comments, or print their name and address on the hearing attendance sheet at the back of the hearing room.

POLK COUNTY BOARD OF COMMISSIONERS
MINUTES December 4, 2024

1. CALL TO ORDER & ATTENDANCE

At 9:00 a.m., Commissioner Pope declared the meeting of the Polk County Board of Commissioners to be in session. Commissioner Mordhorst and Commissioner Gordon were present.

Staff present: Greg Hansen, Administrative Officer
Morgan Smith, County Counsel
Matt Hawkins, Administrative Services Director

2. ANNOUNCEMENTS

Regular meetings of the Board of Commissioners are held on Tuesday and Wednesday each week. Each meeting is held in the Courthouse Conference Room, 850 Main Street, Dallas, Oregon. Each meeting begins at 9:00 a.m. and is conducted according to a prepared agenda that lists the principle subjects anticipated to be considered. Pursuant to ORS 192.640, The Board may consider and take action on subjects that are not listed on the agenda. The Board also holds a department staff meeting at 9:00 a.m. on every Monday in the Commissioners Conference Room at 850 Main Street, Dallas, Oregon.

The Grand Ronde Sanitary District Board is meeting on December 18, 2024 at 9:15 a.m. The meeting will take place in the Polk County Courthouse, 850 Main Street, Dallas, OR, 97338.

3. COMMENTS

None.

4. APPROVAL OF AGENDA

MOTION: COMMISSIONER MORDHORST MOVED, COMMISSIONER GORDON SECONDED, TO APPROVE THE AGENDA.

MOTION PASSED BY UNANIMOUS VOTE OF THE BOARD.

5. APPROVAL OF MINUTES OF November 27, 2024

MOTION: COMMISSIONER GORDON MOVED, COMMISSIONER MORDHORST SECONDED, TO APPROVE THE MINUTES OF November 27, 2024.

MOTION PASSED BY UNANIMOUS VOTE OF THE BOARD.

Commissioner Pope stated that it was that time of year where he would be attending the Annual O & C Timber Meeting and he is requesting that the other two Commissioners sign a proxy letter for him to take to the meeting that allows him to vote on their behalf of Polk County. Commissioner Gordon agreed to sign the letter and Commissioner Mordhorst stated that he planned to attend the meeting.

A 9:05 a.m. County Counsel announced that the Board will meet in Executive Session pursuant to ORS 192.660(2)(h) To consult with counsel concerning the legal rights and duties of a public body with regard to current litigation or litigation likely to be filed.

The executive session ended at 10:09 and Commissioner Pope directed staff to move forward as discussed.

Commissioner Pope adjourned the meeting at 10:09

POLK COUNTY BOARD OF COMMISSIONERS

Craig Pope, Chair

Jeremy Gordon, Commissioner

Lyle Mordhorst, Commissioner

Minutes: Nicole Pineda
Approved: December 11, 2024

POLK COUNTY

POLK COUNTY BOARD OF COMMISSIONERS

POLK COUNTY COURTHOUSE ★ DALLAS, OREGON 97338-3177
(503) 623-8173 ★ FAX (503) 623-0896

Commissioners
CRAIG A. POPE
JEREMY GORDON
LYLER.MORDHORST

GREGORY P. HANSEN
Administrative Officer

TO: **BOARD OF COMMISSIONERS**

FROM: **GREG HANSEN, ADMIN. OFFICER**

DATE: **DECEMBER 5, 2024**

SUBJECT: **POLK COUNTY FAIRGROUNDS OPERATING LEVY**

RECOMMENDATION:

The Polk County Board of Commissioners approve the following:

1. To place a Local Option Tax (operating levy) measure on the ballot for the May 13, 2025, general election to operate and maintain the Polk County Fairgrounds & Event Center.
2. A local option tax (operating levy) in an amount not to exceed $0.15/$1,000 assessed value for the duration of five (5) years.
3. Approve Resolution 24-13, which sets public hearings to receive public comment on the above proposed local option tax.
4. Ratify the publication of the attached hearing notice.

ISSUE:

Should the County Board of Commissioners consider a Fairgrounds & Event Center operating levy for May 13th of 2025?

BACKGROUND:

On November 12th the Polk County Fair Board voted to move a Local Option Tax forward to the Board of County Commissioners to consider placing on the May 2025 election an operating levy for the Polk County Fairgrounds.

Over the past four (4) years the Fairgrounds has made significant improvements to their facilities. Those improvements were made with monies from the State, ARPA, and Polk County General Fund. Unfortunately, those sources of revenue will either be going away (ARPA) or are not stable (State/Polk County).

Recently, a project list was developed for the next five years which totals $4 million. The list (attached) includes required improvements (electrical, asphalt replacement, HVAC upgrades) and other improvements such as Main building, relocation of the maintenance shed and main office and lastly the development of a amphitheater/stage area in the northwest corner of the Fairgrounds property.

In our opinion, the only way to address these needs/improvements is through a new source of revenue. The best option for that revenue source is through a Local Option Tax (operating levy).

For that to occur, the Board of Commissioners must go through a public hearing process and pass a Resolution placing it on the ballot for consideration by the voters of Polk County (attached timetable).

QUESTIONS:

There will be some questions centered on the need for this levy. The following are some of the most likely asked questions:

1. **Why are we seeking a Local Option Tax (operating levy) for the Polk County Fairgrounds?** As the costs associated with operations and maintenance continue to increase and the ability for the County General Fund to pay for these costs, it is apparent that for the Fairgrounds to continue to provide services in the future, supplemental revenue is necessary.

2. **What would the tax rate be?** A levy rate of $0.15/$1,000 would generate approximately $1,237,500 in the first year and would grow by 3%-4% annually thereafter for the next four (4) years.

3. **How many years would the levy be?** Five (5) years. A levy of this length would get us through June of 2029-30.

4. **When would we hold the election?** The earliest we could get an Operating Levy on the ballot would be the May of 2025 election. A May election, if successful would allow the County to levy taxes in November of 2025.

ALTERNATIVE:

The following are alternatives to consider:

1. Authorize a Local Option Tax (operating levy) as proposed by the Fair Board. Requires staff to put together the proper paperwork and public hearings to put it on the May 2025 election.

2. Go forward with a May 2025 election, but change the amount of the levy that we are seeking. Recommend a range not to exceed $0.175/$1,000 and not lower than $0.10/$1,000.

3. Not seek operating levy and live within existing funding. The result would be to push out necessary maintenance and infrastructure upgrades at the Fairgrounds complex.

FISCAL IMPACT:

The revenue generated with an operating levy is dependent upon the amount of the tax rate. A tax rate of $0.15/$1,000 would generate approximately $1,200,000 in its initial year and allow the County to maintain current operations/maintenance and make improvements to the Polk County Fairgrounds.

BEFORE THE BOARD OF COMMISSIONERS
FOR POLK COUNTY, OREGON

In the matter of calling for a Public Hearing on the decision to submit to the voters the question of approving a Polk County Fairgrounds & Event Center Local Option Tax (Operating Levy) in an amount not to exceed $0.15 per $1,000 of assessed value.	)))))))

RESOLUTION NO. 24-13

WHEREAS, the above matter came before the Polk County Board of Commissioners (hereinafter referred to as "County"), in regular sessions on November 13, 2024 and

WHEREAS, the County recognizes that funds are needed to preserve and enhance our existing Fairgrounds & Event Center; and

WHEREAS, the Board is considering whether it will submit substantially the following question to the electors of the County at the May 13, 2025, election:

Shall Polk County levy a five-year Fairgrounds & Event Center local option tax of up to $0.15/$1,000 assessed value beginning in fiscal year 2025-26? and

WHEREAS, Oregon Revised Statute 280.060 requires the County to conduct a public hearing on the proposed local option operating levy;

NOW, THEREFORE, IT IS HEREBY RESOLVED by the Board of Commissioners, County of Polk, that:

Section 1. A public hearing shall be held on the 8th day of January, 2025 at 9:00 a.m. and 6:30 p.m. in the Courthouse Conference Room, Polk County Courthouse, 850 Main Street, Dallas, Oregon 97338, regarding the proposed local option operating levy.

Section 2. The County hereby ratifies publication of a notice of hearing, in substantially the form attached hereto as Exhibit A, once each week for at least two successive weeks in the Itemizer-Observer, a newspaper published in the County and of general circulation throughout the County.

Dated this 11th day of December, 2025 at Dallas, Oregon.

POLK COUNTY BOARD OF COMMISSIONERS

_____
Craig Pope, Chair

_____
Lyle Mordhorst, Commissioner

Approved as to Form:

_____
Jeremy Gordon, Commissioner

_____
Morgan Smith
County Counsel

EXHIBIT A

NOTICE OF PUBLIC HEARINGS ON LOCAL OPTION TAX

Notice is hereby given that public hearings will be held before the Board of County Commissioners of Polk County, Oregon, on the following dates, locations and times:

Date	Location	Time
January 8, 2025	**Polk County Courthouse Courthouse Conference Room 850 Main Street Dallas, OR 97338**	**9:00 am**
January 8, 2025	**Polk County Courthouse Courthouse Conference Room 850 Main Street Dallas, OR 97338**	**6:30 pm**

Regarding the submission of the following question to the electors of the County at the election to be held May 13, 2025:

CAPTION: (10 words)

POLK COUNTY FAIRGROUNDS & EVENT CENTER LOCAL OPTION TAX

QUESTION: (20 words)

Shall Polk County authorize a five-year Fairgrounds/Event Center local option tax of up to $0.15/$1,000 assessed value beginning 2025-26?

PURPOSE:

This measure authorizes Polk County to levy a five (5) year local option tax of up to $0.15/$1,000 assessed value beginning in 2025 for the purpose of providing funding to the Polk County Fairgrounds & Event Center for operations, maintenance and improvements.

Monies generated from the local option tax will be used for electrical replacement/upgrades, the resurfacing of parking areas, replacing interior walkways and paths, interior/exterior improvements to the main building, HVAC upgrades for multiple buildings, the relocation of the maintenance building, building a new main office where the maintenance building was located, and

the building of a new amphitheater/stage in the northwest corner of the property.

All interested persons may attend and shall be given a reasonable opportunity to be heard. The location of this meeting is handicapped accessible. Please advise the Board of Commissioners (623-8173) if you will need any special accommodations to attend or participate in the meeting, at least 24 hours in advance.

BOARD OF COUNTY COMMISSIONERS
OF POLK COUNTY, OREGON

Craig Pope, Chair

To be published in the Itemizer Observer: **December 18 and 25**, 2024.
To be posted no later than: **December 18**, 2024

CONTRACT REVIEW SHEET

Staff Contact: Rosana Warren | Phone Number (Ext): 2550

Department: Health Services: Public Health | Consent Calendar Date: December 11, 2024

Contractor Name: Regence BlueCross BlueShields of Oregon

Address: PO Box 1106

City, State, Zip: Lewiston, ID 83501-1106

Effective Dates - From: September 01, 2024 | Through: EVERGREEN

Contract Amount: $ VARIES

Background:

This provider agreement with Regence BlueCross BlueShields of Oregon is to be considered in-network for immunizations provided through Polk County Public Health to its members.

Discussion:

This Agreement is for the continuation of services with Regence BlueCross BlueShields of Oregon for Polk County to provide its members immunization services through Public Health as an in-network provider and, as directed by OHA to support access to immunizations to all.

Fiscal Impact:

The amount varies as it is dependent on the number of Regence clients served. It is anticipated that there will be a positive impact as there is increased ability to seek revenue from this provider's members.

Recommendation:

It is recommended that Polk County sign this amendment with Regence BlueCross BlueShields of Oregon.

Copies of signed contract should be sent to the following:

Name: Rosana Warren | E-mail: hs.contracts@co.polk.or.us

Name: | E-mail:

REGENCE BLUECROSS BLUESHIELD OF OREGON
PARTICIPATING PROFESSIONAL SERVICES AGREEMENT

This Professional Services Agreement ("Agreement"), effective ("Effective Date"), replaces and supersedes any prior Agreement and is entered into by and between Regence BlueCross BlueShield of Oregon ("Regence") and **POLK COUNTY PUBLIC HEALTH**, and each entity set forth on Attachment B as applicable (collectively, "Provider").

In consideration of the mutual covenants and promises stated herein and other good and valuable consideration, the undersigned have agreed to be bound by this Agreement as of the Effective Date.

I. DEFINITIONS

When used in this Agreement, all capitalized terms have the following meanings:

1.1 **COINSURANCE:** a percentage amount that the Member Contract requires the Member to pay for Covered Services.

1.2 **COPAYMENT:** a fixed dollar amount that the Member Contract requires the Member to pay at the time of the provision of Covered Services.

1.3 **COVERED SERVICES:** Medically Necessary health care services and supplies provided to Members for which benefits are provided under a Member Contract.

1.4 **CREDENTIALING:** the process by which Regence may determine, in its sole discretion, whether Provider may participate with Regence.

1.5 **DEDUCTIBLE**: an amount that a Member must pay for Covered Services during a specified period in accordance with the Member Contract before benefits will be paid.

1.6 **INVESTIGATIONAL**: As applicable to a given line of business, a health intervention that Regence has classified as Investigational. Regence will review scientific evidence from well-designed clinical studies found in peer-reviewed medical literature, if available, and information obtained from Provider regarding the health intervention to determine if it is Investigational. A health intervention not meeting all of the following criteria is, in Regence's judgment, Investigational:

a. The scientific evidence must permit conclusions concerning the effect of the health intervention on health outcomes, which include the disease process, injury or illness, length of life, ability to function, and quality of life.

b. The health intervention must improve net health outcome.

c. The scientific evidence must show that the health intervention is at least as beneficial as any established alternatives.

d. The improvement must be attainable outside the laboratory or clinical research setting.

For purpose of this definition, "scientific evidence" means scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff; or findings, studies, or research conducted by or under the auspices of federal government agencies and/or nationally recognized federal research institutes. However, scientific evidence shall not include published peer-reviewed literature sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer or a single study without other supportable studies.

1.7 **MEDICALLY NECESSARY or MEDICAL NECESSITY**: Please refer to the attached state addendum.

1.8 **MEMBER(S)**: person(s) eligible under a Member Contract to receive Covered Services.

1.9 **MEMBER CONTRACT**: a contract between Regence or Payor and an individual or group in which Regence or Payor agrees to provide and/or administer health care benefits as set forth in the Member's summary plan description, certificate of coverage, or other applicable coverage document.

1.10 **NON-COVERED SERVICE**: a service or supply that is not a Covered Service for any of the following reasons: (a) the service or supply is Investigational or not Medically Necessary; or (b) the service or supply is not an available benefit or a Covered Service under the Member Contract for any reason.

1.11 **OTHER HEALTH CARE PROFESSIONAL**: a person, other than a Physician, who is legally qualified to provide health care services in the state where he or she practices, and who is eligible for reimbursement under a Member Contract.

1.12 **PARTICIPATING PROVIDER**: any hospital, facility, physician, other health care professional, or other provider of medical services or supplies who (a) is duly licensed to provide health care services or supplies; (b) has contracted, and continues to have a valid contract, with Regence, directly or through intermediaries, to furnish Covered Services to Members; and (c) is eligible for payment under a Member Contract and, where applicable, has been credentialed under Regence's credentialing policies.

1.13 **PAYOR**: an employer, insurer, a trust, third-party administrator, subsidiaries and affiliates of Regence, a Blue Cross and /or Blue Shield Plan, Cambia Health Solutions, self-funded health plan, or government entity that has contracted with Regence to offer, issue, and/or administer health benefits and has agreed to be responsible for funding health care services for Covered Services provided to Members under the terms of a Member Contract.

1.14 **PHYSICIAN**: a person who is legally qualified to practice medicine in the state where he or she practices.

1.15 **PROVIDER**: Physician or Other Health Care Professional who is employed by or has contracted with Provider to provide health care services under this Agreement.

1.16 **PROVIDER WEB SITE**: a reference source available within the Regence web site that contains the rules, policies, guidelines, and procedures adopted by Regence or Payor that Provider must follow in providing services and doing business with Regence or Payor under this Agreement. Regence may revise and update the Provider Web Site at Regence's sole discretion from time to time.

1.17 **QUALITY IMPROVEMENT ACTIVITIES**: the programs, processes, and criteria developed by Regence or Payor to monitor, assess, and improve continually the quality of clinical care and services provided to Members, including Quality Improvement, Utilization Management, quality review, credentialing and recredentialing, Member complaints and grievances, Member satisfaction surveys, medical records review, and preventative health care services.

1.18 **RECREDENTIALING**: a periodic process by which Regence may determine, in its sole discretion, whether Provider may continue participating with Regence.

1.19 **UTILIZATION MANAGEMENT**: a set of formal processes developed by Regence or Payor and described on the Provider Web Site including, but not limited to, preauthorization, case management, medical policy development, and retrospective payment review, that are designed to monitor the use or evaluate the Medical Necessity, appropriateness, efficacy, or efficiency of health care services or procedures performed on or rendered to a Member and/or the appropriateness of the setting in which such services were performed.

II. RELATIONSHIP OF THE PARTIES

2.1 STATUS OF PARTIES. By way of this Agreement, the Provider is a Regence Participating Provider. Provider and Regence are independent contractors. This Agreement is not intended to create an employer-employee partnership or joint venture relationship between Regence and Provider or their respective directors, officers, employees, or agents. Regence shall not have the authority to exercise control or direction over Provider or Provider Services provided to Members pursuant to this Agreement. Nothing in this Agreement or in its performance will be construed to result in any person being the officer, servant, agent, or employee of the other party when such person, absent this Agreement and its performance, would not in law have had such status.

2.2 NON-EXCLUSIVITY. Regence may contract with any hospital, physician, facility, groups of physicians, or other health care professional to become a Participating Provider upon such terms and conditions as Regence deems appropriate, without the prior consultation or approval of Provider. Provider may contract with any other health plan without the prior consultation or approval of Regence, as long as such participation or practice does not preclude Provider from complying with the terms of this Agreement.

2.3 TRADE NAMES, SERVICE MARKS, AND TRADEMARKS. Provider and Regence acknowledge that the other party may be the exclusive owner or licensee of various trademarks, service marks, trade names, logos, and symbols used from time to time by that party in connection with its business, and the goodwill associated therewith (collectively, "Marks"). Neither party shall have the right to use, and shall not use any Marks, or any confusingly similar names or Marks, of the other party for advertising or marketing purposes, except as expressly authorized in writing by the other party. Except for Regence's or Payor's use of Provider and Providers' name(s) to notify Members and others that Provider is a Participating Provider (e.g., through the Regence provider directory) and for payment purposes, each party shall submit any proposed advertisements or marketing materials that refer to, or in any way depict, the other party for approval by the other party in advance of publication.

2.4 PROVIDING SERVICES TO MEMBERS OF PAYORS. Provider agrees that Regence may enter into an agreement with Payors that want access to and use of those provider networks in which Provider participates. Provider authorizes Payors contracting with Regence to offer Provider's services to groups of employees or individuals in accordance with the terms of this Agreement and any Member Contract offered or administered by Payor for the payment of Covered Services. Provider agrees to furnish services to Members of such Payors when those Members utilize Regence 's provider networks in accordance with the same terms and conditions of participation and compensation as apply when such services are furnished to Regence 's Members under this Agreement.

2.5 RELATIONSHIP TO BLUECROSS BLUESHIELD ASSOCIATION. Provider hereby expressly acknowledges its understanding that this Agreement constitutes a contract between Provider and Regence; that Regence is an independent corporation operating under a license from the BlueCross BlueShield Association, an association of independent BlueCross BlueShield Plans (the "Association"), permitting Regence to use the BlueCross and/or BlueShield service marks in Regence's service area; and that Regence is not contracting as an agent of the Association. Provider further acknowledges and agrees that it has not entered into this Agreement based upon representations by any person, entity, or organization other than Regence and that no person, entity, or organization other than Regence shall be held accountable or liable to Provider for any of Regence's obligations to Provider created under this Agreement. This paragraph shall not create any additional obligations whatsoever on the part of Regence other than those obligations created under other provisions of this Agreement.

III. REGENCE OR PAYOR OBLIGATIONS

3.1 PAYMENT. Please refer to the attached state addendum.

3.2 **MEMBER IDENTIFICATION**. Regence will issue identification cards to Regence Members and will make eligibility and benefits information available to Provider via either (a) telephone during normal business hours; or (b) Regence's secure web site twenty-four (24) hours a day, subject to technical difficulties that Regence may experience. Confirmation of coverage by Regence is not a guarantee of payment if it is later determined that a Member was not eligible for benefits on the date of service or if the material supplied for review was inaccurate, incomplete, or misleading.

3.3 **BENEFIT DESIGN / COVERAGE DECISIONS.** Regence, Regence's designee, or the Payor will be solely responsible for Member Contract design and for interpreting the terms of and making final coverage determinations under a Member Contract.

3.4 **PARTICIPATING PROVIDER IDENTIFICATION.** Regence may include Provider in the Participating Provider directories for the Member Contracts and products in which Provider is a Participating Provider, including when Provider is designated a preferred participant, and shall make said directories available to Members.

3.5 **LIABILITY INSURANCE.** Regence will procure and maintain professional and general liability insurance and other insurance, as Regence reasonably determines may be necessary, to protect Regence and Regence's employees against claims, liabilities, damages, and judgments that arise out of services provided by Regence or Regence's employees under this Agreement.

3.6 **LICENSURE.** Regence will maintain, without material restriction, such licensure, registration, and permits as are necessary to enable Regence to lawfully perform this Agreement.

