POLK COUNTY BOARD OF COMMISSIONERS

DATE: October 1, 2025
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 Polk County Board of Commissioners will be attending a special meeting for Polk County Local Public Safety Coordinating Council meeting on October 7, 2025 at 12:00 p.m., and is a virtual only meeting.

3. COMMENTS (for items not on this agenda and limited to 3 minutes. We encourage all community members to engage with public comments to the Board of Commissioners. However, out of respect for our audience and a general sense of decorum please refrain from vulgar, threatening or inappropriate language.)

4. APPROVAL OF AGENDA

5. APPROVAL OF THE MINUTES FROM September 25, 2025

6. APPROVAL OF CONSENT CALENDAR

CONSENT CALENDAR

a) Polk County Contract No. 25-172, Oregon Health Authority
(Rosana Warren Rivera, Behavioral Health)

b) Polk County LADPC Member Appointment, Christine Felt
(Jodi Merritt, Community Corrections Director

c) Polk County Contract No. 25-173, Health Net Health Plan of Oregon, Inc
(Rosana Warren Rivera, Public Health)

d) Declaring Surplus Property
(Todd Whitaker, Public Works Director)

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

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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 SPECIAL BOARD MEETING
MINUTES September 25, 2025

1. CALL TO ORDER & ATTENDANCE

At 10:30 a.m., Commissioner Pope declared the meeting of the Polk County Board of Commissioners to be in session. Commissioner Gordon was present and Commissioner Mordhorst was absent.

Staff present: Greg Hansen, Administrative Officer

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 Polk County Board of Commissioners will be attending a special meeting for Polk County Local Public Safety Coordinating Council meeting on October 7, 2025 at 12:00 p.m., and is a virtual only meeting.

3. COMMENTS

None

4. APPROVAL OF AGENDA

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

BOTH VOTED YES.
MOTION PASSED BY VOTE OF THE QUORUM.

5. APPROVAL OF MINUTES OF September 16, 2025 and September 24, 2025

MOTION: COMMISSIONER GORDON MOVED, COMMISSIONER POPE SECONDED, TO APPROVE THE MINUTES OF September 16, 2025 and September 24, 2025.

BOTH VOTED YES.
MOTION PASSED BY VOTE OF THE QUORUM.

At 10:31 a.m. County Counsel announced that the meeting was recessed to 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 10:48 a.m. and Commissioner Pope adjourned the meeting.

POLK COUNTY BOARD OF COMMISSIONERS

Craig Pope, Chair

Jeremy Gordon, Commissioner

Lyle Mordhorst, Commissioner

Minutes: Nicole Pineda
Approved: October 1, 2025

CONTRACT REVIEW SHEET

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

Department: Health Services: Behavioral Health | Consent Calendar Date: October 01, 2025

Contractor Name: Oregon Health Authority

Address: 635 Capitol St NE Suite 350

City, State, Zip: Salem, OR 97301

Effective Dates - From: July 01, 2025 | Through: December 31, 2025

Contract Amount: $94,953.63

Background:

Oregon Health Authority provides funds to finance Community Mental Health, Addiction Treatment, Recovery & Prevention and Problem Gambling services. This is the ninth Amendment to IGA 026022 (No.24-36). This award may be modified from time-to-time throughout the calendar year to reflect changes to funds and/or programs that are made a part of the grant.

Discussion:

Amendment 09 increases the funding awards to MH25 - Mobile Crisis services in the amount of $57,615.42 and MH09 - Jail Diversion services in the amount of $37,338.21 as part of the 6 months extension. No other changes noted.

Fiscal Impact:

Amendment 09 awards a total amount of $94,953.63 for the six month extension of the IGA aligning the total award to expected amounts. The Behavioral Health budget was prepared in anticipation of this funding, but a budget resolution may be needed at a later date.

Recommendation:

It is recommended that Polk County sign Amendment 09 to IGA 026022 with the Oregon Health Authority.

Copies of signed contract should be sent to the following:

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

Name: | E-mail:

In compliance with the Americans with Disabilities Act, this document is available in alternate formats such as Braille, large print, audio recordings, Web-based communications, and other electronic formats. To request an alternate format, please send an e-mail to dhs-oha.publicationrequest@odhsoha.oregon.gov or call 503-378-3486 (voice) or 503-378-3523 (TTY) to arrange for the alternative format.

AGREEMENT # PO-44300-00026022

NINTH AMENDMENT TO OREGON HEALTH AUTHORITY 2024-2025 INTERGOVERNMENTAL AGREEMENT FOR THE FINANCING OF COMMUNITY MENTAL HEALTH, ADDICTION TREATMENT, RECOVERY, & PREVENTION, AND PROBLEM GAMBLING SERVICES

This **Ninth** Amendment to Oregon Health Authority 2024-2025 Intergovernmental Agreement for the Financing of Community Mental Health, Addiction Treatment, Recovery, & Prevention, and Problem Gambling Services effective as of January 1, 2024 (as amended, the "Agreement"), is entered into, as of the date of the last signature hereto, by and between the State of Oregon acting by and through its Oregon Health Authority ("OHA") and **Polk County** ("County").

RECITALS

WHEREAS, OHA and County wish to modify the Financial Assistance Award set forth in Exhibit C of the Agreement.

NOW, THEREFORE, in consideration of the premises, covenants and agreements contained herein and other good and valuable consideration the receipt and sufficiency of which is hereby acknowledged, the parties hereto agree as follows:

AGREEMENT

1. The financial and service information in the Financial Assistance Award is hereby amended as described in Attachment 1 attached hereto and incorporated herein by this reference. Attachment 1 must be read in conjunction with the portion of Exhibit C of the Agreement that describes the effect of an amendment of the financial and service information.

2. Capitalized words and phrases used but not defined herein shall have the meanings ascribed thereto in the Agreement.

3. County represents and warrants to OHA that the representations and warranties of County set forth in section 4 of Exhibit F of the Agreement are true and correct on the date hereof with the same effect as if made on the date hereof.

4. Except as amended hereby, all terms and conditions of the Agreement remain in full force and effect.

5. This Amendment may be executed in any number of counterparts, all of which when taken together shall constitute one agreement binding on all parties, notwithstanding that all parties are not signatories to the same counterpart. Each copy of this Amendment so executed shall constitute an original.

IN WITNESS WHEREOF, the parties hereto have executed this amendment as of the dates set forth below their respective signatures.

6. Signatures.

Polk County
By:

Authorized Signature	Printed Name	Title	Date

State of Oregon, acting by and through its Oregon Health Authority
By:

Authorized Signature	Printed Name	Title	Date

Approved by: Director, OHA Health Systems Division
By:

Authorized Signature	Printed Name	Title	Date

Approved for Legal Sufficiency:

Exempt per OAR 137-045-0050(2)

Oregon Department of Justice Date

ATTACHMENT 1

EXHIBIT C
Financial Pages

MODIFICATION INPUT REVIEW REPORT

MOD#: **M1287**

CONTRACT#: **026022** CONTRACTOR: POLK COUNTY

INPUT CHECKED BY: _____ DATE CHECKED: _____

SE#	FUND	PROJ CODE	CPMS PROVIDER	EFFECTIVE DATES	SLOT CHANGE/TYPE	RATE	OPERATING DOLLARS	STARTUP DOLLARS	PART ABC	PART IV	PAAF CD	BASE	CLIENT CODE	SP#
FISCAL YEAR: 2025-2026														
	BASE		JAIL DIVERSION											
9	806		JAIL	7/1/2025 - 12/31/2025	0 /NA	$0.00	$37,338.21	$0.00	A		1	Y		
				TOTAL FOR SE# 9			$37,338.21	$0.00						
	BASE		MOBILE CRISIS INTER											
25	806		CRISIS	7/1/2025 - 12/31/2025	0 /NA	$0.00	$57,615.42	$0.00	A		1	Y		
				TOTAL FOR SE# 25			$57,615.42	$0.00						
				TOTAL FOR 2025-2026			$94,953.63	$0.00						
				TOTAL FOR M1287 026022			**$94,953.63**	**$0.00**						

OREGON HEALTH AUTHORITY
Financial Assistance Award Amendment (FAAA)

CONTRACTOR: POLK COUNTY Contract#: 026022
DATE: 09/09/2025 REF#: 012

REASON FOR FAAA (for information only):

Jail Diversion Services (MHS 09) and Mobile Crisis Intervention Services (MHS 25) funds have been awarded.

POLK COUNTY COMMUNITY CORRECTIONS

820 SW CHURCH ST SUITE 100 ★ DALLAS, OREGON 97338-5326
(503) 623-5226 ★ FAX (503) 623-5326

JODI MERRITT
DIRECTOR

LEE WARREN
SUPERVISOR

To: Board of Commissioners

From: Jodi Merritt

Date: September 3, 2025

Re: Local Alcohol and Drug Policy Committee Membership

Recommendation:
As Chair of the Local Alcohol and Drug Policy Committee Membership (LADPC) it is recommended that the Board of Commissioners approve the appointment of the following Member-at-Large nominees to the LADPC:

Christine Felt – Reconnections Counseling

Issue:
Shall the Board approve the nominees for the Member-at-Large positions of the LADPC?

Discussion:
The LAPPC membership is comprised of a minimum of eleven (11) voting members, of which six (6) are Standing Members and include: Polk County District Attorney (designee), Community Corrections Director (designee), Public Health Manager (designee), Mental Health Manager (designee), Service Integration Manager (designee), and Oregon Department of Human Services Child Welfare Manager (designee).

The remaining voting members are comprised of Member-at-Large positions that are appointed by consensus of the Standing Members, subject to ratification by the Board of Commissioners. Member-at-Large appointments are for a term of three (3) years and members may serve additional terms. This appointment will replace a current vacant Member-at-Large position.

Fiscal:
No fiscal impact.

CONTRACT REVIEW SHEET

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

Department: Health Services: Public Health | Consent Calendar Date: October 01, 2025

Contractor Name: Health Net Health Plan of Oregon, Inc

Address: 13221 SW 68th Pkwy, Suite 200

City, State, Zip: Tigard, OR 97223

Effective Dates - From: November 01, 2025 | Through: EVERGREEN

Contract Amount: $ Varies

Background:

OHA has awarded funding through PE63 to Polk County Public Health to provide Family Connect services. The Family Connects program is available to all expectant mothers in Polk County regardless of their ability to pay. To ensure access, Polk County is seeking to establish service rate agreements with commercial insurance providers. One such provider is Health Net Health Plan, Inc.

Discussion:

This Agreement with Health Net establishes an in-network service relationship for home visiting services provided through Polk County Public Health's Family Connects program to its members. Rates were negotiated by the Health Services Finance Officer and cover the costs of the service encounters.

Fiscal Impact:

The amount varies as it is dependent on the number of Health Net 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 Agreement with Health Net Health Plan of Oregon, Inc.

Copies of signed contract should be sent to the following:

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

Name: | E-mail:

Name: | E-mail:

PARTICIPATING PROVIDER AGREEMENT

This Participating Provider Agreement (together with all Attachments and amendments, this "***Agreement***") is made and entered by and between Polk County ("***Provider***") and Health Net Health Plan of Oregon, Inc. ("***Health Plan***") (each a "***Party***" and collectively the "***Parties***"). This Agreement is effective as of the date designated by Health Plan on the signature page of this Agreement ("***Effective Date***").

