**SCHEDULE C**
**PREFERRED PROVIDER/GROUP AGREEMENT**
**ALASKA STATE LAW AND REGULATION PROVISIONS**

With respect to any Payor that is a health care insurer as defined in AS 21.54.500, as it may be revised, renumbered, or replaced, the provisions set forth in this Schedule C are fully operative and applicable to FCHN, Provider, and the respective Payors under the Agreement to which this Schedule C is attached. For Payors meeting the definition described above, in the event of any conflict between the provisions set forth in this Schedule C and the other terms of the Agreement, the provisions of this Schedule C shall have priority. Except as modified by this Schedule C, all terms and conditions of the Agreement to which this Schedule C is attached remain in full force and effect.

With respect to any Payor that is a health care insurer as defined in AS 21.54.500, as it may be revised, renumbered or replaced:

**1. Definitions.** Sections 1.9, 1.16, and 1.21 of the Agreement are deleted in their entirety and the following are substituted therefor:

**1.9 Emergency Medical Condition**, also referred to in applicable state law as a medical emergency, means the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain that the absence of immediate medical attention would reasonably be expected by a prudent person who possesses an average knowledge of health and medicine, to result in:

a. placing the Participant’s health in serious jeopardy;
b. serious impairment to bodily functions; or
c. serious dysfunction of any bodily organ or part.

**1.16 Primary Care Provider (“PCP”)** means a Participating Provider who is an allopathic or osteopathic physician or other licensed healthcare provider who provides general medical care services and does not specialize in treating a single injury, illness, or condition or who provides obstetrical, gynecological, or pediatric medical care services.

**1.21 Utilization Review** means a system of reviewing the medical necessity, appropriateness, or quality of medical care services and supplies provided under a Benefit Plan using specified guidelines, including preadmission certification, the application of practice guidelines, continued stay review, discharge planning, preauthorization of ambulatory procedures, and retrospective review.

**2. Responsibilities of Provider.** The first paragraph of Section 2.1 of the Agreement, all of Section 2.5, and the first paragraph of Section 2.9 of the Agreement are deleted in their entirety and the following are substituted therefor:

**2.1 Provide or Arrange for Covered Services.**
For each Participant, Provider shall provide, or arrange for the provision of Covered Services on a timely basis, without regard to health status or medical condition, and in accordance with generally accepted medical practice guidelines and standards pursuant to the terms of this Agreement, and in accordance with applicable FCHN policies and procedures set forth in FCHN's Provider Manual. Except in the case of an Emergency Medical Condition, Provider agrees to verify each Participant's eligibility prior to providing Covered Services. In the case of an Emergency Medical Condition, Provider will use its good faith best efforts to notify FCHN or the appropriate Payor of the provision of Medically Necessary services to treat a Participant’s Emergency Medical Condition during the first business day immediately following the provision of such services.

**2.5 Benefit Plan Participation.** Provider hereby authorizes Payors contracting with FCHN or its Affiliates to offer Provider’s services to groups of employees or individuals in accordance with the provisions of any Benefit Plans offered by such Payors. Provider’s services are not offered in connection with motor vehicle insurance, personal injury protection, workers compensation, or any other program for the payment of healthcare services that is excluded from the definition of a health benefit plan or a health care insurance plan under applicable law.

**2.9 Medical Management, Utilization Review and Quality Improvement.**
Provider agrees to comply with and participate in FCHN's or Payors' Medical Management, Utilization Review, and quality improvement programs and requirements, whichever is applicable, which may include but are not limited to, pre-authorization, notification, concurrent review, retrospective review, case management, disease management programs, pharmacy and specialty pharmacy programs, referral management, quality assurance and improvement programs and Medical Necessity oversight. FCHN will require that Utilization Review decisions to deny, reduce, or terminate a health care benefit or to deny payment for a medical care service because that service is not Medically Necessary shall be made by an employee or agent of a Payor who is a licensed healthcare provider.

**3. Responsibilities of FCHN.** Sections 3.5 and 3.6 of the Agreement are deleted in their entirety and the following are substituted therefor, and the following new Section 3.12 is added to the Agreement:

**3.5 Eligibility.** FCHN shall require all Payors contracting with it to provide timely notification on a Participant's eligibility for Covered Services upon request by Provider. FCHN shall require that during ordinary business hours, Payors shall assure reasonable access, through standard means of communication, for the confirmation that services are Covered Services and a Participant is eligible under a Benefit Plan. FCHN shall require that Payors respond to Provider's request for prior authorization of non-emergency services within 72 hours after receiving the request for preapproval and to Provider's request for approval of Covered Services following emergency services as soon as practicable, but in any event not later than 24 hours after receiving the request for preapproval or coverage determination.