IV. PROVIDER SERVICES AND OBLIGATIONS

4.1 **STANDARD OF CARE.** Provider shall provide only Medically Necessary Covered Services in accordance with (a) the same standard of care, skill, and diligence customarily used by similar physicians in the community in which such services are rendered; (b) the provisions of Regence's quality improvement program; (c) the requirements of applicable law; and (d) the standards of applicable accreditation organizations. Provider agrees to render Medically Necessary Covered Services to all Members in the same manner, in accordance with the same standards, and with the same time availability as offered to other patients. Provider shall ensure that all employees of Provider and all health care professionals and physicians providing services at the Provider's locations meet all applicable state laws and regulations, all applicable legal standards of care, all rules of Provider, and all applicable provisions of this Agreement.

4.2 **COMPLIANCE WITH POLICIES AND GUIDELINES.** Please refer to the attached state addendum.

4.3 **MEMBER IDENTIFICATION.** Provider will request Member identification cards of all patients who present themselves as Members under any Member Contract and will report to Regence any apparent abuse of the privileges of such Member Contract. Regence shall issue identification cards to its Members and will make eligibility and benefits information available to Provider via Regence's secure Provider Web Site.

4.4 **CREDENTIALING/RECREDENTIALING OF PROVIDER.** Provider will comply with Regence Credentialing or Recredentialing criteria then in effect and available in the credentialing section of the Provider Web Site. Except as otherwise required by law or regulation, Provider will also:

a. promptly provide information required by Regence to conduct Credentialing or Recredentialing;

b. notify Regence immediately upon any change in licensure, change in accreditation status, or termination or suspension from any government programs at any time during the term of this Agreement; and

c. notify Regence immediately upon confirmation that Provider is subject to any informal or formal disciplinary orders, decisions, disciplinary actions, or other actions, including but not limited to restrictions, probations, limitations, conditions, and suspensions resulting from Provider's acts, omissions, or conduct.

4.5 REGULATORY COMPLIANCE AND ACCREDITATION. Provider warrants that it is, and at all times during this Agreement will remain, in compliance with all applicable local, state, and federal laws, rules, and regulations, including but not limited to, those (a) regarding licensure, certification, and accreditation; (b) necessary for participation in any government programs; and (c) regulating the operations and safety.

4.6 INSURANCE. Throughout the term of this Agreement, Provider will maintain at Provider's expense general and professional liability coverage in a form and amount as stipulated in accordance with Regence's credentialing criteria. Provider will give Regence a certificate of insurance evidencing such coverage upon request. Provider will give Regence immediate written notice of cancellation, material modification, or termination of such insurance.

If Provider procures one or more claims-made policies to satisfy its obligations under this Agreement, Provider will obtain any extended reporting endorsement ("tail") required to continuously maintain such coverage in effect for all acts, omissions, events or occurrences during the term of this Agreement, without limit or restriction as to the making of the claim or demand.

4.7 CHANGE IN PROVIDER SERVICES OR OTHER INFORMATION. Provider agrees that the following material changes to Provider Services, including but not limited to: (a) discontinuation, reduction, or limitation of Provider Services; (b) expansion of Provider Services through acquisition or implementation of a service, technology, facility, or any type of provider; (c) any change in Provider's ownership, including a change in the facilities and/or providers use of the Provider's tax identification number; and/or (d) a change in Provider's incorporation must be agreed upon in writing by both Parties. Failure to formally incorporate any changes to Provider Services in accordance with this provision will result in non-payment; in such instance, Regence, Payor, and Member shall be held harmless. Provider agrees to provide ninety (90) days advanced written notice to Regence of nonmaterial changes that include but are not limited to (a) a significant change in Provider's management or management company; (b) a filing of any bankruptcy action; or (c) other relevant information regarding Provider's status in the medical community.

4.7.1 Directory Updates. Provider further agrees to comply with Regence policies and procedures related to furnishing information (including but not limited to information on which providers are accepting new patients, the provider's location, contact information, specialty, medical group and any institutional affiliations) necessary to ensure provider directories are up-to-date, accurate, and complete pursuant to federal and state law, including 45 C.F.R. 156.230(b).

4.8 NON-DISCRIMINATION.

4.8.1 Services Provided to Members. Provider will provide Covered Services to Members without regard to race, religion, creed, color, national origin, ancestry, physical handicap, health status, marital status, age, sex, or source of payments. Provider further agrees to provide Covered Services to Members without regard to the Member's enrollment in a health benefit plan as a private purchaser of the plan or as a participant in publicly financed programs of health care services. Provider will include the nondiscrimination provisions of this section in all subcontracts entered into to fulfill its obligations under this Agreement.

4.8.2 Employment. Provider recognizes that as a government contractor with the Federal Employees Health Benefits Program and The Centers for Medicare & Medicaid Services (CMS), Regence is subject to various federal laws, executive orders, and regulations regarding equal opportunity and affirmative action, which may also be applicable to

subcontractors. Consequently, the parties agree that, as applicable, they will abide by the requirements of 41 CFR 60-1.4(a), 41 CFR 60-300.5(a) and 41 CFR 60-741.5(a) and that these laws are incorporated herein by reference. These regulations prohibit discrimination against qualified individuals based on their status as protected veterans or individuals with disabilities and prohibit discrimination against all individuals based on their race, color, religion, sex, sexual orientation, gender identity, or national origin. These regulations require that covered prime contractors and subcontractors take affirmative action to employ and advance in employment individuals without regard to race, color, religion, sex, sexual orientation, gender identity, national origin, protected veteran status or disability. The parties also agree that, as applicable, they will abide by the requirements of Executive Order 13496 (29 CFR Part 471, Appendix A to Subpart A), relating to the notice of employee rights under federal labor laws.

4.9 NOTICE OF ACTIONS. Provider will notify Regence within fifteen (15) business days of the filing of any demand for arbitration or lawsuit against Provider by a Member. Provider will provide Regence with any pertinent information related to such arbitration demands and lawsuits that is requested by Regence. In addition, Provider shall promptly notify Regence of any legal or governmental action initiated against Provider, its employees, or its staff that could affect this Agreement or Provider's performance of this Agreement, including, but not limited to, any action for professional negligence brought by a Member, fraud, or violation of any law or against any license, certification, or accreditation.

4.10 QUALITY MANAGEMENT. Provider shall comply with the requirements of and participate in Regence's and/or other Payor's quality improvement program as specified on the Provider Web Site. Provider will provide quality improvement information pertaining to Provider and Provider's staff to Regence at Regence's request.

4.11 UTILIZATION REVIEW. Regence utilizes processes and systems for Utilization Management and quality management consistent with applicable federal and state laws, to promote adherence to accepted clinical standards and to encourage Participating Providers to avoid unnecessary and/or wasteful costs while acting in a manner consistent with sound medical judgment. To this end, Provider agrees to participate in, and to abide by Regence's Utilization Review, patient management, quality improvement processes and programs, and all other related programs as modified from time to time with respect to all Members as specified on the Provider Web Site.

4.12 REFERRALS. Provider agrees to refer Members only to Participating Providers, regardless of Member Contract, except in cases of an emergency. For the purpose of providing quality care to Members, Provider will notify Regence of any referral to a Non-Participating provider. In the event of referral to any Non-Participating provider and as permitted by law, Regence may hold Provider financially responsible for the cost of any resulting claims.

4.13 INFORMATION AND RECORDS.

4.13.1 Maintenance and Retention of Records. Provider will maintain medical and administrative records related to services provided to Members for a period of ten (10) years from the date of service or such longer period as required by state and federal law for retention of medical records.

Provider shall maintain Member medical records in a format that documents diagnosis, assessment, continuity of care and follow up, in conformity with generally accepted community standards.

Provider will maintain a contemporaneous, written record of all treatment for which payment is requested that supports the diagnosis, shows that the treatment was Medically Necessary and demonstrates that the services were indeed performed by Provider on the date claimed. Any alterations or amendments to these contemporaneous records must include the date and time of the alteration or amendment, be signed by the person making the alteration or amendment, refrain from obliterating or obscuring any prior documentation and be clearly identified and identifiable as an amendment or

alteration. Regence may deny claims in those cases where, in Regence's sole discretion, there is inadequate documentation of the services rendered, in which case Provider shall not bill the Member.

During an audit or review involving Provider's records, such records must be retained until all issues related to the audit are resolved. If the audit results in a good faith determination that the Provider engaged in a pattern of fraudulent or improper billing practice in violation of state law, federal law, or any provision of this Agreement or the Provider Web Site, Provider shall reimburse Regence for its reasonable costs incurred in conducting the audit.

4.13.2 Audit and Access to Records. Provider will provide Regence access to Member medical records, including access to electronic medical records (EMR), and will allow Regence to make or obtain copies of medical and administrative records directly related to services rendered to Members for purposes that may include, but are not limited to: Utilization Management, quality management, Medicare Stars ratings, risk adjustment, appropriateness of billing, Medical Necessity, credentialing and recredentialing, appeals, or other activities necessary to support the administration of a Member Contract or this Agreement. Access to, or copies of, records described in this section, including electronic records, shall be provided at no charge to Regence, Payors, or Members. Additionally, no subscription fee(s) will be assessed for use of the facility's EMR system. If Provider uses a vendor for records acquisition all fees related to a records request, will be the responsibility of the Provider. This provision will survive the termination of this Agreement.

4.13.2.1 Access to Records at Provider Locations. Provider agrees to provide Regence access to records at their location, upon written request by Regence no less than three (3) business days in advance, except when Regence determines there is a significant quality of care issue or risk that the Provider's documents may be altered, created or destroyed. In such case, Provider shall provide Regence with access to locations or records upon twenty-four (24) hours' notice.

4.13.2.2 Record Requests by Regence. Upon written request by Regence, Provider agrees to provide records not otherwise available through access to Provider's EMR within fourteen (14) calendar days of Regence's request for pre-pay reviews. For post-pay audits, Provider agrees to provide records not otherwise available through access to Provider's EMR within thirty (30) days of Regence's request. The request to Provider from Regence and the records submitted from Provider shall include dates of service, name of Member, diagnosis, description of services provided, any supporting documentation, medical and billing records. Records not produced in response to a request for a pre-pay review or a post pay audit within the time frame specified above will be deemed non-existent and will not be processed or paid until all requested records are received. For prepayment reviews or post payment audits, any statutory or contractual requirements for penalties and interest related to late claim payments will be made consistent with the date that Regence received from the Provider all the records that were requested relative to its review/audit. Provider shall send Regence copies of any records requested at no cost to Regence, Payors, or Members. Regence will limit the request to those records necessary to perform the audit.

4.13.2.3 Release of Records. Provider agrees to accept from Regence or its designee, as a legally sufficient release of Members' medical records, Members' participation under a Member Contract, and Regence will not be required to obtain additional medical release from a Member in order to access or make copies of Members' medical records. This provision will survive the termination of this Agreement.

4.13.2.4 Compliance. Record access and review will comply with all laws, statutes, and regulations pertaining to the confidentiality of Member records. These rights shall survive termination of this Agreement. Regence's remedies for the Provider's failure to cooperate with the record access and requests shall include, but not be limited to, one hundred percent (100%) review of Provider's current and future claims and supporting documentation prior to payment; recovery of payments made to Provider for past inappropriately billed claims, including denial of future inappropriately billed claims; and/or immediate termination of Provider's agreements with Regence.

4.14 SUBCONTRACTORS. In the event Provider subcontracts with subcontractors for provision of Covered Services to Members, with the expectation of receiving payment directly or indirectly from Regence, such subcontractors must agree to abide by all appropriate provisions set forth in this Agreement, including, but not limited to, Section 5.9. As applicable under State and/or Federal Law, Regence reserves the right to review, approve, suspend or terminate any subcontracts as they pertain to Covered Services provided to Members.

4.15 PROVIDER DISCRETION. Provider may decline to accept any Member whom Provider has previously discharged from care and may decline to accept a Member for professional reasons. Provider may withdraw from care of a Member when, in their professional judgment, it is in the best interest of the Member to do so.

4.16 PROVIDER-PATIENT RELATIONSHIP. Please refer to the attached state addendum.

4.17 PRIOR AUTHORIZATION. Provider shall obtain prior authorization, when such authorization is required and within the specified time period and in the manner specified on the Provider Web Site, prior to rendering applicable services to Members. Provider shall obtain prior authorization before delivering any services beyond those originally authorized. Except in the event of emergency, Regence is not obligated to compensate Provider for services provided when Provider has not first obtained a required prior authorization or approval from Regence.

4.18 ACCESSIBILITY. Provider will provide or arrange for the provision of Covered Services to Members twenty-four (24) hours a day, seven (7) days per week.

4.19 LABORATORY SERVICES. Upon request by Regence, Provider will provide full laboratory test values and/or data, that support initiatives including, but not limited to, HEDIS measures, Medicare Stars measures, or other quality programs and initiatives at no charge to Regence, Payor, or Member no later than 10 business days following discharge or completion of summaries by attending physicians.

4.20 DATA ACCURACY. Provider agrees to provide Regence with what Provider believes is, to the best of its knowledge, accurate, complete, and truthful claims and encounter data. The claims and encounter data supplied by Provider to Regence will contain International Classification of Diseases, Tenth Revision, Clinical Modification ("ICD-10-CM") diagnosis codes accurately reflecting the diagnoses documented in the accompanying medical record.

4.21 MEMBERS TO BE HELD HARMLESS

4.21.1 Member Hold Harmless. Please refer to the attached state addendum.

4.21.2 Continue Providing Services. Please refer to the attached state addendum.

4.21.3 Member Contract. Please refer to the attached state addendum.

4.21.4 Charges to Members. Please refer to the attached state addendum.

4.21.5 Survival of Termination. Please refer to the attached state addendum.

4.21.6 Provider Contracts with Other Health Care Professionals. Please refer to the attached state addendum.

V. PAYMENT AND BILLING

5.1 PAYMENT FOR COVERED SERVICES. Regence or Payor will reimburse Provider for Covered Services provided to Members in accordance with payment terms set forth and attached to this Agreement. Regence or Payor will not be liable to Provider for payment of applicable Coinsurance, Copayment, or Deductibles or for charges for Provider Services that are determined to be Non-Covered Services. Except as otherwise set forth in Section 5.7, Provider agrees to accept payment, subject to medical and reimbursement policies, as payment in full, whether that amount is paid in whole or in part by the Member, Regence, a Payor, or any combination of third-party Payors that may pay before Regence in the order of benefit determination.

Except as allowed by law, Regence or Payor will not make retroactive denials of Covered Services that were preauthorized or concurrently certified as Medically Necessary unless Regence or Payor finds in good faith that the information supplied for review was substantially inaccurate, incomplete, or misleading, when services submitted on a claim differ from the services approved in the prior-authorization, or the Member was ineligible for Covered Services when the service or supply was provided.

5.2 PAYMENT FOR INELIGIBLE MEMBERS. Except as required by law, neither Regence nor Payor is obligated to make payment to Provider for services provided to any individual who is not, at the time such services are rendered, a duly eligible Member. The fact that an individual possesses an identification card shall not obligate Regence or Payor to pay for or provide coverage if, on the date(s) that such services were rendered, the individual is, or is later found to have been, ineligible for coverage under a Member Contract. Authorization by Regence or Payor to provide services to Members does not guarantee that the Member is eligible for benefits on the date of service and/or that the services furnished are Covered Services under the Member Contract.

5.3 PROMPT PAYMENT OF CLAIMS. Please refer to the attached state addendum.

5.4 COPAYMENTS, COINSURANCE, AND DEDUCTIBLES. Provider will not bill, charge, collect a deposit from, seek remuneration or payment from, or require pre-payment by Members as a condition to rendering Covered Services except for amounts attributable to Copayments, Deductibles, and/or Coinsurance. In the event Provider collects Copayment, Coinsurance, or Deductibles prior to delivery of Covered Services, Provider agrees to refund to Member any overpayments paid by Member within thirty (30) days after receiving a determination of the claim by Regence or Payor. Regence or Payor shall be responsible for only the amount due for Covered Services rendered to a Member less the Member's Copayment, Coinsurance, and/or Deductible, as applicable. Except for infrequent and isolated waivers for charitable purposes, Provider shall charge to and make reasonable attempts to collect from Members all Copayments, Coinsurance and Deductibles. The parties agree that Regence may deny all or part of claims if Provider fails to make a reasonable attempt to collect Copayments, Coinsurance and Deductibles.

5.5 OVERPAYMENTS AND ADJUSTMENTS.

5.5.1 Overpayments. Please refer to the attached state addendum.

5.5.2 Refunds and Adjustments. Please refer to the attached state addendum.

5.6 CLAIM SUBMISSION. Please refer to the attached state addendum.

5.7 COORDINATION OF BENEFITS. Regence and Provider will cooperate to exchange information relating to coordination of benefits with regard to Members and will comply with the following requirements:

5.7.1 Regence or Payor as Primary Payor. When a Member's coverage under Regence or Payor is determined to be primary under applicable coordination of benefits rules, Regence or Payor shall pay Provider in accordance with this Agreement for Covered Services provided to Member without regard for the obligations of any secondary Payors.

5.7.2 Regence or Payor as Secondary Payor. Provider will bill a payor which may be primary under applicable coordination of benefits rules for Covered Services provided to Members when information regarding such primary payor becomes available to Provider and whenever so requested by Regence. Provider will notify Regence when it obtains information regarding such primary payor and will make such information available to Regence. When another payor is primary, Provider will follow that payor's billing rules, including but not limited to the primary payor's limitations on billing. When it is determined that a Member's coverage, under Regence or Payor, is secondary under applicable coordination of benefits rules, Regence or Payor will pay Provider an amount no greater than that which, when added to amounts payable to Provider from other sources under applicable coordination of benefits rules, equals one hundred percent (100%) of Provider's payment for Covered Services pursuant to this Agreement, but may be less as determined by the terms of the Member Contract. Regence will not reimburse claims submitted more than 60 days after payment by the Primary Payor in adherence with CMS regulation or as required by law.

5.8 APPROPRIATE BILLING. Provider agrees to use the most appropriate, current, and specific coding when billing for services rendered. Provider will not engage in misleading billing practices or otherwise interfere with timely and accurate claims adjudication. Such practices include, but are not limited to:

a. Billing for services not rendered by the Provider or entities legally owned and operating under Provider's tax identification number and national provider identifier (NPI);

b. Billing for services that cannot be substantiated from written or electronic medical records;

c. Failing to supply information requested by Regence for claims adjudication;

d. Incorrect coding such as but not limited to MS-DRG, CPT, and Revenue coding;

e. Itemized bills that are not consistent with the electronic claim submission.

5.9 LIMITATIONS ON BILLING MEMBERS. Provider agrees that in no event, including, but not limited to: nonpayment by Regence or Payor, determination that the services furnished were Non-Covered Services; Provider's failure to submit claims within the specified or a regulated time period; Regence or Payor's insolvency; Provider's failure to comply with Regence care management, Utilization Management, and/or quality initiatives, including required pre-authorizations and other administrative requirements or guidelines; denial of payment due to Provider's failure to comply with the terms of this Agreement; and/or, breach of this Agreement by Provider will Provider bill, charge, collect a deposit from, seek compensation, remuneration, or payment from, or have any recourse against a Member or persons acting on behalf of the Member, other than Regence or Payor, for Covered Services provided pursuant to this Agreement, except as described in Section 5.9.1 or unless the Member fails to provide coverage information**.**

This provision will not prohibit collection of the established Deductibles, Copayments, and Coinsurance within the terms of the Member Contract, nor will it prohibit Provider from (a) collecting payment from third-party Payor(s) with primary or secondary responsibility in accordance with Section 5.7, or (b) collecting payment from Members for Non-Covered Services or not Medically Necessary services in accordance with Section 5.9.1.

5.9.1 Limitations on Billing Members for Not Medically Necessary or Non-Covered Services. Provider may bill a Member for Non-Covered Services or not Medically Necessary services, as determined by Regence, Payor, or their designees, only after obtaining appropriate written Member Consent, which lists the specific service, at least twenty-four (24) hours in advance of Provider Services being provided. Neither Regence nor Payor shall be liable for any amounts associated with services or supplies that are determined by Regence, Payor, or their designees to be Non-Covered Services or not Medically Necessary services. Provider may not bill Members for services that are

deemed to be not Medically Necessary or Non-Covered through an adverse determination in any of Regence's appeal processes. In no event will Regence or Payor be responsible for any amount owed by Member to Provider for Non-Covered Services in the event that Provider is unable to collect such amount from Member.

5.9.1.1 Member Consent. At a minimum, the written Member Consent must include the following information: Member name, specific service or supply, expected date of service, condition and diagnosis, a statement informing the Member that the service or supply may be a Non-Covered Service or not Medically Necessary service, an estimation of the cost of the service, and a statement in which the Member agrees to pay for the Non-Covered Service or not Medically Necessary service. The written Member Consent must be signed by the Member, Member's guardian, or Member's authorized health care representative and maintained in the Provider's records. Provider agrees not to bill Regence, Payor, or Member any amount owed for not Medically Necessary or Non-Covered Services or supplies if Provider fails to obtain written Member Consent.

5.9.2 CONTINUATION OF LIMITATIONS. Provider agrees that (a) the provisions in Section 5.9 shall survive termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Members; and (b) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between the Provider and Member, or persons acting on behalf of the Member.

5.10 PROVIDER NETWORKS. Provider agrees to provide Covered Services to any Member under any Provider Network in which Provider participates pursuant to the terms of this Agreement and any addenda or exhibits attached hereto. Nothing in this Agreement gives Provider the right to participate in any new provider networks or lines of business developed by Regence.