WHEREAS, Provider desires to provide certain health care services to individuals in products offered by or available from or through a Company or Payor (as hereafter defined), and Provider desires to participate in such products as a Participating Provider (as defined herein), all as hereinafter set forth.

WHEREAS, Health Plan desires for Provider to provide such health care services to individuals in such products, and Health Plan desires to have Provider participate in certain of such products as a Participating Provider, all as hereinafter set forth.

NOW, THEREFORE, in consideration of the recitals and mutual promises herein stated, the Parties hereby agree to the provisions set forth below.

ARTICLE I - DEFINITIONS

When appearing with initial capital letters in this Agreement (including an Attachment(s)), the following quoted and underlined terms (and the plural thereof, when appropriate) have the meanings set forth below.

1.1. "Affiliate" means a person or entity directly or indirectly controlling, controlled by, or under common control with Health Plan, including, but not limited to, Trillium Community Health Plan, Inc. and Health Net Life Insurance Company.

1.2. "Attachment" means any document, including an addendum, schedule or exhibit, attached to this Agreement as of the Effective Date or that becomes attached pursuant to Section 2.2 or Section 8.7, all of which are incorporated herein by reference and may be amended from time to time as provided in this Agreement.

1.3. "Clean Claim" has, as to each particular Product, the meaning set forth in the applicable Product Attachment or, if no such definition exists, the Provider Manual.

1.4. "Company" means (collectively or individually, as appropriate in the context) Health Plan and/or one or more of its Affiliates, except those specifically excluded by Health Plan.

1.5. "Compensation Schedule" means at any given time the then effective schedule(s) of maximum rates applicable to a particular Product under which Provider and Contracted Providers will be compensated for the provision of Covered Services to Covered Persons. Such Compensation Schedule(s) will be set forth or described in one or more Attachments to this Agreement, and may be included within a Product Attachment.

1.6. "Contracted Provider" means a physician, hospital, health care professional or any other provider of items or services that is employed by or has a contractual relationship with Provider and that provides Covered Services. The term "Contracted Provider" includes Provider for those Covered Services provided by Provider.

1.7. "Coverage Agreement" means any agreement, program or certificate entered into, issued or agreed to by Company or Payor, under which Company or Payor furnishes administrative services or other services in support of a health care program for an individual or group of individuals, and which may include access to one or more of Company's provider networks or vendor arrangements, except those excluded by Health Plan.

1.8. "Covered Person" means any individual entitled to receive Covered Services pursuant to the terms of a Coverage Agreement. Covered Person may also be referred to in certain Coverage Agreements as "Member" or "Beneficiary".

1.9. "Covered Services" means those services and items for which benefits are available and payable under the applicable Coverage Agreement and which are determined, if applicable, to be Medically Necessary under the applicable Coverage Agreement.

1.10. "Medically Necessary" or "Medical Necessity" shall have the meaning defined in the applicable Coverage Agreement or applicable Regulatory Requirements.

1.11. "Participating Provider" means, with respect to a particular Product, any physician, hospital, ancillary, or other health care provider that has contracted, directly or indirectly, with Health Plan to provide Covered Services to Covered Persons, that has been approved for participation by Company, and that is designated by Company as a "participating provider" in such Product.

1.12. "Payor" means the entity (including Company where applicable) that bears direct financial responsibility for paying from its own funds, without reimbursement from another entity, the cost of Covered Services rendered to Covered Persons under a Coverage Agreement and, if such entity is not Company, such entity contracts, directly or indirectly, with Company for the provision of certain administrative or other services with respect to such Coverage Agreement.

1.13. "Payor Contract" means the contract with a Payor, pursuant to which Company furnishes administrative services or other services in support of the Coverage Agreements entered into, issued or agreed to by a Payor, which services may include access to one or more of Company's provider networks or vendor arrangements, except those excluded by Health Plan. The term "Payor Contract" includes Company's or other Payor's contract with a governmental authority (also referred to herein as a "Governmental Contract") under which Company or Payor arranges for the provision of Covered Services to Covered Persons.

1.14. "Product" means any program or health benefit arrangement designated as a "product" by Health Plan (e.g., Health Plan Product, Medicaid Product, PPO Product, Payor-specific Product, etc.) that is now or hereafter offered by or available from or through Company (and includes the Coverage Agreements that access, or are issued or entered into in connection with such product, except those excluded by Health Plan).

1.15. "Product Attachment" means an Attachment setting forth requirements, terms and conditions specific or applicable to one or more Products, including certain provisions that must be included in a provider agreement under the Regulatory Requirements, which may be alternatives to, or in addition to, the requirements, terms and conditions set forth in this Agreement or the Provider Manual.

1.16. "Provider Manual" means the provider manual and any billing manuals, adopted by Company or Payor which include, without limitation, requirements relating to utilization management, quality management, grievances and appeals, and Product-specific, Payor-specific and State-specific requirements, as may be amended from time to time by Company or Payor.

1.17. "Regulatory Requirements" means all applicable federal and state statutes, regulations, regulatory guidance, judicial or administrative rulings, requirements of Governmental Contracts and standards and requirements of any accrediting or certifying organization, including, but not limited to, the requirements set forth in a Product Attachment.

1.18. "State" is defined as the state identified in the applicable Attachment.

ARTICLE II - PRODUCTS AND SERVICES

2.1. Contracted Providers. Provider shall, and shall cause each Contracted Provider, to comply with and abide by the agreements, representations, warranties, acknowledgements, certifications, terms and conditions of this Agreement (including the provisions of Schedule A that are applicable to Provider, a Contracted Provider, or their services, and any other Attachments), and the Provider Manual, and fulfill all of the duties, responsibilities and obligations imposed on Provider and Contracted Providers under this Agreement (including each Attachment), and the Provider Manual.

2.2. Participation in Products. Subject to the other provisions of this Agreement, each Contracted Provider may be identified as a Participating Provider in each Product identified in a Product Attachment designated on Schedule B of this Agreement or added to this Agreement in accordance with Section 2.2 hereof.

2.2.1. Provider shall, at all times during the term of this Agreement, require each of its Contracted Providers to, subject to Company's approval, participate as Participating Providers in each Product identified in a Product Attachment that is designated on Schedule B to this Agreement or added to this Agreement in accordance with Section 2.2 hereof.

2.2.2. A Contracted Provider may only identify itself as a Participating Provider for those Products in which the Contracted Provider actually participates as provided in this Agreement. Provider acknowledges that Company or Payor may have, develop or contract to develop various Products or provider networks that have a variety of provider panels, program components and other requirements. No Company or Payor warrants or guarantees that any Contracted Provider: (i) will participate in all or a minimum number of provider panels, (ii) will be utilized by a minimum number of Covered Persons, or (iii) will indefinitely remain a Participating Provider or member of the provider panel for a particular network or Product.

2.2.3. Provider shall provide Health Plan with the information listed on Schedule C entitled "Information for Contracted Providers" for itself and the Contracted Providers as of the Effective Date. Provider shall provide Health Plan, from time to time or on a periodic basis as requested by Health Plan, with a complete and accurate list of Information for Contracted Providers and such other information as mutually agreed upon by the Parties, and shall provide Health Plan with a list of modifications to such list at least 30 days prior to the effective date of such changes, when possible. Provider shall provide such lists in a manner and format mutually acceptable to the Parties.

2.2.4. Provider may add new providers to this Agreement as Contracted Providers. In such case, Provider shall provide written notice to Health Plan of the prospective addition(s), and shall use best efforts to provide such notice at least sixty (60) days in advance of such addition. Provider shall maintain policies and procedures for each of its employed Contracted Providers and written agreements with each of its subcontracted Contracted Providers (other than Provider) that require the Contracted Providers to comply with Regulatory Requirements and the terms and conditions of this Agreement that apply to Contracted Providers.

2.2.5. If Company desires to add one or more Contracted Providers to an additional Product, Company or Payor, as applicable, will provide advance written notice (electronic or paper) thereof to Provider, along with the applicable Product Attachment and the new Compensation Schedule, if any. The applicable Contracted Providers will not be designated as Participating Providers in such additional Product if Provider opts out of such additional Product by giving Company or Payor, as applicable, written notice of its decision to opt-out within 30 days of Company's or Payor's, as applicable, giving of written notice. If Provider timely provides such opt-out notice, the applicable Contracted Providers will not be considered Participating Providers in such Product. If Provider does not timely provide such opt-out notice, then each applicable Contracted Provider shall be a Participating Provider in such additional Product on the terms and conditions set forth in this Agreement and the applicable Product Attachment.

2.3. Covered Services. Each Contracted Provider shall provide Covered Services described or referenced in the applicable Product Attachment(s) to Covered Persons in those Products in which the Contracted Provider is a Participating Provider, in accordance with this Agreement. Each Contracted Provider shall provide Covered Services to Covered Persons with the same degree of care and skill as customarily provided to patients who are not Covered Persons, within the scope of the Contracted Provider's license and in accordance with generally accepted standards of the Contracted Provider's practice and business and in accordance with the provisions of this Agreement, the Provider Manual, and Regulatory Requirements.

2.4. Provider Manual; Policies and Procedures. Provider and Contracted Providers shall at all times cooperate and comply with the requirements, policies, programs and procedures ("Policies") of Company and Payor, which may be described in the Provider Manual and include, but are not limited to, the following: credentialing criteria and requirements; notification requirements; medical management programs; claims and billing, quality assessment and improvement, utilization review and management, disease management, case management, on-site reviews, referral and prior authorization, and grievance and appeal procedures; coordination of benefits and third party liability policies; carve-out and third party vendor programs; and data reporting requirements. The failure to comply with such Policies could result in a denial or reduction of payment to the Provider or Contracted Provider or a denial or reduction of the Covered Person's benefits. Such Policies do not in any way affect or remove the obligation of Contracted Providers to render care. Health Plan shall make the Provider Manual available to Provider and Contracted Providers via one or more designated websites or alternative means. Upon Provider's reasonable request, Health Plan shall provide Provider with a copy of the Provider Manual. In the event of a material change to the Provider Manual, Health Plan will use reasonable efforts to notify Provider in advance of such change. Such notice may be given by Health Plan through a periodic provider newsletter, an update to the on-line Provider Manual, or any other written method (electronic or paper).

2.5. Credentialing Criteria. Provider and each Contracted Provider shall complete Company's and/or Payor's credentialing and/or recredentialing process as required by Company's and/or Payor's credentialing Policies, and shall at all times during the term of this Agreement meet all of Company's and/or Payor's credentialing criteria. Provider and each Contracted Provider represents, warrants and agrees: (a) that it is currently, and for the duration of this Agreement shall remain: (i) in compliance with all applicable Regulatory Requirements, including licensing laws; (ii) if applicable, accredited by The Joint Commission or the American Osteopathic Association; and (iii) a Medicare participating provider under the federal Medicare program and a Medicaid participating provider under applicable federal and State laws; and (b) that all Contracted Providers and all employees and contractors thereof will perform their duties in accordance with all Regulatory Requirements, as well as applicable national, State and local standards of professional ethics and practice. No Contracted Provider shall provide Covered Services to Covered Persons or identify itself as a Participating Provider unless and until the Contracted Provider has been notified, in writing, by Company that such Contracted Provider has successfully completed Company's credentialing process.