**3.6 Provider's Right to Inform Patients.** FCHN shall not, and shall require that Payors shall not, penalize Provider, and FCHN shall not terminate this Agreement, all of the foregoing on the basis that Provider has acted as an advocate for a Participant in seeking appropriate, Medically Necessary medical care services. FCHN shall not, and shall require that Payors shall not, prohibit or discourage, and nothing in this Agreement shall be construed to prohibit or discourage, Provider from communicating openly with a Participant about all appropriate diagnostic testing and treatment options. Nothing in this Agreement shall be construed to authorize Provider to bind FCHN or Payors to pay for any services.

**3.12 Prohibition on Incentives to Withhold Care.** No provision in this Agreement shall be construed to have as its predominant purpose the creation of direct financial incentives to Provider for withholding Covered Services that are Medically Necessary. Nothing in this Section shall be construed to prohibit this Agreement from containing incentives for efficient management of the utilization and cost of Covered Services.

**4. Claims Submission and Payment.** Section 4.2 of the Agreement is deleted in its entirety, and the following is substituted therefor:

**4.2 Payment of Claims.**
FCHN shall require all Payors to pay Provider pursuant to Schedule B of this Agreement, as soon as practical, subject to the following minimum standards:

**4.2.1** Claims shall be paid or denied, whether or not services were provided by a Participating Provider, within 30 calendar days after the Payor receives a Clean Claim.

**4.2.2** If a Payor does not pay or denies a claim, the Payor shall give notice to the Participant or to the Provider, as appropriate, of the basis for denial or the specific information that is needed for the Payor to adjudicate the claim. Such notice shall be given within 30 calendar days after the Payor receives the claim.

**4.2.3** If a Payor does not provide the notice required under Section 4.2.2, the claim is presumed to be a Clean Claim, and interest shall accrue at a rate of fifteen percent (15%) annually beginning on the day following the day that the notice was due and shall continue to accrue until the date that the claim is paid.

**4.2.4** If a Payor provides the notice required under Section 4.2.2 and requests specific information that is needed to adjudicate the claim, the Payor shall pay the claim not later than 15 calendar days after receipt of the information specified in the notice or within 30 days after receipt of the claim. If a Payor does not pay the claim within the time period required under this Section 4.2.4, the claim is presumed to be a Clean Claim, interest at a rate of fifteen percent (15%) per year accrues, and interest will continue to accrue until the date the claim is paid.

**4.2.5** Interest shall be calculated monthly as simple interest at the rate of 1.25% per month, prorated for any portion of the month. For purposes of Section 4.2.3 and 4.2.4, if only a portion of the claim is covered under the terms of the Benefit Plan, interest accrues based only on the portion of the claim that is covered. For purposes of this Section 4.2, a claim is considered paid on the day a payment is mailed or transmitted electronically. Payment of any interest in the amount of one dollar ($1.00) or less, or such revised amount as may be established under applicable law or regulation, is not required.

**4.2.6** Claims may be subject to code review software or correct coding edits. FCHN will request that Payors inform FCHN of code review or correct coding software and most frequent claims editing issues for FCHN as needed to facilitate Provider education and training.

FCHN is not the guarantor of, or in any way responsible to Providers for, any claims payments, including charges and interest due if applicable. FCHN shall meet with Provider as needed to review claims status of FCHN Payors and to assist Provider in collecting payments due and owing from any such Payor as determined by FCHN to be appropriate.

**5. Term and Termination.** Sections 8.3.3 and 8.3.4 of the Agreement are deleted in their entirety and the following is substituted therefor:

**8.3.3** A Participant may continue to be treated by Provider as provided in this Section. If a Participant is pregnant or being actively treated by Provider on the effective date of termination of this Agreement, the Participant may continue to receive Covered Services from Provider as provided in this Section, and this Agreement shall remain in force with respect to the continuing treatment. The Participant shall be treated for the purposes of benefit determination or claim payment as if Provider were still a party to this Agreement. However, treatment is required to continue only while the Participant's Benefit Plan remains in effect and

a. for the period that is the longest of the following:
   1. the end of the current Benefit Plan year;
   2. up to 90 days after the termination date, if the event triggering the right to continuing treatment is part of an ongoing course of treatment;
   3. through completion of postpartum care, if the Participant is pregnant on the effective date of termination; or

b. until the end of the Medically Necessary treatment for the condition, disease, illness, or injury if the Participant has a terminal condition, disease, illness or injury. In this paragraph, "terminal" means a life expectancy of less than one year.

**6. Dispute Resolution.** Section 9.1 of the Agreement is deleted in its entirety and the following is substituted therefor:

**9.1 Dispute Resolution Process**

Except as otherwise provided in Section 9.2, the following dispute resolution process will be used to resolve disputes between Provider and FCHN as well as disputes between Provider and Payor.

**9.1.1 Process**

In the event of a dispute between Provider and FCHN with regard to performance by either party under this Agreement, including questions regarding existence, enforceability, interpretations, or validity of this Agreement, the parties agree to use the following fair, prompt, and mutual dispute resolution process.