VI. CONFIDENTIALITY

6.1 CONFIDENTIAL AND PROPRIETARY INFORMATION. As used in this Agreement, "Regence Confidential and Proprietary Information" means: (a) proprietary information of Regence in whatever form (hard-copy, electronic, on-line, encoded disk, etc.); (b) information marked or designated by Regence as confidential or proprietary; (c) claims and health information that Regence treats as confidential, including raw claims data, claim data extracts, utilization information, and health information specific to a particular Member or his/her dependents; (d) the names, addresses, and telephone numbers of all Members and employer groups; (e) this Agreement; and (f) other information provided by Regence, which Regence is obligated to keep confidential. "Regence Confidential and Proprietary Information" excludes any information now or hereafter voluntarily disseminated by Regence to the public, which otherwise becomes part of the public domain through lawful means, or which is required to be disclosed by or to a government agency publicly.

As used in this Agreement, "Provider Confidential and Proprietary Information" means (a) information related to an arbitration proceeding; (b) this Agreement; and (c) information marked or designated by Provider as confidential or proprietary. Provider Confidential and Proprietary Information excludes any information now or hereafter voluntarily disseminated by Provider to the public, which otherwise becomes part of the public domain through lawful means, or which is required to be disclosed by or to a government agency publicly.

Regence Confidential and Proprietary Information and Provider Confidential and Proprietary Information collectively shall be hereafter referred to as "Confidential and Proprietary Information." Confidential and Proprietary Information may be used by Provider and Regence as follows:

a. For patient care;

b. For populating a Member's personal health record;

c. For administrative, payment, and/or management functions, including, but not limited to, medical review, quality management, provider Credentialing, and peer review; and

d. For purposes of reviewing Provider's catastrophic expenses and billing Provider's catastrophic reinsurance carrier.

6.2 NON-DISCLOSURE AND NON-USE. Each party recognizes and acknowledges that it shall, in fulfilling its obligations under this Agreement, necessarily become conversant with the other party's Confidential and Proprietary Information that is not generally available to the public and that except as otherwise allowed by law or this Agreement, it would be irreparably damaging to the relevant party and its affiliates, employees, representatives, or agents to disclose such Confidential and Proprietary Information. Either party may seek relief for breach of this Agreement.

Provider agrees that unless required by law or permitted pursuant to applicable provisions of 45 CFR parts 160 and 164, Provider shall not disclose any Regence Confidential and Proprietary Information without the prior written consent of Regence. In the event Provider's employees have the need to know such Regence Confidential and Proprietary Information for the limited purpose of performing the obligations under this Agreement, Provider shall first inform each employee of the confidential nature of the information and the relevant terms of this Agreement related to confidentiality. In the event Provider obtains consulting services from a third party that has access to this Agreement, Provider shall obtain a written confidentiality statement signed by the third party acknowledging its written agreement to be bound to the confidentiality terms of this Agreement and provide a copy to Regence within ten (10) business days.

6.3 SAFEGUARD OF CONFIDENTIAL AND PROPRIETARY INFORMATION. Each party agrees to exercise no less care in safeguarding the other party's Confidential and Proprietary Information against loss, theft, or other inadvertent disclosure than the party exercises in safeguarding the confidentiality of its own Confidential and Proprietary Information. In no event shall either party use less than reasonable care in safeguarding the other party's Confidential and Proprietary Information.

6.4 CONFIDENTIALITY OF MEDICAL RECORDS. Provider will maintain the confidentiality of information contained in Members' medical records including Member identifiable information and will only release such records: (a) to Regence upon request and as is necessary to comply with the terms of this Agreement; (b) subject to applicable laws; (c) as necessary to other providers treating the Member; (d) to Provider's medical review committees; or (e) with the consent of the Member.

6.5 RATE INFORMATION. Notwithstanding the above, Regence may disclose to Participating Providers the information and data required to allow those Participating Providers to effectively manage the quality, care, and cost of Members Regence has attributed to them.

6.5.1 Disclosure of Rates to Members. Notwithstanding any other provision of this Agreement to the contrary, either party may disclose to Members the Member's actual or estimated cost-sharing amount (e.g., Copayment, Deductible, and/or Coinsurance) for a Covered Service, to explain claims payment and to facilitate informed decisions regarding health care services use and cost. The parties understand that in some cases, the cost-sharing amount may be equal to the allowed amount for services under the Agreement.

6.6 THIRD-PARTY SERVICES. In the event Provider utilizes any third-party service provider in any matter that involve claims data or any Provider or Regence Confidential and Proprietary information, Provider shall ensure that such third party executes a business associate agreement and complies with all applicable state and federal laws that relate to privacy. In addition, Provider shall be responsible for notifying Regence of the name and address of any third-party service providers that, in performing Provider duties, are given access to any Provider or Regence Confidential and Proprietary Information and that the third-party service provider has the authority to act on behalf of the Provider. If Provider changes such third-party service provider, Provider shall notify Regence of the change within ten (10) business days.

6.7 **SURVIVAL.** The obligations set forth in this Article VI will survive the termination of this Agreement and shall continue for so long as either party possesses any of the other party's Confidential and Proprietary Information, regardless of the reason, or lack thereof, for termination of this Agreement.

VII. TERM AND TERMINATION

7.1 **TERM.** The "Initial Term" of this Agreement shall be one (1) year from the Effective Date of this Agreement. Thereafter, this Agreement shall continue from year to year unless terminated.

7.2 **TERMINATION WITHOUT CAUSE.** This Agreement, or participation in any provider network addendum attached thereto, may be terminated without cause by either party, after the Initial Term, with at least one hundred and twenty (120) days' advance written notice to the other party, in accordance with Section 9.3. This option may be exercised by either party for any reason and does not require either party to establish or prove that there is cause for the termination or to disclose the basis of its decision to the other party. Both parties agree to accept the other's decision on termination as final, without recourse to further external, internal, judicial, or arbitral process. In the event of a termination, the parties shall have no right to claim and do hereby waive and release any claim for damages that may result from or arise out of that termination, other than any claim that the parties may have for Covered Services rendered to Members prior to the effective date of the termination.

7.3 **TERMINATION FOR CAUSE.** This Agreement may be terminated for cause due to a breach of any material term, covenant or condition at any time by either party upon at least thirty (30) days' prior written notice of such termination, in accordance with Section 9.3. Such notice shall specify the reason(s) for termination. The other party shall be provided thirty (30) days from the date of receipt of the notice of termination to correct the breach to the satisfaction of the party requesting termination. The thirty (30) day cure period may be extended upon mutual written consent of both parties. Should the breach not be corrected within the thirty (30) day cure period or any agreed upon extensions to the cure period, this agreement will terminate.

7.4 **IMMEDIATE TERMINATION.** Notwithstanding any other provision of this Agreement, Regence may terminate this Agreement immediately upon notice to Provider, in accordance with Section 9.3, in the case of any of the following:

7.4.1 Expiration, suspension, restriction, revocation, or non-renewal of required federal, state, or local licensure or certificates that would affect the provision of Covered Services to Members.

7.4.2 Expiration, suspension, restriction, revocation, or non-renewal of Regence's licensure that would affect the ability of Regence to conduct the business of administering and funding Member Contracts.

7.4.3 Continued participation under this Agreement may adversely affect the health, safety or welfare of any Member.

7.4.4 Failure to maintain liability insurance, in amounts required by Regence's credentialing criteria.

7.4.5 Failure to comply completely with Regence Credentialing or Recredentialing standards or procedures then in effect.

7.4.6 Debarment, suspension, or exclusion of Provider from any government-sponsored program.

7.4.7 Deliberate misrepresentation or falsifying any information supplied by Provider to Regence, including but not limited to medical record information.

7.4.8 Engagement in fraud or deception or knowingly permitting fraud or deception by another, in connection with Provider's obligations under this Agreement.

7.4.9 Any final legal or governmental action against Provider which impairs Provider's ability to carry out its duties and obligations under this Agreement.

7.4.10 Failure to comply with Regence's care management programs, Utilization Management, and Quality Improvement Activities.

7.4.11 Failure to comply with the provisions of this Agreement regarding the limitations on billing Members.

7.4.12 Any action or communication that fundamentally undermines or could fundamentally undermine the confidence of Members, potential Members, their employers, unions, physicians, other health care professionals, or the public in Regence or in the quality of care provided to Members.

Any termination under this provision may be appealed by Provider in accordance with Article VIII of the Agreement.

7.5 CONTINUATION OF SERVICES. Upon termination of this Agreement, Regence and Payor will direct Members to Participating Providers. Provider's obligation to provide Covered Services in accordance with the terms of this Agreement to Members will continue for a period of twelve (12) months following the termination effective date ("Continuation Period"). During this Continuation Period, the payment terms defined in the current Attachment A to this Agreement shall prevail. Continuation of Services may not be applied to providers who retire and permanently close their practice, or no longer render services in Regence's service area.

7.6 OBLIGATION TO COOPERATE. Upon notice of termination, and in accordance with Section 7.5 above, Providers will cooperate with Regence in the orderly transfer of Members' care, including the provision of copies of records to other Participating Providers, at no charge to Regence, Payors or Members. The parties will cooperate on promptly resolving any outstanding financial, administrative, or patient care issues upon the termination of this Agreement. This provision will survive termination of this Agreement. Notwithstanding anything in this Agreement to the contrary, either party may seek damages for breach of this provision.

7.7 NOTICE TO MEMBERS. Upon notice of termination of this Agreement, Regence will provide notice of the impending termination to Members currently under the treatment of Provider. In the event of immediate termination, Regence will notify its Members as soon as is practical of Provider's termination. Provider agrees to refrain from any action that interferes with the relationship between Regence and its existing or prospective Members or Participating Providers.

VIII. DISPUTE RESOLUTION

8.1 MEMBER COMPLAINTS. Provider agrees to cooperate fully with Regence in the investigation and resolution of Member complaints and grievances concerning health care services provided under this Agreement. Upon request, Provider will furnish Regence with a copy of its procedures for handling Member complaints.

8.2 INTERNAL PROVIDER APPEAL PROCESSES. Please refer to the attached state addendum.

8.3 POST-APPEAL PROCESSES. Please refer to the attached state addendum.

8.4 FAILURE TO TIMELY APPEAL. If the disputing party (i.e., the party that requests or initiates the post-appeal process) fails to request or initiate a post-appeal process as required by this Agreement, and within the time frames prescribed in this Agreement, Regence's last determination on the disputed issue(s) shall be deemed final and binding. In addition, the disputed issue(s) shall be conclusively deemed to have been waived by the disputing party and shall not be the subject of any further post-appeal process. Once the decision is deemed final,

nothing in this Agreement shall prevent the prevailing party from pursuing remedies available to it, including without limitation a judicial remedy, to collect any amounts owed to it by the other party. Also, nothing in this Agreement shall prevent a party from asserting defenses, claims, causes of action, or demands in response to a post-appeal process initiated by the disputing party. This provision shall survive termination of this Agreement.

8.5 PRECEDENTIAL EFFECT OF DECISIONS. The parties agree that any disputes that arise under this Agreement shall be considered independently and on their own merits without regard for any other determination made by a third party through one of the post-appeal processes or by Regence through the internal provider appeal process or otherwise. The parties agree that none of the determinations made under this Agreement through one of the dispute resolution processes described above shall be used as precedent for other disputes that may arise between Regence and any Participating Provider or between Regence and any third party. This provision shall survive termination of this Agreement.

IX. GENERAL PROVISIONS

9.1 AMENDMENTS WITH NOTICE. Regence may amend this Agreement by providing ninety (90) days' prior written notice to Provider in accordance with Section 9.3.2. If Provider objects to the amendment, Provider may terminate the Agreement by giving Regence written notice no later than thirty (30) days after receipt of the written notice of the amendment. Said termination shall be effective at the end of the ninety (90) day notice period, unless within sixty (60) days of the date of the notice of amendment, Regence gives Provider written notice that it will not implement the amendment. Regence reserves the right to update any document, attachment or addendum to this Agreement to restate Provider's network participation status and will provide such notice with no less than ninety (90) days' prior written notice to Provider.

9.2 AMENDMENTS REQUIRED BY LAW. If state or federal laws or regulations require a change to any provision of this Agreement, this Agreement will be deemed amended to conform to the law or regulation on the date the law or regulation becomes effective. Regence will use reasonable efforts to provide Provider prior written notice of such changes.

9.3 NOTICES AND COMMUNICATION BETWEEN THE PARTIES.

9.3.1 Notices/Communications Containing Confidential and/or Protected Health Information. If a notice or communication includes information that is confidential and proprietary information to either or both parties and/or that includes Protected Health Information ("PHI") as defined under Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 201 et seq.), then the following restrictions must be observed when communicating such information.

a. U.S. mail/certified mail/overnight delivery—No additional requirements.

b. Provider Web Site—Not a permitted method of notice or communication for confidential information and PHI, unless the web site is secured or the information is appropriately encrypted.

c. Electronic mail—Not a permitted method of notice or communication for confidential information and PHI, unless the electronic mail is secured or the information is appropriately encrypted.

d. Facsimile Transmission—The information must be prefaced by a formal cover sheet noting the confidentiality of such information.

9.3.2 All Other Notices. Notices and communications between the parties, which are necessary for the proper administration of this Agreement, will be communicated via regular U.S. mail, Provider Web Site or electronic mail, and when applicable, in accordance with Section 9.3.1, with the exception of notices related to termination or

requests for mediation or arbitration, which must be sent via certified mail, return receipt requested to the address defined in Section 9.3.4.

9.3.3 When Made. Notices and communications will be deemed to have been made on the date of certified delivery, date postmarked, or electronically date stamped based on the method of notice specified in Section 9.3.

9.3.4 Address for Notices. Notices and communications required under this Agreement to Provider shall be sent to: (a) the postal address of Provider's billing service location; or (b) the electronic mail address designated by Provider for electronic notices, indicated on the signature page of this Agreement. Notices to Regence shall be sent to the Contract Notice address listed in the Contact Us section of the Provider Web Site.

9.3.4.1 Notice of Change in Regence Address. Regence agrees to provide ninety (90) days' advance written notice to Provider of a change in Regence's mailing address.

9.3.4.2 Notice of Change in Provider Address. Provider agrees to provide ninety (90) days' advance written notice to Regence of a change in: (a) Provider's physical address, (b) Provider's billing address, and/or (c) Provider's electronic mail address.

9.4 USE OF NAME. Provider consents to the use of Provider's name and other identifying and descriptive material in provider directories. Provider consents to Regence's use of Provider's name on Regence's web site, directories, or lists to identify Provider as contracted. Any other use of Provider's name and other identifying and descriptive material by Regence requires review and written approval by Provider prior to use. Any use of Regence's names, logos, trademarks, or service marks in promotional materials or similar use requires review and written approval by Regence prior to use. Regence consents to Provider's use of Regence's name on Provider's web site, directories, or lists to identify Regence as a health plan with whom Provider is contracted.

9.5 INDEMNIFICATION. To the extent not otherwise inconsistent with the laws of the relevant jurisdiction, each party will indemnify and hold harmless the other and its officers, directors, agents, and employees, individually and collectively, from all fines, claims, demands, suits, or actions of any kind or nature arising by reason of the indemnifying party's negligent or intentional acts or omissions in the course of its performance of its obligations under this Agreement.

9.6 SEVERABILITY. If any provision of this Agreement is determined unenforceable in any respect, the enforceability of the provision in any other respect and of the remaining provisions of this Agreement will not be impaired.

9.7 BANKRUPTCY. If bankruptcy, receivership, or liquidation proceedings are commenced with respect to any party hereto, and if this Agreement has not otherwise been terminated, then a non-filing party may suspend all further performance of this Agreement pursuant to Section 365 of the Bankruptcy Code or any similar or successor provision of federal or state law. Any such suspension of further performance by a non-filing party will not be a breach of this Agreement and will not affect the non-filing party's right to pursue or enforce any of its rights under this Agreement or otherwise.

9.8 ASSIGNMENT. Neither party shall assign any rights or delegate any obligations hereunder without the written consent of the other party, provided, however, that any reference to Regence herein shall include any successor in interest and that Regence may assign its duties, rights, and interests under this Agreement in whole or in part to a Regence affiliate or may delegate any and all of its duties to a third party in the ordinary course of business.

9.9 WAIVER OF BREACH. Waiver of a breach of any provision of this Agreement will not be deemed a waiver of any other breach of that same or different provision. No party will be deemed to have waived that party's rights under this Agreement unless the waiver is made in writing and signed by the waiving party's duly authorized representative.

9.10 FORCE MAJEURE. Neither party will be deemed to be in violation of this Agreement if it is prevented from performing its obligations by events beyond its control, including, without limitations, acts of God, war, or insurrection, terrorism, flood or storm, strikes, or rule or action of the government or agency. The parties shall make a good faith effort, however, to assure Members have access to services consistent with applicable law, despite such events.

9.11 GOVERNING LAW / VENUE. Please refer to the attached state addendum.

9.12 ENTIRE AGREEMENT/SUPERSESSION. This Agreement and its exhibits, attachments, amendments and addenda constitute the entire Agreement between the parties with regard to the subject matter herein and supersede any prior written or oral agreements between the parties or their affiliates with regard to the same subject matter.

9.13 CHANGES TO MEMBER CONTRACTS. Regence or Payor may change, revise, modify or alter the form and/or content of any Member Contract without prior approval and/or notice to Providers. Notwithstanding any other provision of this Agreement, nothing in this Agreement shall be construed to modify the rights and benefits contained in the Member Contract.

9.14 AUTHORITY TO BIND PROVIDERS. Each of the persons executing this Agreement on behalf of Regence and Provider represents and warrants that he or she has the authority to bind his or her respective principals and affiliates listed in Attachment B as applicable and that the respective Parties have the full authority to bind all relevant parties, agents, and affiliates to the terms referenced in this Agreement.

IN WITNESS WHEREOF, the undersigned have executed this Agreement by their duly authorized officers, intending to be legally bound hereby.

UNDER PENALTIES OF PERJURY, I (Provider) certify that:

1. The number(s) shown on this form or otherwise set forth on a subsequent Attachment to this Agreement is/are the correct taxpayer identification number (or Provider is waiting for a number to be issued), **and**
2. Provider is not subject to backup withholding **(a)** exempt from backup withholding, or **(b)** have not been notified by the Internal Revenue Service (IRS) that Provider is subject to backup withholding as a result of a failure to report all interest or dividends, or **(c)** the IRS has notified Provider that it is no longer subject to backup withholding.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

POLK COUNTY PUBLIC HEALTH	**REGENCE BLUECROSS BLUESHIELD OF OREGON**
	
Signature of Authorized Representative	Signature of Authorized Representative
	Gillian Hays, VP Network Management
Print Name	Name and Title of Authorized Representative
Title	
Date	Date

Name of Provider as it corresponds to this Taxpayer Identification Number

936002310

Taxpayer Identification Number

Email Address

REGENCE BLUECROSS BLUESHIELD OF OREGON
PARTICIPATING PROFESSIONAL SERVICES AGREEMENT
OREGON STATE ADDENDUM

This Addendum to the Participating Professional Services Agreement (the "Agreement") is entered into and made part of the Agreement between Regence BlueCross BlueShield of Oregon ("Regence") and **POLK COUNTY PUBLIC HEALTH** ("Provider"), to recognize additional provisions that apply to Member Contracts sponsored, issued or administered by, or accessed through Regence that may be subject to regulation under Oregon law; and for which Oregon laws may control.

Regence and Provider each agree to be bound by the terms and conditions contained in this Addendum. In the event of a conflict or inconsistency between this Addendum and any term or condition contained in the Agreement, this Addendum shall control. This Addendum will be deemed to be updated to incorporate any changes to the laws and regulations referenced herein, effective as of the date of such changes. Except as specifically amended herein, all terms and conditions of the Agreement remain in effect.

The referenced section of the Agreement is deleted in its entirety and replaced with the following:

1.7 MEDICALLY NECESSARY or MEDICAL NECESSITY: Health care services or supplies that a physician or other health care professional, 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; (c) not primarily for the convenience of the patient, physician, or other health care professional; and (d) not more costly than an alternative service or sequence of services or supplies that are 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. For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in applicable peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations, and the views of physicians and other health care professionals practicing in relevant clinical areas and any other relevant factors.

The referenced section of the Agreement is deleted in its entirety and replaced with the following:

3.1 PAYMENT. Regence or Payor will compensate the Provider for Medically Necessary Covered Services provided to Members in accordance with this Agreement and Regence's or Payor's claims payment policies.

The referenced section of the Agreement is deleted in its entirety and replaced with the following:

4.2 COMPLIANCE WITH POLICIES AND GUIDELINES. Provider will comply with rules, guidelines, policies, and procedures whether outlined in this Agreement, or Provider Web Site. To the extent of any inconsistency between this Agreement and the Provider Web Site, this Agreement shall control. Regence may revise the rules, guidelines, policies, and procedures with sixty (60) days' notice. If Provider objects to a change in rules, guidelines, policies, and procedures on the Provider Web Site, Provider may elect to terminate this Agreement pursuant to Article VII of this Agreement.

The referenced section of the Agreement is deleted in its entirety and replaced with the following:

4.16 PROVIDER-PATIENT RELATIONSHIP. Providers will maintain the provider-patient relationship with Members, and Providers will be solely responsible for medical advice to and treatment of Members and for the provision of all health care services set forth in the Member Agreement, in accordance with accepted professional standards and practices. Providers may freely communicate with Members regarding available treatment options, including medication treatment options, regardless of benefit limitations or exclusions in the applicable Member Agreement.

The referenced section of the Agreement is deleted in its entirety and replaced with the following:

4.21.1 Member Hold Harmless. Provider hereby agrees that in no event, including, but not limited to, nonpayment by Regence, Regence's insolvency, or breach of this Agreement, will Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Member or person acting on their behalf, other than Regence, for services provided pursuant to this Agreement. This provision does not prohibit collection of Deductibles, Coinsurance, Copayments, and/or payment for Non-Covered Services, which have not otherwise been paid by a primary or secondary carrier in accordance with regulatory standards for coordination of benefits, from Members in accordance with the terms of the Member's Member Contract.