2.6. Eligibility Determinations. Provider or Contracted Provider shall timely verify whether an individual seeking Covered Services is a Covered Person. Company or Payor, as applicable, will make available to Provider and Contracted Providers a method, whereby Provider and Contracted Providers can obtain, in a timely manner, general information about eligibility and coverage. Company or Payor, as applicable, does not guarantee that persons identified as Covered Persons are eligible for benefits or that all services or supplies are Covered Services. If Company, Payor or its delegate determines that an individual was not a Covered Person at the time services were rendered, such services shall not be eligible for payment under this Agreement. In addition, Company will use reasonable efforts to include or contractually require Payors to clearly display Company's name, logo or mailing address (or other identifier(s) designated from time to time by Company) on each membership card.

2.7. Referral and Preauthorization Procedures. Provider and Contracted Providers shall comply with referral and preauthorization procedures adopted by Company and or Payor, as applicable, prior to referring a Covered Person to any individual, institutional or ancillary health care provider. Unless otherwise expressly authorized in writing by Company or Payor, Provider and Contracted Providers shall refer Covered Persons only to Participating Providers to provide the Covered Service for which the Covered Person is referred. Except as required by applicable law, failure of Provider and Contracted Providers to follow such procedures may result in denial of payment for unauthorized treatment.

2.8. Treatment Decisions. No Company or Payor is liable for, nor will it exercise control over, the manner or method by which a Contracted Provider provides items or services under this Agreement. Provider and Contracted Providers understand that determinations of Company or Payor that certain items or services are not Covered Services or have not been provided or billed in accordance with the requirements of this Agreement or the Provider Manual are administrative decisions only. Such decisions do not absolve the Contracted Provider of its responsibility to exercise independent judgment in treatment decisions relating to Covered Persons. Nothing in this Agreement (i) is intended to interfere with Contracted Provider's relationship with Covered Persons, or (ii) prohibits or restricts a Contracted Provider from disclosing to any Covered Person any information that the Contracted Provider deems appropriate regarding health care quality, medical treatment decisions or alternatives.

2.9. Carve-Out Vendors. Provider acknowledges that Company may, during the term of this Agreement, carve-out certain Covered Services from its general provider contracts, including this Agreement, for one or more Products as Company deems necessary or appropriate. Provider and Contracted Providers shall cooperate with and, when medically appropriate, utilize all third party vendors designated by Company for those Covered Services identified by Company from time to time for a particular Product.

2.10. Disparagement Prohibition. Provider, each Contracted Provider and the officers of Company shall not disparage the other during the term of this Agreement or in connection with any expiration, termination or non-renewal of this Agreement. Neither Provider nor Contracted Provider shall interfere with Company's direct or indirect contractual relationships including, but not limited to, those with Covered Persons or other Participating Providers. Nothing in this Agreement should be construed as limiting the ability of either Health Plan, Company, Provider or a Contracted Provider to inform Covered Persons that this Agreement has been terminated or otherwise expired or, with respect to Provider, to promote Provider to the general public or to post information regarding other health plans consistent with Provider's usual procedures, provided that no such promotion or advertisement is specifically directed at one or more Covered Persons. In addition, nothing in this provision should be construed as limiting Company's ability to use and disclose information and data obtained from or about Provider or Contracted Provider, including this Agreement, to the extent determined reasonably necessary or appropriate by Company in connection with its efforts to comply with Regulatory Requirements and to communicate with regulatory authorities.

2.11. Nondiscrimination. Provider and each Contracted Provider will provide Covered Services to Covered Persons without discrimination on account of race, sex, sexual orientation, age, color, religion, marital status, national origin, place of residence, health status, type of Payor, source of payment (e.g., Medicaid generally or a State-specific health care program), physical or mental disability or veteran status, and will ensure that its facilities are accessible as required by Title III of the Americans With Disabilities Act of 1991. Provider and Contracted Providers recognize that, as a governmental contractor, Company or Payor may be subject to various State and federal laws, executive orders and regulations regarding equal opportunity and affirmative action, which also may be applicable to subcontractors, and Provider and each Contracted Provider agree to comply with such requirements as described in any applicable Attachment.

2.12. Notice of Certain Events. Provider shall give written notice to Health Plan of: (i) any event of which notice must be given to a licensing or accreditation agency or board; (ii) any change in the status of Provider's or a Contracted Provider's license; (iii) termination, suspension, exclusion or voluntary withdrawal of Provider or a Contracted Provider from any state or federal health care program, including but not limited to Medicaid; or (iv) any settlements or judgments in connection with a lawsuit or claim filed or asserted against Provider or a Contracted Provider alleging professional malpractice involving a Covered Person. In any instance described in subsection (i)-(iii) above, Provider must notify Health Plan or Payor in writing within 10 days, and in any instance described in subsection (iv) above, Provider must notify Health Plan or Payor in writing within 30 days, from the date it first obtains knowledge of the pending of the same.

2.13. Use of Name. Provider and each Contracted Provider hereby authorizes each Company or Payor to use their respective names, telephone numbers, addresses, specialties, certifications, hospital affiliations (if any), and other descriptive characteristics of their facilities, practices and services for the purpose of identifying the Contracted Providers as "Participating Providers" in the applicable Products. Provider and Contracted Providers may only use the name of the applicable Company or Payor for purposes of identifying the Products in which they participate, and may not use the registered trademark or service mark of Company or Payor without prior written consent.

2.14. Compliance with Regulatory Requirements. Provider, each Contracted Provider and Company agree to carry out their respective obligations under this Agreement and the Provider Manual in accordance with all applicable Regulatory Requirements, including, but not limited to, the requirements of the Health Insurance Portability and Accountability Act, as amended, and any regulations promulgated thereunder. If, due to Provider's or Contracted Provider's noncompliance with applicable Regulatory Requirements or this Agreement, sanctions or penalties are imposed on Company, Company may, in its sole discretion, offset such amounts against any amounts due Provider or Contracted Providers from any Company or require Provider or the Contracted Provider to reimburse Company for such amounts.

2.15. Program Integrity Required Disclosures. Provider agrees to furnish to Health Plan complete and accurate information necessary to permit Company to comply with the collection of disclosures requirements specified in 42 C.F.R. Part 455 Subpart B or any other applicable State or federal requirements, within such time period as is necessary to permit Company to comply with such requirements. Such requirements include but are not limited to: (i) 42 C.F.R. §455.105, relating to (a) the ownership of any subcontractor with whom Provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request and (b) any significant business transaction between Provider and any wholly owned supplier or subcontractor during the 5 year period ending on the date of the request; (ii) 42 C.F.R. §455.104, relating to individuals or entities with an ownership or controlling interest in Provider; and (iii) 42 C.F.R. §455.106, relating to individuals with an ownership or controlling interest in Provider, or who are managing employees of Provider, who have been convicted of a crime.

ARTICLE III - CLAIMS SUBMISSION, PROCESSING, AND COMPENSATION

3.1. Claims or Encounter Data Submission. As provided in the Provider Manual and/or Policies, Contracted Providers shall submit to Payor or its delegate claims for payment for Covered Services rendered to Covered Persons. Contracted Provider shall submit encounter data to Payor or its delegate in a timely fashion, which must contain statistical and descriptive medical and patient data and identifying information, if and as required in the Provider Manual. Payor or its delegate reserves the right to deny payment to the Contracted Provider if the Contracted Provider fails to submit claims for payment or encounter data in accordance with the Provider Manual and/or Policies.

3.2. Compensation. The compensation for Covered Services provided to a Covered Person ("Compensation Amount") will be the appropriate amount under the applicable Compensation Schedule in effect on

the date of service for the Product in which the Covered Person participates. Subject to the terms of this Agreement and the Provider Manual, Provider and Contracted Providers shall accept the Compensation Amount as payment in full for the provision of Covered Services. Subject to the terms of this Agreement, Payor shall pay or arrange for payment of each Clean Claim received from a Contracted Provider for Covered Services provided to a Covered Person in accordance with the applicable Compensation Amount less any applicable copayments, cost-sharing or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement.

3.3. Financial Incentives. The Parties acknowledge and agree that nothing in this Agreement shall be construed to create any financial incentive for Provider or a Contracted Provider to withhold Covered Services.

3.4. Hold Harmless. Provider and each Contracted Provider agree that in no event, including but not limited to non-payment by a Payor, a Payor's insolvency, or breach of this Agreement, shall Provider or a Contracted Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Covered Person or person acting on the Covered Person's behalf, other than Payor, for Covered Services provided under this Agreement. This provision shall not prohibit collection of any applicable copayments, cost-sharing or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement. This provision survives termination or expiration of this Agreement for any reason, will be construed for the benefit of Covered Persons, and supersedes any oral or written agreement entered into between Provider or a Contracted Provider and a Covered Person.

3.5. Recovery Rights. Payor or its delegate shall have the right to immediately offset or recoup any and all amounts owed by Provider or a Contracted Provider to Payor or Company against amounts owed by the Payor or Company to the Provider or Contracted Provider. Provider and Contracted Providers agree that all recoupment and any offset rights under this Agreement will constitute rights of recoupment authorized under State or federal law and that such rights will not be subject to any requirement of prior or other approval from any court or other government authority that may now have or hereafter have jurisdiction over Provider or a Contracted Provider.

ARTICLE IV - RECORDS AND INSPECTIONS

4.1. Records. Each Contracted Provider shall maintain medical, financial and administrative records related to items or services provided to Covered Persons, including but not limited to a complete and accurate permanent medical record for each such Covered Person, in such form and detail as are required by applicable Regulatory Requirements and consistent with generally accepted medical standards.

4.2. Access. Provider and each Contracted Provider shall provide access to their respective books and records to each of the following, including any delegate or duly authorized agent thereof, subject to applicable Regulatory Requirements: (i) Company and Payor, during regular business hours and upon prior notice; (ii) appropriate State and federal authorities, to the extent such access is necessary to comply with Regulatory Requirements; and (iii) accreditation organizations. Provider and each Contracted Provider shall provide copies of such records at no expense to any of the foregoing that may make such request. Each Contracted Provider also shall obtain any authorization or consent that may be required from a Covered Person in order to release medical records and information to Company or Payor or any of their delegates. Provider and each Contracted Provider shall cooperate in and allow on-site inspections of its, his or her facilities and records by any Company, Payor, their delegates, any authorized government officials, and accreditation organizations. Provider and each Contracted Provider shall compile information necessary for the expeditious completion of such on-site inspection in a timely manner.

4.3. Record Transfer. Subject to applicable Regulatory Requirements, each Contracted Provider shall cooperate in the timely transfer of Covered Persons' medical records to any other health care provider, at no charge and when required.

ARTICLE V - INSURANCE AND INDEMNIFICATION

5.1. Insurance. During the term of this Agreement and for any applicable continuation period as set forth in Section 7.3 of this Agreement, Provider and/or each Contracted Provider shall maintain policies of general and professional liability insurance and other insurance necessary to insure Provider and such Contracted Provider, respectively; their respective employees; and any other person providing services hereunder on behalf of Provider or such Contracted Provider, as applicable, against any claim(s) of personal injuries or death alleged to have been caused or caused by their performance under this Agreement. Such insurance shall include, but not be limited to, any "tail" or prior acts coverage necessary to avoid any gap in coverage. Insurance shall be through a licensed carrier acceptable

to Health Plan, and in a minimum amount of $1,000,000 per occurrence, and $3,000,000 in the aggregate unless a lesser amount is accepted by Health Plan or where State law mandates otherwise. Provider and/or each Contracted Provider will provide Health Plan with at least 10 days prior written notice of cancellation, non-renewal, lapse, or adverse material modification of such coverage. Upon Health Plan's request, Provider and each Contracted Provider will furnish Health Plan with evidence of such insurance.