Provider shall promptly notify FCHN of any failure by a Payor to pay Provider in accordance with the requirements of Section 4.2 of this Agreement, to provide information regarding Participant eligibility and benefit confirmation, to provide any other information required under the terms of this Agreement, or of any disagreement with a determination of Medical Necessity made pursuant to Provider's billing for Covered Services pursuant to this Agreement. Disputes related to the foregoing issues, as well as other disputes between Provider and a Payor regarding performance under this Agreement shall be resolved using the following fair, prompt, and mutual dispute resolution process.

**9.1.2 Initial Meeting**

Where either (i) Provider or FCHN, in the case of a dispute between them, or (ii) Provider or a Payor, in the case of a dispute between them, desires to pursue resolution of a dispute, either party to the dispute in question may provide the other party to the dispute with written notice, describing the nature of the dispute and the proposed resolution with reasonable particularity, and requesting a meeting. In such event, the parties to the dispute will convene an initial meeting at which both parties are present or represented by individuals with authority regarding the matters in dispute. The initial meeting shall be held within ten (10) working days after FCHN or the Payor, as applicable, receives notice of the dispute or gives written notice to Provider, unless the parties agree in writing to a different schedule.

**9.1.3 Nonbinding Mediation**

If Provider and FCHN, in the case of dispute between them, or Provider and Payor, in the case of a dispute between them, have not resolved a dispute within thirty (30) days following the initial meeting described above, the dispute shall be submitted to nonbinding mediation. Promptly after the end of such thirty (30) day period, the parties to the dispute will confer and appoint a mutually acceptable mediator who is not regularly under contract to or employed by either of such parties. If the parties are unable to agree upon the selection of a mediator within five (5) days, they shall jointly petition to the Presiding Judge of a state court of competent jurisdiction to appoint a mediator who satisfies the same qualifications. Mediation shall be conducted pursuant to the mediation rules and procedures of the mediator as consistent with applicable state law, or according to any other rules of mediation agreed to by the parties. Following selection, the mediator shall schedule a mediation conference with the parties, the duration of which shall be one (1) day, or such longer period as the parties to the dispute may agree. Unless otherwise agreed, the mediation conference shall be held within twenty (20) days after appointment of the mediator. The place of mediation shall be a location mutually agreed upon by the parties to the dispute; however, if the parties cannot agree, the mediation will be held in Seattle, Washington. The fees and expenses of the mediator shall be borne equally by the parties to the dispute. Each party shall be responsible for its own costs and expenses incurred in connection with the mediation.

**9.1.4 Other Remedies**

In the event the parties to the dispute cannot resolve a dispute through nonbinding mediation within sixty (60) days following commencement of the mediation, either party may seek other relief allowed by law, which relief shall be pursued and/or enforced, as appropriate, in a court of competent jurisdiction. The parties agree to exhaust the dispute resolution process set forth in Sections 9.1.2 and 9.1.3 above before pursuing such other remedies. The parties consent to the jurisdiction of the Superior Court of the State of Washington, King County, and the United States

District Court for the Western District of Washington, for all purposes in connection with this Agreement.

**9.1.5 Good Faith Discussions**
FCHN and Provider agree, and FCHN will require that Payors agree, to negotiate in good faith in the initial meeting and in mediation.

**7. General Provisions.** Section 10.9 of the Agreement is deleted in its entirety and the following is substituted therefor:

**10.9 Applicable Law.** This Agreement shall be interpreted, enforced, and governed in accordance with the laws of the State of Washington, notwithstanding any conflict of law doctrine to the contrary; provided, however that the substantive laws of the State of Alaska shall govern the interpretation and enforcement of the provisions of Schedule C attached to this Agreement. Venue for any action or proceeding shall lie in King County, Washington.

**8. Additional Provisions applicable to Medical Service Corporations.** AS 21.87 includes additional requirements applicable to agreements between Medical Service Corporations, as defined in AS 21.87.330, and Providers. Therefore, the following new Section 11 is added to the Agreement, and is applicable only to Payors that are Medical Service Corporations as defined in AS 21.87.330, and to FCHN and Provider with respect to such Payors.

**11. Additional Provisions; Medical Service Corporations.**
**11.1 Direct Obligation.** Provider's obligation to furnish Covered Services to Participants shall be a direct obligation of Provider to the Participant as well as to FCHN and Payors.

**11.2 Payment for Covered Services.** Provider shall be compensated for Covered Services rendered to a Participant in accordance with the terms of this Agreement, and Provider may not request or receive from Payors payment for services that is not in accordance with such terms. Payment for Covered Services may be prorated and settled under the circumstances and in the manner referred to in AS 21.87.300, as it may be revised, renumbered, or replaced.

**11.3 Provider Withdrawal.** If Provider withdraws from this Agreement, including by way of termination under Section 8 of this Agreement, the termination of this Agreement may not be effective as to a Participant's Benefit Plan in force on the effective date of termination until the termination of the Participant's Benefit Plan or the next anniversary of the Participant's Benefit Plan, whichever date is earlier.