The referenced section of the Agreement is deleted in its entirety and replaced with the following:

4.21.2 Continue Providing Services. Provider agrees, in the event of Regence's or Payor's insolvency, to continue to provide Covered Services as promised in this Agreement to Members under the Provider's care until the greater of (i) the Member's discharge from inpatient facilities; or (ii) the duration of the period for which premiums on behalf of the Member were paid to Regence or Payor. The provision of such services and the payment to Provider for these services will be subject to the applicable terms of this Agreement and on the same basis as those services provided prior to insolvency.

The referenced section of the Agreement is deleted in its entirety and replaced with the following:

4.21.3 Member Contract. Notwithstanding any other provision of this Agreement, nothing in this Agreement shall be construed to modify the rights and benefits contained in the Member Contract.

The referenced section of the Agreement is deleted in its entirety and replaced with the following:

4.21.4 Charges to Members. In no event will the charge to a Member for Deductibles, Coinsurance or Copayments exceed the amounts established by Regence or Payor, subject to the terms of the "Coordination of Benefits" section of the Agreement.

The referenced section of the Agreement is deleted in its entirety and replaced with the following:

4.21.5 Survival of Termination. Provider further agrees that (i) the above provisions will survive termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Members, and (ii) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between the Provider and Member or persons acting on their behalf.

The referenced section of the Agreement is deleted in its entirety and replaced with the following:

4.21.6 Provider Contracts with Other Health Care Professionals. If Provider contracts with other health care providers who agree to provide Covered Services to Members of Regence or Payor with the expectation of receiving payment directly or indirectly from Regence or Payor, such providers must agree to abide by the above provisions.

The referenced section of the Agreement is deleted in its entirety and replaced with the following:

5.3 PROMPT PAYMENT OF CLAIMS. Regence will pay or deny clean claims in accordance with the prompt payment rules set forth in applicable Oregon state law. If Regence requires additional information to process a claim, Provider will provide such information at no charge. Once the additional information is received by Regence, Regence will process the claim in accordance with the standards required by state law. For purposes of this Section 5.3, a "clean claim" means a claim under a Member Contract that has no defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment.

To the extent required by Oregon state law, Regence will pay simple interest at the rate of one percent (1%) per month on payable clean claims not paid by Regence within thirty-one (31) days of receipt. Such interest will be calculated based on the amount to be paid to Provider for the Covered Services and will be added to Provider's payment without further claim submission from Provider. Notwithstanding the foregoing, neither Regence nor Payor will be subject to interest, penalties, or late fees that may be established by Oregon state law for clean claims for Covered Services provided to Members pursuant to a Member Contract with, or on behalf of, the federal government or otherwise pursuant to federal law, including, but not limited to, those under the Federal Employees Health Benefits Program, Medicare, and self-funded health plans.

The referenced section of the Agreement is deleted in its entirety and replaced with the following:

5.5.1 Overpayments. Regence or Payor may request a refund from Provider of a payment previously made to satisfy a claim within eighteen (18) months after the date that the payment was made or, in the case of a claim involving the coordination of benefits, within thirty (30) months of such date. Any such request must be in writing and must specify why Regence or Payor believes that Provider owes the refund. In the case of a claim involving the coordination of benefits, the request must include the name and mailing address of the other entity that has primary responsibility for payment of the claim. If Provider fails to contest a refund request in writing to Regence or Payor within thirty (30) days of receiving the request, the request is deemed accepted and Provider must pay the refund within thirty (30) days after the request is deemed accepted. If Provider has not paid the refund within thirty (30) days after the request is deemed accepted, Regence or Payor may recover the amount through an offset to a future claim. The parties agree that this Section does not apply in cases of fraud.

The referenced section of the Agreement is deleted in its entirety and replaced with the following:

5.5.2 Refunds and Adjustments. Provider may request additional payment from Regence or Payor to satisfy a claim within eighteen (18) months after the date that the claim was denied or payment intended to satisfy the claim was made or, in the case of a claim involving the coordination of benefits, within thirty (30) months of such date. Any such request must be in writing and must specify why Provider believes that Regence or Payor owes the additional payment. In the case of a claim involving the coordination of benefits, the request must include the name and mailing address of any entity that has disclaimed responsibility for payment of the claim. The original claims decision will be final and binding unless Provider requests additional payment within the eighteen (18) or thirty (30) month time periods, as applicable. The parties agree that this Section does not apply in cases of fraud.

The referenced section of the Agreement is deleted in its entirety and replaced with the following:

5.6 CLAIM SUBMISSION. Provider agrees to submit claims for Covered Services electronically, as prescribed by Regence, CMS regulation or as required by law. Claims shall be submitted within ninety (90) days of the date of service or as otherwise required by law. Except as otherwise set forth in Section 5.7, claims not submitted within the specified time frame(s) shall be disallowed and the Provider shall not bill the Member, Regence or Payor for services or supplies associated with such claims. Provider shall not bill Regence for more than Provider's usual and customary fee for the services rendered, nor shall Provider bill services provided to Members with health care coverage at a rate higher than Provider bills services provided to Members without health care coverage.

The referenced section of the Agreement is deleted in its entirety and replaced with the following:

8.2 INTERNAL PROVIDER APPEAL PROCESSES. Regence shall maintain one or more internal provider appeal processes to adjudicate disputes that may arise between a Participating Provider and Regence. Regence's internal provider appeal processes are set forth on the Provider Web Site, which is incorporated herein by reference. Unless otherwise indicated herein or in the Provider Web Site, the Participating Provider must exhaust the applicable provider appeals process before initiating any of the post-appeal processes set forth herein.

If the Participating Provider submits a dispute to the internal provider appeal process, and Regence fails to render a timely decision based on the time frames described in the Provider Web Site, Provider may bypass the provider appeal process and proceed directly to one or more of the post-appeal processes described below.

The referenced section of the Agreement is deleted in its entirety and replaced with the following:

8.3 POST-APPEAL PROCESSES. If, after the exhaustion of the applicable internal provider appeal process, either party is dissatisfied with the outcome of the internal provider appeal and wants to further dispute the issue(s), the disputed issue(s) must be submitted to one or more of the processes as described below. Any prerequisites to initiating one of the processes described below must be met before the process can be initiated.

8.3.1 Binding External Review. For disputes that have exhausted the billing dispute and Medical Necessity/investigational procedure appeal process, the Participating Provider may elect to resolve the disputed issue(s) by binding external review, if certain conditions are met. In all cases, if a dispute is submitted to external review, the decision of the external reviewer is binding and is the final decision on the disputed issue. Disputes submitted to external review shall not be submitted to mediation or arbitration as provided herein. A description of the external review process and any prerequisites to initiating the external review process can be found on the Provider Web Site. Disputes that do not meet the criteria to be submitted to binding external review may be submitted to binding external review only upon mutual written agreement of the parties.

8.3.2 Mandatory Non-Binding Mediation. For disputes that have not been or cannot be submitted to external review, the disputed issue(s) must be submitted to mandatory non-binding mediation prior to seeking arbitration. Mandatory non-binding mediation must be requested within sixty (60) days following the date of Regence's decision on Provider's last internal provider appeal. Where Provider is allowed to bypass the internal provider appeal process as provided herein, mandatory non-binding mediation must be requested within sixty (60) days from the last day Regence has to timely respond to a dispute. Provider and Regence shall each bear their own costs of mediation and shall split equally the costs of the third-party mediator.

8.3.3 Binding Arbitration. If, after exhausting Regence's internal provider appeals process and mandatory non-binding mediation, either party is still dissatisfied with the outcome and wants to further dispute the issue(s), the disputed issue(s) must be submitted to binding arbitration. Such arbitration must be initiated by making a written demand for arbitration on the other party. The demand for arbitration must identify all issues on which the party seeks arbitration, the contractual provisions on which the party relies, the amount in dispute, and the relief requested.

The arbitration shall be conducted in a city within reasonable distance of both parties and mutually agreed upon by both parties. The parties agree that the dispute shall be submitted to one (1) arbitrator mutually selected by the parties. If the parties cannot agree on an arbitrator, they shall obtain a list of ten (10) possible arbitrators from a neutral source, such as the Judicial Arbitration and Mediation Services (JAMS), and shall strike arbitrators from the list in turn, beginning with the party who won a coin toss, until only one arbitrator remains. The remaining arbitrator shall hear the dispute. The parties shall share equally the fee of the arbitrator, excluding the filing fee, if any, incurred in commencement of the proceeding. The parties shall have the right to make substantive motions. The arbitrator shall be bound by applicable federal and state law and shall render a written decision within thirty (30) days of the hearing. The arbitrator shall award the prevailing party any applicable filing fees and arbitrator's fees paid by the prevailing party. The arbitrator also may award the prevailing party attorneys' fees and costs associated with the arbitration proceeding. Judgment upon an award rendered by the arbitrator may be entered in any court having jurisdiction thereof.

The referenced section of the Agreement is deleted in its entirety and replaced with the following:

9.11 GOVERNING LAW / VENUE. This Agreement is governed by the laws of the State of Oregon, without giving effect to any conflict-of-law principle that would result in the laws of any other jurisdiction governing this Agreement. Any action, suit, or proceeding arising out of the subject matter of this Agreement will be litigated in courts located in Multnomah County, Oregon. Each party consents and submits to the jurisdiction of any local, state, or federal court located in Multnomah County, Oregon.

REGENCE BLUECROSS BLUESHIELD OF OREGON
DATA ACCESS, USE, AND TRANSFER ADDENDUM

This Addendum ("Addendum"), effective ("Effective Date") is entered into by and between Regence BlueCross BlueShield of Oregon ("Regence") and **POLK COUNTY PUBLIC HEALTH**, and each entity set forth on Attachment B as applicable (collectively "Provider").

As part of the Agreement, Regence will disclose to Provider Regence Confidential and Proprietary Information, defined below, provided that the Provider agrees to the following terms of this Addendum.

I. DEFINITIONS

1. **CONFIDENTIAL AND PROPRIETARY INFORMATION.** As used in this Addendum, "Regence Confidential and Proprietary Information" means: (a) proprietary information of Regence in whatever form (hard-copy, electronic, on-line, encoded disk, etc.); (b) information marked or designated by Regence as confidential or proprietary; (c) claims and health information that Regence treats as confidential, including raw claims data, claim data extracts, utilization information and health information specific to a particular Member or his/her dependents; (d) the names, addresses and telephone numbers of all Members and employer groups; (e) this Agreement; and (f) other information provided by Regence, which Regence is obligated to keep confidential. "Regence Confidential and Proprietary Information" excludes any information now or hereafter voluntarily disseminated by Regence to the public, which otherwise becomes part of the public domain through lawful means, or which is required to be disclosed by or to a government agency publicly.

2. **PERSON** means any natural person, corporation, limited liability company, partnership, trust, organization, association or other entity, including any government entity.

3. **REPRESENTATIVES** means directors, officers, managers, employees, partners, affiliated entities (i.e., an entity controlling, controlled by, or under common control with either Regence or Provider), subcontractors, agents, consultants, advisors and other authorized representatives.

4. **SECURITY INCIDENT** means the HIPAA Security Rule which defines a security incident as an attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

II. PROVIDER OBLIGATIONS

1. **Purpose and Use.** The Provider will hold the Regence Confidential and Proprietary Information in confidence and will use the Regence Confidential and Proprietary Information for the sole and limited purpose for which it was disclosed, namely, providing the services set out in the Agreement ("Purpose"). Provider shall make reasonable efforts to use, disclose and request only the minimum amount of Regence Confidential and Proprietary Information necessary to accomplish the intended purposes of the use, disclosure, or request. The Provider agrees to implement and follow appropriate minimum necessary policies in the performance of its obligations under the Agreement.

   Without limiting the foregoing, the Provider will not, in whole or in part, use the Regence Confidential and Proprietary Information in either aggregate or de-identified form: (i) for any purpose other than the Purpose; (ii) to provide services to any other party; or (iii) for its own benefit to develop normative and benchmarking data, internal or external research, analysis and product development, without the prior written consent of Regence.

2. **Resale of Regence Confidential and Proprietary Information.** The Provider will not resell Regence Confidential and Proprietary Information.

3. **De-Aggregation and Identification.** The Provider will not re-identify or de-aggregate de-identified or aggregate Regence Confidential and Proprietary Information without prior written consent from Regence.

4. **Comingling.** Unless permitted in the Agreement of with prior written approval from Regence, the Provider will not comingle Regence Confidential and Proprietary Information with any other information or data.

III. CONFLICTS

All obligations in this Addendum are in addition to, and not a replacement of, obligations in the Agreement. Should there be a direct conflict between this Addendum and the Agreement, the Agreement shall control except with regard to Provisions II, IV, V(1), and VI as they apply to Regence Confidential and Proprietary Information.

IV. DESTRUCTION OR RETURN OF DATA

Upon termination of this Agreement, or at the request of Regence, the Provider will return or securely destroy Regence Confidential and Proprietary Information in Provider's possession, including any derivative materials containing Regence Confidential and Proprietary Information. If Provider is unable to return or destroy Regence Confidential and Proprietary Information due to legal or licensure requirements, including but not limited to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009, the Provider must maintain the confidentiality of the Regence Confidential and Proprietary Information until the expiration of the applicable legal or licensure requirements and then destroy or return such data.

V. CHANGE OF OWNERSHIP/CONTROL

1. **Provider** must notify Regence immediately, but no later than 30 days, following a change of ownership or control, whether direct or indirect, of or by the Provider.

2. **Termination.** Should there be a change of ownership or control, whether direct or indirect of or by the Provider, Regence at its option may terminate the Agreement, this Addendum, any other data sharing agreement pertaining to Regence Confidential and Proprietary Information, or Agreement. Upon termination, Provider shall return or destroy Confidential Data as described under Provision IV.

VI. RECORDKEEPING AND AUDIT RIGHTS

The Provider shall maintain complete and accurate records relating to the obligations under this Addendum, including but not limited to information, materials, records, or procedures related to (i) use, access, transfer, or disclosure of Regence Confidential and Proprietary Information; (ii) security measures related to the use, receipt, transfer, storage, maintenance, or disposal of Regence Confidential and Proprietary Information. No more than once a year, upon fifteen (15) days' notice, Regence or a Regence representative shall be allowed to inspect, to audit and to make copies of such records and interview Provider personnel to ensure compliance with the Addendum relative to the use, access, transfer and disclosure of Regence Confidential and Proprietary Information or with Provider's obligations under this Addendum.

1. **Occurrences.** Notwithstanding the above, the parties agree that Regence may conduct an audit at any time, in the event of (i) audits required by governmental or regulatory authorities, (ii) investigations of breaches of Provider's obligations under the Addendum, Security Incidents, or potential Security Incidents.

2. **Costs.** Regence shall pay the costs of an audit conducted under this provision, provided that the audit does not (i) involve a Security Incident or event or potential Security Incident or event, or (ii) does not identify, as it relates to Regence Confidential and Proprietary Information, any failure to perform under this Addendum or the Agreement, breach of this Addendum or the agreement, or negligence or willful misconduct by Provider; in those circumstances, Provider shall pay the cost of the audit.

REGENCE BLUECROSS BLUESHIELD OF OREGON
PART 2 PROGRAM PROVIDER ADDENDUM

This Addendum ("Addendum"), effective ("Effective Date") is entered into by and between Regence BlueCross BlueShield of Oregon ("Regence") and **POLK COUNTY PUBLIC HEALTH**, and each entity set forth on Attachment B as applicable (collectively "Provider").

1. **Substance Use Disorder Claims and Information.** If Provider treats or diagnoses patients for Substance Use Disorders or refers patients for treatment of Substance Use Disorders and is subject to the Confidentiality of Substance Use Disorder Patient Records Rule (42 C.F.R. Part 2) as a Part 2 Program, Provider shall comply with the terms of this Addendum with respect to any claim or other communication it submits to Regence that contains Patient Identifying Information. Regence payment of such claims is contingent upon compliance with these requirements.

   a. **Definitions.** For purposes of this Addendum, the capitalized terms "Part 2 Program," "Patient Identifying Information," and "Substance Use Disorder" shall have the meanings provided in 42 C.F.R. § 2.11. Other capitalized terms will have the meanings established in this Addendum or elsewhere in the Agreement, as applicable.

   b. **Consent.** Provider is prohibited by law from disclosing Patient Identifying Information to Regence without obtaining the patient's consent. Regence is prohibited by law from using Patient Identifying Information to pay any claim (or to process other information) in the absence of such consent. Accordingly, by submitting any claim (or other record) that contains Patient Identifying Information to Regence, Provider represents and warrants that Provider has first obtained patient consent that meets the requirements established in the Provider Web Site under Claims and Payment>Claims Submission>Other Billing Information. Regence reserves the right to deny payment of any claim (and the right to refuse to process other information) in the event that Provider fails to obtain such consent.

   c. **Notice.** Provider is prohibited by law from disclosing Patient Identifying Information to Regence pursuant to the patient's consent, unless it includes with the Patient Identifying Information a specific statement to notify Regence that the information is subject to Substance Use Disorder confidentiality restrictions (the "Part 2 Disclaimer"). Accordingly, Provider shall include the Part 2 Disclaimer with any claim (or other record) that contains Patient Identifying Information when submitting the claim (or other information) to Regence. Specifically, Provider shall include the Part 2 Disclaimer in the manner established in the Provider Web Site under Claims and Payment>Claims Submission>Other Billing Information. Regence reserves the right to deny payment of any claim (and the right to refuse to process other information) in the event that Provider fails to include the Part 2 Disclaimer in a communication containing Patient Identifying Information.

   d. **Audits and Evaluations.** Upon request, Provider shall provide to Regence Patient Identifying Information that Regence deems reasonably necessary to perform evaluations, audits and health care operations, including, but not limited to, utilization review, quality assessment and improvement activities (such as collection of HEDIS data), and reviewing qualifications of health care providers. For purposes of any such request, Regence agrees that it will:

      i. Maintain and destroy the Patient Identifying Information in a manner consistent with 42 C.F.R. § 2.16;
      ii. Retain records that contain Patient Identifying Information in compliance with applicable federal, state, and local record retention laws; and
      iii. Comply with the limitations on disclosure and use of Patient Identifying Information in 42 C.F.R. § 2.53(d).

Provider is permitted to make such disclosures pursuant to 42 C.F.R. § 2.53(b).

REGENCE BLUECROSS BLUESHIELD OF OREGON
PROVIDER NETWORK ADDENDUM
Effective:

This Addendum to the Agreement between Regence BlueCross BlueShield of Oregon ("Regence") and POLK COUNTY PUBLIC HEALTH ("Provider"), is to recognize network participation and additional provisions which apply to the networks. Except as specifically amended herein, all terms and conditions of the Agreement remain in effect.

WHEREAS, All references herein to "Provider" shall mean "Provider," "Medical Group," "Physician or Other Health Care Professional," "IPA," or "Hospital" as those terms are used and defined in the Agreement; and

WHEREAS, Regence and Provider are parties to the Agreement, whereby Provider agrees to provide Covered Services to Members; and

WHEREAS, Regence desires Provider to participate in the networks indicated below pursuant to the terms of this Addendum; and

NOW, THEREFORE, in consideration of the covenants and agreements contained herein, and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereto, intending to be legally bound, agree as follows:

I. PROVISIONS

1.1 This Addendum shall continue in effect, unless terminated according to the process set forth in the Agreement. Provider has the right to discontinue participation in any network(s) pursuant to the terms of the Agreement.

1.2 Provider shall admit or arrange for hospital admissions and referral services of Members only to network providers within their applicable network, unless the Member's condition makes it impossible, the service is not available through the network, or the Member chooses care outside the network. Provider should advise the Member whenever health care services are to be obtained outside of their network that the Member may be subject to additional out-of-pocket expense. Any questions regarding network participation and benefit levels should be directed to Regence.

1.3 Provider agrees to accept the network payment set forth on the Reimbursement Schedule and Medicare Advantage Addendum, if applicable, as payment in full for Covered Services rendered to Members for networks in which Provider is participating as indicated below.

Provider is to participate in those networks indicated with a "Yes" below.

Participation	Commercial Networks
Yes	Participating
Yes	Preferred
Yes	Individual and Family Network
Yes	RealValue
	Legacy
	Blue High Performance Network
Participation	**MedAdvantage Networks**
Yes	Regence MedAdvantage PPO
Yes	Regence BlueAdvantage HMO

ATTACHMENT A
REGENCE BLUECROSS BLUESHIELD OF OREGON
PROFESSIONAL REIMBURSEMENT SCHEDULE

This Professional Reimbursement Schedule, Attachment A to the Agreement, applies to services incurred on or after **.** This reimbursement schedule replaces and supersedes any prior reimbursement attachments, exhibits or schedules. Any term not defined herein shall have the meaning set forth in the Agreement. Reimbursement for all commercial networks that Provider participates in, according to the Provider Network Addendum, will be reimbursed according to the same terms as defined in this Reimbursement Schedule, unless specifically noted otherwise.

All references herein to "Provider" shall mean "Physician or Other Health Care Professional," "Provider," "Medical Group," "Medical Group Provider" or as otherwise defined in the Agreement(s).

Notwithstanding anything in this Agreement to the contrary, for urgent and emergent Covered Services delivered to Members covered under a Member Contract that uses the Blue High Performance Network, Provider agrees to accept, as payment in full and subject to applicable Copayments, Coinsurance, and Deductibles, the Maximum Allowable reimbursement specified for such services when participating in the Participating network regardless of Provider's participation in the Blue High Performance Network as specified in the Provider Network Addendum.

I. DEFINITIONS

1.1 **Allowable Billed Charges** – charges submitted by Provider for Covered Services subject to standard Regence administrative guidelines, reimbursement policies and payment methodologies.