5.2. Indemnification by Provider and Contracted Provider. Provider and each Contracted Provider shall indemnify and hold harmless (and at Health Plan's request defend) Company and Payor and all of their respective officers, directors, agents and employees from and against any and all third party claims for any loss, damages, liability, costs, or expenses (including reasonable attorney's fees) judgments or obligations arising from or relating to any negligence, wrongful act or omission, or breach of this Agreement by Provider, a Contracted Provider, or any of their respective officers, directors, agents or employees.

5.3. Indemnification by Health Plan. Health Plan agrees to indemnify and hold harmless (and at Provider's request defend) Provider, Contracted Providers, and their officers, directors, agents and employees from and against any and all third party claims for any loss, damages, liability, costs, or expenses (including reasonable attorney's fees), judgments, or obligations arising from or relating to any negligence, wrongful act or omission or breach of this Agreement by Company or its directors, officers, agents or employees.

ARTICLE VI - DISPUTE RESOLUTION

6.1. Informal Dispute Resolution. Any dispute between Provider and/or a Contracted Provider, as applicable (the "Provider Party"), and Health Plan and/or Company, as applicable (including any Company acting as Payor) (the "Administrator Party"), with respect to or involving the performance under, termination of, or interpretation of this Agreement, or any other claim or cause of action hereunder, whether sounding in tort, contract or under statute (a "Dispute") shall first be addressed by exhausting the applicable procedures in the Provider Manual pertaining to claims payment, credentialing, utilization management, or other programs. If, at the conclusion of these applicable procedures, the matter is not resolved to satisfaction of the Provider Party and the Administrator Party, or if there are no applicable procedures in the Provider Manual, then the Provider Party and the Administrator Party shall engage in a period of good faith negotiations between their designated representatives who have authority to settle the Dispute, which negotiations may be initiated by either the Provider Party or the Administrator Party upon written request to the other, provided such request takes place within one year of the date on which the requesting party first had, or reasonably should have had, knowledge of the event(s) giving rise to the Dispute. If the matter has not been resolved within 60 days of such request, either the Provider Party or the Administrator Party may, as its sole and exclusive forum for the litigation of the Dispute or any part thereof, initiate arbitration pursuant to Section 6.2 below by providing written notice to the other party.

6.2. Arbitration. If either the Provider Party or the Administrator Party wishes to pursue the Dispute as provided in Section 6.1, such party shall submit it to binding arbitration conducted in accordance with the Commercial Arbitration Rules of the American Arbitration Association ("AAA"). In no event may any arbitration be initiated more than 1 year following, as applicable, the end of the 60 day negotiation period set forth in Section 6.1, or the date of notice of termination. Arbitration proceedings shall be conducted by an arbitrator chosen from the National Healthcare Panel at a mutually agreed upon location within the State. The arbitrator shall not award any punitive or exemplary damages of any kind, shall not vary or ignore the provisions of this Agreement, and shall be bound by controlling law. Any arbitration in which the total amount in controversy is less than $100,000 shall be conducted in a single hearing day. The Parties and the Contracted Providers, on behalf of themselves and those that they may now or hereafter represent, agree to and do hereby waive any right to pursue, on a class basis, any Dispute. Each of the Provider Party and the Administrator Party shall bear its own costs and attorneys' fees related to the arbitration except that the AAA's Administrative Fees, all Arbitrator Compensation and travel and other expenses, and all costs of any proof produced at the direct request of the arbitrator shall be borne equally by the applicable parties, and the arbitrator shall not have the authority to order otherwise. The existence of a Dispute or arbitration proceeding shall not in and of itself constitute cause for termination of this Agreement. Except as hereafter provided, during an arbitration proceeding, each of the Provider Party and the Administrator Party shall continue to perform its obligations under this Agreement pending the decision of the arbitrator. Nothing herein shall bar either the Provider Party or the Administrator Party from seeking emergency injunctive relief to preclude any actual or perceived breach of this Agreement, although such party shall be obligated to file and pursue arbitration at the earliest reasonable opportunity. Judgment on the award rendered may be entered in any court having jurisdiction thereof. Because of the confidential nature of this Agreement, the Provider and Administrator Parties further agree that in any action to compel arbitration or enforce any arbitration award, no party may file any part of this Agreement (including

Attachments) in the court record, except this Section 6.2. Nothing contained in this Article VI shall limit a Party's right to terminate this Agreement with or without cause in accordance with Section 7.2.

ARTICLE VII - TERM AND TERMINATION

7.1. Term. This Agreement is effective as of the Health Plan Effective Date, and will remain in effect for an initial term ("Initial Term") of 3 year(s), after which it will automatically renew for successive terms of 1 year each (each a "Renewal Term"), unless this Agreement is sooner terminated as provided in this Agreement or either Party gives the other Party written notice of non-renewal of this Agreement not less than 180 days prior to the end of the then-current term. In addition, either Party may elect to not renew a Contracted Provider's participation as a Participating Provider in a particular Product for the next Renewal Term, by giving Provider written notice of such non-renewal not less than 180 days prior to the, as applicable, last day of the Initial Term or applicable Renewal Term; in such event, Provider shall immediately notify the affected Contracted Provider of such non-renewal. Termination of any Contracted Provider's participation in a particular Product will not have the effect of terminating either this Agreement or the Contracted Provider's participation in any other Product in which the Contract Provider participates under this Agreement.

7.2. Termination. This Agreement, or the participation of Provider or a Contracted Provider as a Participating Provider in one or more Products, may be terminated or suspended as set forth below.

7.2.1. Upon Notice. This Agreement may be terminated by either Party giving the other Party at least 180 days prior written notice of such termination. The participation of any Contracted Provider as a Participating Provider in a Product may be terminated by either Party giving the other Party at least 180 days prior written notice of such termination; in such event, Provider shall immediately notify the affected Contracted Provider of such termination.

7.2.2. With Cause. This Agreement, or the participation of any Contracted Provider as a Participating Provider in one or more Products under this Agreement, may be terminated by either Party giving at least 60 days prior written notice of termination to the other Party if such other Party (or the applicable Contracted Provider) is in breach of any material term or condition of this Agreement and such other Party (or the Contracted Provider) fails to cure the breach within the 60 day period immediately following the giving of written notice of such breach. Any notice given pursuant to this Section 7.2.2 must describe the specific breach. In the case of a termination of a Contracted Provider, Provider shall immediately notify the affected Contracted Provider of such termination.

7.2.3. Suspension of Participation. Unless expressly prohibited by applicable Regulatory Requirements, Health Plan has the right to immediately suspend or terminate the participation of a Contracted Provider in any or all Products by giving written notice thereof to Provider when Health Plan determines that (i) based upon available information, the continued participation of the Contracted Provider appears to constitute an immediate threat or risk to the health, safety or welfare of Covered Persons, or (ii) has failed to meet objective patient care quality standards, or (iii) the Contracted Provider's fraud, malfeasance or non-compliance with Regulatory Requirements is reasonably suspected. Provider shall immediately notify the affected Contracted Provider of such suspension. During such suspension, the Contracted Provider shall, as directed by Health Plan, discontinue the provision of all or a particular Covered Service to Covered Persons. During the term of any suspension, the Contracted Provider shall notify Covered Persons that his or her status as a Participating Provider has been suspended. Such suspension will continue until the Contracted Provider's participation is reinstated or terminated.

7.2.4. Insolvency. This Agreement may be terminated immediately by a Party giving written notice thereof to the other Party if the other Party is insolvent or has bankruptcy proceedings initiated against it.

7.2.5. Credentialing. The status of a Contracted Provider as a Participating Provider in one or more Products may be terminated immediately by Health Plan giving written notice thereof to Provider if the Contracted Provider fails to adhere to Health Plan's credentialing criteria, including, but not limited to, if the Contracted Provider (i) loses, relinquishes, or has materially affected its license to provide Covered Services in the State, (ii) fails to comply with the insurance requirements set forth in this Agreement; or (iii) is convicted of a criminal offense related to involvement in any state or federal health care program or has been terminated, suspended, barred, voluntarily withdrawn as part of a settlement agreement, or otherwise excluded from any state or federal health care program. Provider shall immediately notify the affected Contracted Provider of such termination.

7.3. Effect of Termination. After the effective date of termination of this Agreement or a Contracted Provider's participation in a Product, this Agreement shall remain in effect for purposes of those obligations and

rights arising prior to the effective date of termination. Upon such a termination, each affected Contracted Provider (including Provider, if applicable) shall (i) continue to provide Covered Services to Covered Persons in the applicable Product(s) during the longer of the 90 day period following the date of such termination or such other period as may be required under any Regulatory Requirements, and, if requested by Company, each affected Contracted Provider (including Provider, if applicable) shall continue to provide, as a Participating Provider, Covered Services to Covered Persons until such Covered Persons are assigned or transferred to another Participating Provider in the applicable Product(s), and (ii) continue to comply with and abide by all of the applicable terms and conditions of this Agreement, including, but not limited to, Section 3.4 (Hold Harmless) hereof, in connection with the provision of such Covered Services during such continuation period. During such continuation period, each affected Contracted Provider (including Provider, if applicable) will be compensated in accordance with this Agreement and shall accept such compensation as payment in full.

7.4. Survival of Obligations. All provisions hereof that by their nature are to be performed or complied with following the expiration or termination of this Agreement, including without limitation Sections 2.8, 2.10, 3.2, 3.4, 3.5, 4.2, 5.1, 5.2, 5.3, 6.2, 7.3, and 7.4 and Article VIII, survive the expiration or termination of this Agreement.

ARTICLE VIII - MISCELLANEOUS

8.1. Relationship of Parties. The relationship between or among Health Plan, Company, Provider, Payor and any Contracted Provider hereunder is that of independent contractors. None of the provisions of this Agreement will be construed as creating any agency, partnership, joint venture, employee-employer, or other relationship. References herein to the rights and obligations of any Company or Health Plan, as applicable, under this Agreement are references to the rights and obligations of each such Company of Health Plan individually and not collectively. A Company or a Health Plan is only responsible for performing its respective obligations hereunder with respect to a particular Product, Coverage Agreement, Payor Contract, Covered Service or Covered Person. A breach or default by an individual Company or Health Plan shall not constitute a breach or default by any other Company or Health Plan.

8.2. Conflicts Between Certain Documents. If there is any conflict between this Agreement and the Provider Manual, this Agreement will control. In the event of any conflict between this Agreement and any Product Attachment, the Product Attachment will control as to such Product.

8.3. Assignment. This Agreement is intended to secure the services of and be personal to Provider and may not be assigned, sublet, delegated, subcontracted or transferred by Provider without Health Plan's prior written consent. Health Plan shall have the right, exercisable in its sole discretion, to assign or transfer all or any portion of its rights or to delegate all or any portion of its interests under this Agreement or any Attachment to an Affiliate, successor of Health Plan, or purchaser of the assets or stock of Health Plan, or the line of business or business unit primarily responsible for carrying out Health Plan's obligations under this Agreement. Health Plan (or any successor assignee) may assign one or more Product Attachments to an Affiliate. Following such assignment, Health Plan will retain all rights, title, and interests in and to the Product Attachments that are not assigned, and Health Plan will be released from all liabilities and obligations arising on or after the date of the assignment under the Product Attachments that are assigned. For the purposes of this paragraph, the term "Product Attachment" will refer collectively to the applicable Product Attachment or any portions thereof, as well as this Agreement (including one or more schedules, exhibits and attachments) as it relates to such Product Attachment or portions thereof.

8.4. Headings. The headings of the sections of this Agreement are inserted merely for the purpose of convenience and do not limit, define, or extend the specific terms of the section so designated.

8.5. Governing Law. The interpretation of this Agreement and the rights and obligations of Health Plan, Company, Provider and any Contracted Providers hereunder will be governed by and construed in accordance with applicable federal and State laws.

8.6. Third Party Beneficiary. This Agreement is entered into by the Parties signing it for their benefit, as well as, in the case of Health Plan, the benefit of Company, and in the case of Provider, the benefit of each Contracted Provider. Except as specifically provided in Section 3.4 hereof, no Covered Person or third party, other than Company, will be considered a third party beneficiary of this Agreement.

8.7. Amendment. Except as otherwise provided in this Agreement, this Agreement may be amended only by written agreement of duly authorized representatives of the Parties.

8.7.1. Health Plan may amend this Agreement by giving Provider written notice of the amendment to the extent such amendment is deemed necessary or appropriate by Health Plan to comply with any Regulatory Requirements. Any such amendment will be deemed accepted by Provider upon the giving of such notice.

8.7.2. Health Plan may amend this Agreement by giving Provider written notice (electronic or paper) of the proposed amendment. Unless Provider notifies Health Plan in writing of its objection to such amendment during the 30 day period following the giving of such notice by Health Plan, Provider shall be deemed to have accepted the amendment. If Provider objects to any proposed amendment to either the base agreement or any Attachment, Health Plan may exclude one or more of the Contracted Providers from being Participating Providers in the applicable Product (or any component program of, or Coverage Agreement in connection with, such Product).

8.8. Entire Agreement. All prior or concurrent agreements, promises, negotiations or representations either oral or written, between Health Plan and Provider relating to a subject matter of this Agreement, which are not expressly set forth in this Agreement, are of no force or effect.

8.9. Severability. The invalidity or unenforceability of any terms or provisions hereof will in no way affect the validity or enforceability of any other terms or provisions.

8.10. Waiver. The waiver by either Party of the violation of any provision or obligation of this Agreement will not constitute the waiver of any subsequent violation of the same or other provision or obligation.

8.11. Notices. Except as otherwise provided in this Agreement, any notice required or permitted to be given hereunder is deemed to have been given when such written notice has been personally delivered or deposited in the United States mail, postage paid, or delivered in hard copy or electronically by a service that provides written receipt or acknowledgment of delivery, addressed as follows:

To Health Plan at:	To Provider at:
Attn: President	Attn: Rosana Warren
Health Net Health Plan of Oregon, Inc.	Polk County
13221 SW 68th Pkwy, Suite 200	850 Main Street
Tigard, OR 97223	Dallas, OR 97338
	warren.rosana@co.polk.or.us

or to such other address as such Party may designate in writing. Notwithstanding the previous paragraph, Health Plan may provide notices by electronic mail, through its provider newsletter or on its provider website.

8.12. Force Majeure. Neither Party shall be liable or deemed to be in default for any delay or failure to perform any act under this Agreement resulting, directly or indirectly, from acts of God, civil or military authority, acts of public enemy, war, riots, civil disorders, accidents, fires, explosions, earthquake, flood, lockouts, strikes or other work stoppages by either Party's employees, injunctions-intervention-acts, a governmental authority's failure or refusal to act, or any other similar cause beyond the reasonable control of the affected Party which that Party is unable to prevent by exercising reasonable diligence and that occurs without that Party's fault or negligence.

8.13. Proprietary Information. Each Party is prohibited from, and shall prohibit its Affiliates and Contracted Providers from, disclosing to a third party the substance of this Agreement, or any information of a confidential nature acquired from the other Party (or Affiliate or Contracted Provider thereof) during the course of this Agreement, except to agents of such Party as necessary for such Party's performance under this Agreement, or as required by a Payor Contract or applicable Regulatory Requirements. Provider acknowledges and agrees that all information relating to Company's programs, policies, protocols and procedures is proprietary information and Provider shall not disclose such information to any person or entity without Health Plan's express written consent.

8.14. Authority. The individuals whose signatures are set forth below represent and warrant that they are duly empowered to execute this Agreement. Provider represents and warrants that it has all legal authority to contract on behalf of and to bind all Contracted Providers to the terms of the Agreement with Health Plan.

8.15. Rights and Obligations of Health Plan, Payor. Provider and each Contracted Provider acknowledges that references herein to the rights and obligations of any "Health Plan" or a "Payor" under this Agreement are references to the rights and obligations of such Health Plan and Payor individually and not of the Company or Payors collectively. Each Health Plan and/or Payor is only responsible for performing its obligations hereunder with respect to those Products, Coverage Agreements, Payor Contracts, Covered Services or Covered Persons furnished by, entered into with, enrolled in or relating to such Health Plan or Payor. References to each Company as "Health Plan" herein in no way imposes any cross-guarantees or joint responsibility or liability by, between or among such individual Company. A breach or default by an individual Health Plan or Payor shall not constitute a breach or default by any other Company or Payor, and the exercise of any right under this Agreement by or as relating to Health Plan or Payor does not by operation of this Agreement constitute the exercise of such right by or relating to any other Company, Payor or other entity.

* * * * *

THIS AGREEMENT CONTAINS A BINDING ARBITRATION PROVISION THAT MAY BE ENFORCED BY THE PARTIES.

IN WITNESS WHEREOF, the Parties hereto have executed this Agreement, including all Product Attachments noted on Schedule B, effective as of the date set forth beneath their respective signatures.

HEALTH PLAN:	**PROVIDER:**
Health Net Health Plan of Oregon, Inc.	Polk County (Legibly Print Name of Provider)
Authorized Signature:	Authorized Signature:
Print Name: Sarah Brewer	Print Name:
Title: Plan President & CEO	Title:
Signature Date:	Signature Date:
ICM #: ICMProviderAgreement_369133	Tax Identification Number: 93-6002310
To be completed by Health Plan only: Effective Date:	National Provider Identifier: 1881401735 Medicare Number: R00WCHCR

PARTICIPATING PROVIDER AGREEMENT

SCHEDULE A
CONTRACTED PROVIDER-SPECIFIC PROVISIONS

Provider and Contracted Providers shall comply with the applicable provisions of this Schedule A.

1. Hospitals. If Provider or a Contracted Provider is a hospital ("Hospital"), the following provisions apply.

1.1 24 Hour Coverage. Each Hospital shall be available to provide Covered Services to Covered Persons twenty-four (24) hours per day, seven (7) days per week.

1.2 Emergency Care. Each Hospital shall provide Emergency Care (as hereafter defined) in accordance with Regulatory Requirements. The Contracted Provider shall notify Company's medical management department of any emergency room admissions by electronic file sent within 24 hours or by the next business day of such admission. "Emergency Care" (or derivative thereof) has, as to each particular Product, the meaning set forth in the applicable Coverage Agreement or Product Attachment. If there is no definition in such documents, "Emergency Care" means inpatient and/or outpatient Covered Services furnished by a qualified provider that are needed to evaluate or stabilize an Emergency Medical Condition. "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

1.3 Staff Privileges. Each Hospital shall assist in granting staff privileges or other appropriate access to Company's Participating Providers who are qualified medical or osteopathic physicians, provided they meet the reasonable standards of practice and credentialing standards established by the Hospital's medical staff and bylaws, rules, and regulations.

1.4 Discharge Planning. Each Hospital agrees to cooperate with Company's system for the coordinated discharge planning of Covered Persons, including the planning of any necessary continuing care.

1.5 Credentialing Criteria. Each Hospital shall: (a) currently, and for the duration of this Agreement, remain accredited by the Joint Commission or American Osteopathic Association, as applicable; and (b) ensure that all employees of Hospital perform their duties in accordance with all applicable local, State and federal licensing requirements and standards of professional ethics and practice.

1.6 National Committee for Quality Assurance ("NCQA") Accreditation of Health Plans Standards. Each Hospital agrees to: (i) cooperate with Quality Management and Improvement ("QI") activities; (ii) maintain the confidentiality of a Covered Persons information and records pursuant to the Agreement; and (iii) allow the Company to use Hospital's performance data.

2. Practitioners. If Provider or Contracted Provider is a physician or other health care practitioner (including physician extenders) ("Practitioner"), the following provisions apply.

2.1 Contracted Professional Qualifications. At all times during the term of this Agreement, Practitioner shall, as applicable, maintain medical staff membership and admitting privileges with at least one hospital that is a Participating Provider ("Participating Hospital") with respect to each Product in which the Practitioner participates. Upon Company's request, Practitioner shall furnish evidence of the foregoing to Company. If Practitioner does not have such admitting privileges, Provider or the Practitioner shall provide Company with a written statement from another Participating Provider who has such admitting privileges, in good standing, certifying that such individual agrees to assume responsibility for providing inpatient Covered Services to Covered Persons who are patients of the applicable Practitioner.

2.2 Acceptance of New Patients. To the extent that Practitioner is accepting new patients, such Practitioner must also accept new patients who are Covered Persons with respect to the Products in which such Practitioner participates. Practitioner shall notify Company in writing 45 days prior to such Practitioner's decision to

no longer accept Covered Persons with respect to a particular Product. In no event will an established patient of any Practitioner be considered a new patient.

2.3 Preferred Drug List/Drug Formulary. If applicable to the Covered Person's coverage, Practitioners shall use commercially reasonable efforts, when medically appropriate under the circumstances, to comply with formulary or preferred drug list when prescribing medications for Covered Persons.

2.4 National Committee for Quality Assurance ("NCQA") Accreditation of Health Plans Standards. Each Practitioner agrees to: (i) cooperate with Quality Management and Improvement ("QI") activities; (ii) maintain the confidentiality of a Covered Persons information and records pursuant to the Agreement; and (iii) allow the Company to use Practitioner's performance data.

3. Ancillary Providers. If Provider or Contracted Provider is an ancillary provider (including but not limited to a home health agency, durable medical equipment provider, sleep center, pharmacy, ambulatory surgery center, nursing facility, laboratory or urgent care center)("Ancillary Provider"), the following provisions apply.

3.1 Acceptance of New Patients. To the extent that Ancillary Provider is accepting new patients, such Ancillary Provider must also accept new patients who are Covered Persons with respect to the Products in which such Ancillary Provider participates. Ancillary Provider shall notify Company in writing 45 days prior to such Ancillary Provider's decision to no longer accept Covered Persons with respect to a particular Product. In no event will an established patient of any Ancillary Provider be considered a new patient.

3.2 National Committee for Quality Assurance ("NCQA") Accreditation of Health Plans Standards. Each ancillary provider agrees to: (i) cooperate with Quality Management and Improvement ("QI") activities; (ii) maintain the confidentiality of a Covered Persons information and records pursuant to the Agreement; and (iii) allow the Company to use ancillary provider's performance data.

4. FQHC. If Provider or a Contracted Provider is a federally qualified health center ("FQHC"), the following provision applies.