1.2 **Anesthesia Services** – services described by the American Society of Anesthesiologists that has assigned a base unit.

1.3 **Total Anesthesia Units** – ASA base unit for a CPT® code plus time units, which are defined as total time for a service in 15-minute increments. Sixty minutes is 4 time units. Per the Regence's reimbursement policy, after one minute, Regence rounds units up to the next 15-minute increment.

1.4 **CMS RVUs** – the Centers for Medicare & Medicaid Services (CMS) 2021-D site-of-service based (facility or non-facility), non-GPCI adjusted Relative Value Units (RVUs), which are updated annually in the Federal Register.

1.5 **Maximum Allowable** – the amount that Regence agrees to pay, subject to standard Regence administrative guidelines, reimbursement policies and payment methodologies, including but not limited to reimbursement for CPT® code modifiers.

II. REIMBURSEMENT SCHEDULE/PAYMENT METHODOLOGY

2.1 Provider agrees to accept as payment in full the lesser of Allowable Billed Charges or the Maximum Allowable for Covered Services provided to Members.

2.2 The Maximum Allowable for covered Anesthesia Services shall be calculated by multiplying the anesthesia conversion factor set forth in section 2.4 below times the Total Anesthesia Units for the service.

2.3 The Maximum Allowable for Covered Services are generally based upon a modified version of the Medicare Resource Based Relative Value Scale ("RBRVS") fee schedule and payment systems, including the site-of-service payment differential (facility and non-facility) CMS RVUs multiplied by the conversion factors set forth in section 2.4 below:

2.4 Conversion Factors:

	Provider Types				
	Registered Pharmacist, Licensed Acupuncturist, Licensed Massage Therapist, Licensed Lactation Consultant	Doctor of Chiropractic Medicine	Doctor of Naturopathy	Physical Therapist, Occupational Therapist, Speech/ Language Therapist	Physician (MD, DO, DPM), Physician's Assistant (PA), Nurse Practitioner (NP) Certified Nurse Midwife, Optometrist, Registered Dietician, Audiologist
General Service Description*	**Conversion Factor**				
Evaluation & Management:	$33.50	$34.00	$30.00	$39.80	$58.00
Surgery:	$33.50	$34.00	$30.00	$39.80	$64.00
Radiology:	$33.50	$34.00	$30.00	$39.80	$61.25
Laboratory/ Pathology:	$33.50	$34.00	$30.00	$39.80	$63.00
Medicine:	$33.50	$34.00	$30.00	$39.80	$67.25
General Ophthalmologic:	$33.50	$34.00	$30.00	$39.80	$45.45
Speech & Physical Rehabilitation:	$33.50	$34.00	$30.00	$39.80	$39.80
Chiropractic and Osteopathic Manipulation:	$33.50	$34.00	$30.00	$39.80	$34.00
Anesthesia:	N/A	N/A	N/A	N/A	$58.50
All other Reimbursable CPT & HCPCS:	$33.50	$34.00	$30.00	$39.80	$57.00

*A supplemental document and additional information regarding fee schedules are available for viewing on Availity. This general description is provided as a guide but does not necessarily reflect all CPTs within a category range.

2.5 Unless Regence establishes specific fees for services and/or Current Procedural Terminology ("CPT") and Healthcare Common Procedure Coding System ("HCPCS") codes, various percentages are applied by Regence to the fees in the schedule for specific CPT and HCPCS codes or ranges of CPT and HCPCS codes.

2.6 Additionally, Regence may incorporate new CPT and HCPCS codes into its fee schedules. The fee(s) attributable to such code(s) will be determined by applying the same conversion factor and/or percentage as Regence has applied to other codes within such code range to that code's RBRVS which is current as of the date of creation of the code. Updates to CMS RVU and Clinical Laboratory will be implemented on a prospective basis.

2.7 **Laboratory:** The Maximum Allowable for Covered Services shall be eighty-five percent (85.00%) of Medicare's current Clinical Laboratory Fee Schedule (CLAB).

2.8 **Durable Medical Equipment, Medical Supplies, Orthotics and Prosthetics (DMEPOS):** The Maximum Allowable of DMEPOS codes shall be the lesser of billed charges or one hundred ten percent (110.00%) of the current DMEPOS fee schedule published by CMS. PEN codes shall be reimbursed at the lesser of billed charges or eighty percent (80.00%) of the current PEN fee schedule published by CMS.

2.9 **Drugs, Vaccinations:** The Maximum Allowable for drugs and medications, including but not limited to biologicals, immune globulins, vaccines and immunizations, shall be Regence's medication fee schedule in effect on the date of service. Drug pricing generally varies between one hundred percent (100.00%) of CMS or AWP –15%, when no CMS fee is available.

2.10 The Maximum Allowable for Covered Services rendered by behavioral health providers shall be calculated by multiplying the conversion factors set forth below times the CMS RVUs, with the exception of 2.10.1 below.

Provider Types			
MD/DO and PMHNP/ARNP	PhD/PsyD	Masters Level Counselor	Alcohol/Drug Program
Conversion Factors			
• Medicine - $67.25 • Evaluation and Management - $58.00	$44.54	$34.80	$32.63

2.10.1 The Maximum Allowable for CPT 90837 rendered by behavioral health providers shall be:

Provider Types			
MD/DO and PMHNP/ARNP	PhD/PsyD	Masters Level Counselor	Alcohol/Drug Program (ADTS)
CPT 90837-Maximum Allowable Non-Facility Setting Fee			
$228.33	$175.36	$137.00	N/A
CPT 90837-Maximum Allowable Facility Setting Fee			
$201.34	$154.63	$120.80	$113.25

2.11 For services for which no RVU has been established by CMS, the Maximum Allowable for Covered Services shall be determined using Regence's policy for services without RVUs. In these cases, we establish allowances using various methods as explained in our Pricing Codes without RVUs (Administrative #113) reimbursement policy. Our Reimbursement Policy Manual is available on our provider website at **regence.com**: Library>Policies and Guidelines>Reimbursement Policy.

2.12 For services for which no RVU has been established by CMS, the Maximum Allowable for Covered Services shall be Regence's Reimbursement Schedule in effect on the date of service.

2.13 Access the current Regence BlueCross BlueShield of Oregon Commercial Reimbursement Schedule at **availity.com**: Claims and Payments>Fee Schedule Listing

III. COPAYMENT, COINSURANCE, DEDUCTIBLE

Where the Member Agreement provides for payment of copayment, coinsurance or deductibles by the Member, payment by Regence for Covered Services shall be less the applicable copayment, coinsurance or deductible.

IV. NON-DISCLOSURE

Provider agrees that unless required by law or otherwise allowed by the Agreement, Provider shall not disclose the reimbursement rates established by Regence without prior written consent of Regence. Provider further agrees not to disclose the reimbursement rates to individual health care Providers, other than those health care Providers on its Board, if applicable, in any format.

ATTACHMENT B

TO THE PARTICIPATING AGREEMENT
LOCATIONS & IDENTIFICATION NUMBERS

Entities Covered by this Agreement	Tax ID Number	National Provider Identifier	Address

ATTACHMENT C

AFFILIATES & SUBSIDIARIES

As of the effective date of this Agreement, listed below are the affiliates and subsidiaries of Regence:

Entity	Home Jurisdiction (State)
Asuris Northwest Health	WA
BridgeSpan Health Company	UT
Healthcare Management Administrators	WA
LifeMap Assurance Company	OR
Regence BlueCross BlueShield of Oregon	OR
Regence BlueCross BlueShield of Utah	UT
Regence BlueShield	WA
Regence BlueShield of Idaho, Inc.	ID
ValueCare	UT

REGENCE BLUECROSS BLUESHIELD OF OREGON
MEDICARE ADVANTAGE PPO REIMBURSEMENT ADDENDUM

This is an Addendum ("Addendum"), effective on , to the Participating Agreement ("Agreement"), by and between Regence BlueCross BlueShield of Oregon ("Regence") and **POLK COUNTY PUBLIC HEALTH** ("Provider"). All references herein to "Provider" shall mean "Medical Group," or "Physician or Other Health Care Professional," as defined in the Agreement(s).

WHEREAS, Regence has a contract to serve as a Medicare Advantage (MA) plan for the U.S. Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS), to administer Medicare benefits within certain counties in the Regence service areas;

WHEREAS, Provider has an existing Agreement to provide medical services to Members, as more particularly set forth in the Agreement;

WHEREAS, Provider is entering into this Addendum to provide medical services to MA PPO Members;

NOW THEREFORE, in consideration of the foregoing premises and other good and valuable consideration, receipt and sufficiency of which are acknowledged, the parties hereby agree as follows:

A. REIMBURSEMENT PROVISIONS

The following reimbursement provisions and fee schedule amounts shall apply to Provider for Covered Services rendered to MA PPO Members:

1. The fee schedule for professional providers is structured on the most recent edition of the CPT coding manual. For most procedures, Regence will determine Maximum Allowable Fees using the Resource Based Relative Value Scale (RBRVS) published by the Centers for Medicare & Medicaid Services (CMS). In the absence of CMS RBRVS unit values for specific procedures, Regence will establish such unit values for purposes of its Maximum Allowable Fee determination. For certain procedures, the Maximum Allowable Fee will be individually determined at Regence's discretion. Procedures assigned "by report" status are paid as determined by Regence's Medical Director.
2. The allowance for each CPT procedure code is the lesser of the charge or the fee assigned to that procedure code under the fee schedule. Payment for Covered Services is based upon this allowance.
3. For Covered Services provided by MDs, and DOs, the fee schedule shall be based upon one hundred percent (100.00%) of the current Medicare fee schedule and payment methodologies for the locale where the service is rendered. Regence will update within sixty (60) days of the release/publication date with regard to the Medicare Pricer updates of the Medicare Physician rates.
4. For Covered Services provided by Nurse Practitioners and Physician Assistants, the fee schedule shall be based eighty-five percent (85.00%) of the MD and DO rate listed above. Payments for Physician Assistants and Certified Registered Nurse First Assistants assisting at surgery shall be reimbursed based on Medicare guidelines.
5. For Covered Services provided by other provider types (i.e., <u>not</u> MDs, DOs, NPs and PAs), including but not limited to: PT, OT, ST, CRNAs, DCs, DPMs, ODs the fee schedule shall be based upon the current Medicare allowable for the provider type based on the locale where the service is rendered. Regence follows Chapter 12 of the Medicare Claims Processing Manual for the provider type, example: Licensed Clinical Social Worker (LCSW) is paid seventy-five percent (75%) of the Medicare physician fee schedule. Regence will update within sixty (60) days of the release/publication date with regard to the Medicare Pricer updates of the Medicare Physician rates.
6. Reimbursement for Naturopathic, Acupuncture and Massage provider types will be set at the Regence fee schedule which is equivalent of 100% of current Medicare for the location the service is rendered, including sequestration.
7. For Covered Services for Laboratory and Pathology services for which Medicare has established a fee through its Clinical Laboratory Fee Schedule, reimbursement shall be based upon sixty-eight percent (68.00%) of the current Medicare fee schedule for the locale where the service is rendered. Regence will update within sixty (60) days of the release/publication date with regard to the Medicare Pricer updates of the Medicare rates.

8. Durable Medical Equipment, Prosthetics, Orthotics, Supplies (DMEPOS) and Drugs will be reimbursed according to Regence reimbursement policy.
9. Rural Health Clinics (RHC). The Maximum Allowable amount for Covered Services provided to MA Members under this Addendum is based upon one hundred percent (100%) of the current Medicare all- inclusive reimbursement rate (AIRR) established for the RHC. Covered Services must be billed using electronic UB format according to Medicare RHC requirements, including but not limited to, Type of Bill, Revenue Codes and HCPCS/CPT codes.

   Provider agrees that it is their responsibility to provide Regence with the most current version of the Interim Payment Rate letter, within 10 business days of receipt, from the CMS Medicare Administrative Contractor. From the date of Regence's receipt of the CMS payment letter, Regence will use reasonable efforts to ensure that any change to the Maximum Allowable amounts herein will occur within sixty (60) days of the submission. Notices to Regence shall be sent to the Contract Notice address listed in the Contact Us section of the Provider Web Site.
10. Federally Qualified Health Center (FQHC). The Maximum Allowable amount for Covered Services provided to MA Members under this Addendum is based upon one hundred percent (100%) of the current Medicare rate as determined by CMS for the FQHC. Covered Services must be billed using electronic UB format according to Medicare FQHC requirements, including but not limited to, Type of Bill, Revenue Codes and HCPCS/CPT codes. Regence will update within sixty (60) days of the release/publication date with regard to the Medicare Pricer updates of the Medicare inpatient rates.

B. MISCELLANEOUS PROVISIONS

1. Regence will not make any additional payment for facility or professional services based upon a rural health care designation under the Medicare program, including any designation such as a Critical Access Hospital (CAH), Physician Scarcity Area (PSA) or any other designation, unless the resulting payment is agreed to by Regence in advance and in writing.
2. Provider agrees to look solely to Regence for compensation for Covered Services provided to Members. Provider agrees to collect directly from Member any outpatient co-payment which may be established from time to time by Regence for each office call and for each home visit. The co-payment shall be a credit against the amount due from Regence for Covered Services rendered to a Member, without regard to whether the Provider has actually collected any co-payment.
3. For purposes of prompt payment of claims under this MA Addendum only, claims for Covered Services provided to MA Members under this Addendum shall not be subject to any late fees, interest, or other penalties as established by the Agreement or by state law. See 42 CFR § 422.520(b).
4. Consistent with all other MA Member Agreements offered by Regence, Regence will follow CMS's standards in determining Medical Necessity, including, without limitation, Medicare's national coverage decisions (NCDs) and applicable local medical review policies (LMRPs).
5. This Addendum shall continue, unless terminated according to the process set forth in the Agreement. Either party may terminate this Addendum without terminating the remainder of the Agreement. However, in the event either party terminates the Agreement, this Addendum terminates as well.

Any term not defined herein shall have the meaning set forth in the Agreement. The terms of this Addendum shall become a part of, and shall be specifically incorporated into, the terms of the Agreement. In the event of any conflict or inconsistency between the terms of this Addendum and the terms of the Agreement, the terms of this Addendum shall apply. This Addendum supersedes and replaces in its entirety any prior MA Addenda between the parties.

REGENCE BLUECROSS BLUESHIELD OF OREGON
MEDICARE ADVANTAGE HMO REIMBURSEMENT ADDENDUM

This is an Addendum ("Addendum"), effective on , to the Participating Agreement ("Agreement"), by and between Regence BlueCross BlueShield of Oregon ("Regence") and **POLK COUNTY PUBLIC HEALTH** ("Provider"). All references herein to "Provider" shall mean "Medical Group," or "Physician or Other Health Care Professional," as defined in the Agreement(s).

WHEREAS, Regence has a contract to serve as a Medicare Advantage (MA) plan for the U.S. Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS), to administer Medicare benefits within certain counties in the Regence service areas;

WHEREAS, Provider has an existing Agreement to provide medical services to Members, as more particularly set forth in the Agreement;

WHEREAS, Provider is entering into this Addendum to provide medical services to MA HMO Members;

NOW THEREFORE, in consideration of the foregoing premises and other good and valuable consideration, receipt and sufficiency of which are acknowledged, the parties hereby agree as follows:

A. REIMBURSEMENT PROVISIONS

The following reimbursement provisions and fee schedule amounts shall apply to Provider for Covered Services rendered to MA HMO Members:

1. The fee schedule for professional providers is structured on the most recent edition of the CPT coding manual. For most procedures, Regence will determine Maximum Allowable Fees using the Resource Based Relative Value Scale (RBRVS) published by the Centers for Medicare & Medicaid Services (CMS). In the absence of CMS RBRVS unit values for specific procedures, Regence will establish such unit values for purposes of its Maximum Allowable Fee determination. For certain procedures, the Maximum Allowable Fee will be individually determined at Regence's discretion. Procedures assigned "by report" status are paid as determined by Regence's Medical Director.
2. The allowance for each CPT procedure code is the lesser of the charge or the fee assigned to that procedure code under the fee schedule. Payment for Covered Services is based upon this allowance.
3. For Covered Services provided by MDs, and DOs, the fee schedule shall be based upon one hundred percent (100.00%) of the current Medicare fee schedule and payment methodologies for the locale where the service is rendered. Regence will update within sixty (60) days of the release/publication date with regard to the Medicare Pricer updates of the Medicare Physician rates.
4. For Covered Services provided by Nurse Practitioners and Physician Assistants, the fee schedule shall be based upon eighty-five percent (85.00%) of the MD, and DO, rate listed above. Payments for Physician Assistants and Certified Registered Nurse First Assistants assisting at surgery shall be reimbursed based on Medicare guidelines.
5. For Covered Services provided by other provider types (i.e., <u>not</u> MDs, DOs, NPs and PAs), including but not limited to: PT, OT, ST, CRNAs, DCs, DPMs, ODs the fee schedule shall be based upon the current Medicare allowable for the provider type based on the locale where the service is rendered. Regence follows Chapter 12 of the Medicare Claims Processing Manual for the provider type, example: Licensed Clinical Social Worker (LCSW) is paid seventy-five percent (75%) of the Medicare physician fee schedule. Regence will update within sixty (60) days of the release/publication date with regard to the Medicare Pricer updates of the Medicare Physician rates.
6. Reimbursement for Naturopathic, Acupuncture and Massage provider types will be set at the Regence fee schedule which is equivalent of 100% of current Medicare for the location the service is rendered, including sequestration.
7. For Covered Services for Laboratory and Pathology services for which Medicare has established a fee through its Clinical Laboratory Fee Schedule, reimbursement shall be based upon sixty-eight percent (68.00%) of the current Medicare fee schedule for the locale where the service is rendered. Regence will update within sixty (60) days of the release/publication date with regard to the Medicare Pricer updates of the Medicare rates.

8. Durable Medical Equipment, Prosthetics, Orthotics, Supplies (DMEPOS) and Drugs will be reimbursed according to Regence reimbursement policy.

9. Rural Health Clinics (RHC). The Maximum Allowable amount for Covered Services provided to MA Members under this Addendum is based upon one hundred percent (100%) of the current Medicare all- inclusive reimbursement rate (AIRR) established for the RHC. Covered Services must be billed using electronic UB format according to Medicare RHC requirements, including but not limited to, Type of Bill, Revenue Codes and HCPCS/CPT codes.

   Provider agrees that it is their responsibility to provide Regence with the most current version of the Interim Payment Rate letter, within 10 business days of receipt, from the CMS Medicare Administrative Contractor. From the date of Regence's receipt of the CMS payment letter, Regence will use reasonable efforts to ensure that any change to the Maximum Allowable amounts herein will occur within sixty (60) days of the submission. Notices to Regence shall be sent to the Contract Notice address listed in the Contact Us section of the Provider Web Site.

10. Federally Qualified Health Center (FQHC). The Maximum Allowable amount for Covered Services provided to MA Members under this Addendum is based upon one hundred percent (100%) of the current Medicare rate as determined by CMS for the FQHC. Covered Services must be billed using electronic UB format according to Medicare FQHC requirements, including but not limited to, Type of Bill, Revenue Codes and HCPCS/CPT codes. Regence will update within sixty (60) days of the release/publication date with regard to the Medicare Pricer updates of the Medicare inpatient rates.

B. MISCELLANEOUS PROVISIONS

1. Regence will not make any additional payment for facility or professional services based upon a rural health care designation under the Medicare program, including any designation such as a Critical Access Hospital (CAH), Physician Scarcity Area (PSA) or any other designation, unless the resulting payment is agreed to by Regence in advance and in writing.

2. Provider agrees to look solely to Regence for compensation for Covered Services provided to Members. Provider agrees to collect directly from Member any outpatient co-payment which may be established from time to time by Regence for each office call and for each home visit. The co-payment shall be a credit against the amount due from Regence for Covered Services rendered to a Member, without regard to whether the Provider has actually collected any co-payment.

3. For purposes of prompt payment of claims under this MA Addendum only, claims for Covered Services provided to MA Members under this Addendum shall not be subject to any late fees, interest, or other penalties as established by the Agreement or by state law. See 42 CFR § 422.520(b).

4. Consistent with all other MA Member Agreements offered by Regence, Regence will follow CMS's standards in determining Medical Necessity, including, without limitation, Medicare's national coverage decisions (NCDs) and applicable local medical review policies (LMRPs).

5. This Addendum shall continue, unless terminated according to the process set forth in the Agreement. Either party may terminate this Addendum without terminating the remainder of the Agreement. However, in the event either party terminates the Agreement, this Addendum terminates as well.

6. Other Provisions. The provisions of the Agreement, and any addendum(-a) thereto, that are not changed by this Addendum remain unchanged and in full force and effect.

C. PROVIDER SERVICES AND OBLIGATIONS

1. Primary Care Physicians. Provider understands that under the MA HMO, MA Members will designate a primary care physician ("PCP") at the time of enrollment in the MA HMO and that MA HMO Members will have the flexibility to change their choice of PCP periodically. The designated PCP will be responsible for referring MA HMO Members for Covered Services pursuant to the Members' benefits and to in-network providers. Claims payment will be contingent on referral guidelines established by Regence.

2. PCP Responsibilities. Provider shall:

   a. Provide or arrange for the provision of Covered Services on a routine, urgent, and emergency care basis for MA HMO Members assigned to Provider.

   b. Accept MA HMO Members assigned to Provider without discrimination or screening of such members based upon their health status.

   c. Be responsible twenty-four (24) hours a day, seven (7) days a week for providing, prescribing, directing and authorizing all Covered Services.

   d. Provide to Regence a description of arrangements for urgent and emergency care and service coverage in the event a PCP is unavailable due to vacation, illness or after hours, and will assure that the physician providing coverage will provide services under the same terms and conditions and in compliance with all provisions of the Provider's Agreement with Regence. Provider shall be responsible for any and all compensation for such other physician(s). Neither Provider nor the physician(s) shall seek additional compensation from Regence or MA HMO Members assigned to Provider for services rendered.

   e. Issue referrals for MA HMO Members assigned to Provider in accordance with Regence referral guidelines.