4.1 FQHC Insurance. To the extent FQHC's employees are deemed to be federal employees qualified for protection under the Federal Tort Claims Act ("FTCA") and Health Plan has been provided with documentation of such status issued by the U.S. Department of Health and Human Services (such status to be referred to as "FTCA Coverage"), Section 5.1 of this Agreement will not apply to those Contracted Providers with FTCA Coverage. FQHC shall provide evidence of such FTCA Coverage to Health Plan at any time upon request. FQHC shall promptly notify Health Plan if, any time during the term of this Agreement, any Contracted Provider is no longer eligible for, or if FQHC becomes aware of any fact or circumstance that would jeopardize, FTCA Coverage. Section 5.1 of this Agreement will apply to a Contracted Provider immediately upon such Contracted Provider's loss of FTCA Coverage for any reason.

5. Facility Providers. If Provider or a Contracted Provider is a facility (including but not limited to Clinic, FQHC, LTAC, Nursing Home, Rehab, Rural Health Clinic, Skilled Nursing) ("Facility Provider") the following provision applies.

5.1 National Committee for Quality Assurance ("NCQA") Accreditation of Health Plans Standards. Each facility agrees to: (i) cooperate with Quality Management and Improvement ("QI") activities; (ii) maintain the confidentiality of a Covered Persons information and records pursuant to the Agreement; and (iii) allow the Company to use facility's performance data.

6. Long Term Services and Supports ("LTSS") and Home and Community-Based Services ("HCBS") Providers. If Provider or a Contracted Provider is a provider of LTSS and/or HCBS services, the following provisions apply.

6.1 Definition. LTSS generally includes assistance with daily self-care activities (e.g., walking, toileting, bathing, and dressing) and activities that support an independent lifestyle (e.g., food preparation, transportation, and managing medications). The broad category of LTSS also includes care and service coordination for people who live in their own home, a residential setting, a nursing facility, or other institutional setting. Home and community-based services ("HCBS") are a subset of LTSS that functions outside of institutional care to maximize independence in the community.

6.2 HCBS Waiver Authorization. Provider shall not provide HCBS Covered Services to Covered Person without the required HCBS waiver authorization.

6.3 Conditions for Reimbursement. No payment shall be made to the Provider unless the Provider has strictly conformed to the policies and procedures of the HCBS Waiver Program, including but not limited to not providing HCBS Covered Services without prior authorization of Health Plan. For the purposes of this Exhibit, "HCBS Waiver Program" shall mean any special Medicaid program operated under a waiver approved by the Centers for Medicare and Medicaid Services which allows the provision of a special package of approved services to Covered Person.

6.4 Acknowledgement. Health Plan acknowledges that Provider is a provider of LTSS and is not necessarily a provider of medical or health care services. Nothing in this Agreement is intended to require Provider to provide medical or health care services that Provider does not routinely provide, but would not prohibit providers from offering these services, as appropriate.

6.5 Notification Requirements. Provider or the applicable Contracted Provider shall provide the following notifications to Health Plan, via written notice or via telephone contact at a number to be provided by Health Plan, within the following time frames:

6.5.1 Provider or the applicable Contracted Provider shall notify Health Plan of a Covered Person's visit to urgent care or the emergency department of any hospital, or of a Covered Person's hospitalization, within 24 hours of becoming aware of such visit or hospitalization.

6.5.2 Provider or the applicable Contracted Provider shall notify Health Plan of any change to the designated/assigned services being provided under a Covered Person's plan of care and/or service plan, within 24 hours of becoming aware of such change.

6.5.3 Provider or the applicable Contracted Provider shall notify Health Plan if a Covered Person misses an appointment with Provider, within 24 hours of becoming aware of such missed appointment.

6.5.4 Provider or the applicable Contracted Provider shall notify Health Plan of any change in a Covered Person's medical or behavioral health condition, within 24 hours of becoming aware of such change. (Examples of changes in condition are set forth in the Provider Manual.)

6.5.5 Provider or the applicable Contracted Provider shall notify Health Plan of any safety issue identified by Provider or Contracted Provider or its agent or subcontractor, within 24 hours of the identification of such safety issue. (Examples of safety issues are set forth in the Provider Manual.)

6.5.6 Provider or the applicable Contracted Provider shall notify Health Plan of any change in Provider's or Contracted Provider's key personnel, within 24 hours of such change.

6.6 Minimum Data Set. If Contracted Provider is a nursing facility, Provider or such Contracted Provider shall submit to Health Plan or its designee the Minimum Data Set as defined by CMS and required under federal law and Health Plan policy as it relates to all Covered Persons who are residents in Contracted Provider's facility. Such submission shall be via electronic mail, facsimile transmission, or other manner and format reasonably requested by Health Plan.

6.7 Quality Improvement Plan. Each Contracted Provider shall participate in Health Plan's LTSS quality improvement plan. Each Contracted Provider shall permit Health Plan to access such Contracted Providers' assessment and quality data upon reasonable advance notice, which may be given by electronic mail.

6.8 Electronic Visit Verification. If Contracted Provider provides in-home services, Contracted Provider shall comply with 21st Century Cures Act and Health Plan's electronic visit verification system requirements where applicable and accessible.

6.9 Criminal Background Checks. Provider shall conduct a criminal background check on each Contracted Provider prior to the commencement of services under this Agreement and as requested by Health Plan thereafter. Provider shall provide the results of such background checks to Health Plan and member, if self-directed, upon request. Provider agrees to immediately notify Health Plan of any criminal convictions of any Contracted or sub-contracted Provider. Provider shall pay any costs associated with such criminal background checks.

7. Person-Centered Planning, Care/Service Plan, and Services ("PCSP"). Provider shall comply with all state and federal regulatory requirements related to person-centered planning, care/service plans, and services including, but not limited to:

7.1 Covered Persons shall lead the person-centered planning process and can elect to include, and/or consult with, any of their LTSS providers in the care/service plan development process.

7.2 The care/service plan must be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation through the mechanism required by state and federal requirements. Non-medical service providers (such as meals or assistive technology) can signify their agreement through this contract or written agreement in lieu of directly in the plan, if permitted by the Covered Persons.

7.3 LTSS Provider shall be aware of, respect, and adhere to a Covered Person's preferences for the delivery of services and supports.

7.4 LTSS Provider shall ensure services and supports are culturally appropriate, provided in plain language (where applicable), and accessible to Covered Persons and the person(s) supporting them who have disabilities and/or are limited English proficient.

7.5 Health Plan agrees to complete the care/service plan in a timely manner (within at least one hundred twenty (120) days of enrollment or annually, or less if state requirements differ) and provide a copy to LTSS Provider(s) responsible for implementation.

7.6 Any Covered Persons communications furnished by Subcontractor shall be subject to review and approval by Contractor and shall contain Contractor's name.

7.7 Notwithstanding any provision of this Agreement, Contractor may terminate this Agreement immediately in the event that Contractor reasonably determines that the continuation of this Agreement presents a risk to Covered Persons health and safety.

PARTICIPATING PROVIDER AGREEMENT

SCHEDULE B
PRODUCT PARTICIPATION

Provider will be designated as a "Participating Provider" in the Product Attachments listed below as of the date of successful completion of credentialing in accordance with this Agreement.

List of Product Attachments:

Attachment A: [Reserved]
Attachment B: [Reserved]
Attachment C: [Reserved]
Attachment D: Commercial
Attachment E: [Reserved]

PARTICIPATING PROVIDER AGREEMENT

SCHEDULE C
INFORMATION FOR CONTRACTED PROVIDERS

Provider shall provide Health Plan with the information set forth below with respect to: (i) Provider; (ii) each Contracted Provider; and (iii) if applicable, each Contracted Provider's locations and/or professionals. To the extent Provider provides the name of any Contracted Provider to Health Plan hereunder, such entity and/or individual will be considered a Contracted Provider under this Agreement regardless of whether the complete list of information set forth below relating to such Contracted Provider is provided by Provider.

1. Name
2. Address
3. E-mail address
4. Telephone and facsimile numbers
5. Professional license numbers
6. Medicare/Medicaid ID numbers
7. Federal tax ID numbers
8. Completed W-9 form
9. National Provider Identifier (NPI) numbers
10. Provider Taxonomy Codes
11. Area of medical specialty
12. Age restrictions (if any)
13. Area hospitals with admitting privileges (where applicable)
14. Whether Providers are employed or subcontracted with Contracted Provider using the designation "E" for employed or "C" for subcontracted.
15. For a subcontracted Provider, whether its Providers are employed or contracted with the subcontracted Provider using the designation "E" for employed or "C" for contracted.
16. Office contact person
17. Office hours
18. Billing office
19. Billing office address
20. Billing office telephone and facsimile numbers
21. Billing office e-mail address
22. Billing office contact person
23. Ownership Disclosure Form, as required to comply with Regulatory Requirements and Governmental Contract

NOTE: For a complete listing of the information and additional documentation required, please refer to the enrollment application.

Attachment D: Commercial

PRODUCT ATTACHMENT
(INCLUDING REGULATORY REQUIREMENTS AND COMPENSATION SCHEDULE)

THIS PRODUCT ATTACHMENT (this "***Attachment***") is incorporated into the Participating Provider Agreement (the "***Agreement***") is made and entered into by and between Polk County ("***Provider***") and Health Net Health Plan of Oregon, Inc. ("***Health Plan***") (each a "***Party***" and collectively the "***Parties***").

WHEREAS, Health Plan and Provider entered into that certain Participating Provider Agreement, as the same may have been amended and supplemented from time to time (the "***Agreement***"), pursuant to which Provider and its Contracted Providers or other Downstream Entities participate in certain Products offered by or available from or through a Company; and

WHEREAS, pursuant to the provisions of the Agreement, this Product Attachment is identified on Schedule B of the Agreement and, as such, the Contracted Providers identified herein will be designated and participate as Participating Providers in the commercial and exchange Products described in this Product Attachment, and will be considered to be and will be governed under this Product Attachment as Downstream Entities as defined in this Product Attachment; and

WHEREAS, the Agreement is modified or supplemented as hereafter provided.

NOW THEREFORE, in consideration of the recitals, the mutual promises herein stated, the parties hereby agree to the provisions set forth below.

1. Defined Terms. For purposes of the Commercial Product, the following terms have the meanings set forth below. All capitalized terms not specifically defined in this Product Attachment will have the meanings given to such terms in the Agreement.

1.1 "***Commercial Product***" refers to those programs and health benefit arrangements offered by a Company that provide incentives to Covered Persons to utilize the services of certain contracted providers. The Commercial Product includes those Coverage Agreements entered into, issued or agreed to by a Payor under which a Company furnishes administrative services or other services in support of a health care program for an individual or group of individuals, which may include access to one or more of the Company's provider networks or vendor arrangements, and which may be provided in connection with a state or governmental-sponsored, employer-sponsored or other private health insurance exchange, except those excluded by Health Plan. The Commercial Product does not apply to any Coverage Agreements that are specifically covered by another Product Attachment to the Agreement.

1.2 "***Delegated Entity***" means any party, including an agent or broker, that enters into an agreement with Health Plan to provide administrative services or health care services to qualified individuals, qualified employers or qualified employees and their dependents (as such terms are defined in 45 C.F.R. §156.20).

1.3 "***Downstream Entity***" means any party, including an agent or broker, that enters into an agreement with a Delegated Entity or with another Downstream Entity for purposes of providing administrative or health care services related to the agreement between the Delegated Entity and Health Plan. The term "Downstream Entity" is intended to reach the entity that directly provides administrative services or health care services to qualified individuals, qualified employers, or qualified employees and their dependents (as such terms are defined in 45 C.F.R. §156.20).