3. Services to Members. In the event Provider provides a MA HMO Member a non-covered service, Provider shall, prior to the provision of such non-covered service, inform the MA HMO Member: (i) of the service(s) to be provided; (ii) that Regence will not pay or be liable financially for such non-covered service(s); and (iii) that MA HMO Member will be responsible financially for non-covered service(s) that are requested by the MA HMO Member.

   Provider agrees to be responsible twenty-four (24) hours a day, seven (7) days a week for providing Covered Services for MA HMO Members including, but not limited to, prescribing, directing and monitoring all urgent and emergency care for Members.

   In the event that emergency or urgent care services are needed by a MA HMO Member outside the service area, Provider agrees to monitor and authorize the out-of-area care, to the extent they are aware of such event, and to provide direct care as soon as the MA HMO Member is able to return to the service area for treatment without medically harmful or injurious consequences.

4. Specific Referrals. Except in the case of a medical emergency, Provider agrees to use its best efforts to admit, refer, and cooperate with the transfer of MA HMO Members for Covered Services only to providers designated, specifically approved by or under contract with Regence. In addition, Provider acknowledges and agrees that certain MA HMO Members may have health benefits contracts that limit coverage to certain types of participating providers. For such MA HMO Members, referrals are required to be made to specific providers designated by Regence.

5. Referral System Rules. Regence has established and may at times revise, amend or, modify its referral system rules with respect to payment of claims for certain services without a referral. This includes, but is not limited to, services mandated by state or federal laws, rules or regulations, certain low cost diagnostic services, other routine services and urgent and emergency care. Provider agrees that such claims shall not be contested by Provider for Provider's failure to comply with Regence referral system rules.

Any term not defined herein shall have the meaning set forth in the Agreement. The terms of this Addendum shall become a part of, and shall be specifically incorporated into, the terms of the Agreement. In the event of any conflict or inconsistency between the terms of this Addendum and the terms of the Agreement, the terms of this Addendum shall apply. This Addendum supersedes and replaces in its entirety any prior MA Addenda between the parties.

REGENCE
MEDICARE ADVANTAGE PROVIDER COMPLIANCE ADDENDUM

Provider, as a first-tier, downstream, or related entity ("FDR") defined within the Medicare Advantage Provider Compliance Addendum to the Participating Agreement, acknowledges that it is an FDR and agrees to review and comply with CMS requirements and Regence's Medicare Advantage Compliance Requirements located in the Administrative Manual on the provider website **regence.com,** which may be amended from time to time.

REGENCE
MEDICARE ADVANTAGE SEQUESTRATION ADDENDUM

This Medicare Advantage Sequestration Addendum to the Agreement and any and all amendments, addenda, attachments or exhibits to the Agreement, by and between Regence and the Provider named therein, as that term is defined below, effective for services provided on or after :

WHEREAS, All references herein to "Provider" shall mean "ASC," "Clinic," "Facility," "Hospital," "IPA," "EMS," "Medical Group," "Physician," "Physician or Other Health Care Professional," "Practitioner," "Provider" or as otherwise defined in the Agreement as those terms are used and defined in the Agreement; and

WHEREAS, All references herein to "Regence" shall mean "Regence BCBSO," "Company," "The Plan," "Organization," or any additional alternate reference term, as those terms are used and defined in the Agreement; and

I. RECITALS

1.1 Regence desires to amend the Agreements to address changes in Provider compensation payable under the Medicare Advantage program to account for (i) the federal sequestration announced for 2013, and (ii) other future unplanned, unforeseen, or unusual events.

1.2 Therefore, in consideration of those premises and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree to the terms and conditions set forth in this Addendum.

AGREEMENT

II. DEFINITIONS

For purposes of this Addendum, the following terms will have the following stated meanings. Any term not defined in this Addendum will have the meaning given to the term in the Agreement.

2.1 **Advance Monthly CMS Payments** means the advance monthly payments that are made by CMS to Regence, in Regence's capacity as a Medicare Advantage organization, in return for providing Covered Services to MA Members during those months.

2.2 **Advance Payment Adjustment** means the amount of any reduction in the Advance Monthly CMS Payments that are made by CMS to Regence, expressed as a percentage reduction from the amount of the Advance Monthly CMS Payments that Regence would have otherwise received in the absence of the reduction, and that is caused by or that results from any unplanned, unforeseen, or unusual budgetary event that was not contemplated by Regence, or that was not contemplated by Provider, or that was not contemplated by both Regence and Provider, when Regence and Provider agreed upon the Medicare Advantage Compensation that is otherwise applicable or payable to Provider under the Agreement. Unplanned, unforeseen, or unusual events include without limitation any state or federal budgetary sequestrations, any changes in state or federal law or policy, any mid-year budget adjustments, or any unanticipated taxes or fees that cause a reduction in the Advance Monthly CMS Payments otherwise due to, or expected to be received by, Regence.

2.3 **Medicare Advantage Compensation** means the compensation payable under the Agreement by Regence to Provider in return for providing Covered Services to MA Members.

III. COMPENSATION

The Medicare Advantage Compensation paid to Provider for Covered Services received by MA Members during a particular month will be reduced by the same percentage as, or by such lower percentage as Regence may determine in Regence's sole discretion, any Advance Payment Adjustment imposed upon or levied against the Advance Monthly CMS Payments that are paid to Regence during that month. For example, if a federal budgetary sequestration reduces the Advance Monthly CMS Payments paid to Regence by 2% during the months of April and May of a particular year, then the Medicare Advantage Compensation payable under the Agreement to Provider for any Covered Services received by MA Members during April and May of that year will also be reduced by 2%, or by such other lower percentage that Regence may determine in Regence's sole discretion.

IV. OTHER PROVISIONS

The provisions of the Agreement that are not amended or deleted by this Addendum remain unchanged and in full force and effect.

CONTRACT REVIEW SHEET

Staff Contact: Rosana Warren | Phone Number (Ext): 2550

Department: Health Services: Public Health | Consent Calendar Date: December 11, 2024

Contractor Name: Regence BlueCross BlueShields of Oregon

Address: PO Box 1106

City, State, Zip: Lewiston, ID 83501-1106

Effective Dates - From: December 01, 2024 | Through: EVERGREEN

Contract Amount: $ Varies

Background:

Polk County Public Health has agreed to be an in-network provider for Regence BlueCross BlueShields of Oregon members for immunizations services only. This is the first Amendment to the renewal agreement with Regence BlueCross Blue Shields of Oregon.

Discussion:

This Amendment 1 is to include Regence BlueCross BlueShields of Oregon's additional subnetworks members to be eligible to receive immunization services from Public Health.

Fiscal Impact:

It is anticipated that this Amendment 1 will have a positive impact as there is increased ability to seek revenue from this provider's members.

Recommendation:

It is recommended that Polk County sign this amendment with Regence BlueCross BlueShields of Oregon.

Copies of signed contract should be sent to the following:

Name: Rosana Warren | E-mail: hs.contracts@co.polk.or.us

Name: | E-mail:

AMENDMENT TO
REGENCE BLUECROSS BLUESHIELD OF OREGON
PARTICIPATING AGREEMENT

THIS AMENDMENT, effective **December 01, 2024**, hereby amends the following agreements (collectively, the "Agreements" and each individually, the "Agreement") and any and all amendments, addenda, attachments or exhibits thereto by and between **Regence BlueCross BlueShield of Oregon** (Regence or as otherwise defined in the Agreement and hereafter referred to as “Regence”) and **Provider:**

Contracting Hospital Agreement
Dental Provider Agreement
Independent Practice Association Agreement
Independent Physicians Association Agreement
Medical Equipment Vendor Agreement
Medical Group Agreement
Medical Services Agreement
Medicare Advantage Participating Ancillary Provider Agreement
Medicare Physician and Other Health Care Professional Agreement
Participating Ambulatory Surgery Center
Participating Ambulatory Surgery Center Agreement
Participating Ancillary Agreement
Participating Ancillary Provider Agreement
Participating Chiropractic Clinic Agreement
Participating Clinical Laboratory Agreement
Participating Dental Provider Agreement
Participating Dental Provider Agreement for Dental Clinics
Participating Dental Provider Agreement for Dental Groups
Participating Emergency Medical Services Agreement
Participating Facility Agreement
Participating HME Agreement
Participating Hospital Agreement
Participating Laboratory Agreement
Participating Medical Equipment Agreement
Participating Medical Equipment Vendor Agreement
Participating Medical Group Agreement
Participating Medical Services Agreement
Participating Organizational Provider (Facility) Agreement
Participating Organizational Provider (Laboratory) Agreement
Participating Physician and Other Health Care Professional Agreement
Participating Physician or Other Healthcare Professional Agreement
Participating Practitioner Agreement
Participating Professional Services Agreement
Participating Provider Agreement
Participating Services Agreement
Participating Technical Medical Facility Contract
Participating Vision Clinic Agreement
Participating Vision Practitioner Agreement
Physician and Other Health Care Professional Agreement
Physician Hospital Organization
Professional Services Agreement

All references herein to “Provider” shall mean “Physician or Other Health Care Professional,” “Provider,” “Practitioner,” “Medical Group,” “Medical Group Provider,” “Hospital,” "Facility," “Dental Clinic,” “Dental Group,” “Dental Provider,” or as otherwise defined in the Agreement(s).

RECITALS

WHEREAS, Regence and Provider entered into the Agreement, wherein Provider agreed to provide Covered Services to Members; and

WHEREAS, Regence and Provider agree to continue their contract to provide health care services to Members, and amend the Agreement pursuant to the amendment with notice clause in the Agreement for the purpose of incorporating the provisions set forth below; and

NOW, THEREFORE, in consideration of the foregoing premises and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree as follows:

AGREEMENT

1. Attachment A, Regence BlueCross BlueShield of Oregon Professional Reimbursement Schedule, is hereby deleted in its entirety and replaced with the enclosed, revised Attachment A, Regence BlueCross BlueShield of Oregon Professional Reimbursement Schedule.

Any term not defined herein shall have the meaning set forth in the Agreement.

To the extent that there is any conflict between the terms of the Agreement and the terms of this Amendment, the terms of this Amendment will prevail.

Except as expressly amended and supplemented by this Amendment, all other terms and conditions of the Agreement shall remain in full force and effect.

REGENCE BLUECROSS BLUESHIELD OF OREGON

Gillian Hays
Vice President, Network Management

ATTACHMENT A
PROFESSIONAL REIMBURSEMENT SCHEDULE
REGENCE BLUECROSS BLUESHIELD OF OREGON

This Professional Reimbursement Schedule Attachment A ("Professional Reimbursement Schedule") to the Agreement applies to Covered Services incurred on or after **December 01, 2024** and is hereby incorporated into the Agreement by reference**.** This Professional Reimbursement Schedule replaces and supersedes any prior reimbursement attachments, exhibits, or schedules. Any term not defined herein shall have the meaning set forth in the Agreement. This Professional Reimbursement Schedule will apply to all commercial networks that Provider participates in, according to the Provider Network Addendum, unless specifically noted otherwise.

All references herein to "Provider" shall mean "Physician or Other Health Care Professional," "Provider," "Medical Group," "Medical Group Provider" or as otherwise defined in the Agreement(s).

Notwithstanding anything in this Agreement to the contrary, for urgent and emergent Covered Services delivered to Members covered under a Member Contract that uses the Blue High Performance Network, Provider agrees to accept, as payment in full and subject to applicable Copayments, Coinsurance and Deductibles, the amount specified in Section 2.2.3 for such services when participating in the Participating network regardless of Provider's participation in the Blue High Performance Network as specified in the Provider Network Addendum.

I. DEFINITIONS

1.1 **Allowable Billed Charges** – Charges submitted by Provider for Covered Services subject to the standard Regence administrative guidelines, reimbursement policies, including medical policies, and payment methodologies.

1.2 **Anesthesia Services** – Services described by CPT® codes in which the American Society of Anesthesiologists (ASA) has assigned a base unit. Anesthesia base unit values will be determined utilizing the Relative Value Guide published by the ASA. Except as described in Regence anesthesia reimbursement policies, Anesthesia Services are reimbursed on a per unit basis and time applied where applicable.

1.3 **Center for Medicare & Medicaid Services (CMS) DMEPOS Fee Schedule** –The CMS DMEPOS fee schedule in effect at the time the Covered Service is rendered, inclusive of any adjustments and quarterly updates to the schedule made by CMS.

1.4 **Claim -** The CMS-1500, standard electronic format or successor, as required by applicable federal authority and state regulatory authority, submitted to Regence for payment to Provider for services rendered to Members.

1.5 **CMS RVUs** – The Centers for Medicare and Medicaid Services (CMS) 2023-D site-of-service based (facility or non-facility), non-GPCI adjusted Relative Value Units (RVUs) as published in the Federal Register.

1.6 **Maximum Allowable** – The maximum compensation amount Regence will pay Provider for Covered Services delivered to Members based on the conversion factors, rates, and reimbursement methodologies set forth in Article II and subject to standard Regence administrative guidelines, reimbursement policies, including medical policies, and payment methodologies.

1.7 **Optum RVUs** – The site-of-service based (facility or non-facility), non-GPCI adjusted Relative Value Units in the 2023 edition of *The Essential RBRVS - A Comprehensive Listing of RBRVS Values for CPT® and HCPCS Codes*, published by Optum.

1.8 **Parenteral and Enteral Nutrition Items and Services (PEN) Fee Schedule** - The PEN fee schedule is based upon the CMS PEN Fee Schedule in effect at the time the Covered Service is rendered, inclusive of any adjustments and updates to the schedule made by CMS.

II. REIMBURSEMENT FOR STANDARD COMMERCIAL NETWORKS

2.1 **Compensation for Covered Services.** Provider agrees to accept as payment in full for all Covered Services provided to Members the lesser of the Maximum Allowable and Allowable Billed Charges. Provider will be compensated for Medically Necessary Covered Services provided to Members in accordance with the Agreement, the Member Contract and Regence's standard fee schedule for the applicable provider network in which Provider participates.

2.2 **Network Participation Rate Adjustments**: the rates specified in this Agreement are the standard commercial network rates. These Maximum Allowable is adjusted for Covered Services provided to Members with access to certain networks in accordance with the following:

2.2.1 Individual and Family Network rates are ninety-five percent (95%) of the standard commercial network rates.

2.2.2 RealValue rates are ninety-five percent (95%) of the standard commercial network rates.

2.2.3 Blue High Performance Network rates are ninety-two percent (92%) of the standard commercial network rates.

2.3 **Standard Commercial Networks Conversion Factors.** Except as applied to Covered Services rendered by behavioral health providers as defined in Sections 2.3.1 and 2.3.1.1, the Maximum Allowable for Covered Services shall be calculated using the conversion factors in the following table:

	Doctor of Chiropractic Medicine, Doctor of Naturopathy, Registered Pharmacist, Licensed Acupuncturist, Licensed Massage Therapist, Licensed Lactation Consultant	Physical Therapist, Occupational Therapist, Speech/ Language Therapist	Physician (MD, DO, DPM), Physician Assistant/Physician Associate (PA), Nurse Practitioner (NP), Clinical Nurse Specialist, Certified Nurse Midwife, Certified Registered Nurse Anesthetist, Optometrist, Registered Dietician, Audiologist
General Service Description*	**Conversion Factor**		
Evaluation & Management	$34.00	$40.67	$58.50
Surgery	$34.00	$40.67	$64.74
Radiology	$34.00	$40.67	$63.00

Laboratory/ Pathology (except that for codes on Medicare's clinical laboratory fee schedule, the Maximum Allowable is as described in Section 2.7)	$34.00	$40.67	$63.00
Medicine	$34.00	$40.67	$66.65
General Ophthalmologic	$34.00	$40.67	$45.85
Speech & Physical Rehabilitation	$34.00	$40.67	$40.67
Chiropractic and Osteopathic Manipulation	$34.00	$40.67	$34.00
Anesthesia	N/A	N/A	$58.50
All other Reimbursable CPT & HCPCS	$34.00	$40.67	$57.00

*A supplemental document and additional information regarding fee schedules are available for viewing on Availity. This general description is provided as a guide but does not necessarily reflect all CPTs within a category range.

2.3.1 The Maximum Allowable for Covered Services rendered by behavioral health providers shall be calculated by multiplying the conversion factors set forth below times the CMS RVUs, with the exception of Section 2.3.1.1 below.

Provider Types			
MD/DO and PMHNP/ARNP/PA	PhD/PsyD	Masters Level Counselor/Social Worker	Alcohol/Drug Program
Conversion Factors			
• Medicine - $66.65 • Evaluation and Management - $58.50	$51.19	$39.99	$37.50

2.3.1.1 Special Reimbursement Categories/Codes. Notwithstanding the terms of Sections 2.3 and 2.3.1, the Maximum Allowable for 90837 rendered by behavioral health providers shall be at the rates defined in the following table:

Provider Type	Site of Service	Reimbursement Fee
MD/DO and PMHNP/ARNP/PA	Non-Facility	$248.88
MD/DO and PMHNP/ARNP/PA	Facility	$219.46
Psychologist (PhD/PsyD)	Non-Facility	$191.14
Psychologist (PhD/PsyD)	Facility	$168.55
Masters Level (Counselor/Social Worker)	Non-Facility	$149.33
Masters Level (Counselor/Social Worker)	Facility	$131.67
Alcohol/Drug Program (ADTS)	Non-Facility	N/A
Alcohol/Drug Program (ADTS)	Facility	$123.44

2.4 The Maximum Allowable for drugs and medications, including but not limited to biologicals, immunoglobulins, vaccines and toxoids, shall be Regence's medication fee schedule. The Regence medication fee schedule is determined using Regence's policy applicable to drugs and medications reimbursed under medical coverage, which is available on the Provider Web Site. The medication fee schedule utilizes the following methodologies: Best Contracted Rate, Noridian Medicare Fee Schedules, CMS Part B ASP fee schedule, Average Wholesale Price (AWP), and invoice pricing.

2.5 DMEPOS Codes: The Maximum Allowable for DMEPOS codes shall be the lesser of Allowable Billed Charges or one hundred-ten percent (110%) of the applicable rate in the current CMS DMEPOS fee schedule.

2.6 PEN Codes: The Maximum Allowable for PEN codes shall be the lesser of Allowable Billed Charges or eighty percent (80%) of the applicable rate in the current CMS PEN fee schedule.

2.7 The Maximum Allowable for Covered Services included in Medicare's clinical laboratory (CLAB) fee schedule shall be eighty-five percent (85%) of the applicable rate in the most current version of that fee schedule.

2.8 For services for which no RVU has been established by CMS, the Maximum Allowable for Covered Services shall be determined using Optum RVUs.

2.9 For services for which no RVU has been established by CMS or by Optum, the Maximum Allowable for Covered Services shall be determined using Regence's policy applicable to services without RVUs, which is available on the Provider Web Site. The reimbursement is based on methodologies that may include the following: local carrier published fees where applicable, most closely comparable code, appropriate combination of CPT or HCPCS codes or components of codes, or percentage of billed charges.

2.10 Provider acknowledges that Regence may establish exceptions to the methodology described in Article II by establishing specific fees for particular services and/or CPT and HCPCS codes set by Regence at its discretion.

2.11 Regence may incorporate new CPT and HCPCS codes into its fee schedules. The fee(s) attributable to such code(s) will be determined by applying the same conversion factor and/or percentage as applied to other codes within such code range to that code's RVU which is current as of the code effective date.

2.12 The Maximum Allowable for Covered Services rendered by other licensed providers not specifically identified above shall be subject to any applicable Regence reimbursement schedule for the provider type.

2.13 **Default Pricing.** Regence reserves the right to assign a payment amount for payable services/items that are not addressed or described in Article II.

2.14 A current fee schedule listing is available for viewing at availity.com.

III. REIMBURSEMENT POLICIES AND CODING EDITS

All claims and billed amounts are subject to (a) standard Regence administrative guidelines, reimbursement policies, including medical policies, and payment methodologies and (b) edits in compliance with correct coding policies as determined by the Centers for Medicare & Medicaid Services (CMS) or Regence. Appearance of a Current Procedural Terminology (CPT®) and/or Healthcare Common Procedure Coding System (HCPCS) code on the Regence commercial Professional Reimbursement Schedule is not an indication that reimbursement will be made for that code.

IV. MISCELLANEOUS

Notwithstanding anything in the Agreement to the contrary, the parties understand and agree that payment for services that Provider does not normally provide within its scope of business, will not be provided under the terms of the Agreement, unless mutually agreed to in writing by the parties.

V. COPAYMENT, COINSURANCE, DEDUCTIBLE

Where the Member Contract provides for payment of Copayment, Coinsurance or Deductibles by the Member, payment by Regence for Covered Services shall be the amount specified in Section 2.1 less the applicable Copayment, Coinsurance and/or Deductible.

VI. TERMS

To the extent the terms of this Professional Reimbursement Schedule are inconsistent or in conflict with the terms of the Agreement or Provider Web Site, the terms of this Professional Reimbursement Schedule prevail.

VII. NON-DISCLOSURE

Provider agrees that unless required by law or otherwise allowed by the Agreement, it shall not disclose the reimbursement rates set forth in this Attachment A without prior written consent of Regence. Provider acknowledges that the unauthorized disclosure of this information may cause irreparable damage to Regence and Provider agrees that Regence may seek relief for breach of the Agreement.

CONTRACT REVIEW SHEET

Staff Contact: Rosana Warren | Phone Number (Ext): 2550

Department: Health Services | Consent Calendar Date: December 11, 2024

Contractor Name: A5 Interpreting dba Bridges Oregon Inc

Address: 1115 Madison Street, NE #1069

City, State, Zip: Salem, OR 97301

Effective Dates - From: November 01, 2024 | Through: June 30, 2025

Contract Amount: VARIES

Background:

A5 Interpreting, doing business as Bridges Oregon Inc, is an American Sign Language interpreting organization who provides translation services for those who are Deaf, DeafBlind, and Hard of Hearing.

Discussion:

This agreement sets the terms for delivery of service to referred individuals or at planned events where individuals who are Deaf, DeafBlind, and Hard of Hearing are expected to attend. This contract will support program delivery in all Health Services divisions.

Fiscal Impact:

The respective Health Services division budgets have sufficient expenditure authority to accommodate this contract.

Recommendation:

It is recommended that Polk County sign this agreement with A5 Interpreting, dba Bridges Oregon Inc.

Copies of signed contract should be sent to the following:

Name: Rosana Warren | E-mail: hs.contracts@co.polk.or.us

Name: | E-mail:

BUSINESS ASSOCIATE AGREEMENT
Between
POLK COUNTY and A5 INTERPRETING (dba BRIDGES OREGON, INC)

A. DEFINITIONS: Except as otherwise defined in this *Business Associate Agreement* (BA Agreement), any and all italicized terms herein shall have the same definition as those in the HIPAA Privacy Rule.[1] Henceforth, Polk County, a political subdivision of the State of Oregon, shall be referred to as "COUNTY" and A5 Interpreting (dba Bridges Oregon, Inc) shall be referred to as "CONTRACTOR".

B. OBLIGATIONS AND ACTIVITIES OF CONTRACTOR:

1. CONTRACTOR agrees to not use or disclose *Protected Health Information* other than as permitted or required by this BA Agreement or as permitted or required by law.

2. CONTRACTOR agrees to use appropriate safeguards to prevent use or disclosure of Protected Health Information other than as provided for by this BA Agreement.

3. CONTRACTOR agrees to mitigate, to the extent practicable, any harmful effect that is known to CONTRACTOR of a use or disclosure of Protected Health Information by CONTRACTOR in violation of the requirements of this BA Agreement.

4. CONTRACTOR agrees to report to the COUNTY any use or disclosure of the Protected Health Information not provided for by this BA Agreement of which it becomes aware.

5. CONTRACTOR agrees to ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by, CONTRACTOR on behalf of the COUNTY agrees to the same restrictions and conditions that apply through this BA Agreement to CONTRACTOR with respect to such information.

6. In the event that it is found to be applicable, CONTRACTOR agrees to provide access, at the request of the COUNTY, and in the time and manner necessary for reasonable compliance, to Protected Health Information in a *Designated Record Set* to the COUNTY or, as directed by the COUNTY, to an *Individual* in order to meet the requirements under 45 CFR § 164.524.

[1] The use and disclosure of protected health information in performance of Business Associate functions is governed by the Standards for Privacy of Individually Identifiable Health Information (45 CFR Parts 160 and 164), referred to as the Privacy Rule, which were issued by the United States Department of Health and Human Services pursuant to Public Law 104-191, the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The use and disclosure of protected health information is also governed by laws of the State of Oregon and by other federal laws.

7. In the event that it is found to be applicable, CONTRACTOR agrees to make any amendment(s) to Protected Health Information in a Designated Record Set that the COUNTY directs or agrees to pursuant to 45 CFR § 164.526 at the request of CONTRACTOR, or an Individual, and in the time and manner necessary for reasonable compliance.

8. CONTRACTOR agrees to make internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, or created or received by CONTRACTOR on behalf of the COUNTY available to the COUNTY or to the *Secretary of the Department of Health and Human Services*, in a time and manner agreed between the COUNTY and CONTRACTOR or designated by the Secretary, for purposes of the Secretary determining the COUNTY'S compliance with the Privacy Rule.

9. CONTRACTOR agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for the COUNTY to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR § 164.528.

10. CONTRACTOR agrees to provide to the COUNTY or an Individual, in the time and manner necessary for reasonable compliance, information collected in accordance with section 2.1 of this BA Agreement, to permit the COUNTY to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR § 164.528.

C. PERMITTED USES AND DISCLOSURES BY CONTRACTOR: Except as otherwise limited in this BA Agreement, CONTRACTOR may use or disclose Protected Health Information to perform certain health plan functions for or on behalf of the COUNTY as specified in the Polk County Agreement and in this BA Agreement provided that such use or disclosure would not violate the Privacy Rule if done by the COUNTY or the minimum necessary policies and procedures of the COUNTY.

D. OBLIGATIONS OF THE COUNTY:

1. The COUNTY shall notify CONTRACTOR of any limitation(s) in the *Notice of Privacy Practices* of the COUNTY in accordance with 45 CFR § 164.520, to the extent that such limitation may affect CONTRACTOR'S use or disclosure of Protected Health Information.

2. The COUNTY shall notify CONTRACTOR of any changes in, or revocation of, permission by Individual to use or disclose Protected Health Information, to the extent that such changes may affect CONTRACTOR'S use or disclosure of Protected Health Information.

3. The COUNTY shall notify CONTRACTOR of any restriction to the use or disclosure of Protected Health Information that the COUNTY has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect CONTRACTOR'S use or disclosure of Protected Health Information.

E. PERMISSIBLE REQUESTS BY THE COUNTY: The COUNTY shall not request CONTRACTOR to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if done by the COUNTY except if such use or disclosure is permitted under the Agreement between the COUNTY and CONTRACTOR.

F. TERM AND TERMINATION:

1. Term. This BA Agreement shall be effective as of November 01, 2024, and shall terminate when all of the Protected Health Information provided by the COUNTY to CONTRACTOR, or created or received by CONTRACTOR on behalf of the COUNTY, is destroyed or returned to the COUNTY, or, if it is infeasible to return or destroy Protected Health Information, protections are extended to such information, in accordance with the termination provisions in this Section.

2. Termination for Cause. Upon the COUNTY'S knowledge of a material breach by CONTRACTOR, the COUNTY shall either:

   a. Provide an opportunity for CONTRACTOR to cure the breach without the intervention of the COUNTY within the timeline specified in Section 16.B1 of the Polk County Agreement; or

   b. Provide an opportunity for CONTRACTOR to terminate this BA Agreement and the Polk County Agreement within the timeline specified in Section 16 of the Polk County Agreement. At the direction of its Board of Directors, the COUNTY may terminate this BA Agreement and the Polk County Agreement as permitted in Section 16 of the Polk County Agreement if CONTRACTOR has not cured the breach upon conclusion of the technical assistance and corrective action described in paragraph (i.) of this section; or

   c. If neither termination nor cure is feasible, the COUNTY shall report the violation to the Secretary.

3. Effect of Termination.

   a. Except as provided in paragraph (ii.) of this section, upon termination of this BA Agreement, for any reason, CONTRACTOR shall return or destroy all Protected Health Information received from the COUNTY, or created or received by CONTRACTOR on behalf of the COUNTY. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of CONTRACTOR. CONTRACTOR shall retain no copies of the Protected Health Information.

   b. In the event that CONTRACTOR determines that returning or destroying the Protected Health Information is infeasible, CONTRACTOR shall provide to the COUNTY written notification of the conditions that make return or destruction infeasible. Upon written acknowledgement by the COUNTY that the return or destruction of Protected Health Information is infeasible, CONTRACTOR shall extend the protections of this BA Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposed that make the return or destruction infeasible, for so long as CONTRACTOR maintains such Protected Health Information.

G. MISCELLANEOUS:

1. Regulatory References. References in this BA Agreement to the Privacy Rule or any section of the Privacy Rule means the Privacy Rule or section as in effect or as amended.

2. Amendment. The COUNTY and CONTRACTOR agree to take such action as is necessary to amend this BA Agreement from time to time as is necessary for the COUNTY to comply with the requirement of the Privacy Rule and HIPAA.

3. Survival. The respective rights and obligations of CONTRACTOR under Section 6.C of this BA Agreement shall survive the termination of this BA Agreement.

4. Interpretation. Any ambiguity in this BA Agreement shall be resolved to permit the COUNTY to comply with the Privacy Rule. In the event of any inconsistency between the provisions of this BA Agreement and the mandatory provisions of the Privacy Rule, the Privacy Rule shall control. Where laws in the State of Oregon or other federal law is more stringent than the Privacy Rule, the more stringent Oregon or federal law shall control.

H. SECURITY RULE BUSINESS ASSOCIATE AGREEMENT LANGUAGE:

1. Background Requirement: The COUNTY, in accordance with § 164.306 and § 164.308 (b), may permit the CONTRACTOR to create, receive, maintain, or transmit Electronic Protected Health Information on the COUNTY'S behalf only if the COUNTY obtains satisfactory assurances, in accordance with § 164.314(a) that the CONTRACTOR will appropriately safeguard the information. The COUNTY must document the satisfactory assurances through a written contract or other arrangement with the CONTRACTOR.

2. Part I. Security Assurances: The CONTRACTOR will Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the COUNTY as required by the Health Insurance Portability and Accountability Act of 1996 and the requirements of Health Insurance Reform, the Security Standards (45CFR Parts 160, 162 & 164);

    a. Ensure that any agent, including a SUBCONTRACTOR, to whom it provides such information, agrees to implement reasonable and appropriate safeguards to protect it.

    b. Report to the COUNTY any security incident of which it becomes aware.

    c. Authorize termination of the contract by the COUNTY, if the COUNTY determines that the business associate has violated a material term of the contract.

3. Part II. Other arrangements: When the COUNTY and the CONTRACTOR are both governmental entities, the COUNTY is in compliance with the requirements if:

    a. It enters into a memorandum of understanding with the CONTRACTOR that contains terms that accomplish the objectives of Part I.; or

    b. Other law (including regulations adopted by the COUNTY or the CONTRACTOR) contains requirements applicable to the CONTRACTOR that accomplish the objectives of Part I.

4. If the CONTRACTOR is required by law to perform a function or activity on behalf of the COUNTY or to provide a service described in the definition of CONTRACTOR as specified in § 160.103 of the regulation to the COUNTY, the COUNTY may permit the CONTRACTOR to create, receive, maintain, or transmit Electronic Protected Health Information on its behalf to the extent necessary to comply with the legal mandate without meeting the requirements of Part I., although the COUNTY will attempt in good faith to obtain satisfactory assurances as required by Part I. (A), and will document the attempt and the reasons that these assurances cannot be obtained, if not obtained.

CONTRACTOR SIGNATURE

Chad A. Ludwig

Authorized Signer

10/22/2024

Date

COUNTY SIGNATURE

Authorized Signer

Date

A5 Interpreting
POWERED BY
BRIDGES OREGON, INC.

Agreement for Provision of Interpreting and Accommodation Services

Thank you for choosing A5 Interpreting (dba Bridges Oregon, Inc.) to fulfill your American Sign Language (ASL) interpreting and accommodation needs.

Mission: Bridges Oregon, Inc. is a nonprofit organization serving Oregonians who are Deaf, DeafBlind, or Hard of Hearing, or who face other communication barriers. It is our mission to facilitate equity and inclusiveness and to create bridges to opportunities through advocacy, education, and communication. ***100% of all net proceeds go to provide services to Deaf, DeafBlind, and Hard of Hearing Oregonians.***

A5 Interpreting is a Bridges Oregon program that connects freelance American Sign Language interpreters from all over the state of Oregon with businesses and individuals to meet their communication needs. We pride ourselves in assessing each request individually to customize the best services possible. When you make a request, our coordination team may ask for additional details so we can connect you with service providers that have the experience and skills to best meet your needs.

CONTRACTOR
A5 Interpreting
dba Bridges Oregon, Inc.
1115 Madison St NE, #1069
Salem, OR 97301
Requests: support@A5interpreting.org | Accounting: accounting@bridgesoregon.org
Tel: (971) 202-1500

Oregon Business Registry: 1337956-90 | Nonprofit 501(c)(3): 82-2053319

Please read this agreement in full, and let us know any questions you may have. Then return a copy of the signed document by fax or email to establish an account with A5 Interpreting. Once a signed copy of this document has been filed with our office, we can begin coordinating services for your requests. Please also retain a copy of this agreement for your records and reference.

Terms:

1. Scope of Services. A5 Interpreting, herein referred to as “A5 Interpreting,” agrees to provide services to the organization or individual signed below, herein referred to as “Client,” to facilitate communication between English speakers and Deaf, DeafBlind, and Hard of Hearing patients, customers, and/or employees, herein referred to as “Consumers.” Client contact and billing information are agreed to as completed in Exhibit A of this agreement. This agreement is entered into on the date specified below on an on-going basis or as specified in Exhibit B “Scope of Services.”

1.1 Independent Contractor Status: A5 Interpreting is an independent contractor and not an employee of Client. Nothing in this agreement shall be construed to create a relationship of employer-employee. As the contractor, A5 Interpreting is responsible for all costs and expenses incurred in the course of doing business.

2. Professional Ethics. A5 Interpreting agrees to adhere to the NAD-RID Code of Professional Conduct.

3. Requests for Interpreting Services. Requests for interpreting services may be made by existing Clients through our HIPAA compliant portal: a5interpreting.usked.com, or by emailing support@A5Interpreting.org with the request details:

- date and start/end time of event,
- whether or not the interpreter(s) will be recorded at the event (interpreters must give consent to be recorded),
- location (physical address, suite/room number, etc.) or virtual link, and
- description of the event.
- Whenever possible, requests also include:
    - contact information for English- and ASL-using consumers,
    - any known specialized needs or preferences, and
    - any related websites or other resources about the event.

3.1 Interpreter Availability. A5 Interpreting makes every effort to fulfill requests. Interpreting services are in high demand, so submitting requests as early as possible, even with partial information, raises chances of interpreter availability.

3.2 Interpreter Selection. A5 Interpreting reserves the right to select interpreters for each Assignment based upon its understanding of the skill-set required. A5 Interpreting

may contact Consumers directly to gather pertinent information for selecting the appropriate interpreter for the Assignment.

3.3 Preferred Interpreters. Requests for a particular interpreter are honored, pending the interpreter's availability and ability to provide quality services for the communication needs as described in the request.

3.4 Multi-Interpreter Teams. Some Assignments require more than one interpreter. At the time of processing the request, A5 Interpreting assesses the number of interpreters required and advises Client if more than one is necessary.

Scenarios that require two or more interpreters include, but are not limited to: events exceeding an hour in length, multi-party meetings, conferences, legal proceedings, working with consumers who are DeafBlind, or working with signing consumers who are not fluent in American Sign Language.

If the nature of the Assignment is not appropriately communicated in advance, A5 Interpreting reserves the right to dispatch additional interpreters and to adjust the charge according to the additional services needed and provided.

4. Preparation Materials. Any relevant materials that will be used during the course of the Assignment should be forwarded to A5 Interpreting as soon as available so that the interpreters may prepare in advance. These materials will be handled with strict confidence and will be destroyed following the Assignment.

Examples of preparation materials include:

- the names and roles of people who will be involved or referenced during the Assignment,
- meeting agendas,
- speaker biographical information,
- handouts, slides or other visual aids planned for presentations.

5. Scheduled Versus Actual Service Time. Client is responsible to pay for the full duration of services as scheduled even if the Assignment ends early.

5.1 Extended Appointment Time. If the appointment extends past its scheduled time, the interpreter may or may not be able to continue. All efforts are made to secure an interpreter beyond the requested time. Client is responsible for payment of any service time provided beyond originally scheduled duration.

5.2 No Show. Interpreter(s) wait a minimum of 15 minutes for Consumers to arrive at Assignment. If Consumer has not arrived or communicated an anticipated time of arrival at 15 minutes, the Assignment is considered canceled and billed as scheduled.

5.3 Breaks. Interpreters are granted breaks and meal times according to local regulation during which they do not perform any interpreting services. Service time is billed from start to end time of interpreting services, regardless of interpreter breaks. When more than one interpreter is providing services, interpreters may rotate duties so that interpreting services are provided continuously.

6. Cancellation Policy. A5 Interpreting aims to give timely notice of cancellation to interpreters who contract through our agency, enabling them to cover other interpreting needs in the community and replace work lost to them by canceled Assignments. Client is responsible for informing A5 Interpreting of canceled appointments according to the following.

6.1 Notice to A5 Interpreting. Cancellations must be submitted to our office during business hours within the guidelines stated below. Cancellation requests submitted during non-business hours are time stamped at 8AM on the next business day. It is strongly suggested that Client submit notice of cancellation via email.

6.2 Cancellation Deadlines. To avoid being charged for services as scheduled, cancellations must be received by A5 Interpreting as follows:

- Events of 2 hours or less require 2 business days notice
- Events of 2-4 hours require 3 business days notice
- Events of 4-8 hours require 4 business days notice
- Events lasting 2 or 3 days require 5 business days notice
- Longer events, as negotiated at time of request

6.3 Reassignment of Interpreter. In the event that an assignment is canceled and the interpreter is needed on-site for a different assignment, please check with A5 Interpreting to ensure that the change of assignment can be accommodated.

7. Training and Quality Assurance. A5 Interpreting is committed to providing quality services, which from time to time requires an additional person attending an Assignment along with working interpreters. Trainees and supervisors are bound by the same confidentiality and other ethical requirements as all A5 Interpreting contractors.

7.1 Intern Attendance. A5 Interpreting is committed to on-going training of interpreters and reserves the right to send interns to observe Assignments where appropriate at no

additional cost to Client. Any party to the Assignment may decline involvement of an intern at any time verbally or in writing.

7.2 Interpreter Supervision. A5 Interpreting reserves the right to send a representative from A5 Interpreting to attend any interpreting Assignment at any time to complete quality assurance at no additional cost to the Client. Any party to the Assignment may decline involvement of a representative at any time verbally or in writing.

8. Compensation and Billing. Client agrees to compensate A5 Interpreting as follows. All fees and rates are charged per each interpreter scheduled for the Assignment.

- **Initial fee: $230.00.** The initial fee is charged per interpreter for each Assignment. This initial fee covers scheduling and coordinating services from A5 Interpreting, and up to two hours of interpreting services.

- **Hourly rate: $115.00.** For services rendered beyond 2 hours (or if a shorter scheduled Assignment runs overtime), the hourly rate is added to the initial fee at 15 minute increments.

- **Additional Fees.** Additional fees described below are added to the hourly rate. Multiple additional fees may apply, such as an Assignment during evening hours that requires an interpreter with a specialty.

  8.1 Nights/Weekend/Holiday Differential. Any hours of an Assignment that occur during nights (M-F 5pm-8am) or weekends, or on federal holidays are billed with a $20.00 hourly differential.

  8.2 Specialty Differential. Assignments that require specialization in conference, legal settings, tactile/ProTactile interpreting, medical, or mental health settings are billed with a $20.00 hourly differential.

  8.3 Additional Requirements. Additional requirements set by Client (e.g. trainings, vaccinations, special certification requests, security clearance, unique scheduling or communication requirements, multiple billing entities, etc.) incur additional administrative or service fees.

  8.4 Travel. A5 Interpreting prioritizes finding qualified interpreters local to each Assignment. However, if interpreters must travel more than two hours roundtrip, that travel time is charged to the Client at the standard hourly rate. For extended out-of-town

Assignments, travel, per diem, and additional expenses (flight, hotel, etc.) are negotiated on a case-by-case basis.

9. Payer Obligation.
Client shall pay the fees set forth above plus any applicable taxes as invoiced by A5 Interpreting to the billing contact recorded in this Agreement.

In the event payments are not received by A5 Interpreting within 30 days after becoming due, A5 Interpreting may:

1. Charge interest on any unpaid amounts at a rate of 2% per month or, if lower, the maximum amount permitted under applicable law, from the date such payment was due until the date paid.
2. Suspend performance for all Services until payment has been made in full.
3. Transfer unpaid balance to a third-party collections agency and charge Client a collection fee of up to 50% of the unpaid balance or charge Client reasonable attorney and court fees incurred in collecting payment.

9.1 Third Party Payment. Billing to a third party (such as ODHS or Labor & Industries) must be identified each time a request is made. If invoices for services are denied, payment becomes the responsibility of the requestor. Please note that insurance companies do not ordinarily reimburse for interpreting services.

10. Term of Agreement. The rates and terms of this agreement shall be valid until terminated in writing by either party. Prices and terms are subject to change through written agreement of both parties.

10.1 Arbitration. Any controversies arising out of the terms of this Agreement or its interpretation shall be settled in Marion County, Oregon in accordance with the rules of the American Arbitration Association, and the judgment upon award may be entered in any court having jurisdiction thereof.

10.2 Force Majeure. A5 Interpreting shall not be liable or responsible to Client, nor be deemed to have defaulted or breached this Agreement, for any failure or delay in fulfilling or performing any term of this Agreement when and to the extent such failure or delay is caused by or results from acts or circumstances beyond the reasonable control of A5 Interpreting including, without limitation, acts of God, flood, fire, earthquake, explosion, governmental actions, war, invasion or hostilities (whether war is declared or not), terrorist threats or acts, riot, or other civil unrest, national emergency, revolution, insurrection, epidemic, lock-outs, or strikes.

11. Feedback. A5 Interpreting wishes to receive feedback about the performance of its interpreters. Please forward any compliments, complaints, or questions to (971) 202-1500 or email support@a5interpreting.org.

THIS AGREEMENT is effective from 11/01/2024 (date) by and between A5 Interpreting, and Polk County Health Services (name/organization name) as a Client requesting interpretation and accommodation services through A5 Interpreting.