1.4 "***Emergency" or "Emergency Care***" has the meaning set forth in the Covered Person's Coverage Agreement.

1.5 "***Emergency Medical Condition***" has the meaning set forth in the Covered Person's Coverage Agreement.

1.6 "***State***" means the State of Oregon, State of Washington as applicable, or such other state to the extent that a Coverage Agreement or Covered Person is subject to such other state's law.

2. Commercial Product. This Product Attachment constitutes the "Commercial Product Attachment" and is incorporated into the Agreement between Provider and Health Plan. It supplements the Agreement by setting forth specific terms and conditions that apply to the Commercial Product with respect to which a Participating Provider has agreed to participate, and with which a Participating Provider must comply in order to maintain such participation. This Product Attachment applies with respect to the provision of health care services, supplies or accommodations (including Covered Services) to Covered Persons enrolled in or covered by a Commercial Product.

3. Participation. Except as otherwise provided in this Product Attachment or the Agreement, all Contracted Providers under the Agreement will participate as Participating Providers in this Commercial Product, and will provide to Covered Persons enrolled in or covered by a Commercial Product, upon the same terms and conditions contained in the Agreement, as supplemented or modified by this Product Attachment, those Covered Services that are provided by Contracted Providers pursuant to the Agreement. In providing such services, Provider shall, and shall cause Contracted Providers, to comply with and abide by the provisions of this Product Attachment and the Agreement (including the Provider Manual).

4. Attachments. This Product Attachment includes, Schedule A, the Regulatory Requirements with which Participating Providers are required to comply based on State laws governing the applicable Coverage Agreement or Covered Person and a Compensation Schedule Exhibit(s) for the Commercial Product, each of which are incorporated herein by reference.

5. Construction. This Product Attachment supplements and forms a part of the Agreement. Except as otherwise provided herein or in the terms of the Agreement, the terms and conditions of the Agreement will remain unchanged and in full force and effect as a result of this Product Attachment. In the event of a conflict between the provisions of the Agreement and the provisions of this Product Attachment, this Product Attachment will govern with respect to health care services, supplies or accommodations (including Covered Services) rendered to Covered Persons enrolled in or covered by a Commercial Product. To the extent Provider or any Contracted Provider is unclear about its, his or her respective duties and obligations, Provider or the applicable Contracted Provider shall request clarification from the Company.

6. Term. This Product Attachment will become effective as of the Effective Date, and will be coterminous with the Agreement unless a Party terminates the participation of the Contracted Provider in this Commercial Product in accordance with the applicable provisions of the Agreement or this Product Attachment.

7. Federal Requirements. The following requirements apply to Delegated and Downstream Entities under this Commercial Product Attachment, which includes but is not limited to Provider and all Contracted Providers.

7.1 Provider's delegated activities and reporting responsibilities, if any, are specified in the Agreement or applicable attachment to the Agreement (e.g., Delegated Credentialing Agreement, Delegated Services Agreement, Statement or Work, or other scope of services attachment) attached to this Agreement. If such attachment is not executed, no administrative functions shall be deemed as delegated.

7.2 CMS, Health Plan and Payor reserve the right to revoke the delegation activities and reporting requirements or to specify other remedies in instances where CMS, Health Plan or the Payor determine that Provider or any Downstream Entity has not performed satisfactorily.

7.3 Provider and all Downstream Entities must comply with all applicable laws and regulations relating to the standards specified under 45 CFR §156.340(a);

7.4 Provider and all Downstream Entities must permit access by the Secretary and OIG or their designees in connection with their right to evaluate through audit, inspection or other means, to the Provider's or Downstream Entities' books, contracts, computers, or any other electronic systems including medical records and documentation, relating to Health Plan's obligations in accordance with federal standards under 45 CFR §156.340(a) until ten (10) years from the termination date of this Product Attachment.

8. Other Terms and Conditions. Except as modified or supplemented by this Product Attachment, the compensation hereunder for the provision of Covered Services by Contracted Providers to Covered Persons enrolled in or covered by the Commercial Product is subject to all of the other provisions in the Agreement (including the Provider Manual) that affect or relate to compensation for Covered Services provided to Covered Persons.

Attachment D: Commercial

SCHEDULE A
STATE-MANDATED REGULATORY REQUIREMENTS

This Schedule sets forth the provisions that are required by State or federal law to be included in the Agreement with respect to all Commercial Product Types under this Commercial Product Attachment. Any additional Regulatory Requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product may be set forth in the Provider Manual or another Attachment. To the extent that a Coverage Agreement, or a Covered Person, is subject to the law cited in the parenthetical at the end of a provision on this Schedule A, such provision will apply to the rendering of Covered Services to a Covered Person with such Coverage Agreement, or to such Covered Person, as applicable.

OR-1 Hold Harmless. In the event the Payor fails to pay for Covered Services as set forth in the Coverage Agreement, each Participating Provider agrees that the Covered Person shall not be liable for any sums owed by the Payor. Participating Provider is prohibited from maintaining a civil action against a Covered Person to collect any amounts owed by the Payor for which the Covered Person is not liable to under Section 750.095 of the Oregon Revised Statutes. If a Payor is found impaired by the Director of the Department of Consumer and Business Services or a final order of liquidation is entered, as described in Section 750.085 of the Oregon Revised Statutes, any Covered Service furnished within the State by a Participating Provider to a Covered Person will be considered to have been furnished pursuant to the Agreement, provided that Payor was the payor for the Covered Services at the time they were furnished. (OR. REV. STAT. § 750.095)

OR-2 Termination; Withdrawal. Participating Provider acknowledges and agrees that this Agreement: (i) sets for adequate notice and hearing procedures, or such other procedures as are fair under the circumstances, prior to termination or nonrenewal of the Agreement when such termination or nonrenewal is based upon issues relating to the quality of patient care rendered by Participating Provider; (ii) generally provides the criteria used for the termination or nonrenewal of the Agreement; (iii) entitles Provider, upon written request by Provider, to an annual accounting summarizing the financial transactions between the Provider and HMO; and (iv) is not intended, and will not be construed, as prohibiting or restricting a Participating Provider from withdrawing from the care of a Covered Person when, in the professional judgment of the Participating Provider, he or she believes it to be in the best interest of the Covered Person to do so. (OR. REV. STAT. § 743.803(2)(a)-(d))

OR-3 Medical Director. HMO will retain a State-licensed doctor of medicine or doctor of osteopathy who will be responsible for all final medical and mental health decisions relating to Covered Services or payment made pursuant to the Coverage Agreement. (OR. REV. STAT. § 743.803(2)(e))

OR-4 No Retaliation. If Participating Provider is a State-licensed physician practicing in conformity with Oregon Revised Statute Section 677.095, the Participating Provider may advocate a decision, policy or practice without being subject to termination or penalty for the sole reason of such advocacy. (OR. REV. STAT. § 743.805(2)(f))

OR-5 Withholds. If Participating Provider is reimbursed by Payor on a basis that includes financial risk withholds, Participating Provider will make available to Payor a full accounting of health benefits claims data and related financial information in accordance with Oregon Revised Statute Section 743.803(2)(g) on no less than a quarterly basis. (OR. REV. STAT. § 743.805(2)(g))

OR-6 Continuation of Care. Participating Provider will provide continuity of care to Covered Person as provided in Oregon Revised Statute Section 743.854. (OR. REV. STAT. § 743.805(2)(h))

OR-7 Third Party Access. In accordance with Oregon Revised Statute Section 743.085, Participating Provider acknowledges and agrees that third parties (i.e., Payors) are specifically authorized by the Agreement to access the services of such Participating Provider in accordance with the terms and conditions of the Agreement.

Attachment D: Commercial

EXHIBIT 1
COMPENSATION SCHEDULE
PROFESSIONAL SERVICES

Polk County

This compensation schedule ("Compensation Schedule") sets forth the maximum reimbursement amounts for Covered Services provided by Contracted Providers to Covered Persons enrolled in a Commercial Product. Where the Contracted Provider's tax identification number ("TIN") has been designated by the Payor as subject to this Compensation Schedule, Payor shall pay or arrange for payment of a Clean Claim for Covered Services rendered by the Contracted Provider according to the terms of, and subject to the requirements set forth in, the Agreement and this Compensation Schedule. Payment under this Compensation Schedule shall consist of the Allowed Amount as set forth herein less all applicable Cost-Sharing Amounts. All capitalized terms used in this Compensation Schedule shall have the meanings set forth in the Agreement, the applicable Product Attachment, or the Definitions section set forth at the end of this Compensation Schedule.

The maximum compensation for professional Covered Services rendered to a Covered Person shall be the "Allowed Amount." Except as otherwise provided in this Compensation Schedule, the Allowed Amount for professional Covered Services is the lesser of: (i) 90% of the Allowable Charges; or (ii) the applicable "Contracted Rate" set forth below in Table 1.

Covered Services reimbursement shall be based on the current CMS RBRVS.

Table 1.

Service Category	Identifier Codes	Contracted Rate
Professional Services	As applicable	125% of the current CMS RBRVS
Allied Health Professional	As applicable	110% of the current CMS RBRVS
Drugs, Biologicals, Vaccines and Immunizations	As applicable	100% of CMS allowable.
Durable Medical Equipment and Supplies	As applicable	50% of applicable CMS DMERC allowable.
Laboratory Services	As applicable	50% of the CMS Clinical Laboratory Fee Schedule
Anesthesia Services	Anesthesia/15 minute unit. Anesthesia services reimbursed using the American Society of Anesthesiologists (ASA) guidelines	$28.80 per unit

Additional Provisions:

1. Fee Sources. In the event CMS contains no published fee amount, alternate (or "gap fill") fee sources may be used to supply the fee basis amount for deriving fee amount (the "Alternative Fee Source Amount"). Company will utilize such Alternative Fee Source Amount until such time that CMS publishes its own RBRVS value. At such time in the future as CMS publishes its own RBRVS value for that CPT/HCPCS code, Payor will use the CMS fee amount for that code and no longer use the Alternate Fee Source Amount. If there is no established payment amount on the current Medicare fee schedule or a gap fill fee source is not available for a Covered Service provided to a Covered Person, Payor may establish a payment amount to apply in determining the Allowed Amount. Until such time as Payor establishes such a payment amount, the maximum compensation shall be 30% of Allowable Charges.

2. Code Change Updates. Payor utilizes nationally recognized coding structures (including, without limitation, revenue codes, CPT codes, HCPCS codes, ICD codes, national drug codes, ASA relative values, etc., or their successors) for basic coding and descriptions of the services rendered. Updates to billing-related codes shall become effective on the date ("Code Change Effective Date") that is the later of: (i) the first day of the month following 60 days after publication by the governmental agency having authority over the applicable Product of such governmental agency's acceptance of such code updates, (ii) the effective date of such code updates as

determined by such governmental agency or (iii) if a date is not established by such governmental agency or the applicable Product is not regulated by such governmental agency, the date that changes are made to nationally recognized codes. Such updates may include changes to service groupings. Claims processed prior to the Code Change Effective Date shall not be reprocessed to reflect any such code updates.

3. Fee Change Updates. Updates to the fee schedule shall become effective on the effective date of such fee schedule updates, as determined by the Payor ("Fee Change Effective Date"). The date of implementation of any fee schedule updates, i.e., the date on which such fee change is first used for reimbursement ("Fee Change Implementation Date"), shall be the later of: (i) the first date on which Payor is reasonably able to implement the update in the claims payment system; or (ii) the Fee Change Effective Date. Claims processed prior to the Fee Change Implementation Date shall not be reprocessed to reflect any updates to such fee schedule, even if service was provided after the Fee Change Effective Date.

4. Carve-Out Services. With respect to any "Carve-Out" Covered Services as contemplated in this Agreement, any payment arrangement entered into between Provider and a third party vendor of such services shall supersede compensation hereunder.

5. Payment under this Compensation Schedule. Claims should be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative (CCI) Policy Manual, CCI table edits and other CMS guidelines). All payments under this Compensation Schedule are subject to the terms and conditions set forth in the Agreement, the Provider Manual, and any applicable billing manual and claims processing policies.

6. Modifier. Unless specifically indicated otherwise, fee amounts listed in the fee schedule represent global fees and may be subject to reductions based on appropriate Modifier (for example, professional and technical modifiers). As used in the previous sentence, "global fees" refers to services billed without a Modifier, for which the fee amount includes both the professional component and the technical component. Any Cost-Sharing Amounts that the Covered Person is responsible to pay under the Coverage Agreement will be subtracted from the Allowed Amount in determining the amount to be paid.

7. Place of Service Pricing Rules. This fee schedule follows CMS guidelines for determining when services are priced at the facility or non-facility fee schedule (with the exception of services performed at Ambulatory Surgery Centers, POS 24, which will be priced at the facility fee schedule).

8. Anesthesia Modifier Pricing Rules. The dollar amount that will be used in the calculation of time-based and non-time based anesthesia management fees in accordance with the anesthesia payment policy. Unless specifically stated otherwise, the anesthesia conversion factor indicated is fixed and will not change. The anesthesia conversion factor is based on an anesthesia time unit value of 15 minutes.

9. Durable Medical Equipment and Supplies mean the fee schedule is based upon a percentage of the CMS DMERC fee schedule applicable to the state of Oregon. Health Plan shall implement Medicare updates within 90 days of the date Health Plan receives updates from CMS.

10. Drugs, biologicals, vaccines and immunizations shall include inhaled, infused, and/or injected, supplied by, and delivered in, Provider office. Medicare Part B average sales price (ASP) will be updated quarterly, and Provider shall bill administered dosage and administration of those medications in accordance with applicable HCPCS code and the appropriate National Drug Code (NDC) number.

11. Allied health professionals include, but are not limited to Physician Assistants (PA), Certified Nurse Midwife (CNM), RN First Assist, Therapist (PT/OT/SP) and Nurse Practitioner (NP). Allied health professionals that request credentialing, as a primary care provider (PCP) and meet Health Plan's requirements for PCP status will be reimbursed at the full provider rate.

Definitions:

1. **Allowable Charges** means a Contracted Provider's billed charges for services that qualify as Covered Services.

2. **Allowed Amount** means the amount designated in this Compensation Schedule as the maximum amount payable to a Contracted Provider for any particular Covered Service provided to any particular Covered Person, pursuant to this Agreement or its Attachments.

3.

4. **Cost-Sharing Amounts** means any amounts payable by a Covered Person, such as copayments, cost-sharing, coinsurance, deductibles or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement, if applicable.

5. **DMERC** means Durable Medical Equipment Regional Carrier.

6. **Resource Based Relative Value Scale (RBRVS)** means the physician payment system used by the Centers for Medicare & Medicaid Services (CMS) and Health Plan. The locality applied will be the "Rest Of" locality for Provider's state.

Attachment D: Commercial

EXHIBIT 2
COMPENSATION SCHEDULE
EPO/PPO/POS
PROFESSIONAL SERVICES
Family Connects Oregon (FCO)

Polk County

Family Connects Oregon (FCO) has been selected as the service delivery model for the universally offered Newborn Nurse Home Visiting Program described in Oregon Administrative Rules (OARs) 333-006-0000 through 333-006-0190 (the "Program").

March 31, 2023, the Oregon Health Authority (OHA) issued coding guidance for commercial health benefit plans and outlined the reimbursement requirements for the provision of newborn nurse home visiting services (hereafter, the "OHA Guidance").

To bill for services covered under the Program, Provider must be certified as a Newborn Nurse Home Visiting Provider (NNHVP) with the Maternal Child Health section of the OHA.

In Home Visits (IHV), as defined in the OHA Guidance, and any support newborn home visits, shall be billed as a single claim and as a one-time case rate. The case rate is paid only when an IHV is completed and includes all services provided through the Program from the birth of the newborn through five months of age. A FCO case rate claim is submitted with the date of the IHV as the date of service.

There are two additional claim types for the Program. One is for a single support visit rate (Pre-IHV only) and one for services provided to multiples (twins, triplets, etc.).

Provider shall include an ICD-10-CM diagnosis code. Z76.2 (Encounter for health supervision and care of other healthy infant and child) is suggested as an appropriate diagnosis code for Family Connects claims.

CPT Code 99502 - "Home visit for newborn care and assessment", is the procedure code used for FCO claims.

A primary modifier must be added to the procedure code to indicate that a family was served through the Program. The primary modifier for all claims as part of the Program is 32. Place the primary modifier in the first modifier field on the claim.

Secondary modifiers are used with a Pre-IHV only claim and when the IHV and support visits are provided to multiple newborns (twins, triplets, etc.).

Additional modifiers should be used if services are provided using telehealth by video technology.

Notwithstanding the foregoing, any updates or changes by the OHA to the OHA Guidance or the Program that conflict with this, Attachment D shall control.

See Table A and Table B below for Family Connects billing by visit type.

Table A: Family Connects Oregon Billing by Visit Type for Single Newborn

Submit a single claim for either the single support visit rate or the case rate, but not both.			
Visit Type 333-006- 0180 through 333- 006-0190	**Family Connects Model Name**	**Coding**	**Notes**
Comprehensive newborn nurse home visit and optional support newborn home visits	IHV, Pre-IHV, and up to two follow- up visits	99502 32*Case rate- $1856.00	Submit a single claim for the IHV when 75% or more of nursing assessments are completed. One-time billing for the newborn.
A single support newborn home visit occurring before the comprehensive newborn nurse home visit	Pre-IHV only	99502 32 **TD*** Single support visit rate=$427.00	Submit a single support visit claim when the Pre-IHV: • is completed prior to 3 weeks of age AND • addresses an immediate concern AND • is the only visit completed (for example, the IHV was planned but subsequently not completed) Do not submit a single support visit claim in addition to a claim for the case rate.

*add additional modifiers as applicable.

Table B: Family Connects Oregon Billing by Visit Type for Multiple Newborns**

Submit a single claim for each newborn. Do not submit a single support visit claim in addition to a claim for the case rate/multiple newborn rate.			
Visit Type 333-006-0180 through 333-006-0190	**Family Connects Model Name**	**Client**	**Coding**
Comprehensive newborn nurse home visit and optional support newborn home visits	IHV, Pre-IHV and up to two follow-up visits	Newborn #1	99502 32* Case rate= $1856
		Each additional newborn	99502 32 TT* Multiple newborn rate= $297.00
A single support newborn home visit occurring before the comprehensive newborn nurse home visit	Pre-IHV only	Newborn #1	99502 32 TD* Single support visit rate=$427.00
		Each additional	None

*add additional modifiers as applicable. **all notes from Table A apply to Table B.

POLK COUNTY

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PUBLIC WORKS

820 S.W. ASH STREET ★ DALLAS, OREGON 97338-2112
(503) 623-9287 ★ FAX (503) 623-0897

MEMORANDUM

TO: Board of Commissioners

FROM: Todd Whitaker, Public Works Director

DATE: October 1, 2025

SUBJECT: Declaring Surplus Property

Wednesday Board Meeting
October 1, 2025

RECOMMENDATION:
That the Board approves the equipment listed on the attached spreadsheet as surplus property and instructs the Public Works Department to sell the equipment in accordance with the requirements of Polk County Code of Ordinances 15.135(1)(c) – Disposition of Personal Property.

ISSUE:
Shall the Board declare the referenced equipment as surplus and dispose of these assets?

DISCUSSION:
The list of vehicles and equipment on the attached spreadsheet have outlived their useful life. The passenger vehicles are planned to be auctioned on Public Surplus. The Heavy equipment and commercial vehicles will be sold through Bar None.

FISCAL IMPACT:
The revenue from the sale of each piece of equipment will be deposited into line item 7100 Sale of Surplus Equipment – in each of the corresponding department's budgets who purchased the equipment.

Equipment List

Polk Co. Project Code	Description	Year	Make	Model	Verified Mileage/Hours	Engine	Features	Serial #/VIN	Original Price	Salvage Value (est)
G0501	Stationary Generator w/ Transfer Switch	2005	OLYMPIAN	D150P1	220 Hrs		187.5KVA, 150KW, 3 Phase, 120/240v, 300 gal. capacity	014358(engine interface module)	$ 41,742	
T0408	1999 Freightliner Box Truck	1999	Freightliner	FL70	220,000	Cat 3126	24 Ft Box with liftgate		$ 16,000	
P1922	2015 Starcraft Bus	2015	Ford	E350 Econoline	53,152	5.4L V-8	12 seated passengers plus driver w/ 2 wheelchair positions.	1FDEE3FL4FDA12207	$ 48,580	
P0315	2003 Ford E350 Bus	2003	Ford	E350 Econoline	87,575	5.4L V-8	A/C Not Working		$ 24,470	
T942	Culvert Truck	1994	GMC	W5		6.5 L Diesel	No box on the truck, Auto Transmission		$ 55,909	
S2020	2020 Dodge Durango	2020	Dodge	Durango Pursuit	103,000	5.7 L V8 Hemi	Engine Overheats, All Wheel Drive , Auto Transmission	1C4SDJFT2LC448554		$ 18,000
P0413	Red GRSD Truck	2000	GMC	S15	191,851	2.2 4 Cyl	Check Engine light is on. Auto Trans			$ 1,500
P9914	Survey Pickup	2000	Ford	F150	192,201	4.6 V8 Engine	4x4 Supercab, Auto transmission	1FTRX18WXYNA89933	$ 21,556	$ 2,500
S1811	2019 Dodge Durango	2019	Dodge	Durango Pursuit	127,682	5.7 L V8 Hemi	Engine Overheats, All Wheel Drive , Auto Transmission	1C4SDJFT6JC474359		$ 17,000
S1910	2019 Dodge Durango	2019	Dodge	Durango Pursuit	138,135	5.7 L V8 Hemi	Engine Overheats, All Wheel Drive , Auto Transmission	1C4SDJFT4KC812214		$ 17,000
S1724	2018 Ford Explorer	2018	Ford	Explorer	186,120	V-6	All Wheel Drive, Auto Transmission	1FM5K8AR2JGA15843	$ 32,892	$ 7,000
S2024	2014 Chevy Tahoe	2014	Chevrolet	Tahoe	119,454	5.3 L V-8	4x4 Auto transmission	1GNSK2E02ER175335	$ 4,500	$ 4,000
P0803	Turtle Truck	2001	Ford	F350	193,938	v10	Auto Transmission	1FDWW36S31ED08878		$ 4,000

Plan to sell through Bar None auctionhouse.
Plan to sell through Public Surplus online auction.