_____ _____

Client Representative Signature Date

Greg P. Hansen

Client Representative Name (please print)

Chad A. Ludwig _____

A5 Interpreting Representative Signature Date

Chad A. Ludwig, MSW, ADAC, OHCI, CDI

A5 Interpreting Representative Name (please print)

Exhibit A - Client Contact and Billing Information Form

Please complete the following information for each section of your company (Department/Division/Program/etc.) that will request services and/or be responsible for billing.

Please submit one form for each department as needed. (For information that is the same across all departments, Client may write “See above” after completing it for the first deparment.)

CLIENT

Organization Name: Polk County

Department Name (if applicable): Health Services

Primary Contact Name: Rosana Warren Primary Telephone: 503-623-9289

Primary Contact Email: hs.contracts@co.polk.or.us

Billing Contact Name: HS Fiscal Billing Telephone: 503-623-9289

Billing Email: hs.fiscal@co.polk.or.us Billing Fax: 503-831-1726

Billing Address: 182 SW Academy Street, Suite 220, Dallas, OR 97338

PO # (if needed): _____

Authorized Requesters for this Department (As many as applicable - add lines as needed)

1. Name: Developmental Disabilities Staff Email: 503-831-5969
2. Name: Public Health Staff Email: 503-623-8175
3. Name: Behavioral Health Staff Email: 503-623-9289
4. Name: _____ Email: _____
5. Name: _____ Email: _____

A5Interpreting
POWERED BY
BRIDGES OREGON, INC.

Exhibit B - Scope of Services

Thank you for choosing A5 Interpreting (dba Bridges Oregon, Inc.) to fulfill your American Sign Language (ASL) interpreting and accommodation needs. If needed for your organizational records, please complete the scope of services requested below with the rates as indicated in Section 8 of this agreement.

Date(s) for Services: _____

Start and End Times for Services: _____

Type(s) of Services: _____

Initial Fee: _____ Hourly Rate (beyond two hours): _____

Travel or other anticipated expenses: _____ Total Estimate: _____

Rate for overage: Prorated hourly rate in 15 minute increments

1115 Madison St NE, #1069 • Salem, OR 97301
(971) 202-1500 • support@A5interpreting.org • A5interpreting.org

LEASE AGREEMENT

THIS LEASE AGREEMENT ("Lease Agreement" or "Lease"), dated December 11, 2024, is by and between:

WILLAMETTE HEALTH COUNCIL, ("Lessor"),

and

POLK COUNTY, ("Lessee"),

Recitals:

WHEREAS, Willamette Health Council has entered into a ground lease agreement with Falls City for a lot located at located at 200 Parry Rd, Falls City, Polk County, Oregon ("Premises"); and

WHEREAS, Willamette Health Council has purchased and placed a modular building ("Building") in Falls City for the purposes of the development of the Falls City Community Health Center; and

WHEREAS, Willamette Health Council seeks to have Polk County sublease the Building to providers to provide services at the Falls City Community Health Center, and to otherwise provide staffing for the operation of the Falls City Community Health Center; and

WHEREAS, Polk County has agreed to provide such staffing and to coordinate subleases of the Falls City Community Health Center.

AGREEMENT:

Article 1
GENERAL TERMS

1.1. **Lessee:** Polk County; Notice Address: 850 Main St, Dallas OR 97338
1.2. **Lessor:** Willamette Health Center; Notice Address: 205 Chemeketa St NE, Salem, OR 97301
1.3. **Initial Term:** 12 months
1.4. **Building:** This refers to the modular office building Willamette Health Council has purchased and placed on the Premises.
1.5. **Ground Lease Agreement:** This is the agreement between Falls City and Lessor and is the master lease ("Ground Lease Agreement").
1.6. **Operating Expense Responsibilities:** Refer to Exhibit A.

Article 2
LEASE TERMS

2.1. **Lease.** Subject to the terms and conditions of this Lease, Lessor hereby leases to the Lessee and Lessee hereby leases from Lessor, the Building.
2.2. **Term.** The initial term of this lease is set forth commenced upon the full execution of this agreement and terminates on December 31, 2025.

2.3. **Renewal Option.** This Lease will automatically renew unless terminated or unless a Party notifies, in writing, the other of its intention to not renew not less than 60 days before expiration.

ARTICLE 3
USE OF PREMISES

3.1. **Permitted Use.** Lessee may use the Premises for any purpose proper to effectuate the purposes of operating and maintaining the Falls City Community Health Center.

3.2. **Equipment.** Lessee will only install such equipment on the Premises and in the Building as is customary for the Permitted Use and will not overload the floors or electrical circuit of the Premises or the Building. Any additional equipment, cables, wirings, conduits, additional dedicated circuits, and any additional other equipment required because of any such equipment installed by Lessee will be installed, maintained, and operated at Lessee's expense.

3.3. **Compliance with Laws.** Lessee will, at Lessee's expense, comply with all laws and requirements of any public authorities ("Laws") that, in respect of the Premises or the use and occupancy thereof, or the abatement of any nuisance in, on, or about the Premises, impose any violation, order, or duty upon the Lessor, Lessor, or Lessee, arising from: (a) Lessee's use of the Premises; (b) the manner of conduct of Lessee's business or operation of its installations, equipment, or other property therein; (c) any cause or conditions created by the Lessee; or (d) breach any of the Lessee's obligations hereunder.

3.4. **ADA Compliance.** Lessor and Lessee acknowledge that the provisions of the Americans with Disabilities Act (the "ADA") allow allocation of responsibility for compliance with the terms and conditions of the ADA in this Lease. Responsibility for compliance with the ADA is allocated as set forth in this subsection. Lessor is responsible for responsible for compliance with the ADA with respect to all issues that arise due to structural features of the subleased space. With respect to each Party's area of responsibility, each Party shall take all steps necessary to comply with the ADA, shall pay all costs of compliance, promptly when due, and shall pay all penalties, fines, judgments, including attorney fees and court costs, levied or assessed because of a failure to comply with the ADA.

a. **Costs.** In the event Lessor is required to make a change to the subleased space to comply with the ADA at a cost exceeding $5,000, Lessor shall notify Lessee. In accordance with the Ground Lease Agreement, the Lessor has the option to terminate the Ground Lease Agreement. If the Lessor elects to terminate the Ground Lease Agreement, the Lessor will provide Lessee 60 days prior notice. Upon this notice Lessee shall begin to leave and vacate the Premises within 60 days. Lessor may elect to pay for the costs of the change to ensure the Premises are ADA complaint.

b. **Environmental Law Compliance.** For the purposes of this subsection, "Hazardous Substances" means and includes all hazardous and toxic substances, waste, or materials; and any pollutant or contaminant, including without limitation, PCBs, asbestos, asbestos-containing materials, and raw materials that are included under or are regulated by Environmental Laws. For the Purposes of this Lease Agreement, the term "Environmental Laws" means and includes all federal, sate, and local, statutes, ordinances, regulations, and

rules presently in force or hereafter enacted relating to environmental quality, contamination, and clean-up of Hazardous Substances. References to "Laws" in this Lease Agreement are deemed to include Environmental Laws.

Article 4
MAINTENANCE AND REPAIR

4.1. **Lessor Repairs.** Lessor shall maintain and repair, at its expense, the roof, structural parts of the modular office building. At the termination of this lease, Lessee shall surrender the premises to Lessor in broom swept condition, ordinary wear and tear and casualty excepted.

4.2. **Lessee Repairs.** Lessee shall maintain the interior of the premises in reasonably good condition, at its expense Lessee, shall maintain all plumbing, electrical, lighting fixtures and bulbs on the premises.

Article 5
ALTERATIONS

5.1. **Alternations by Lessee in Building.** Lessee may not make any alterations, additions, or improvements to the Building without obtaining consent of the Lessor. Lessor shall not unreasonably withhold consent. If Lessor consents, in writing, to any proposed alteration of the Building, Lessee will: (a) contract only with a Lessor-approved contractor for the performance of the alterations; (b) obtain all necessary governmental permits and approvals and deliver copies thereof to Lessor; and (c) cause all alterations to be completed in compliance with Lessor-approved plans and specifications with all due diligence. Except for removable machinery and unattached movable trade fixtures, all improvements, alterations, wiring, cables, or conduit installed by Lessee will immediately become part of the Building, with title vested in Lessor. Lessor may require that Lessee remove any such improvements, alterations, wiring, cables, or conduit installed by or for Lessor and restore the Building to good condition and repair upon expiration or earlier termination of this Lease. All work performed on the Premises must comply with applicable laws. Lessee will not permit any liens to attach to the Lessee's interest in the Premises.

5.2. **Alterations by Lessee of the Premises.** Lessee shall not make any alterations, additions, or improvements to or upon the premises without the consent of the Lessee.

Article 6
UTILITIES AND SERVICES

6.1. **Utilities.** Lessor shall pay for all utilities, servicing the Premises and the Building, including, but not limited to electricity, natural gas, telephone and data services, and garbage service.

6.2. **Lessee's Right to Hire.** Lessee will be able to choose utility services providers for the services described in subsection 6.1.

6.3. **Notice.** Any and all utilities statements will be sent to Lessor by Lessee. If any are not sent to the Lessor and instead sent to the Lessee, Lessee shall, as soon as possible deliver those statements to the Lessor. Failure to do so will relieve the Lessor of its duty to pay for the undelivered statements. Any late fees that the Lessee's failure to properly deliver to Lessee

will be the responsibility of the Lessee.

6.4. Hold Blameless for Failure to Notice. In the event Lessee fails to submit a utility statement to the Lessor and that given utility is shut off for failure to pay, the Lessee shall hold the Lessor blameless.

Article 7
INSURANCE

7.1 Lessee Insurance. Lessee, at its expense, shall maintain insurance to cover its activities on the Premises and in the Building including but not limited to commercial general liability for bodily injury and property damage with limits of not less than $1,000,000 per occurrence or $2,000,000 general aggregate coverage. All such insurance policies shall cover all risks arising directly or indirectly out of Lessee's activities and any condition of the Premises whether or not related to an occurrence caused or contributed by Lessee's negligence. All such insurance policies shall protect Lessee against claims of Lessor on account of the obligations assumed by the Lessee and all such policies shall name the Lessor as an additional insured. Certificates of such insurance shall be provided by Lessee to Lessor to not less than 10 days before occupancy of the Premises by Lessee.

7.2 Lessee's Sublessees and Assignees. Lessee shall also require its sublessees/assignees to carry insurance to cover their activities on the Premises and in the Building including but not limited to commercial general liability insurance with limits of not less than $1,000,000 per occurrence or $2,000,000 general aggregate coverage. All such insurance policies shall cover all risks arising directly or indirectly out of Lessee's activities and any condition of the Premises whether or not related to an occurrence caused or contributed by Lessee's sublessor's/assignee's negligence. Certificates of such insurance shall be provided by Lessee to Lessor not less than 10 days before occupancy of the Premises by Lessee's Lessees/assignees.

7.3 Failure to Provide Certificate of Insurance. In the event Lessor has not provided certificates pursuant to the above subsections, Lessee shall not be allowed to take possession of the Premises. Lessee may cure this defect by providing certificates of such insurance. If cured, Lessee may take possession of the property within 10 days. Lessee shall not hold Lessor liable for damages, defaults of other agreements, or any other impacts related to Lessee's failure to provide the certificates.

7.4 Failure to Provide Lessee's/Assignee's Certificates of Insurance. Lessee shall not allow any of Lessee's Lessees or assignees take possession of the property if certificates of insurance to cover the Lessees' or assignees' activities on the property.

Article 8
INDEMNIFICATION

By Lessee. Lessee will indemnify, defend, and hold harmless Lessor and its managing agents and employees from any claim, liability, damage, or loss, or any cost or expense in connection therewith (including reasonable attorney fees), whether suffered directly or from a third-party claim arising out of (a) any damage to any person or property occurring in, on, or about the Premises or the Building; (b) use by Lessee or its agents, invitees, or contractors of the Building and the Premises; or (c) Lessee's breach or violation of any term of this Lease. The provisions of

Article 8 will survive termination of this Lease.

Article 9
FIRE OR CASUALTY

Major Damage. In case of major damage, Lessor may elect to terminate this Lease by notice in writing to the Lessee within 30 days of the Major Damage. "Major Damage" means damage by fire or other casualty to the Building or Premises: (a) that causes the Premises or any substantial portion of the Building unusable; (b) the repair of which will cost more than 25% of the replacement value of the building; or (c) that is not required under this Lease to be covered by insurance. If Lessor does not terminate this Lease after any Major Damage, or if damage occurs to the Building or Premises that is not Major Damage, Lessor will promptly restore the Premises to the condition existing immediately before the damage, and this Lease will continue in full force and effect. In the event of any damage to the Building or Premises from a fire or other casualty, Lessor will promptly repair and restore all Lessor improvements or alterations installed or paid for by Lessee or pay the cost of the restoration to Lessor if Lessor performs the restoration.

Article 10
ASSIGNMENT AND SUBLETTING

Lessee's Assignment. Lessee may assign its Lease or sublet its Lease without the consent of the Lessor only if that other Party is entering in an agreement to provide services as the Falls City Community Health Center, consistent with Lessor's mission. Before such agreement is to begin, Lessee must inform Lessor as soon as practicable about such agreement.

Article 11
DEFAULT

11.1 Events of a Default. Each of the following is an Event of Default by Lessee under this Lease Agreement:

- **a)** Failure by Lessee to comply with any other obligation of this Lease within 20 days following written notice from Lessor specifying the failure (except in the case of emergency, in which event Lessor will be required to give only such notice as is reasonable under the circumstances); however, if the nature of Lessor's default requires more than 20 days to correct, Lessee will not be deemed in default of this Lease as long as Lessee commences the cure of the failure within the 20-day period and thereafter proceeds in good faith and with all diligence to complete the cure as soon as possible but in no event later than 90 days after the date of Lessor's notice of default.
- **b)** Lessee's abandonment of the Premises and/or Building or failure to occupy the Premises or Building within 20 days' notice from Lessor.

11.2 Remedies for Default. Upon commencement of an Event of Default described in Section11.2, Lessor may exercise the following remedies as well as any other remedies at law in equity, by statute or as set forth in this Lease:

- **a)** Lessor may terminate this Lease, reserving all rights to damages resulting from Lessee's breach. Whether or not Lessee terminates this Lease, Lessor may retake possession of the Premises by any legal means including self-help, and

any relet or use of the Premises by Lessor will not be deemed a surrender or waiver of Lessor's right to damages.

b) Lessee will be liable to Lessor for all damages caused by Lessor's default, including, but not limited to the unamortized cost of all improvements to the Premises installed or paid for by Lessor. Lessor may periodically sue Lessor to recover damages as they accrue, and no action therefor will bar a later action for damages accruing thereafter. Lessor may elect in any one action to recover both accrued damages as well as damages attributable to the remaining term of the Lease.

11.3 Lessor's Right to Cure Default. Lessor may cure any Lessee default at its discretion. Lessor's right to cure any Lessee default is for the sole protection of Lessor, and in no event will Lessee be released from any obligation to perform all of Lessee's obligations and covenants under this Lease.

11.4 Default of Lessor. Lessor will not be deemed to be in default of the performance of any obligation required to be performed by Lessor hereunder unless and until Lessor fails to perform the obligation within 20 days after written notice by Lessee to Lessor specifying the nature of Lessor's alleged default; however, if the nature of Lessor's alleged default is such that more than 20 days are required for its cure, then Lessor will not be deemed to be in default if Lessor commences performance within the 20-day period and thereafter diligently prosecutes the same to completion. In the event of any default by Lessor, Lessee may exercise any and all rights and remedies available at law or in equity.

Article 12
NOTICES

All notices, demands, consents, approvals, and other communications provided for herein will be invalid unless set forth in a writing and delivered by facsimile transmission, personal delivery, or registered or certified U.S. mail with return receipt requested to the appropriate Party at its address as set forth in Article 1. Addresses for notices may be changed from time to time by written notice to all other Parties. Any communication given by facsimile transmission must be confirmed within 48 hours. If any communication is given by mail, it will be effective on the earlier of: (a) 48 hours after deposit in the U.S. mail, with postage prepaid; or (b) actual receipt, as indicated by the return receipt, if given by facsimile, when sent. If communication is given by personal delivery it will be effective when delivered.

Article 13
ACCESS

Access. Lessee shall have access to the Building 24 hours per day, 7 days per week, and 52 weeks per year. Subject to any federal or state security regulations, Lessor will not be liable to Lessee for permitting or refusing to permit access to Building by anyone. After reasonable notice to Lessee, Lessor may enter the Building to perform required or necessary services, maintenance, repairs, alterations, or services to the Building. Except in case of emergency, all entry to the Building will be at times and in a manner that minimizes interference with Lessee's use of the Building.

Article 14
SURRENDER; HOLDOVER

Upon expiration or earlier termination of this Lease, Lessee will surrender the Premises and, at Lessor's option, all improvements and alterations therein, vacuumed, swept, and free of debris and in good and serviceable condition, subject to ordinary wear and tear. Lessee will remove all of its personal property and any conduits, wiring, cables, or alterations if required by this Lease and will repair all damage to the Premises and the Building resulting from that removal. If Lessee fails to remove any such personal property or alterations, those items will be deemed abandoned, and Lessor may remove or dispose of the items without liability to Lessee or others. Upon demand, Lessee will reimburse Lessor for the cost of such removal. If Lessee fails to surrender the Premises and remove all its personal property as set forth herein, Lessor may evict Lessee from the Premises and recover all damages resulting from Lessee's wrongful holdover.

Article 15
HAZARDOUS MATERIALS

Neither Lessee nor Lessor's agents or employees will cause or permit any Hazardous Material, as hereinafter defined, to be brought, stored, used, generated, released into the environment, or disposed of on, in, under, or about the Premises or Building, except reasonable quantities necessary to or required as part of Lessee's and Sublessees' services that are generated, used, kept, stored, or disposed of in a manner that complies with all laws regulating any such Hazardous Materials and with good business practices. Lessee covenants to remove from the Premises and Building, upon the expiration or sooner termination of this Lease and at Lessee's sole cost and expense, any and all Hazardous Materials brought, stored, used, generated, or released on, in, or into the environment by Lessee or its Sublessees, agents, employees, or invitees during the term of this Lease. To the fullest extent permitted by law, Lessee hereby agrees to indemnify, defend, protect, and hold harmless Lessor, their respective agents and employees, and their respective successors and assigns, from any and all claims, judgments, damages, penalties, fines, costs, liabilities, and losses that arise during or after the term directly or indirectly from the use, storage, disposal, release, or presence of Hazardous Materials by Lessee or its agents, employees, or invitees on, in, or about the Premises the Building, that that occurs during the term of this Lease. As used herein, the term "Hazardous Material" means any hazardous or toxic substance, material, or waste that is or becomes regulated by any local governmental authority, the state of Oregon, or the United States government. The term "Hazardous Material" includes, without limitation, (a) any material or substance that is defined as a "hazardous waste," "extremely hazardous waste," "restricted hazardous waste," "hazardous substance," "hazardous material," or "waste" under any federal, state, or local law; (b) petroleum; and (c) asbestos. The provisions of this Article 15, including, without limitation, the indemnification provisions set forth herein. will survive any termination of this Lease.

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Article 16
ATTORNEYS' FEES

If suit or action is instituted in connection with any controversy arising out of this Lease, including any arbitration proceeding, the prevailing party will be entitled to recover, in addition to costs, such sums as the court may adjudge reasonable as attorney fees at trial and on all appeals or petitions for review arising out of the suit or action.

Article 17
FORCE MAJEURE

If the performance by either Party of any provision of this Lease (is prevented or delayed by any strikes, lockouts, labor disputes, acts of God, government actions, civil commotions, fire or other casualty, or other causes beyond the reasonable control of the Party from whom performance is required, the Party will be excused from such performance for the period of time equal to the time of that prevention or delay up to a maximum of 180 days.

Article 18
GOVERNING LAW

This Lease Agreement will be construed and interpreted, and the rights of the Parties determined in accordance with the laws of the state of Oregon.

Article 19
NONWAIVER

No delay by either party in promptly enforcing any right or remedy set forth in this Lease Agreement will be deemed a waiver thereof, and that right or remedy may be asserted at any time after the delaying party becomes entitled to the benefit of the right or remedy notwithstanding the delay.

Article 20
CAPTIONS

The article and section headings of this Lease Agreement are for descriptive purposes only and in no way define, limit, or describe the scope, intent, or meaning of this Lease Agreement.

Article 21
COMPLETE AGREEMENT

This Agreement and the attached exhibits and schedules, if any, contain the entire agreement of Lessee and Lessor concerning the Premises and Building, and all prior written and oral agreements and representations between the Parties are void. Lessee and Lessor agree that there are no implied covenants or other agreements between the Parties except as expressly set forth in this Agreement. Neither Lessee nor Lessor is relying on any representations of the other Party except those expressly set forth herein.

Article 22
CONFLICT WITH LEASE AGREEMENT

If a term of this Lease Agreement is in conflict with the Ground Lease Agreement between Willamette Health Council and Falls City, the terms of the Ground Lease Agreement control.

IN WITNESS WHEREOF, the duly authorized representatives have executed this Lease Agreement:

LESSOR:	LESSEE:
Willamette Health Council	**Polk County**
_____	_____
_____	_____
DATE	DATE

Exhibit A- Operating Expense Responsibilities

From the execution of the lease through December 31, 2025, Willamette Health Council has already provided one-time funding to contribute to the following operating expenses that will be completed by Polk County:

1. Custodial
2. Maintenance
3. Landscaping and irrigation systems maintenance
4. Staffing of reception
5. Real property taxes, if applicable

From the execution of the lease through December 31, 2025, Polk County will be responsible for the following operating expenses:

1. Liability insurance covering operations of Falls City Community Health Center
2. Staffing to manage subleases.